Who are we?

The Health and Wellbeing Board is a joint board of the Council and CCG which provides the strategic leadership for the health and social care in the city. Meetings are open to the public and everyone is welcome.

Where and when is the Board meeting?

This next meeting will be held in the **Auditorium - The Brighthelm Centre** on **Tuesday, 7 June 2016**, starting at **4.00pm**. It will last about two and a half hours.
There is public seating and observers are welcome.

Please note that there will be no informal Q&A session preceding this meeting.

What is being discussed?

There are **three** main items on the agenda:

- The Sustainability & Transformation Plan for Sussex and East Surrey
- The Annual Report of the Director of Public Health for Brighton & Hove
- Quarterly Update on the Better Care Fund – including information about Delayed Transfers of Care, the Living Well project and the Disabled Facilities Grant

Health & Wellbeing Board

Geoff Raw
Chief Executive - BHCC
(Non-voting)

Cllr Yates
Chair
(Voting member)

Natasha Watson
Lawyer BHCC

Giles Rossington
Secretary - BHCC

Dr. Christa Beesley
CCG
(Voting member)

Cllr K. Norman
(Voting member)

Cllr Brown
(Voting member)

Peter Wilkinson
Public Health Manager - BHCC
(Non-voting Statutory member)

John Child
CCG
(Voting member)

Dr. Manas Sikdar
CCG
(Voting member)

Graham Bartlett
Safeguarding Children's & Adults
(Non-voting co-optee)

Pinaki Ghoshal
Director Children's Services - BHCC
(Non-voting Statutory Member)

Lead Member
(In attendance - Non-voting)

Denise D'Souza
Director Adult Services - BHCC
(Non-voting Statutory member)

Dr. Xavier Nalletamby
CCG
(Voting member)

Cllr Page
(Voting member)

Dr. George Mack
CCG – Lay Member
(Voting member)

David Liley
Healthwatch
(Non-voting Statutory member)

Pennie Ford
NHS England
(Non-voting co-optee)

Cllr Barford
Lead Member for Adult Services
(Voting member)

Cllr Penn
Lead Member for Mental Health
(In attendance – Non-voting)

Presenting Officer
or
Public Speaker

Presenting Officer
or
Public Speaker

Press

Public Seating

Officers and Representatives
attending

Health & Wellbeing Board
MeetingDate
4.00pm
Brighthelm Church & Community
CentreAuditorium - The Brighthelm Centre

Who is invited:

Yates (Chair), K Norman (Opposition Spokesperson), Brown, Page and Barford; Dr Christa Beesley (Brighton and Hove Clinical Commissioning Group), Dr George Mack (Brighton and Hove Clinical Commissioning Group), Dr Xavier Nalletamby (Brighton and Hove Clinical Commissioning Group) and Dr. Manas Sikdar (Brighton and Hove Clinical Commissioning Group); Denise D'Souza (Statutory Director of Adult Services), Pinaki Ghoshal (Statutory Director of Children's Services), Graham Bartlett (Brighton & Hove Local Safeguarding Children's Board & Adult Safeguarding (Combined Role)), Pennie Ford (NHS England), David Liley (Healthwatch) and Peter Wilkinson (Acting Director of Public Health)

Contact: **Giles Rossington**
Senior Scrutiny Officer
01273 29103806
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This Agenda and all accompanying reports are printed on recycled paper

Date of Publication - Friday, 27 May 2016

AGENDA

Formal matters of procedure

This short formal part of the meeting is a statutory requirement of the Board

Page

1 DECLARATIONS OF SUBSTITUTES AND INTERESTS AND EXCLUSIONS

The Chair of the Board will formally ask if anyone is attending to represent another member, and if anyone has a personal and/or financial interest in anything being discussed at the meeting. The Board will then consider whether any of the discussions to be held need to be in private.

2 MINUTES **1 - 22**

The Board will review the minutes of the last meeting held on the 19th April 2016, decide whether these are accurate and if so agree them.

3 CHAIR'S COMMUNICATIONS

The Chair of the Board will start the meeting with a short update on recent developments on health and wellbeing.

4 FORMAL PUBLIC INVOLVEMENT

This is the part of the meeting when members of the public can formally ask questions of the Board or present a petition. These need to be notified to the Board in advance of the meeting. Ring the Secretary to the Board, Giles Rossington on 01273 295514 or send an email to giles.rossington@brighton-hove.gov.uk

The main agenda

Papers for Discussion at the Health & Wellbeing Board

5 SUSTAINABILITY & TRANSFORMATION PLAN (STP)

Presentation on progress in developing a Sustainability & Transformation Plan for Sussex and East Surrey (verbal)

Health & Wellbeing

6 **Annual Report of the Director of Public Health** 23 - 28

Contact: *Peter Wilkinson* *Tel: 01273 296562*
Ward Affected: *All Wards*

7 **Section 75 Better Care Fund Quarterly Report - March 2016** 29 - 42

Contact: *Ramona Booth*
Ward Affected: *All Wards*

8 **Living Well Project Update** 43 - 52

Contact: *Joel Caines* *Tel: 01273 292027*
Ward Affected: *All Wards*

9 **Disabled Facilities Grant (DFG) Update Report** 53 - 58

Contact: *Sarah Potter* *Tel: 01273 293168*
Ward Affected: *All Wards*

Papers to Note at the Health & Wellbeing Board

10 **Brighton and Hove Clinical Commissioning Group - Final Commissioning Intentions 2016/17** 59 - 220

Contact: *John Child*
Ward Affected: *All Wards*

11 **Monitoring Quality in Care Services** 221 - 244

Contact: *Marnie Naylor* *Tel: 01273 296033*
Ward Affected: *All Wards*

Part Two

12 **PART TWO MINUTES** 245 - 246

To consider the part two minutes of the meeting held on 19th April 2016.

13 **PART TWO PROCEEDINGS**

To consider whether the items listed in Part Two of the agenda and decisions thereon should remain exempt from disclosure to the press and public.

Health & Wellbeing

WEBCASTING NOTICE

This meeting may be filmed for live or subsequent broadcast via the Council's website. At the start of the meeting the Chair will confirm if all or part of the meeting is being filmed. You should be aware that the Council is a Data Controller under the Data Protection Act 1988. Data collected during this web cast will be retained in accordance with the Council's published policy (Guidance for Employees' on the BHCC website).

For further details and general enquiries about this meeting contact Democratic Services, 01273 2910386 or email democratic.services@brighton-hove.gov.uk

Public Involvement

The Health & Wellbeing Board actively welcomes members of the public and the press to attend its meetings and holds as many of its meetings as possible in public.

If you wish to attend and have a mobility impairment or medical condition or medical condition that may require you to receive assisted escape in the event of a fire or other emergency, please contact the Democratic Services Team (Tel: 01273 291066) in advance of the meeting. Measures may then be put into place to enable your attendance and to ensure your safe evacuation from the building.

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An Induction loop operates to enhance sound for anyone wearing a hearing aid or using a transmitter and infra-red hearing aids are available for use during the meeting. If you require any further information or assistance, please contact the receptionist on arrival.

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- You should proceed calmly; do not run and do not use the lifts;
- Do not stop to collect personal belongings;
- Once you are outside, please do not wait immediately next to the building, but move some distance away and await further instructions; and

Do not re-enter the building until told that it is safe to do so.

Health & Wellbeing

1. Procedural Business

(a) Declaration of Substitutes: Where Members of the Board are unable to attend a meeting, a designated substitute for that Member may attend, speak and vote in their place for that meeting.

(b) Declarations of Interest:

(a) Disclosable pecuniary interests
(b) Any other interests required to be registered under the local code;
(c) Any other general interest as a result of which a decision on the matter might reasonably be regarded as affecting you or a partner more than a majority of other people or businesses in the ward/s affected by the decision.

In each case, you need to declare
(i) the item on the agenda the interest relates to;
(ii) the nature of the interest; and
(iii) whether it is a disclosable pecuniary interest or some other interest.

If unsure, Members of the Board should seek advice from the Lawyer or Secretary preferably before the meeting.

(c) Exclusion of Press and Public: The Board will consider whether, in view of the nature of the business to be transacted, or the nature of the proceedings, that the press and public should be excluded from the meeting when any of the items are under consideration.

NOTE: Any item appearing in Part Two of the Agenda states in its heading the category under which the information disclosed in the report is exempt from disclosure and therefore not available to the public.

A list and description of the exempt categories is available from the Secretary to the Board.

4.00pm 19 April 2016

The Ronuk Hall,
Portslade Town Hall

Minutes

Present: Councillors Yates (Chair), K Norman (Opposition Spokesperson), Mac Cafferty (Group Spokesperson), Barford, G Theobald Dr. Christa Beasley, John Child, Dr. George Mack; Dr. Xavier Nalletamby, and Jennifer Oates, Clinical Commissioning Group.

Other Members present: Frances McCabe Healthwatch, Pennie Ford, NHS England, Mia Brown, Adults and Children's Safeguarding Boards, Pinaki Ghoshal, Statutory Director of Children's Services Denise D'Souza, Statutory Director of Adult Social Care, Peter Wilkinson, Acting Director of Public Health and Geoff Raw, Chief Executive of Brighton & Hove City Council.

Also in attendance: Councillor Penn.

Apologies: Dr Manas Sikdar and Graham Bartlett.

Part One

68 DECLARATIONS OF SUBSTITUTES AND INTERESTS AND EXCLUSIONS

68.1. The Chair noted that the following were attending the meeting as substitutes for their respective colleagues:

Ms. Jenny Oates for Dr. Manas Sikdar
Ms. Mia Brown for Graham Bartlett

1

68.2. The Chair also welcomed Peter Wilkinson to the meeting and noted that following Tom Scanlon's departure he was the Acting Director of Public Health.

68.3. The Chair noted that there were no declarations of interest in matters appearing on the agenda and that were no items listed in Part 2 of the agenda, although confidential appendices relating to Items 72 and 73 had been circulated to Members of the Board. He hoped that discussions could be kept in the open session of the meeting but noted that should Members of Board wish to discuss specific matters there may be a need to move into closed session and aske members of the press and public to withdraw for the duration of the discussion. Otherwise he sought agreement that the meeting should remain open to the press and public.

68.4. **RESOLVED:** That the press and public be not excluded from the meeting subject to the exception highlighted by the Chair above.

69 MINUTES

69.1. The minutes of the last meeting held on the 15th March 2015 were approved as a correct record and signed by the Chair.

69.2. The Chair noted that at the last meeting of the Board, it had been agreed that a response to Mr. Kapp's question would be provided by NHS England which had been done. However, for the benefit of the Board and the record, he asked that a copy of the response be included in the minutes:

"Dear Mr Kapp

Wish Park Surgery moved into new purpose-built premises in August 2015 and the practice is confident that this will provide them with the opportunity to expand services for their existing patients and to provide care to more local patients over the coming years.

After the closure of the former Goodwood Court GP practice, Wish Park Surgery confirmed that they would be able to register a number of patients from this practice if they wished to register with them. Some former Goodwood patients did subsequently register with Wish Park Surgery, although the majority of these patients have been able to remain being treated by Charter Medical Centre in Hove following initial arrangements that were made there for their ongoing care.

Following Wish Park Surgery's move to new premises, the practice has been working to increase the number of clinical staff employed at the surgery in order to support patient care. Unfortunately, the practice has not yet been able to recruit an additional permanent GP to work at the practice, but is continuing work to get additional clinical staff in place as soon as possible.

In order to ensure a continued safe and good quality service to their existing patients in the meantime, the practice has informed NHS England that they need to temporarily halt new patient registrations at the immediate time, while work takes place to secure the additional clinical staff necessary to enable the practice to treat additional patients.

The practice is however able to register the children of parents already registered at the practice, or any first degree relatives of patients already registered at the practice who live at the same address.

The practice is hoping to start accepting new patient registrations again as soon as possible.

NHS England is continuing to liaise with local GP practices in Brighton and Hove following the decision of the Practice Group to give notice on their contract to provide services at five local GP surgeries. We have determined a plan to secure the future care of patients who use the Brighton Homeless Healthcare Surgery and are continuing work to secure ongoing care for patients who use the other four surgeries affected.

We are mindful of the need to make sure we respond to this situation in a planned and managed way, which supports sustainability and does not have a detrimental impact on services for other patients in the city."

70 CHAIR'S COMMUNICATIONS

70.1. The Chair outlined the following as part of his Chair's communications.

The Power of Volunteering

70.2. On 21st April there will be an event to celebrate the fantastic work being done across the city by our volunteers and organisations, as well as looking to the future and how we can continue to make Brighton & Hove a city which champions volunteering. If you wish to attend please contact Charmian Hay-Ellis on 01273 291036 or charmian.hay-ellis@brighton-hove.gov.uk

Martin Fisher Foundation

70.3. Professor Martin Fisher who led the HIV services in Brighton and Hove passed away last year. Since then The Martin Fisher Foundation has been established to take forward the legacy of the incredible work which Martin led to treat with dignity, compassion and respect patients with HIV and focus on the development of new strategies for effective treatment and prevention.

70.4. I will be meeting with some of the Foundation Advisory Committee this month to get an understanding of their work and how the Board can support their activities.

Brighton and Hove Impetus Peer review

70.5. Impetus is engaging in a Peer Review of its BHCC-contracted NHS Independent Complaints Advocacy Service (ICAS) in the spring of 2016. The review will work with peer services in Bexley and Dorset to assess service delivery in relation to the LGA Practice Guidelines for Independent Health Complaints Advocacy Services, share best practice, consider value for money, and make recommendations for service improvements. It is thought this is the first review of its kind in the country, and look forward to using the process to continue to develop the service. Members of the Board may be involved and the Board would welcome an update on the review when it has been finished.

The Practice Group

70.6. As the Board are aware we had an open and informative Q&A panel at the last meeting which enabled a number of residents and Board members ask questions about the Practice Group and what may happen to their services. Following on from that meeting a range of activity has been undertaken to further understand the specific needs of local communities and their access to alternative services.

70.7. As Chair of the Board I will be attending a further meeting with the Chair of Overview and Scrutiny that is being convened on 25th April by NHS England, where the ongoing care of patients will be discussed further with local community and patient representatives.

70.8. NHS England will then update patients as soon as the final decision regarding their ongoing care has been made. Our next Board after today is not until 7th June. As decisions and information becomes known I will ask NHS England to inform me and I will circulate to Board members. I will also ensure that there is an update on the Councils website for residents.

Progress Report on Community Meals End of Contract

70.9. Brighton & Hove City Council's Community Meals Service contract (meals delivered to people in their own homes) with the Royal Voluntary Service ('the RVS') ended on the 31st of March 2016. This followed a significant reduction in numbers requesting the service year on year and lead to the RVS concluding that due to the costs of their current operating model, they could not continue the Contract without uplift in funding from the Council. This was not available.

70.10. In December 2015, following market research, the Council conducted a procurement exercise to seek new providers who operated meals delivery services. The intention was to find multiple providers who would be 'approved' by the council to ensure choice for customers. The goal of the service would still be to provide wholesome and nutritious meals to customers and to promote the health, wellbeing and independence of people living at home at risk of being malnourished.

Providers would be asked to offer nutritious meals, a Safe and Well check and meals would be available 365 days a year. The service would be solely funded by customers and there would be no subsidy.

70.11. At the end of February 2016 three providers had come forward, two providing hot & chilled meals (License to Freeze and Mother Theresa's) and one providing frozen meals (Oakhouse). The two providers of hot food were already on the approved list for East Sussex County Council. The applications were assessed in conjunction with the Brighton & Hove Food Partnership, all satisfying the criteria around nutrition and the Safe and Well check. In addition the two hot meal providers locally source their food.

70.12. In moving to a change of community meals provider, communication to existing RVS customers was clearly critical:

- The Adult Social Care Commissioning team engaged with the meal customers regularly, sending out letters and information about the meal changes once known, with phone numbers and emails to contact the council. The RVS delivered these communications personally

- Letters were sent to any relatives who were involved and a series of FAQs were placed onto the council website.

- All social work teams were informed and the commissioning team allocated a member of staff to analyse the client list and find support for as many clients as possible to transition to a new provider. This included Seniors Housing, home care providers, voluntary sector providers and the operational social work teams, particularly the SPFT Mental Health team.

- The RVS also flagged vulnerable clients they considered would need support.

- This was then followed up by the Commissioning team telephoning the 200 customers and in many cases their relatives. By 29th March there were only 21 people who had not been contacted (no phone number, wrong number, not returning calls) and during the first week of April they were all mailed with offers of support again.

70.13. AccessPoint, Carelink, Seniors Housing & homecare providers (independent & in-house) were alerted on 31st March that it was the last day of the RVS meal service in case of issues. Since this time AccessPoint have only informed of two customers contacting them with queries which were easily solved.

70.14. The commissioning team have also been keeping in close contact with the new providers to deal with queries. In summary, customers have mainly been positive about the changes, many of the older people phoning to inform what they are doing (including where to buy cheap microwaves). Fears around higher costs of the new

meals (at least £2 more for two courses) do not seem to have been realised as many customers had not realised that their meals were subsidised. Many have chosen one of the new providers – License to Freeze have taken on 60+ customers, Oakhouse 10 customers, and Mother Theresa's up to 20 customers. Others have chosen to use Coleman's (about 8) and Wiltshire Farm Food (about 13) – providers of chilled food neither of whom applied to be on our approved list. Marks & Spencer food also features. Feedback from License to Freeze confirmed that they think it is going well – each day the meals are getting there more quickly as the addresses are becoming known by the drivers. People receiving the meals are happy with the food and accept that that there will be a delay whilst a new service beds in.

70.15. The commissioning team plan to do follow-up calls in about a month to see how the smooth the transition has been followed by a full report to HWB in July 2016

National Carers Week

70.16. National Carers Week this year is from the 6th to 12th June, the theme builds on last years "Carer Friendly Communities" - places where carers feel supported to look after their family or friends, and recognised as individuals with their own needs. Focusing on four keys areas that need to become more Carer Friendly - Health Services; Care Services; Employers; and Education.

70.17. Adult Social Care will be co-ordinating a range of events in partnership with members of the local Carers Strategy Group - CCG, Children's Services, Public Health, and key third sector organisations - aiming to raise awareness of carers locally, surveying how carer friendly local services are, and promoting the range of services and opportunities that are available for carers.

70.18. We are planning 2 large events - one aimed at Young Carer, and one at Adult Carers, as well as a number of promotional events launching new initiatives for carers locally - new local Carers Guide; Carers Self Assessment; and the Carers Digital Offer. Should you wish to know more, or want to get involved please contact Gemma Scambler (gemma.scambler@brighton-hove.gov.uk, or 01273-295045)

Sustainability and Transformation Plan

70.19. This is the name of the new planning framework for the NHS services that was announced in December. A draft initial submission has been made for our area and John Child will be giving us an update as part of the Board later.

South East Coast Ambulance Service – Patient Transport Service

70.20. At the last Board we reported that the Chief Executive of SECamb is currently on a leave of absence and the Chair has resigned. Since this meeting, Sir Peter Dixon

has been appointed as Interim Chair. Sir Peter has been making contact with the various organisations and committees and we look forward to meeting him.

70.21. The Board is aware of the recent news items about SECamb and are also aware that Overview and Scrutiny will continue to monitor this. A letter from the Chief Operating Officer of the CCG has also been circulated and will be listed as a supporting document to the minutes of the meeting.

71 FORMAL PUBLIC INVOLVEMENT

71.1. The Chair noted that a total of 5 public questions had been submitted and that 3 of these related to Item 76, Sustainability and Transformation Plan. In view of this he proposed to take the questions when the item was reached so that they could be considered as part of the wider discussion on the issue.

71.2. The Chair then invited Mr. Kapp to come forward and to put his question to the Board.

71.3. Mr. Kapp thanked the Chair and asked the following, "Will Rough Sleepers be treated under the Better Care Fund Plan (item 75) and the Wellbeing Service Contract 2017/22 (agenda item 74)?"

71.4. The Chair replied, "Yes they are included under the model described on 115-116 of the papers (11-12 of the Better Care Plan). With regard to the Wellness Strategy, yes, we do we want rough sleepers to be able to access the support that is available both in the IAPT and the community wellbeing service and we think it is important that people with complex needs, including people who are homeless are supported to access these services and that the services are able to respond to their needs. This could include for example the provision of support to help people prepare for a course of treatment or offering flexible appointments in a range of locations."

71.5. Mr. Kapp asked the following supplementary question, "Will persons receiving Personal Independence Payments (PIPs) be required to attend treatment under the Better Care Fund Plan (item 75) or the Wellbeing Service Contract (agenda item 74)?"

71.6. The Chair replied, "PIP funding is from the Department of Work and Pensions. It is a non means tested disability payment for either supporting activities of daily living (commonly called the care component) and / or mobility. It is paid via an independent assessment of needs that is not done by local social care or health services. While using such local services may be supportive of an application it is not a requirement nor essential."

71.7. The Chair thanked Mr. Kapp for attending the meeting and invited Ms. Ingrid Ashberry to come forward and to put her question to the Board.

71.8. Ms. Ashberry thanked the Chair and asked the following, "Although the report recommends alternative providers for all services apart from Beaconsfield Villas it hints that this might not be possible either because of some service design to save money or some services becoming too expensive. How much explorations of these possibilities have been done already and what reassurance can we have that the Council are committed to working with the new providers to ensure residents can stay in their homes in the long term?"

71.9. The Chair replied, "We have carried out some soft market testing and further information regarding this is set out in the report in paragraph 6. There was good interest shown by providers, however until we tender for new service providers we do not know what the specific interest will be. The Council are committed to working with service users, their families and new providers to ensure that changes to services are managed in a planned and sensitive way with least disruption to service users.

71.10. We are expecting that most people will remain in their homes. However there may be some people whose needs could be met more effectively in alternative accommodation and until we carry out the procurement process we won't know exactly what alternative accommodation or services might be available. Any changes to accommodation would only be made where people wanted to move, or where their existing accommodation did not meet their needs in the most effective way. It is important that people are given the opportunity to move to more independent living where this can meet their needs."

71.11. Ms. Ashberry asked the following supplementary question, "Will the Board continue to offer real choice to users for their lives?"

71.12. The Chair stated that it was the council's intention to involve all service users in the decisions that affected them and to consider their needs and engage with broader groups so that as much information as possible could be taken into account.

71.13. The Chair noted that there were no further questions and thanked Ms. Ashberry for attending the meeting.

72 TOWER HOUSE DAY SERVICES

72.1 The Statutory Director for Adult Social Care introduced the report which detailed the outcome of a three-month consultation in relation to four options concern the future of the day centre at Tower House. She noted that the uncertainty around the future of the day centre meant that it was proving to be a difficult time for those people who use the centre and the staff who supported those users. She also acknowledged that a period of change was not easy for some people and that there

was a degree of anxiety about any changes that may result as well as it being seen as an opportunity to do something different.

72.2 The Head of Adults Provider stated that Tower House was a day centre for older people and people with disabilities and following a decision at the Policy & Resources Committee in November, a 3-month consultation had been undertaken to assess the viability of the centre and options for future provision for the service users. She outlined the consultation process and noted that all the various responses had been collated and included in a confidential appendix that had been provided to the members of the Board. She stated that in regard to the 72 responses received, 43 preferred Tower House to continue with a reduced level of provision. However, taking into consideration the need to deliver £150k savings, with only 13 people sing the facility for 2 days a week, costs would increase. There was also a duty under the Care Act to offer personalised budgets to users which enabled them to use alternative providers that were more cost effective than attending Tower House; e.g. they could pool budgets to use other services and maintain friendship groups.

72.3 The Head of Adults Provider stated that consideration had been given to cross-subsidising the service at Tower House; however the lease agreement was restrictive and did not allow for sub-letting. Officers had also sought to contact the freeholder but had had no response. There had also been an approach to the Council by a charity which was seeking to provide a service for older people at Tower House, however even if it was able to lease the facilities the service would not meet the needs of the 13 people that currently used Tower House as their primary service.

72.4 The Head of Adults Provider stated that in considering all the aspects regarding Tower House, it was considered not cost effective to continue to provide a day centre service to 13 people. She also noted that the number of people using Tower House had been decreasing and others would be able to access alternative provision to meet their needs.

72.5 The Chair stated that he wished to thank everyone who had been involved in the consultation process and the drafting of the report. He also noted Mr. Griffin had asked to address the Board and put a question in relation to Tower House and therefore invited him to come forward and speak to the Board.

72.6 Mr. Griffin thanked the Chair, and stated that he had Acquired Brain Injury and had been referred to Headway for support. However, he also volunteered at Tower House and had seen the benefits that users gained from attending, especially those with brain injuries and suggested that the centre should be a specialist service that was made available to others. He also believed that there were a number of people waiting to be assessed who could use Tower House which would increase the numbers. He therefore asked what would happen to those who currently used

Tower House and the 4 people who were unlikely to be able to be offered anything if it closed.

72.7 The Chair thanked Mr. Griffin for attending and for raising his concerns; and asked for clarification in regard to alternative provision that was available in the city to meet complex needs.

72.8 The Head of Adults Provider stated that the Council contracts with Headway for people with an acquired brain injury who require this service and this would continue. People requiring this specialist service would not attend Tower House and people with specific needs would continue to receive specialist services, which was not the role of Tower House. She acknowledged that there were some users of Tower House that would need a similar service to that currently provided at Tower House and their needs would be reviewed and there were providers in the city who could be contracted to provide a similar service. She stated that should the Policy & Resources Committee approve the closure of Tower House, staff would work with the users to ensure everyone's needs were met.

72.9 The Chair noted that he had met with the Older People's Council earlier in the day and they had raised the question of providers in the city having waiting lists and therefore there was uncertainty about vacancies.

72.10 The Head of Adults Provider stated that she was aware of one service provider that had a waiting list for one of the four days that a service was provided. However, if there was sufficient demand further work could be carried out to see whether that service could extend their opening to five days per week

72.11 The Chair also queried how personal budgets and pooled budgets would work and what support was available to people to manage these.

72.12 The Head of Adults Provider stated that staff would work closely with individuals to look at their needs and interests and assess the level of budget that would be available to them. There was also support available from the voluntary sector organisations including the Fed to enable people to purchase servies to meet their needs.

72.13 The Statutory Director for Adult Social Care stated that depending on the outcome at the Policy & Resources Committee meeting, officers would look to work with staff and volunteers at Tower House to ensure a smooth transition. She acknowledged the work and value contribution of staff and volunteers at Tower House and stated that volunteers would be encouraged and supported to seek other opportunities if they wished. She also noted that some people at Tower House were already using personalised budgets and the intention would be to expand on that use.

72.14 Councillor Mac Cafferty referred to the Policy & Resources Committee in November and stated that he believed it had requested officers to consult on maintaining the existing Day Centre service and this had not been undertaken in regard to the report that was before the Board today. He disagreed with the comments that had been made so far and believed that the overwhelming majority of users wanted to stay at Tower House. It was also misleading to suggest that the centre was in decline when there were others waiting to be assessed and to use it. He did not accept that with personalised budgets people may opt not to use Tower House as they could choose to do so. He also questioned how friendship groups would be maintained and queried whether this was properly addressed in the Equalities Impact Assessment (EIA). He referred to a number of moving comments in the appendices and stated that what had been requested in November was not included in the report that was before the Board today.

72.15 The Statutory Director for Adult Social Care stated that there was a need to give consideration to the financial situation and the best use of services. In regard to Tower House there had been no more than ten referrals for the day service since last summer. People were sign-posted to services that were available and how they could meet their eligible need.

72.16 The Head of Adults Provider noted that the Care Act 2015 placed a duty on the local authority to offer everyone a personal budget and to look at the options available to meet their needs. If they choose not to have a personal budget then day service provision can be looked at. However, there had not been the number of referrals or people choosing to come forward for day services that would maintain Tower House.

72.17 Councillor Barford stated that it was a complex and emotional issue and she wanted to thank everyone who had taken part in the consultation and in producing the report. She would have preferred to find a way to keep the service open but noted that the direction of travel had been set by the Board last year. There was a need to ensure that services were personable and people had a choice. She was aware that Tower House was valued by those that used it; however it needed to be fit for purpose now and for the future. The 13 people identified would be supported in every way possible as it was recognised that change wasn't necessarily an easy process. She also hoped that the staff and volunteers who did an amazing job would be retained and their skills utilised. She also wished to propose an additional recommendation, 'That the Health & Wellbeing Board recommend to the Policy & Resources Committee that the Council write to the Freeholder of the Tower House site inviting them to retain it for community use.'

72.18 Councillor K. Norman stated that he would prefer to see Tower House remain open and available for community use and agreed with Councillor Barford's comments. He had been contacted by a charity about the possible use of Tower House and hoped that could be explored. He also accepted the conclusions that had been

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reached and noted that service users would be supported to make use of alternative providers and remain part of the community.

72.19 The Chief Executive noted the comments regarding the Freeholder and stated that officers would endeavour to contact them prior to the meeting of the Policy & Resources Committee on the 28th April.

72.20 The Head of Adults Provider stated that the council was limited in regard to the terms of the lease and that the Charity has expressed an interest in sub-letting facilities so that a service for older isolated people could be offered. This would not meet the needs of the 13 people in question. There was the possibility that the Council could grant a licence which would be on certain terms only, and it would need to be explored further to see if this is a viable or realistic option.

72.21 Frances McCabe asked what the status of the consultation was in terms of the decision-making process.

72.22 The Lawyer to the Board stated that an informed decision of the Board needed to be taken which took into account the consultation process, which was not a referendum, and findings and all other information relating to the matter. It needed to be satisfied that the issues raised could be addressed and taking all aspects into consideration, a reasonable decision could be reached.

72.23 The Statutory Director for Adult Social Care referred to paragraph 10.2 of the report and noted that, "In considering its statutory duties the Local Authority must be mindful of the resources available…"

72.24 Councillor Mac Cafferty referred to the 4 gunning principles around the consultation and that the majority of respondents wanted the status-quo. The service was fit or purpose and he referred to comments in the appendix which indicated that if people did not attend Tower House their health and wellbeing would go downhill.

72.25 The Lawyer to the Board stated that the Board needed to take into account all the information available, i.e. the consultation responses, the financial position, alternatives that were available, assessed needs, to reach a reasonable decision.

72.26 Councillor Barford stated that she could understand that there were genuine fears about the changes that could result from a closure of Tower House. However, there was a need to consider the future and to be able to maintain services for that and to meet individual needs. She hoped that there would be positive outcomes and noted that the Board had already heard about how a change of service had seen improved delivery.

72.27 Councillor K. Norman noted that there had been similar decisions taken in the past which resulted in service changes that had been difficult to take but had resulted in positive outcomes.

72.28 The Chair noted that comments and acknowledged that the service at Tower House was well regarded and that people had confidence in it and that their concerns were not just about social care but about socialisation and friendship groups as well. The decision for the Board was not a reflection on the work and support at Tower House. He also noted that an amendment had been moved to add an additional recommendation and asked if there was a seconder.

72.29 Councillor K. Norman formally seconded the amendment.

72.30 The Chair asked the Lawyer to the Board to confirm the proposed amendment.

72.31 The Lawyer stated the a new recommendation 3.3 had been proposed which read as follows, "That the Health & Wellbeing Board recommend to the Policy & Resources Committee that the Council write to the Freeholder of the Tower House site inviting them to retain it for community use."

72.32 The Chair then put the recommendations to the Board and took a vote on recommendation 3.2 which was carried by 8 votes to 1.

72.33 **RESOLVED:** That the Health & Wellbeing Board having read and considered the consultation outcome and equalities impact assessment to inform its decision making recommends;

(1) That the Policy & Resources Committee agree that Tower House Day Service should close and that appropriate alternative arrangements should be made for service users to ensure their social care needs are met; and

(2) That the Policy & Resources Committee agree that the Council should write to the Freeholder of the Tower House site inviting them to retain it for community use.

72.34 The Chair noted that the meeting had been in session for an hour and half and adjourned the meeting for a short comfort break.

72.35 The meeting was then adjourned at 5.30pm.

72.36 The Chair reconvened the meeting at 5.40pm.

73 LEARNING DISABILITIES ACCOMMODATION SERVICES

73.1 The Statutory Director for Adult Social Care introduced the report which detailed the outcome of a three-month consultation with all service users and their families,

living in the Council's directly provided accommodation services for people with a learning disability. She noted that there were 51 service users and that there had been a mixture of views expressed to the proposed changes with some people clearly anxious about the implications for them and the staff that supported them.

73.2 The Head of Adults Provider stated that the council provided a range of services within supported and residential care homes for 51 service users. The Policy & Resources Committee had agreed to a consultation exercise last November based on three options, which involved a questionnaire, meetings with families, advocated meetings with users, social work assessments/reviews and provider engagement. A total of 31 families responded with 28 stating preference to remain in their existing homes with an alternative Provider. In view of the reservations raised by families about the availability of other Providers in the city, a provider event was held and attended by 9 families and 7 Providers. Having completed the consultation process and looked at the options, it was felt that a procurement exercise should be undertaken with a view to support being made available from alternative providers. The Head of Adults Provider also noted that the people living in Beaconsfield Villas residential care home would move to the Beach House, and the people living in Ferndale Road would be supported to move together to alternative accommodation.

73.3 Jenny Oates referred to paragraph 5.34 and the need to demonstrate value for money and queried how the level of provision would differ with alternative Providers to the council given the difference in the level of cost.

73.4 The Head of Adults Provider stated that council staff would transfer across to an alternative Provider under TUPE regulations however any future recruitment would be based on the new Provider's terms and conditions. In relation to the costs, an alternative Provider was likely to have lower on-costs, have more staff flexibility which enabled them to have lower rates than the council. She also noted that an Independent review of Learning Disability Services last year recognised the quality of service and staff but was critical of the culture of not encouraging people to move to more independent living when they should be. This was something that was more likely to happen with an alternate Provider in place.

73.5 The Statutory Director for Adult Social Care noted that the Learning Disability Strategy had been developed following the Independent Review and stated that the independent expert had been shocked at the council's staff levels and resource provision and suggested that could be provided in a different way, e.g. the council's units were operated on an individual basis whereas under another Provider they would be operated differently.

73.6 Councillor Barford wished to thank everyone involved in the process of bringing the report to the meeting and was sure that officers and staff would work with partners, service users and families to ensure a suitable outcome was achieved for all concerned. It was not possible to maintain the status-quo and every support

would be made available to all those affected by the level of change and the need to review their needs and adapt as necessary.

73.7 Councillor Mac Cafferty noted that a number of the respondents had said they were happy with their current situation and wanted the status-quo to remain. He also questioned what assurances there were for the service users that provision would remain and felt that the cumulative impact on these people was not reflected in the Equalities Impact Assessment (EIA), in terms of a way forward. He also queried whether there was any reason why some Providers did not attend the Provider event and if one was selected how would they engage with the users and what assurances were there that would meet the person's needs.

73.8 The Head of Adults Provider stated that the majority of people would remain in their homes that they were in and staff would TUPE across to the new Provider. Where there was a change then the council would work with those people to support any move. She noted that the Provider event had been called at short notice and some Providers had been unable to attend, whilst of those that did some were accompanied by service users who were able to give assurances about provision. She also noted that 80% of services were delivered by the independent and voluntary sector and those Providers had a lot of experience in the city.

73.9 The Chair referred to the Independent Review and queried whether it was felt that the Council was providing a 'Gold Service' or was applying too much resource for the outcome of the individual.

73.10 The Statutory Director for Adult Social Care stated that in comparison to other authorities/Providers the Council had a high level of spend and was seen to be risk averse. The review was critical of the level of services provided and raised the need for a more individualised approach. It was considered to be too protective and should enable people to have a wider opportunity. She also noted that there were some people who wanted to move on and should be encouraged to do so.

73.11 The Statutory Director for Children's Services stated that there was a parallel situation for Children's Services and the themes reflected in the comments were similar for service provision. There was a need to have a regard to the use of public money and how the best outcomes were achieved for service users.

73.12 The Statutory Director for Adult Social Care noted that concerns had been expressed about those people who had specialist needs and had built particular relationships with staff. She stated that should there be any moves as a result of reviews it was intended that the staff would be fully involved to support that process.

73.13 Councillor Mac Cafferty stated that he felt there was an inference in the report that people would be forced to move and he sought an assurance that this would not be the case even if there was another Provider.

73.14 The Head of Adults Provider stated that there were some people whose needs were not best met by their current provision and this could be better with different accommodation. There would be individual reviews undertaken and discussions with the families to consider whether any needs had changed and/or alternative provision would be more suitable before any action was taken. The aim would be to ensure that all needs could be met fully.

73.15 The Chair thanked everyone for their comments and put the recommendations to the Board, with recommendation 3.2 being put to the vote and carried by 6 votes to 1.

73.16 **RESOLVED:** That the Health & Wellbeing Board having read and considered the consultation outcome and equalities impact assessment to inform its decision making recommends:

(1) That the Policy & Resources Committee agree that the Learning & Disability Services should be re-provided as set out in paragraph 8 of the report.

74 RE-PROCUREMENT OF THE IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES SERVICE (IAPT) FOR ADULTS AND THE ALL AGE COMMUNITY WELLBEING SERVICE

74.1. The Commissioning Manager, Adult Mental Health and Wellbeing introduced the report which provided the Board with an update on the procurement for new services for Improving Access to Psychological Therapies Services (IAPT), for adults and All age Community Wellbeing Service. She noted that the contract had been previously extended on two occasions and with other potential Providers available it was appropriate to put it out to tender. The aim being that the Invitation to Tender (ITT) documents would be issued in June and the contract awarded in November by the CCG Board with a view to its implementation from April 2017.

74.2. Councillor Penn stated that as the Lead Member for Mental Health as well as a service user, she was disappointed that she had not been aware of the re-procurement of the contract and the consultation process. She was concerned that other users of the Wellbeing service were not aware and asked for confirmation of who was involved in the consultation process and whether it could be extended.

74.3. Frances McCabe welcomed the intention to look at Children's services and the transition process as it was important to ensure that there were no gaps in terms of service provision. She also echoed Councillor Penn's concerns and was not clear whether Health Watch had been consulted.

74.4. Councillor Mac Cafferty stated that he was unclear as to when the re-procurement process had been approved. He also referred to the Equalities Impact Assessment

(EIA) and queried whether it would include reference to people with protected characteristics and how their needs would be met.

74.5. The Commissioning Manager, Adult Mental Health and Wellbeing stated officers were in the process of completing a rapid needs assessment and various groups including GP's, Healthwatch and the pubic had been consulted. A number of responses had been received although she was not sure if the information had put on the council's website. She also stated that the EIA was under development and she would ensure that people with protected characteristics were included in that and in the new service provision. She noted that the decision to involve Children's services was to ensure that the transition process was picked up and any gaps covered with the new contract. She also noted that there would be an exit strategy within the process for any new Providers.

74.6. The Head of Commissioning, Mental Health and Children's Services at the CCG, stated that the need to re-procure the contract had arisen because of the previous extensions and alternative Providers that existed in the city. It had been raised with the CCG Board and within the JNSA and she assured the Board that the needs of those with protected characteristics would be taken into consideration and included within the EIA. The service specification was currently being drawn up and she was happy to ensure that Board Members and others were able to engage in the process prior to the ITT being issued.

74.7. The Chief Operating Officer of the CCG stated that any feedback on the services would be welcome and taken into consideration as part of the review process on the quality impact of the service.

74.8. The Chair noted the comments and welcomed the opportunity to feed into the review process. He therefore put the recommendation to note the report to the Board.

74.9. **RESOLVED:** That the report be noted.

75 BETTER CARE PLAN

75.1. The Chair noted that the Better Care Fund was due to be considered for approval by the Better Care Board on the 21st July and would then have come to the Health & Wellbeing Board for final sign-off. Unfortunately the timings of the two meetings and the requirement for the Better Care Fund to be approved and submitted by the 6th May 2016 meant that the report had to come to the Health & Wellbeing Board first. He therefore hoped that the Board would be supportive and agree to the Fund being approved in principle and for the Better Care Board to approve the submission of the Better Care Plan and associated pooled budget arrangements.

75.2. The Chief Operating Officer for the Clinical Commissioning Group (CCG), introduced the report and noted that the Board had already approved the Plan and associated pooled budget arrangements at a previous meeting. The report outlined the final version for submission which clearly outlined the joint working between the local authority and the CCG and showed how resilience and pro-active action was being taken to meet the financial challenges that were being faced. He also noted the joint working with the voluntary sector and multi-disciplinary approach that was being taken to address needs.

75.3. The Head of Financial Services referred to the overall budgetary position and noted that both the City Council and the CCG had made contingencies within their respective budgets for any savings that may not be achieved and additional pressures that may result. He also noted that the Better Care Programme Board regularly reviewed the budget position and would report to the Health & Wellbeing Board as necessary.

75.4. Fran McCabe welcomed the report and noted that a lot of work had gone into developing the Plan and raised some points in regard to whether there would be any sanctions if performance targets were not met. She also queried how the new governance structure would look and suggested that more information would be helpful in regard to the outcomes that were highlighted and how the Plan related to other plans such as the CCG Operating Plan and Workforce Strategy.

75.5. The Chief Operating Officer stated that the Better Care Board was the responsible body for considering all the plans and ensuring that they were taken into consideration and reflected in the Annual Operating Plan. He also noted that the System Resilience Group reported to the Better Care Board and was responsible for ensuring that the Plan was implemented and how it delivered.

75.6. Pennie Ford noted that the process for submission of the Better Care Plan, provided for feedback to the CCG from NHS England in order for the final submission to be revised and ensure it was able to sign-post how challenges would be met and related to other plans.

75.7. George Mack stated that he had previously suggested that quarterly or half-yearly highlight reports should be brought to the Health & Wellbeing Board on this area and asked that this be incorporated into the Board's work plan.

75.8. The Chair noted the comments and agreed that greater clarity was needed in terms of the oversight of the Plan and the role of the Better Care Board.

75.9. The Statutory Director for Adult Services stated that it would be possible to bring highlight reports on specific areas of the Plan to the Board on a quarterly basis with a half-yearly update on the overall Plan.

75.10. **RESOLVED:**

(1) That the Better Care Plan for 2016/17 and pooled fund be approved;

(2) That the achievements made during 2015/16 be noted;

(3) That the proposed changes to the pooled fund hosting arrangements be approved.

76 SUSTAINABILITY AND TRANSFORMATION PLAN - PRESENTATION

76.1. The Chair stated that the future of the NHS was being looked at and he hoped that the presentation would give some insight into what was being considered. He also noted that there were three public questions in regard to the item and he would therefore take them after the presentation.

76.2. The Chief Operating Officer of the CCG gave a presentation on the Sustainability and Transformation Plan, (STP) which was the proposed new planning framework for NHS services that had been announced in December 2015.

76.3. The Chief Operating Officer noted that it was still early in the process in terms of finalising the new framework and that it would need to reflect the previous plans that had been referred to in earlier discussions.

76.4. The Chair thanked Mr. Child for his presentation and invited Mr. Graham to put the first public question to the Board on behalf of Mr. Walker.

76.5. Mr. Graham thanked the Chair and asked the following, "What impact does the Health & Wellbeing Board believe the Sustainability and Transformation Plan and the new geographic alliances which are being generated to implement it, have on health and social care services in Brighton and Hove? What analysis of this and other potential impacts of such radical change in the organisation and structuring of health and care services, for e.g. socio-economic, have been carried out or are planned?"

76.6. The Chair noted that Ms. Mainstone had not been able to stay for the item and read her question, "According to the STP Planning Guidelines issued by NHS England, the success of the Plan 'depends on having open, engaging and iterative processes that harness the energies of clinicians, patients, carers, citizens and local community partners and local government.' Can the Board explain how they plan to comply with this instruction on this issue of unprecedented significance for our local democracy and for all residents of the city? Are local trade unions being consulted about the budgetary and staffing implications?"

76.7. Ms. Dickens then asked the third public question, in regard to item 4.9 page 55 of the February HWB agenda, recommending "Return the system to aggregate financial balance. Efficiency savings with the Lord Carter provider productivity

work programme, complying with the maximum total agency spend and hourly rates set out by NHS Improvement. CCGs to deliver savings tackling unwarranted variation in demand through implementing the RightCare programme in every locality." How would 'aggregate financial balance' be achieved with the current BSUHT deficit of £37 million, what would such mechanisms mean in relation to savings and cuts in NHS budgets and what consultation has there been with unions involved?"

76.8. The Chair thanked the questioners and in regard to Ms. Mainstone's question stated that the position had not been reached as yet. There had not been any public engagement or discussions with the Board in regard to the STP, although input had been and was being made by the CCG and officers.

76.9. The Chief Operating Officer stated that it was still too early to be able to respond to the questions. The STP was likely to go across a wider footprint and include economies of scale. He noted that the Chair of the STP Programme Board had recently written to the Chairs of Health & Wellbeing Boards asking for their views on how public engagement should take shape and noted that it was too early to involve the trade unions. It was intended to develop an engagement plan and once this was agreed a lot of the questions being raised would be addressed.

76.10. The Chair suggested that there was a need to enable engagement in the process before a final version of the STP was determined and stated that he hoped there would be an opportunity to influence the make-up of the Plan.

76.11. Ms. Dickens asked a supplementary question, did the Board anticipate that greater aggregation would result and workforce savings that would lead to implications for the future of the NHS?

76.12. The Statutory Director for Adult Services stated that she was a member of the STP Programme Board and other partner agencies were also represented on the Board. There was a degree of concern about the level of engagement that could be achieved when the Plan was due to be submitted by the 23rd June. She had put herself forward to sit on the Southern Regional Board and hoped that greater clarity would be forthcoming. However, it was not possible to answer the question at this stage.

76.13. Councillor Barford stated that it was important to be able to have a level of engagement that people trusted and hoped that this would be given further consideration.

76.14. Pennie Ford stated that it was early days for the development of the STP and that there would be different levels of planning, with local integrated work being a core element of provision along with areas that needed a wider footprint e.g. mental health and workforce challenges.

76.15. The Statutory Director for Children's Services noted that the current version of the STP had a lack of reference to Children & Young People and hoped that this would be addressed.

76.16. Councillor Mac Cafferty referred to figures published by the King's Fund which suggested that there would be a 20% cut in the NHS by 2020. He fully understood why people were anxious about the way forward and suggested that the Board could submit a request for the process to be halted pending a consultation process being undertaken before any decision was taken.

76.17. Councillor Penn stated that she wished to echo the comments made by Councillor Mac Cafferty and queried how many people were aware of the process and proposals contained in the STP. She felt that there was a need for more engagement and to raise awareness of the situation.

76.18. The Chief Operating Officer noted the comments and stated that the Chair of the Board had been asked for comments on the engagement process by the Chair of the STP Programme Board. He also stated that he would take on board the point raised about Children & Young People.

76.19. The Chair stated that he was happy to write to the Chair of the Programme Board and reflect the Health & Wellbeing Board's concerns/views. He would also invite him to attend the next meeting of the Health & Wellbeing Board.

76.20. **RESOLVED:** That the information contained in the presentation be noted.

77 ADULT SOCIAL CARE CHARGING POLICY 2016: AMENDMENT

77.1. The Cahir stated that the report concerning Adult Social Care Charging Policy 2016: Amendment was before the Board for information and therefore moved that it be noted.

77.2. **RESOLVED:** That the report be noted.

PART 2 SUMMARY

78 TOWER HOUSE DAY SERVICES: APPENDICES - EXEMPT CATEGORY 3

78.1. **RESOLVED:** That the information be noted.

79 LEARNING DISABILITIES ACCOMMODATION SERVICES - EXEMPT CATEGORY 3

79.1. **RESOLVED:** That the information be noted.

80 PART TWO PROCEEDINGS

80.1. **RESOLVED:** That the information contained in the appendices to Items 72 and 73, listed as items 78 and 79 on the agenda remain exempt from disclosure to the press and public.

The meeting concluded at 7.40pm

Signed Chair

Dated this day of 2016

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Although a formal committee of the city council, the Health & Wellbeing Board has a remit which includes matters relating to the Clinical Commissioning Group (CCG), the Local Safeguarding Board for Children and Adults as well as Healthwatch. Papers come from a variety of sources. The format for Health & Wellbeing Board papers is consequently different from papers submitted to the city council for exclusive city council business.

1. Annual Report of the Director of Public Health 2015/16

1.1. The contents of this paper can be shared with the general public.

1.2 This paper is for the Health & Wellbeing Board meeting on the 7th June 2016.

1.3 Author of the paper and contact details:
Dr Peter Wilkinson, Acting Director of Public Health, Brighton & Hove City Council.
Email: peter.wilkinson@brighton-hove.gov.uk Tel 01273 296555

2. Summary

2.1 Directors of Public Health are required to produce an annual independent report on the state of local public health. There are no requirements as to the content or format of the report.

2.2 This year's Report "Public Health and the Embrace of Social Media" looks at social media and its relation to public health. The report has been produced in an on-line format. The paper copy is just one sheet with web links (Appendix one).

The report can be accessed here online: https://www.brighton-hove.gov.uk/content/health/public-health-brighton-hove/annual-report-director-public-health-201516-social-media

2.3 This report covers the period 2015/16; the last year of Dr Tom Scanlon's tenure as Director of Public Health.

2.4 The Acting Director of Public Health will make a brief presentation of the report.

3. Decisions, recommendations and any options

3.1 The report is presented to the Board for information.

4. Relevant information

4.1 The Report deals with areas of public health where on-line and social media behaviours and resources play a key role. As well as a broad overview of social media and public health, there are sections on diet, exercise, mental wellbeing, addictions, suicide, substance misuse, sexual health, important diseases, cyber-bullying, loneliness and social connections.

4.2 The Report also describes findings from the analysis of social media activity to see how this relates to issues such as anxiety, depression and self-harm.

4.3 The Report contains many links to local health information, research papers, and has links to over 100 films.

5. Important considerations and implications

Legal:

5.1 The NHS Act 2006 and the Health and Social Care Act 2012 requires Directors of Public Health to write an annual report on the health of their local population. The content and structure of the report can be determined locally.

Lawyer consulted: Natasha Watson Date: 26.05.16

Finance

5.2 None for this report, as for information only.

Finance Officer consulted: Mike Bentley Date: 10/05/16

Equalities:

5.3 Where appropriate the report highlights local inequalities

Sustainability:

5.4 None identified

Health, social care, children's services and public health:

5.5 The Annual Report is relevant to all age groups and services.

6. Supporting documents and information

6.1 Appendix one: Public Health and the Embrace of Social Media summary booklet

APPENDIX ONE

Brighton & Hove City Council

SHN

Covering:
Diet • Sex • Drug use
Isolation • Cyber-bullying
Exercise • Disease patterns
Addictions • Self-harm

ANNUAL REPORT OF THE DIRECTOR OF PUBLIC HEALTH

PUBLIC HEALTH AND THE EMBRACE OF SOCIAL MEDIA

2015/16

27

Watch the report's opening and closing films at:

YouTube **http://bit.ly/PBHintro**
http://bit.ly/PHBsummary

5731 Brighton & Hove City Council
Communications Team

NHS

Brighton & Hove City Council

USES & ABUSES

61% of adults in 2015

In 2015, **61% of adults** in the UK used social media on the internet. How does such widespread adoption affect public health and the surrounding issues?

