NHS

Horsham and Mid Sussex
Clinical Commissioning Group

Annual Report and Accounts 2018/19

Contents

Foreword from the Interim Clinical Chair and Accountable Officer

Welcome to the NHS Horsham and Mid Sussex Clinical Commissioning Group (CCG) Annual Report 2018/19 which provides a comprehensive overview of our performance, progress, and challenges during the last twelve months.

2018/19 has been a year of change and a year of progress. The last twelve months has seen changes in leadership at the CCG, greater collaboration with our partners both in commissioning and the wider health and care system, and improvements for our local population.

After working closely with NHS Crawley CCG since our CCG's authorisation, we began the year as part of the newly formed Central Sussex and East Surrey Commissioning Alliance (the Alliance). Working in partnership with four other CCGs (NHS Brighton and Hove, NHS Crawley, NHS East Surrey, and NHS High Weald Lewes Havens) over the year we have been working together to improve the efficiency and effectiveness of how we commission services for our population.

In particular this has strengthened the working relationships we have developed with our colleagues at NHS Crawley CCG, and with our counterparts in NHS East Surrey CCG as part of the Alliance 'North' team. This has led to us developing new ways to collaborate, share best practice and use our combined expertise to improve the care we commission for our local populations.

The collaborative approach of the Alliance has allowed the CCG to stabilise the leadership and financial situation of our organisation and we were delighted during the year to have the legal directions that were in place related to the quality of leadership lifted by NHS England this year. These directions had been in place since November 2017 and having them lifted was a reflection of the work that has taken place to improve the governance, capacity, and capability of the organisation.

We do still continue to work under legal directions related to the financial performance of the CCG and we continued to face a significant financial challenge this year. A financial recovery plan was developed with our Alliance partners and agreed with our regulators, and whilst there is further work still to do next year to fully address the challenges we face, we end this financial year on a more sound financial footing compared to previous years. We finished the financial year following receipt of Commissioner Sustainability Funding with an actual deficit of £1.6m against a planned breakeven deficit of £0.0m and addressing this gap will be a key focus on the year ahead.

As well as making progress around our internal processes and governance we have also continued to improve clinical pathways and services for our patients. For example we started a pilot within musculoskeletal services which has seen practitioners being available in GP practices to provide specialist physiotherapy

assessments without patients needing to see a GP first. This initiative has streamlined the referral process into physiotherapy, orthopaedic, rheumatology, and pain services and has allowed patients to get the treatment they need quicker. We have also successfully introduced a pilot tele-dermatology service which has improved the transfer of information for dermatology patients, and started a new repeat management policy which has reduced the wastage and improved the safety of medicines significantly by empowering patients to manage the ordering of their own medicines. We will continue to focus on improving services for our patients in the year ahead particularly within general practice across Horsham and Mid Sussex.

This year has also presented the opportunity to work more closely with our partners across West Sussex, in particular our colleagues on the West Sussex Health and Wellbeing Board. In January the NHS Long Term Plan was published, and at this point at the end of the year we are looking forward to the launch of the new West Sussex Health and Wellbeing Strategy. We are committed to our involvement in the Health and Wellbeing Board, and fully support the strategy.

This year we said farewell to Dr Minesh Patel, who decided not to stand for re-election at the end of the financial year after seven years as the CCG's Clinical Chair, to enable him to take up the role of Chair of the National Association of Primary Care. There has been widespread appreciation across our CCG for the work Dr Patel has done, particularly in the active role he has played in ensuring that the local voice of clinicians and patients has been central to how services have been commissioned and planned for our local population. We both want to take this opportunity to thank Dr Patel for all that he has done for the CCG and wish him well in his new role.

It has definitely been a busy year; one of stabilisation, partnership and progress for our CCG as we have built strong foundations for collaboration with our partners. We have made significant progress to address some of the internal challenges we faced at the start of the year, and continued to make progress to improve care for our local population. The next twelve months present even further opportunities, especially as the NHS continues to change, and we look forward to working with our partners and our communities to deliver the best we can for people across Horsham and Mid Sussex.

