NHS
Brighton and Hove
Clinical Commissioning Group

Annual Report

Brighton and Hove CCG

NHS
Brighton and Hove
Clinical Commissioning Group

Contents

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

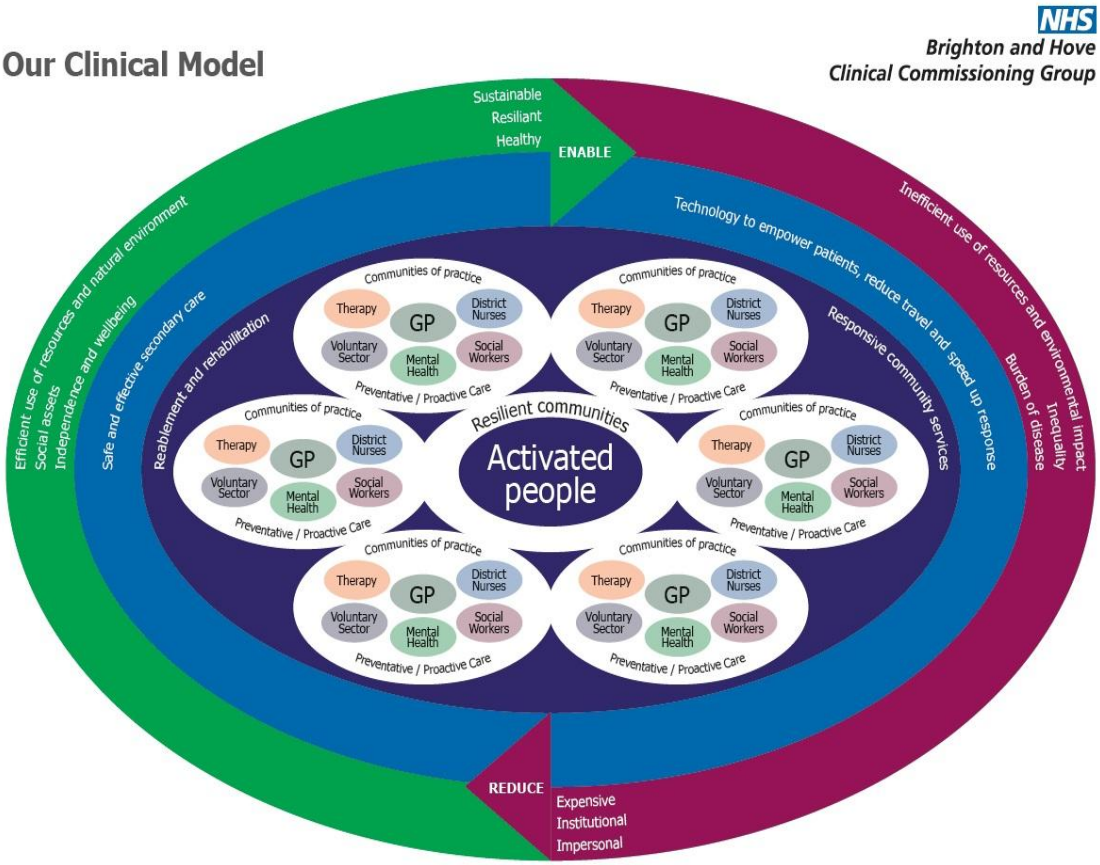
Abiding by the principles of good governance, accountability and service delivery the CCG organisational direction is determined by the organisational strategic objectives. These are agreed by our clinical leadership and ratified by the CCG Governing Body. The organisational strategic objectives are 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.