Right to disappear
Revenge Porn
Internet Trolls
Hacking
Cyber Warfare
Radicalisation
Online Security
Whistleblowing

Read this chapter online at **www.brighton-hove.gov.uk/health-report**

DISEASE & SOCIAL MEDIA

RIP

We and others are using social media to help with mapping drug use, racism and mortality

Find out more at: http://bit.ly/bhcc454

80% Parents
3000 Pupils
10 Schools

Studybugs is an online service which helps schools manage and maximise attendance.

To view live Studybugs data for Brighton & Hove, visit
www.studybugs.com/clientdata/brightoncc

Studybugs

Read this chapter online at **www.brighton-hove.gov.uk/health-report**

SEXUAL HEALTH

Social media – a conduit to more risk and a fast track to treating people

Sexually transmitted infections – a **large** local difficulty. What are we observing, and how we are responding

Read this chapter online at **www.brighton-hove.gov.uk/health-report**

DIET & EXERCISE

TEN CANCERS caused by obesity – Read the report!

Takeaway apps and **social media** are changing the way people eat

Sugar levels are impacting public health

Find out what we are doing about it

Take a look at **how people stay fit** in Brighton & Hove

Read this chapter online at **www.brighton-hove.gov.uk/health-report**

ADDICTION

Find out what's happening with **legal highs** in Brighton & Hove

Social media and addictions can go hand in hand – we look at drugs, alcohol, gambling and even addiction to social media itself.

Take a look at what school children want to know

Read this chapter online at **www.brighton-hove.gov.uk/health-report**

MENTAL HEALTH

A tipping point – more older people are using the internet

79% can (with confidence) use e-mail (92% of 55+)

Take a look at some of the **worrying self-harm images and conversations** shared on-line

Find out how we're using a **whole-school approach** to reduce bullying across the city

Read this chapter online at **www.brighton-hove.gov.uk/health-report**

Although a formal committee of the city council, the Health & Wellbeing Board has a remit which includes matters relating to the Clinical Commissioning Group (CCG), the Local Safeguarding Board for Children and Healthwatch. Papers come from a variety of sources. The format for Health & Wellbeing Board papers is consequently different from papers submitted to the city council for exclusive city council business.

1. Better Care Plan

1.1. The contents of this paper can be shared with the general public.

1.2 This paper is for the Health and Wellbeing Board meeting on **7th June 2016**

1.4 Author of the Paper and contact details:
Ramona Booth, Head of Planning and Delivery
Brighton and Hove Clinical Commissioning Group
ramona.booth@nhs.net

2. Summary

2.1 The Brighton and Hove Better Care Plan was co-produced by health and care partners in Brighton and Hove in July 2014. It was the product of extensive partnership work supported by NHS IQ and outlines our collective vision for the delivery of Better Care across the local health and care system.

2.2 **Appendix 1** provides an update on our 2016/17 Better Care Plan submission and the further work that is required prior to the end of June 2016. **Appendix 2** provides an exception report on delayed transfer of care.

3. Decisions, recommendations and any options

3.1 That the Health and Wellbeing Board note the progress achieved to date.

4. Relevant information

4.1 Each year the Better Care Plan is updated. Progress is noted and the years work plan is agreed.

4.2 The Better Care Plan delivery is overseen by the Better Care Board. This Board reports to the Health and Wellbeing Board by exception.

4.3 In preparing this Plan the Brighton and Hove Better Care Board has undertaken a review of local outcome measures to ensure that they are ambitious and robust enough to steer the transformational change required to deliver integrated care across the city to 2020.

4.4 A series of measures were developed by the Better Care Board for testing with local partners and community stakeholders. This included an engagement workshop with the community / voluntary sector. The event focused on the five broad outcome domains of: prevention, proactive care, recovery and rehabilitation, personalised care and integration.

4.5 There was a strong support from those attending that the outcomes approach helped clearly articulate local expectations for integrated care. In particular there was an emphasis on how integrated care services could build local resilience and help reduce isolation, support the role of carers, and utilise voluntary and community assets to coordinate personal care.

4.6 The revised set of outcome measures were then incorporated into a second event held in March 2016 with local NHS and adult social care commissioning and provider colleagues. This second event aimed to ensure that the Brighton and Hove care system has the appropriate governance arrangements in place to take forward integrated care commissioning, and provider delivery, to help address the local challenges faced.

4.7 The Board have asked for exception reporting and the detailed focus for this report is delayed transfers of care which is an area of challenge (see **Appendix 2**).

5. Important considerations and implications

The submission paper will be considered in detail at the officer board prior to being submitted and any exception issues identified and reported to the Board in due course.

5.1 Legal

The Care Act 2014 amended the NHS Act 2006 to provide the legislative basis for the Better Care Fund. In 2016-17, NHS England have set a number of conditions for the fund, which local areas need to meet to access the funding, and which were reflected in the 2016/17 Better Care Plan submitted on 3rd May 2016. As described in the report, the Better Care Board is required to refresh its Section 75 agreement by the end of June 2016, so as to reflect the new plan and the pooled fund arrangements for 2016/17.

5.2 Finance

The Council's Pooled Fund Manager will, in collaboration with the CCG Finance Lead produce quarterly finance reports for the Health and Wellbeing Board going forward on expenditure against this budget on an exception basis.

5.3 Equalities

An equality impact assessment will be completed on specific commissioned services within the overall programme.

5.4 Health, social care, children's services and public health

Health, social care, and public health are all key members of the Better Care Programme Board and have been fully involved in the development and delivery of the Better Care Plan.

6. Supporting Information

6.1 Please see **Appendix 1** Section 75 HWB Update May 2016; and **Appendix 2** exception report on Delayed Transfers of Care.

Section 75 HWB Update May 2016

1. Introduction

The 2016/17 Better Care Plan was submitted on 3rd May 2016 and reflected feedback from the Health and Wellbeing Board and the Better Care Board.

The plan will now be reviewed by NHS England and an assurance rating assigned (assured, assured with support or not assured). We expect to receive notification of our assurance status by end of May 2016.

The next steps are to update our Section 75 agreement to reflect the new plan and the pooled fund arrangements for 2016/17.

2. Developing Our Section 75 Agreement

The Better Care Board is required to refresh its Section 75 agreement by the end of June 2016.. The key elements that require update are as follows:

- Work programme – requires update of the narrative in S75 to reflect the 2016/17 plan and clearly articulated key milestones with dates of delivery
- Local Metrics – requires confirmation of which of the local metrics will be reported quarterly to NHS England alongside the national metrics
- Pooled fund amount and breakdown – to reflect the agreed changes to the pooled fund as per the 2016/17 plan
- Risk Share Agreement – requires review to ensure compliance with updated guidance

2.1 Updated work Programme

The Better Care Delivery Group has developed the Better Care work plan (from the Better Care Plan 2016/17) to ensure robust arrangements are in place to deliver;

- The national conditions required from the 16/17 Better Care Plan
- The services/projects supported by the local Better Care section 75 agreement
- The organisational development work required to take forward the broader ambition for integration across the city i.e. revised governance arrangements

The plan will be completed on receipt of feedback from NHS England on the Brighton and Hove 16/17 Plan. The aim is to finalise the workstream plan and clear delivery milestones at the June Better Care Board for inclusion in the final 2016/17 Section 75 agreement.

The Delivery Group will oversee achievement of the programme and report progress to the Board.

2.2 Local Metrics

In addition to the Nationally Mandated metrics there is a requirement for BCF plans to include a locally determined metric and a locally determined patient experience metric.

The Better Care Metrics Group members compiled a list of all indicators that are currently measured that relate to the Better Care Workstreams and programme objectives and identified four measures which would be appropriate for submission to NHS England alongside the national metrics:

A. Reduction in A&E frequent flyers (no. of individuals and no. of attendances)

B. Proactive care programme: Percentage of people identified as at risk who received assessment and case management
C. Telecare: Number of people accessing the Telecare project
D. Integrated Community Equipment: Equipment issued at access point as a percentage of overall equipment issued.

The Better Care Board recommended that both metric A and B were included in the quarterly reporting to NHS England. Better Care Board also requested that the full suite of metrics are reviewed monthly by the Better Care Delivery Group and reported by exception to the Better Care Board and Health and Wellbeing Board.

The metrics group also reviewed the local Patient Centred Outcome Measures and concluded that the following related most specifically to the criteria set out in the 2016/17 guidance and therefore should be reported quarterly to NHS England:

I have a positive relationship with my GP and care team and feel involved in decisions

The Better Care Board endorsed the use of the above metric and recommended that the full suite of Patient Centred Outcome Measures are reviewed monthly by the Better Care Delivery Group and reported by exception to the Better Care Board and Health and Wellbeing Board.

2.3 Pooled Fund and Risk Share Arrangements

The Section 75 has been updated to reflect the 2016/17 pooled fund and pooled fund management arrangements as described in the 2016/17 Better Care Plan.

Risk Share Arrangements are under development and will be presented to at the June 2016 Better Care Board meeting.

3. Recommendations

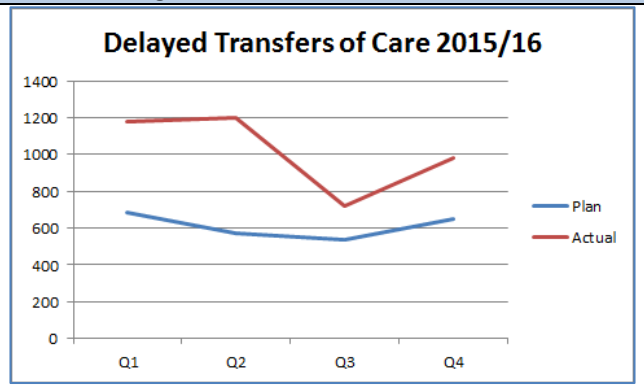
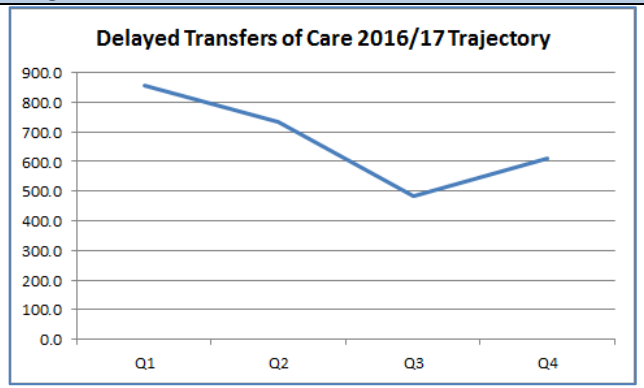
The Better Care Board noted the assurance process for the 2016/17 plan and progress to date with refreshing the local Section 75 Agreement. The Board also endorsed the indicators for inclusion the in quarterly reporting to NHS England.

Appendix 2

Better Care Fund

Exception Report to the Health and Wellbeing Board 7th June 2016

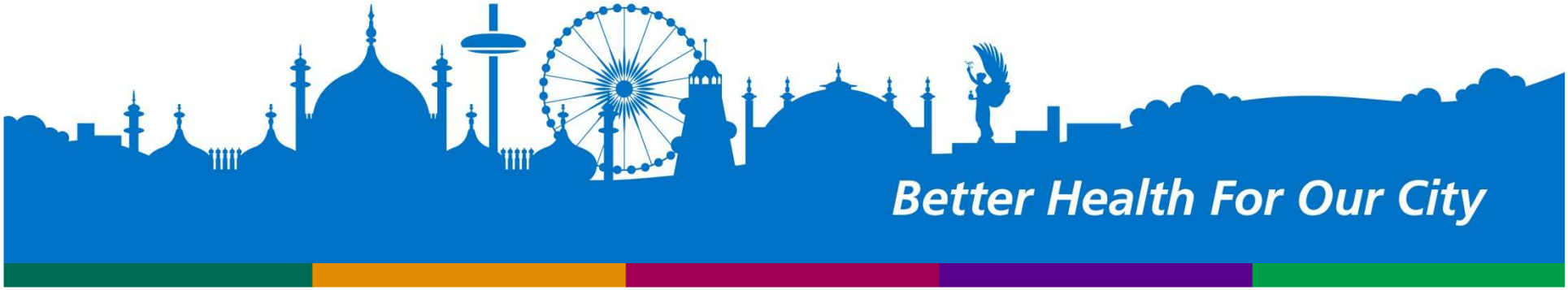
Target Area: Delayed Transfer of Care

Measure	2015/16 Target Vs Actual achieved	Target 2016/17	Trend	Mitigation
Delayed transfers of care (delayed days) from hospital per 100,000 population (aged 18+)	 Full year average 1018.3 against target of 610.3	 Full Year Average 671.3	Provisional data for April 2016 shows the upward trend continuing.	See attached action plan

NHS
Brighton and Hove
Clinical Commissioning Group

Improving Discharges and Reducing Delayed Transfers of Care

2016/17



Improving Discharge and Reducing DToCs - Key Issues

Process

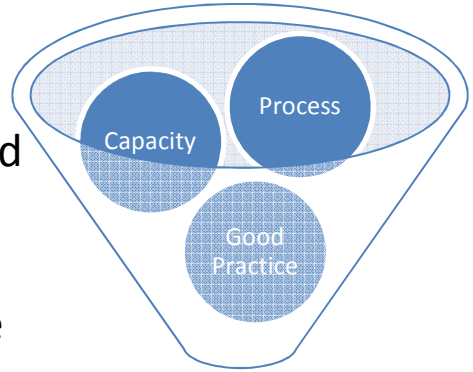
- Patient/family choice makes up 19% (2319) of lost beds days at BSUH, and 12% (1073) at SCT
- Admission processes to B&H beds causes delays in the system – average time referral to admission 4 days (56 days per week in BSUH)
- Threshold calls – different process needed that adds value and empowers operational leads underpinned by a properly integrated discharge team

Capacity

- 85% increase in patients waiting for packages of care across acute and community
- D2A (integrated with CRRS) needs to be the intermediate service for all patients going home with a care need
- Hospital at Home model
- Reduction of Nursing Home capacity following adverse CQC inspections

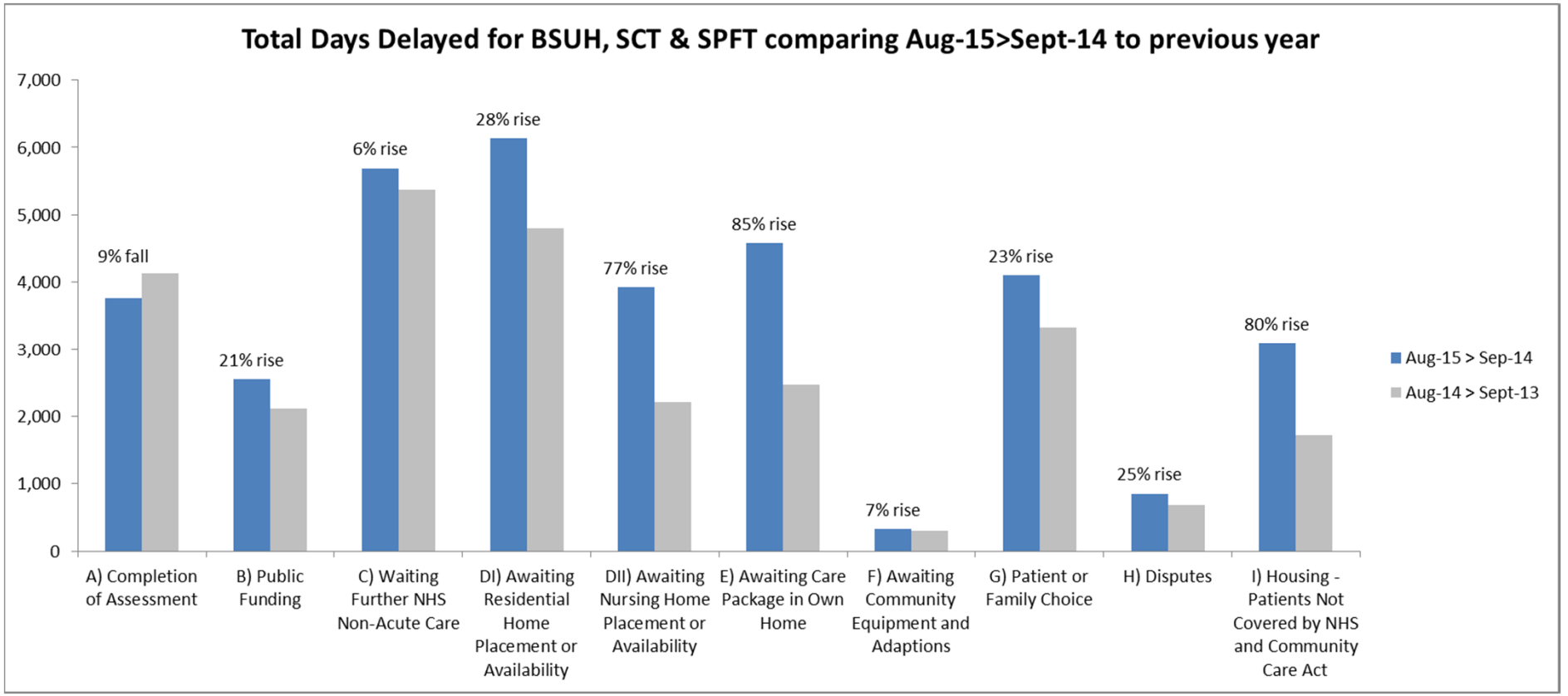
Good Practice

- SAFER Flow Bundle – needs to be BAU in all bedded units and community services
- Implementation of new CHC requirements – all assessments in the community



50% reduction in lost bed days across the system?

Improving Discharge and Reducing DToC



Improving Discharge and Reducing DToC - Actions

Key Issue	Action	By When	By who	Expected Impact
Homecare capacity	Independence at Home service redesign Securing additional interim capacity to support CRRS and CSTS Re-procurement of independent sector homecare service System wide workshop to review demand and capacity and market for home care Recruitment of East Sussex ASC homecare team	June 2016 April 2016 Oct 2016 July 2016 October 2016	ASC CCG/SCT ASC All East Sussex ASC	50% reduction in lost bed days = 5 extra beds across BSUH, SCT , SPFT
Care home capacity	Workshop as above to include care homes	July 2016	All	
Community Beds	ECIP facilitated workshop to agree quicker processes for accessing beds Re-procurement of beds according to new service specification (B&H)	May 2016 Complete April 2017	SCT/ASC B&H CCG	Reducing average referral to admission time by 50% = 3 beds at BSUH
Managing patient expectations	Implementation of new national choice policy across whole system Patient discharge information on admission	June 2016 June 2016	All providers of beds(HWLH facilitating) All providers	50% reduction in lost bed days = 3 beds at BSUH, 2 beds at SCT, 1 bed at SPFT
Complex Discharges	Revise daily threshold approach – operational managers do their job and escalate issues if required Explore options to more closely align HRDT and SW Assessment team across beds at RSCH	May 2016 Dec 2016	BSUH/SCT/ASC BSUH/ASC	To be quantified

Improving Discharge and Reducing DToC - Actions

Key Issue	Action	By When	By who	Expected Impact
Good practice discharge planning	SAFER Flow Bundle implemented across all bedded and relevant community services	Oct 2016	All providers	To be quantified
Hospital at Home	Implement Hospital at Home model	June 2016	SCT/BSUH	Re-provision of 20 Newhaven beds
Discharge to Assess	Fully integrate D2A and CRRS to be intermediate service for all patients needing a service on discharge Define longer term model linking integration of discharge functions	June 2016 To be agreed	SCT	To be quantified
Assisted Discharge	Continue current pilot and procure long term service, which will be designed to dovetail with East Sussex Service(in development)	Oct 2016	Red Cross/ successful provider	To be quantified and set in new procurement model
Continuing Healthcare	Implement new national CHC requirements i.e. no assessment in acute bed	Dec 2016	CCG	

Although a formal committee of the city council, the Health & Wellbeing Board has a remit which includes matters relating to the Clinical Commissioning Group (CCG), the Local Safeguarding Board for Children and Adults as well as Healthwatch. Papers come from a variety of sources. The format for Health & Wellbeing Board papers is consequently different from papers submitted to the city council for exclusive city council business.

1. Living Well project update

1.1 This paper can be seen by the general public.

1.2 This paper is for the Health & Wellbeing Board meeting on the 7th June 2016.

1.3 The author of this paper is:
Joel Caines, Project Manager
Health and Adult Social Care
Brighton & Hove City Council
joel.caines@brighton-hove.gcsx.gov.uk

2. Summary

2.1 The Living Well project is managed and delivered by the Council's CareLink Plus service. The project has an emphasis on early help and prevention by supporting people to maintain their independence and preventing the need for more intensive services in the future.

2.2 The project seeks to target and support people who are experiencing deterioration in health, have lower level social care needs or are struggling to cope with aspects of daily living.

2.3 The project started in June 2015 and this report provides an update on project activity and the outcomes it is providing for people. The project is funded by the better care fund and supports the Council's Value for Money (VfM) programme.

3. Decisions, recommendations and any options

This paper is presented to the Health and Wellbeing Board to consider:

3.1 The successes achieved since the start of the project show encouraging signs that this type of intervention can play an important role in the wider prevention agenda by supporting individuals and communities, as well as delivering cost-effective care. This report recommends that opportunities through the Better Care plan are explored to mainstream the Living well Project to enable more people to be supported.

4. Relevant information

4.1 The Living Well project forms part of the Brighton & Hove Better Care plan. There is £0.235 million funding in 2016/17.

4.2 As well as supporting people with telecare services, the project works closely with other services across Brighton and Hove to help people maintain their dignity, encouraging people to do the things they enjoy, to get out and about and to live well.

The project has 2 areas of focus:

- **Hospital in reach**: To support timely discharge from hospital and to prevent further avoidable admission to hospital
- **Community support (prevention)**: To promote *living well* at home to reduce, delay or avoid the need for care and support

4.3 The core staffing of the project consists of three CareLink Plus Care Managers. These are newly-designed posts which have an emphasis on early help, prevention and integrated working. The CareLink Plus Care Managers assess and install telecare themselves and carry out a strengths-based conversation around maintaining independence.

4.4 The project supports the current strategic vision (Adult Social Care Services; The Direction of Travel 2016 – 2020) with an emphasis on signposting, supporting communities, getting people 'back on track' and helping people self manage their own care. Furthermore, the project supports strategic priorities of the Brighton & Hove Joint Health & Wellbeing Strategy 2015 to help people to age well and provide better outcomes for people by working in close partnership with NHS and community and voluntary sector colleagues.

4.5 The project starting taking referrals in August 2015 and has so far worked with 305 people. Key referrers include the Hospital Rapid Discharge Team, Hospital Social Work team, Integrated Primary Care Teams and the Access Point.

4.6 The person-centred approach to supporting people enables individuals to express areas of help that will make a difference to their lives and to support people to continue doing the things they like to do. This approach is highlighted in three stories in the appendix of this report which emphasise the human impact of the project interventions.

4.7 The project outcomes support the Council's VfM programme by providing early interventions for people which can help to reduce, prevent or delay the need for long-term care and support. By supporting people at an earlier stage and linking people with the right sources of support, it can help prevent small problems escalating, becoming larger and more difficult to manage.

4.8 It is accepted that the financial evaluation of preventative interventions such as Living Well are inherently hard to quantify. The project team has recognised, though, the importance of evaluation information and has developed a methodology to estimate where costs have been avoided through project interventions. This approach is based upon the professional evaluation of each case and the views of each person supported. It uses professional data sources to help quantify where care and support costs have been avoided. Since the start of the project, through this approach it is estimated that preventative savings of £1.565 million (after costs) have been achieved. Examples of this include where care home costs, home care provision or falls in the home have been avoided.

4.9 Whilst these figures are based on estimations, it is worth noting they are broadly consistent with other local telecare outcome studies. The study carried out by the Department of Health's Care

Services Efficiency Delivery (CSED) Programme in 2011 on Brighton & Hove telecare activity, and a similar exercise carried out by East Sussex County Council in 2014/15, showed preventative savings of between £5,000- £6,000 per person. This analysis provides an average figure per person which falls within this range, adding weight to the outcomes provided in this report.

4.10 One of the project's areas of focus is to build partnerships to support good integrated working. Strong partnerships and pathways can lead to more holistic and sustainable outcomes for people. The project has built strong links with NHS organisations, East Sussex Fire & Rescue and local community sector organisations such as Time to Talk befriending service and Crossroads respite care.

4.11 Feedback from partner organisations include;

"The ease of the referral and the fact that Living Well was able to see her the day she was discharged made the process quick and easy, and prevented a delayed discharge from hospital"
Emma Ball, Hospital Social Work Team

"It's been great for the fire service to work in partnership with CareLink Plus. We have seen a big rise in home safety visits and we are working together on a new hoarding framework. This is real action based partnership working to help make vulnerable people safer"
Mel King, East Sussex Fire & Rescue

"Without the support of the CareLink Plus team we quite simply wouldn't be able to successfully help individuals who are isolated, vulnerable and alone! Through a strong partnership approach to identifying need; assessing individuals; and providing joint provision, we have worked together to help older people living in the Brighton and Hove community who say their lives have been completely transformed for the better. "
Emily Kenward, Time to Talk Befriending

5. Important considerations and implications

5.1 Legal:

It is a function of the Health and Wellbeing Board to oversee and monitor provision of Adult Social Care in the City. The primary legislation governing Adult Social Care is the Care Act 2014. Section 2 of the Care Act 2014 imposes a duty on the Local

Authority to provide or arrange for the provision of services, facilities or resources, or take other steps, which it considers will—
(a)contribute towards preventing or delaying the development by adults in its area of needs for care and support;
(b)contribute towards preventing or delaying the development by carers in its area of needs for support;
(c)reduce the needs for care and support of adults in its area;.
(d)reduce the needs for support of carers in its area.

The Care Act also imposes duties to promote wellbeing, provide information and advice, work in co-operation and partnership with other organisations and meet care and support needs on a person centred basis.

Additionally in carrying out its functions the Local Authority must have regard to the Human Rights Act 1998; Article 8 of the European Convention on Human Rights provides for the individual's right to privacy and family life.

Lawyer consulted: Sandra O'Brien Date: 23/05/16

5.2 Finance:

The living well project is funded through the Better Care Programme in 2016/17 with a budget of £0.235 million. The project was within budget for 2015/16 and the expectation is the same for 2016/17.

The project provides early interventions for people, which can help to reduce, prevent or delay the need for long-term care and support. A review on clients that the project has worked with to date, estimate cost reductions (non cashable savings) in the region of £1.565 million (£5,000 per client). Examples of these savings are by mitigation of residential placements, night care and falls prevention.

Finance Officer consulted: Neil J Smith Date: 17/05/16

5.3 Equalities:

The project officers have received equalities related training and through their professional approach seek to provide good outcomes for all people supported, recognising and supporting specific

equalities issues and needs. An equalities impact assessment will be completed on the project impacts.

5.4 Sustainability:

The preventive approach which this project provides supports the delivery of sustainable adult social care provision.

5.5 Health, social care, children's services and public health:

A partnership approach has been a key feature of this project to provide wide reaching outcomes for people. The project has been developed in conjunction with CCG colleagues and reports to the better care board.

6. Supporting documents and information

Appendix 1 Case study: Maisie's story
Appendix 2 Case study: Jean and Ron's story
Appendix 3 Case study: Jim's story

Please note, these case studies have been anonymised but are based on real-life situations.

Appendix 1

Maisie's story

Maisie is a retired nurse in her nineties, and lives by herself in Woodingdean, with a son living close by. She has a sharp sense of humour, a poor memory, and a history of falls. Community Short Term Services made contact with Living Well to request support around discharge planning to help Maisie to return home from inpatient rehab, following a best interest meeting. The understanding was that there would be a two week timeframe during which Maisie could still return to the short term service (nursing home) if discharge was not felt to be a success. While still at the nursing home, we were able to show Maisie a falls pendant, which would raise an alert for help if she were to have a fall, even if she didn't remember to press the button, and we discussed other equipment that could be a help to her. The decision following the meeting was that it was in Maisie's best interest to return home with support from a package of care and Telecare.

As Maisie returned home she was distressed and distraught as she didn't recognise her home environment. Just that week our team had become Dementia Friends, so we recognised straightaway that Maisie was expecting to see a home of her youth, and we encouraged her to recognise objects which may be familiar to her, like photos, cards, and ornaments, which would help to orient her to time and place.
Once Maisie was feeling a little more settled, we installed a bed sensor, smoke detector, carbon monoxide detector, a falls detector, and two flood detectors. Prior to Maisie's hospital admission she had tried to flush incontinence pads down the toilet which had caused flooding, and which had resulted in Maisie's landlord serving an eviction notice. Living Well were able to identify a suitable place for a temporary keysafe to be fitted until permission from the landlord was obtained for a permanent keysafe. This was crucial to the discharge going ahead that day and prevented re-admission to the nursing home.

The bed sensor and special falls pendant will support issues with night-time and day-time falls, alerting CareLink Plus if a fall occurs so help can be quickly accessed.

With the support of telecare alongside the home care calls, Maisie has been able to return home safely rather than move into longer term residential care. Maisie enjoys the social interaction with the carers, and looks forward to seeing her son.

Appendix 2

Jean and Ron's story

Jean cares for her husband Ron who has advanced Alzheimer's Disease. With no package of care currently in place, Jean supports Ron with all activities of daily living. A recent assessment of Ron's needs confirmed that if he were to move into a residential placement he would need one to one support around the clock due to his high care needs and risks of falls.

At the point of referral to Living Well, Jean felt close to being unable to continue in her caring role. She was unable to attend her own health appointments, and had become low in mood – expressing suicidal thoughts and was unable to leave the house with Ron, as they were waiting for a wheelchair from the Wheelchair Service.

Through a referral to Living Well, a CareLink Plus unit was installed and a GPS device set up, giving Jean support at the touch of a button, in out of the home. She was referred to Crossroads, to allow her to attend her own appointments, and a referral was made to the Red Cross Equipment Loan service, through which Jean was able to rent a wheelchair. A Carers' Emergency Back-Up Plan was completed, and respite options were discussed. At the moment Jean and Ron are being supported to plan a holiday together at a Revitalise break, which will support Jean in her caring role, and give Jean and Ron some quality time together. A Playlist for Life is also being created, made up of Ron's favourite songs, which he will be able to listen to on an iPod.

Jean said the support from Living Well "has made such a difference to our lives. Installation of the CareLink unit and GPS has made me feel a lot safer. The Emergency Back-Up Plan means I don't worry so much about being ill, wondering how I would cope with caring for Ron whilst I was ill, because now I know I can call for back up. I am also so excited about the playlist for Life project. I know Ron will enjoy listening and singing along to his favourite music. I feel that the staff from Carelink are more like friends. They make time to listen, especially for people like me who are not always in contact with other people. I cannot thank you enough Charlotte, Carelink, Crossroads and all the staff who make life a lot easier."

Appendix 3

Jim's story

Jim is a fiercely independent 96 year old man who lives in Brighton. He has a history of recurring pneumonia, a heart bypass, severe hearing impairment, and he's awaiting a cataract operation.
Jim was admitted to hospital with community acquired pneumonia, and was referred to Living Well by the Hospital Social Work Team to support him to return home. We were able to visit Jim on the same day we received the referral, and made a visit at the same time as Community Rapid Response Service (CRRS) who were also supporting Jim to return home safely. In addition to installing the CareLink unit and alarm pendant so Jim could call for help in an emergency, we identified that Jim would benefit from a smoke detector and carbon monoxide detector as there was a note on Care First reporting a small house fire in 2013. For the moment Jim has declined these but we are hoping that he will accept these.

A week after the CareLink unit and pendant had been installed Jim pressed his button and reported shortness of breath, and was able to be admitted to hospital in an appropriately timely way, and receive treatment as soon as possible. After returning home for a second time, Jim reported being very cold at home, and we contacted the Red Cross Discharge service who were able to provide extra blankets and a warm pack straightaway. The Red Cross also got in touch with Jim's GP, who was able to confirm an appointment for his cataracts, which is hoped will improve his eyesight and reduce the discomfort he has been experiencing.

At this time, Jim said he would like to move, as his bedsit flat has one small fire which he sits in front of to keep warm, there is a communal toilet and shower at the end of the corridor down one step, and this involves walking in the dark to get to the light switch. A urine bottle has been ordered to reduce the risk of falls at night, and an application to Homemove is going to be completed to support Jim to move into more appropriate accommodation.

We have also been able to refer to initial Response Service Technicians (IRST) to trial hearing equipment for his door bell, phone and the TV, which will help Jim to hear when he has visitors and phone calls, as well as ensure he can enjoy the programmes he likes to watch. Jim receives a daily meal from Coleman's Meals, he continues to be able to get out and about, and is independently completing activities of daily living.

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1. Disabled Facilities Grant (DFG) Update Report

1.1. The contents of this paper can be shared with the general public.

1.2 This paper is for the Health & Wellbeing Board meeting on the 7 June 2016

1.3 Author of the Paper and contact details
Sarah Potter, Operational Manager Housing Adaptations, Hove Town Hall, Tel: 01273 290789, email: sarah.potter@brighton-hove.gov.uk

2. Summary

2.1. This report gives an overview of the Disabled Facilities Grant (DFG), how it contributes to Better Care work streams, capital pressures and financial recovery plan measures in place and proposals to cover overspends, a forecast overspend for 2015/16 previously shown within the Better Care Fund reporting.

2.2. It sets out the value for money case as research suggests the DFG can support people to remain independent in their own homes – reducing or delaying the need for care and support, and improving the quality of life of residents

3. Decisions, recommendations and any options

3.1 That the Board notes the contribution to Better Care work streams around prevention and Keeping People Well

3.2 That the Board notes the value for money case and approves an approach to budget setting which takes account of the Govt allocation via the DFG announced February, and projected spend

4. Relevant information

4.1 **Overview:** DFG is a mandatory housing grant (Housing Grants, Construction & Regeneration Act 1996); the legislation sets out the type of work grant can be claimed for, the assessment process, the test of resource and maximum amount of grant payable.

4.2 In 2015/16 there were 130 grant completions of which 12 were Children's cases (£221,063) and 118 were Adults (£958,554) In B&H the DFG also pays for some equipment (e.g. lifts , hoists specialist bathing and toilet equipment) which in other local authorities is not funded via DFG. Equipment accounts for about 20% of our total DFG spend. This spend directly reduces pressure on other Health and Social Care equipment budgets

4.3 The DFG only funds major adaptations in the private sector. The Housing Revenue Account (HRA) funds adaptations and equipment in council homes. While Ccouncil households make up just 9.8% of all households in the City (2011 census) they account for around 50% of referrals for major adaptations and a comparable investment. In 2015/16 there were 258 major adaptations funded via the HRA, an investment of £1.067m

4.4 **Contribution to Better Care work streams**: DFG funded adaptations contribute to meeting a range of Public Health, NHS and Social Care outcomes, around prevention and Keeping People Well:

- the vast majority of disabled people live in general (not Specialist) housing and so home adaptations play a key role in enabling safe, healthy, independent living at home.
- adaptations can reduce health and social care costs, help to reduce risk of injury [e.g. from falls], enable faster hospital discharge, delay onset of admission to residential care and reduce care costs
- Studies in a range of disciplines confirm that the home environment is a quantifiable determinant of health, quality of

life and well-being. The quality and suitability of the home environment is particularly important for disabled people, older people, those living with a chronic disease or the consequences of a serious injury, and those who experience functional and cognitive difficulties.

- DFG provides the financial help with home adaptations where disability coincides with low income and health inequalities.

4.5 The cost benefit of timely adaptations is well documented. The Audit Commission (2009) 'Building Better Lives – getting the best from strategic housing' found that spending between £2,000 and £20,000 on adaptations that enable an elderly person to remain in their own home can save £6,000 per year in care costs.

4.6 **Capital pressures:** Reports to Housing Committee in 2014 and 2015, all with Finance comments, have flagged:

- capital pressures in context of rising demand and impact of the end of the private sector housing renewal capital programme and Housing 'top up' of the DFG allocation
- The work in Housing to proactively manage demand e.g. through its commissioning of new affordable housing including wheelchair accessible homes, over the Homes & Communities Agency 2011 – 15 Programme delivering 64 new affordable fully wheelchair accessible homes exceeding the target 10% , and making the best use of the Council's adapted and accessible housing stock
- all financial recovery measures in place to manage spend

Extracts from the Housing Committee meetings, minutes and recommendations have been shared with Health & Well Being Board.

4.7 In 2014/15 the total DFG budget was £1.075m (made up of £0.751m Govt DFG allocation, £0.138m grant carried forward against existing commitments and £0.186m private sector housing 'top up') The total spend against the mandatory grant was £1.441m. This resulted in an overspend of £0.368m.

4.8 An action plan was put in place to address the capital pressures in 2015/16 and to manage the spend within an indicative budget £0.911m over a three year period, measures included:

- conditions on all DFG grant approvals in 2015/16 to defer payment until April 2016

- 65% of grant assisted work in the private sector going through the Council's Adaptations Framework – saving an estimated 17% on price
- stopping paying for extended warranties on equipment
- reducing fees
- seeking a greater contribution from Registered Providers (RPs) for up to 40% of the overall cost of works to their homes.

The cost of equipment continued to be funded through the DFG route

4.9 The measures above helped manage the spend in year however deferring the payment of grants approved after 1April 2015 until April 2016 did result in delayed starts on site. The Housing Adaptations team worked with the Council's Framework contractors to mitigate the impact as far as possible, e.g. continuing to prioritise Critical cases, however 51 grants were deferred and start dates were delayed in some cases

4.10 In 2015/16 the DFG spend was £1.179m. This results in an overspend of £0.268m.

4.11 It is proposed to treat the overspend of £0.368m for 2014/15 separately to the £0.268m overspend in 2015/16. The 2014/15 overspend has now been reduced to £0.305m and continuation of the financial recovery plan by Housing should reduce this overspend to zero during 2018/19. The £0.268m overspend for 2015/16 has been funded from the reallocation of underspends elsewhere within Better Care and Adults.

4.12 For 2016/17, the estimated spend is £1.570m which is higher than 2015/16 due to grants being deferred. The DFG grant for 2016/17 is £1.597m which is to be allocated by this Board

4.13 The Dept. of Health recognises the importance of the DFG in its announcement in February about the increase in funding nationwide, the duty of Housing authorities to administer the grant and flexibility to use specific DFG funding for wider purposes, which may be more appropriate for individuals, such as moving home, where this is a more appropriate solution.

5. Important considerations and implications

Legal:

5.1 Part 1 of the Housing Grants, Construction and Regeneration Act 1996 deals with the administration of Disabled Facilities Grants. The measures outlined in paragraph 4.8 to address capital pressures are permitted within the statutory framework.
Lawyer consulted: Liz Wooodley Date: 13/05/16

Finance:

5.2 The current overspend carried forward from 2014/15 is £0.305m. Continuation of the financial recovery plan within Housing should reduce this overspend to zero during 2018 as long as spending plans for DFG are fully funded going forward. The forecast spend for 2016/17 is £1.57m which is higher than 2015/16 due to payments being deferred. The DFG grant for 2016/17 is £1.597m, which is to be allocated by this board. If the amount of grant allocated does not cover costs, further efficiencies or reductions to this service will be necessary to ensure costs are within budget.

Finance Officer consulted: Monica Brooks Date: 19/05/2016

Equalities:

5.3 The Department of Health recognises the value for money of concentrating its social care capital grant funding into the Disabled Facilities Grant as research suggests it can support people to remain independent in their own homes – reducing or delaying the need for care and support and improving the quality of life of residents. Adequate funding of the DFG is critical to meet the statutory duty and to ensure we can deliver timely adaptations supporting people to remain as independent for as long as possible, to remain healthy and well and to manage their physical and mental health condition.

Sustainability:

5.4 The delivery of major housing adaptations enabling people to live as independently as possible for as long as possible is an investment in the existing housing stock, increasing the supply and quality of accessible and adapted homes for current and future occupiers.

5.5 Using the council's Adaptations Framework for DFG funded work ensures private sector housing adaptations are carried out by

contractors who scored highly on sustainability including energy use, recycling, procurement of sustainable products and accreditations such as ISO 14001. In addition the Framework Agreement requires use of sustainable timber in line with FLEGT, the standard for all relevant BHCC contracts

Health, social care, children's services and public health:

5.6 These are covered within the paper.

6. Supporting documents and information

6.1 none

Although a formal committee of the city council, the Health & Wellbeing Board has a remit which includes matters relating to the Clinical Commissioning Group (CCG), the Local Safeguarding Board for Children and Healthwatch. Papers come from a variety of sources. The format for Health & Wellbeing Board papers is consequently different from papers submitted to the city council for exclusive city council business.

1. Brighton and Hove Clinical Commissioning Group draft Annual Report 2015/16 and Group Operating Plan 2016/17

1.1 The contents of this paper can be shared with the general public

1.2 This paper is for the 7th June 2016 Health and Wellbeing Board meeting.

1.3 Author of the Paper and contact details

John Child
Chief Operating Officer
Brighton and Hove Clinical Commissioning Group
johnchild@nhs.net

2. Summary

Each year the CCG have to provide an Annual Report detailing their performance and accountability of the pervious year. In addition there is a yearly Operating Plan which lays out what the CCG intend to deliver in the forthcoming year.

The Report and Plan go through the CCG governance processes then come to the Health and Wellbeing Board.

While the Annual Report comes to the Board for information, the Operating Plan gives detail of the commissioning intentions of the CCG. The Health and Wellbeing Board has a responsibility to ensure that the commissioning intentions have sufficient regard to the Joint Health and Wellbeing Strategy of the city.

The Board has already received a draft Operating Plan which was duly noted. This is the final document and this comes to the Board for information.

3. Decisions, recommendations and any options

The Annual Report is in draft and is for noting. This paper has come in draft form as it will need to be submitted as final before our next Board meeting in July 2016.

The Operating Plan has been to the Board in draft form. It is now final and is for noting.

4. Relevant information

5. Important considerations and implications

5.1 Legal

The CCG has a legal obligation to draw up both reports.
The CCG has a duty to share commissioning intentions with the Board. The Health and Wellbeing Board has to ensure that the commissioning decisions have clear regard to the Health and Wellbeing Strategy.

4.2 Finance

No implications for this report for information.

4.3 Equalities

No implications for this report for information.

4.4 Sustainability

No implications for this report for information.

4.5 Health, social care, children's services and public health
No implications for this report for information.

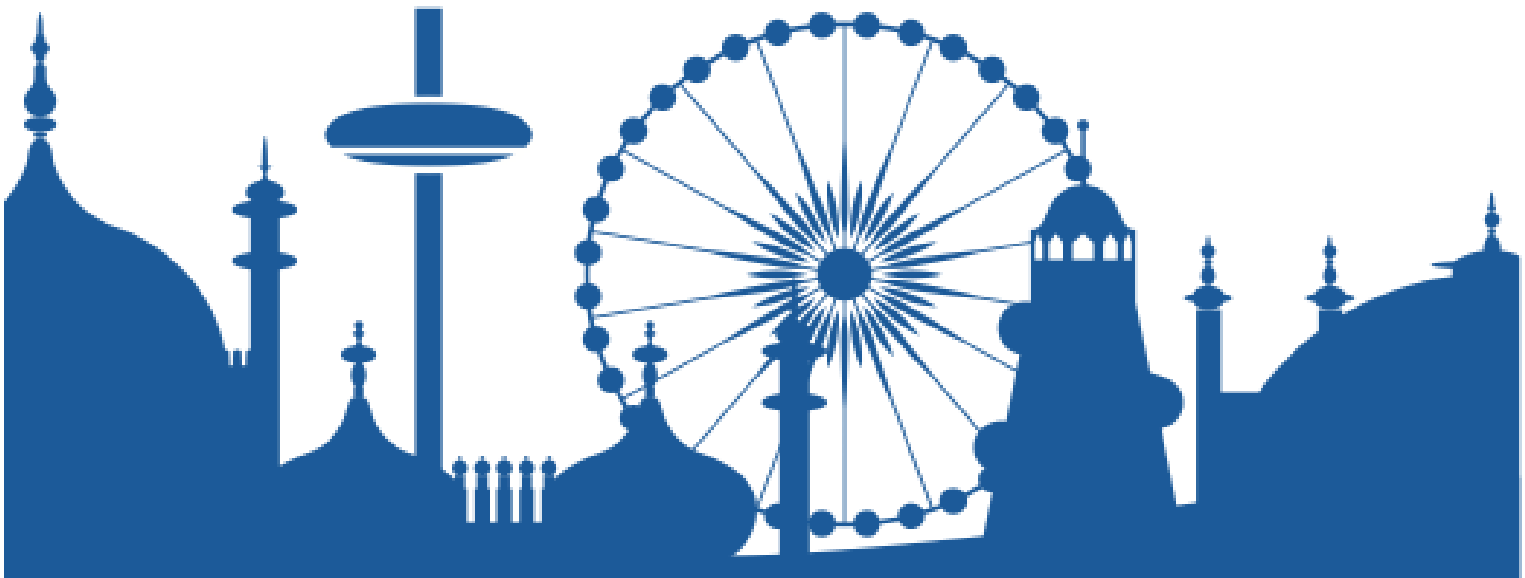
5 Supporting documents and information

Appendix 1 Brighton and Hove Clinical Commissioning Group Draft Annual Report

Appendix 2 Brighton and Hove Clinical Commissioning Group Operating Plan 2016/17 (Final)

NHS
Brighton and Hove
Clinical Commissioning Group

Operating Plan 2016/17



Better Health For Our City

Contents

1. Introduction and Background

1.1 Introduction

The Brighton and Hove Operating Plan 2016/17 describes how the CCG will deliver the vision outlined in the Brighton Clinical Strategy and is set in the context of the emerging themes of the Sustainability and Transformation Plan.

The Brighton and Hove Clinical Strategy describes how as system leaders the CCG will deliver rapid recovery and a sustainable future model of care that addresses 3 key gaps identified by the 5 Year Forward View – in terms of health, quality and finance. The Strategy defines Brighton and Hove's CCG's vision for improvement and sustainability for our local health system, and aligns with the direction and purpose of our neighbouring CCGs' strategies and plans for the catchment of our local trust (BSUH).

The CCG Clinical Strategy provides a coherent strategic framework from which our more detailed local implementation plans, which are evidenced in this annual operating plan, are developed.

Our vision is to radically transform the local model of healthcare from one that is reactive, bed based and generally delivered in crisis, to one that is more person-centred, proactive, preventative and built on the foundation of sustainable and high quality general practice and truly, integrated partnership working.

Our aim is to strengthen integration between:

- health and social care services;
- primary and secondary care services;
- mental and physical health services;

to improve health outcomes and increase the quality and efficiency of services.

During 2015/16 the local health economy has faced significant performance challenges. Access to emergency care services has been below the required standards and patients have faced long waits for planned care services. Improving the performance against key national and local targets is of paramount importance to the CCG. As such, our plans focus on the dual themes of delivering short term recovery whilst laying the foundations for the longer term models of care which will ensure sustainable delivery of high quality health and care services in the future.

Fundamental to developing this plan has been an in depth analysis of our current performance in terms of both spend and outcomes. This has allowed us to target resources to those areas of the highest need and those that will deliver the highest impact. The plan has also been shaped by the national guidance including the Five Year Forward View: Shared Planning Guidance and the NHS Mandate.

1.2 National Context

NHS England and independent analysts have calculated that a combination of growing demand and flat real terms funding would produce a mismatch between NHS resources and patient needs of nearly £30 billion a year by 2020/21.

This scale of challenge cannot be met by efficiencies alone and the expectation is that transformational change will support the delivery of this ambition. The change needed is described in the national planning guidance: NHS Mandate and Five Year Forward View Shared Planned Guidance, which are summarised below.

NHS Mandate

The Government's NHS Mandate 2016-2017 sets out the budget, objectives and expected deliverables for the NHS in both the short term, with details of specific outcomes for 2016-2017 and staged through to 2020. It outlines the objectives and goals for the NHS in delivering sustainable improvements in care, outcomes quality and equity of access for patients as well as the expected engagement with new technologies and achieving financial security. The Mandate for 2016-2017 makes clear the commitment to a multiyear budget and planning programme which supports NHS England's and the CCGs delivery to 2020. The requirements of the mandate form the backbone of this operating plan.

Shared Planning Guidance

The Five Year Forward View Planning Guidance sets out the priorities for local and national NHS organisations for 2016/2017 and the expected scale and pace of delivery of change and services forward to 2020. The guidance highlights the expectation that all NHS developments must be based on three deliverables:

- The implementation of the Five Year Forward View
- Restore and maintain financial balance
- Deliver core access and quality standards for patients.

The Planning Guidance further states the CCG Operating Plans for 2016-2017 should be ambitious in the visioning and implementation of new models of care, promote engagement with new technologies and focus on supporting actions to drive clinical priorities. In developing the Operating Plan for 2016-2017, the CCG have used this guidance as a template to articulate credible and far reaching plans, initiating the progressive steps towards working with other organisations to facilitate the goal of place-based planning and the associated governance to assure the success of this.

Sustainable Transformation Plan

As described above, the delivery of a sustainable, transformed NHS, which is place based and facilitates commissioning and integration across all services, is dependent on the development of a credible, ambitious sustainable transformation plan (STP).

Work on the Sustainable Transformation Plan is well underway. The Sustainable Transformation Plan submission to NHS England in early April 2016 defines the geographical and provider footprint for the STP. The footprint covers East and West Sussex and East Surrey and is comprised of 23 partner organisations including commissioners and providers and health and social care organisations. The footprint covers service provisions for a population of two million people which includes pockets of severe deprivation and substantial health inequalities

A programme board has been formed, with established Terms of Reference, and meets fortnightly. The Board membership includes the Chief Officers/ Chief Executives of all partner organisations, representatives from 4 county councils and GP representatives. The Urgent and Emergency Care Network (UECN) share their footprint with the STP area and the chair of the UECN is a member of the STP Programme Board. This will facilitate coordination and planning and provides opportunity to drive improvements in Urgent and Emergency Care at pace. Decisions at Programme Board will be reached by discussion and consensus.

To support the initial phase of framing the problems, sub-groups have been formed and tasked with defining the performance gaps: Health and Wellbeing is led by the local Public Health leads, Care and Quality by partner quality leads and Finance and Efficiency by partner Directors of Finance. Healthwatch will be invited to attend so the views of the public and patients are well represented at this level. For further details please see the Sustainable Transformation Plan.

1.3 Working with Patients, Carers and the Public

In addition to using the above guidance as a planning framework, the CCG has also developed our plans with extensive engagement with patients, carers and the public. Over the past year, the CCG has built on existing work to engage with patients, carers and the public to ensure we achieve our aim that patients and their carers are at the heart of the CCG's work. The means to achieving this is described in our Patient and Public Participation Strategy.

To support the delivery of the Patient and Public Participation Strategy the CCG has established the Participation and Communication Assurance Committee (PARC), a sub-committee of the Governing Body. This committee has a role in assuring the Governing Body that we hear and act on the voice of local patients and their carers. It is chaired by the Governing Body's Lay Member for Patient and Public Participation. The membership of the group includes the Community and Voluntary Sector, Healthwatch, Public Health and an elected member from the PPG Network whose role includes bringing issues from the Network to PARC.