Dr Laura Hill
Interim Clinical Chair
NHS Horsham and Mid Sussex
Clinical Commissioning Group

Adam Doyle
Chief Executive Officer
Sussex and East Surrey
Clinical Commissioning Groups

Section 1: Performance Report

Who we are and what we do

This performance report provides a comprehensive overview of the work of NHS Horsham and Mid Sussex CCG and an analysis of our performance during the year and our position at year end. It also describes how we have identified the risks and uncertainties facing the CCG and how we have managed them.

NHS Horsham and Mid Sussex Clinical Commissioning Group (the CCG) is responsible for planning and buying (commissioning') healthcare services for the people living across Burgess Hill, East Grinstead, Haywards Health, Horsham, and the surrounding areas.

The CCG is made up of the 23 GP practices in our area and is responsible for the health and wellbeing of more than 225,000 people.

We have a leadership team of local doctors, hospital consultants, and nurses who are working alongside an experienced local management team to make sure that local services are providing the best possible care for local people.

Each year we are allocated government money to spend on behalf of our population and our purpose is to improve the health of the people living in Horsham and Mid Sussex. As well as planning and buying services we also monitor the quality of the majority of local NHS services covering the care and treatment you may need in hospital and in the community, prescribing, mental health services, and support and services for people living with learning disabilities. The CCG has taken on delegated responsibility for the commissioning of primary care services.

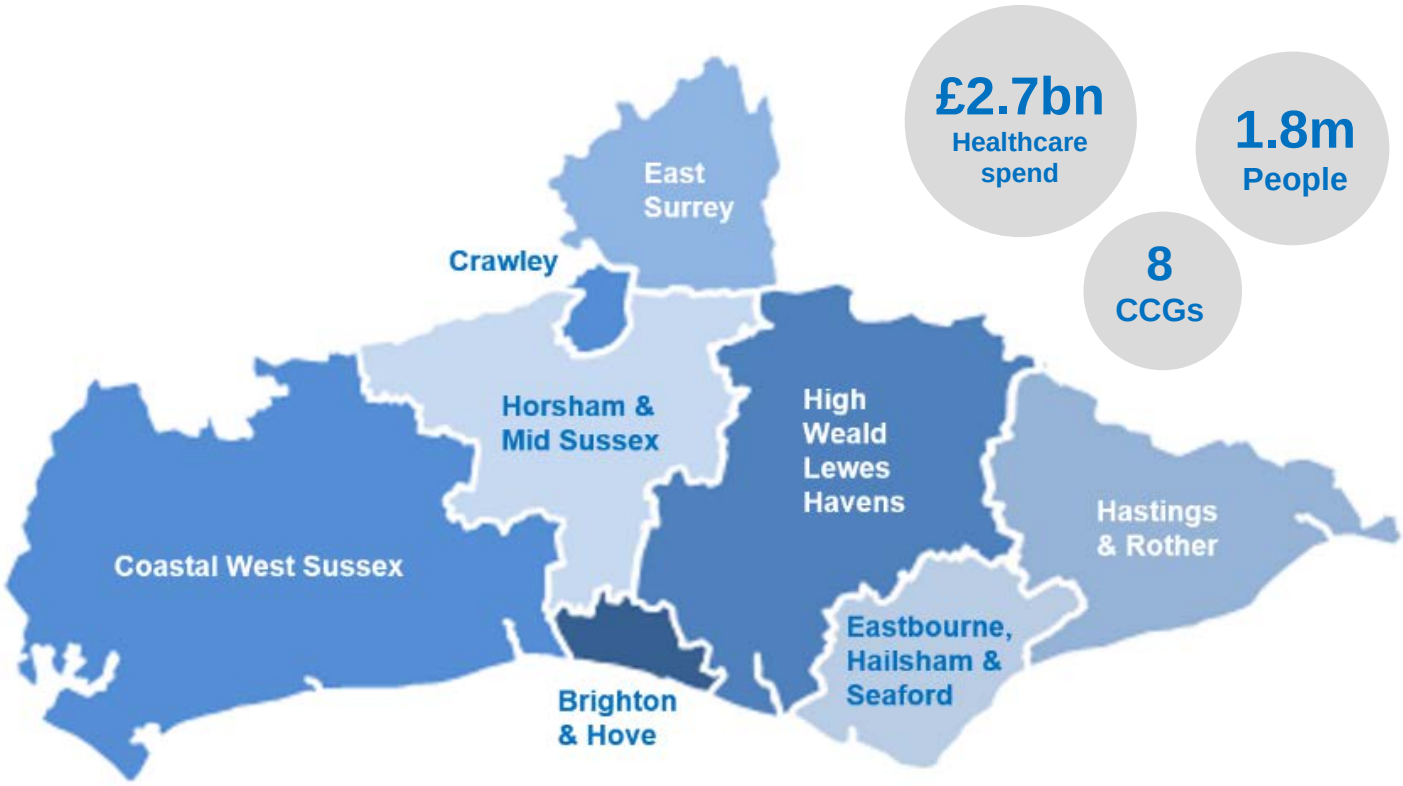
We are committed to ensuring that our public, patients, and carers are at the heart of what we do. We aim to be an organisation that takes account of their views and experiences and use what we have heard to inform our plans and influence our commissioning of local health services.