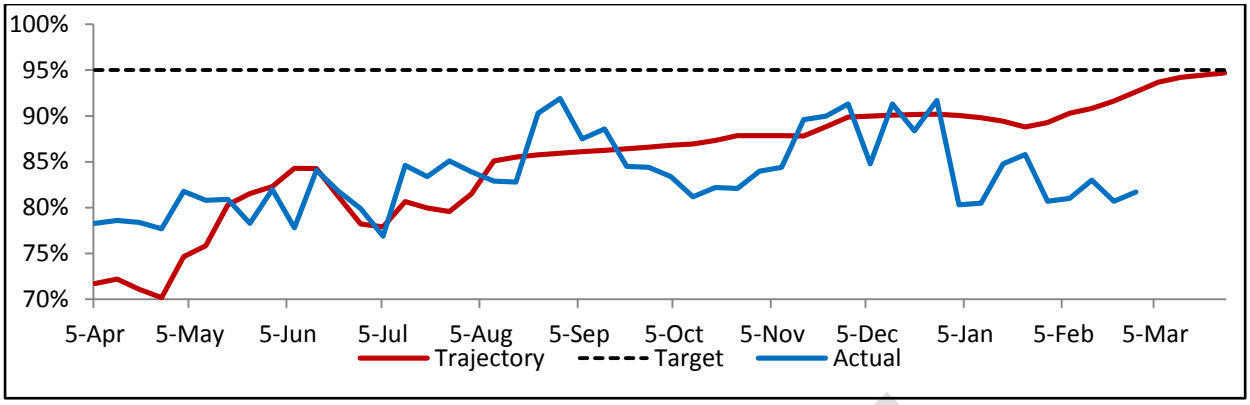
We are committed to meeting the obligations and expectations placed upon the CCG by the NHS Constitution. We will also do all we can to promote patient rights, address concerns where these are brought to our attention, and support our providers in doing the same.

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.

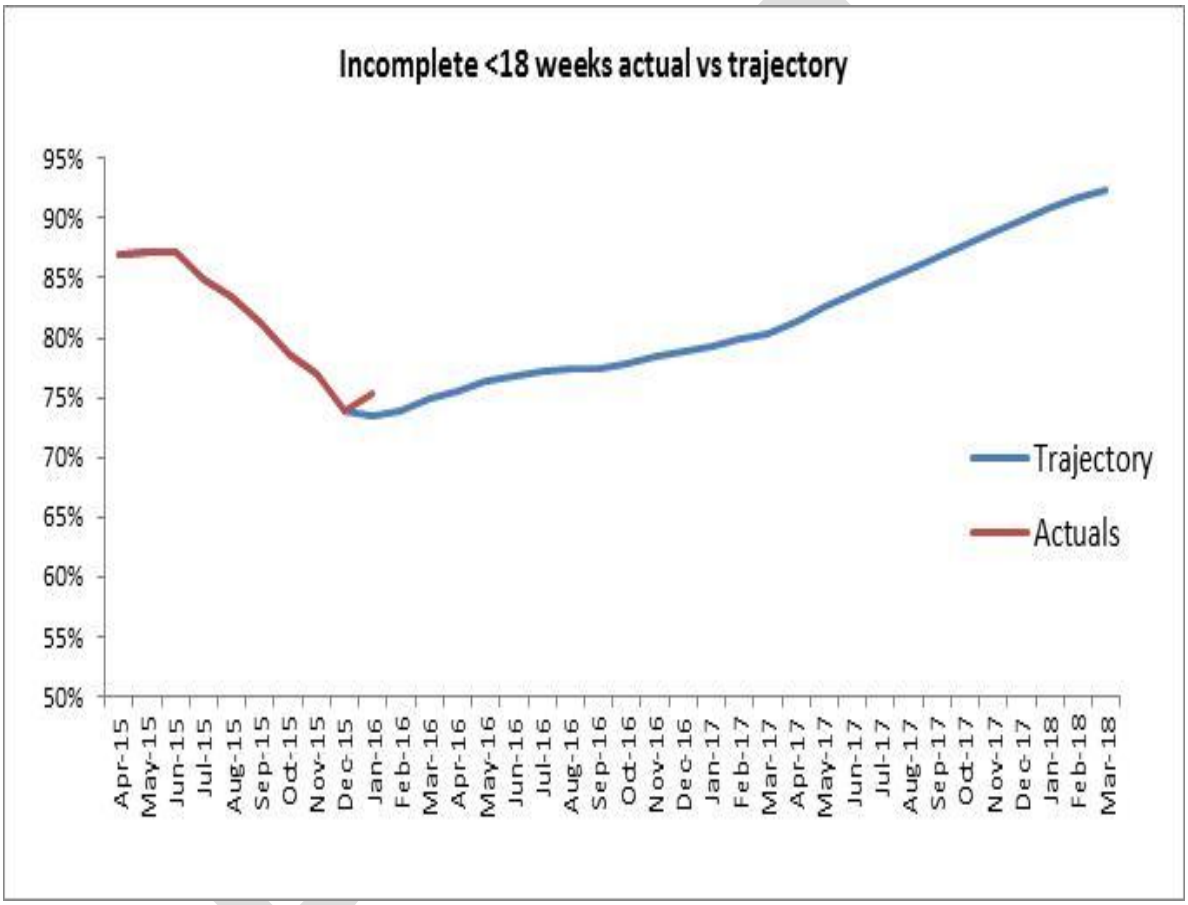
The partners in the local health and care system have worked together to develop plans for improvements in the 4-hour performance which aim to deliver a stable, sustainable basis for delivery of 95%. The plan has been initiated and improvements are starting to be realised. The plan architecture includes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