We have continued to build our Patient Participation Groups in each GP practice, supported by Community Development organisations through a commission overseen by Community Works. This expertise enabled the development of groups and supported our GP practices to understand and appreciate the potential of a Patient Participation Groups. We continued to develop the Hangleton and Knoll Health forum, which incorporates 4 PPG's and takes a community based approach to looking at primary care and community support in this

discrete geographical area. We have awarded 10 small grants to PPGs in the city this year, against criteria to further develop PPGs, link with local communities and support community approaches to health and wellbeing.

We have carried out engagement for many of our clinical work streams through the year; one highlight was the work we carried out, with support from the National Commissioning for Better Patient Experience programme, on support for those who have lived with, or continue to live with, cancer after active treatment ceases. A number of peer researchers gathered the views and experiences of cancer patients and survivors, and worked in collaboration to pull out key themes and develop solutions for future action.

In late 2015 the CCG and Healthwatch commissioned a community engagement specialist to engage with seldom heard groups and individuals. We heard from over 750 individuals whose responses provided insight into views and experiences of accessing and using primary care. The work helped us understand the barriers to people looking after their physical and mental wellbeing.

During 2015 we worked with local people with complex conditions and their carers to collaboratively develop Person Centred Outcome Measures. We used these insights to develop "I statements" based on what is important to these individuals and their carer's. We are currently trialling the use of these measures in person centred care planning within our proactive care teams.

2. Local Strategic Context

2.1 Adult Social Care

Financial pressures are challenging the scope and means of delivery of adult social care services for Brighton and Hove. Adult Social Care are identified to deliver £7.14 million savings for 2015-2016 and are anticipating delivery of further savings of £21.9 million by 2020.

Further enhancement of partnership working with the City Council will progress the integration of health and social care services, mental health services and children's health services to ensure we are achieving the best value for money from the public purse and to deliver better outcomes and improved experiences for our population.

The Brighton and Hove's City Council's vision going forward to 2020 includes:

- Signposting- information and advice to enable people to look after themselves and each other and get the right help at the right time
- Stronger communities- help people to build support networks by working in partnership with local health and community services
- Getting people on the right track- preventative services that help people stay independent for longer and support them to recover after illness
- Citizens will be in control of their own care- when people do need extra care and support, services will be personalised and joined up around individual needs

This vision aligns with the direction of the CCG plans and the work to progress this has already commenced and will continue through 2016-2017 year. The challenges and aspirations both organisations face going forward to 2016-2017 will foster greater and more efficient integration and joint working on programmes. Services separately commissioned by the CCG and the Council have been similar in the past and closer working will avoid this in the future and deliver efficiencies.

The ambitions for the diverse population of Brighton and Hove are the same across the organisations; a desire to promote and improve wellbeing in individuals and support them in actions to prevent them becoming unwell. For those who are in need of support and help in living we will commission services that will support independence, personal choice and control.

2.2 Brighton and Hove Joint Health and Wellbeing Strategy 2015

The draft Brighton and Hove Joint Health and Wellbeing Strategy (JHWS) 2015 outlines the health and wellbeing goals for the people and communities of Brighton and Hove City. The strategy aims to improve the health and vitality of the Brighton and Hove population and communities while also striving to reduce the inequalities that exist within it. These goals will be progressed through a multiagency, cross sector approach

which will deliver a range of plans across the city over the next 5 years. The JHWS is to undergo further development in response to the forthcoming outcomes reported by the Fairness Commission in summer of 2016. In addition, baseline data for a number of initiatives cited in the strategy is being gathered. The final iteration of the Health and Wellbeing Strategy will be published in summer 2016.

The JHWS is based on a partnership approach which recognises the contributing influences on health and inequality; these include education, housing and employment. Further to this, the strategy partners acknowledge these change ambitions are being initiated in a time of financial constraint. In response, partners in the strategy have agreed the need to "pull the resources together- not only money but staff, buildings and resources- to ensure that together we maximise the impact of what we already have". JHWS priorities identified for the population of Brighton and Hove are summarised below.

- Reducing Inequalities across the city
- Safe, Healthy, Happy Children, Young People and Families
- Provide each individual the chance to live and age well
- Develop Healthy and Sustainable Communities and Neighbourhoods
- Provide Better Care Through Integrated Services

2.3 Our Population

The population of Brighton and Hove is distinctively different from that of most cities in England, it has lower proportions of people aged between 65 and 74 years old and children, and a higher proportion of adults aged between 19 and 44 years old. There is also an unusually high proportion of students and Lesbian Gay Bisexual Trans (LGBT) residents. This type of population is classed as a 'Sphere population' in the NHS Atlas of Variation, and is seen in only 20 cities in England.

The City currently has approximately 281,100 residents, with an equal male to female ratio. The life expectancy for females (82.6 years) is higher than that of males (78.5), and the main all-age mortality causes are similar for both. Males experience a higher proportion of deaths due to external causes, and emergency hospital admissions.

It is estimated that the LGB communities account for 15% of the Brighton and Hove population, and there are approximately 2,760 transgender people residing here. LGBT residents have an increased risk of mental disorders, homelessness and domestic violence.

According to the latest census in 2011, White British people account for around 80.5% of the city's population, and 19.5% identify as BME. One-quarter of births within the city are to mothers who were born outside of the United Kingdom, and 8.3% of people over 3 years old do not have English as their primary language. BME residents tend to have a lower uptake of services due to a multitude of factors, including lack of cultural awareness within service delivery, and difficulties in access. Migrant residents have a higher prevalence of infectious diseases and a lower uptake of cancer screening.

There are an estimated 17,400 military veterans residing in Brighton and Hove, the majority of which are male. This is an important sub-group of the population to consider due to their increased risk of mental illness, limb loss and musculoskeletal disorders.

Around 9% of the city's population identify as carers, and it is estimated that around 2,000 a year will need treatment for stress-related illness or physical injuries sustained through their role.

There are currently 34,335 students registered with the universities of Brighton and Sussex. This sub-group have increased need for mental health, sexual health and alcohol and drug misuse services. Students account for over 10% of the local population, and a proportion choose to stay in the city after graduation each year.

2.4 Joint Strategic Needs Assessment

The CCG identify health and social needs by working with public health staff to develop the Joint Strategic Needs Assessment (JSNA). The JSNA enables us to understand the different needs of people in different areas based on factors such as the age structure of the population, socio-economic status, ethnicity, and access to health services which are all associated with particular health risks. It also identifies areas where we are doing well and those which need improvement.

The JSNA identifies the following key health and wellbeing issues in the City:

- Increasing rates of limiting long term illness: The majority of people aged 75 years and over in Brighton & Hove live with a limiting long term illness, as do a significant proportion of those aged under 75 years (38% of males aged between 65-75 years);
- Social isolation and relationship with health: Brighton & Hove has a relatively large proportion of older people living alone and potentially isolated who are more dependent upon public services. Single pensioner households are higher than average and the majority of people aged 75 or over live alone; of those living alone, 34% are male, 61% female;
- High levels of mental health & substance misuse (drugs and alcohol): The City has almost twice the national suicide and undetermined injury death rate in older people. 13% of adults have a common mental health disorder while 1% has a more severe disorder. Both of these rates are higher than average levels. 18% of adults in the city are believed to engage in increasing or higher risk drinking. Rates of alcohol-related A&E attendance and hospital admissions have increased in recent years. In addition, the city faces challenges from substance misuse.
- Homeless: We have increasing levels of homeless and housing pressure. We have seen homelessness increased by 38% over the last three years. There is a huge inequality in terms of morbidity and mortality; the average age of death of a homeless man living on the streets of Brighton is 47 years compared with an average of 77 years for the population of Brighton as a whole. The JSNA estimates that the homeless population A&E attendance rates are 5x higher than B&H average.
- Cancer Outcomes**:** 1200 of people in Brighton and Hove are diagnosed with cancer annually, predicted to rise by 2% annually. In Brighton and Hove the 2012-2013 Royal College of General Practitioner's cancer audit showed:
    - 10% of cancer diagnosis were made through the emergency route
    - One third of cancers with a recorded stage are diagnosed at a late stage
    - High levels of deprivation are associated with lung cancer which has the poorest prognosis
    - 17% of cancers in the East of the city were lung cancer compared with 12% of all cancers in the rest of Brighton
    - Unacceptable delays in the pathway from primary care and secondary care and to first definitive treatment.

2.5 Right Care Approach

The Right Care approach brings together a variety of evidence sources to optimise and target commissioning and maximise value.

Brighton and Hove CCG has adopted the Right Care approach in the development of this plan. A high level summary of the evidence from Right Care, Commissioning for Value and Atlas of variation is outlined below.

There are 5 conditions/areas where the outcomes for patients in Brighton and Hove are significantly worse than our peers: musculoskeletal (MSK), diabetes, respiratory, circulation and mental health. The CCG have started to address the poor outcomes in these areas. During 2015/16 a new MSK service was implemented, the CCG procured a new diabetes service and reconfigured the city's respiratory services. Our plans for 2016/17 include further development of our plans for circulation and mental health conditions.

There are 5 areas where we spend significantly more than our peer CCGs: trauma and injuries, mental health, neurological conditions, cancer and circulation. Additionally Brighton and Hove CCG have four key areas where we spend more and have worse outcomes than our peers: trauma and injuries, mental health, diabetes and circulation.

Using the evidence collated as part of our JSNA and Right Care we have developed a list of clinical priorities from which we have derived the programmes for 2016/17.

3. Local Financial Context

Brighton and Hove CCG has consistently achieved a surplus above the required 1%. In 2015/16 the CCG will post a surplus of £12.6m (3.4%). The requirement in the planning guidance is for the excess surplus to be drawdown by the CCG over the next three years.

The CCG is deemed to be overfunded under the weighted capitation formula in 2016/17. Moving into 2016/17 the CCG has moved closer to its fair shares target. This exerts a financial pressure on the CCG as it has received no real terms growth and this will be the case over the next five years. Even with the restriction on growth of the CCG allocations the CCG remains at c4.5% over funded.

The lack of real terms growth makes it difficult for the CCG to progress the transformational changes were it not for the ability to drawdown £9m of our carried forward surplus over the next three years. To do so will require the production of robust business cases to NHS England. These are also a requirement of our internal planning process and CCG governance. As a planning assumption we are assuming NHSE agree to a £3m drawdown in 2016/17. This will take the CCG surplus control total for 2016/17 to £9.7m (2.6%).

The plans for 2016/17 commits none of the (now) 1% Non-Recurrent reserve. This is in line with planning guidance but we will need to allocate these funds during the year on items such as the transitional support to BSUHT for the implementation of 3T's once the transitional costs are determined. In previous years we have maintained the recurrent/non-recurrent split at 98% recurrent and 2% non-recurrent but have now moved to the minimum requirement of 1% non-recurrent reserve. This is part of the medium term financial plan and assists the CCG in coping with the lack of real terms growth.

The plans contain a 0.5% contingency reserve as required in the planning guidance financial rules. The overall framework will be challenging for the CCG given the context of our distance from target and the resultant restriction on growth.

The CCG has set a QIPP efficiency savings target at 2.6% (£10.0m), which currently includes £4.6m of unidentified QIPP savings, which increases the challenge to the health and social care system. The planning guidance encourages joint working with the City Council, the Better Care Programme Board and partners across the whole health and social care system. The CCG plans are being developed with partners and providers in the context of a wider strategic planning footprint. The CCGs have, historically, a good working relationship in relation to planning across the Sussex area. The national planning guidance recognises that this scale of planning needs to develop and continue to deliver the changes set out in the Five Year Forward View. This joint working will be evidenced during 2016-2017 though the development and delivery of Sustainable Transformation Plan.

Once we have finalised our income and expenditure plans for 16/17, we will undertake a full risk assessment and begin the task of identifying further savings initiatives. We will also review all investment plans with a view to scaling them back to meet the currently unidentified QIPP savings target and bring plans within the funding available.

Contractual Approach

Our contractual approach for 2016/17 builds the foundation for future models of care by moving away from traditional activity based contracts to outcomes and pathway commissioning. During this transitional year we will use all of the contractual levers available to us to drive improvements in quality and delivery of standards.

4. Delivering the NHS Constitution

The NHS Constitution establishes the principles and values of the NHS in England; it sets out the legal rights of patients, public and staff, the further pledges the NHS is committed to achieve and sets out the responsibilities of public, patients and staff.

We are committed to meeting the obligations and expectations placed upon the CCG by the NHS Constitution. We will do all we can to promote patient rights, address concerns where these are brought to our attention and support our providers in doing the same.

Whilst historically we performed well in delivering NHS Constitution standards and key national performance indicators, we have recently seen deterioration in a few key areas. In response to this we have strengthened our programme and performance management approach, made a clear commitment to use the contractual levers at our disposable and worked collaboratively with the local health and care economy to develop credible and deliverable plans. The sections below provide a high level summary of each of the recovery plans:

4 Hour A&E

Our previous plans failed to improve the achievement of the 4-hour operational standard. However, the improvement in the unscheduled care performance remains of the highest priority for the CCG, the Brighton and Sussex University Hospital (BSUH) Trust and for the local health economy. In line with the tripartite discussion in April 2016, the Trust has agreed an attainment of 89% against the A&E standards by September 2016. Section 5.6 outlines the plans which underpin this improvement. The plan is overseen by a Joint PMO and the Systems Resilience Group and has delivered improved A&E performance compared to last year.

The poor A&E performance has had a knock on effect on ambulance handover times. Whilst ambulance handover delays decreased in the second half of 2015/16 maintaining this target will remain a high priority. The Acute Trust is currently working up Ambulance Handover Trajectory for 2016-2017 for agreement at the next System Resilience Group.

Referral to Treatment (RTT)

Demand for planned care services from GPs has reduced this year. However, during this period, referral to treatment performance has been significantly challenged at our local acute trust. Detailed analysis of referral data has shown significant increases in referrals from consultants and other sources such as allied health professions and dentists. There has also been increasing levels of two week wait referrals.

The CCG are supporting general practice in making informed decisions with the patients through providing monthly updates of waiting times by specialty. Additionally the referral management service identify alternative providers and provide patients with appointments with these as a default position for all new outpatient appointments in specialities with long wait times.

We have worked with our local acute provider to model the available capacity and recognise that additional activity will be required to reduce the existing backlog and return to a system where demand and capacity are matched.

In order to meet the existing level of demand, we have commissioned 3% more new patient pathways per month. In addition, we have commissioned 4% more activity to ensure that those patients already on a waiting list are treated in 2016/17. The CCG is seeking to commission new capacity with local independent sector providers. This will improve patient waits and reduce pressure on the acute trust. Section 6.6 outlines the plans which underpin the delivery of this extra activity.

Diagnostics

Key to the delivery of the RTT standard is the diagnostic waiting time target of 6 weeks. During 2015/16 a validation exercise highlighted that a proportion of the diagnostic waiting list was not being correctly reported and resulting in a backlog of patients waiting for echocardiograms. Significant additional activity has taken place in recent months to reduce this backlog.

Demand and capacity modelling has highlighted some areas of concern in 2016/17. These are primarily related to endoscopy (digestive diseases) and increased diagnostic activity as a result of implementing the new NICE guidelines for cancer. We have included in our contracts for 2016/17 the additional activity required to accommodate these changes.

Cancer Access

Historically the CCG performs well on cancer access targets, however, we recognise that the number of two week referrals has increased this year and, as result of new NICE guidelines, is forecast to increase further in 2016/17. In light of this and in response to the national Cancer Taskforce Call to action the CCG and public health partners have developed a Joint Cancer Strategy, This Strategy provides a transformational framework for the diagnosis, treatment and care for people affected by cancer in the city. The approach addresses all components needed to deliver a gold standard service in the city.

A number of specific projects are being developed and implemented to support the strategy ambitions. These are detailed in section 6.6 and collectively evidence our commitment to improving and transforming the experience of those whose lives are touched by cancer.

Mental Health Access Targets

The new waiting time standard requires that 75% of people with common mental health conditions

referred to the Improved Access to Psychological Therapies (IAPT) programme will be treated within 6 weeks of referral, and 95% will be treated within 18 weeks of referral. These targets have been monitored throughout 2015/16 and our local IAPT provider is meeting both.

In addition to these new targets the services will continue to be required to maintain the access standard of ensuring that at least 15% of adults with relevant disorders will have timely access to IAPT services with a recovery rate of 50%. The CCG have consistently achieved the coverage element of this target but have struggled to deliver the recovery target; the eligibility criteria of our local service make delivery of this target more difficult. In response the CCG, is recommissioning the service in 2016/17 to ensure delivery of the required standards.

The expectation is that the new service provider will meet all national standards for IAPT services and this expectation has been clearly set out within the procurement process. The CCG have taken into account the ambition to reach 25% access to IAPT by 2020 in its re-procurement of the IAPT service. The Memorandum of Interest (MOI) which has recently been published as part of the procurement documents states the CCG's intent to commission a service that can provide 18% access within the first full year of operation (2017-18). The CCG has also made it clear that the new service will need to be responsive to changing national standards in relation to access, with an expected rise to 25% by 2020.'

NHS England has identified a 50% recovery rate as a required standard outcome for IAPT services. Brighton and Hove residences who meet the service access criteria tend to have a high acuity. We will continue to work with the existing provider and the provider of the new contract from 2017 to secure delivery of the national target to meet the recovery rate for IAPT.

Brighton and Hove CCG has invested additional money with the provider of Early Intervention in Psychosis service in 2016/17 to ensure they could achieve the access targets by April 2016. They are currently achieving the access targets and will be regularly monitored against these. A service specification has been agreed and a Service Development Improvement Plan (SDIP) will commence in 2016/17 which builds on the SDIP implemented in 2015/16. The CCG will to continue to monitor on-going service improvements.

5. Our Commissioning Plans for 2016/17

5.1 Clinical Delivery Model

Our strategic vision and clinical priorities translate into a model of transformation and care delivered through 5 interdependent elements (Responsive community services, Safe and effective secondary care, Communities of practice, Proactive/ preventative care, Reablement and Rehabilitation and) with the patient at its core, as highlighted in figure 1. The model illustrates our ambition to move from expensive, institutional and impersonal care, exemplified by inequality, disease burden and inefficient use of resources, to a sustained, resilient and healthy population with increased independence and wellbeing and efficient services. The diagram below illustrates the clinical delivery model which we believe will ensure our vision is realised.

Central to this is prevention through the active empowerment and engagement of patients and communities. People will thus have more choice and control and more ability to care for their own health.

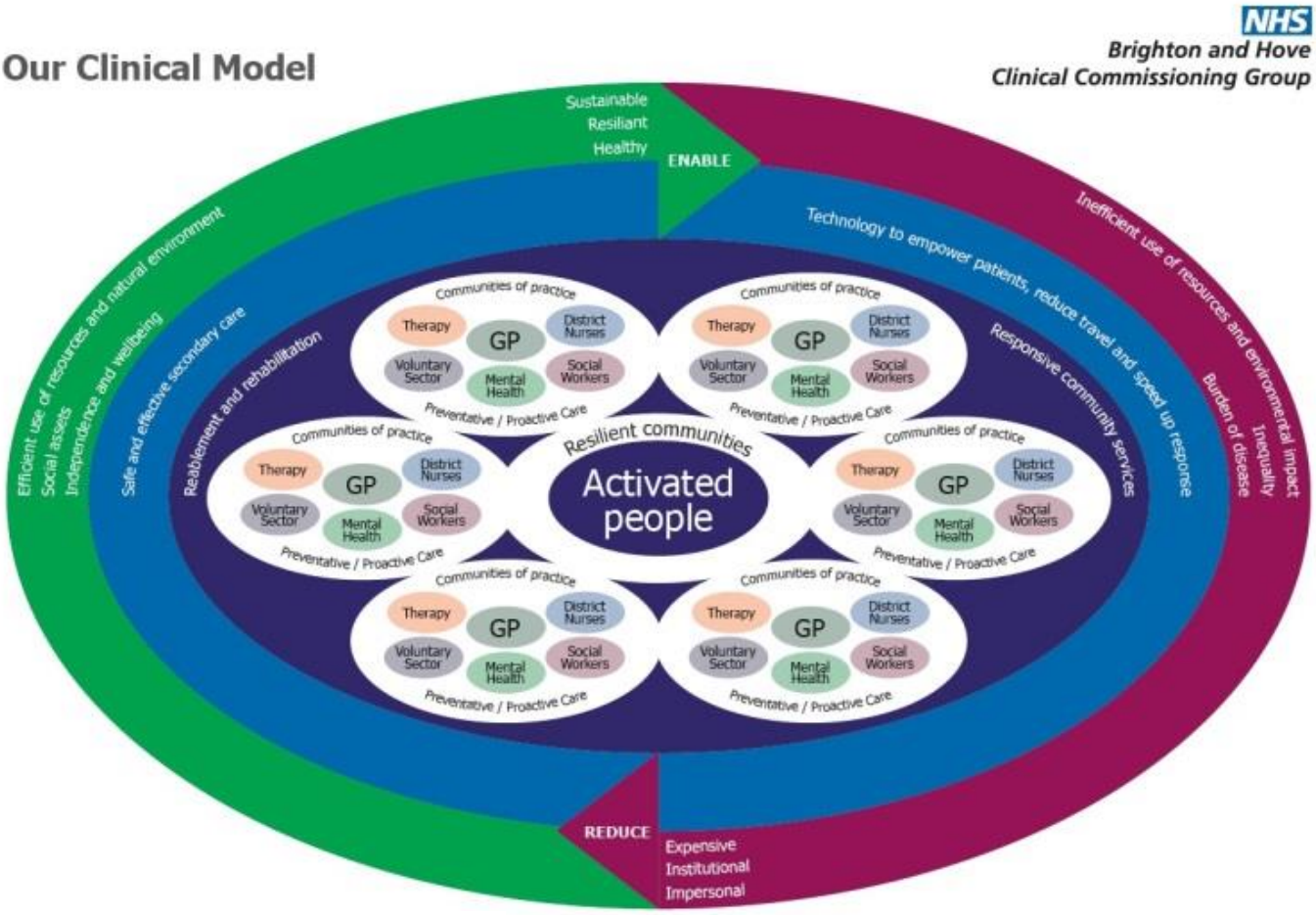


Figure 1: Our Clinical Delivery Model

5.2 Person at the Centre

The individual is at the core of our clinical delivery model and is the starting point for the development of an embedded ethos of proactive self-managed care with a focus on prevention and maintenance of independence.

Fundamental to this shift in focus, and the development of the empowered and engaged patient, is the establishment of a more collaborative model of General Practice and aligning/integrating community resources to deliver more joined up health and social care and preventative proactive support services. The patient centred vision of our clinical strategy is intended to improve the person's lifelong health pathway, support patients to have choice and control and to reduce the power imbalance between patient and service provider.

The following sections describe how we will start to deliver the clinical model in 2016/17. Our plans are summarised in Appendix 3.

Activated People

'Patient activation' is a concept that refers to the engagement of the individual in the knowledge, skills and confidence in managing their own health and health care. People who have low levels of activation are less likely to play an active role in staying healthy. They are less likely to seek help when they need it and less inclined to follow doctor's advice. Further these patients are perceived to be reticent at managing their health when they are no longer being treated.

The CCG has developed a self-management strategy that supports and encourages people to manage their own health, to stay healthy, self-manage their conditions and avoid complications where possible. In 2016/17 we will further progress this agenda by:

- completing a mapping exercise of voluntary/ community sector and self-management/peer support resources and assimilate this information into local My Life information portal for the city

- ensuring promotion of self-management through primary care cluster proactive care working (care coaches/navigators)
- utilising the CCG Locally Commissioned Services (LCS) framework to explore opportunities for a small number of projects for the self-management of long term conditions consistent with CCG objectives and JSNA priorities such as hypertension and obesity
- supporting the effective promotion of self-care personalisation initiatives such as Telecare/Living Well and Carers support projects across primary and community services
- working with Sussex Community Trust to ensure that self-management is embedded across specialist and generalist community services and integrated into care pathways; and to review the introduction of local Telehealth initiatives.

Personal Health Care Budgets

The CCG actively supports the continued rollout of personal health care budgets for individuals as a factor in the delivery of a personalised agenda for care.

The CCG already have a number of clients, funded under NHS Continuing Healthcare, who manage their own care packages, either by a direct payment or with a third party managing the budget. The CCG are working to extend this approach to a wider client group.

During 2016-17 the CCG will continue to offer the 'right to have' a personal health budget to all people eligible for NHS Continuing Healthcare and to families of children eligible for Continuing Care. We will develop a local plan that will confirm the extension of the personal health budget (PHB) offer to other care groups beyond Continuing Healthcare in 2017-20. Effectively delivery of this ambition is dependent on working with social care, NHS providers and the local voluntary/community sector to identify cohorts of people who may benefit from a PHB. This will include the following care groups:

- People with long term conditions including mental health
- People with a learning disability (within the Transforming Care programme)
- Children with complex needs.

By autumn 2016 we will confirm the approach to budget setting across these agreed care groups. This will provide consistent clarification to individuals on the amount of their PHB. The CCG will develop structure and guidance to enable individuals to exercise choice and control over how the budget is used and what mechanisms are in place for payment. These options include:

- National PHBs- where the budget remains within the NHS who commission services on behalf of the individual person
- Third party arrangements- where the budget is passed to a third party (non-NHS) organisation to purchase services on behalf of the individual
- Direct Payments- where the budget is passed to the individual who may choose to purchase services from NHS, voluntary or private providers.

The CCG is looking to establish a partnership approach with social care, NHS providers and the voluntary sector that establishes the most cost effective implementation of the PHB expansion. The plan will enable the CCG to contribute to the national target of 50-100,000 PHBs in place by 2020/21 through an aspiration to achieve at least 225 PHBs across Brighton and Hove by end 2020/21.

5.3 Transforming Primary Care

Brighton and Hove CCG are acutely aware of the challenges facing general practice and along with national initiatives are striving at a local level to support our practices in maximising the resources available to them. NHS England's new General Practice: Forward View details the additional support for general practice, from investment in training and estates to addressing the red tape and workload issues. The CCG support practices at a local level in the development of community services and to work at scale through cluster working. The CCG is also supporting practices across the City to explore the potential and opportunity to form a more formal collaborative such as a legal federation.

The requirements of the Five Year Forward View will further support this national initiative through new models of working. In Brighton and Hove some general practices, for example, have developed a robust protocol which supports clerical staff in addressing additional administrative tasks to free

up GP's time; this can include reading, coding and taking appropriate action on clinical correspondence. Brighton and Hove practices have also undertaken a recruitment drive for proactive care programme and successfully recruited additional GP capacity and non-clinical support to promote proactive care. There is an on-going review and consideration of new ways of working such as the pooling of resources through the LCS and addressing needs at scale.

We will be working with NHS England during 2016-2017 to plan co-commissioning, which along with new models of working, will ensure the CCG can actively support a more sustainable primary care sector within the City.

Section 6- Quality and Patient Safety of the plan provides detail on how we will support the development of the workforce in general practice and in the development of staff in new services to support general practice.

Proactive Care

Establishing a more proactive approach to care and support remains an integral part of this wider agenda to provide integrated care across the system. We want to connect all parts of the system, whether they are proactive or urgent, so that people receive responsive care at the right time from the right service. The capacity and system leadership from proactive care will support these wider changes in the future.

Growing evidence suggests that achieving closer integration between health and social care is key to addressing the challenges of improving outcomes for patients and reducing pressure on services, particularly acute care. This integrated approach is especially important for people with long term conditions and older people whose needs are rarely just health or social care.

Proactive care is a model of care aimed at improving the identification and management of patients at risk of deterioration in independence. The model aims to provide pre-emptive support to avoid a hospital admission or care home placement. It is designed to improve the health outcomes for patients based on holistic and personalised care planning, proactive case management. This approach focuses on self-management, early intervention and health and wellbeing. It is anticipated that implementation of the service model will have a significant impact on our frail population, targeting support at the 1% of the population who are at highest risk of loss of independence due to complex needs.

Communities of Practice

The proactive service model will be grounded in primary care with a multidisciplinary team providing wrap around care for both patient and carer. Proactive care will be delivered by services that are arranged around clusters/communities of GP practices, centred on the needs of the registered population. General Practice will provide greater continuity of care, with more time to for patients who need it and will work in partnership with other parts of the health and care system to provide integrated care plans and service delivery.

Additional investment has been agreed to implement the proactive care model across Brighton and Hove in order to achieve the intended outcomes. It is anticipated that as the effect of proactive care is realised the investment can be offset through savings gained from a reduction in acute care activity and fewer conveyances and ambulance activity.

Alongside the developments in proactive care being coordinated and delivered by General Practice, work is being undertaken to improve the support and management of people with lower risk levels through a more preventative approach. This will be facilitated by the development of an outcome based Locally Commissioned Service (LCS), commissioned jointly with Brighton and Hove City Council.

This approach is based on combining all existing LCS's with all practices making the services available to their patients. It will provide an opportunity for practices working in clusters to design and deliver additional services to meet their specific patient needs. The delivery of this Locally Commissioned Service provides a significant opportunity to transform the delivery of primary care in Brighton and Hove, ensuring patients receive safe and effective care, reducing inequalities and improving the health and wellbeing of the population, with general practices working together to deliver better coordinated care.

General Practices, working in clusters, are currently developing cluster action plans. These will form the foundation of business cases for the detailed phasing of implementation and benefits during

16/17. There will be dependencies between these business cases and the Proactive Care Business Case to ensure a preventative approach is implemented across our population with a resulting reduction in the escalation of people to higher levels of the stratification model.

Workforce

General Practice is facing significant workforce issues across the country, and Brighton and Hove is no different. Our current Primary Care Strategy recognises the need for a primary care workforce that is skilled and able to deliver best practice to all age groups. We know that delivering the ambitions behind the new LCS outcomes framework will require a focus on developing our clinical and non-clinical workforce. The CCG is working with practices across the city to quantify the work force implications. We will continue to support primary care to access high quality training and education that is matched to the health needs of our population as well as supports a sustainable workforce. Along with the outputs of our recent Sustainable General Practice Conference this will inform a refreshed strategy for 16/17 onwards. See page 22 for more information on workforce development.

Homeless

In Brighton and Hove, homeless support services estimate that over 80 people are rough sleeping in the city currently (November 2015). In addition to this there are approximately 400 single homeless people in emergency and temporary accommodation while the city has 272 hostel places for single homeless people, with a current waiting list of 125 people.

The complexity of homelessness often requires a system wide response including the resources of: health, public health, social care, housing and community safety. Current services in Brighton and Hove are not well integrated, and are frequently commissioned by setting. This configuration does not reflect the service users experience or maximise the opportunity for people to recover from homelessness and move on to independence. To meet the increasing demands of homelessness and to provide more effective and efficient service responses, the CCG has developed a model based on a proactive approach to prevent homelessness and increase opportunities to support recovery and the journey to independence. The model has been developed with a wide stakeholder network.

This future model of care has at its centre a primary care led hub with a multidisciplinary outreach team working across the city in a number of spokes or settings. Health and care services are integrated within the Hub model and are proactive in their delivery to change the way care is accessed, increasing utilisation of primary and community services and reducing reliance on unscheduled and emergency care.

During 2014-2016 the CCG have tested the effectiveness and efficiency of this model with a number of pilots. Procurement for the model will commence in April 2016 with a phased implementation during 2016-17 with the intention of having the whole fully integrated model established by 2017.

Once fully established this model will deliver a number of benefits for the individual. These will include improved health through better access to the most appropriate services and preventative pathways as well as an increase in registrations with GPs and Dentists. It also covers effective and preventative health and social care and support in moving out of homelessness. The local healthcare system will benefit in terms of reduced reliance on unplanned and emergency care and a reduction in length of stay and excess bed days.

5.4 Responsive Community Services

To support the continued development of the CCG Clinical Strategy and our vision for transformation of care via the activated, supported patient and communities of practice, Brighton and Hove CCG has initiated a number of community based services and support mechanisms which work together to support independence and keep people out of hospital. To achieve this, our services need to be configured to facilitate quick responses for people when they have an urgent need for support. The CCG will deliver this by offering integrated community alternatives to hospital admission 24/7. Over recent years we have mitigated any increase in the number of A&E attendances and non-elective admissions by developing and strengthening community services.

In 2016/17 we want to move towards a whole system approach to integrated care with a focus on

prevention, self-management and coordinated support for our frail population. This will require the development of plans for clinical and service integration and the development of our commissioning and contracting approach in line with new models of care. We will use 2016/17 to work with our partners to redesign and organise community services around clusters of GP practices, with increased specialist support in the community.

New Model of Care for Community Beds

The preferred service model for patients is to receive rehabilitation and reablement within their normal place of residence but the CCG recognise that for a few patients this is not always possible/ desirable and some bedded facilities will be required.

The CCG is procuring is a more responsive and appropriate model of care for step-up/ step-down and rehabilitative care beds that is consistent across the Local Health Economy. The current model has experienced delays to admission and higher length of stays and it is expected that the new model will increase the flexibility and flow through the system.

To deliver this model the CCG is bringing together a range of partners under a single contract with a lead provider accountable for all aspects of the service delivery. This model will expand the availability of step-up care for primary and social care services and prevent avoidable admissions to acute care. Flow through the community bed service will further be optimized by cross system decision making, a clear focus on reablement, (aligning expected discharge dates to treatment goals) and access and discharge processes standardized. The acceptance of new referrals and patient discharge protocols will operate seven days a week.

This model will support optimised throughput and timely onward referral and discharge, thereby reducing lengths of stay across all bedded units. This new model of care will be in place in April 2017.

Discharge to Assess

This approach to discharge recognises that it is more appropriate to assess the future care and support needs of people who are medically ready to leave hospital within their own home, where they are familiar with the environment and are likely to feel more confident to engage in their own recovery and rehabilitation planning.

This model has been in operation since early 2015 with a dedicated team of qualified therapists and healthcare assistants. The CCG plans to extend this programme to enable 15 discharges per week initially, increasing to 30 plus per week during 2016/17.

The service will be integrated with our Community Rapid Response Service to ensure a consistent rapid response for both admission avoidance and supported discharge. This will include support provided by SCT Intermediate Care Services and Independence at Home.

Integrated Community Neurological Hub

The CCG seeks to improve the quality of life and health outcomes for people with long term neurological conditions in the city by establishing an integrated community specialist neurological hub. Current services are configured in condition - specific silos which are in contrast to ever increasing patient profile of comorbidities demanding holistic service solutions. The hub, although primarily containing neurological community services, would form the basis of a specialist hub in the community as part of the wider integration agenda. Expected outcomes include improved patient access and quality of intervention through improved service resilience and support through shared resources and capacity.

Integrated Social Care and Health Care Home Programme

The CCG continues to develop support for improved outcomes for people living in care homes by establishing an integrated Social Care and Health Care Home Programme. This work will bring together existing projects and work; spanning commissioning, contracts and quality across NHS and city council organisational boundaries and bringing them into a single programme to jointly tackle challenges, share resources, learning and relationships to make a greater impact on the sector.

Diabetes

The CCG awarded Sussex Community Trust a contract to deliver a 'one-stop shop' approach for Community Diabetes Service in 2015/16 with the aim of providing personalised support for patients in their local community. This integrated, consultant-led service will launch in 2016/17 and provide psychological, podiatry and dietetics support services to people living with diabetes. This service works in partnership with primary care to support patients to self-manage their condition with personalised care plans and improved access to high quality education and information.

The service will bring hospital and community teams closer together, working under a single leadership structure in collaboration with GP practices and Diabetes UK. It will support local GPs, nurses and healthcare assistants to increase skills and knowledge around the management of Diabetes in primary care. The Memorandum of Understanding has now been signed between BHCCG, Public Health and South East Clinical Networks (SECN) for the National Diabetes Prevention Programme. The prospectus (specification) has been submitted by SECN and The National Procurement Programme has appointed 4 providers from 9 bids. The Local evaluation of provider submissions (mini competition) will take place in early June 2016 with contracts awarded in late June. The providers have requested a 6-12 week mobilisation period and the NDPP will start working with people from the beginning of September.

The Local Authority Public Health service has also commissioned services which support diabetes prevention. These mainly focus on preventing type-2 diabetes through healthy weight and lifestyle and include: Active for Life physical activity interventions, health walks and Shape Up, and Weight Management Courses provided by the Food Partnership.

Joint Dementia Plan

Brighton and Hove's Joint Dementia Plan 2014/17 sets out the strategic vision for improving care and support to people with dementia as well as their carers. This plan is focused on improving and maintaining an integrated pathway for dementia from diagnosis through all stages of disease progression. During 2016-17 the focus will be on improving the quality of in inpatient dementia services and drive forward integration with other services in the community and voluntary sector. The CCG will support the implementation of community post diagnostic support, early interventions and action alliance services and will introduce and embed the Admiral Nurses service. The Dementia Action Alliance and a range of services will meet the second part of the Prime Minister's Dementia Challenge and provide support for people who have just been diagnosed with a dementia and their carers. The CCG will continue to work with primary care, and through reprocurement we will strengthen our Memory Assessment Model to ensure we sustain and meet the national targets for dementia diagnosis.

End of Life Care Plans

The requirement to have a system capable of sharing end of life care plans (sometimes referred to as an Electronic Palliative Care Coordination Systems (EPaCCS) is a key factor to improving quality of care for palliative patients and is a requirement of DH End of Life Care Strategy 2008. The way we manage and share information about people who are in contact with health and social care services plays a pivotal role in achieving higher quality care and improving outcomes for patients and service users. Electronic palliative care information sharing will be fully implemented in 2016-17. This is a whole system project, with providers from across the palliative care pathway involved. This includes; BSUH, SECAmb, SCT, Martlet's and all 44 GP practices in the city.

Greater analysis of equality of access to palliative and end of life care will be the focus of 2016/17, working to identify and spot health inequalities and develop mitigating strategies.

5.5 Safe and Effective Hospital care

Urgent Care Services

We will promote personal responsibility and self-care by providing readily accessible and reliable advice to help people make informed choices and access self-treatment options. This will include work promoting the role of the community pharmacy and continuing our innovative public information campaigns on how and when to access urgent care services and what alternatives are available.

During 2016/17 the CCG will recommission NHS 111 as a service that integrates with GP out of

hours, 999 and the local urgent care. We will streamline the entry points to emergency and urgent care by delivering a primary care led Urgent Care Centre which integrates a walk-in centre, minor illness and minor injury service and out-of–hours GP services.

We will ensure responsive crisis services by developing the role of 999 ambulances as mobile urgent treatment services and avoiding unnecessary journeys to hospital by using Community Paramedics. These will be aligned to communities of practice and work flexibly to undertake urgent home visits and respond to Red 1 and 2 calls.

Alongside the system changes led by the CCG, the CCG expects BSUH to undertake a programme of work to transform their Emergency Department in line with national recommendations and in response to "Transforming urgent and emergency care services in England – safer, faster, better: good practice in delivering urgent and emergency care". Specifically this includes:

- Remodelling the Level 5 accident and emergency area at the Royal Sussex County Hospital to make best use of the physical space;
- Focusing on early senior decision making and effective streaming of patients;
- Ensuring early clinical assessment of patients and clear clinical pathways for prompt transfer to specialist teams;
- Fast track and direct access for patients with clearly identified conditions;
- Calibrating staffing levels in the emergency department to match known variation in demand;
- Effectively managing ambulance handovers safely, via shared operating procedures thereby minimising delay and the need for cohorting;
- Further expansion of the ambulatory emergency care model;
- Expanding access for GPs and community teams to acute medical/surgical advice as an alternative to ED attendance;
- Fully supported Acute Medical Unit with consultant led twice daily reviews, therapy input and effective discharge arrangements;
- Improving flow through the hospital with effective and early discharge planning, criteria lead expected discharge date, daily reviews etc;
- Improving the discharge profile so that the majority of patients are discharged in the morning and consistently throughout the entire week.

Detailed information on these initiatives is contained in the Urgent Care Strategy and associated system wide plan.

Planned Care Services

We will continue to optimise the impact of our Referral Management System (RMS) by offering patients a choice of provider informed by average waiting time information at specialty level, prioritising clinical triage in key specialties.

The CCG, working with the local acute Trust and neighbouring CCGs, via the Planned Care Programme Board, has developed a detailed plan to maximise efficiency in pathways and free up capacity. This work is initially focusing on where BSUH is struggling to achieve Referral to Treatment compliance and includes Digestives Diseases and Neurology. So far the improvement plan includes the following workstreams:

- Reviewing existing primary care referral guidelines, low priority procedures, commissioning policies and existing community pathways to ensure they are fit for purpose, and being used to maximum effect and where possible, harmonised across the patch;
- An audit of two week wait referrals to understand recent increases in demand and ensure adherence to current referral criteria;
- Repatriation of activity that more appropriately sits with existing services but is currently undertaken within BSUH e.g. micro suction activity that should be delivered by the Community ENT service.

The CCG are also developing plans to expand even further the scope of our community services to enable a shift of activity from the local Trust. These plans include:

- The expansion of the community ENT and urology services
- The implementation of a community Irritable Bowel Service
- The expansion of our current ophthalmology service to include lens capsulotomy

Additionally the CCG is working with the Trust to implement more efficient and streamlined pathways in challenged specialties such as direct to test pathways in Digestive Diseases and one-stop pathways for hysteroscopy. We will continue to work with other providers in the NHS and independent sector to grow the market and offer a greater range of choice to patients. In particular, we intend to work with our neighbouring CCGs to commission, at scale, alternative provision for non-complex Digestive Diseases surgery pathways on a longer term basis.

5.6 Transforming Cancer Care

In response to both the national challenge and local need a "Five Year Forward Future Vision for Strategic Transformational Cancer Programme" has been developed in collaboration with the City Council. This Strategy provides a transformational framework for the diagnosis, treatment and care for people affected by cancer in the city. The approach addresses all components needed to deliver a gold standard service.

A number of specific projects are being developed and implemented to support the strategy ambitions. These are detailed below and collectively evidence our commitment to improving and transforming the experience of those whose lives are touched by cancer.

Raising Awareness and Earlier Diagnosis of Cancer

Evidence has shown that certain population groups within the city are more likely to experience specific types of cancer, experience delays in diagnosis and have a decreased survival time. Key to improving cancer outcomes and improving one year cancer survival rates overall is the early diagnosis and treatment of all types of cancer.

To address this crucial survival factor the CCG is working with the City Council and Public Health on a city wide Health Promotion Strategy. This strategy focuses on raising awareness of symptoms and improves access to diagnosis pathways for specific cancers, such as bowel, lung and breast. To further address those groups who experience inequitable diagnosis and outcomes these campaigns will also target specific population profiles through outreach work, communications campaigns and social marketing.

Improve Cancer Waiting Times to National Standards

The CCG are expected to support our patients and providers to deliver three key cancer access and treatment targets. These are 31 and 62 day waiting time target and the implementation of National Institute of Clinical Excellence (NICE) guidance for suspect cancer referrals. To achieve these standards, the CCG has increased endoscopy capacity for diagnosis of cancers. We are working with the Trust on the development of a diagnostic hub which will support direct test pathways for lung/chest X-rays and test colonoscopy. In addition to these, the CCG are commissioning a remote clinic for indolent haematological malignancies and implementing a suspect lung cancer pathway. The above measures will support waiting time and referral targets by increasing capacity, more efficient diagnostic access and clearer guidance when cancer is suspected.

Enhanced Survival

Raising awareness and increasing and supporting access to diagnostics tests and treatment is fundamental to increased cancer survival rates and to addressing premature mortality from cancer. Enhanced survival and improved life experience of those who have been treated for cancer is also crucial for patients. This approach provides support for those experiencing cancer to aid recovery and improve their experience of living with the condition. To this end the CCG has developed and initiated a Cancer Recovery Package to improve the health and outcomes during and post treatment. The programme covers a wide range of initiatives which in total deliver a comprehensive package of care, services and actions to improve the experience and outcomes of cancer patients.

5.7 Improving Mental Health

At a local level, mental health and wellbeing is identified as a clinical priority in the CCG Clinical Strategy. This also aligns with the ambitions across the city organizations to prioritise mental health prevention and treatment and improve the experience of those affected by mental health issues. This ambition is underpinned by our commitment to delivering parity of esteem for mental health services/treatment ensuring that those affected by mental health receive treatment and care of the same standard as physical health conditions. To support this commitment the CCG

and the City Council launched the Happiness Strategy in 2014.

The Happiness Strategy forms the bedrock of a holistic approach to mental health and wellbeing in Brighton and Hove. It includes developments for mental health services and provides a framework to embed mental health in all aspects of life, businesses and services across all ages. To achieve this, The Happiness Strategy covers a broader set of actions relating to employment, employers, training, and working with schools among others. Further to this, and in line with our concept of communities of practitioners, the CCG is committed to working with a wide range of providers across the City, including the community and voluntary sector, to provide services across a range of needs in a range of settings.

The CCG has specific mental health service developments planned for 2016-2017. These will support and facilitate our ambitions to create happier city, improve care pathways and deliver improved care and support for our population. During 2016-17, the CCG will:

- reduce the numbers of people detained under section 136, and continue to reduce the numbers of people being detained to custody;
- work with Brighton and Hove City Council to ensure that we review services offered to those individuals who have a diagnosis of autism or another autistic spectrum disorder. This will include scoping the need for additional diagnostic and support services for children, young people and adults;
- continue to develop our Transforming Care Partnership plan across Sussex to support the provision of out of hospital care for patients with complex learning disabilities and/or autism and mental health needs;
- invest in the mental health rehabilitation pathway across the city to better meet the changing needs of our population;
- re-procure Primary Care Mental Health Services as the current contract ends March 2017. The reprocurement provides the opportunity to extend the scope of the service to children and young people as well as ensuring that those people who neither meet the criteria for secondary or primary mental health services receive the support they need within a community setting.

Children and Young People's Mental Health and Well Being Transformation Plan

Brighton and Hove CCG has led the development of the Brighton and Hove Children's Mental Health and Wellbeing Transformation Plan which describes the vision of the City for services and support up to 2020. The Plan has been developed in response to findings from the Joint Strategic Needs Assessment and engagement activities with children, young people, their parents and carers as well as a range of providers, community and voluntary sector organisations and the NHS and Local Authority organisations.

The Local Transformation Plan outlines our plans around Children and Young Peoples IAPT and Brighton and Hove in the process of applying to become a member of the London and South East Learning Collaborative. During 2016-2017 the CCG will undertake a whole system scoping exercise to determine the current outcome measures and tools, evidence base and workforce and skills required to deliver CYP IAPT. The CCG will use this to identify and learn from best practice and other CCGs. This will form the base from which we develop an action plan to take forward CYP IAPT from 2017/18 onwards.

During 2016-2017 the CCG will progress and deliver the work streams which are briefly summarised in the sections below.

Innovative Communications and Support - The CCG will commission easily accessible, consistent, youth friendly, electronic and social media portals to promote mental health and wellbeing and facilitate access to the right help at the right time. This will include an anti-stigma campaign and is intended to reach all ages.

Primary Mental Health and Wellbeing- The CCG will extend the primary mental health and wellbeing in reach to all school clusters and through community and primary care services.

Sustain and Develop the E Motion Online Counseling Service -The CCG is investing in the development of this free online counselling service for young people aged 13-25 years who live in Brighton and Hove to deliver "live" counselling and increase its use by BME, young men and LBGT groups.

Complex Trauma Pathway - The CCG has commissioned a complex trauma pathway that will provide support to people aged 14 and over who have experienced trauma by offering a range of therapeutic interventions.

Investing in Vulnerable Groups - During 2016-2017 the CCG's working group will develop a mental health resource to support vulnerable groups such as children in care and adopted and fostered children.

Crisis and Out of Hours Care - The transformation plan for 2016-2017 includes the establishment of a working group to review and scope service and service developments for children and young people in crisis or needing out of hours mental health care

Youth Counseling Outreach - The CCG intends to continue to support an outreach counselling model to youth environments/clubs where young people spend time.

Teenage to Adult Personal Advisor Team - This team works with Brighton and Hove young people, aged between 14 – 25, who have an emotional, psychological or mental health need and where a specialist mental health service is required. During 2016-2017 the CCG will invest in this service to ensure it has the capacity to meet the needs of young people in transition from children's to adult's services.

Community Eating Disorder Service for Children and Young People (CEDS-CYP) - To address the new access target for Eating Disorders, Sussex CCGs (East and West Sussex and Brighton and Hove) will develop a Sussex-wide all ages pathway. The service will provide a comprehensive assessment and evidence-based treatment pathway for those with an eating disorder. The service will provide support to children, young people and their families as well as advice and guidance and awareness training for the whole system. This new provision will support a smooth transition to adult eating disorder services where required.

5.8 A Good Start

Children and Young People

The path to lifelong good health and wellbeing begins with ensuring our children have a good start. A foundation of the CCG Clinical Strategy is the engagement of the individual in embracing healthy behaviours and lifestyle choices. This culture starts with the children and families and the services which support them to make these choices. Children can also feedback into family/support units certain measures and actions which impact on health outcomes. Having happy, healthy children in our city will lead to happy, healthy adults and contribute to reduced reliance on the health and social care system.

The majority of health care for children and young people is provided by GPs in primary care and is in the context of looking after the family unit. The CCG aims to ensure that primary care services in the city have the capacity and capability to offer high quality health care to children and young people. We will do this through the Locally Commissioned Service (LCS) outcomes contract, building on the work done throughout 2015-16. The future vision is to develop children's health hubs around GP clusters providing for more integrated and multi-disciplinary approaches. In particular to look at more joined up care and sharing of skills across secondary and primary care.

The CCG are committed to bringing care for children and young people, particularly those with the most complex needs, closer to home and away from hospital based settings. This is reflected in the work we will do to review and re-design children's community nursing; the development of pathways to provide closer integration of mental and physical health care and work to develop streamlined pathways for early help in social care. We will be working closely with our key partners, BSUH, SCT and the Local Authority, to achieve this.

The work we are doing to re-design our children's community nursing services will support the timelier discharge of children and young people from acute care, and support them and their families to recover more quickly form episodes of illness or to manage longer term conditions more effectively at home.

A Joint Children and Young People's Health and Wellbeing Strategy has been developed with Brighton and Hove City Council and will support the delivery of more integrated, proactive and preventive services. Further to the CCG considers how the change can include all ages in service developments and improvements to services. A recent example is the Sussex wide Eating Disorder service and Autism pathway.

Maternity

Maternity Services in Brighton and Hove are provided by Brighton and Sussex University Hospitals Trust. There is an obstetric led unit at the Royal Sussex County Hospital site and women can also choose to have a home birth which account for about 6% of local births. Brighton does not currently provide full choice of birth place as it does not have a midwifery-led unit (Birth Centre). A wider independent review of NHS maternity services, published in February 2016, was undertaken to assess how best to respond to England's growing birth rate and the need for well-staffed and safe services that give mums more say over their care.