Our partnership working

Our CCG has been working over the last year as part of the Central Sussex and East Surrey Commissioning Alliance (the Alliance). This comprises five CCGs (NHS Brighton and Hove, NHS East Surrey, NHS High Weald Lewes Havens, NHS Horsham and Mid Sussex, and NHS East Surrey) and represents a joint way of working between the organisations.

There is one management structure and teams and functions have been working together to commission services in a more effective and efficient way for our populations. By working at a larger scale, it is recognised that we will be able to streamline processes, avoid duplication and have consistency of quality in services across a larger area for our patients. The Alliance is not a formal merger of the organisations and the CCG Governing Bodies remain accountable for healthcare commissioning to meet the needs of their local populations.

Since November 2018 the Alliance has been working much more closely with the other CCGs in the Sussex and East Surrey STP – NHS Coastal West Sussex CCG, NHS Eastbourne, Hailsham and Seaford CCG, and NHS Hastings and Rother CCG. This reflects the fact that all eight CCGs have had the same accountable officer since September 2018, and the same executive management team since November 2018. A single substantive Chief Executive was appointed in January 2019 and the CCGs are now collectively looking at how they can work much more closely together during 2019/20 and reform the commissioning system to support the direction of travel set out in the NHS Long Term Plan published in January 2019.



Sussex and East Surrey Sustainability and Transformation Partnership (STP)

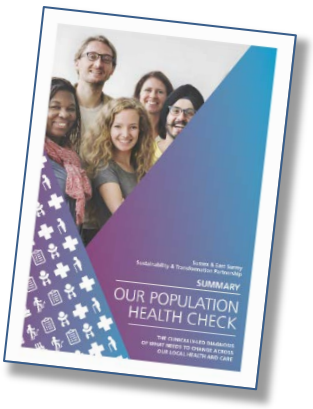
Our CCG is part of the Sussex and East Surrey Sustainability and Transformation Partnership (STP) and our local plans support the wider aims to improve health and social care services for our local populations.

The STP is made up of 24 organisations, which includes CCGs, local authorities and hospital, mental health, and community trusts. By working together we have the opportunity to ensure services remain sustainable and can cope with future challenges.

The STP is a partnership within which there are different 'place-based plans' that focus on places and populations. The aim of these plans is to create new ways of working that will bring hospital, community, mental health, social care, and GP services closer together and bring care closer to people's homes. There is also a number of workstreams that focus on priority areas for improvement across the STP. These include workforce, IT, unwarranted variation in care, and urgent and emergency care. We believe that by working together as a partnership we can make real positive differences to how we deliver care for our patients.