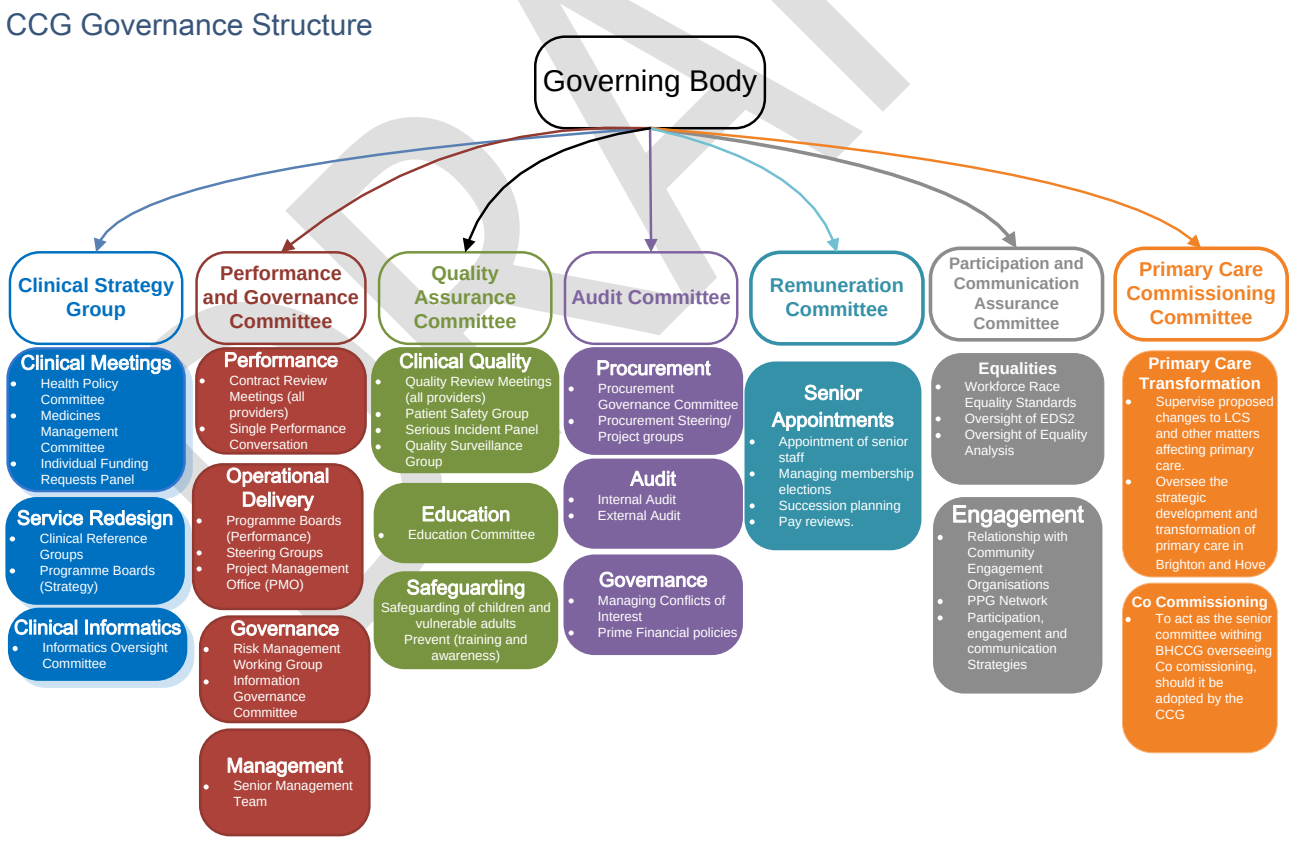
The initial terms of the CCG's two independent clinical members came to an end in September 2015. The CCG's remuneration and nominations committee was very pleased to reinstate the post holders for a further term of 3 years.