The CCG commissioners have reviewed the recommendations from the national maternity review, published in February 2016, and these will be taken into account in the development of our maternity commissioning plans. The key recommendations are:

- **Personalised care** – centred on the woman, her baby and her family. This includes having a genuine choice over where and how she gives birth; development of personalised care plans setting out decisions about her care; the use of personal maternity budgets.
- **Continuity of care** – women having access to the same team of midwifes throughout pregnancy, birth and the postnatal period.
- **Safer care** – developing a culture of learning and continuous improvement; good quality data and robust referral pathways ensuring access to the right care, particularly specialist care, when needed.
- **Better postnatal and perinatal mental health care** – to address historical underfunding in this area and reduce the number of postnatal maternal deaths associated with mental health needs.
- **Multi-professional working** – including multi-professional learning as part of pre-registration training and continuous professional development for midwives.
- **Working across boundaries** – this includes working across geographical and organisational boundaries; development of community hubs and agreed standards and protocols across a local maternity system. The Sustainability and Transformation Plan will help to support planning and delivery across a wider geographical area and to further develop partnerships across the local maternity system.
- **A payment system** – that fairly and adequately compensates providers for delivering high quality care to all women.

Brighton & Hove CCG has already begun to make progress against some of the key Maternity Review recommendations. We are working with our local provider on developing small teams of midwives to deliver continuity of care and the development of community hubs. The City has had a Perinatal Mental Health Team for 3 years. We have invested in this service during 15/16 to ensure it has the capacity and skills to meet the needs of pregnant women and new mothers who have mental health needs. We will continue to focus on this area in line with national requirements.

A safe, reliable and high quality maternity service should be consistently provided twenty-four hours a day. The CCG has a number of assurance measures in place which provide information on the safety and quality of the maternity services provided. These include a monthly dashboard with a range of key indicators of performance and safety; some benchmarks have been agreed and set nationally by the Royal Colleges and other professional bodies so that we can ensure our local services are following best and safe practice. Such indicators cover the hours of consultant presence on wards in relation to the number of births and the ratio of midwives and one-to-one care when women are in established labour. These indicators are reviewed and monitored in conjunction with a range of clinical outcomes. Together, with patient experience surveys, this information provides triangulated intelligence about the quality and safety of our local maternity service.

In addition to this monitoring the CCG and the maternity service work with work with our parent – led Maternity Services Liaison Committee and are responsive to the range of high profile national and regional initiatives to drive improvements in quality and patient safety. The recommendations from the Morecombe Bay enquiry, for example, have provided additional benchmarks to ensure robust governance arrangements in maternity units.

Further to the measures taken above there is also a significant national initiative to reduce the numbers of stillbirths and early neonatal deaths with the introduction of a "care bundle". Extensive evidence gathering and clinical engagement has

identified four elements which if implemented as a package of care to all pregnant women, has huge potential to significantly reduce stillbirth rates. These elements are:

- Smoking cessation
- Identification of fetal growth restriction
- Raising awareness of reduced fetal movements
- Effective fetal monitoring in labour

We will be working closely with BSUH to support the delivery of the Secretary of State's challenge to reduce infant mortality and to ensure that Brighton and Hove is a safe place to give birth.

5.9 Medicines Management

Medicines are the most common intervention and biggest cost, after staff, in healthcare. Getting the most from medicines for both patients and the NHS is becoming increasingly important as more people are taking more medicines. There are a number of concerns about England's use of medicines:

- 30-50%* of medicines are not taken as intended and patients have insufficient information to support taking medicines;
- 5-8%* of hospital admissions are due to preventable adverse reactions to Medicines;
- Medication errors have risen as a proportion of all errors reported from 8.19% to 11.02% from 2005 to 2010;
- Medication wastage in England per year is approximately £300 million of which 50% is estimated to be preventable;
- There is a real threat to healthcare from antibiotic resistance.

*Range comes from different studies in the literature

Our medicines optimisation strategy is central to the work of the CCG due to the key role medicines have in our health system. It sets out six key approaches to medicine optimisation for Brighton and Hove and these are outlined in the paragraphs below and full details are contained within our CCG Medicines Management Strategy.

The CCG will maximise care gains across health and social care by innovative management of medicines at the best obtainable value. We will continue to monitor prescribing spend against budgets set for GP practices and other providers. We will use our prescribing monitoring dashboards to identify outliers with prescribing and work with partners to address any problems or learning needs

The CCG will support workforce development activity to create a sustainable healthcare system with particular emphasis on the pharmacy workforce and medication review. To realise the potential efficiencies from the prescribing budget we will need to increase the capacity and skills in Primary Care to change how we use medicines at practice and cluster level. Our work will need to include engagement of the partner organisations in joint policy across the whole health economy with leadership for implementation provided by the specialists for each therapeutic area.

The CCG will continue to deliver Medicines Optimisation which aims to engage with patients to better understand their issues around medicines and to co-develop solutions that support them with their medicines taking. There will be specific focus around medicines use in care homes and in the over 75s because of the known adverse impact of high medicine usage in the frail elderly population (polypharmacy).

We will look at the following specific areas/projects as part of our workplan:

- Polyprescribing and Deprescribing,
- Stoma,
- Continence,
- Antimicrobial Stewardship (AMS),
- Atrial Fibrillation,
- Hypertension,
- Diabetes,
- Neuropathic Pain,
- Nutrition,
- Respiratory,
- Medicines Safety and Risk Reduction,
- Medicines Waste.

We have set KPIs for all our projects and will be monitoring performance against KPIs on a regular basis.

5.10 Information Management and Technology

The CCG recognises that the opportunities provided by technological developments, and their facilitation in information sharing and management, are core to the future design and innovation in service improvement. New technologies offer

significant opportunities to improve patient experience, productivity and quality across health and social care services. The CCG will begin the implementation of the CCGs Digital Roadmap during 2016-17.

During 2016-2017, the CCG are preparing the foundations to ensure effective development and delivery of the national 2020 vision. To do this, the CCG has taken steps to ground the prerequisites for successful delivery in our operational thinking. These enablers include a CCG informatics vision and strategy embedded within our commissioning pathway; the two are intrinsically linked and to deliver this ambition effectively the CCG recognise the need for resources of expertise, seniority, and time. Assurance of these innovations will need effective governance and coordination mechanisms, particularly across organisations.

This organisational bedrock will support the streamlined care delivery which makes effective use of information and technology wherever there is a benefit. This will include a view only portal for professionals across organisations to access patient records held in multiple organisations. It is envisaged that these professionals will share working space to record and work together on a subset of care plans for patients with complex needs or a high level of risk. This will be facilitated by an effective management / intervention planning toolset. Patient care will be improved through the effective use of specialist clinical expertise through teleworking initiatives. For patients there will be a patient portal to view records, enter and access information.

These ambitions will be evidenced and measured by the following key performance and quality indicators:

- All discharge summaries to be send electronically;
- Full implementation of the 2015/16 priority digital standards;
- Implementation plan for pipeline digital standards 2016-2020;
- Improved use of available shared records such as SCR;
- Full engagement with development of the Digital Footprint and dedicated resource to support delivery.

6. Quality and Patient Safety

The CCG monitors patient safety measures and holds commissioned service providers to account through a range of measures. These include monthly Quality Review meetings, which consider mortality rates – including governance systems in place to review, and investigate where required, unexpected deaths. Where deaths or serious harm occur as a result of service failures, the CCG ensures providers report these as Serious Incidents (in line with NHS England Framework 2015).

The CCG continues to host a pan-Sussex fortnightly serious incident scrutiny panel – the panel reviews all investigation reports and identify any themes across the county. When common themes are identified specific support and training is provided for organisations to address the issues and support improvement. For the past two years Brighton and Hove CCG has hosted the annual Patient Safety Conference and have established a pan Sussex learning model developed from the identifications/analysis of national and local issues and incidents.

Locally, the CCG Quality team undertakes a timetable of quality assurance visits, both planned and unannounced. These may be actioned following any themes/issues identified from serious incidents or from triangulation with other sources of quality-related information.

In line with national targets, relating to zero hospital acquired MRSAs and reducing numbers of C.Difficile infections and healthcare associated infections, the quality team focus on both hospital and community services with specialist input from the CCG Infection Prevention Nurse. The CCG also monitor outcomes of agreed CQUINs linked to patient safety - including sepsis, acute kidney injury, mental health care in A&E and medications safety.

Although NHS England has the immunisation programmes and directly commissioning cancer screening programmes, there are direct linkages through to primary care in the support of patients and the promotion of these services. The CCG works closely with these bodies and local public health to improve immunisation uptake within the

City. This includes identification and provision of training for primary care.
Safeguarding of vulnerable members of our population, both adults and children, is a priority for the CCG. Services are monitored against agreed safeguarding standards and against the CCGs Safeguarding Assurance Framework, with provision of specialist advice and support from CCG Designated and Named Safeguarding leads.

The CCG continues to monitor patient experience measures and hold commissioned service providers to account via Quality Review meetings. These measures include:

- complaints – looking at numbers, types of complaints, trends in reporting, with assurance that providers make changes to services based on complaints they receive;
- friends and family test – response rates and, as for complaints, focussing on a qualitative feedback to FFT and seek assurance that providers make changes based on feedback;
- receiving feedback from providers' internal Patient Experience' and Patient Engagement meetings, and ensure providers have robust methods of receiving patient feedback;
- ensuring themes and trends from soft intelligence received by the CCG via the 'Feedback on Providers' mechanism is addressed with providers.

Patient experience data also supports quality monitoring and improvement in primary care through the engagement of the Friends and Family Test information. In addition patient experience issues are conveyed to the CCG Governing Body via the Lay member on the Governing Body. Our lay member chairs the Patient and Public Involvement leads meeting and provides direct input to Governing Body meetings.

Transforming Care Plan

Transforming Care is a program of work to improve the care for people with learning disabilities, autism and/or challenging behaviour. Brighton and Hove has made considerable progress in supporting people in in-patient care to move toward discharge in line. Brighton and Hove commissioners continue to work with local providers to plan and develop future services that meet the needs of people with learning disabilities who are currently in hospital, or who are at risk of admission.

In June 2015, the CCG agreed funding to enhance the integrated Community Learning Disability Team (CLDT). This will enable the team to deliver a model of crisis prevention and to reduce the frequency of specialist hospital admissions for people with learning disabilities. The CLDT, together with commissioners, have worked to ensure that pre-admissions CTRs are completed in a timely manner to ensure the appropriateness of admissions to hospital and develop a discharge plan is from the point of admission.

The CCG have also funded a community based reviewing post to ensure that lengths of stay for people in specialist hospital provision are minimised. This post also proactively supports those who have been in longer term to move to more community based provision where appropriate.

The development of county wide partnerships support the ambition of transformational change to the services which support individuals and their families with learning disabilities, autism and or mental health issues with or without challenging behaviour from birth to grave. Brighton and Hove CCG is a part of the Sussex "footprint" which includes the seven Sussex CCGs and East Sussex, West Sussex and Brighton and Hove Local Authorities. Please refer to the Transforming Care Plan for full details.

CCG Workforce Wellbeing

The CCG is signed up to the Public Health England Workplace Wellbeing Charter and is due to be assessed in May 2016 against its criteria. Through much of the work which has been done with HR, Organisational Development and the staff themselves, we believe we will have achieved a very good level of commitment to staff wellbeing. Our recent staff survey results show that our staff recognises the CCGs commitment to their wellbeing within the workplace. CCG staff are offered lunchtime yoga sessions, after work netball and the sports and social club organise a range of events such as attendance at Glyndebourne and monthly socials.

Workforce Development

The CCG provides an extensive training and development programme and support all staff training needs which are identified in annual appraisals and PDPs. Staff also partake in NHS Leadership academy courses

Further to the support and development of our own staff, the CCG will also focus on working with Primary Care and the CRN KSS primary care delivery manager to raise awareness of research involvement through the patient participation groups. We will also identify and work with providers to support the application of research findings in new models of service delivery. During 2015-2016 the CCG has been trialling a knowledge awareness librarian pilot to support MDT Cluster development and new ways of working. We will continue to support post in 16-17 and an evaluation is planned for 2016/17.

The CCG will up-skill the non-medical workforce in Primary Care with education and training. This will support the expansion of their roles and help to fill the gaps in the workforce, so effective patient-centred care can still be delivered within Primary Care. Reception staff will be offered training to improve communication skills, and help them to look at improving patient satisfaction. The CCG will also support work with receptionists who would like to become Healthcare Assistance (HCA), providing Phlebotomy training and competencies within HCA framework.

The CCG supports training for practice managers to help them with the transformation of primary care and adopt new ways of working, and take on more leadership roles within the Clusters.

The CCG will continue to work with providers to deliver City and Guilds QCF (NVQ) level 2 and 3 for Healthcare assistants so they can expand their role within the practice and support practice nurses. This will support practice nurse capacity for focus on patients who have more complex needs.

Training is also provided for new practice nurses so their transition into Primary Care is smoother and they can deliver safe and effective care and be autonomous sooner.

Practice nurses, supported through commissions from HEE-KSS, will have the opportunity to train as specialist practitioners so they can become leaders within the practice and in the Clusters, or work as advanced practitioners allowing GP's more time with patients with more complex needs. The CCG deliver various workshops so staff can keep up to date and deliver safe quality care. We are also involved in helping practice nurses to attend modules at University so they can expand their roles.

We encourage further general practice workforce development via mentorship training for practice nurses so they can then mentor Pre-Registration Student nurses in practice. The aim is to attract nurses into primary care by showing them what it is like to work in Primary Care. There are 22 planned placements of students for 2016 and the aim is to increase this number. Positive feedback from students wishing to now work in Primary Care when they qualify has already been received. It is hoped this will increase the workforce in the future.

The CCG is working with other stakeholders in Brighton and Hove to link up training of non - registered professionals. The aim is to increase awareness of home carers, care home and nursing home staff of when to seek further help and when to refer people so problems can be detected sooner, the aim being to prevent hospital admissions. This project is due to be completed in 2016/17.

Continuing Health Care

The NHS Continuing Healthcare National Framework provision can be delivered through a care home placement or a package of care in the clients own home. Support plans are individualised to meet the client's health care needs. Care is commissioned using clinical expertise and local social care networking; this empowers clients to take control of their own health needs. This is facilitated through health education and to provide the tools to enhance best health outcomes.

Recent changes to legislation provide some challenges to NHS Continuing Healthcare (CHC) Theses include the following:

- The National Living Wage 2016 – this new legislation will commence in April 2016 and will have a financial impact on the continuing healthcare budget. Providers are contacting the CCG seeking increases in their care fees;
- Under the Care Act 2014 the CCG now ensures that clients have access to an advocate or Independent Mental Capacity Advocate (IMCA) if they lack capacity and have no other means of advocacy;
- Constraints to the Local Authority budget mean that nursing homes are increasing their care fees to ensure that their

businesses remain financially viable. This could impact on local placements for clients and will impact on patient choice;
- The ageing population living longer with more complex health needs, keeping the older people population longer, increasing pressure on CHC budgets;
- Personal health budgets figures suggest that the numbers of PHB's are increasing and the costs may be more than traditional packages of care.

Brighton and Hove CCG will take action to mitigate the risks identified and to ensure all individuals who are entitled to continuing healthcare support have access to timely high quality services and support by:

- Working in partnership with individuals and their family and carers;
- Working collaboratively with partners to deliver consistent care both national and locally;
- The Continuing Healthcare Assurance Tool (CHAT) has been implemented to help improve standards, support, and improve assessments and care pathway delivery;
- Brighton and Hove CCG have continued to progress Closedown cases and are on target to complete this work stream by September 2016;
- There is an increasing need to respond to people at the end of their life with increasing requests for "Fast-track" assessments and rapid implementation of packages of care and support. The Funded Care Team are working to extend an existing model of block contracted hours for end of life care with local providers. This approach is to stabilise the delivery of appropriate care in a timely manner.

During the last quarter Adult Continuing Healthcare has funded 532 clients. Children's Continuing Healthcare is currently funding 13 children.

7. Governance and Assurance

Good Governance

The CCG has a clear and systematic governance and decision making process which is articulated in detail in our constitution. During 2015/16 the CCG made a number of changes to committees, policies and governance to further strengthen our governance and assurance processes.

This included reviewing and strengthening the governance arrangements for the Performance and Governance Committee. The CCG appointed a lay member as chair and formalising and refocusing the meeting on key performance issues. The Terms of Reference were amended to reflect this and another forum created to address operational issues with the CCG Senior management team forming the membership.

The role of the Clinical Strategy Group, a subcommittee of the Governing Body, has been reviewed and emphasis placed on its role in focusing on the long term strategic development of the CCG reemphasised alongside its role of clinical pathway development. The CCG Clinical Strategy has been driven by the aspirations and goals of the CSG to deliver the FYFV recommendations and improve care and services for our patients.

Further to these developments and in response to the Annual Assurance rating of not assured from NHS England, the CCG have commissioned a Capability and Capacity Review from an external consultancy with the specific remit to consider the leadership and committee structure of the CCG. This is due to report in early 2016.

Performance Management

The CCG has taken a range of steps to improve its management of the performance of both the system as a whole and our individual providers. These steps have been taken in response to the on-going challenges of our provider performance specifically in A&E, referral to treatment times and cancer 62 day waits.

Measure taken to enhance existing contract and performance management processes to include:

- Changes to the contract management meetings with increased focus on timely and accurate reporting of attainment and provider accountability for compliance against standards;
- Requesting credible remedial/recovery actions plans as standard and requesting evidence that these are having desired impact;

- In-depth performance reports under regular scrutiny at the Performance and Governance Committee;
- Joint CCG/BSUH PMO formed to review and challenge the unscheduled care plan which underpins the recovery trajectory;
- Issuing contractual penalties to providers for non-delivery of mandated targets;
- Monthly Single Performance Conversations and Quality Review meetings with BSUH;
- Regular Executive Level PMO meetings which include neighbouring CCGs and Unscheduled Care Operational Resilience Group meetings.

Completely new performance management processes include the introduction of formal multi-partner Director level reviews for the major change programmes – Performance Review Meetings. These forums will address issues by exception and will be underpinned by effective programme tracking by the PMO analysts. In addition the Unscheduled Care Operation Group PMO is informed by bi-monthly highlight reports which are completed by project leads across the local health economy organisations involved in the drive for improved performance in this area. These highlight reports are also presented to the System Resilience group on a regular basis.

Programme Management Office

The CCG has an established Programme Management Office (PMO) to oversee and ensure the effective, consistent and co-ordinated delivery of projects. The PMO is an organisation-wide function that has two important roles:

- It supports the planning, delivery and evaluation of programmes by providing advice, guidance, standard operating procedures and templates.
- It monitors the performance of programmes to ensure that work is on track, delivering within budget and achieving the expected benefits.

During 2015-2016 the PMO team has been strengthened with an increase in dedicated resources and a clearly defined remit. The Core PMO team now includes two business intelligence analysts, representations from finance officers and a dedicated PMO support officer. The focus of this team is the support of programme development and the assurance of plans.

Risk Management

Risk management is a fundamental part of quality and safety assurance and the CCG has an integrated Risk Management Framework covering clinical, financial and corporate risks.

The organisation has an established risk management system which identifies and tracks project and team level risks. These are reviewed monthly and are recorded and reported on dedicated Ulysses Safeguard Risk Management Software. The Corporate Risk Register and Report are reviewed and discussed monthly at the Performance and Governance Committee, prior to presentation to the Governing Body. Clinical Risks are also reviewed at the Quality Assurance Committee and there are clear mechanisms through which quality and patient safety risks are escalated and resolved. The CCG risk management and recording process is assured through review at the monthly Audit Committee and the Annual Internal Annual Audit. For 2015/2016 the Internal Audit Team reported they were reasonably assured by the CCG risk management process and reporting. The CCG Risk Manager has responded to and implemented recommendations from this audit.

The CCG Corporate Risk Register brings together the risks collected from team and project risk registers and maps them to the principal organisational risks identified by the Governing Body and partners across the city. These in turn are mapped to our strategic objectives. The Governing Body review and update the CCG Strategic Objectives and risks to these on an annual basis. This process is described in our Assurance Framework.

The Operating Plan Risk register is contained in Appendix 1.

8. Conclusion

The CCG Operating Plan 2016-2017 confirms the commitment the CCG has to meeting the challenges set by the NHS Five Year Forward View, the NHS Mandate and the transformational ambitions described in the CCG Clinical Strategy. While acknowledging the challenges the CCG has faced in terms of the performance of the local hospital trust the plan provides solutions to the attainment of a recovered and a sustainable future model of care which is set in the context of the

emerging themes of the Sustainability and Transformation Plan.

Although described in separate sections the totality of our 2016-2017 building block plans are co-dependent, driving service and workforce development towards a model of sustainable, high quality and truly, integrated partnership working. Key to the success of this delivery is the development and support of the engaged and empowered patient. By coming together, as organisations and individuals, and making fundamental shifts in our perception of models of service delivery and whole system engagement this approach aims to deliver a local health and care service that engenders equality, improvement, independence and engagement.

Appendix 1 – Risk Register

Primary Risk	Risk Score	Mitigation	Residual Rating
There is a risk that performance against targets may not be met in 2016/17, particularly in A&E access targets including 18 weeks, IAPT, RTT ,HCAI and cancer 62 day wait.	20	• System wide demand and capacity planning including detailed referral analysis to understand the level of demand for planned care services and the distribution of the demand. • Delivery of the integrated urgent care model • Increased primary and community services including delivery of proactive care, IBS and LUTS services	12
There is a risk that the CCG will not secure adequate activity to sustainably deliver standards for planned care	20	The CCG is actively seeking additional planned care activity from independent sector and NHS providers	16
There is a risk that Brighton and Hove increasing pressures on primary care organisations may impact on their ability to deliver a robust and sustainable primary care structure which will adequately support the delivery of GMS services for the people of Brighton and Hove	20	• Workforce and development programme specifically for general practice • Workforce and organisational development group for delivery of the MCP new ways of working being trialled by primary care in an effort to ensure that general practice is effective, well organised and, above all, sustainable in the future	16
There is an expectation that NHS and social care funding will be restricted over the next 5 years and there is a risk that the CCG will be unable to contain costs in the same time frame. This is because of the time lag in the development of transformational programmes designed to deliver efficiencies	16	Ongoing assessment of likely impact of plans. Operational and Strategic Plans reviewed and refreshed annually enabling the CCG to anticipate pressures and adjust accordingly	12
The CCG recognise that during the current period of local executive transition there is a risk that an interim loss of corporate knowledge may impact on the timely delivery of 2016/2017 ambitions	9	All executive team posts have been successfully recruited to, both the Chief Operating Officer and the Director of Finance are now in post	6
There is a risk that the recognised workforce shortages and workforce capacity issue, reported nationally and locally may have an impact on the CCG plans to deliver new and changed services	16	• up-skill the non-medical workforce in Primary Care with education and training • training for practice managers to help them with the transformation of primary care and adopt new ways of working, and take on more leadership roles within the Clusters.	12

Appendix 2 - Glossary of Abbreviations

AMU	Acute Medical Unit
BHCC	Brighton and Hove City Council
BME	Black and Minority Ethnicity
BSUH	Brighton and Sussex University Hospital Trust
CCG	Clinical Commissioning Group
CEDS-CYP	Community Eating Disorder Service for Children and Young People
CHC	Continuing Healthcare
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CRN: KSS	Clincal Research Network: Kent, Surrey and Sussex
CVS	Community and Volunteer Sector
DFT	Direct Funds Transfer
DH	Department of Health
ED	Emergency Department
EDD	Estimated Discharge Date
ENT	Ear, Nose and Throat
EPaCCS	Electronic Palliative Care Coordination Systems
FFT	Friends and Family Test
FYFV	NHS Five Year Forward View
GMS	General Medical Services
GP	General Practitioner
HCA	Health Care Assistant
HEE-KSS	Health Education England-Kent, Surrey and Sussex
IAPT	Improved Access to Psychological Therapies
IBS	Irritable Bowel Syndrome
IPCT	Integrated Primary Care Team
JHWS	Joint Health and Wellbeing Strategy
JSNA	Joint Strategic Needs Assessment
LA	Local Authority
LCS	Locally Commissioned Service
LGBT	Lesbian, Gay, Bisexual and Transgender
LUTS	Lower Urinary Tract Service
MDT	Multi-disciplinary Team
MRSA	Methicillin-resistant *Staphylococcus Aureus*
MSK	Musculoskeletal
NHSE	National Health Service England
NICE	National Institute for Health and Clinical Excellence
PHB	Personal Health Budget
PMO	Programme Management Office
PPG	Patient Participation Group
QIPP	Quality, Innovation, Productivity and Prevention
RMS	Referral Management System
RTT	Referral to Treatment Time
SALT	Speech and Language Therapy Service
SCR	Shared Care Record
SCT	Sussex Community Trust
SECAmb	South East Coast Ambulance
SPFT	Sussex Partnership Foundation Trust
SRO	Senior Responsible Officer
TCP	Transforming Care Partnership

Appendix 3 – Summary of Plan

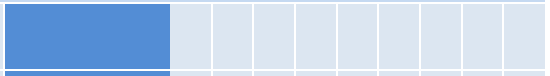
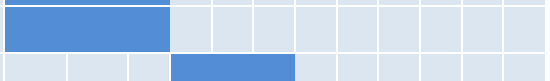
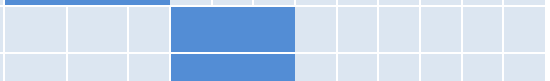
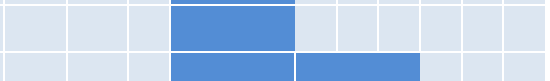
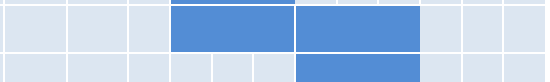
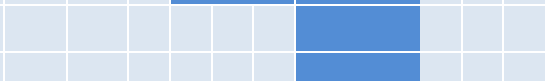
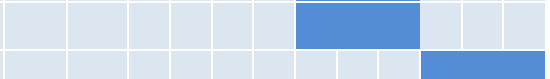
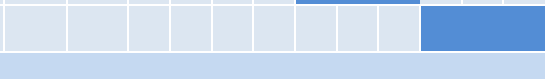
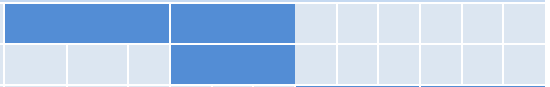
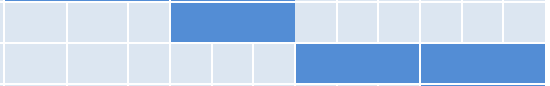
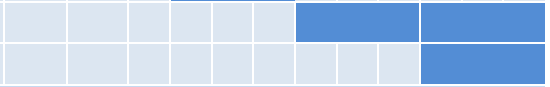
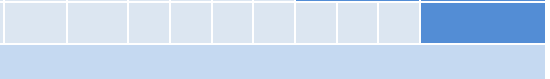
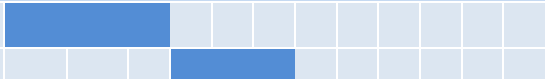
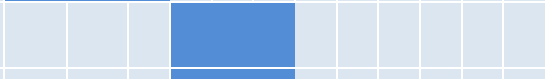
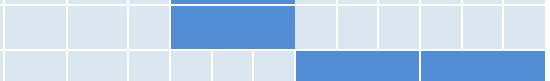
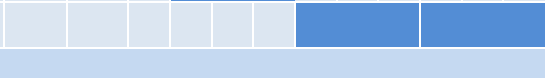
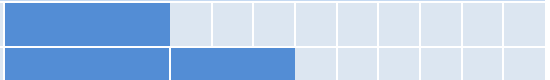
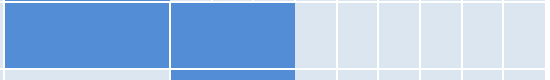
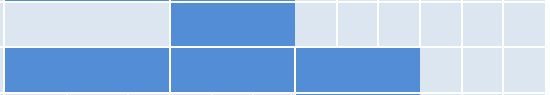
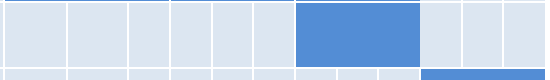
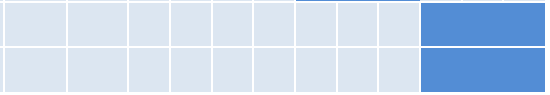
Appendix 4 – Gantt Chart

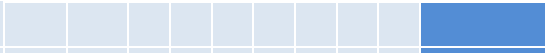
BH CCG AOP MILESTONE PLAN 2016-17

Overall RAG Rating - Scoring Key

- <1 month delay; 90% KPIs achieving target; risk scores <9
- 1-2 month delay; 50-89% KPIs achieving target; risk score >9
- 2+ months delay; <50% KPIs achieving target; risks 12+

REF	ACTION/TASK	RESPONSIBLE TEAM	2016/17 Q1	Q2	Q3	Q4
001 PLANNING, DELIVERY AND FINANCE						
1.1	Business Case to agree drawdown amount of excess surplus	Finance				
1.2	Contribute to the development of the Sussex-wide Sustainable Transformation Plan (STP)	Planning & Delivery				
1.3	Identify QIPP saving initiatives and review investment plans	All				
002 ACTIVATING PATIENTS						
2.1	CCG Self-management strategy developed	Commissioning - PC				
2.2	Full roll-out of single information portal for the public (MyLife)	Communications & Engagement				
2.3	Detailed plan with approach for PHB budget setting	Commissioning - PRIM. C				
2.4	Agree system-wide CQUINs with an umbrella theme of patient activation and care planning	Quality & Safety				
2.5	Extend roll-out of Personal Health Budgets (PHBs) to a wider client group	Commissioning - PRIM. C				
003 TRANSFORMING PRIMARY CARE						
3.1	Review of cluster level Business Cases submitted to CCG	Commissioning - PRIM. C				
3.2	Continuation of Knowledge Awareness Librarian pilot to support MDT cluster development	Quality & Safety				
3.3	Evaluation of Knowledge Awareness Librarian pilot	Quality & Safety				
3.4	Refreshed Primary Care strategy developed	Commissioning - PRIM. C				

004 IMPROVING MENTAL HEALTH			
4.1	Implement new access and waiting standards in Early Intervention in Psychosis pathways	Commissioning - MH	
4.2	Develop an all-age complex trauma pathway	Commissioning - CYP & MH	
4.3	Develop a Sussex-wide Community Eating Disorder Service all-ages pathway	Commissioning - CYP & MH	
4.4	Review of all contracts with the Community Voluntary Sector (CVS)	Commissioning - MH	
4.5	Reprocurement of the Wellbeing Service, including IAPT services	Commissioning - MH	
4.6	Re-procure Primary Care Mental Health Services	Commissioning - MH	
4.7	Develop a Sussex-wide plan to transform care for people with learning disabilities	Commissioning - MH	
4.8	Mobilisation of an all-age complex symptomology pathway	Commissioning - CYP & MH	
005 INTEGRATING HEALTH AND SOCIAL CARE			
5.1	Phased implementation of a specialist integrated community neurology hub	Commissioning - Community	
5.2	Procurement of the integrated homeless model	Commissioning - MH	
5.3	City-wide services for befriending and navigation in place	Communications & Engagement	
5.4	Phased implementation of the homeless model across the city	Commissioning - MH	
006 CARE CLOSER TO HOME			
6.1	Integrated Primary Care Teams (IPCT) aligned with six GP clusters	Commissioning - Community	
6.2	Discharge to Assess service integrated with Community Rapid Response Service (CRRS)	Commissioning - Community	
6.3	Integrated consultant-led Community Diabetes Hub launch	Commissioning - Community	
6.4	Mobilisation of a new model of care for community beds	Commissioning - Community	
007 SAFE AND EFFECTIVE HOSPITAL CARE			
7.1	Develop a detailed plan to maximise efficiency in pathways and free up capacity	Commissioning - PC	
7.2	Commission alternative provision for non-complex Digestive Diseases surgery pathways	Commissioning - PC	
7.3	Full delivery of ECIST recommendations to transform RSCH Emergency Department	Commissioning - UC	
7.4	Design primary care led Urgent Care Centre (UCC)	Commissioning - UC	
7.5	Develop a diagnostic hub to support direct test pathways for lung/chest X-rays/test colonoscopy	Commissioning - PC	
7.6	Begin implementation of the new UCC model	Commissioning - UC	
7.7	Recommission NHS 111 to integrate with GP OHH, 999 and the local urgent care	Commissioning - UC	

	system		
7.8	Undertake an audit of patient experiences at different stages in cancer pathways	Commissioning - PC	
008 MATERNITY AND CHILDREN'S SERVICES			
8.1	Develop a service specification for maternity services	Commissioning - CYP	
8.2	Establish baseline against national maternity services review	Commissioning - CYP	
8.3	Develop a performance reporting dashboard for paediatric hospital	Commissioning - CYP	
8.4	Introduction of a care bundle to tackle still birth by improving four elements of care	Commissioning - CYP	
8.5	Develop a performance reporting dashboard for community based services	Commissioning - CYP	
8.6	Recruitment and mobilisation of children's community nursing	Commissioning - CYP	
8.7	Brighton & Sussex Universities Hospital Trust (BSUH) to develop a co-located Birth Centre	Commissioning - CYP	
009 MEDICINES MANAGEMENT			
9.1	Recruit a Stoma Nurse to improve stoma care prescribing in primary care		
9.2	Recruit Prescribing Support Dietitian to work with primary care on oral nutritional supplements		
9.3	Pharmacist in post for each cluster to support Proactive Care		
0010 TECHNOLOGY TO EMPOWER PATIENTS			
10	Publish CCG Local Digital Roadmap	Planning & Delivery	
10	Begin implementation of Digital Roadmap	Planning & Delivery	
10	View only portal in place for professionals across organisations to access patient records	Planning & Delivery	

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COMMISSIONING TEAM KEY

MH - Mental Heath Services
CYP - Children & Young People's Services
UC - Urgent Care
PC - Planned Care
COMM - Community Services
PC - Planned Care
PRIM. C - Primary Care

NHS
Brighton and Hove
Clinical Commissioning Group

Annual Report

Brighton and Hove CCG

NHS
Brighton and Hove
Clinical Commissioning Group

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Performance Report

Statement of the Chief Clinical Officer

During 2015/16 the local health economy has faced significant performance challenges. Access to emergency care services has been below the required standards and patients have faced long waits for planned care services. Improving the performance against key national and local targets has been of paramount importance to the CCG and partner CCGs in the Brighton and Sussex Hospital Trust local health economy over the past year. As an organisation the CCG has undertaken detailed and critical analysis of our 2015-2016 performance in terms of both spend and outcomes. The organisation has used this analysis to inform our plan development so as to address and successfully mitigate these performance issues during 2016-2017 and beyond.

The CCG has employed different methodologies to maximise the value and impact of our limited resources in the past year and to support this, the CCG will move away from traditional activity based contracts and drive forward outcomes and pathway commissioning. The CCG will use all of the contractual levers available to us to drive improvements in quality and delivery of standards, particularly during this transitional year.

The CCG plans going forward to 2016-2021 will continue to focus on the dual themes of delivering short term recovery whilst laying the foundations for the longer term models of care which will ensure sustainable delivery of high quality health and care services in the future. We are working with partners across the Sussex and East Surrey footprint to address the aggregate urgent care and planned care delivery problems using the resources of our whole secondary care network.

While acknowledging and identifying the concerns we have regarding our performance over the last year I have no reason to doubt the ability to treat the CCG as a going concern. We have received no report or notification of concern form the CCG's auditors or from NHS England.

Information on the Entity, statement of purpose and activities of the organisation

NHS Brighton and Hove Clinical Commissioning Group (CCG) is a membership organisation made up of 44 GP practices, formed following the model required in the Health and Social Care Act of 2012. It is co-terminus with Brighton and Hove City Council and has the Royal Sussex County Hospital based within its boundaries. The CCG is lead commissioner for the Brighton and Sussex University Hospitals Trust which serves the population across Sussex. It is responsible for commissioning a range of health services on behalf of people in Brighton and Hove. The CCG is involved in partnership commissioning across the city and wider geographical area. This includes organisations such as the City Council, Community and Voluntary Sector and local NHS Trusts.

The CCG, under the clinical lead of our members, aims to deliver a local healthcare system which improves the quality and outcomes of healthcare for the population of Brighton and Hove. CCG commissioners will deliver this by promoting equality and paying particular attention to sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population. The CCG's direction and operation is driven by the desire to improve the health of all the people in Brighton and Hove and includes a commitment to ensure that the needs of all our communities are well served. The delivery of this ambition is guided by a series of principles which include our vision, values and aims. Our vision is:

"to be an excellent clinical commissioning group bringing clinicians, local people and managers together to make sure that there is help to stay healthy, as well as high quality, easy to use comprehensive health care for those who are unwell'.

This vision is underpinned by a number of values which describe our requirement to be accountable to the public as well as our members, to be open in our stewardship of public funds and to listen to and respect patient, the public, staff and clinicians. These values are set in an arena which requires the highest standards of excellence and professionalism in the provision of healthcare that is safe, effective and focussed on patient experience.

The delivery of our organisational vision and our organisational operation are governed by a number of legal requirements which address the issues of our membership, accountability and governance.

Our Strategic Objectives

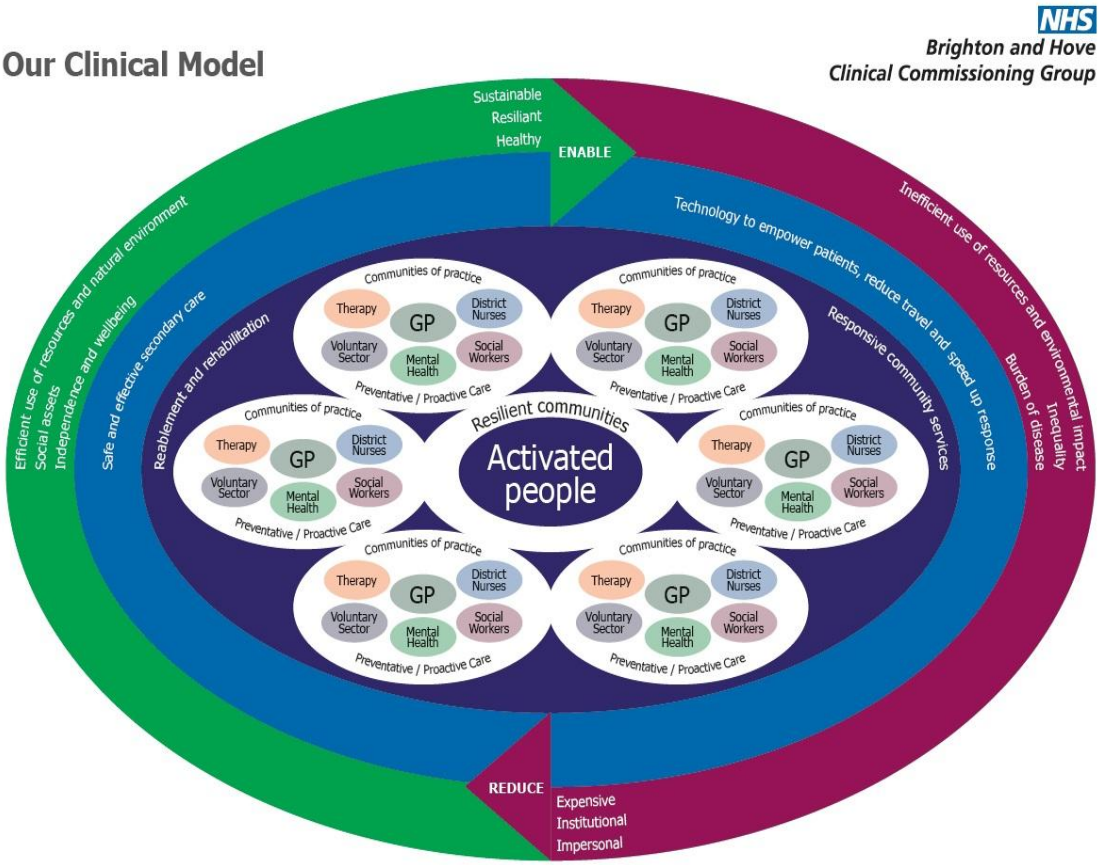
Abiding by the principles of good governance, accountability and service delivery the CCG organisational direction is determined by the organisational strategic objectives. These are agreed by our clinical leadership and ratified by the CCG Governing Body. The organisational strategic objectives are frequently reviewed to ensure they are contemporaneous and align with national guidance. In accordance with this best practice the CCG Governing Body completed a detailed assessment of where Brighton and Hove CCG was placed in terms of the needs of our population, our progress and means of travel in delivery of the national guidance and mandates, the improvement of services and the provision required to deliver our vision. The outcome resulted in the development of the following objectives:

- **Reduce Inequalities** – Focus on prevention and early detection. Plans should be targeted specifically at areas identified in the Joint Strategic Needs Assessment and the Annual Public Health Report.
- **Involving Patients and the Public** – The CCG will have a greater emphasis on self-management and empowering patients. We should include patients and the public in all of the decisions we make including the difficult decisions about resource and local services
- **Integration** – Integration should be at the heart of our commissioning agenda – services should be integrated to ensure efficiency and improve wellbeing
- **Quality and efficiency** – The CCG should always commission the most cost effective intervention delivered in the most appropriate setting. Our focus should remain on achieving financial balance but equally on improving the quality of local services.

Brighton and Hove CCG Clinical Strategy

The Brighton and Hove Clinical Strategy draws together the goals and themes of all our constituent plans and strategies to present a cohesive, progressive vision. The CCG Clinical Strategy has been developed by our Clinical Leads to provide a coherent strategic framework to address the strategic objectives described above. From this framework more detailed local implementation plans are formulated. The Brighton and Hove Clinical Strategy describes how the CCG will support the recovery of our local trust's performance and develop a sustainable model of care that addresses 3 key gaps in terms of health, quality and finance.

The vision for the improvement and sustainability of our local health system aligns and occludes with the direction and purpose of our neighbouring CCGs strategies and the plans while also being tailored to the diverse characteristics of the population of Brighton and Hove. The CCG Clinical Strategy comprises of four interdependent elements; our vision for the future (2021), identified clinical priority areas, the clinical delivery model to address these priorities and the recovery plan for our local trusts.



Future Model of Care

Our vision is to radically transform the local model of healthcare from one that is reactive, bed based and generally delivered in crisis to one that is more person-centred, proactive, preventative and built on the foundation of sustainable and high quality general practice and truly integrated partnership working. Our vision is to strengthen integration between health and social care services, primary and secondary care services and mental and physical health services the CCG will improve health outcomes and increase the quality and efficiency of services.

Clinical Priorities

Delivery of this vision is underpinned by key clinical priorities aligned to national guidance and local need. These identified priorities are aimed at:

- Transforming care for complex patients of all ages;
- Transforming cancer care;
- Transforming mental health care;
- Transforming long term conditions care;
- Reducing inefficiency;
- Ensuring a good start for all

Clinical Delivery Model

The strategic vision and clinical priorities for Brighton and Hove CCG translate into a model of transformation and care delivered through 5 interdependent elements with the patient at its core, as highlighted in figure 1. The model illustrates our ambition to move from expensive, institutional and impersonal care, exemplified by inequality, disease burden and inefficient use of resources, to a sustained, resilient and healthy population with increased independence and wellbeing and efficient services. The diagram below illustrates the clinical delivery model which we believe will ensure our vision is realised.

Central to this is prevention through the active empowerment and engagement of patients and communities. Consequently people will have more choice and control and increased ability to care for their own health. They will be better supported by general practices working together with integrated mental and physical health

community services. These local teams will be supported by City-wide integrated specialist teams who will treat people during health crises, preventing admission where possible, or supporting people to leave hospital at the earliest opportunity if an admission is needed. Growing evidence suggests that achieving closer integration between health and social care is key to addressing the challenges of improving outcomes for patients and reducing pressure on services, particularly acute care.

The Annual Operating Plan

The Brighton and Hove Operating Plan 2016/17 describes how the CCG will initiate the delivery of the vision outlined in the CCG Clinical Strategy. Through the delivery of the Operating Plan 2016-2017 emerging service and infrastructure developments will form the staging posts for the progression and delivery of our transformational ambitions and focus for the next five years. These will be articulated through the Sustainability and Transformation Plan for 2017-2020. The Operating Plan is set in the context of these longer term goals.

During 2015/16 the local health economy has faced significant performance challenges. Access to emergency care services has been below the required standards and patients have faced long waits for planned care services. Improving the performance against key national and local targets is of paramount importance to the CCG and as such our 2016-2017 plan focuses on the dual themes of delivering short term recovery whilst laying the foundations for the longer term models of care which will ensure sustainable delivery of high quality health and care services in the future.

An in depth and critical analysis of our current performance in terms of both spend and outcomes has formed the bedrock of the development of the Operating Plan 2016-2017. The CCG has employed the Right Care approach to maximise the value and impact of our limited resources. Additionally, the CCG will use all of the contractual levers available to drive improvements in quality and delivery of standards, particularly during this transitional year. During 2016-2017 the CCG will move away from traditional activity based contracts and drive forward outcomes and pathway commissioning models.

Aligning with the requirements of the Five Year Forward View, the Operating Plan 2016-2017 for Brighton and Hove fits within a set of strategies that cover differing geographical footprints. The underlying principles and vision are consistent for all of the plans but recognise that there are some service developments that relate specifically to needs of Brighton and Hove, some which are better aligned to the patient flows to the local acute trust and some which provide a more sustainable solution when applied to the whole county or region.

The Operating Plan has been developed, and is articulated, in relation to each of the elements of our Clinical Strategy identified above. The plan also includes information on achieving the NHS Constitution Targets, Quality Improvement, Governance and Assurance, Medicines Management and Information Management and Technology. The Plan forms the foundation for the development and implementation of the Sustainability and Transformation Plan.

Local Financial Context

Brighton and Hove CCG has consistently achieved a surplus above the required 1%. In 2015/16 the CCG will post a surplus of £12.6m (3.4%). The requirement in the planning guidance is for the excess surplus to be drawdown by the CCG over the next three years.

The CCG is deemed to be overfunded under the weighted capitation formula in 2016/17. Moving into 2016/17 the CCG has moved closer to its fair shares target. This exerts a financial pressure on the CCG as it has received no real terms growth and this will be the case over the next five years. Even with the restriction on growth of the CCG allocations the CCG remains at c4.5% over funded.

The lack of real terms growth makes it difficult for the CCG to progress the transformational changes were it not for the ability to drawdown £9m of our carried forward surplus over the next three years. To do so will require the production of robust business cases to NHS England, these are also a requirement of our internal planning process and CCG governance. As a planning assumption we are assuming

NHSE agree to a £3m drawdown in 2016/17. This will take the CCG surplus control total for 2016/17 to £9.7m (2.6%).

The plans for 2016/17 commits none of the 1% Non-Recurrent reserve. This is in line with planning guidance but we will need to allocate these funds during the year on items such as the transitional support to BSUHT for the implementation of 3T's once the transitional costs are determined. In previous years we have maintained the recurrent/non-recurrent split at 98% recurrent and 2% non-recurrent but have now moved to the minimum requirement of 1% non-recurrent reserve. This is part of the medium term financial plan and assists the CCG in coping with the lack of real terms growth.

The plans contain a 0.5% contingency reserve as required in the planning guidance financial rules. The overall framework will be challenging for the CCG given the context of our Distance from Target and the resultant restriction on growth.

The CCG has set a QIPP efficiency savings target at 2.6% (£10.0m), which currently includes £4.6m of unidentified QIPP savings, which increases the challenge to the health and social care system. The planning guidance encourages joint working with the City Council, the Better Care Programme Board and partners across the whole health and social care system. The CCG plans are being developed with partners and providers in the context of a wider strategic planning footprint. The CCGs have, historically, a good working relationship in relation to planning across the Sussex area. The national planning guidance recognises that this scale of planning needs to develop and continue to deliver the changes set out in the Five Year Forward View. This joint working will be evidenced during 2016-2017 though the development and delivery of Sustainable Transformation Plan.

Once we have finalised our income and expenditure plans for 16/17 we will undertake a full risk assessment and begin the task of identifying further savings initiatives and review all investment plans with a view to scaling them back to meet the currently unidentified QIPP savings target and bring plans within the funding available.

Performance Analysis

Delivering the NHS Constitution

The NHS Constitution establishes the principles and values of the NHS in England; sets out the legal rights of patients, public and staff, and the further pledges which the NHS is committed to achieve; and sets out the responsibilities of the public, patients and staff.

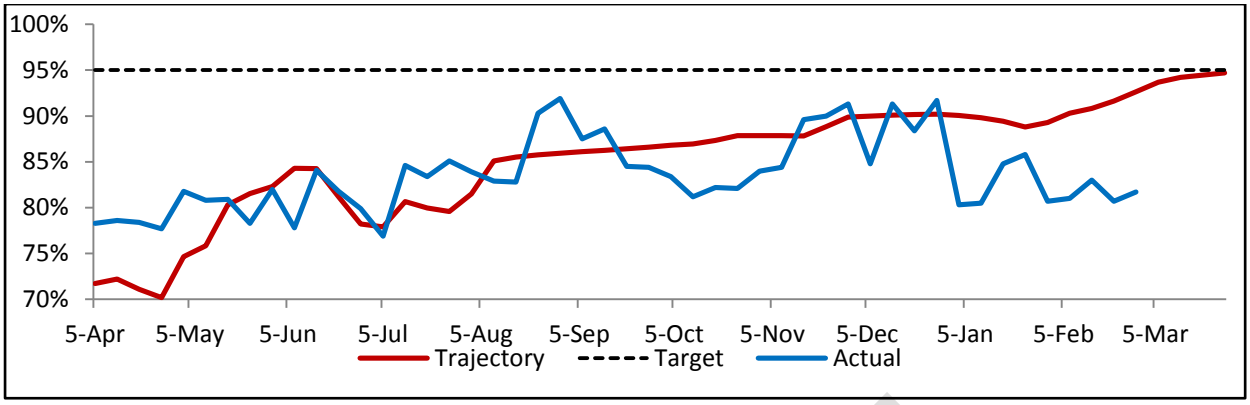
We are committed to meeting the obligations and expectations placed upon the CCG by the NHS Constitution. We will also do all we can to promote patient rights, address concerns where these are brought to our attention, and support our providers in doing the same.

Whilst historically we performed well in delivering NHS Constitution standards and key national performance indicators, we have of late seen a deterioration in a few key areas.

In response to this we have strengthened our programme and performance management approach and made a clear commitment to use the contractual levers at our disposal and worked collaboratively with the local health and care economy to develop credible and deliverable plans. The sections below provide an analysis of performance in 2015/16 and a summary of our plans to address areas of poor performance.

Urgent Care

Performance against the 4 hour A&E target has been below the NHS Constitution standard and our locally set recovery trajectory. Our previous plans failed to improve the achievement of the 4-hour operational standard and the improvement of unscheduled care performance remains the highest priority for the CCG, Trust and for the local health economy



During 2015/16 detailed performance and correlation analysis allowed us to target our plans at the areas which had the most impact on performance. Delivery of the first and second phase of the recovery plan delivered peaks in performance in September 2015 and November 2015 however did not deliver sustainable improvements.