The publication of the NHS Long Term Plan in January 2019 represents an opportunity to build on the integrated and collaborative work that the STP has achieved so far. The Long Term Plan sets the target of having 'Integrated Care Systems' (ICSs) across the country by 2021 and our STP will be working towards achieving this aim. Becoming an ICS will allow health and care organisations to work more closely as a 'system' and look at commissioning and providing services for populations more effectively. The CCGs across the STP will play an integral part of shaping how our health and care system will work in the future and the progress we have already made over the last year in working closer with our partner CCGs have laid strong foundations for us to build on.

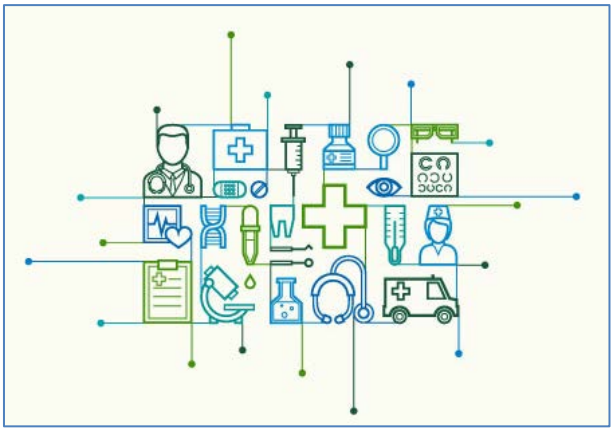
Following the publication of the NHS Long Term Plan all STPs across the country have been asked to set out how the national plan will work across local systems. To help develop this local plan doctors, specialists, and clinicians came together from across Sussex and East Surrey during the year to develop a *Population Health Check*. They looked at clinical evidence, patient experience, and local knowledge and gave a diagnosis of what needs to change from their expert point of view.



The Population Health Check was published in January 2019 and a period of engagement has taken place with the public, patients, staff, carers, volunteers, and stakeholders to get their views and experiences. This engagement – called 'Our Health and Care Our Future' - will enable feedback to be collated that will inform and influence the local plan.

OUR HEALTH & CARE
Our FUTURE

Looking forward to the year ahead



The NHS Long Term Plan, published in January 2019, outlined how the NHS will change in the future. Most notably it sets the target of having **Integrated Care Systems (ICSs)** covering the whole country by April 2021 which will involve a fundamental shift in how CCGs will work and how future commissioning will be done.

The formation of ICSs aims to build on the work that has already been established across the country through Sustainability and Transformation Partnerships (STP). They will involve NHS organisations, in partnership with local councils, taking a collective responsibility for managing resources, delivering NHS standards, and improving the health of the populations they serve.

Along with the formation of ICSs, the Long Term Plan also sets out the future formation **of Integrated Care Partnerships (ICPs)** and **Primary Care Networks (PCNs)**. Both represent a transformation of how health and care services will be provided and will also involve some commissioning requirements at a more local level.

Integrated Care Partnerships will be alliances of NHS providers that work together alongside local authorities and the third sector to provide care for populations of around 250,000 to 500,000 people. To support the formation of an ICP a new contract will be made available from this year that will allow the contractual integration of primary medical services with other services.

Primary Care Networks will involve GP practices and community teams working together to serve communities of around 30,000 to 50,000. They will involve multidisciplinary teams with a range of staff, such as GPs, pharmacists, district nurses, dementia workers, physiotherapists, and social care and the voluntary sector workers.

It is recognised that the future of commissioning needs to focus on **'Population Health'**. This is a term used to describe the health outcomes and needs of a defined group of people and involves having a focus on reducing variation and inequality of care for people living across an area.

To be able to commission for population health, it is recognised that there needs to be a joined-up approach between NHS organisations and partners, particularly local authorities. We will, therefore, be looking at how we can best commission in this way for our populations over the coming year.

The development of ICPs and PCNs, and the shift towards population health, will require the CCG to work in a very different way and we are actively exploring with our partner CCGs within the STP how we will further develop our joint work together and adapt to support delivery of the NHS Long Term Plan.