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

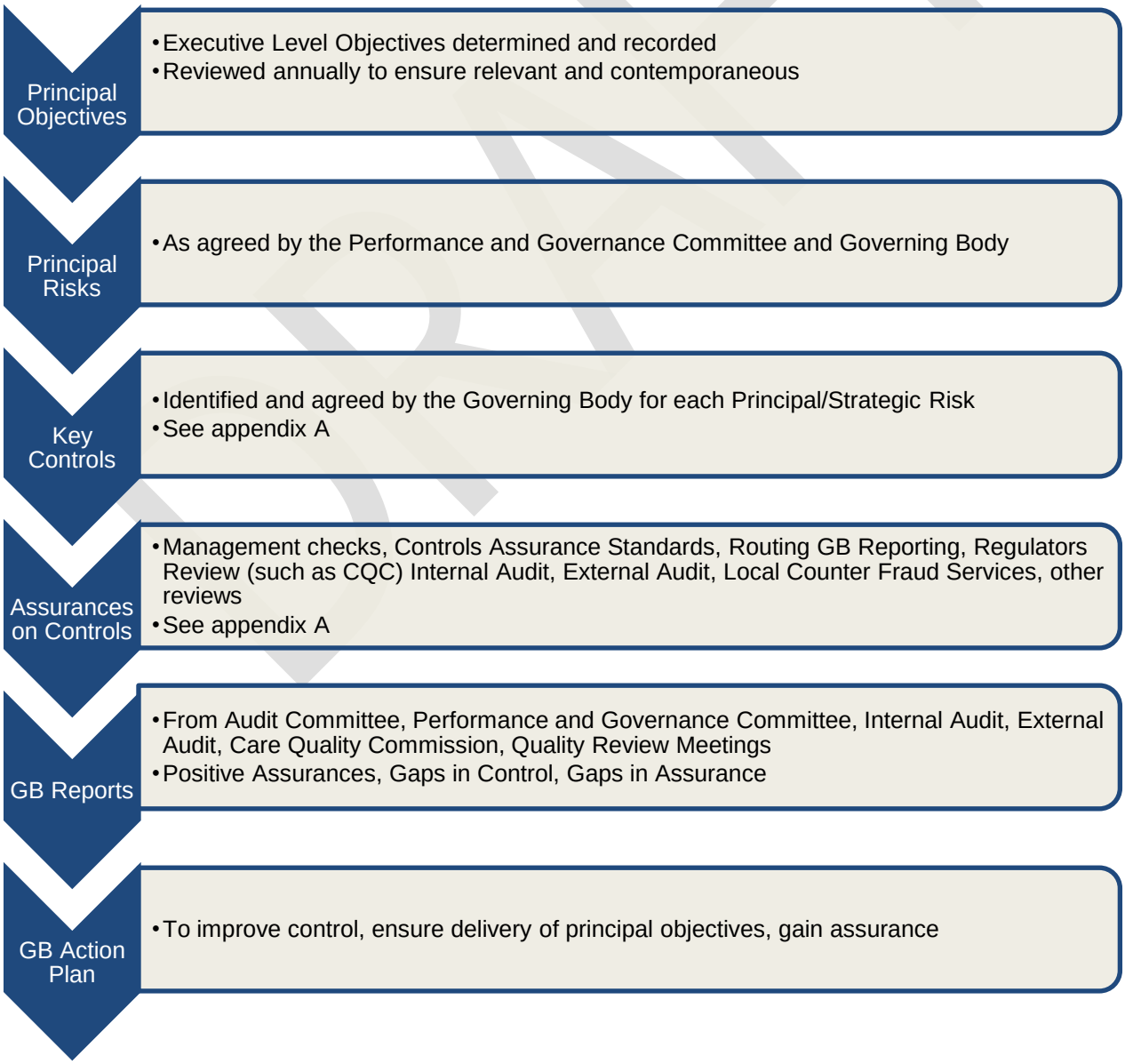
The Clinical Commissioning Group Risk Management Framework

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.