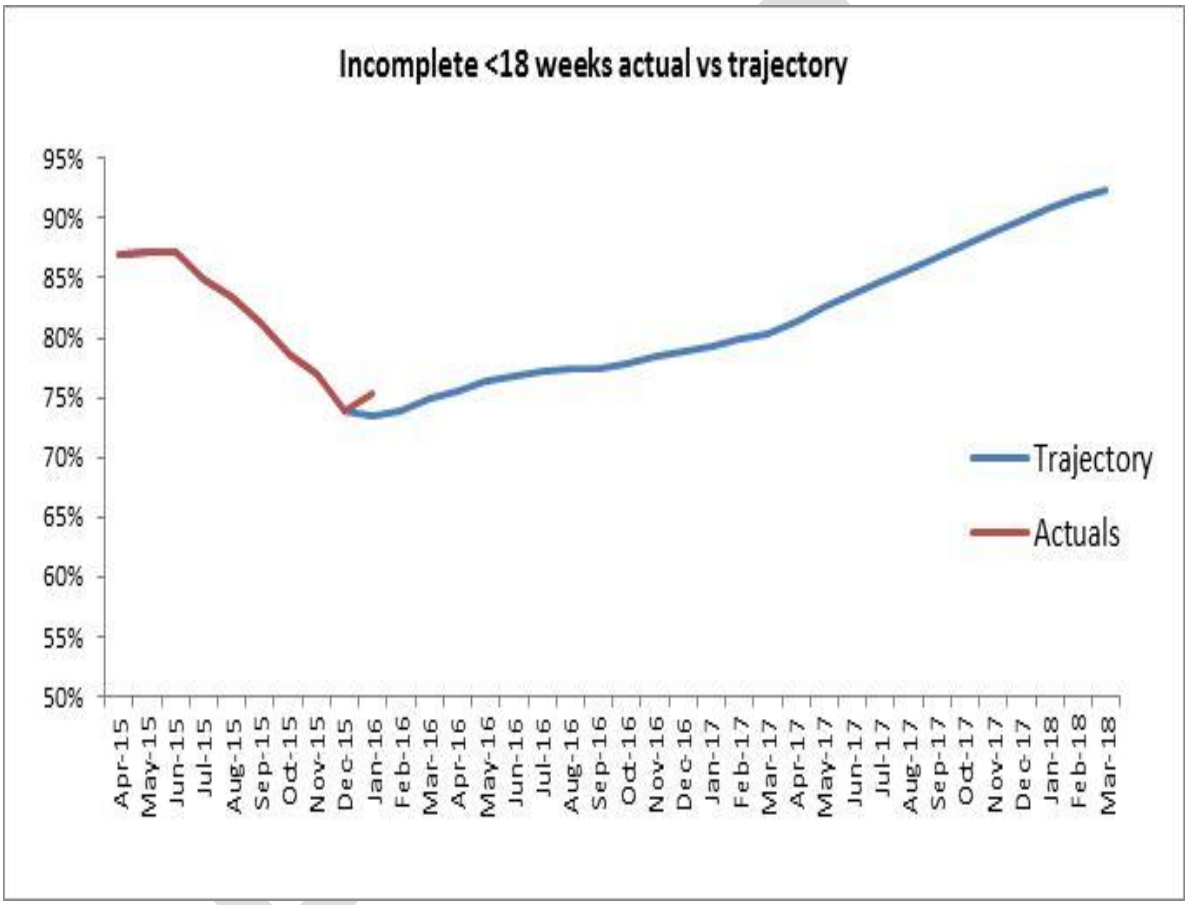
The partners in the local health and care system have worked together to develop plans for improvements in the 4-hour performance which aim to deliver a stable, sustainable basis for delivery of 95%. The plan has been initiated and improvements are starting to be realised. The plan architecture includes the following key programmes of work:

- Re-procurement of NHS 111 delivering a twin hub model - the regionally procured NHS 111 service and a locally procured community hub of services or Single Point of Access
- Integrated Front Door – a primary care led Urgent Care Centre integrating ED minors, out of hours and walk
- Responsive Crisis Services – including the extension of CRRS, alignment of the community beds in line with the recommendations of the Ernst &Young demand and capacity review and the, extension of ambulance non-conveyance pathways
- Improved Flow – including the implementation of the SAFER Flow bundle across bedded services, and full implementation of discharge models such Discharge to Asses and Hospital at Home

Further to the above the local health economy has also agreed a recovery trajectory for ambulance handovers which has been exceeded since November 2015. These plans are overseen by a Joint PMO and the Systems Resilience Group.

Planned Care

Demand for planned care services from GPs has reduced in the past year however during this period referral to treatment performance has been significantly challenged at our local acute trust.



Detailed analysis of referral data has shown significant increases in referrals from consultants and other sources such as allied health professions and dentists. There has also been increasing levels of two week wait referrals.

In order to return to equilibrium of demand and capacity, and following a modelling exercise with the acute provider, the CCG recognise that additional activity will be required to reduce the existing backlog. In response we plan to commission 5.8% more elective and outpatient pathways.

To provide this additional activity and deliver compliance in 2017/18 the CCG Annual Operating plans are fourfold:

- Existing capacity - Work with our local acute trust to maximise the capacity available locally
- Patient Choice – ensure that every patients is given the appropriate choice of provider
- Market development – work with independent sector and NHS providers to grow the market
- Pathway Redesign – deliver services outside of hospital in community or primary care setting wherever possible and appropriate e.g. Community IBS service, develop local direct access diagnostic pathways

Key to the delivery of the RTT standard is the diagnostic waiting time target of 6 weeks. During 2015/16 a validation exercise highlighted that a proportion of the diagnostic waiting list was not being correctly reported and this led to the development of a backlog of patients waiting for echocardiograms. Significant additional activity has taken place in recent months to reduce this backlog.

Diagnostic demand and capacity modelling has highlighted some areas of concern for 2016/17. Primarily related to endoscopy (digestive diseases) and increased diagnostic activity as a result of implementing the new NICE guidelines for Cancer. We are working with the national PMO to secure sufficient additional activity to meet the anticipated demand.

Cancer Access

The CCG has performed poorly against the 62 day cancer waiting target for most of 2015/16 towards the end of the year performance against the two week wait standard also deteriorated due primarily to operational challenges in digestive diseases.

Indicator	Standard / Threshold	15/16 YTD	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
Cancer: 2 week wait referral to date first seen	93%	91%	92%	96%	94%	94%	93%	93%	95%	93%	87%	80%	87%
Cancer: 2 week wait referral to date first seen - Breast Symptomatic	93%	98%	99%	97%	99%	95%	98%	98%	100%	99%	97%	98%	97%
Cancer: 31 day wait from diagnosis to first treatment	96%	97%	97%	96%	97%	96%	97%	94%	96%	97%	97%	97%	99%
Cancer: 62 day wait for first treatment from urgent GP referral	85%	77%	79%	67%	75%	73%	76%	82%	68%	86%	86%	80%	73%

Historically the CCG has performed well on cancer access targets but the number of two week referrals has increased this year and is forecast to increase further in 2016/17. The CCG will continue to work closely with our local acute trust to maintain access time standards and will secure additional capacity for diagnostics via the national PMO.

Mental Health Access Targets

The new waiting time standard requires that 75% of people with common mental health conditions referred to the Improved Access to Psychological Therapies programme will be treated within 6 weeks of referral, and 95% will be treated within 18 weeks of referral. These targets have been monitored throughout 2015/16 and our local IAPT provider is meeting both.

In addition to these new targets the services will continue to be required to maintain the access standard of ensuring that at least 15% of adults with relevant disorders will have timely access to IAPT services with a recovery rate of 50%. The CCG have consistently achieved the coverage element of this target but have struggled to deliver the recovery target; the eligibility criteria of our local service make delivery of this target more difficult. In response the CCG is recommissioning the service in 2016/17 to ensure delivery of the required standards.

Current reporting suggests that our local mental health trust is achieving the new early intervention for psychosis target. We are working with the trust to ensure that data quality is robust.

Steps to Transformation

Moving the focus from the CCG recovery plans the Operating Plan 2016-2017 also forms the foundation and staging platform for the development of a sustainable health and care system. The following sections provide a high level summary of our plans to bring about this transformation.

Patient Engagement and Empowerment

Central to the delivery of our vision for Brighton is patient activation. 'Patient activation' is a widely recognised concept. It describes the knowledge, skills and confidence a person has in managing their own health and health care. People who have low levels of activation are less likely to play an active role in staying healthy. They are less good at seeking help when they need it, at following a doctor's advice and at managing their health when they are no longer being treated. Through the delivery of our Better Care Plan and new model of locally commissioned services we will focus on patient activation and self-management.

Primary Care

Brighton and Hove CCG's vision for our frail population in 2020 is to help them stay healthy and well by providing more pro-active preventative services that promote independence and enable people to fulfil their potential.

Establishing a more proactive approach to care and support is part of the wider agenda to provide integrated care across the system. We want to connect all parts of the system, whether they are proactive or urgent, so that people receive responsive care at the right time from the right service. The capacity and system leadership from proactive care will support these wider changes in the future.

In 2015/16 we have rolled out this new model of care to 3 of the 6 local GP clusters. In 2016/17 we will complete the roll out and as a result expect to see a reduction of 1013 non elective admissions.

Community Services

Our services need to be configured so that they quickly respond to people when they have an urgent need for support, offering integrated community alternatives to hospital admission 24/7. We know that demand for services is increasing and that with an ageing population this is likely to continue. However over recent years we have mitigated any increase in the number of A&E attendances and non-elective admissions by developing and strengthening community services. Our plans for 2016/17 include:

- a single point of access for responsive community teams across the whole BSUH catchment area;
- Align this model of a “community hub” with the reprocurement of NHS 111;
- Extend rapid response service to provide 24/7 cover;
- Develop a system–wide frailty pathway including a single integrated model for community geriatrics

Mental Health

Mental health remains a key commissioning priority for the CCG. In collaboration with Brighton and Hove City Council, we launched the Happiness Strategy in the summer of 2014.

Huge change has taken place in adult mental health services in Brighton and Hove over the last few years and the CCG intend to continue to work collaboratively with Sussex Partnership Foundation Trust to ensure that wherever possible care is delivered outside hospital. The CCG is also committed to working with a wide range of providers across the City, including the community and voluntary sector, to provide services across a range of needs.

As part of our commitment to Parity of Esteem, in addition to our planned improvements to mental health services we will continue to ensure mental health becomes an integral part of all relevant care pathways. Where appropriate, the CCG will look at commissioning all age pathways to ensure that individuals at the point of transition (between children’s and adult services) get the most appropriate care to meet their needs.

Children and Young People

The majority of health care for children and young people is provided by GPs in primary care and is in the context of looking after the family as a whole. Children in the pre-school tend to see their GP 6 times a year on average, with school age children seeing their GP 2 to 3 times per year. The CCG wants to ensure that primary care has the capacity and capability to offer high quality health care to children and young people. We will do this through the Locally Commissioned

Service (LCS) outcomes contract, building on the work done throughout 2015-16. Having happy healthy children in our city will lead to happy healthy adults and less reliance on the health and social care system.

Digital Roadmap

The CCG intends, in line with national ambition for electronic (paperless), interoperable and real-time health records by 2020 (NHS England, 2015), to implement the CCGs Digital Roadmap during 2016-17. The CCGs Digital Roadmaps will be published by April 2016 following consultation with Local Authorities, NHS providers and the Health & Wellbeing Boards. The CCG intends to embed technology and use of information in core CCG decision making in order to use them much more fundamentally to improve productivity and quality. The draft roadmap consists of:

- A view only portal for professionals across organisations to access patient records held in multiple organisations.
- A shared working space where professionals can record and work together on a subset of care plans for patients with complex needs or a high level of risk.
- A portal for patients/potential patients, with a view of records, ability to record, and access to relevant evidence.
- Effective use of specialist clinical expertise through teleworking initiatives.
- Streamlined care delivery making effective use of information and technology wherever there is a benefit.

Avoidable Deaths and Seven Day Services

Working with the SCN and HEKSS the CCG are actively working with our acute provider to introduce a care bundle which tackles still birth by improving 4 elements of care. In addition the CCG will be locally monitoring outcomes from the homebirth team; this team is delivering above national average numbers for home birth. The CCG has a plan in place for the development of midwife led unit in Brighton and Hove.

Brighton and Hove CCG host the pan Sussex serious incident reporting system and review all reports and identify themes across the county and once identified specific support and training is provided for organisations to support improvement. In addition to this Brighton and Hove CCG has hosted the yearly Patient Safety Conference for past 2 years and have developed from this a pan Sussex learning model developed from the identifications/analysis of National and Local issues and incidents.

Patient Experience

The CCG Quality Team have regular engagement with the maternity liaison committee which regularly reviews Friends and Family Test and other sources of patient feedback such as "walk the patch" and monitors the implementation of identified findings. Quality Review Meetings also receive regular updates of Friends and Family Test uptake and scores and actions taken as a result. Further to this patient experience data supports quality monitoring and support of primary care through the engagement of the Friends and Family Test information. In addition patient experience issues are conveyed to the CCG Governing Body via the Lay member on the Governing Body chairing the Patient and Public Involvement leads meeting and providing direct input to Governing Body meetings.

Improving take up of personal care budgets- CCG plans include the proactive management of vulnerable groups and provision of personalised care and support plans. This includes the development of strong proactive services for individuals with learning disabilities and/ or autism including assuring recognition of risk of carer and/ or accommodation breakdown and a proactive support planning and case management approach. Brighton and Hove CCG is lead for the pan Sussex transforming care program.

The CCG's duty to involve the public

Brighton and Hove Clinical Commissioning Group takes its duty to involve the public very seriously and we have taken a number of steps to ensure we are actively engaged with patients in the city. The CCG has a head of engagement who promotes a variety of engagement groups in the city supporting underrepresented

and harder to reach groups of patients such as patient with disabilities, BME groups or patients from the traveling community. The Head of Engagement has been working with these groups over the year to ensure that have opportunities to feed into discussions around service redesign and ensure their views are taken into account.

The CCG takes its responsibility to involve the public seriously at the most senior level. The CCG has two lay members, one of whom has a specific responsibility towards Patient and Public Involvement. The lay member with a responsibility for PI has the task of ensuring that the patient voice is heard at the highest level and is the champion of patient inclusion at meeting of the Governing Body. In order to ensure that the lay member with responsibilities for patient and public involvement has the ability to be the champion for the patient voice, it is required that the member is also the chair of the Patient Participation Group Network in the city.

During the year the CCG has recognised that its committee structure needed further development to assure the Governing Body that the CCG is meeting its responsibility to involve the public. Accordingly the CCG has created the Participation d Communication Assurance which is chaired by the Lay Member with responsibilities for Patient and Public Involvement. Through the work of this committee, the Governing Body is assured that the CCG is meeting its duty to involve the public.

The CCG's duty to reduce inequalities

Brighton and Hove CCG is committed to reducing health inequalities within the city and we are working hard with our partners in the city to do so. The first step in reducing health inequalities if to identify the nature of the inequalities to be addressed. This has largely be done in the through the creation of the Joint Strategic Needs Assessment (JSNA) carried out by Brighton and Hove City Council's department of public health. The JSNA take a detailed look at the population of the city and creates a detailed overview of the city's demographics and the health needs at the present time and identifies what those needs are likely to be going forward. Using this as a basis we can commission services the address the identified health needs

The CCG's commissioning plans are informed by the outcome of the JSNA which seeks to identify the health services, be they preventative or treatment services, which the CCG needs to address in the coming years.

Using the JSNA has been identified that there is an expanding gap between the life expectancy between those living in more affluent parts of the city compared to those living in less affluent parts of the city. In order to tackle this issue the CCG is exploring a new approach to funding GP practices to deliver proactive care services, developing a funding formula which will award funds on the basis of patient need rather than based on the size of patient lists.

Bright and Hove City Council working with the CCG and other partners in the city have conducted a reducing and inequalities review. The review sought to look at the available evidence and understand where and amongst which communities inequality is experienced in the city. The review then considered what priorities would be needed to reduce deprivation and disadvantage. The review is conducted in two parts, the first seeking to identify the needs to be address and the second to produce the plans and strategies to require to respond to the inequalities identified.

Appendix 1-Principal Risks 2015-2016

Strategic Objective	Primary Risk	Risk Score	Mitigation	Residual Rating
Align our commissioning to the health needs of our population and ensure we are addressing health inequalities across the City'	There is a risk that the most vulnerable people and those who live in deprived areas of the city will not have equitable access to health care resulting in increased health inequalities	12	• Outcomes based commissioning of LCS • Expanded Health trainers programme • Targeted investment in cancer • Targeted programmes with hard to reach groups	6
'Ensuring that citizens will be fully included in all aspects of service design and change and that patients will be fully empowered in their own care'	There is a risk that the patient and public voice will not be clearly heard in all of our commissioning plans resulting in services that are not truly person-centred	9	• Experience led commissioning programme for better care • Delivery of the public and patient participation strategy	6
Increase capacity and capability in primary and community services so that we focus on preventative and proactive care – particularly for the most frail and disadvantaged communities;	There is a risk that workforce required to deliver the ambitious changes in primary and community care will not be available	16	• Workforce and development programme specifically for general practice • Workforce and organisational development group for delivery of the MCP	8
Plan services that deliver greater integration between health, social care and housing and promote the use of pooled budgets'	There is a risk that services will not fully integrate resulting in potential duplication and inefficiencies	12	• Development of the MCP model • Alternative contracting methods which support integration such as outcomes based contracts	6
Design high quality urgent care services that are responsive to patient needs and delivered in the most appropriate setting'	There is a risk that increased demand and service pressures will result in the non-delivery of the A&E target	16	• Delivery of the integrated urgent care model • System wide demand and capacity planning • Increased primary and community services	8

Strategic Objective	Primary Risk	Risk Score	Mitigation	Residual Rating
Integrate physical and mental health services to improve outcomes and the health and wellbeing of all our population'	There is a risk that physical and mental health services will not achieve parity	12	• Use contractual incentives to ensure parity • Ensure all newly commissioned services include parity of esteem	6
Exploit opportunities provided by technology to deliver truly integrated digital care records, derived from the GP Record as the primary source which will be made "Fit for caring, fit for sharing" through a programme of information management and data quality initiative	There is a risk that the NHS number will not be available on all health and social care records	9	• Use contractual levers with NHS provider organisations to ensure utilisation of NHS number • Work with adult social care to increase use of NHS number	6

Appendix 2-Principal Risks 2016-2017

Primary Risk	Risk Score	Mitigation	Residual Rating
There is a risk that performance against targets may not be met in 2016/17, particularly in A&E access targets including 18 weeks, IAPT, RTT ,HCAI and cancer 62 day wait.	20	• System wide demand and capacity planning including detailed referral analysis to understand the level of demand for planned care services and the distribution of the demand. • Delivery of the integrated urgent care model • Increased primary and community services including delivery of proactive care, IBS and LUTS services	12
There is a risk that the CCG will not secure adequate activity to sustainably deliver standards for planned care	20	The CCG is actively seeking additional planned care activity from independent sector and NHS providers	16
There is a risk that Brighton and Hove increasing pressures on primary care organisations may impact on their ability to deliver a robust and sustainable primary care structure which will adequately support the delivery of GMS services for the people of Brighton and Hove	20	• NHS England Primary Care Commissioning Panel meeting to discuss the options for on-going primary care services • Workforce and development programme specifically for general practice • Workforce and organisational development group for delivery of the MCP new ways of working being trialled by primary care in an effort to ensure that general practice is effective, well organised and, above all, sustainable in the future	16
There is an expectation that NHS and social care funding will be restricted over the next 5 years and there is a risk that the CCG will be unable to contain costs in the same time frame. This is because of the time lag in the development of transformational programmes designed to deliver efficiencies	16	On-going assessment of likely impact of plans. Operational and Strategic Plans reviewed and refreshed annually enabling the CCG to anticipate pressures and adjust accordingly	12
The CCG recognise that during the current period of local executive transition there is a risk that an interim loss of corporate knowledge may impact on the timely delivery of 2016/2017 ambitions	9	All executive team posts have been successfully recruited to, both the Chief Operating Officer and the Director of Finance are now in post	6
There is a risk that the recognised workforce shortages and workforce capacity issue, reported nationally and locally may have an impact on the CCG plans to deliver new and changed services	16	• up-skill the non-medical workforce in Primary Care with education and training • Training for practice managers to help them with the transformation of primary care and adopt new ways of working, and take on more leadership roles within the Clusters.	12

NHS
Brighton and Hove
Clinical Commissioning Group

Accountability Report

Brighton and Hove CCG

Details of Membership and the Governing Body

Details of the CCG's Member Practices, Governing Body and Audit Committee are described below:

CCG Chair and Accountable Officer

As a clinical organisation, Brighton and Hove CCG is pleased to have appointed GPs from practices within the city to the roles of Chair and Accountable Officer. As a reflection of this we have chosen to use the title "Chief Clinical Officer" rather than Accountable Officer. Dr Christa Beesely is the Chief Clinical Officer for the CCG and has been in post since the CCG was established on 1st April 2013.

The CCG's Chair is Dr Xavier Nalletamby. Dr Nalletamby was initially appointed as CCG Chair prior to establishment, whilst the CCG was still a shadow organisation. Dr Nalletamby was appointed for a second term in April 2014

Composition of the CCG Governing Body

Full details of the CCG's Governing Body membership including the membership of the various committees of the Governing Body can be found in the Annual Governance Statement later in this report.

The membership of the Governing Body, including the dates of appointment within the year are set out below. The table also shows the membership of the CCG's Audit committee:

Name	Position		Audit Committee Member
Dr Xavier Nalletamby	CCG Chair	Appointment continuous throughout the period.	
Dr Christa Beesley	Clinical Chief Officer (Accountable Officer)	Appointment continuous throughout the period.	
John Child	Chief Operating Officer	(commenced 1/2/16)	
Geraldine Hoban	Chief Operating Officer(Departed 31/10.15)	(Departed 31/10.15)	
Pippa Ross - Smith	Chief Financial Officer (commenced 1/3/16)	(commenced 1/3/16)	
Michael Schofield	Chief Financial Officer (Departed 28/2/16)	(Departed 28/2/16)	

Soline Jerram	Director of Clinical Quality and Patient Safety	Appointment continuous throughout the period.	
Dr Naseer Kahn	Chief of Clinical Leadership and Engagement	Appointment continuous throughout the period.	
Dr Manas Sikdar	LMG Chair (East Locality)	(commenced 1/9/15)	
Dr Darren Emilianos	LMG Chair (East Locality)	(departed 30/04/15)	
Dr Jim Grahame	LMG Chair (Central Locality)	(commenced 1/3/16).	
Dr Jonny Coxon	LMG Chair (Central Locality)	(commenced 7/7/16).	
Post Vacant	LMG Chair (West Locality)	Vacant since 1st January 2016	
Dr Anne Miners	LMG Chair (West Locality)	Departed 31/12/15	
Dr George Mack	Lay Member - Governance	Appointment continuous throughout the period.	✓ Chair
Mike Holdgate	Lay Member – Patient and Public Involvement	Appointment continuous throughout the period.	✓
Jennifer Oates	Independent Member-Registered Nurse	Appointment continuous throughout the period	✓
Dr Dinesh Sinha	Independent Member – Secondary Care Clinician	Appointment continuous throughout the period	✓
Dr Tom Scanlon	Director of Public Health (non-voting member)	Standing Down 31/3/19	
Denise D'Souza	Director of Adult Social Care (non-voting member)	Standing Down 31/3/19	

Further details of the committee structure of the Clinical Commissioning Group may be found in the Annual Governance Statement and are contained in full in the CCG's constitution.

During the course of the year the Governing Body has seen the following changes:

LMG Chair East

Dr Darren Emilianos stood down as the Chair for the East Locality in April 2015. He is replaced by Dr Manas Sikdar who commenced this role with the CCG on 1st September 2015.

LMG Chair Central

Dr Jonny Coxon stood down as the Chair for the Central locality on 7th July 2015 to take up a role with the local acute trust. Dr Jim Grahame commenced in this role on 1st March 2016.

LMG Chair West

Dr Anne Miners' term as Chair for the western Locality came to an end at the end of October 2015. In order to support the new Chair for the East locality Dr Miners agreed to extend her term until 31st December 2015. The CCG has not yet identified a new Chair for the West Locality.

Independent Clinical Members

The initial terms of the CCG's Independent Clinical Members came to an end in September 2015. Both independent members agreed to remain with the CCG for a further term.

Lay Members

The initial term of the lay member for governance, Dr George Mack, expired on 31st March2016. It was agreed that the Dr Mack would be reappointed for a further term

Chief Operating Officer

The Chief Operating Officer left CCG on 31st October to take up a role with another CCG. The post was filled on an interim basis pending the appointment of a permanent Chief Operating Officer. John Child took up this post with the CCG commencing on 1st February 2016.

Chief Finance Officer

Michael Schofield retired from the CCG, standing down from this post on 29th February 2016. Pippa Ross-Smith has been appointed to the CFO position commencing on 1st March 2016.

Director of Delivery and Performance

It was recognised by the CCG's Governing Body that, as a leader of the local health economy, it was necessary to create a new post with specific oversight of the delivery of services and the performance of providers. This post was filled on an interim basis on 15th June 2016 and Lola Banjoko commenced as the permanent post holder on 21st March 2016.

Membership of the Clinical Commissioning Group

The CCG membership is comprised of each for the 44 GP practices within Brighton and Hove. Each practice falls within one of the city's three localities which is in turn represented on by a GP who is a member of the Governing Body.

The tables below show the practices which make up the membership of the Brighton and Hove CCG, including the locality of which they are a member.

East Brighton Local Member Group	
Practice Name	**Address**
Albion Street Surgery	9 Albion Street, Brighton, BN2 9PS
School House Surgery	Hertford Road, Brighton, BN1 7GF
Ardingly Court Surgery	1 Ardingly Street, Brighton, BN2 1SS
Brighton Homeless Healthcare	The Practice, Morley Street, Brighton, BN2 9DH
Broadway Surgery	Wellsbourne Health Centre, 179 Whitehawk Road, Brighton, BN2 5FL
Lewes Road Surgery	188/189 Lewes Road, Brighton, BN2 3LA
Park Crescent Health Centre	1 Lewes Road, Brighton, BN2 3HP
Pavilion Surgery	2-3 Old Steine, Brighton, BN1 1FZ
Regency Surgery	4 Old Steine, Brighton, BN1 1EJ
Ridgeway Surgery	130 The Ridgeway, Woodingdean, Brighton, BN2 6PB
Saltdean & Rottingdean Medical Practice	20 & 21 Grand Ocean, Longridge Avenue, Brighton, BN2 8LG
St Luke's Surgery	20 & 21 Grand Ocean, Longridge Avenue, Brighton, BN2 8SN
The Avenue Surgery	1 The Avenue, South Moulsecoomb, Brighton, BN2 4GF
Whitehawk Medical Practice	Wellsbourne Health Centre, 179 Whitehawk Road, Brighton, BN2 5FL
Willow Medical Centre	50 Heath Hill Avenue, Lower Bevendean, Brighton, BN2 4FH
Woodingdean Surgery	1 The Ridgeway, Woodingdean, Brighton, BN2 6PE

Dr Manas Sikdar is the chair for the East locality

Central Brighton Local Member Group	
Practice Name	**Address**
Beaconsfield Medical Practice	175 Preston Road, Brighton, BN1 6AG
Brighton Station Health Centre	Aspect House, 84 - 87 Queens Road, Brighton, BN1 3XE
Carden Surgery	County Oak Medical Centre, Carden Hill, Brighton, BN1 8DD
The Haven Practice	100 Beaconsfield Villas, Brighton, BN1 6HE
New Larchwood Surgery	Waldron Avenue, Coldean, Brighton, BN1 9EZ
Montpelier Surgery	2 Victoria Road, Brighton, BN1 3FS
North Laine Medical Centre	12-14 Gloucester Street, Brighton, BN1 4EW
Preston Park Surgery	2A Florence Road, Brighton, BN1 6DJ
St Peter's Medical Centre	30-36 Oxford Street, Brighton, BN1 4LA
Ship Street Surgery	65-67 Ship Street, Brighton, BN1 1AE
Stanford Medical Centre	175 Preston Road, Brighton, BN1 6AG
The Practice (Boots)	First Floor Boots the Chemist, 129/132 North Street, Brighton, BN1 2BE
The Seven Dials Medical Centre	24 Montpelier Crescent, Brighton, BN1 3JJ
University of Sussex Health Centre	University of Sussex, Falmer, Brighton, BN1 9RW
Warmdean Surgery	Carden Hill, Brighton, BN1 8DD

Dr Jim Grahame is Chair for the Central locality

West Brighton Local Member Group	
Practice Name	**Address**
Brighton Health and Wellbeing Centre	18/19 Western Road, Hove, BN3 1AE
The Central Hove Surgery	Ventnor Villas, Hove, BN3 3DD
The Charter Medical Centre	88 Davigdor Road, Hove, BN3 1RF
Hangleton Manor Surgery	96 Northease Drive, Hove, BN3 8LH
Hove Medical Centre	West Way, Hove, BN3 8LD
Wish Park Surgery	124 New Church Road, Hove, BN3 4JB
Hove ParkVillas Surgery	18 Hove Park Villas, Hove, BN3 6HG
Links Road Surgery	27-29 Links Road, Portslade, BN41 1XH
Matlock Road Surgery	10 Matlock Road, Brighton, BN1 5BF
Mile Oak Medical Centre	Chalky Road, Portslade, BN41 2WF
Benfield Valley Health Care Hub	Old Shoreham Road, Portslade, BN41 1XR
Portslade Health Centre	Church Road, Portslade, BN41 1LX
Sackville Medical Centre	20 Sackville Road, Hove, BN3 3FF

The Chair for the West Locality is currently vacant

Governing Body Members Interests

The CCG maintains a register of interests which is made available to the public on its website.

The table below shows the registered interests in respect of its Governing Body members:

Name	Role	Declaration of Interest
Dr Christa Beesley	Chief Clinical Officer	• Works as a locum GP in Brighton, primarily at The Practice, Whitehawk.
Dr Jim Grahame	Local Member Group GP Lead (Central)	• Director of Stanford Medical Centre (SMC) Ltd, which is a provider of vasectomy services and community ENT services. • Director of Oxymon Ltd, which is an oxygen therapy monitoring medical device company that to date has done product development and field trials but has no product on the market. • Cluster Lead for Brighton and Hove Wellbeing Service, a primary care mental health service. • Partner at GP Practice, Stanford Medical Centre, 175 Preston Road, Brighton.
Denise D'Souza	Director of Adult Social Care	• Dual role as both a commissioner and provider of services for the city council. • Employed by the Local Authority (BHCC) and is their rep on the GB. • Two children work in clinical roles within Sussex Partnership Foundation Trust.
Dr Manas Sikdar	Local Member Group GP Lead (East)	• Senior Partner at Albion Street Surgery, Albion Street, Brighton, BN2 9PS. • Practice Clinical Lead for pro-active care. • Partner is Mari Jones, a salaried GP at Charter Medical Centre (currently on maternity leave).
John Child	Chief Operating Officer	• Brother is the Director of the Brighthelm Centre. • Partner is a Senior Social Worker within Brighton and Hove City Council's Children's Services department.
Soline Jerram	Director of Clinical Quality and Patient Safety	• Trustee of St Wilfred's Hospice, Chichester, West Sussex.
Dr Naseer Khan	Chief of Clinical Leadership and Engagement	• GP Principal at Warmdene Surgery. • Warmdene Surgery provides the community eye service. • Member of the Medical Advisory Committee Nuffield Hospital Woodingdean. • Wife is a nurse in the Montefiore Hospital, Hove.
Dr George Mack	Lay Member – Governance	No interests declared
Lola Banjoko	Directory of Delivery and Performance	• Member of NHS International group supporting developing countries • Council member of the Royal African Society

		(NFP) • Glabal Health (volunteer)
Dr Xavier Nalletamby	Chair	• Senior partner at St Peter's Medical Centre, Brighton. • Sessional doctor for EPIC part of Prime Minister's Challenge Fund. • Appraiser for NHSE.
Jennifer Oates	Lay Member - Registered Nurse	• Trustee of Brighton Natural Health Centre (a charity). • Mental Health Act Reviewer and Specialist Advisor with the Care Quality Commission. • Volunteer with St John's Ambulance Homeless Service (a charity that receives funding from the CCG). • Has received funding from the Florence Nightingale Foundation. • On nursing bank with Sussex Partnership NHS Foundation Trust.
Dr Tom Scanlon	Director of Public Health	Executive Director of Brighton and Hove City Council. Sessional GP, Lime Tree Surgery, Findon, West Sussex. Wife is employed by SPFT CAMHS.
Pippa Ross-Smith	Chief Financial Officer	No interests declared.
Dr Dinesh Sinha	Lay Member – Secondary Care Clinician	• Independent clinical member of Ashford CCG Governing Body. • Consultant and Assistant Medical Director (Interim) East London NHS Foundation Trust • Independent Medico Legal work. • Brother works at St Peters. • Sister in law works at St Georges.

Disclosure of Personal Data Related Incidents

The CCG has not reported any serious untoward incidents in respect of breaches of confidentiality or loss or personal data during the year to 31st March 2016. Further details in relation to Information Governance may be found in the Governance Statement.

The CCG considers that suitable robust processes have been put in place in respect of Information Governance, including robust reporting process should any incident arise, to minimise the risk of any Serious Untoward Incidents.

Statement as to disclosure to auditors

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

- So far as the member is aware, that there is no relevant audit information of which the Clinical Commissioning Group's external auditor is unaware; and,
- That the member has taken all the steps that they ought to have taken as a member in order to make them self-aware of any relevant audit information and to establish that the Clinical Commissioning Group's auditor is aware of that information.

Dr Christa Beesley

Accountable Officer

NHS Brighton and Hove Clinical Commissioning Group

[X] May 2016

NHS
Brighton and Hove
Clinical Commissioning Group

Statement of Chief Clinical Officer's Responsibilities

Brighton and Hove CCG

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 Dr Christa Beesley to be the Accountable Officer of Brighton and Hove Clinical Commissioning Group. As a GP within a clinically lead organisation the Accountable Officer is more usually known as the Chief Clinical Officer.

In accordance with the Clinical Commissioning Group Accountable Officer Appointment Letter, the responsibilities of an Accountable Officer 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 Clinical Commissioning Group and enable them to ensure that the accounts comply with the requirements of the Accounts Direction);
- and for safeguarding the Clinical Commissioning Group's assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities),

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

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

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

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my Clinical Commissioning Group Accountable Officer Appointment Letter and the financial statements have been produced in accordance with the Manual for Accounts and the Accounts Directions provided by NHS England.

I have taken all necessary steps to assure myself that those who have been appointed to audit Brighton and Hove Clinical Commissioning Group have been made aware of all of the relevant audit information.

It is my responsibility to ensure that the annual report and accounts are submitted to NHS England and that they are a fair, balanced and understandable representation of Brighton and Hove Clinical Commissioning Group. I confirm that the have taken such reasonable steps as are necessary to assure myself that this is the case.

[signature]

Dr Christa Beesley

Chief Clinical Officer (Accountable Officer)

Brighton and Hove Clinical Commissioning Group

[x]May 2016

NHS
Brighton and Hove
Clinical Commissioning Group

Annual Governance Statement

Brighton and Hove CCG

Annual Governance Statement

Introduction and context

The Clinical Commissioning Group was licensed from 1 April 2013 under provisions enacted in the Health and Social Care Act 2012, which amended the National Health Service Act 2006.

As at 1 April 2015, the Clinical Commissioning Group was licensed without conditions.

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 in my Clinical Commissioning Group Accountable Officer Appointment Letter.

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

Compliance with the UK Corporate Governance Code

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

For the financial year ended 31st March 2016 and up until the date of signing this statement, we have complied with the provisions of the Code as would be expected of a Clinical Commissioning Group

Brighton and Hove CCG seeks to comply with the following principles of the UK Corporate Code:

Leadership

The CCG has an effective Governing Body which has a collective responsibility for the CCG's long term success. Although the Governing Body is not a Board as described in the Code, it is established in a similar way and carries out many of the same functions.

The CCG Governing Body clearly divides its responsibilities between its executive, lay and independent members. No single member of the Governing Body has unfettered powers of decision making and all members are encouraged to constructively challenge and help develop proposals on strategy.

Effectiveness

The Governing Body ensures that within its own membership and within the membership of its committees there is an appropriate balance of skills, experience, independence and knowledge of the CCG and its activities to enable them to discharge their respective duties and responsibilities effectively.

The Remuneration and Nominations Committee ensures that there is an rigorous and transparent procedure for the appointment of new members to the Governing Body and ensures that they are able to allocate sufficient time to the CCG to discharge their responsibilities effectively.

The Governing Body regularly assess its performance, seeking the views of stakeholders across the Local Health Economy and within the CCG.

The quality of data received by the Governing Body is reviewed regularly and ensure that that suitable information is provided to members to ensure that they are able to discharge their obligations effectively.

Accountability

The Governing Body presents a fair, balanced and understandable assessment of the CCG's position and performance.

The Governing Body is responsible for determining the nature and extent of the principal risks it is willing to take in achieving its strategic objectives. The Governing Body maintains sound risk management and internal control systems.

The Governing Body, via the Audit Committee, has established formal and transparent arrangements for considering how corporate reporting, risk management and internal control principles are applied and for maintaining an appropriate relationship with the CCG's auditors.

Remuneration

The remuneration of the CCG's Executive Team is intended to promote the long term success of the CCG and is bench marked against other local organisations.

The procedure for considering executive remuneration is formal and transparent. The process is governed by the CCG's Remuneration and Nominations Committee and no member of the CCG is involved in deciding their own package of remuneration.

Relations with Member Practices

The CCG, via the CCG Chair, LMG Chairs and Chief of Clinical Engagement and Leadership, has an on-going dialogue with its member practices based on the mutual understanding of objectives. The Governing Body as a whole has the responsibility for ensuring that a satisfactory dialogue with member practices takes place.

The CCG uses a variety of methods to engage and communicate with its member practices, most notably the full meetings of the CCG membership which take place six times a year and to which all member practices are encouraged to attend.

The Clinical Commissioning Group Governance Framework

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

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

A description of Brighton and Hove CCG's Governance arrangements are set out in the following sections of this document.

CCG Membership and the Governing Body

CCG Membership

The CCG is a membership organisation for the 44 GP practices within Brighton & Hove. The membership meets as a body every other month and the representatives of each GP practice discuss the direction of the CCG, its plans for commissioning services and seek assurance that commissioned services are performing effectively.

Each Practice within the city falls within one of three localities (East, West and Central). Each locality is represented by a GP who is also a member of the Governing Body. As a clinically led organisation it is important for us to have clinical leadership which represents the views of our membership at the most senior level. Under the scheme of delegation, contained within the constitution, the CCG's membership has reserved to it the most senior decisions of the organisation. A copy of the scheme of delegation is set out at Annex A of this statement.

In November 2015 the membership were asked to decide is if the CCG should take on responsibility for the co-commissioning of primary care. Although the majority of CCGs locally have voted to take on the co-commissioning of primary care, our membership did not feel that it was the right time to take on this additional responsibility. The decision will be reviewed in 2016. The membership has agreed the committee structure, including the introduction of the Primary Care Commissioning Committee, which will facilitate co-commissioning should the membership decide to accept this responsibility in the future.

The Governing Body

The Governing Body meets formally and in public every other month. It is responsible for developing the CCG's strategy, exerting financial control, ensuring value for money and effectively managing risk. The Governing Body must provide assurance to the membership and NHS England that it is effectively managing the organisation and meeting the CCG's objectives. The Governing Body uses a number of sub-committees to oversee the work of the CCG, these sub-committees are described later in this section.

The requirements for membership of CCG Governing Bodies are set out in the National Health Service (Clinical Commissioning Group) Regulation 2012. These regulations specify the minimum number and qualification required for membership of the Governing Body.

As clinical organisation it is necessary for there to be strong clinical representation on the Governing Body and Brighton and Hove CCG has included within its constitution that the majority of the members of the Governing Body should also be clinicians. Additionally the constitution provides that the Chair, the Accountable Officer (Chief Clinical Officer), Chief of Clinical Engagement and the Chair of each of the locality group must also be GPs.

In addition to the GP members, the Governing Body is supported by experienced lay members overseeing governance and patient & public involvement. We are also supported by two independent clinical members and experienced executive managers employed the CCG.

In addition to the full members of the CCG's Governing Body, Brighton & Hove City Council's Director or Public Health and Director of Adult Social Care are included within our membership. Although they are not voting members of the Governing Body they are invited to attend each meeting and debate each matter brought before the Governing Body.

The full membership of the Governing Body is described later in this section, along with the details the Governing Body's subcommittees attended by each member.

In accordance with the scheme of delegation contained within the CCGs constitution, a number of decisions are reserved to the CCG's Governing Body. A copy of the scheme of delegation is set out at Annex A of this statement.

The table below shows which subcommittee membership for each member of the Governing Body:

		Memberships of Governing Body Sub-Committee						
Name	**Position**	**Audit Committee**	**Remuneration and Nomination Committee**	**Quality Assurance Committee**	**Performance and Governance Committee**	**Clinical Strategy Group**	**Primary Care Commissioning Committee**	**Participation and Communication Assurance Committee**
Dr Xavier Nalletamby	CCG Chair				x	x		
Dr Christa Beesley	Clinical Chief Officer (Accountable Officer)		x	x	x	x		x
John Child	Chief Operating Officer (commenced 1/2/16)				x	x	x	x
Geraldine Hoban	Chief Operating Officer (Departed 31/10/15)				x	x	x	x
Pippa Ross -Smith	Chief Financial Officer (commenced 1/3/16)				x	x	x	
Michael Schofield	Chief Financial Officer (Departed 28/2/16)				x	x	x	
Soline Jerram	Director of Clinical Quality and Patient Safety			x	x	x	x	
Dr Naseer Kahn	Chief of Clinical Leadership and Engagement					x Chair		
Dr Manas Sikdar	LMG Chair (East Locality) (commenced 1/9/15)			x	x	x		
Dr Darren Emilianos	LMG Chair (East Locality) (departed 30/04/15)			x	x	x		
Dr Jim Grahame	LMG Chair (Central Locality) (commenced 1/3/16).			x	x	x		
Dr Jonny Coxon	LMG Chair (Central Locality)			x	x	x		
Post Vacant	LMG Chair (West Locality)							
Dr Anne Miners	LMG Chair (West Locality) (Departed 31/12/15)			x	x	x		
Dr George Mack	Lay Member - Governance	x Chair	x Chair	x	x Chair		x	
Mike Holdgate	Lay Member – Patient and Public Involvement	x	x	x			x	x chair
Jennifer Oates	Independent Member-Registered Nurse	x	x	x Chair			x co chair	
Dr Dinesh Sinha	Independent Member – Secondary Care Clinician	x	x			x	x co chair	
Dr Tom Scanlon	Director of Public Health (non-voting member)					x	x	
Denise D'Souza	Director of Adult Social Care (non-voting member)						x	

Each year the Governing Body carries out an appraisal process of its individual members, led by the Chair, to review the group's effectiveness and ability to work together. This appraisal is facilitated by independent consultants who facilitate the assessment. This year the Governing Body has completed a 360 degree assessment, requiring input from members of the Governing Body, staff and other stakeholders to provide a complete review of their effectiveness.

The Governing Body meets informally every other month to discuss matters that arise during the course of the CCG's business and share thoughts concerns and ideas with other members of the Governing Body. These meetings are also used for training and reflection. This is an on-going process and seeks to ensure that the Governing Body remains effective and focused on its objectives.

Additionally, coaching has been obtained for individual members of the Governing Body to assist them to develop as leaders of the organisation.

During the course of the year there have been a number of changes in the membership of the Governing Body. The term of the CCG's locality chairs has come to an end and the CCG has been successful in appointing chairs in the for the East and Central localities. The position of chair for the Western locality remains vacant and a further recruitment exercise will be carried out to ensure that that an appropriate member is appointed.

The CCG's Chief Financial Officer retired and stood down in January. A new CFO was appointed and commenced in post at the beginning of March. In order to ensure that there was appropriate cover for this role the outgoing Chief Finance Officer agreed to remain in an interim position until an effective handover was possible.

The Chief Operating Officer stood down at the end of October to take a role with another CCG. A new Chief Operating Officer was appointed, commencing in post at the beginning of February. In order to ensure the role was covered effectively, a very experienced interim Chief Operating Officer was appointed prior to the outgoing Chief Operating Officer standing down, to cover the intervening period and ensure effective coverage of the post.

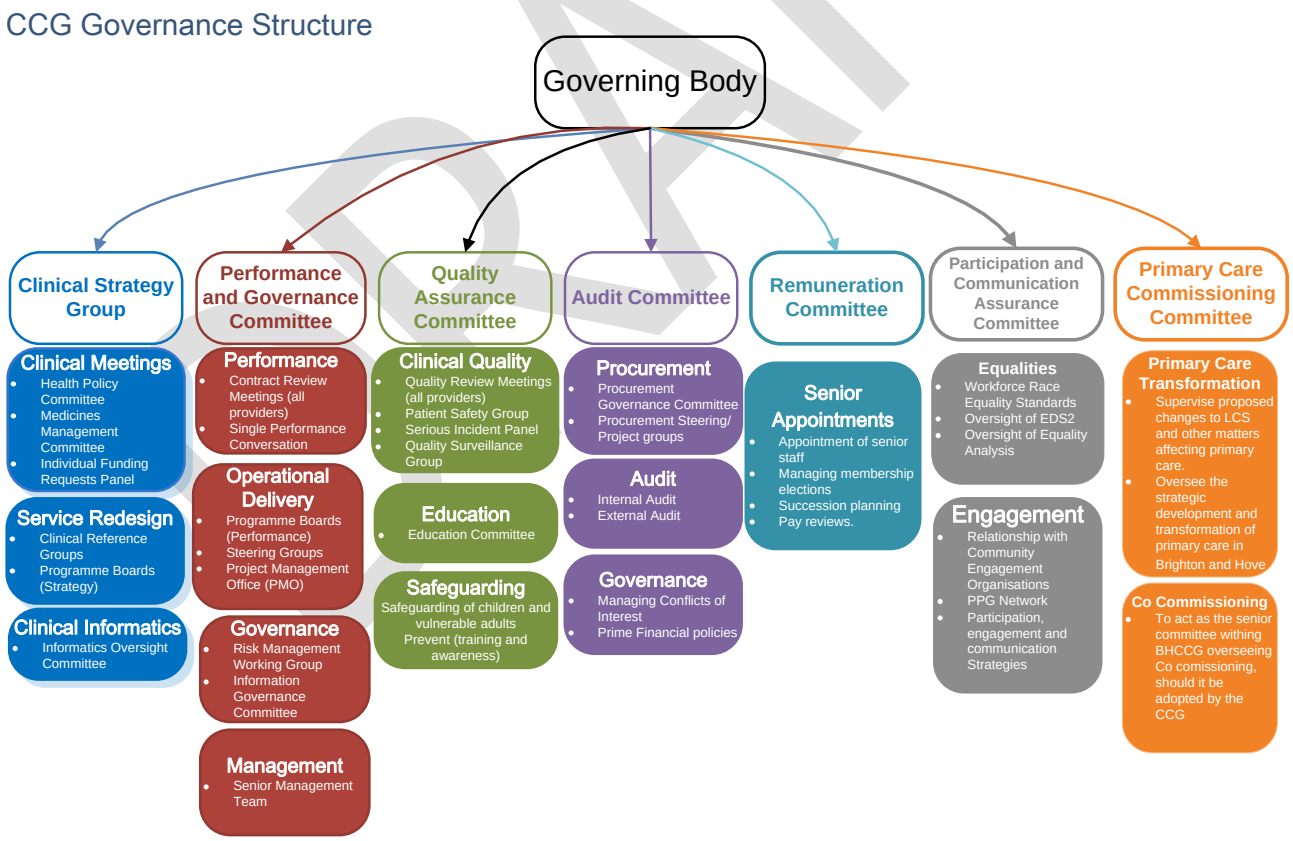
The initial terms of the CCG's two independent clinical members came to an end in September 2015. The CCG's remuneration and nominations committee was very pleased to reinstate the post holders for a further term of 3 years.

In addition to the changes in post identified above, a new executive role has been identified and the CCG has now appointed an Executive Director of Delivery and Performance. This

role has been included within the constitution and the post holder is an executive member of the Governing Body. The need for this post was identified through the CCG's annual assurance process with NHS England in the first quarter of the year. It was concluded during this process that NHS England was not assured in respect of the "Well Led Organisation" domain. In order to address this it was agreed that the CCG would undertake a capability and capacity review to establish whether the leadership of the CCG required further support. Prior to the capacity and capability review the Governing Body had identified the need to create a new executive level post which was filled on an interim basis whilst a permanent post holder was recruited, commencing in March 2016.

CCG Committee Structure

The Governing Body is supported by seven subcommittees. The following diagram describes these subcommittees and their areas of work:



Each committee has robust terms of reference describing its membership and the scope of its authority. These terms of reference are reviewed annually and amended in respect of the evolving needs of the CCG.

As part of the review of each committee we maintain a record of attendance of the committee's membership. This record of attendance may be found at annex I of this statement.

The full Terms of Reference for each committee is set out at as annexes to this statement, but a brief description of each committee is set our below.

Clinical Strategy Group

The Clinical Strategy Group is a committee, comprising of most of the clinical members of the Governing Body, with an oversight of the clinical direction the CCG. The CSG gives consideration to the CCG's commissioning activity and make appropriate recommendations to the Governing Body. The CSG has oversight of the development of service specifications when services are redesigned.

The main points of the committee are set out below:

- The CSG provides the Governing Body with an overview of the commissioning activity of the CCG, its effectiveness and the necessary strategy to meet the CCG's objectives.
- The Committee decides which strategies to recommend to the Governing Body for approval and raises performance concerns with providers and commissioners. The committee oversees performance management plans in respect of services.
- CSG has oversight of clinical education and training within the CCG and investigates innovation in clinical projects and reviews commissioning practice.
- The CSG has oversight of the joint working arrangements in relation to commissioning activity.

Performance and Governance Committee

The Performance and Governance committee focuses on strategic management of the CCG. Matters of general management and operation of the CCG are considered by the Senior Management Team which is a subcommittee of this committee.

The main duties of the Performance and Governance Committee are as follows:

Contract Performance and Annual Operating Plan Development and Delivery:

- be responsible for the operational delivery of agreed strategy and strategic commissioning intentions;
- Agree and oversee the planning process and contract negotiation strategy
- Review and approve all business cases relating to the Annual Operating Plan, in year service redesign and primary care development
- recommend to the Governing Body the strategic, business and financial plan for the Group taking into account the input of the committees and the Local Member Groups;
- monitor Member performance against their duties and responsibilities as Members of the Group in line with the membership agreement and Constitution, QIPP Plans and overall use of resources;

Integrated Governance

- Provide leadership and commitment to the management of risk across the organisation including development of the Corporate Risk Register and Assurance Framework.
- Develop and review the CCG's risk management policies and strategies.
- Monitor the delivery of action plans developed in response to the findings of external reviews e.g. special reviews conducted by the Care Quality Commission
- Approve all internal policies and procedures including information governance policies and operational human resources policies.