Our local population

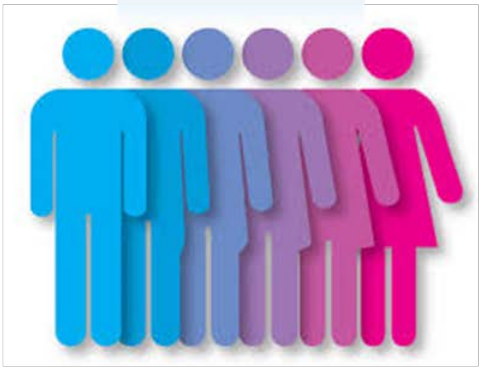
2,044
deaths
*2016/17 data

236,110
residents

85
females

46,000
over 65s

2,535
births
*2017 data



Life expectancy
*2012-14 data

81.4
males

240,764
Registered with a GP practice
* 2017/18 data

Performance Overview: A year in the life of the CCG

This section of the Annual Report provides our Chief Executive Officer's perspective on the performance of the CCG over the last twelve months. It includes information about the CCG, our main objectives and strategies, the principal risks that we face, and how we have performed during the year.

Performance summary

Every CCG is measured against national and local health priorities to ensure patients are receiving a high standard of care within key services. We are continuously assessed by the Department of Health and NHS England on a number of financial and performance measures, within various national standards and frameworks. These include the NHS Constitution and the NHS England Improvement and Assessment Framework (IAF), which rates CCGs on key areas.

For 2017/18 the CCG received a rating of 'inadequate' against the IAF. (The assessment for 2018/19 will be published in summer 2019).

Accident & Emergency Department

One area that has been particularly challenging has been in urgent care and specifically the performance of the Emergency Departments (A&E) at our local acute hospital Trust, Brighton and Sussex University Hospitals NHS Trust (BSUH). An increase in the number of people using the departments has meant patients have had to wait longer than we would have liked to be seen, treated, and either admitted or discharged. This was particularly challenging during the winter months, when the NHS experienced one of the busiest periods in its history. We have worked hard with all local health and social care organisations to ensure the safety and quality of services was maintained and a number of initiatives and improvements have been introduced. These aim to reduce the number of people going to A&E for treatment and make it easier for patients to leave hospital when they are ready, which frees up space for other patients who need hospital care.

Referral to Treatment (RTT)

Another area we need to improve is the performance against the waiting times from GP referral to when the patient is treated. The national target is 18 weeks and this has not been achieved locally, mainly due to how busy our local hospital Trust has been. Additionally, over the winter NHS England asked hospitals to pause planned care procedures in January 2019 to ensure they could focus on giving patients the urgent treatment they needed. As a result, waiting lists have developed and we are working very hard with BSUH and other CCGs to reduce these. We have paid for patients to be treated at other hospitals and providers to speed up their treatment but we recognise there is still work to do in this area.

Cancer

We also need to focus on improving some areas of performance for local cancer patients. There have been circumstances where some patients have had to wait longer than they should for treatment, particularly those being referred urgently for their first treatment. This is something we are working with providers to improve as our priority is to ensure all cancer patients receive the care they need in the quickest possible way.

Diagnostics

Historically the CCG has performed well in relation to patients waiting for diagnostic tests and we have mainly met the national targets of patients waiting no longer than six weeks. However, the CCG has struggled to achieve the target over recent winter months due to issues with equipment and winter pressures. We have achieved the target for people requiring psychological therapies services experiencing improvements to their condition.

More information on the CCG's performance can be found on MyNHS https://www.nhs.uk/service-search/Performance/Search.

Key issues and risks

No organisation operates without risk and the effective management of risk is a key function of the CCG's leadership. During 2018/19 the Alliance CCGs adopted an integrated risk register and assurance framework aligned to our shared Strategic Goals. The CCGs collectively identified the principal risks to delivering those goals as well as identifying local CCG- and place-specific risks aligned to the same. These risks have been reviewed regularly alongside any operational risks escalated from within the organisation.