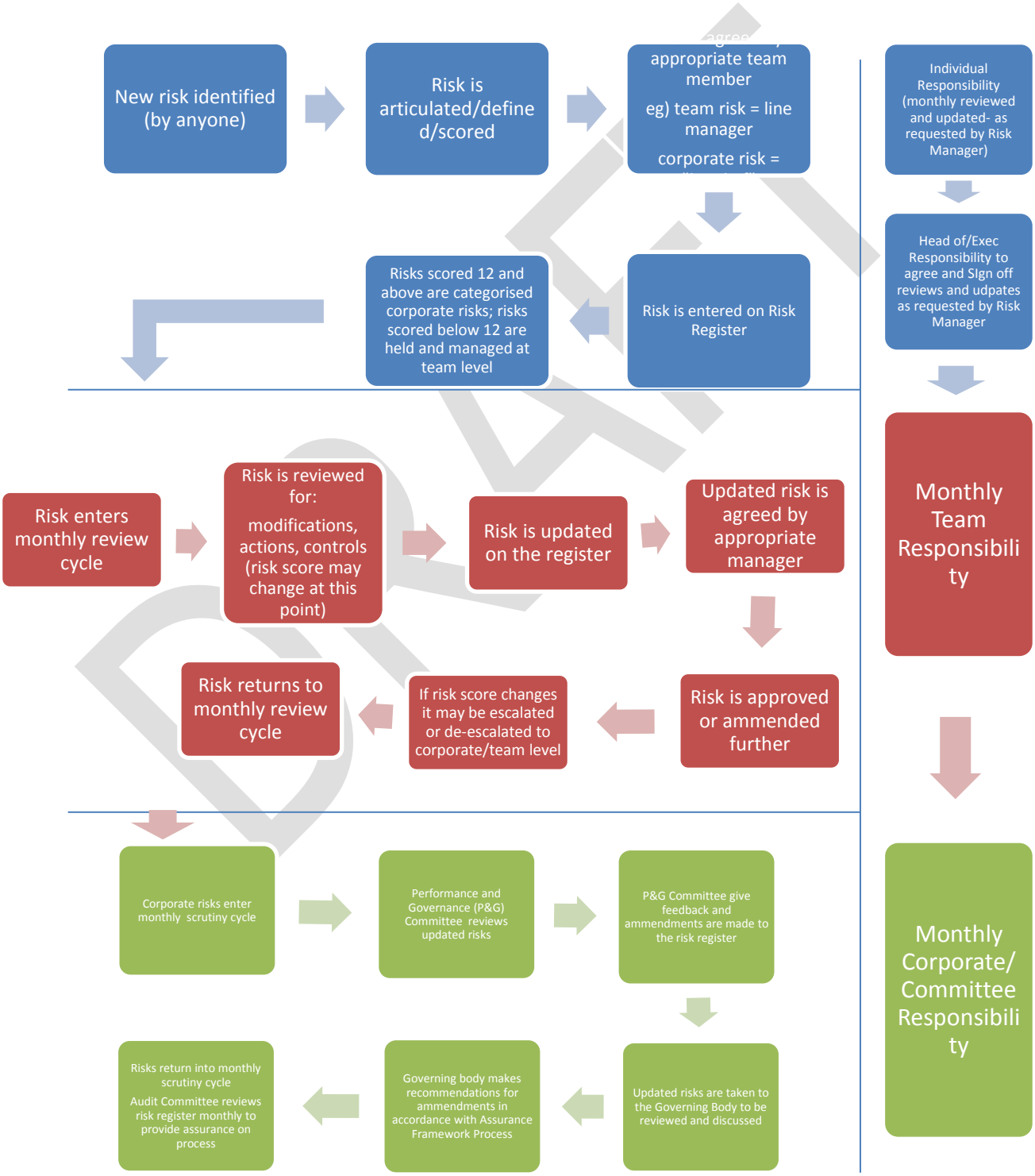
By focusing on risks to strategic and directorate objectives, the CCG can identify its principal risks in its operating plan. A summary of the principal risks and the work undertaken to mitigate their impact is reported at each meeting of the Governing Body in the Corporate Risk Register. The Corporate 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