CCG Performance and Organisational Development

- To oversee the development and implementation of the CCG Organisational Development Plan
- Review and oversee staff turnover, staff appointments, sickness absence and staff survey results
- manage the overall communications and stakeholders, patient and public consultation process for the Group, including publishing information about health services on the Group's website;
- Sign off annual and longer term budgets relating to the running costs of the CCG, regularly receive and review financial reports, identify and agree action in relation to any areas of risk.
- Receive, disseminate and respond as appropriate to emerging guidance and best practice in relation to the development of clinical commissioning.

Audit Committee

The Audit Committee provides the Governing Body with an independent and objective view of the CCG's financial systems, financial information and its compliance with financial regulations. As well as this, in order to make sure the CCG is meeting its financial responsibilities, the Governing Body has delegated several specific responsibilities around financial robustness to the Audit Committee as set out in section five of the constitution and its scheme of delegation.

The terms of reference for the Audit Committee include:

- Integrated governance, risk management and internal control
- Internal and external audit
- Assurance
- Counter fraud
- Management
- Financial Reporting

The membership of the committee is the lay and independent members of the Governing Body, who may seek advice from such other members of the CCG as they may deem necessary.

Quality Assurance Committee

The Quality Assurance Committee is there to make sure that the services commissioned by the CCG are of high quality and safe and effective for patients offering a good patient experience to everyone that uses them. Specifically the Quality Assurance Committee is there to monitor and improve performance in care commissioned by the CCG. This includes monitoring patient care and performance against targets. It is there to make sure the voice of the patient is included in commissioning strategies and that all provider organisations have rigorous processes for safeguarding children and adults, monitoring equality and diversity and meet their other statutory obligations. It also makes sure organisations meet their requirements for information governance, governance of research and oversee clinical governance arrangements in commissioned services. It is this committee's role to look at Serious Incidents (SIs) and Never Events which take place to make sure there are robust systems and processes in place to deal with these.

The Quality Assurance Committee is chaired by a lay or independent member of the Governing Body and membership includes another lay member of the Governing Body, at least two GP members of the Governing Body, the Director Clinical Quality and Patient Safety and the Accountable Officer. It is also supported by the Chief Operating Officer, a public health consultant and clinicians and managers who have responsibilities for corporate governance and safeguarding.

Primary Care Commissioning Committee

When a CCG agrees to take on the responsibility for co-commissioning primary care it is necessary to put in place a committee constructed in accordance with NHS England guidance to manage the potential conflict of interest which may arise as the CCG commissions services provided by its own members.

The Primary Care Commissioning Committee has a membership drawn from the non-GP members of the Governing Body along with a representative from NHS England. The committee meets in public, usually following a meeting of the Governing Body.

The Committee oversees the strategic development of transformational change within primary care in Brighton and Hove and will oversee the strategic commissioning of primary care in the city should the membership agree to take on greater responsibility for co-commissioning primary care.

The Committee oversees the work of the Primary Care Transformation Board, details of which are found in the section below

Participation and Communication Assurance Committee

The purpose of this committee is to assure the Governing Body that the views of patients and the public are used to shape the services commissioned by the CCG. The committee has oversight of the CCG' strategies for communications, engagement and public participation.

The Committee also ensures that the quality of CCG's published materials are of a suitable standard and have an overview of the development of equalities in the engagement activity of the CCG.

Remuneration and Nominations Committee

It is required of all CCGs that they have remuneration and nominations committee to decide on matters relating to the remuneration policy within the CCG and considering nominations for the appointment of new members of the Governing Body.

The members of the committee are the lay and independent members of the Governing Body, supported by advice from the CCG's Human Resources Advisor.

The committee may make recommendations on the remuneration, benefits and terms of service of employees of the CCG.

Additionally the committee shall monitor the performance of the members of the Governing Body.

Supporting Meetings

In addition to the committees of the Governing Body it has been necessary to establish a number of subcommittees to support some specific work areas of the CCG. Each subcommittee has robust terms of reference A brief description of each subcommittee is included below:

Primary Care Transformation Board

This committee has oversight of locally commissioned services. It is anticipated that the nature of the relationship with primary care is likely to change in the future when the CCG takes on the responsibility for co-commissioning primary care. The CCG membership has decided at this stage not to submit an expression of interest in relation to becoming a co-commissioner of primary care, but it is likely that the CCG may become a co-commissioner going forward. The purpose of the board is, under the oversight of the Primary Care Commissioning Committee, to develop the CCG's strategy for primary care, including the implementation of a locally commissioned contract to replace locally enhanced services.

The Information Governance Committee

Information Governance Committee is an internal committee reporting to the Quality Assurance Committee. The committee is chaired by the CCG's Caldecott Guardian and considers IG matters facing the CCG, including guidance issued and the IG implications of projects.

The committee considers the implications of privacy impact assessments and the CCG's ability to respond to requests for information.

Procurement Governance Committee

The Procurement Governance Committee has oversight of the governance arrangements surrounding all CCG procurement activity and the management of conflicts of interest in procurement. The committee ensures compliance with the CCG's procurement policy.

The Procurement Governance Committee reports to the CCG's Audit Committee.

Clinical Education and Knowledge Committee

The Clinical Education and Knowledge Committee supports the promotion of education and training as set out by The Education Outcomes Framework by:

- Ensuring that assurance processes have workforce training/education issues/implementation built into them. That issues/concerns are escalated at the earliest opportunity to the provider of training.
- Leading, implementing and monitoring all elements of the Clinical Education Framework
- Ensuring all service specification have identified commitment to training and development of staff
- Ensuring development and monitoring of future strategies are in line with the transformation of healthcare delivery in Brighton and Hove
- Supporting internal and external organisational development

Safeguarding Committee

The Safeguarding Committee reports to the Quality Assurance Committee (QAC) to provide the following assurance:

- That services commissioned by the CCG have effective systems in place to safeguard, protect and promote the welfare of children, young people and vulnerable adults.
- That statutory responsibilities and duties in relation to safeguarding adults and children, the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) are being effectively discharged.
- That systems and local practices are informed by legislation, latest government guidance and learning from serious case reviews and Serious Incidents (SIs).

Joint Committees

In addition to the committees and subcommittee described above the CCG has membership of the following joint committees.

Health and Wellbeing Board

The Health and Wellbeing Board is a statutory body comprising members of the CCG and Brighton & Hove City Council working in partnership to improve health, public health and social care across the city.

The health and wellbeing board is responsible for the production of a joint health and wellbeing strategy and the joint strategic needs assessment. The Health and Wellbeing Board is responsible for promoting co-working across local health and social care services and ensuring that local commissioning is based on local needs.

The Health and Wellbeing board has an equal number of voting member from the CCG and the Council and oversees joint working between the council and the CCG including the Better Care Plan

Better Care Programme Board

The Better Care Programme Board reports to the Health and Wellbeing Board and provides system wide leadership for the Better Care agenda. The Board is made up of members of members form the Council and the CCG and is Co-Chaired by the Council's Director of Adult Social Care and the CCG's Chief Operating Officer.

The Better Care Programme Board has specific oversight of the Integrated Frailty Programme Board and the Integrated Homeless Programme Board

Local Safeguarding Children's Board

The functions undertaken by the Brighton and Hove LSCB follow the requirements of the Children Act 2004 and are based on the objectives set out in Chapter 3 of the revised 'Working Together to Safeguard Children' issued in March 2010. The core objectives of Local Safeguarding Children Boards (LSCB) are:

- To coordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area of the authority by which it is established; and
- To ensure the effectiveness of what is done by each such person or body for that purpose.

The Board monitors partner's performances and produces policies and procedures to improve safeguarding outcomes.

The Adult Safeguarding Board

The Adult Safeguarding Board is the multi-agency partnership that leads the strategic development of safeguarding adults work in Brighton and Hove.

Member organisations work together – and with other partnerships - to create an effective net of safety for adults living in Brighton and Hove. The particular focus of this Board is the safeguarding of adults, and their informal carers, who may use health and social care services.

The Board and its members are visible advocates of good practice in safeguarding adult's work and the use of learning from current practice to improve the outcomes for those at risk of abuse and neglect.

Brighton and Hove Violence against Women and Girls Programme Board

The Violence against Women and Girls (VAWG) Board will assure the delivery of the VAWG Strategy through joint commissioning, awareness raising and partnership activities to:

- Increase survivor safety;
- Hold perpetrators to account;
- Decrease social tolerance and acceptance of VAWG crime types; and
- Increase people's ability to have violence-free, safe and equal lives.

The Board is made up of members from the Council, the CCG, and other health bodies in the city, the police and some members of the voluntary and community sector.

The Board has the following responsibilities:

- To agree and assure delivery of a VAWG Strategy for Brighton & Hove, with a particular focus on women and girls, but with actions as appropriate to address the needs of men as victims, perpetrators, boys and allies.
- To be guided by learning from best practice in commissioning in order to deliver services in relation to the implementation of the relevant priorities of the VAWG Strategy.
- To make recommendations for the commissioning of services that take into consideration and have a demonstrable impact in achieving the purpose of the board, in particular longer term social change.
- To performance manage progress against agreed/high level outcomes, targets and indicators, highlighting and raising issues of concern.
- To identify lead responsibility (communications expert) and target audience for a communications plan to support the VAWG Strategy.

In addition to the joint committees noted above, the CCG is a standing attendee of the City Council's Corporate Parenting Board, representing the health needs of the Council's looked after children. The CCG is also has a standing invite to attend Brighton's Safe in the City Partnership, responding to issues of crime and anti-social behaviour within the city

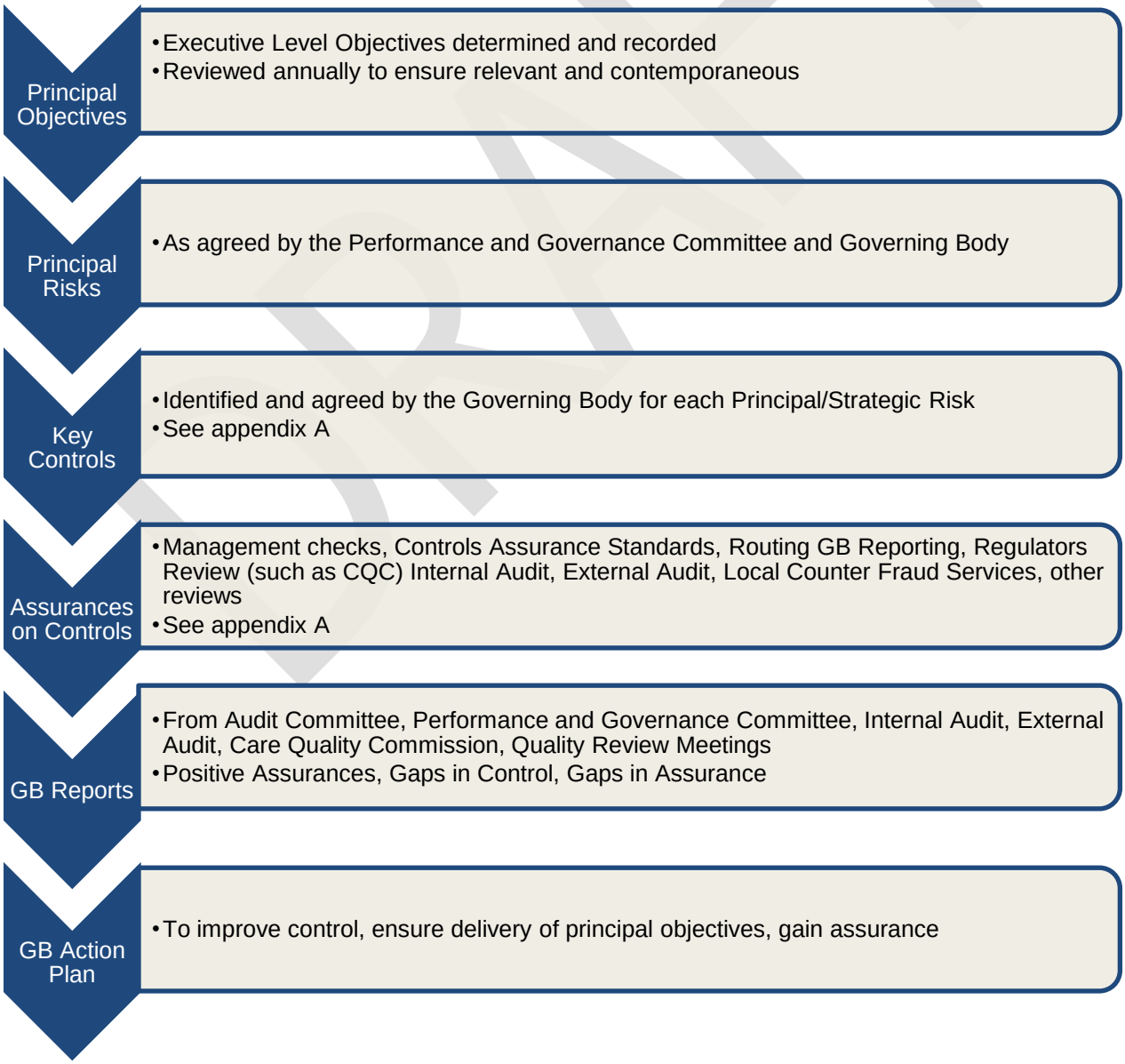
The Clinical Commissioning Group Risk Management Framework

The CCG uses an Assurance Framework which provides the CCG with a simple but comprehensive method for the effective and focused management of the principal risks to meeting their objectives.

The Assurance Framework simplifies reporting to the Governing Body and the prioritisation of action plans, which in turn allows for more effective performance management.

The diagram below sets out an overview of the process that the CCG takes to identify and manage its risks.

Diagram 1: Assurance Framework Process



Identifying the CCG's Objectives

The Governing Body is responsible for identifying the CCG's strategy and objectives, but this process does not work as a top-down exercise. The CCG has established a number of ways of setting its objectives including staff and stakeholder involvement. The process used to identify strategy and objectives is cyclical and should never be seen as being complete.

Principal Objectives and Risks

Principal risks are defined as those that threaten the achievement of the organisation's principal objectives. The Governing Body understands that they need to manage principal risks, rather than reacting to the consequences of risks materialising.

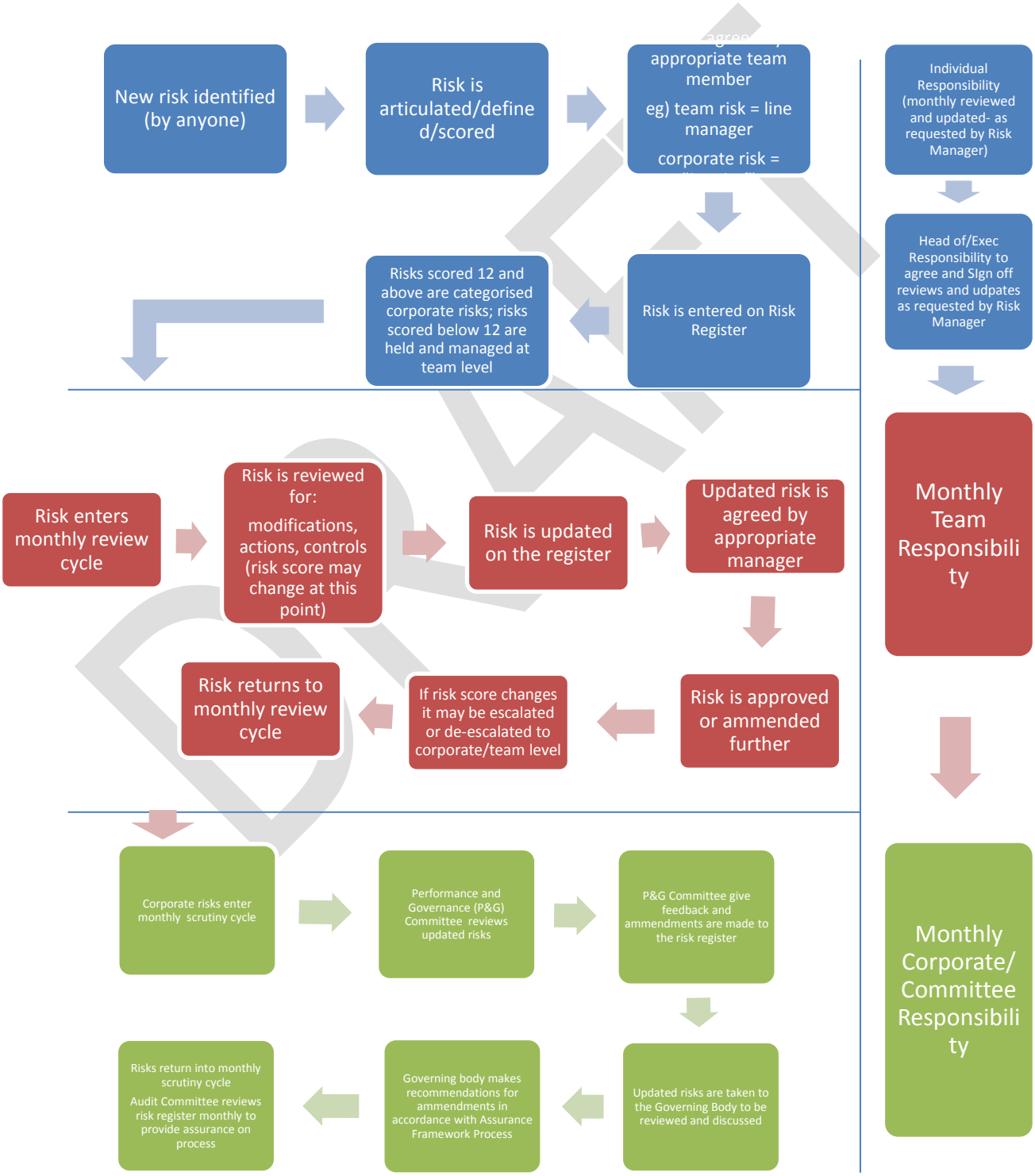
By focusing on risks to strategic and directorate objectives, the CCG can identify its principal risks in its operating plan. A summary of the principal risks and the work undertaken to mitigate their impact is reported at each meeting of the Governing Body in the Corporate Risk Register. The Corporate Risk Register records each principal risk to the CCG's objectives, including changes to the risk score as work under each action plan progresses.

The Performance and Governance Committee (P&G) is primarily responsible for ensuring that risks are managed through the organisation. The committee structure of the CCG allows for corporate risk and clinical risk to be addressed at key meetings reporting up to the Governing Body. Key members of the CCG are members of several of the CCGs committees, ensuring developments in relation to risk are reported across the necessary committees as work plans develop and that risks can be reported accurately to the Governing Body.

In order to ensure that the full consideration of risk is taken at each decision making level, the sponsor of any report to any committee of the CCG is obliged to report on legal, financial and risk implications of the decision they request. Additionally the sponsor must demonstrate that necessary consideration has been given to equality issues and appropriate stakeholder engagement or consultation has been undertaken.

Identifying Risk

The process of identifying risk usually begins at an operational level within the CCG. Each team maintains a register of the risks identified within their work area and assigns a score based on the severity of the risk and the likelihood of the risk arising. Those risks identified on team risk registers which have sufficiently high scores will be escalated to the Corporate Risk Register monitored by the Governing Body.



Risk Assessment

Risk is assessed based on two elements, severity and likelihood. Each element is given a score between 1 and 5 and the combination of these score generates a risk score. Risks with a score of 12 or above are managed on the Corporate Risk Register whilst lower scoring risks are managed at a team level within the CCG. Risks are assessed on an on-going basis, and changes in risk score may see new risks being escalated to the Corporate Risk Register or referred back to teams if mitigating actions effectively reduce the risk score.

The CCG's Corporate Risk Register currently identifies 11 significant risks, 6 of which are specifically concerned with the provision of clinical services. The remaining risks are concerned with the reporting of national targets, financial stability, integration of health and social care and the CCG's ability as a commissioning organisation to reduce health inequalities within the city. It is likely that these risks are shared with many CCGs across the county.

The Governing Body discusses the risk register at each meeting of the Governing Body. The report received by the members includes the information about changes in the risk score and the actions being taken to mitigate risks. This is an opportunity to publicly assure itself that the CCG is taking appropriate steps to respond to arising risks and ensure that suitable information is being provided to the Governing Body.

Each risk is assigned an assessor and an owner. The assessor has operational oversight of the risk whist the owner is the senior manager of the risk area. Where a risk is reported on the Corporate Risk Register its owner will usually be an executive member of the Governing Body. The risk owner is accountable to the Governing Body for the management of that risk assigned to them.

The Clinical Commissioning Group Internal Control Framework

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

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

The CCG, through its planning and delivery team, has established a Project Management Office (PMO) to oversee the project work of the CCG and ensure that project risks are captured and reported to the appropriate level. The PMO works with the manager or the project team to help them to identify action plans and timescales for the successful completion of the project. The PMO will also help to identify project risks and the actions necessary to mitigate those risks.

The PMO will identify any corporate risks associated with projects carried out by the CCG and will add these risks to the Corporate Risk Register. The Corporate Risk Register is monitored by performance and governance committee, the audit committee and the Governing Body.

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 assurance to the Clinical Commissioning Group, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively.

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 Committee and we continue 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 a staff information governance handbook 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 are developing information risk assessment and management procedures and a programme will be established to fully embed an information risk culture throughout the organisation.

Review of economy, efficiency & effectiveness of the use of resources

Through the use of the ISFE (Integrated Single Financial Environment) monthly finance reports are produced which are consistent in terms of information extracted from the ledgers and reported to budget holders and the Governing Body. The annual budget has been set to ensure the delivery of the financial framework that underpins the annual operating plan and variations from this plan are closely monitored.

Each month there is a triangulation of financial ledger information, contract monitoring information and reports from the PMO (Programme Management Office) which oversees the delivery of the Quality, Innovation, Productivity and Prevention programme (QIPP).

The delivery of savings from the QIPP programme is always a key component of the assurance given to the Governing Body on effectiveness of use of resources.

Each month the finance report gives the assurance needed by the Governing Body that the control total surplus will be delivered and sets out what intervention has been made to address any shortfall in the QIPP savings and any other financial pressures in the overall forecast outturn.

As part of their work, the Internal Auditors have reviewed and reported upon the financial reports presented to the Governing Body. This review assists the Audit Committee be assured that reporting is accurate.

Review of the effectiveness of Governance, Risk Management & Internal Control

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control within the Clinical Commissioning Group.

Capacity to Handle Risk

The CCG has appointed a Risk Manager with responsibility for managing the risk register on behalf of the CCG. The Risk Manager maintains the Corporate Risk Register and reports to the performance and governance committee, the audit committee and the Governing Body on a regular basis. Each identified risk has an identified risk owner and where this is a significant risk, this will usually be an executive member of the Governing Body.

The Corporate Risk Register includes all risks that have been identified as having a significantly high risk score, considering both the likelihood of the risk occurring and potential damage caused in the event of the risk occurring.

The Risk Manager also works with team leaders within the CCG to ensure the team risk registers are produced, allowing teams to manage risks internally where the risk score is not so significant that it should be reported on the Corporate Risk Register.

The Risk Manager works across the CCG to identify risk owners and to work with them to identify mitigating actions in respect of specific risks, forming action plans to ensure risk reducing actions are carried out and reporting significant risk to the appropriate group within the organisation.

The Risk Manager is a member of the project management office and as such has an oversight of the CCG's projects with a view to identifying project related risks.

Review of Effectiveness

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

Our Assurance Framework provides me with evidence that the effectiveness of controls that manage risks to the Clinical Commissioning Group achieving its principal objectives have been reviewed.

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

The internal control for the organisation is maintained through the work of the audit committee overseeing the process of internal audit and liaising with our external auditors. The work of the CCG is reviewed through a robust committee structure and overseen by the Governing Body.

Head of Internal Audit Opinion

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

"Reasonable assurance can be given that there are adequate and effective management and internal control processes to manage the achievement of the organisation's objectives."

During the year, Internal Audit issued the following audit reports which identified governance, risk management and/or control issues which were significant to the organisation:

Audit Area	Opinion
Budgetary Control & Financial Management	Substantial Assurance
Critical Applications & Data Flows	Reasonable Assurance
Governance Controls	Reasonable Assurance
Risk Management & Assurance Framework	Reasonable Assurance
Management of Conflict of Interests Arrangements	Reasonable Assurance
Emergency Preparedness Resilience	Reasonable Assurance
Integrated Diabetes Project	Substantial Assurance
Personal Health Budgets	Limited Assurance
Recruitment Processes and Controls	Substantial Assurance
Review of the MSK Contract Monitoring Arrangements	Reasonable Assurance
Critical Financial Assurance – Financial Accounting/Non Pay Expenditure	Reasonable Assurance
Critical Financial Assurance - Pay	Substantial Assurance
Endpoint Protection	Limited Assurance
HR Controls (part 2) (draft report)	Limited Assurance
IG Toolkit	Reasonable Assurance

The CCG received no reports with an opinion of no assurance.

The CCG has received three reports with an opinion of Limited Assurance during 2015 -16, relating to Personal Health Budgets, Endpoint Security and HR Controls.

The report in relation to personal health budgets and looks at the risk of transferring the responsibility for expenditure of health budgets from the CCG to individual patients. This report has identified several actions to be taken to minimise the identified risks and the CCG has taken steps to implement these actions.

The report in relation Endpoint Security identifies a small number of weaknesses in relation to the security of CCG computers and makes recommendations to improve security. These actions have been initiated to mitigate the low risk potential data loss.

The report in relation to HR controls was received during the drafting of this statement and a management action plan is being considered.

We do not consider that the issues identified in these reports pose an unacceptable risk to the CCG and the actions taken since the reports were received have significantly improved the position. Because the audit report has as noted only limited assurance in relation to these areas, action plans have been put in place to respond to the identified issues. The Audit Committee will continue to monitor progress against these plans as it has been since the limited assurance was identified. The Committee is satisfied with the progress made so far.

Data Quality

In the year to 31st March 2016 the out-turn of our commissioning budget at year end is as we forecast 12 months before, with the support of analysis from Public Health (via the Joint Strategic Needs Assessment (JSNA)) and the CSU (annual contract model).The annual contract model is built on Secondary User Service (SUS) and Service Level Agreement Monitoring (SLAM) data. For our main provider we continue to work with Brighton and Sussex University Hospital Trust to reconcile SUS data to their contract monitoring. The Data Quality Improvement Plan (DQIP) in the contract has been used during 2015-16 to improve data quality in a number of areas and has been refreshed for 2016-17 to continue this work.

The data received by the Governing Body and the committees of the CCG is continuously reviewed and the contents of reports are refreshed regularly to ensure that suitable information is available to the CCG's committees.

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. All business critical models have been identified and information about quality assurance processes for those models has been provided to the appropriate teams within the Department of Health

Data Security

We have submitted an above satisfactory level of compliance with the information governance toolkit assessment. We have reached Level 3 in 5 requirements and level 2 in the remaining applicable requirements. We are satisfied that the data held by the CCG is suitably secure.

During the course of the year the CCG has not reported any Serious Untoward Incidents in relation to data security breaches and we believe there to be suitable processes in place to ensure there will be no breaches in the future. However, we will continue to review and update our policies and procedures and ensure that staff are appropriately trained in respect of their Information Governance responsibilities.

Discharge of Statutory Functions

Arrangements put in place by the Clinical Commissioning Group and explained within the corporate governance framework have been developed with extensive expert external legal input, to ensure compliance with the all relevant legislation. That legal advice also informed the matters reserved for Membership Body and Governing Body decision and the scheme of delegation.

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

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

Conclusion

No significant issues have been identified in relation to the system of internal control for Brighton and Hove Clinical Commissioning Group. Where we have identified minor issues in relation to internal control throughout the year we have taken forward actions to address these issues.

In my opinion there are no significant issues in relation to the internal control of Brighton and Hove Clinical Commissioning Group that the CCG is required to address. Following the expansion of the executive team, I am satisfied that the structure of the CCG is sufficient to meet the requirements of the organisation.

Dr Christa Beesley

Chief Clinical Officer (Accountable Officer)

[x] May 2016

Annex A - SCHEME OF RESERVATION & DELEGATION

SCHEDULE OF MATTERS RESERVED TO THE CLINICAL COMMISSIONING GROUP AND SCHEME OF DELEGATION

Policy Area	Decision	Reserved to the Membership	Reserved or delegated to Governing Body	Accountable Officer	Committee or Sub-Committee	Specified Individual
REGULATION AND CONTROL	Determine the arrangements by which the Members of the CCG approve those decisions that are reserved for the membership.	✓				
REGULATION AND CONTROL	Consideration and approval of applications to NHS England on any matter concerning changes to the CCG's Constitution	✓				
REGULATION AND CONTROL	Exercise of delegation of those functions of the CCG which have not been retained as reserved by the CCG, delegated to the Governing Body or other committee or sub-committee or Member or employee			✓		

Policy Area	Decision	Reserved to the Membership	Reserved or delegated to Governing Body	Accountable Officer	Committee or Sub-Committee	Specified Individual
REGULATION AND CONTROL	Prepare the CCG's overarching scheme of reservation and delegation, which sets out those decisions of the CCG reserved to the membership and those delegated to the ○ Group's Governing Body ○ committees and sub-committees of the CCG, or ○ its members or employees and sets out those decisions of the Governing Body reserved to the Governing Body and those delegated to the ○ Governing Body's committees and sub-committees, ○ members of the Governing Body, ○ an individual who is member of the CCG but not the Governing Body or a specified person for inclusion in the CCG's Constitution.			✓		
REGULATION AND CONTROL	Approval of the CCG's overarching scheme of reservation and delegation.	✓				

Policy Area	Decision	Reserved to the Membership	Reserved or delegated to Governing Body	Accountable Officer	Committee or Sub-Committee	Specified Individual
REGULATION AND CONTROL	Prepare the CCG's operational Scheme of Reservation and Delegation, which sets out those key operational decisions delegated to individual employees of the CCG, not for inclusion in the CCG's Constitution.			✓		
REGULATION AND CONTROL	Approval of the CCG's operational Scheme of Reservation and Delegation that underpins the CCG's 'overarching scheme of reservation and delegation' as set out in its Constitution.		✓			
REGULATION AND CONTROL	Prepare detailed financial policies that underpin the CCG's Prime Financial Policies.					✓ Chief Finance Officer
REGULATION AND CONTROL	Approve detailed financial policies.			✓ (Appendix E, Para 1.1.3 & 1.1.4)		
REGULATION AND CONTROL	Approve amendments to Prime Financial Policies		✓ (Appendix E, para 1.5.1)			
REGULATION AND CONTROL	Approve arrangements for managing exceptional funding requests.		✓			
REGULATION AND CONTROL	Set out who can execute a document by signature / use of the seal	✓				

Policy Area	Decision	Reserved to the Membership	Reserved or delegated to Governing Body	Accountable Officer	Committee or Sub-Committee	Specified Individual
REGULATION AND CONTROL	Approve any changes to the provision or delivery of assurance services to the CCG				✓ (See Appendix E, para 3.3(b))	
REGULATION AND CONTROL	Receive information relating to allotments to the CCG, and approve as necessary		✓ (Appendix E, para 6.1(b))			
REGULATION AND CONTROL	Reviewing the CCG's governance arrangements to ensure that the CCG continues to reflect the principles of good governance.		✓ (Para 4.5.3)			
REGULATION AND CONTROL	Exercise the powers that the Governing Body has reserved to itself in an emergency or for an urgent decision.					✓ (Accountable Officer and Chair)
PRACTICE Clinical Commissioning Leads AND MEMBERS OF GOVERNING BODY	Approve the arrangements for ○ identifying practice members to represent Members in matters concerning the work of the CCG; and ○ appointing clinical leaders to represent the CCG's membership on the CCG's Governing Body, for example through election (if desired).	✓ Appendix C, para 2.2.13 ✓ Appendix C - Various				

Policy Area	Decision	Reserved to the Membership	Reserved or delegated to Governing Body	Accountable Officer	Committee or Sub-Committee	Specified Individual
PRACTICE CLINICAL COMMISSIONING LEADSAND MEMBERS OF GOVERNING BODY	Approve the appointment of Governing Body members, the process for recruiting and removing non-elected members to the Governing Body (subject to any regulatory requirements) and succession planning.	✓ Appendix C, para 2.2.8				
PRACTICE CLINICAL COMMISSIONING LEADS AND MEMBERS OF GOVERNING BODY	Approve arrangements for identifying the CCG's proposed Accountable Officer.	✓				
STRATEGY AND PLANNING	Agree the vision, values and overall strategic direction of the CCG.	✓				
STRATEGY AND PLANNING	Approval of the CCG's commissioning plan.		✓ (Para 6.6.1)			
STRATEGY AND PLANNING	Monitoring performance of the CCG against plans		✓ (Para 6.6.1)			
STRATEGY AND PLANNING	Providing assurance of strategic risk		✓ (Para 6.6.1)			
STRATEGY AND PLANNING	Approval of the CCG's operating structure.	✓ Paragraph 6				
STRATEGY AND PLANNING	Approval of the CCG's corporate budgets that meet the financial duties as set out in section 5.3 of the main body of the Constitution.		✓ Para 7.2 of Appendix E			

Policy Area	Decision	Reserved to the Membership	Reserved or delegated to Governing Body	Accountable Officer	Committee or Sub-Committee	Specified Individual
STRATEGY AND PLANNING	Approval of variations to the approved budget where variation would have a significant impact on the overall approved levels of income and expenditure or the CCG's ability to achieve its agreed strategic aims.		✓			
STRATEGY AND PLANNING	Approval of spending or other commitment of funds and resources under a joint Commissioning Strategy, or use of Joint Commissioning funds				✓ Joint England/Health and Wellbeing Board)	
STRATEGY AND PLANNING	Approve consultation arrangements for the CCG's commissioning plan.			✓ Para 7.5 of Appendix E		
STRATEGY AND PLANNING	Prepare the CCG's annual commissioning plan setting out how the CCG will promote awareness and have regard to the NHS Constitution.		✓ (Para. 5.2.2(a))			
STRATEGY AND PLANNING	Approve the CCG's annual commissioning plan		✓ (Para. 5.1.2			
ANNUAL REPORTS AND ACCOUNTS	Approval of the CCG's annual report and annual accounts.				✓ Para 8.2 of Appendix E Audit Committee	

Policy Area	Decision	Reserved to the Membership	Reserved or delegated to Governing Body	Accountable Officer	Committee or Sub-Committee	Specified Individual
ANNUAL REPORTS AND ACCOUNTS	Approving a timetable for producing the annual report and account				✓ Para 8.1(b) of Appendix E Audit Committee	
ANNUAL REPORTS AND ACCOUNTS	Approval of the arrangements for discharging the CCG's statutory financial duties.		✓			
HUMAN RESOURCES	Recommend the terms and conditions, remuneration and travelling or other allowances for Governing Body members, including pensions and gratuities				✓ Remuneration & Nominations Committee	
HUMAN RESOURCES	Recommend terms and conditions of employment for all employees of the CCG including, pensions, remuneration, fees and travelling or other allowances payable to employees and to other persons providing services to the CCG.				✓ Remuneration & Nominations Committee	
HUMAN RESOURCES	Approve any other terms and conditions of services for the CCG's employees		✓			
HUMAN RESOURCES	Determine the terms and conditions of employment for all employees of the CCG.		✓			

Policy Area	Decision	Reserved to the Membership	Reserved or delegated to Governing Body	Accountable Officer	Committee or Sub-Committee	Specified Individual
HUMAN RESOURCES	Determine pensions, remuneration, fees and allowances payable to employees and to other persons providing services to the CCG.		✓			
HUMAN RESOURCES	Recommend pensions, remuneration, fees and allowances payable to employees and to other persons providing services to the CCG.				✓ Remuneration & Nominations Committee (Para 6.6.5(b))	
HUMAN RESOURCES	Approve disciplinary arrangements for employees, including the Accountable Officer (where he/she is an employee or Member of the CCG) and for other persons working on behalf of the CCG.		✓			
HUMAN RESOURCES	Review disciplinary arrangements where the Accountable Officer is an employee or member of another Clinical Commissioning Group		✓			
HUMAN RESOURCES	Approval of the arrangements for discharging the CCG's statutory duties as an employer.		✓			
HUMAN RESOURCES	Approve human resources policies for employees and for other persons working on behalf of the CCG		✓			

Policy Area	Decision	Reserved to the Membership	Reserved or delegated to Governing Body	Accountable Officer	Committee or Sub-Committee	Specified Individual
QUALITY AND SAFETY	Approve arrangements, including supporting policies, to minimise clinical risk, maximise patient safety and to secure continuous improvement in quality and patient outcomes.		✓			
QUALITY AND SAFETY	Approve arrangements for supporting NHS England in discharging its responsibilities in relation to securing continuous improvement in the quality of general medical services		✓			
OPERATIONAL AND RISK MANAGEMENT	Prepare and recommend an operational Scheme of Reservation and Delegation that sets out who has responsibility for operational decisions within the CCG.		✓			
OPERATIONAL AND RISK MANAGEMENT	Approve the CCG's counter fraud and security management arrangements.				✓ Audit Committee (Appendix E, Para 4.1)	
OPERATIONAL AND RISK MANAGEMENT	Approval of the CCG's risk management arrangements.		✓ Appendix E, Para 15			

Policy Area	Decision	Reserved to the Membership	Reserved or delegated to Governing Body	Accountable Officer	Committee or Sub-Committee	Specified Individual
OPERATIONAL AND RISK MANAGEMENT	Approve arrangements for risk sharing and or risk pooling with other organisations (for example arrangements for pooled funds with other Clinical Commissioning Groups or pooled budget arrangements under section 75 of the NHS Act 2006).		✓			
OPERATIONAL AND RISK MANAGEMENT	Approval of a comprehensive system of internal control, including budgetary control, that underpins the effective, efficient and economic operation of the CCG.			✓ (Appendix E, Para 2.2)		
OPERATIONAL AND RISK MANAGEMENT	Approve proposals for action on litigation against or on behalf of the CCG.		✓			
OPERATIONAL AND RISK MANAGEMENT	Approve the CCG's arrangements for business continuity and emergency planning.		✓			
OPERATIONAL AND RISK MANAGEMENT	Approve the CCG's banking arrangements					✓ Appendix E, Para 11.2
OPERATIONAL AND RISK MANAGEMENT	Approve the level of all fees and charges other than those determined by NHS England or by statute.					✓ Chief Finance Officer (Appendix E, Para 12.1(c))

Policy Area	Decision	Reserved to the Membership	Reserved or delegated to Governing Body	Accountable Officer	Committee or Sub-Committee	Specified Individual
OPERATIONAL AND RISK MANAGEMENT	Ensuring that the Registers of Interest are reviewed regularly, and updated as necessary					✓ Chief Finance Officer Para 8.3.5 of Appendix E
OPERATIONAL AND RISK MANAGEMENT	Responsibility for overseeing conflicts of interest					✓ Chief Finance Officer Para 8.4.2 of Appendix E
OPERATIONAL AND RISK MANAGEMENT	Approving the level of non-pay expenditure		✓ Appendix E, Para 17.1			
INFORMATION GOVERNANCE	Approve the CCG's arrangements for handling complaints.				✓ Quality Assurance Committee	
INFORMATION GOVERNANCE	Approval of the arrangements for ensuring appropriate and safekeeping and confidentiality of records and for the storage, management and transfer of information and data.		✓			
TENDERING AND CONTRACTING	Approval of the CCG's contracts for any commissioning support.		✓			
TENDERING AND CONTRACTING	Approval of the CCG's contracts for corporate support (for example finance provision).		✓			

Policy Area	Decision	Reserved to the Membership	Reserved or delegated to Governing Body	Accountable Officer	Committee or Sub-Committee	Specified Individual
TENDERING AND CONTRACTING	Scrutiny of Procurement processes in advance of and during the procurement process				✓ Procurement Committee – a subcommittee of the Audit Committee	
TENDERING AND CONTRACTING	Negotiate contracts on behalf of the CCG				✓ Performance & Governance Committee Appendix E, para 13.2	
TENDERING AND CONTRACTING	Oversee and manage each contract on behalf of the CCG					✓ Individual nominated through detailed scheme of delegation
PARTNERSHIP WORKING	Approve decisions that individual members [of the Governing Body] or employees of the CCG participating in joint arrangements on behalf of the CCG can make. Such delegated decisions must be disclosed in this Scheme of Reservation and Delegation.		✓			
PARTNERSHIP WORKING	Approve decisions delegated to joint committees established under section 75 of the 2006 Act.		✓			

Policy Area	Decision	Reserved to the Membership	Reserved or delegated to Governing Body	Accountable Officer	Committee or Sub-Committee	Specified Individual
COMMISSIONING AND CONTRACTING FOR CLINICAL SERVICES	Approval of the arrangements for discharging the CCG's statutory duties associated with its commissioning functions, including but not limited to promoting the involvement of each patient, patient choice, reducing inequalities, improvement in the quality of services, obtaining appropriate advice and public engagement and consultation.		✓			
COMMISSIONING AND CONTRACTING FOR CLINICAL SERVICES	Approve arrangements for co-ordinating the commissioning of services with other Clinical Commissioning Groups and or with the local authority(ies), where appropriate		✓			
COMMISSIONING AND CONTRACTING FOR CLINICAL SERVICES	Approval of the CCG's procurement strategy		✓ Para 8.6.2			
COMMUNICATIONS	Determining arrangements for handling Freedom of Information requests.			✓ Appendix E, Para 19.1		

ANNEX B

CLINICAL STRATEGY GROUP

NHS Brighton and Hove Clinical Commissioning Group

Governing Body Clinical Strategy Group

Terms of Reference

1. Introduction

1.1 The Clinical Strategy Group (the Committee) is established in accordance with NHS Brighton and Hove Clinical Commissioning Group's (the Group's) Constitution, Standing Orders and Scheme of Reservation and Delegation. These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the Committee and shall have effect as if incorporated into the Group's Constitution and Standing Orders.

1.2 The Committee is authorised by the Governing Body to act within its terms of reference. All Members and employees of the Group are directed to co-operate with any request made by the Committee.

2. Membership

2.1 The Committee shall be appointed by the Group as set out in the Group's Constitution and may include individuals who are not on the Governing Body.

2.2 The membership of the Committee shall consist of:

2.2.1 the Chief of Clinical Leadership and Engagement (who will chair the Committee);

2.2.2 six Clinical Programme Leads;

2.2.3 the Director of Clinical Quality and Patient Safety;

2.2.4 Accountable Officer;

2.2.5 Director of Public Health;

2.2.6 Chief Finance Officer

2.2.7 the Chief Operating Officer; and

2.2.8 members of the Local Member Group Teams.

3. Secretary

3.1 The Secretary shall record the minutes of all meetings of the Committee.

4. Quorum

4.1 A quorum shall be five (5) members.

5. Frequency and notice of meetings

5.1 Meetings shall be held monthly.

5.2 Arrangements for calling meetings will be in writing to the Chair of the Committee with a minimum of ten (10) days' notice.

6. Remit and responsibilities of the Committee

6.1 The Committee shall:

6.1.1 develop and recommend a commissioning strategy to the Governing Body informed by each Local Member Group and aligned with the Joint Health & Well-Being Strategy;

6.1.2 develop and oversee the necessary programme and/or project management arrangements to effectively inform the development of clinical strategy and to develop annual commissioning plans for certain categories of care e.g. planned care, urgent care, long term conditions, etc.;

6.1.3 support joint commissioning arrangements with local authorities and other partners;

6.1.4 generate new QIPP ideas and recommend to the Governing Body QIPP business cases for approval and release of finance from reserves;

6.1.5 assess the clinical outcomes for provider contracts (e.g. CQUINs);

6.1.6 determine tactical investments/interventions with authority delegated to it;

6.1.7 promoting education and training;

6.1.8 supporting innovation; and

6.1.9 assist and support the NHS Commissioning Board in its duty to improve the quality of tertiary care.

7. Relationship with the Governing Body

7.1 The Committee will report to the Governing Body after each meeting.

8. Policy and best practice

8.1 The Committee is authorised by the Governing Body to instruct professional advisors and request the attendance of individuals and authorities from outside the Group with relevant experience and expertise if it considers this necessary for or expedient to the exercise its functions.

8.2 The Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.

9. Conduct of the Committee

9.1 The terms of reference of the Committee shall be reviewed by Governing Body at least annually.

ANNEX C

Performance and Governance Committee

NHS Brighton and Hove Clinical Commissioning Group

Performance and Governance Committee

Terms of Reference

1. **Introduction**

1.1 The Performance and Governance Committee (the Committee) is established in accordance with NHS Brighton and Hove Clinical Commissioning Group's (the Group's) Constitution, Standing Orders and Scheme of Reservation and Delegation. These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the Committee and shall have effect as if incorporated into the Group's Constitution and Standing Orders.

1.2 The Committee is authorised by the Governing Body to act within its terms of reference. All Members and employees of the Group are directed to co-operate with any request made by the Committee.

2. **Membership**

2.1 The Committee shall be appointed by the Group as set out in the Group's Constitution and may include individuals who are not on the Governing Body.

2.2 The Lay Member for Governance will chair the Committee.

2.3 The core membership of the Committee shall consist of:

- Accountable Officer (Deputy Chair)
- Chief Finance Officer;
- Chief Operating Officer;
- Director of Clinical Quality and Patient Safety
- Director of Performance
- CCG Chair
- Local Member Group Chair(s)

2.4 The Committee shall have additional attendance for specific elements of the agenda as required, including, but not limited to:

- Head of Corporate Affairs
- Head of Planning and Delivery
- Heads of Commissioning
- Head of Contracting
- Deputy Chief Finance Officer
- Head of Medicines Management
- Head of Quality
- Head of Continuing Health Care

3. **Secretary**

3.1 The Secretary shall record the minutes of all meetings of the Committee. As a formal sub-committee of the Governing Body, the minutes of the Committee will be will be made available at public meeting of the Governing Body.

4. **Quorum**

4.1 A quorum shall be four (4) members (or appropriate deputies) and must include the Chair or Deputy Chair and one Non-Executive Member of the Governing Body.

5. **Frequency and notice of meetings**

5.1 Meetings shall be held monthly

6. **Remit and responsibilities of the Committee**

6.1 **Contract Performance and Annual Operating Plan Development and Delivery:**

- be responsible for the operational delivery of agreed strategy and strategic commissioning intentions;
- Monitor the performance of commissioned services in relation to activity, finance, and compliance with national and local targets and KPIs.
- Where performance is deviating, agree and oversee required action to mitigate impact.
- Oversee the development and delivery of annual QIPP programme, regularly monitoring savings and recommending appropriate action as required.
- Agree and oversee the planning process and contract negotiation strategy
- Review and approve significant business cases over a value of £50,000 relating to the Annual Operating Plan, in year service redesign and primary care development. These business cases should be developed and reported via the agreed Brighton and Hove CCG PMO process prior to discussion at P&G. Business cases under £50,000 or as otherwise indicated by the CCG executive team will be agreed by Senior Management team and the CCG executive.
- recommend to the Governing Body the strategic, business and financial plan for the Group taking into account the input of the committees and the Local Member Groups;
- monitor Member performance against their duties and responsibilities as Members of the Group in line with the membership agreement and Constitution, QIPP Plans and overall use of resources;
- Ensure that a collaborative approach is taken with neighbouring CCGs
- Ensure that joint commissioning arrangements with local authorities and other partners are overseen and developed appropriately

6.2 **Integrated Governance**

- ensure the Group is aware of and complies with its legal and statutory obligations and operates in a safe and legally compliant manner, taking appropriate professional advice where necessary;
- Provide leadership and commitment to the management of risk across the organisation including development of the Corporate Risk Register and Assurance Framework.
- Develop and review the CCG's risk management policies and strategies.

- Ensure that risk management is embedded across the CCG and monitor and scrutinise directorate and team risk registers and progress with action plans.
- Monitor the delivery of action plans developed in response to the findings of external reviews e.g. special reviews conducted by the Care Quality Commission
- Monitor and report to the Governing Body on the CCG's high level risks as contained in the Corporate Risk Register.
- Review all strategic human resources policies advising the Board on their adoption as required.
- Provide assurances to the Board on information governance compliance and the appropriate identification and management of information risks.
- Provide oversight of risks to the health and safety of staff and visitors and link to the Pan Sussex Health and Safety Committee.
- To oversee the review and updating of the CCG Constitution

6.3 **CCG Performance and Organisational Development**

- To oversee the development and implementation of the CCG Organisational Development Plan
- Receive and oversee the annual review of staff turnover, staff appointments, sickness absence and staff survey results
- Ensure that robust systems and processes are in place - and adhered to - in relation to the recruitment, line management and development of all staff aligned to the CCG;
- Sign off annual and longer term budgets relating to the running costs of the CCG, regularly receive and review financial reports, identify and agree action in relation to any areas of risk.
- Consider and disseminate all new guidance and other relevant information relating to commissioning and ensure appropriate action taken

7. **Relationship with the Governing Body**

7.1 The Committee will report to the Governing Body after each meeting.

8. **Policy and best practice**

8.1 The Committee is authorised by the Governing Body to instruct professional advisors and request the attendance of individuals and authorities from outside the Group with relevant experience and expertise if it considers this necessary for or expedient to the exercise its functions.

8.2 The Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.

9. **Conduct of the Committee**

9.1 The terms of reference of the Committee shall be reviewed by Governing Body at least annually.

ANNEX D

QUALITY ASSURANCE COMMITTEE

NHS Brighton and Hove Clinical Commissioning Group

Governing Body Quality Assurance Committee

Terms of Reference

1. Introduction

1.1 The Quality Assurance Committee (the Committee) is established in accordance with NHS Brighton and Hove Clinical Commissioning Group's (the CCG's) Constitution, Standing Orders and Scheme of Reservation and Delegation. These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the Committee and shall have effect as if incorporated into the CCG's Constitution and Standing Orders.

1.2 The Committee is authorised by the Governing Body to act within its terms of reference. All Members and employees of the CCG are directed to co-operate with any request made by the Committee.

2. Membership

2.1 The Committee shall be appointed by the CCG as set out in the CCG's Constitution and may include individuals who are not on the Governing Body.

2.2 The Independent Registered Nurse on the Governing Body will chair the Committee.

2.3 The membership of the Committee shall consist of:

2.3.1 The Independent Registered Nurse on the Governing Body (who will chair the Committee) as referred to in paragraph 2.2 above;

2.3.2 The Lay Members on the CCG Governing Body;

2.3.3 The Independent Members on the CCG Governing Body;

2.3.4 The Local Member Group Chair members of the CCG Governing Body.

2.3.5 the Chief of Clinical Leadership and Engagement;

2.3.6 the Director of Clinical Quality and Patient Safety; and

2.3.7 the Accountable Officer; and

2.4 The Committee shall be supported by:

2.4.1 a public health consultant.

2.4.2 Chief Operating Officer

2.4.3 Group clinicians and managers with responsibility for corporate governance and safeguarding,

but such persons shall not be members of the Committee.