During most of the financial year risks were defined at the CCG-, place- or Alliance-wide level. As the financial year drew to an end, and a single Chief Executive Officer was appointed to the eight Sussex and East Surrey CCGs, the Alliance CCGs also started to define some risks in terms of impact upon all eight CCGs.

The key areas of risk identified during 2018/19 are summarised against our strategic goals as follows:

Alliance Strategic Goal One: To take control of and lead our system by being stronger commissioners in order to deliver better outcomes for our population

The risks to the achievement of operational standards by our commissioned providers were an area of significant risk to all five Alliance CCGs.

The risks to the achievement of operational standards by our commissioned providers were an area of significant risk to all five Alliance CCGs. The highest-rated overall Alliance risk areas included:

- Achievement of constitutional standards
- General Practice Information Technology

- The achievement of the Transforming Care Programme (to transform the treatment, care, and support available to people of all ages with a learning disability, autism or both), and
- Workforce (acute, community, and primary care).

The risk of the Alliance failing to achieve the benefits of working at scale and in collaboration was acknowledged given that the governance and management of the individual CCGs and Places were still in transition and not yet aligned and fully effective pending agreement of the final commissioning structures.

The Alliance CCGs also identified additional local risks to the achievement of Strategic Goal One which generally related to specific providers and / or commissioned services.

Alliance Strategic Goal Two: To enable the development of new local models of care for the benefit of our patients and public

A key risk to the achievement of Strategic Goal Two across the five CCGs arose from delays to the re-procurement process of the new NHS 111 / Clinical Assessment Service.

The Alliance CCGs also noted that if the new whole system models of care (the Integrated Care Partnerships) were not developed and adopted fast enough there would be a risk of continued misalignment of system priorities resulting in continued financial unbalance across systems and the inability further to improve patient outcomes and their experience of services.

A related risk was that the emerging primary care arrangements were deemed as being not yet sufficiently mature to support transformation. The CCGs also collectively acknowledged a risk relating to the lack of clear articulation of the type of relationship and interface they wished to nurture with their local authorities in order to support each other in areas where close working is required.

The Alliance CCGs also identified specific local risks threatening the delivery of Strategic Goal Two relating to local estates issues and individual CCG relationships with their own commissioned providers and / or local authorities.

Alliance Strategic Goal Three: Deliver the best outcomes for our population and the individual within our allocated resources, and through the effective engagement of patients, staff, and stakeholders.

The Alliance CCGs identified a principal risk of not making reductions as per the NHS England financial recovery plan (FRP) leading to a failure to achieve the statutory duty to break even. As with Strategic Goals One and Two the Alliance CCGs also identified their own local risks to achievement of this financial goal.

The CCGs also identified collectively that performance of their commissioning support service providers created risks to delivery of this goal as did the ongoing threat of continued cuts and reductions in services across adult and children's social care.

Risks relating to various areas of compliance and corporate governance / management were also identified including Equality and Diversity, the risk of a cyber-attack affecting the IT systems, poor quality working environments for staff and primary care premises, and the lack of a consistent policy framework across the Alliance CCGs.

Effective engagement of patients and the public in the design and delivery of services, and with other stakeholders in developing a transformed system of care, were also identified as key risks to operational delivery, to the delivery of improved outcomes for patients, the ability to introduce new services successfully, to compliance with equality and diversity responsibilities, and to the CCGs' reputation.

The Alliance CCGs have also identified a number of risks associated with the UK leaving the European Union (EU) without a transition agreement in place.

These risks include:

- The potential for transport disruption surrounding the ports to the East and West of Sussex which may prevent patients from attending appointments or staff from attending their place of work
- The potential disruption to the supply of medicines and clinical consumables meaning that the local NHS will not be able to provide the medicines required by our patients nor be able to provide some of the services that we have commissioned within Sussex, and
- The potential for staffing issues if EU staff members leave the UK.