3. Secretary

3.1 The Secretary shall record the minutes of all meetings of the Committee.

4. Quorum

4.1 A quorum shall be four members including one member of the CCG Executive , one clinician and one Lay or Independent member of the CCG, or their nominated deputy.

5. Frequency and notice of meetings

5.1 Meetings shall be held at least six (6) times a year.

5.2 Arrangements for calling meetings will be in writing to the Chair of the Committee with a minimum of ten (10) days' notice.

6. **Remit and responsibilities of the Committee**

6.1 The Committee shall:

6.1.1 monitor and drive forward the quality of all commissioned care, recommending courses of action where concerns have been raised;

6.1.2 receive and discuss reports on primary care with a view to assisting and supporting NHS England in its duty to improve the quality of such care;

6.1.3 receive and review reports on quality in respect of commissioned services to include performance against CQUINs, patient experience (including complaints and compliments) and clinical performance indicators;

6.1.4 ensure the patient voice is captured and changes in commissioning strategies are recommended to improve patient experience;

6.1.5 ensure that there are robust systems and processes in place to safeguard adults and children and the Mental Capacity Act (including DOLS);

6.1.6 monitor arrangements in place with the CCG relating to equality and diversity issues, ensuring compliance with statutory obligations;

6.1.7 ensure delivery of the requirements for Information Governance;

6.1.8 ensure adequate systems are in place for the governance of research in line with the Department of Health's requirements;

6.1.9 oversee and provide assurance on the clinical governance arrangements in commissioned services;

6.1.10 receive, review and scrutinise reports on serious incidents (SIs), Patient Safety Alerts and Never Events occurring in commissioned services and monitoring associated action plans and;

6.1.11 ensure that there are robust systems and processes in place to monitor and reduce inequalities

7. Relationship with the Governing Body

7.1 The Committee will report to the Governing Body after each meeting.

8. Policy and best practice

8.1 The Committee is authorised by the Governing Body to instruct professional advisors and request the attendance of individuals and authorities from outside the CCG with relevant experience and expertise if it considers this necessary for or expedient to the exercise its functions.

8.2 The Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.

9. Conduct of the Committee

9.1 The terms of reference of the Committee shall be reviewed by Governing Body at least annually.

ANNEX E

AUDIT COMMITTEE

NHS Brighton and Hove Clinical Commissioning Group

Governing Body Audit Committee

Terms of Reference

1. Introduction

1.1 The audit committee (the Committee) is established in accordance with NHS Brighton and Hove Clinical Commissioning Group's (the CCG's) Constitution. These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the Committee and shall have effect as if incorporated into the Constitution.

1.2 The Committee is authorised by the Governing Body to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any Member, officer or employee who is directed to co-operate with any request made by the Committee.

2. Membership

2.1 The Committee shall be appointed by the CCG as set out in the CCG's Constitution and may include individuals who are not on the Governing Body.

2.2 The Lay Member on the Governing Body, with a lead role in overseeing key elements of governance, will need to be able to chair the Committee and must have qualifications, expertise or experience such as to enable the person to express informed views about financial management and audit matters.

2.3 There will be two other Independent Members of the Governing Body on the Committee.

3. Attendance

3.1 In addition to the Committee members, the Accountable Officer, Chief Finance Officer and any other relevant parties where appropriate shall generally attend routine meetings of the Committee.

3.2 A representative of each of the internal and external auditor may also be invited to attend meetings of the Committee.

3.3 Members of the Governing Body shall be invited to attend those meetings in which the Committee will consider areas of risk or operation that are their responsibility.

3.4 The Chair of the CCG may be invited to attend meetings of the Committee as required.

3.5 A representative of the local counter fraud service may be invited to attend meetings of the Committee.

4. Secretary

4.1 The Secretary shall be the secretary to the Committee and will provide administrative support and advice. The duties of the secretary in this regard include but are not limited to:

4.1.1 agreement of the agenda with the chair of the Committee and attendees together with the collation of connected papers;

4.1.2 taking the minutes and keeping a record of matters arising and issues to be carried forward;

4.1.3 advising the Committee as appropriate on best practice, national guidance and other relevant documents.

5. Quorum

5.1 A quorum shall be the chair of the Committee and one other member.

6. Frequency and notice of meetings

6.1 Meetings shall be held at least four (4) times per year, with additional meetings where necessary.

6.2 The external auditor shall be afforded the opportunity at least once per year to meet with the Committee without members of the Governing Body present.

6.3 The Committee members shall be afforded the opportunity to meet at least once per year with no others present. Arrangements for calling meetings will be in writing to the chair of the Committee with a minimum of ten (10) days' notice.

7. Remit and responsibilities of the Committee

7.1 The Committee shall critically review the CCG's financial reporting and internal control principles and ensure an appropriate relationship with both internal and external auditors is maintained.

Integrated governance, risk management and internal control

7.2 The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the CCG's activities that support the achievement of the CCG's objectives.

7.3 In particular, the Committee will review the adequacy and effectiveness of:

7.3.1 all risk and control related disclosure statements (in particular the governance statement), together with any appropriate independent assurances, prior to endorsement by the CCG;

7.3.2 the underlying assurance processes that indicate the degree of achievement of Group objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements;

7.3.3 the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certification; and

7.3.4 the policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the NHS Counter Fraud and Security Management Service.

7.4 The Committee shall seek reports and assurances from members of the Governing Body and senior employees as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness evidenced through the Committee's use of an effective assurance framework to guide its work and that of the audit and assurance functions that report to it.

Internal audit

7.5 The Committee shall ensure that there is an effective internal audit function that meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Committee, Accountable Officer and the CCG.

7.6 The Committee shall achieve an effective internal audit function by:

7.6.1 consideration of the provision of the internal audit service, the cost of the audit and any questions of resignation and dismissal;

7.6.2 review and approval of the internal audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation, as identified in the assurance framework;

7.6.3 considering the major findings of internal audit work (and the senior team's response) and ensuring co-ordination between the internal and external auditors to optimise audit resources;

7.6.4 ensuring that the internal audit function is adequately resourced and has appropriate standing within the CCG; and

7.6.5 an annual review of the effectiveness of internal audit.

External audit

7.7 The Committee shall review the work and findings of the external auditors and consider the implications and the senior team's responses to their work.

7.8 The Committee shall achieve this by:

7.8.1 consideration of the performance of the external auditors, as far as the rules governing the appointment permit;

7.8.2 discussion and agreement with the external auditors, before the audit commences, on the nature and scope of the audit as set out in the annual plan, and ensuring co-ordination, as appropriate, with other external auditors in the local health economy;

7.8.3 discussion with the external auditors of their local evaluation of audit risks and assessment of the CCG and associated impact on the audit fee;

7.8.4 review of all external audit reports, including the report to those charged with governance, agreement of the annual audit letter before submission to the CCG and any work undertaken outside the annual audit plan, together with the appropriateness of management responses;

7.8.5 overseeing the conduct of a market testing exercise for the appointment of an auditor at least once every five years and, based on the outcome, make a recommendation to the Governing Body with respect to the appointment of the auditor;

7.8.6 developing and implementing a policy on the engagement of the external auditor to supply non-audit services; and

7.8.7 considering the provision of the external audit service, the cost of the audit and any questions of resignation and dismissal.

Other assurance functions

7.9 The Committee shall review the findings of other significant assurance functions, both internal and external, including but not limited to:

7.9.1 any reviews by Department of Health arm’s length bodies or regulators/inspectors (for example, the Care Quality Commission and NHS Litigation Authority); and

7.9.2 professional bodies with responsibility for the performance of staff or functions (for example, Royal Colleges and accreditation bodies),

and consider the implications for the governance of the CCG.

Counter fraud

7.10 The Committee shall satisfy itself that the CCG has adequate arrangements in place for countering fraud and shall review the outcomes of counter fraud work. It shall also approve the counter fraud work programme.

Management

7.11 The Committee shall request and review reports and positive assurances from members of the Governing Body and senior employees on the overall arrangements for governance, risk management and internal control.

7.12 The Committee may also request specific reports from individual functions within the CCG as they may be appropriate to the overall arrangements.

Financial reporting

7.13 The Committee shall monitor the integrity of the financial statements of the CCG and any formal announcements relating to the CCG's financial performance.

7.14 The Committee shall ensure that the systems for financial reporting to the CCG, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the CCG.

7.15 The Committee has delegated authority to approve the annual report and financial statements and shall approve them on behalf of the Governing Body and the CCG having reviewed them, focused particularly on the CCG:

7.15.1 the wording in the governance statement and other disclosures relevant to the terms of reference of the Committee;

7.15.2 changes in, and compliance with, accounting policies, practices and estimation techniques;

7.15.3 unadjusted mis-statements in the financial statements;

7.15.4 significant judgements in preparing of the financial statements;

7.15.5 significant adjustments resulting from the audit;

7.15.6 letter of representation; and

7.15.7 qualitative aspects of financial reporting.

8. Relationship with the Governing Body

8.1 The minutes of all meetings of the Committee shall be formally recorded and submitted, together with recommendations where appropriate, to the Governing Body. The submission to the Governing Body shall include details of any matters in respect of which actions or improvements are needed. This will include details of any evidence of potentially ultra vires, otherwise unlawful or improper transactions, acts, omissions or practices or any other important matters. To the extent that such matters arise, the chair of the Committee shall present details to a meeting of the Governing Body in addition to submission of the minutes.

8.2 The Committee will report annually to the Governing Body in respect of the fulfilment of its functions in connection with these terms of reference. Such report shall include but not be limited to:

8.2.1 functions undertaken in connection with the statement of internal control;

8.2.2 the assurance framework;

8.2.3 the effectiveness of risk management within the CCG;

8.2.4 the integration of and adherence to governance arrangements;

8.2.5 its view as to whether the self-assessment against standards for better health is appropriate; and

8.2.6 any pertinent matters in respect of which the audit committee has been engaged.

8.3 The CCG's annual report shall include a section describing the work of the audit committee in discharging its responsibilities.

9. Policy and best practice

9.1 The Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.

10. Conduct of the Committee

10.1 The terms of reference of the Committee shall be reviewed by the Governing Body at least annually.

10.2 Members of the Committee must attend at least three (3) of all meetings each financial year but should aim to attend all scheduled meetings.

ANNEX F

REMUNERATION AND NOMINATIONS COMMITTEE

NHS Brighton and Hove Clinical Commissioning Group

Governing Body Remuneration and Nominations Committee

Terms of Reference

1. **Introduction**

1.1 The remuneration and nominations committee (the Committee) is established in accordance with NHS Brighton and Hove Clinical Commissioning Group's (the CCG's) Constitution, Standing Orders and Scheme of Reservation and Delegation. These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the Committee and shall have effect as if incorporated into the CCG's Constitution and Standing Orders.

1.2 The Committee is authorised by Governing Body to act within its terms of reference. All Members and employees of the CCG are directed to co-operate with any request made by the Committee.

2. **Membership**

2.1 The Committee shall be appointed by the CCG from amongst its Governing Body members.

2.2 The membership of the Committee shall consist of:

2.2.1 the Lay Member for governance (who will chair the Committee). All members of the Governing Body other than the Lay Members are disqualified from being the chair of the Committee;

2.2.2 the Lay Members for patient and public participation matters, the secondary care specialist doctor and the registered nurse

3. **Secretary**

3.1 The Governing Body Secretary shall record the minutes of all meetings of the Committee. These will be retained by the chair and not shared with members of the Governing Body who are not members of the Committee.

4. **Quorum**

4.1 A quorum shall be two (2) members.

5. **Frequency and notice of meetings**

5.1 Meetings shall be held at least every six months and additional meetings shall be held as and when required to act as a screening penal for Governing Body appointments.

5.2 Arrangements for calling meetings will be in writing to the Chair of the Committee with a minimum of ten (10) days' notice.

6. **Remit and responsibilities of the Committee**

6.1 The Committee shall:

6.1.1 make recommendations on determinations of the remuneration and conditions of service of employees of the CCG, the members of the Governing Body and people who provide services to the CCG including:

(a) salary, including any performance-related pay or bonus;

(b) provisions for other benefits, including pensions and cars;

(c) allowances under any pension scheme it might establish as an alternative to the NHS pension scheme; and

(d) other allowances;

6.1.2 consider the severance payments of the Accountable Officer and other senior employees, seeking HM Treasury approval as appropriate in accordance with HM Treasury guidance;

6.1.3 monitor and evaluate the performance of members of the Governing Body;

6.1.4 adhere to all relevant laws, regulations and policy in all respects, including:

(a) national guidance;

(b) the management cost cap;

(c) benchmarked information of other Clinical Commissioning Groups' costs; and

(d) the competing earnings potential in primary care,

to determine levels of remuneration that are sufficient to attract, retain and motivate members of the Governing Body and senior employees whilst remaining cost effective;

6.1.5 advise upon and oversee contractual arrangements for members of the Governing Body and senior employees, including but not limited to termination payments;

6.1.6 ensure that the Governing Body has the right balance of skills, knowledge and perspectives required for members of the Governing Body;

6.1.7 oversee the appointment or election process for members of the Governing Body, and acting as a screening panel for the clinical members of the Governing Body;

6.1.8 develop an approach to succession planning for key members of the Governing Body;

6.1.9 set the terms of office for members of the Governing Body;

6.1.10 oversee the performance review process for all members of the Governing Body including the Chair; and

6.1.11 arrange regular performance evaluation of the effectiveness of the Governing Body and its committees.

7. **Relationship with the Governing Body**

7.1 The Committee will report to the Governing Body after each meeting.

8. **Policy and best practice**

8.1 The Committee is authorised by the Governing Body to instruct professional advisors and request the attendance of individuals and authorities from outside the CCG with relevant experience and expertise if it considers this necessary for or expedient to the exercise its functions.

8.2 The Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.

9. **Conduct of the Committee**

9.1 The terms of reference of the Committee shall be reviewed by Governing Body at least annually.

Annex G

Participation and Communication Assurance Committee

NHS Brighton and Hove Clinical Commissioning Group

Participation and Communication Assurance Committee

Terms of Reference

1.0 Introduction

The Participation and communication Assurance Committee (PCAC) is established as a subcommittee of the CCG's Governing Body. These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the committee.

2.0 Membership

2.1 The membership of the group shall comprise:

- CCG Governing Body Lay Member for Participation (Chair)
- CCG Chief Clinical Officer
- CCG Chief Operating Officer (Chair)
- CCG Head of Planning and Delivery
- CCG Head of Engagement
- CCG Head of Communications
- CCG Heads of Commissioning
- Brighton & Hove City Council – Community Engagement Lead
- Brighton and Hove Community Works representative
- Public Health representative
- Healthwatch Chief Executive Officer
- PPG Network elected representatives x 2
- CCG Clinical lead (tbc)
- CCG Practice Manager lead (tbc)

2.2 The Lay Member for Participation on the Governing Body will Chair the committee. In the event of the Chair being unable to attend, he/she will nominate a replacement from within the meeting membership in order to deputise.

3.0 Attendance

3.1 Only members of the committee have the right to attend committee meetings; other individuals may be invited to attend for all or part of the meeting as appropriate.

4.0 Minutes and Administration

4.1 The CCG will provide a minute taker who will :

- minute the meetings
- provide administrative support to the Chair in developing the agenda
- coordinate and issue papers

5.0 Quorum

5.1 No business will be agreed unless at least three committee members are present, including the Chair or his/her nominated deputy.

6.0 Frequency and notice of meetings

6.1 The committee will meet bi monthly for two hours.
6.2 The agenda will be sent to members no less than seven days before the meeting; supporting papers should, where possible, accompany the agenda or be despatched no later than three days prior to the meeting.
6.3 The committee may determine that certain matters be standing items on the agenda.
6.4 No business shall be discussed at the meeting other than that on the agenda.
6.5 Members wishing to place an item on the agenda should put this in writing to the Chair no less than 14 days before the meeting. Requests made less than 14 days before the meeting may be included at the Chair's discretion.

7.0 Remit and Responsibilities of the committee

7.1 The committee will consider all aspects of patient and public participation, including the thematic findings of engagement activity and the quality of engagement carried out, and be responsible for developing, reviewing and overseeing implementation of the CCG's Patient and Public Participation Strategy.

7.2 The committee will be responsible for developing, reviewing and overseeing implementation of the Communications plan.

7.3 The committee will be responsible for assuring the CCG's Governing Body on PPP and Communications

7.4 The general areas of responsibility for the committee relating to PPP are:

7.4.1 Ensuring that principles of good PPP are applied in all areas of the CCG's work

7.4.2 Ensure that meaningful PPP is used effectively to influence the commissioning processes and the setting of commissioning intentions

7.4.3 Ensure that findings of the CCG's PPP activity influence all stages of the Commissioning Cycle, specifically in:
- Strategic planning : engaging with the groups, communities and individuals and meaningfully involving them in decisions about priorities and strategies.
- Service (re) design: involving service users and carers in service (re) design and improvement
- Specifying outcomes and procuring services : involving patients and carers in specifying service outcome measures for improving quality, and ensuring patient centred procurement and contracting
- Patient centred monitoring, evaluation and performance management: involving patients and carers in the monitoring, evaluation and performance management of commissioned services and in managing demand

7.5 Oversee the quality of PPP in all stages of the commissioning cycle

7.6 Oversee the quality, appropriateness and value of engagement with a range of stakeholders, including:
- patients and carers
- patient forums and user led groups (including PPG's)
- Healthwatch
- the Community and Voluntary Sector
- the Local Authority
- community networks

ensuring that opportunities for joint working are explored and developed appropriately.

7.7 Oversee equalities based participation, ensuring that the city's protected characteristic groups are consulted and involved appropriately.

7.8 The general areas of responsibility for the committee related to communications are:

7.8.1 Oversee the quality and content of CCG e-communications, including websites, social media platforms and e-bulletins.

7.8.2 Ensure that CCG media relations promote and explain CCG priorities and encourage PPP.

7.8.3 Ensure that CCG communication strategies and channels support effective two-way communication with PPGs, the Community and Voluntary Sector, Healthwatch and protected characteristic/marginalised groups

8.0 Relationship with the Governing Body

8.1 The committee shall present its approved minutes and a bi monthly PPP/Communications report to the Governing Body

8.2 The committee shall produce an annual summary of its work and outcomes

8.3 The Chair of the committee will bring to the attention of the Quality Assurance Committee, executive and Governing Body any matter that the committee considers a significant risk.

Annex H

Primary Care Commissioning Committee

NHS Brighton and Hove Clinical Commissioning Group

Primary Care Commissioning Committee

Terms of Reference

Introduction

1. The CCG has established the Brighton and Hove CCG Primary Care Commissioning Committee ("Committee"). The Committee is a subcommittee of the Governing Body and will make decisions on behalf of the CCG in respect developing primary care including investment and commissioning decisions.

2. The Membership of Brighton and Hove Clinical Commissioning Group (the "CCG") have not yet agreed to formally seek responsibility for the Co-Commissioning of Primary Care. However, the CCG has recognised that it is necessary to create a formal committee to oversee the governance of developments in primary care. In the event that the CCG's membership decides to take on a greater responsibility for commissioning primary care the CCG will review these terms of reference to incorporate those changes.

Role of the Committee

3. The purpose of the committee is to oversee the strategic development and implementation of transformational change in primary care in Brighton & Hove as commissioned by the CCG. This will include oversight of the development of practice clusters and working with the membership to develop options for different organisational forms across the city.

4. In the event that the CCG membership takes greater responsibility for the co-commissioning of primary care the terms of reference for this committee will be revised to ensure that it will be in a position to take more commissioning decisions around primary care. Until such time as the CCG receives either joint or delegated authority from NHS England for the Co-commissioning of Primary Care, this committee shall oversee the strategic commissioning of primary care and shall advise the Governing Body regarding whether the CCG is in a position to take on further responsibility for co-commissioning.

5. The Committee will oversee the work of the Primary Care Transformation Board and shall be authorised to make decisions based on the recommendations from the membership.

6. The Committee shall consist of:
    - Independent Clinical Member (Nurse) (Chair)
    - Independent Clinical Member (Secondary Care) (Co-Chair)
    - Lay Member (PPE)
    - Lay member (Governance)
    - Chief Operating Officer
    - Chief Financial Officer
    - Director of Clinical Quality and Patient Safety
    - Director of Public Health
    - Director of Adult Social Care
    - Head of Primary Care, NHS England

7. The Chair of the Committee shall be the Independent Nurse Member of the CCG's Governing Body.

8. The Co-Chair of the Committee shall be the Independent Secondary Care Clinician Member of the CCG's Governing Body.

9. In addition to the list of Members above, the following non-voting members shall be invited to all meetings of the Committee:
    - HealthWatch
    - Local Medical Council

10. On occasion, other non-voting representatives shall be invited from:
    - NHS England
    - CCG Staff
    - Members of the Primary Care workforce within Brighton and Hove
    - Other Stakeholders

Meetings and Voting

11. The Committee will operate in accordance with the CCG's Standing Orders. Notice of the meeting, the agenda and supporting papers will be sent to each member representative no later than 5 days before the date of the meeting. When the Chair of the Committee deems it necessary in light of the urgent circumstances to call a meeting at short notice, the notice period shall be such as they shall specify.

12. Each member of the Committee shall have one vote. The Committee shall reach decisions by a simple majority of members present, but with the Chair having a second and deciding vote, if necessary. However, the aim of the Committee will be to achieve consensus decision-making wherever possible.

Quorum

13. A Quorum shall require 4 voting members of the committee, including at least 1 lay or independent member (who shall be Chair). A majority of lay and executive members of the CCG Governing Body shall be maintained

Frequency of meetings

14. The Committee shall meet as frequently as is required for the performance of its functions and in any event not less than 4 times time in any financial year. Each meeting shall not be more than 3 month since the following meeting.

15. Meetings of the Committee shall:
    a) be held in public, subject to the application of 23(b);
    b) the Committee may resolve to exclude the public from a meeting that is open to the public (whether during the whole or part of the proceedings) whenever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time.

16. Members of the Committee have a collective responsibility for the operation of the Committee. They will participate in discussion, review evidence and provide objective expert input to the best of their knowledge and ability, and endeavour to reach a collective view.

17. The Committee may delegate tasks to such individuals, sub-committees or individual members as it shall see fit, provided that any such delegations are consistent with the parties' relevant governance arrangements, are recorded in a scheme of delegation, are governed by terms of reference as appropriate and reflect appropriate arrangements for the management of conflicts of interest.

18. The Committee may call additional experts to attend meetings on an ad hoc basis to inform discussions.

19. Members of the Committee shall respect confidentiality requirements as set out in the CCG's policy and code of conduct.

20. The CCG will also comply with any reporting requirements set out in its constitution.

21. These Terms of Reference will be reviewed annually to reflect the experience of the Committee in fulfilling its functions

Accountability of the Committee

22. For the avoidance of doubt, in the event of any conflict between the terms of the Scheme of Delegation, this Terms of Reference and the Standing Orders of Standing Financial Instructions of the CCG, the latter will prevail.

Decisions

23. The Committee will make decisions within the bounds of its remit.

24. The decisions of the Committee shall be binding on the CCG.

Annex I

Record of Attendance

The tables below show the attendance of each committee meeting by its members. An "X" indicates attendance. Shaded cells indicate that the member was not a meeting member at the time of the meeting.

Audit Committee

Name	Position	Mar -15	Apr - 15	May - 15	Jul - 15	Sep - 15	Jan - 16	Mar - 16
George Mack	Lay Member (Governance)		X (Chair)	X (Chair)	X (Chair)	X (Chair)	X (Chair)	X (Chair)
Jennifer Oats	Independent Clinical Member (Registered Nurse)	X	X	X	X	X	X	X
Mike Holdgate	Lay Member, Patient & Public Participation	X (Chair)		X	X	X	X	

Clinical Strategy Group

Name	Position	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15
Dr Naseer Khan (Chair)	Chief of Clinical Leadership & Engagement		x	x		x	x	x
Dr Xavier Nalletamby	Chairman		x		x		x	x
Dr Christa Beesley	Chief Clinical Officer						x	x
Dr Jonny Coxon	LMG GP Lead (Central)	x		x	x			
Dr Darren Emilianos	LMG GP Lead (East)	x	x	x	x			
Geraldine Hoban	Chief Operating Officer							
John Child	Chief Operating Officer							
Dr Anita Amin	Macmillian Cancer GP					x		x
Soline Jerram	Lead Nurse, Director of Clinical Safety & Patient						x	
Dr Rachel Cottam	Clinical Lead Sustainability		x	x				
Nicky Daborn	Clinical Lead Diabetes, Palliative Care and Primary Care	x	x	x	x	x	x	
Dr Jim Graham	Clinical Programme Lead Planned Care		x	x	x	x	x	x
Dr Liz McCulloch	Clinical Programme Lead Maternity and Children	x	x	x	x	x	x	x
Dr Anne Miners	LMG GP Lead (west)	x	x	x		x	x	
Dr Rebecca Jarvis	Clinical Programme Lead Mental Health	x				x		
Deirdre Prower	Clinical Programme Lead Long Term Conditions			x	x			
Dr Manas Sikdar	LMG GP Lead (East)							
Dr Dinesh Sinha	Clinical Independent Member (Secondary Care Consultant)	x	x		x	x	x	x
Dr Katie Stead	Clinical Lead for Locally Commissioned Services and Quality for Primary Care		x	x	x	x		x
Dr Tim McMinn	Clinical Programme Lead Urgent Care and Medicines Management	x	x	x	x	x		x
Michael Schofield	Chief Finance Officer	x	x				x	

Participation and Communication Assurance Committee Attendance

Name	Position	22nd May 15	22nd July 15	3rd Sept 15	4th Nov 15	13th Jan 16	9th March 16
Mike Holdgate (Chair)	Lay Member for Patient, Public Participation	x	x	x		x	x
Dr Christa Beesley	Chief Clinical Officer	x	x	x	x	x	
John Child	Chief Operating Officer						x
Geraldine Hoban	Chief Operating Officer	x	x	x			
Claire Holloway	Interim Chief Operating Officer						

Quality Assurance Committee

Name	Position	Mar – 15	Apr – 15	May -15	Jun – 15	Jul – 15	Aug -15	Sep-15	Oct -15	Nov – 15	Dec – 15	Jan - 16	Feb-16	Mar - 16
Jennifer Oates **(Chair)**	Clinical Independent Member (Registered Nurse)	x	x	x	x	x	x	x	x	x		x	NO MEETING	x
Dr Christa Beesley	Chief Clinical Officer	x						x	x			x		
Dr Jonny Coxon	LMG GP Lead (Central)	x		x		x								
Dr Naseer Khan	Chief of Clinical Leadership & Engagement					x								x
Dr Anne Miners	LMG GP Lead (Central)		x		x		x		x	x	x			
Dr Manas Sikdar	LMG GP Lead (East)								x	x	x	x		
Mike Holdgate	Lay Member for Patient, Public Participation	x	x		x		x	x			x	x		
Soline Jerram	Lead Nurse, Director of Patient Safety and Clinical Quality	x	x	x		x	x	x		x		x		x
Dr George Mack	Lay Member (Governance)		x	x	x			x	x	x	x	x		x

Performance and Governance Committee

Name	Position	3rd March	17th March	31st March	14th April	28th April	12th May	26th May	9th June
George Mack	Chair (Lay Member to Governance)		x				x		x
Dr Christa Beesley	Chief Clinical Officer	Chair	Chair	Chair		Chair		Chair	
Geraldine Hoban	Chief Operating Officer	x	x		Chair	x	Chair		Chair
Claire Holloway	Interim Chief Operating Officer								
John Child	Chief Operating Officer								
Xavier Nalletamby	Chair of Brighton and Hove CCG	x							
Soline Jerram	Lead Nurse Dir. of Clinical Quality and Primary Care	x	x			x			
Darren Emilianos	Locality Chair East	x	x		x				
Anne Miners	Locality Chair West	x	x		x	x	x		x
Jonny Cox	Locality Chair Central	x		x		x	x	x	x
Michael Schofield	Chief Finance Officer	x	x	x	x	x	x	x	
Pippa Ross-Smith	Chief Finance Officer								
Charles Wheatcroft	Interim Director of Performance and Delivery	x	x	x	x	x	x	x	
Lisa Durrant	Interim Director of Performance and Delivery								
Lola Banjoko	Director of Performance and Delivery								

Performance and Governance Committee (continued)

		23rd June	7th July	21st July	4th Aug	18th Aug	1st Sept	29th Sept	Oct	Nov	Dec	Jan	Feb	March
George Mack	Chair (Lay Member to Governance)					x	Chair	Chair	Chair	Chair	Chair	Chair	Chair	Chair
Dr Christa Beesley	Chief Clinical Officer	Chair	Chair	Chair		Chair	x	x	x	x	x		x	x
Geraldine Hoban	Chief Operating Officer	x	x	x		x	x	x	x					
Claire Holloway	Interim Chief Operating Officer								x	x	x			
John Child	Chief Operating Officer												x	
Xavier Nalletamby	Chair of Brighton and Hove CCG		x		x	x	x							
Soline Jerram	Lead Nurse Dir. of Clinical Quality and Primary Care				Chair	x	x		x		x	x	x	x
Darren Emilianos	Locality Chair East													
Anne Miners	Locality Chair West	x		x	x									
Jonny Cox	Locality Chair (Ctrl)	x												
Michael Schofield	Chief Finance Officer	x		x	x	x	x	x	x	x	x	x	x	x
Pippa Ross-Smith	Chief Finance Officer													x
Lisa Durrant	Interim Director of Performance and Delivery		x	x	x	x	x	x	x	x	x	x	x	x
Lola Banjoko	Director of Performance and Delivery												x	x

Primary Care Commissioning Committee Attendance

Name	Position	Nov-15	Jan -16	Mar -16
Jennifer Oates (Co-chair)	Clinical Independent Member (Registered Nurse)	x	x	x
Dr Dinesh Sinha (Co-chair)	Clinical Independent Member (Secondary Care Consultant)	x	x	
Dr George Mack	Lay Member (Governance)	x	x	x
Mike Holdgate	Lay Member for Patient, Public Participation		x	x
Pippa Ross Smith	Chief Finance Offier			x
Michael Schofield	Chief Finance Officer	x	x	
Claire Holloway	Interim Chief Operating Officer	x	x	
John Child	Chief Operating Officer			
Tom Scanlon	Public Health Director	x	x	
Denise D'Souza	Director of Adult Social Care	x	x	
Soline Jerram	Lead Nurse, Director of Patient Safety and Clinical Quality		x	

Remuneration and Nominations Committee Attendance

Name	Position	July-15	Oct-15
Dr George Mack (Chair)	Lay Member (Governance)	x	x
Dr Christa Beesley	Chief Clinical Officer		x
Mike Holdgate	Lay Member for Patient, Public Participation	x	
Jennifer Oates	Clinical Independent Member (Registered Nurse)	x	x
Michael Schofield	Chief Finance Officer	x	x
Dr Dinesh Sinha	Clinical Independent Member (Secondary Care Consultant)	x	

Governing Body Meeting

Name	Position	Mar-15	May-15	Jul-15	Sep-15	Nov-15	Jan - 16	Mar-16
Dr Xavier Nalletamby	Chairman	x	x	x	x	x	x	x
Dr Christa Beesley	Chief Clinical Officer	x	x		x	x		x
Dr Jonny Coxon	LMG GP Lead (Central)	x	x					
Denise D'Souza	Director of Adult Social Care, Brighton and Hove City Council			x	x	x	x	x
Lisa Durant	Interim Director of Performance and Delivery			x	x	x	x	x
Dr Darren Emilianos	LMG GP Lead (East)	x						
Geraldine Hoban	Chief Operating Officer	x			x			
Claire Holloway	Interim Chief Operating Officer					x	x	
Mike Holdgate	Lay Member for Patient, Public Participation	x	x	x	x	x	x	x
Soline Jerram	Lead Nurse, Director of Patient Safety and Clinical Quality	x	x	x	x		x	
Dr Naseer Khan	Chief of Clinical Leadership & Engagement	x	x	x	x	x	x	x
Dr George Mack	Lay Member (Governance)	x	x	x	x	x	x	x
Dr Anne Miners	LMG GP Lead (West)	x	x	x		x		
Jennifer Oates	Clinical Independent Member (Registered Nurse)	x	x	x	x	x	x	x
Dr Tom Scanlon	Director of Public Health	x	x	x	x	x	x	
Michael Schofield	Chief Finance Officer	x	x	x	x	x	x	
Dr Manas Sikdar	Local Member Group GP Lead (East)					x	x	x
Dr Dinesh Sinha	Clinical Independent Member (Secondary Care Consultant)		x	x	x	x	x	x
Charles Wheatley,	Interim Director of Performance and Delivery	x	x					
Pippa Ross-Smith	Chief Finance Officer							x

NHS
Brighton and Hove
Clinical Commissioning Group

Remuneration Report

Brighton and Hove CCG

Remuneration Report

Introduction

This Remuneration Report discloses all relevant information with respect to Senior Managers in NHS Brighton and Hove CCG. The definition of 'Senior Manager' in the guidance is:

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

The Accountable Officer has confirmed that the definition of Senior Manager does not extend beyond the members of the Governing Body and the remuneration of any additional regular attendees of the Governing Body is disclosed via the employee benefits expenditure tables in the annual accounts.

Details of the Remuneration Committee

The Remuneration Committee is established in accordance with the CCG Constitution, Standing Orders and Scheme of Delegation. It has delegated authority from the Governing Body to ensure appropriate remuneration, allowances and terms of services for the CCG Chief Officer and Chief Financial Officer, having proper regard to the organisation's circumstances and performance and to the provisions of any national arrangements where appropriate, pension contributions for senior employees and from the Membership via the Constitution, to determine the remuneration including allowances for members of the Governing Body who are not employees.

The membership of the Remuneration Committee consists of:

Member	Position
Dr George Mack	Lay Member (Governance) Chair
Mike Holdgate	Lay Member (PPI)
Dr Dinesh Sinha	Independent Member (Secondary Care Consultant)
Jennifer Oates	Independent Member (Registered Nurse)

There were two Meetings of the Remuneration Committees during the period. The record of attendance at those meetings is included within the appendices to the Annual Governance Statement.

It has not been necessary for the Remuneration Committee to seek specialist HR advice during the year, however the meeting is supported by the CCG's HR advisors where appropriate.

The Human Resources Service provided to the CCG Sussex Community Trust commenced in October 2015. Prior to the commencement of this service the Remuneration Committee received specialist HR advice from South East Commissioning Support Unit (SeCSU). The HR service provides specialist advice in relation to HR, employment law and NHS terms and conditions, the interpretation of NHS England remuneration guidance for CCGs and the provision of benchmarking information relating to local and regional CCG Governing Bodies.

The Committee was satisfied that the advice received for our HR providers has been objective and independent due to the objective nature of the data provided and the fact that the service provider had no other association or involvement with the CCG Officers or Senior Employees.

Policy statement on remuneration of senior managers for current and future years

In setting levels of remuneration, the Committee takes into account national guidance for CCGs, CCG benchmarking, locally prevailing employment conditions and the levels of responsibility associated with each post.

The current remuneration policy does not include performance related awards or targets. The Nomination and Remuneration Committee will determine any considered amendments to the remuneration of Governing Body Members as may be necessary throughout the year.

There is no additional pay allowance for performance for any CCG employee.

Policy on duration of Senior Manager contracts, notice periods and termination payment

Members of the Governing Body are either elected by the membership, selected by the Governing Body, or employed by the CCG. The method of appointment for each role is described within the CCG's constitution. Non- Executive members of the Governing Body are appointed for a term of 3 years and for a maximum of 2 terms. This is to ensure that their independence is maintained and that the membership can be reviewed at regular periods as required by the UK Corporate Code.

Notice periods for senior managers are generally set at such a period as to allow adequate opportunity to identify a replacement. The CCG considers that 3 months is generally an acceptable notice period for senior managers although certain key posts, such as the CFO have notice periods of six months.

The CCG does not have a policy of paying termination payments to senior managers or employees leaving the CCG, save for such payments that they may be entitled to under their contact of employment or appointment. The CCG acknowledges that payments in respect of confidentiality agreements when a senior manager's appointment is terminated are generally considered unacceptable and abides by the guidance issued by NHS England. We confirm that the CCG has made no such payment in respect of any Employee or Governing Body Member leaving the CCG.

Senior Managers Service Contracts

Below are the contractual details of the employees on the Governing Body who served in 2015/16:

Name	Position	
Geraldine Hoban	Chief Operating Officer	Appointed 1 April 2013. Left 31 October 2015.
Claire Holloway	Chief Operating Officer	Temporary Appointment - 26 October 2015 until 5 February 2016.
John Child	Chief Operating Officer	Appointed 1 February 2016.
Michael Schofield	Chief Financial Officer	Appointed 1 April 2013. Left 31 March 2016.
Pippa Ross-Smith	Chief Financial Officer	Appointed 1 March 2016.
Charles Wheatcroft	Director of Delivery and Performance	Temporary Appointment - 26 January 2015 until 28 May 2015.
Lisa Durant	Director of Delivery and Performance	Temporary Appointment - 15 June 2015 until 31 March 2016.
Lola Banjoko	Director of Delivery and Performance	Appointed 21 March 2016.
Soline Jerram	Director of Clinical Quality and Primary Care	Appointed 1 April 2013.

The following table shows the elected/selected members of the Governing Body, including those who have stepped down during the year.

Name	Position	Date Term Due to expire	Potential for a Further Term	Notice Period
Dr Xavier Nalletamby	Chair	31st March 2017	No	3 Months
Dr Anne Miners	LMG Chair (West)	Appointment Expired on 31st Decemeber 2015 following resignation		
Dr Jonny Coxon	LMG Chair (Central)	Appointment Expired on 7th July 2015 following resignation		
Dr Darren Emilianos	LMG Chair (East)	Appointment Expired on 31st March 2015 following resignation		
Dr Mannas Sikdar	LMG Chair (East)	5th October 2018	Yes	3 Months
Dr Jim Graham	LMG Chair (Central)	28th February 2019	Yes	3 Months
Dr Naz Kahn	Chief of Clinical Engagement	1th November 2018	No	3 Months
Dr George Mack	Lay Member (Governance)	31st March 2018	No	3 Months
Mike Holdgate	Lay Member (Patient and Public Involvement)	31st August 2017	Yes	3 Months
Jenny Oates	Independent Nurse	30th November 2018	No	3 Months
Dinesh Sinha	Independent Secondary Care Consultant	30th November 2018	No	3 Months
Jayem Dalal	Lay Member (Patient and Public Involvement)	Term expired and stood down 30th June 2015		
Janice Robinson	Lay Member (Patient and Public Involvement)	Term expired and stood down 30th June 2015		

Section two of the CCG's standing orders contained in appendix C to the Constitution, described the process for appointment, term of appointment and process for removal of appointment for all members of the CCG's Governing Body.

Remuneration tables

Salaries and Allowances for Governing Body Members

Name & Title	(a) Salary (bands of £5,000)	(b) Expense Payments (Taxable) (rounded to the nearest £100)	(c) Performance Pay and Bonuses (bands of £5,000)	(d) Long-term Performance Pay and Bonuses (bands of £5,000)	(e) All Pension Related Benefits (bands of £2,500)	Total (a to e) (bands of £5,000)
	£000	£00	£000	£000	£000	£000
Dr Xavier Nalletamby, Chair	70 - 75	-	-	-	n/a	70 - 75
Dr Christa Beesley, Accountable Officer	130 - 135	-	-	-	5 - 7.5	135 - 140
Geraldine Hoban, Chief Operating Officer (left 31/10/15)	55 - 60	-	-	-	30 - 32.5	85 - 90
John Child, Chief Operating Officer (started 1/2/16)	15 - 20	-	-	-	25 - 27.5	40 - 45
Michael Schofield, Chief Financial Officer	75 - 80	-	-	-	n/a	75 - 80
Pippa Ross-Smith, Chief Financial Officer (started 1/3/16)	5 - 10	-	-	-	30 - 32.5	40 - 45
Lola Banjoko, Director of Delivery and Performance (started 21/3/16)	0 - 5	-	-	-	15 - 17.5	15 - 20
Soline Jerram, Director of Clinical Quality and Primary Care	80 - 85	-	-	-	0	70 - 75
Dr Naseer Kahn, Chief of Clinical Leadership and Engagement	40 - 45	-	-	-	n/a	40 - 45
Dr Jonny Coxon, Local Member Group - Clinical Lead (left 7/7/15)	5 - 10	-	-	-	n/a	5 - 10
Dr Manas Sikdar, Local Member Group - Clinical Lead (started 6/10/15)	10 - 15	-	-	-	n/a	10 - 15
Dr Anne Miners, Local Member Group - Clinical Lead (left 31/12/15)	20 - 25	-	-	-	n/a	20 - 25
Dr Jim Graham, Local Member Group - Clinical Lead (started 1/3/16) (2)	30 - 35	-	-	-	0	25 - 30
Denise D'Souza, Director of Adult Social Care, B&HCC (1)	n/a	n/a	n/a	n/a	n/a	n/a
Dr Tom Scanlon, Director of Public Health (1)	n/a	n/a	n/a	n/a	n/a	n/a
Dr Dinesh Sinha, Independent Member – Secondary Care Clinician	5 - 10	-	-	-	n/a	5 - 10
Jennifer Oates, Independent Member - Registered Nurse	5 - 10	-	-	-	n/a	5 - 10
Dr George Mack, Lay member - Governance	10 - 15	-	-	-	n/a	10 - 15
Mike Holdgate, Lay Member – Patient and Public Involvement	10 - 15	-	-	-	n/a	10 - 15

(1) Not in receipt of remuneration from CCG
(2) Salary includes £28.8k relating to clinical role at the CCG.

The following table contains details of individuals who covered Governing Body posts on an interim basis. These officers remuneration was paid via a company or agency and therefore the gross payment includes VAT, administration fees and the equivalent of employer's pension contributions and NI.

Claire Holloway, Chief Operating Officer (26/10/15 - 5/2/16)	45 - 50
Charles Wheatcroft, Director of Delivery and Performance (26/1/15 - 28/5/15)	30 - 35
Lisa Durant, Director of Delivery and Performance (15/6/15 - 31/3/16)	205 - 210

2014-2015 for Comparison

Name & Title	(a) Salary (bands of £5,000)	(b) Expense Payments (Taxable) (rounded to the nearest £100)	(c) Performance Pay and Bonuses (bands of £5,000)	(d) Long-term Performance Pay and Bonuses (bands of £5,000)	(e) All Pension Related Benefits (bands of £2,500)	Total (a to e) (bands of £5,000)
	£000	£00	£000	£000	£000	£000
Dr Xavier Nalletamby, Chair	80 - 85	-	-	-	n/a	80 - 85
Dr Christa Beesley, Accountable Officer	120 - 125	-	-	-	27.5 - 30	150 - 155
Geraldine Hoban, Chief Operating Officer	80 - 85	-	-	-	0 - 2.5	80 - 85
Michael Schofield, Chief Financial Officer	65 - 70	-	-	-	n/a	65 - 70
Soline Jerram, Director of Clinical Quality and Primary Care	80 - 85	-	-	-	10 - 12.5	90 - 95
Dr Naseer Kahn, Chief of Clinical Leadership and Engagement	40 - 45	-	-	-	n/a	40 - 45
Dr Jonny Coxon, Local Member Group GP Lead (Central)	25 - 30	-	-	-	n/a	25 - 30
Dr Darren Emilianus, Local Member Group GP Lead (East)	55 - 60	-	-	-	n/a	55 - 60
Dr Anne Miners, Local Member Group GP Lead (West)	40 - 45	-	-	-	n/a	40 - 45
Denise D'Souza, Director of Adult Social Care, B&HCC (1)	n/a	n/a	n/a	n/a	n/a	n/a
Dr Tom Scanlon, Director of Public Health (1)	n/a	n/a	n/a	n/a	n/a	n/a
Dr Dinesh Sinha, Independent Member – Secondary Care Clinician	5 - 10	-	-	-	n/a	5 - 10
Jennifer Oates, Independent Member - Registered Nurse	5 - 10	-	-	-	n/a	5 - 10
Dr George Mack, Lay member - Governance	10 - 15	-	-	-	n/a	10 - 15
Janice Robinson, Lay member – Patient and Public Involvement (2)	0 - 5	-	-	-	n/a	0 - 5
Jayam Dalal, Lay Member – Patient and Public Involvement (2)	0 - 5	-	-	-	n/a	0 - 5
Mike Holdgate, Lay Member – Patient and Public Involvement (3)	5 - 10	-	-	-	n/a	5 - 10

(1) Not in receipt of remuneration from CCG
(2) Left position 30 June 2014
(3) Started in position 1 September 2014

Pension Benefits

Name & Title	(a) Real increase in pension at age 60 (bands of £2,500)	(b) Real increase in pension lump sum at age 60 (bands of £2,500)	(c) Total accrued pension at age 60 at 31 March 2016 (bands of £5,000)	(d) Lump sum at age 60 related to accrued pension at 31 March 2016 (bands of £5,000)	(e) Cash Equivalent Transfer Value at 31 March 2015	(f) Real increase in Cash Equivalent Transfer Value	(g) Cash Equivalent Transfer Value at 31 March 2016	(h) Employer's contribution to partnership pension
	£000	£000	£000	£000	£000	£000	£000	£000
Dr Christa Beesley, Accountable Officer	0 - 2.5	2.5 - 5	20 - 25	60 - 65	338	42	389	n/a
Geraldine Hoban, Chief Operating Officer	0 - 2.5	5 - 7.5	20 - 25	65 - 70	354	28	391	n/a
John Child, Chief Operating Officer	0 - 2.5	-	0 - 5	-	6	2	8	n/a
Pippa Ross-Smith, Chief Financial Officer	0 - 2.5	2.5 - 5	20 - 25	65 - 70	440	45	497	n/a
Lola Banjoko, Director of Delivery and Performance	0 - 2.5	0 - 2.5	10 - 15	35 - 40	220	19	245	n/a
Soline Jerram, Director of Clinical Quality and Primary Care	0 - 2.5	0 - 2.5	35 - 40	105 - 110	678	24	721	n/a
Dr Jim Graham, Local Member Group - Clinical Lead	0	0	15 - 20	45 - 50	285	6	299	n/a

Below are the definitions for the relevant columns in the tables reported above:

(1) The remaining members of the Governing Body are not members of the NHS Superannuation scheme
(2) There were no employer contributions to stakeholder pensions
(3) An inflation factor of 2.7% has been used to calculate the real movement in pensions and pension lump sums, as advised by NHS Pensions.

Salary

The salary column contains the total of any pensionable and non-pensionable amounts paid in respect of the period the senior manager held office. Where an individual did not complete the full year, only the remuneration for the time they held office is shown. Where there has been an overlap in post both post holders are shown together with the date the post was started or vacated.

Cash Equivalent Transfer Values

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's 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 benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

On 16 March 2016, the Chancellor of the Exchequer announced a change in the Superannuation Contributions Adjusted for Past Experience (SCAPE) discount rate from 3.0% to 2.8%. This rate affects the calculation of CETV figures in this report.
Due to the lead time required to perform calculations and prepare annual reports, the CETV figures quoted in this report for members of the NHS Pension scheme are based on the previous discount rate and have not been recalculated. NHS Pensions have confirmed that they will not be reissuing figures using the new discount rate.

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 the period.

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 member of the Governing Body in the clinical commissioning group in the financial year 2015/16 was £175,000 - £180,000 (2014/15 £175,000 - £180,000), this was 3.5 times (2014/15 3.4) the median remuneration of the workforce, which was £51,266 (2014/15 £53,379).

The mid-point of the banded remuneration was £37,904 (2014/15 £39,239)

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

Off-payroll Engagements

Off-payroll engagements as of 31 March 2016, for more than £220 per day and that last longer than six months are as follows:

		Number
Number of existing engagements as of 31 March 2016		8
Of which, the number that have existed:		
	For less than one year at the time of reporting	3
	For between one and two years at the time of reporting	
	For between two and three years at the time of reporting	5
	For between three and four years at the time of reporting	
	For four or more years at the time of reporting	

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 2015 and 31 March 2016	11
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.	11
Number for whom assurance has been requested	
Of which, the number:	
for whom assurance has been received	
for whom assurance has not been received	
of engagements terminated as a result of assurance not being received	

Where an off payroll engagement is arranged through a third party organisation, the CCG would seek assurance of the correct treatment of PAYE Income Tax and National Insurance Contributions, through the terms of the contract between the CCG and the Employment Agency .

	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	3
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	22

Exit Packages

In the Year 2015-16 there were no exit payments or severance packages.

NHS
Brighton and Hove
Clinical Commissioning Group

Staff Report

Brighton and Hove CCG

Staff Report

The following report provides information about the CCG's workforce:

Senior Managers by Band

As part of this Staff report the CCG is required to publish information showing the number of staff employed in senior management. Senior management captures a wide variety of roles performing a wide range of duties with the CCG. Information regarding the management structure of the CCG is published later on in this report, but for simplicity we have published the numbers of staff employed at senior grades (8a-VSM) in the table below (information accurate at 31st March 2016 and includes two an additional 2 members of the Executive Team who are handing over to 2 new members of the Executive team):

Grade	Staff Number
VSM	4 (2)
Band 9	1
Band 8d	2
Band 8c	5
Band 8b	6
Band 8a	18

CCG Staff Numbers

The following table shows how the Clinical Commissioning Groups workforce displayed by staff number at the various levels of seniority required by the NHS Occupational Code Manual. This information is correct as of 31st March 3016.

Definition	Code	Total Male	Total Female	Staff Total
Chair and non-executive directors.	Z2E	4	1	5
Clinical Chief Officer and Executives	G0	2	4	6
Senior managers who directly report to the executive team	G0	2	9	11
Managers reporting directly to senior managers who are responsible for a significant area of work / budget	G1	3	10	13
Clerical and Administrative Staff, Line Managers, Team Leaders, Supervisors and Analysts	G2	14	67	81

Gender Distribution

In addition to the information on gender shown above the CCG is specifically required to publish the following information regarding gender distribution in accordance with the Department of Health Group Manual for Accounts (Chapter 2 CCG Appendix 1):

Position	Total Male	Total Female	Total
Governing Body	6	5	11
Senior Managers (Inc all at VSM not on the Governing Body)	2	9	11
Remaining Workforce not included above	17	77	94

Sickness Absence Data

In summary the sickness absence date for Brighton and Hove Clinical Commissioning Group is as follows. The figures are presented as calendar year figures (January to December 2015). Further details in relation the Staff Sickness Absence and employee benefits may be found in the in the employee benefits note to the financial statements:

Number of staff days lost to sickness: 991

Average absences per staff year: 6.2

Number of staff Retired on Ill health grounds: 0

Whole time equivalent Staff: 99

Total Number of Staff: 119

Staff Policies applied during the financial year

The Clinical Commissioning Group has a suite of employment policies which it keeps under reviewed regularly. The Brighton and Hove CCG maintains strong links with the Sussex CCGs and maintains a joint committee where the CCGs and the staff side representatives can keep the agreed policies under review. Brighton and Hove

CCG, along with our partners through the Joint Staff Committee are currently reviewing the all policies affecting our staff to ensure that they remain up to date.

We are proud to be accredited under the “Two Ticks” scheme. Our recruitment and selection policy states that where a person applies for a role with the CCG, who meets the essential criteria and notifies us that they have a disability, we will always offer them an interview. We will of course be happy to make any reasonable adjustment to enable the applicant to attend an interview.

In relation to staff members with disabilities, we will make all reasonable adjustments to facilitate them in their role with us. If necessary we will liaise with external professionals, such as “Access to Work” and our Occupational Health provider, who will assess the employee and make recommendations as to what adjustments can be made to assist them in the workplace.

It is the CCG’s policy to develop a personal development plan for each member of staff which is kept under review as part of the staff appraisal process. Our policy on equal opportunities is clear that we will treat staff with disabilities no less favourably if they have a disability. It is our intention to at all times comply with the Public Sector Equality Duty and meet our wider obligations under the Equality Act.

Expenditure on Consultancy

Throughout this financial year Brighton and Hove CCG has made payments for consultancy services totalling £303k. Further details can be found in note 4 of the Annual Accounts.

Exit Packages

The CCG is required to report on payments made to departing staff in respect of compulsory and non- compulsory departures. The CCG has not made any redundancies during the 2015-16 financial year. It is our policy not to agree exit payments with staff who are leaving the CCG for reasons other than compulsory redundancy

Off-payroll Engagements

Off-payroll engagements as of 31 March 2016, for more than £220 per day and that last longer than six months are as follows:

		Number
Number of existing engagements as of 31 March 2016		8
Of which, the number that have existed:		
	For less than one year at the time of reporting	3
	For between one and two years at the time of reporting	
	For between two and three years at the time of reporting	5
	For between three and four years at the time of reporting	
	For four or more years at the time of reporting	

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 2015 and 31 March 2016	11
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.	11
Number for whom assurance has been requested	
Of which, the number:	
for whom assurance has been received	
for whom assurance has not been received	
of engagements terminated as a result of assurance not being received	

Where an off payroll engagement is arranged through a third party organisation, the CCG would seek assurance of the correct treatment of PAYE Income Tax and National Insurance Contributions, through the terms of the contract between the CCG and the Employment Agency .

	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	2
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	20

Although a formal committee of the city council, the Health & Wellbeing Board has a remit which includes matters relating to the Clinical Commissioning Group (CCG), the Local Safeguarding Board for Children and Adults as well as Healthwatch. Papers come from a variety of sources. The format for Health & Wellbeing Board papers is consequently different from papers submitted to the city council for exclusive city council business.

1. Title of Paper: Monitoring Quality in Care Services

1.1. The contents of this paper can be shared with the general public.

1.2 This paper is for the Health & Wellbeing Board meeting on the:
7th June 2016

1.3 Author of the Paper and contact details

Marnie Naylor: Commissioning & Performance Manager
G31 Kings House
Email:marnie.naylor@brighton-hove.gov.uk

Ian Wilson: Clinical Quality & Patient Safety Lead CCG
Lanchester House
Brighton
Email: ian.wilson7@nhs.net

2. Summary

2.1 This paper is for information only and outlines an overview of how care services (Nursing/Care Homes, Home Care, and Supported Living) provided for vulnerable adults within the city of Brighton & Hove are quality assured (monitored) to ensure a good quality standard and safety for those that use these services.

3. Decisions, recommendations and any options

This paper is being presented for information only:

4. Relevant Information

4.1 Background information about the care sector:

Please refer to the Care Governance report *appendix three* for further background information relating to numbers of registered care home, supported living & home care providers in the city. 90% of care services for adults are purchased in the independent sector, with the remaining 10% provided by the council's directly provided services.

4.2 Issues facing the care sector

There are a number of issues that are affecting providers locally. This reflects national trends:

- The home care market in the city is fragmented, with many providers struggling to attract staff.
- Difficulties with recruitment and retention exist across the whole care sector.
- Levels of need are increasing across all client groups. People with dementia and end of life care needs are more likely to be supported at home.
- Care home places for this cohort of people are increasingly costly and difficult to secure at Local Authority rates.

4.3 Rates paid to providers

- **Care Homes:** The Health & Wellbeing Board agreed to a 2% increase in care home & home care fees from April 2016. In order to get a better understanding of the cost of care the Council and Health commissioners are working with stakeholders to construct a methodology for fee calculation for care homes. This work is currently in progress and the outcome will be known in the summer of 2016.
- **Home Care providers:** There will be a new home care contract in place from September 2016. Key to the new contract is a commitment to quality. It will be outcome focussed, and will enable the partnership working between the service users and providers. Care will be delivered more flexibly and should better fit with service user's needs. Commissioners have worked closely with stakeholders, assessment teams, users, carers and potential providers. The aim is build a well-trained and motivated workforce, paid the National Living Wage Foundation living wage. There is also a drive to minimise disruption to service users. Key to making

the service work in the longer term is the fair and robust monitoring system.

4.4 Promoting Quality in Social Care

4.4.1 Service providers have responsibility for the quality of their care services, and to ensure they meet the CQC standards of being safe, caring, responsive, effective and well led. They must effective systems in place to assure themselves of quality and drive forward improvement.
Promoting quality in care services needs to be grounded in:
Commissioning strategies and actions;
Procurement processes;
Contract documentation and management that actively promote and support the delivery of services that are of good and sustainable quality.

4.4.2 **Workforce Development:**

The Workforce Development team at Brighton & Hove City Council provide and deliver a comprehensive funded training programme to both council employed care and assessment services, and external care providers and partners across the city. The programme offers over 7,000 training places, + online learning, and access to relevant conferences (Safeguarding & ASC Showcase) and other resources to support the wider health and social care sector to deliver high quality cost effective services.

In addition, the Workforce Development team provide workforce development advice and guidance for service providers on regulation, quality issues and workforce interventions. As well as responding to developments like the recent Care Act, the team has representation at a number of strategic forums (Care Governance Board, Skills for Care, SE ADASS Workforce Group, Clinical Education Committee, Health Integration Group) and other local provider forums that help to develop policy and the wider workforce delivering adult social care across the city.

4.4.3 **Dignity in Care Group**:

A group of dedicated dignity champions identified from each care home (that have signed up to this initiative) meets on a quarterly basis. The group is self-managed 'peer' support and meets to discuss common themes, provide support for each other to maintain high standards of care and to share/promote 'good' practice. Themes discussed can lead to bespoke training requirements provided

through the workforce development team e.g. nutritional values and fluid intake for people with dementia.

4.4.4 **Forums**:

(Good News story see: appendix two) recent consultation to streamline resources, and to minimise duplication are another way for BHCC and CCG to find out who is linking in e.g. if 'end of life care' formed part of the agenda this would lead to targeted emails for care staff to link into the joint forums. BHCC and CCG will hold three joint care home forums per year and forward plan agenda items generated by ideas from providers, the forums will also be used to inform attendees of any new guidance and to share best practice locally. Other regular forums include: Home Care, Learning Disabilities and Dementia Care forums. There are also regular Dignity champion meetings chaired by registered managers of care homes.

4.4.5 **Health & Safety (Fire Safety Compliance) Role:**

The Council are responsible to ensure a good quality standard of care and safety is provided in Nursing/Care Homes, Supported Living and community support provided by Home care services across the City. The 'Quality Team' function has an excellent relationship with the Health & Safety team to ensure H&S and Fire compliance is met making recommendations where shortfalls are identified. This joined up and flexible approach enables vital intelligence to be shared to enable any risks identified to be addressed in a timely manner by offering advice, guidance and support to ensure people receiving services are kept safe.

4.5 Monitoring Quality in the care sector

Background to Quality Roles: *(see Quality flow chart **Appendix One**)*

4.5.1 Brighton and Hove City Council (**BHCC**), Clinical Commissioning Group (**CCG**), and Care Quality Commission (**CQC**) work in partnership to gather intelligence to prioritise intervention following any significant concerns about services provided to vulnerable adults living in the City.

4.5.2 **Significant concerns** may arise from CQC inspections resulting in 'requires improvement' or 'inadequate' for key areas e.g. are services safe, well-led, caring, responsive and effective? There is a joint emphasis to support providers to improve by offering support and advice through the quality assurance role. This could include clinical advice and improvement to support Care Homes e.g. links to

various services 'SALT' (speech and language team), falls prevention, end of life care, support regarding medication issues, bespoke training for autism awareness etc.

4.5.3 **Following information gathered** from a variety of sources including any safeguarding concerns, complaints, intelligence gathering from the CCG's Continuing Health Care Team (CHC) commissioning packages of care and CQC inspections outcomes etc. a joint or individual quality assurance visit would take place (BHCC or/and CCG staff). These visits would be either planned or unplanned balancing the risks and how responsive these need to be met.

4.5.4 **Quality assurance visits** may in turn feed into the intelligence to bring forward or put back regulated inspections to be carried out by CQC, and vice a versa, CQC outcomes may bring forward more focussed visits for BHCC and/or CCG to carry out.

4.5.5 **Service Improvement**: both BHCC and CCG work closely together to risk rate quality of all provider services. BHCC uses a red, amber, green system. Meetings are held monthly to discuss services of high concern and may result in a professionals meeting taking place. This meeting would include various health and social care professionals, and the 'registered' provider manager and other key staff to devise supportive action plans to make improvements to services in a reasonable time frame. Training may be a key area in supporting some areas of improvement and this would be factored into the action plans, working closely with workforce development. CCG staff are working with partner agencies on developing the Care Certificate for unregistered care staff, to enable staff to recognise when they need to refer clients and seek advice and support from more specialist community services when needed e.g. specialist respiratory nurses, wound care services etc. to enable ongoing support to individuals in a home or other community setting.

On rare occasions services may need to be suspended (during suspension services are not permitted to take any further residents, provide home care packages etc. if they are suspended) due to extremely high risks/concerns e.g. an overall 'inadequate' CQC rating or complex significant safeguarding issues resulting in staff suspensions, police investigations etc. Extra support is given to enable suspensions to be lifted as swiftly and safely as possible. Without this joined up offer of support, advice and guidance services could potentially leave the market.

4.5.6 **Communication between organisations**: BHCC, CCG and CQC meet on a regular basis with planned meetings held at least quarterly, additional regular planned and unplanned telephone conferences

are also arranged to discuss any concerns or general updates or emerging issues of concern on a more ad-hoc basis.

4.5.7 **Home closures last six months:** There has been one learning disability home that has left the market in the past six months; all seven individuals were placed successfully in alternative services including supported living in the local community.

4.5.8 **Care Governance:** *(Care Governance report* ***see Appendix Three*** *example of Quarterly Report)* All information gathered each quarter by BHCC 'Quality' function is summarised in a quarterly report for the Care Governance Board, chaired by the Director of Adult Social Care and attended by key Managers including the Lead Nurse, Director of Clinical Quality and Patient Safety at the CCG.

4.6 Gathering the views of service users:

4.6.1 Healthwatch and Impetus volunteer visits:

Healthwatch Brighton & Hove CIC is a registered Community Interest Company. The role of Healthwatch CIC is a health and social care watch dog run by and for local people. It is independent of the NHS and Brighton and Hove City Council. Some volunteers work across both Healthwatch and Impetus (voluntary organisation).

Each month Impetus and Healthwatch have volunteers (lay assessors) that visit a selection of Home Care Providers and care Homes. Healthwatch undertake 'enter and view' visits to selected care Homes identified by the BHCC Quality Team. The purpose of these visits is to gain a 'service user' perspective on the services provided.

Both BHCC and CCG meet on a regular basis with Healthwatch to inform the programme of work 'enter and view' visits.

Impetus visit a number of 'service users' each month in receipt of Home care packages. Outcomes of these reports are shared with the relevant provider and the BHCC Quality Team.

This information helps inform the 'Quality Team' determine whether a broader focussed quality audit is required by the 'Quality Team' e.g. monitoring of staff training records or focussing on medication recording etc.

5. Important considerations and implications

There are a number of formal requirements of papers coming to the Health and Wellbeing Board. You need to consider any important legal, financial, equalities, sustainability, health, public health, social care and children's services implications. You will have to consult officers in the council to complete any relevant section. State who you consulted, when and summarise what advice was given.

Legal: 5.

5.1 It is a function of the Health and Wellbeing Board to monitor and oversee adult health and social provision in the City. The Care Act 2014 requires the Local Authority and Health partners to work in partnership in ensuring the care and support needs of the people in the city are met. The Care Act 2014 also requires the Local Authority to both shape and have market oversight of provision in the City to ensure care and support needs of the local populace can be met.

Lawyer consulted: Sandra O'Brien Date: 4 May 2016

Finance:

5.2
There are no financial implications as a direct result of the recommendations of this report, however, any plans or new initiatives for service improvements should be rigorously appraised to ensure the best value for money for service delivery is achieved.

Finance Officer consulted: David Ellis Date: 26th April 2016

Equalities: N/A

5.3

Consider and address any equalities implications. This section should be completed and approved with relevant equalities officer support.

Sustainability: N/A

5.4

Consider and address any sustainability implications. This section should be completed and approved with relevant sustainability officer support.

Health, social care, children's services and public health: N/A

5.5

Unless already covered within the paper, address any health, social care, children's or public health implications, including the impact on established services in the city. This section should be completed and approved with support from the CCG and the Council's Public Health Directorate.

6. Supporting documents and information

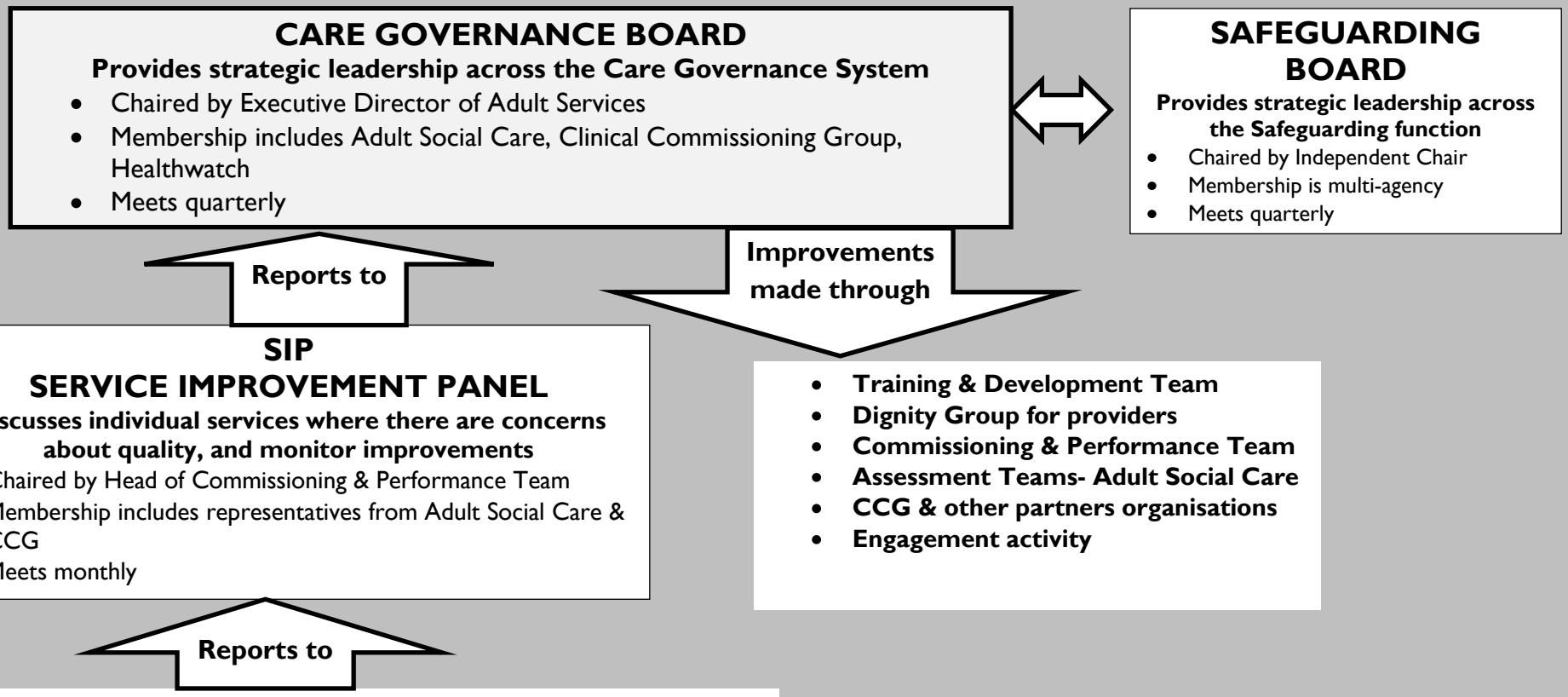
Appendix one: Care Governance flow chart
Appendix Two: Good news story Care-Home Dementia outreach Team (CHIRT)
Appendix Three: Care Governance Report
Include any relevant information that you want the Health and Wellbeing Board to read. If you have considerable further information that you want the Board to be aware of, but not necessarily read, you can also deposit information with the lead officer for the Health and Wellbeing Board (Barbara Deacon) who will make it available for the Health and Wellbeing Board.

6.1

Appendix one

Care Governance Flow Chart

Adult Social Care services, including independent sector and Council run services (March 2016)



- **Gather all intelligence regarding the safety and quality of services**
- **Undertake robust and proportionate monitoring of service quality through audits**
- **Undertake timely and effective intervention where service quality is failing**
- **Support providers in service improvements**
- **Complete quarterly compact reviews (in-house provider services lead)**
- **Carry out Desk top reviews**

Appendix two: Forums Dementia Care-Home in Reach Team Good news stories

Provided by Rachael Jeacock: Occupational Therapist Sussex partnership Trust B&H Dementia Care-Home in Reach Team

The Brighton and Hove Dementia Care Home in Reach team (CHIRT) work in partnership with care homes, the care staff and residents' families to promote quality of life and meaningful occupation for the residents with a dementia. As part of a bespoke action plan with each home CHIRT develop evidence based psycho-social interventions. Below are some examples of best practise within the care homes following CHIRT involvement:

- **The environment:**

Homes are recognising the importance of developing dementia friendly resources and the CHIRT assess and advise the homes with recommendations such as clear signage, contrasting colours, lighting, orientation boards, visual timetables and menus which all help residents to maintain their independence and orientation for as long as possible.

- **Meaningful occupation:**

CHIRT advise and promote the importance of 24 hour meaningful occupation and activity for residents with dementia. Homes are employing activity workers who are working collaboratively with the carers and offering activities throughout the day and evening. This can be individual short meaningful interventions focusing on the residents' sensory choices and /or group activities. Homes are feeding back that by offering meaningful occupation their residents are less agitated, are sleeping better and are more engaged. CHIRT promote best practise with the activity workers by running a bi-monthly Activity Workers Forum which enables the members to develop their confidence and their skills.

- **Dementia friendly resources:**

CHIRT promote best practise initiatives such as Doll Therapy, personalised music choices using headphones, Reminisce Therapy and rummage boxes, encouraging residents to do every day activities.

- **Appropriate use of medication in Dementia:**

CHIRT have promoted appropriate use of medication in dementia. They have completed over 120 medication reviews which have resulted in the stopping of anti-psychotic medication which in turn homes have reported an increase in residents' positive well-being. They report residents are more alert, are eating and drinking better, a reduction in falls and more socially engaged.

Quality Monitoring Report
Care Governance Board

Reporting period (01 January- March-31st 2016)

Q1	Q2	Q3	Q4

Adult Social Care

Commissioning and Performance Team

Marnie Naylor: Quality Lead
Jess Harper: Engagement Lead

Introduction

This report provides the Care Governance Board with an overview of quality monitoring activity carried out within the Commissioning & Performance Team (**CPT**) and to report on joint working with Clinical Commissioning Group (**CCG**) /Care Quality Commission (**CQC**). The report highlights the key quality themes identified in the care market and to give feedback on how these are being addressed

The report is in nine sections:

Section: 1. to report on the total number of places/services contracted (including Council run services)

Section: 2. to report on Key quality themes identified from the quality monitoring reports (including Safeguarding) and how these are being addressed

Section: 3. to report on quality monitoring visits undertaken during each quarter

Section: 4. to give an overview of service user feedback

Section: 5. to report on the health and safety audits undertaken by the Lead Health and Safety Business partner

Section: 6. to state the number and type of services currently suspended

Section: 7. to report on the current monitoring activity of the Service Improvement Panel (SIP)

Section: 8. to update on other key themes and general activity

Section: 9. to update on CQC inspection methodology each quarter (**Q4** also end of year breakdown)

Appendix: 1. In-House Services summary of Activity

Glossary of Terms	
CCG	Clinical Commissioning Group
CQC	Care Quality Commission
LD	Learning Disability
ABI	Acquired Brain Injury
PD	Physical Disability
VFM	Value for Money
CPT	Commissioning & Performance Team
H&S	Health & Safety
BHCC	Brighton and Hove City Council
DoLs	Deprivation of Liberty Safeguarding

Section: 1. Current total numbers of places/services contracted including Council provided Care Home, Home Care, Supported Living and Community Support Services.

Table one: Contracted services

Service Type	Q1	Q2	Q3	Q4	Reason for reduction
Independent sector Care homes	106	106	106	106	
Council run Care Homes	8	8	8	8	
Independent sector Home Care Providers on Framework Contract	12	10	10	10	De-registration x2(Q2)
Independent sector Home Care Approved Back up Providers	6	6	6	6	
Council run Home Care Providers	1	1	1	1	
Independent sector Supported Living	20	20	20	19	X1 de-registered Jan 2016 (Q4)
Council run Supported Living	6	6	6	6	
Independent Sector Community Support	18	18	18	18	
Council run Community Support	1	1	1	1	
Total	**178**	**176**	**176**	**175**	

Update on Care Market:
X 1 Care Home for people with a Learning Disability has left the market deregistration took place 04.02.2016,

Section: 2. Key quality themes identified from the quality monitoring reports including safeguarding

2.1: Quality Improvement Themes Q4 overview

There were a number of key themes identified during the auditing process for Q4 these are highlighted in *table three*:

Recruitment: In-House services: recruitment records not held on site except for one service. Currently Human Resources hold these. The Quality Compliance Manager for these services is looking into this for future arrangements for each service to hold records.

Training Non Attendance: In-House services: This quarter has seen a high level of staff not attending training sessions that have been pre-booked. Learning Disability Services a total of 18 staff did not attend over a period of 12 months in training areas that had been highlighted as required. The Quality Compliance Manager for these services is investigating this further.

Services without Registered Managers: There are a number of services this quarter that do not have registered managers or managers have indicated they are leaving or have left. The Commissioning & Performance team are not always made aware of this, and sometimes this is not known until a visit is required or soft intelligence gathered. Further work required to look at quarterly reporting working closely with **CQC** for data.

Professionals Meetings to address quality issues: This quarter (Q4) three 'professionals' meetings have taken place broken down as follows: x1 for Learning Disability (L.D) service not on the contract framework, due to five safeguarding issues being raised in one week; a separate safeguarding meeting also took place. Two separate professionals meetings have taken place to date (Q4) for a service for people with Acquired Brain Injury (ABI specialist service) following major concerns from a quality assurance audit including a significant high number of safeguarding issues.

2.2 Safeguarding (Section 42 enquiries) and Impact of the Care Act:

The Care Act places duty on local authorities to make enquiries, or cause other agencies, such as NHS Trusts to do so, to establish whether action is needed to prevent abuse, harm, neglect, or self-neglect to an adult at risk of harm. The objectives of an enquiry into abuse or neglect are to:

- Establish facts
- Ascertain the adult's views and wishes
- Assess the needs of the adult for protection, support and redress and how they might be met
- Protect from the abuse and neglect, in accordance with the wishes of the adult
- Make decisions as to what follow-up action should be taken with regard to the person or organisation responsible for the abuse or neglect
- Enable the adult to achieve resolution and recovery.

The local authority retains the responsibility for overseeing the enquiry and ensuring that any investigation satisfies its duty under section 42 to decide what action (if any) is necessary to help and protect the adult, and to ensure that such action is taken when necessary.

The Commissioning & Performance Team (CPT) continues to monitor the impact of 'issues relating to quality' no longer being dealt with under Section 42 safeguarding enquiries. Members of the Team took part in two safeguarding multidisciplinary meetings: x1 for a Care Home for people with a Learning Disability due to a high level of safeguarding issues identified, and a further safeguarding meeting took place following poor practice reported during staff training (whistleblowing) at a Care Home (without nursing) supporting Learning Disabilities, Physical Disabilities and Sensory impairment.

Table two: number of issues of concern leading to section 42 enquiries

Category	**No of Issues of Concern Logged**	**No of issues that became section 42 enquiries**	**No remained logged as issues of concern only**	**Unknown**	Notes
Nursing Homes	**9**	**9**	**0**		***x5 raised for 1 individual x4 separate individuals
Care Homes	**5**	**3**			
Day Service	**0**	**0**	**0**		
Community Support	**0**	**0**	**0**		
Supported Living	**4**	**4**			All for one service
Homecare	**15**	**12**			x4 for one service
Total					

*****Nursing Home x Five alerts received all dated 25/01/2016, regarding the same perpetrator and inappropriate behaviour. Protective measure was put into place and the perpetrator is in the process of being moved to a more secure setting.*

A meeting took place in February between, Commissioning & Performance Team, Head of Safeguarding and the quality lead in Assessment services to discuss how to improve the pathway and communication between teams. It was recognised in the meeting that there had been some improvement in the quality of information coming into the Commissioning & Performance Team since earlier communications late last year. However, there are still gaps in the information that the Commissioning & Performance Team receive in relation to safeguarding activity. Agreed future actions to tackle this are (i) for the Commissioning & Performance Team to continue to communicate clearly the level of information the team needs and the route to share this at all opportunities (ii) to utilise the 'Practise Development' meetings that the Head of Safeguarding facilities with her team of senior social workers to embed the message (iii) to explore how client systems development can support business processes (iv) to undertake some spot checks to demonstrate where there are gaps to help identify patterns.

Table three: Key themes from Section 42 enquiries and quality monitoring visits (Q4)

Key themes (recurrent :previous report/s)	**New themes(Q4)**
Duty of candour	Supervisions: not always consistently carried out or recorded in some services
Care Plans do not consistently reflect people's diverse needs or consider equality such as: Religious beliefs/ sexual orientation etc. Possibly a problem around equality monitoring	Notifications to CQC: DoLS (deprivation of liberty safeguarding) and Safeguarding not always being highlighted to CQC or Safeguarding to the 'Quality Team' Function. DoLs not being correlated to ascertain intelligence within the Local Authority e.g. how many raised at any one particular Care Home, or no DoLS authorisations being raised etc.
Medication Errors, on-going issues including medications procedures not always being adhered too	Training: Non-attendance high for In-House learning Disability Services.
Recording of controlled drugs	Impact on minimum wage changes taking effect from 01 April 2016 (need to keep a close eye on this, and future U.K living wage changes Sep 2016)
Evidencing of quality assurance both by the care home and by the organisation which runs/owns the care home	Food and Fluid monitoring: not always being recorded consistently, Registered mangers requesting more input re Nutrition and Hydration training (common theme CQC inspections)
Value For Money (VFM) e.g. contracts for L.D and Home Care services not always delivering what they should be	Registered managers: Not always made aware registered manager has left or leaving Information exchange not always taking place in handover, so knowledge lost
Behavioural Support Plans (Learning Disability)	Care Quality Assurance in residential settings. CQC reports do not always provide evidence of this. Particular risk for standalone homes.
Staffing levels in particular not using the dependency profile to calculate levels e.g. completing hours required for care needs.	Whistleblowing activity has increased-mainly reported during training sessions provided by council.
Mandatory training- gaps	

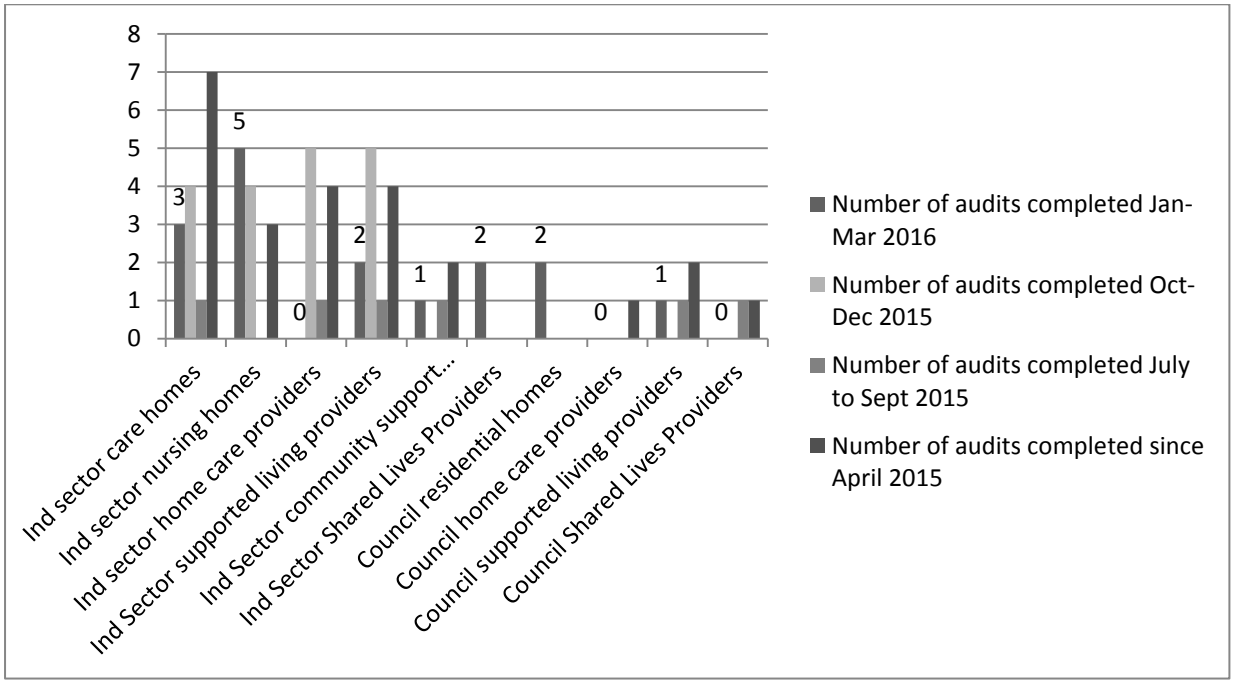
As a result of some of the issues highlighted in *table three* providers have been requested to provide robust action plans to rectify these issues. The Commissioning & Performance Team (**CPT**) will also consider review visits where required with set timeframes as agreed during the feedback report or subsequent 'professionals' meetings taking place if services continue to fail in these areas, are seen (and rated) to be high risk, or receive inadequate CQC ratings. Where the issue is deemed to be a training shortfall this will be shared with workforce development or for services to give **CPT** reassurance that their own internal training mechanism is fit for purpose and utilised appropriately and all training is recorded using the training matrix. Clinical Commissioning Group (CCG) colleagues have supported services where clinical issues have been highlighted and arranged clinical input/support. Additional/separate action plans may be recorded for this purpose. Some other areas may require on-going monitoring form the 'quality' function e.g. poor or non-attendance to training sessions etc.

Recent Whistle blowing raised during a training session was addressed through a multidisciplinary safeguarding meeting. A further professionals meeting took place 13.04.2016.

Section: 3.Number of quality monitoring visits undertaken by the Commissioning and Performance Team between: 01 January -31st March 2016 Total including reviews and joint visits with CCG:

3.1 Number of quality monitoring visits undertaken by the Commissioning & Performance Team between Jan-Mar (Q4) Oct-Dec (Q3), July -September (Q2) and April-June (Q1)

Table four: Quality monitoring visits undertaken



3.2 Breakdown of visits and activity Q4 (Jan-Mar 2016):

Table five: Overall Activity of the Adult Social Care Monitoring Team Q4

Activity	N0.	Reasons
Focussed Audits	7	Part of annual audit cycle/CQC concerns/issues raised through soft intelligence/other
Contract Reviews	2	Contract review audit cycle
Joint Audits (CCG)	4	Nursing Homes CQC concerns re quality
Singular visits	0	
Desk Top Reviews	0	New system still in progress to commence Q1 (April 2016)
Meet & Greet	5	New Manager started, part of induction for team member
Health & Safety	2	CQC /other priorities (3rd visit postponed due to register manager moving to April).
Review Meeting	1	Follow up monitoring from previous audit/concerns raised about the quality of service
Professionals Meeting	4	X1 L.D non contracted service multiple safeguarding issues. X1 L.D contracted service multiple safeguarding issues. x2 ABI/PD following CQC inspection and quality audit visit
Safeguarding (multidisciplinary)	2	Multiple safeguarding and whistle blowing
Suspensions	2	x1 ABI/PD Community Support Services x1 ABI/PD Care Home
Other: Services serving notice	1	X1 Learning Disability Service supported living due to close April 2016

Section: 4. Sources of service user feedback on the services they are receiving

Healthwatch: The focus of the Enter and View visits this time round has been to evaluate the access to primary care in-reach for people living in local residential services. 5 visits have been completed. The reports for these visits have not been completed to date; this work has been delayed whilst Healthwatch have undergone a staffing re-structure. Healthwatch have recently appointed a new Chief Executive- David Lilley & Evidence and Insight Manager- Dr Roland Marden. We are hoping to be in a position to report on the themes linked to this work by next Care governance board in June.

Impetus Lay Assessors Scheme: Each month Impetus continue to interview a selection of service users from one of the home care providers on the framework contract. Outcomes of those reports are then shared with the relevant provider via the quality team. This quarter Impetus has interviewed 94 people in receipt of care from 5 care providers. The feedback in relation to care quality is reported to be largely good; however there are variations between providers in relation to timeliness, continuity of care and the level of support & communication provided by office staff. These variants are discussed with providers individually as part of monitoring processes.

Section: 5. Number of Health and Safety audits undertaken by the lead Health and Safety Business Partner

A total of **2 H& S audits** were carried out (Q4) between 1st January-31st March 2016. A third visit was planned but postponed by the manager of the service until April. One was undertaken for a Nursing Home, the other for ABI/PD service. A meeting was held on 13th January to update the service level agreement between H&S business partners and the Quality Team, to include prioritising visits from Q1 (April 2016) on-wards. A new system has now been set up to prioritise between 4-6 visits each quarter to be identified by the 'quality' team. These visits will be prioritised through use of gathering soft intelligence and CQC inspections results.

Section: 6. Number of services which are currently suspended because of quality concerns

There are currently two services suspended

- X1 Care Home ABI/PD following Quality Assurance Audit January 2016
- X1 Specialist Community Service ABI/PD following inadequate CQC inspection rating

One Nursing Home had their suspension lifted 16.03.2016 following progress re actions relating to 'inadequate' inspection rating.

Section: 7. Providers currently being actively monitored through the Service Improvement Panel (SIP)

Since 01 January 2016 SIP has monitored **16** separate services, comprising **six** nursing homes, **four** domiciliary community support providers, **five** supported living providers Learning Disabilities and **one** specialist service for Acquired Brain Injury. This was a slight decrease of one from the previous quarter period Q3. These were 16 separate services being monitored. Through monthly scrutiny during the SIP meeting, the new quarter starts with eight services that are being closely monitored.

One L.D supported living services remains on SIP due to serving notice to close; this service will remain on SIP until closure: date to be confirmed.

The reasons that the **16** services were included on SIP are as follows in *table six* with multiple reasons applying to some services:

Table six: SIP inclusions

Type of Service	Reasons for inclusion in SIP				
	Poor CQC rating	Concerns raised by service users/family or visitor	Concerns identified following an audit	Safeguarding concerns	Miscellaneous Reasons*

Nursing Homes	**√√**	**√**	**√**	**√√**	
Care Homes					
Supported Living	**√√**		**√**	**√**	**√**
Community Domiciliary Support		**√**		**√√√**	

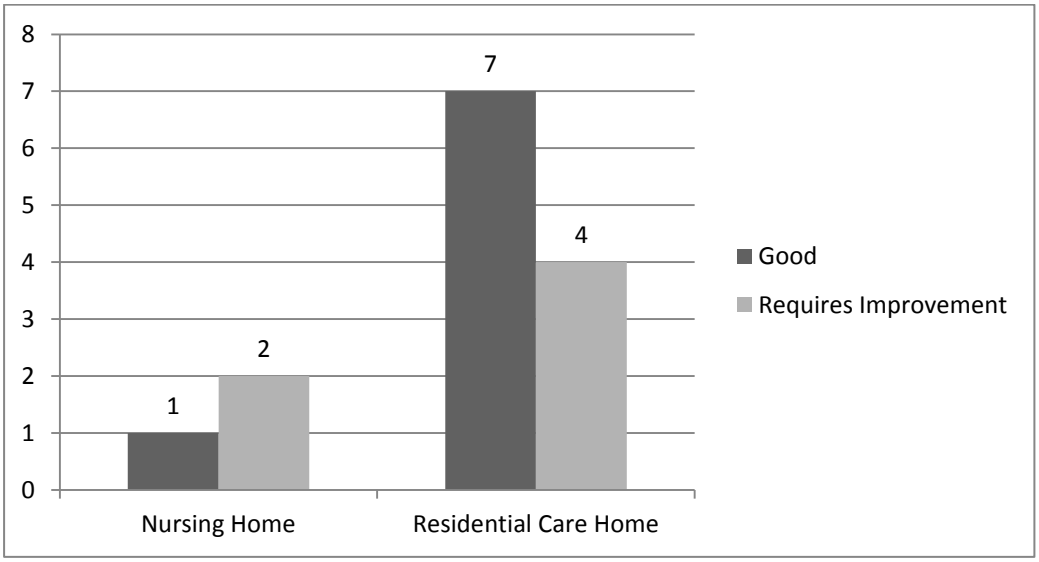
*****Miscellaneous reasons included whistleblowing concerns raised during a member of staff during a training session.

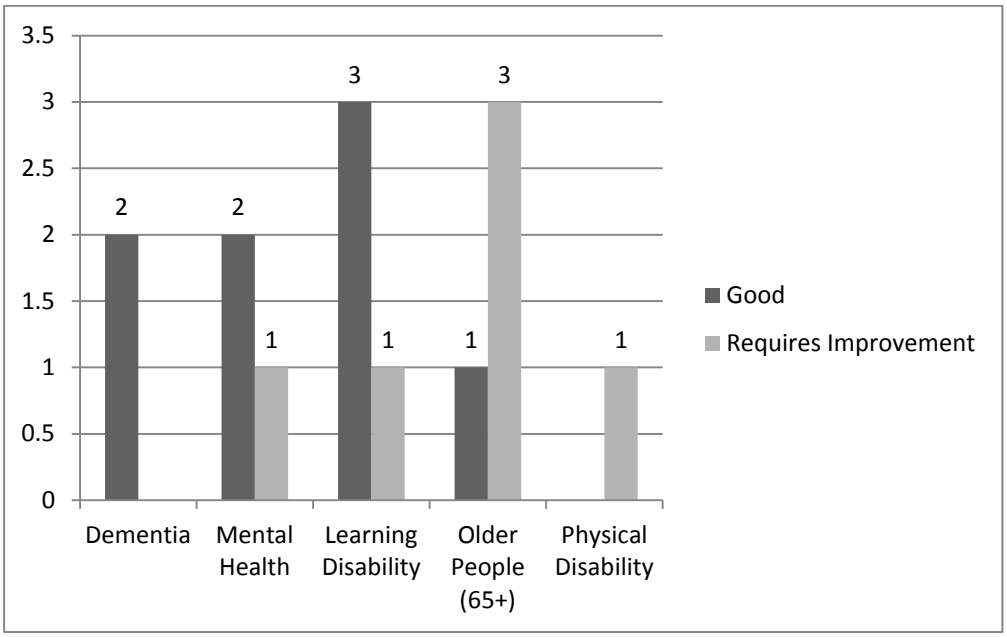
Section: 8. Other Key current issues and activity supported by the quality team function and how these are being addressed

Issues identified	Action in place to address issues	Further actions identified	Comments
Provider Forums	Following a review of the forums, it was decided that the Nursing Home Forum (Lead by CCG) and the Care Home Forum (Lead by BHCC) will be merging to form one meeting. The membership will be open to care homes and nursing homes and three meetings will be scheduled per year; May, September and January. The first meeting will take place on 5th May. The aim is to link the two forums together to identify training needs and share information.		
Desk Top Reviews	The template for the new desk top review process is already in use. A Commissioning & Support Officer will take overall lead to monitor and ensure at least six are completed on a monthly basis. These will also help form future intelligence and prioritising of visits. The desk top review process can be used across all service types.		
Quality Team new Role following re-structure	Quality Team members have attended key meetings since the new year to promote the role of the team; this included the Adult Social Care Management Team meeting, the Community Learning Disability Team and the Mental Health team meetings in the New Year to explain their role and responsibilities in the new structure. This will include how the quality team can help other teams when identifying quality issues etc.		
Safeguarding	Please see update on page 4		

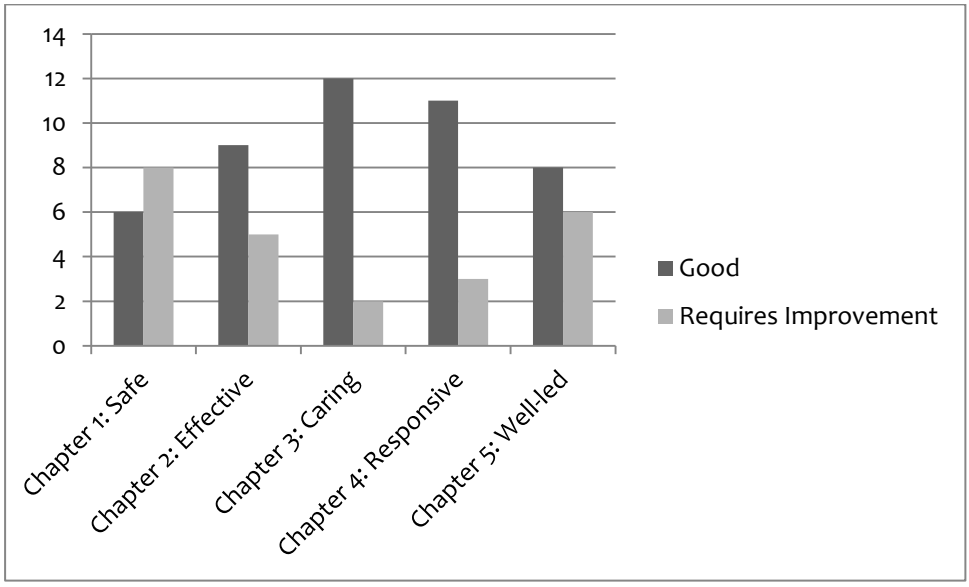
Section: 9. CQC Inspections in Brighton & Hove: Inspection Activity October-December 2015

Fundamental Standards overall CQC inspection activity summary Q4



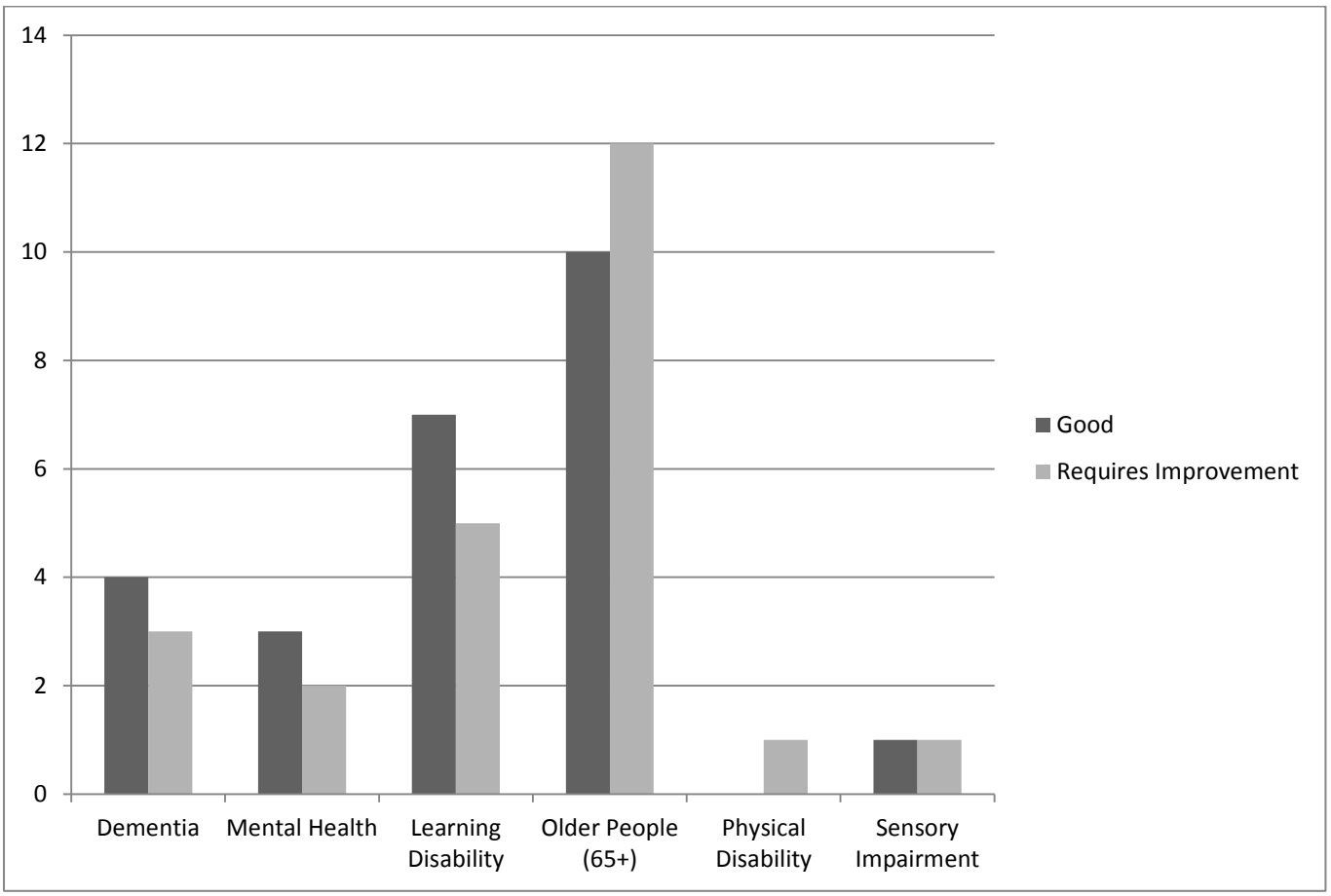


Row Labels	Good	Requires Improvement	Grand Total
Dementia	2		2
Mental Health	2	1	3
Learning Disability	3	1	4
Older People (65+)	1	3	4
Physical Disability		1	1
Grand Total	8	6	14



Overall activity 01 April 2015-31 March 2016 CQC inspections carried out

During the past four quarters a total of 49 CQC inspections were carried out. Overall ratings 25 Good and 24 requires improvement. There were no Outstanding or Inadequate outcomes.



Count of Overall Rating	Column Labels		
Row Labels	**Good**	**Requires Improvement**	**Grand Total**
Dementia	**4**	**3**	**7**
Mental Health	**3**	**2**	**5**
Learning Disability	**7**	**5**	**12**
Older People (65+)	**10**	**12**	**22**
Physical Disability		**1**	**1**
Sensory Impairment	**1**	**1**	**2**
Grand Total	**25**	**24**	**49**

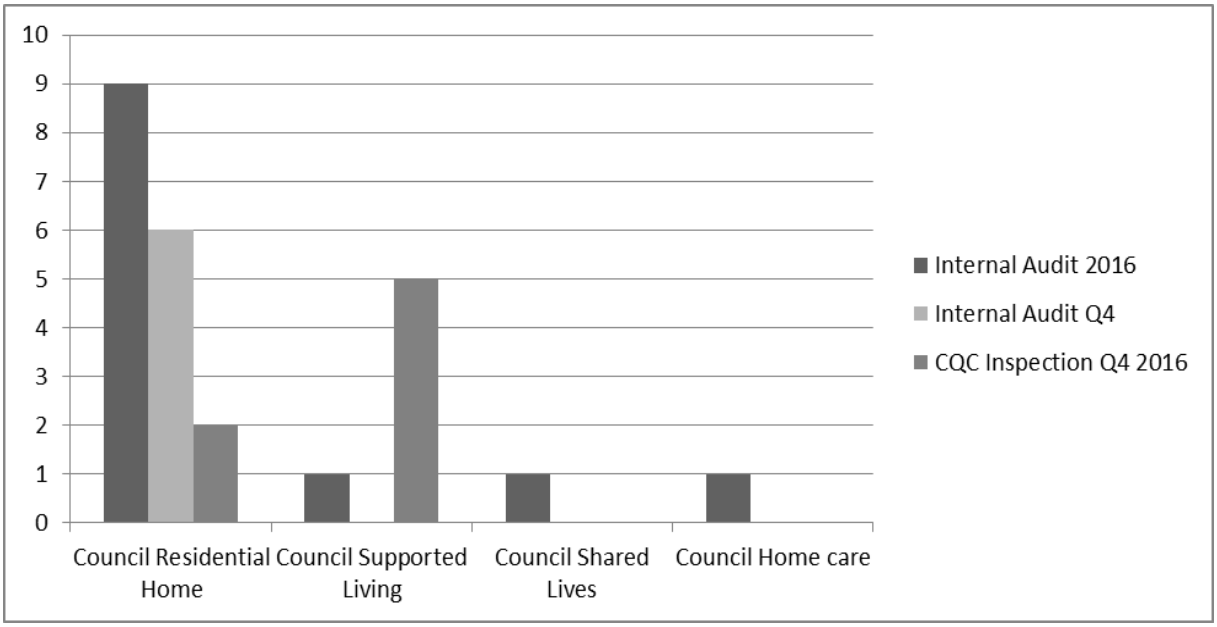
Appendix one:

Summary: In-house services quality period Q4

Care Governance report

Summary in-house services

The below table shows the number of quality monitoring audits undertaken by the Quality, Compliance and Performance Manager between January and March 2016, total number of audit visits undertaken between April 2015 and April 2016 and the total number of Care Quality Commission (CQC) inspections undertaken between January and March.



CQC inspection updates with outcomes

7 Published CQC Inspection reports between January and March 2016.

5 services within Learning Disability Service rated as Good.

1 Short Term Mental Health service rated as Good.

1 Community Short Term Service rated as Requires Improvement.

Monitoring visits by Quality, Compliance and Performance Manager

There have been 6 quality assurance audits completed between January and March 2016.

2 full audits occurred as follow up action to CQC inspections to ensure actions identified as requiring improvement have been completed.

2 spot check visits to audit recruitment records and training records.

2 full audits of Learning Disability residential care homes.

Quality improvement themes identified between January and March 2016:

- Non-attendance to training courses- 14.5% of all training courses booked non-attended amounting to a total of 292 courses.
- Essential training not renewed within identified timeframes required by Brighton and Hove City Council (BHCC).
- Recruitment details for some staff required by CQC not held at service location.
- Supervision frequency not meeting timescales required by BHCC.

Any other issues of concern and key activity

Increase in medication errors – 14 errors in January, 26 February (March statistics unavailable at time of report).

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