These risks are regularly reviewed by the CCGs' management teams and any potential impacts are mitigated by local, regional, and national plans.

The Alliance CCGs took a wide range of actions to minimise and manage the above risks during 2018/19. This has included work to align and improve the following corporate areas:

- Contract and performance management
- Financial management, reporting and forecasting
- Governance structures and processes, and
- Quality and safety.

The Alliance CCGs have also minimised risk by working strategically at scale including:

- Continuing their focus on the clinical effectiveness of services using 'RightCare' data which benchmarks CCG performance, and
- Working to improve the resilience of the local health system.

There is more detail about how we manage the risks facing us in the Annual Governance Statement.

Going concern

The annual accounts have been prepared on a going concern basis. In accordance with Section 30 of the Local Audit and Accountability Act 2014 our auditors issued a referral to the Secretary of State for Health and Social Care in relation to the CCG's breach of its financial duty to operate within its revenue resource limit for the year ended March 2019.

Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents. There is no evidence that the services provided by the CCG will cease in the future. The CCG has been given notification of a five year allocation for the period 2019/20 to 2023/24. This provides evidence that 'going concern' is an appropriate basis for the preparation of financial statements.

The CCG has developed a commissioning alliance with NHS Crawley CCG, NHS Brighton and Hove CCG, NHS East Surrey CCG and NHS High Weald Lewes Havens CCG. The Alliance works closely with NHS Coastal West Sussex CCG, NHS Eastbourne Hailsham and Seaford CCG, and NHS Hastings and Rother CCG. The CCG is currently reviewing the implications of the NHS Long Term Plan to ensure it can ensure it has the most appropriate organisational form from 2020/21

In addition, the CCG has identified no threats to operational stability, from finance or income that has not yet been approved, and services will continue to be provided, which supports preparing the financial statements on a going concern basis.

Financial summary

The detail of the CCG's financial performance for 2018/19 is set out in the annual accounts. In summary the CCG delivered a deficit of £3.6m against allocation after receiving Commissioner Sustainability Funding (CSF) of £26.7m and did not meet NHS business rules.

As the CCG exceeded the control total deficit in Quarter 4 by £1.9m the CSF funding was reduced in Quarter 4 by £1.7m.

A number of factors contributed to the deficit position in 2018/19. In response to a deteriorating financial position the CCG undertook a number of actions to manage this position including implementing a Financial Recovery Plan to achieve financial balance over the next 3-5 years and implementing the recommendations of a financial governance review. As part of the Alliance since January 2018 the CCG had been placed into formal turnaround by the Executive Team along with all of the other Alliance CCGs. This has established a common approach to financial savings

and a new set of financial controls to minimise expenditure. The Alliance CCGs produced a Financial Recovery Plan that was approved by NHS England in July 2018.

The key element underlying the 2018/19 out-turn position and variance to plan was:

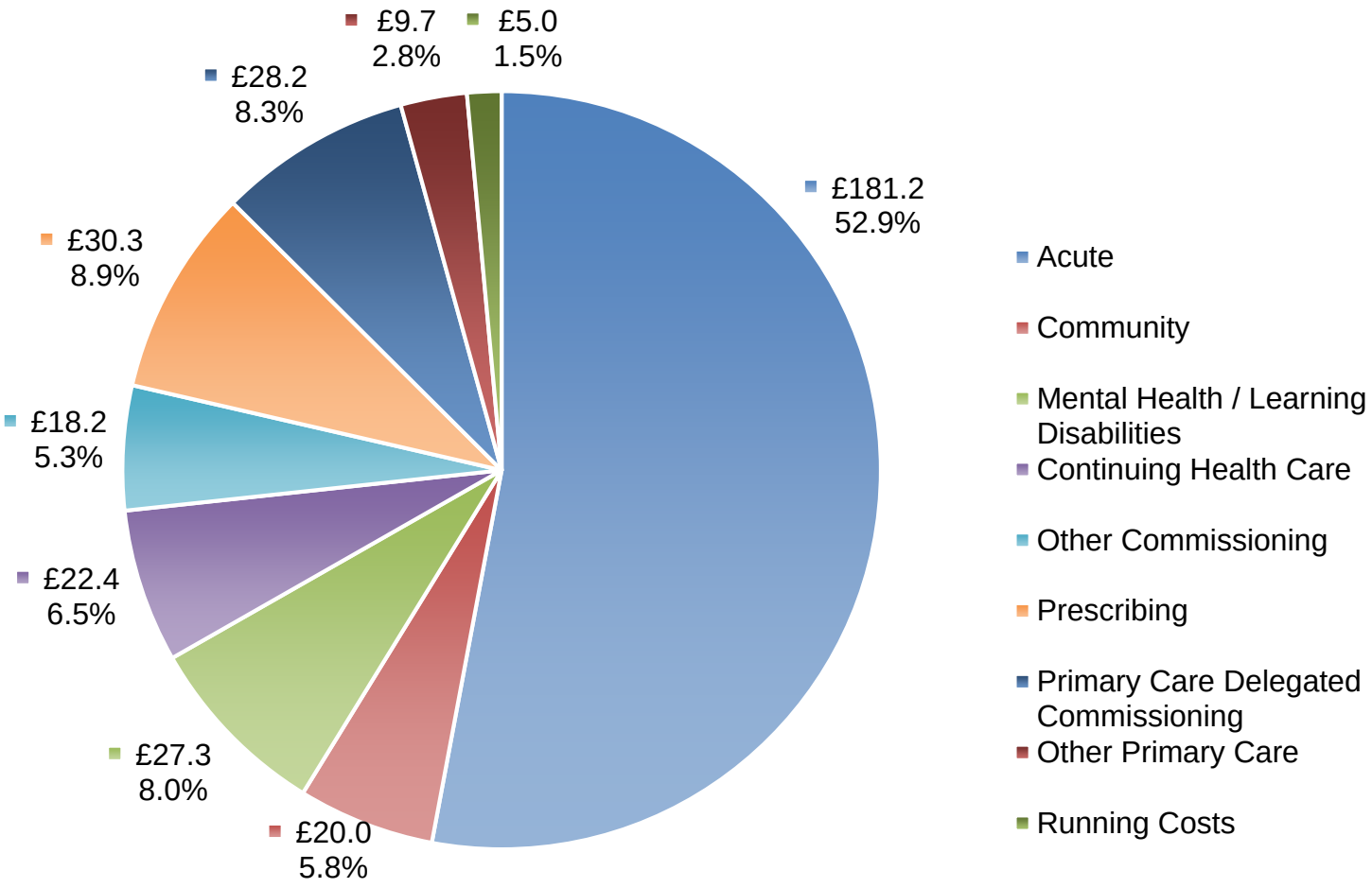
- A contractual difference with the main acute provider that had been included as an unmitigated risk in the plan and was resolved close to year end resulting in the crystallising of some of the risk.

During the year the CCG implemented the Financial Recovery Plan following a thorough and comprehensive financial recovery diagnostic which has been used to develop plans to address the financial deficit and reduce expenditure in line with allocation. This has been developed into the Financial Recovery Plan which indicates a timescale of up to five years for the CCG to manage annual expenditure in line with its allocation. During 2018/19 the CCG has focused the Financial Recovery Plan on stabilising the financial position in year with a focus on discretionary spend savings.

NHS England has placed the CCG under legal directions. As a consequence the CCG's financial position is subject to greater scrutiny and approvals are required for significant contract awards and financial commitments.

The chart below shows how the £342m expenditure was shared across the services that the CCG commissioned in 2018/19.

CCG's Net Expenditure 2018/19 (£m)



The Governing Body notes that the underlying position indicates on-going risk because we will start the 2019/20 financial year with a forecast deficit for the year and a cumulative debt from prior years of £53.5m (£14.8m for 2016/17 and £38.7m for 2017/18).

Ensuring financial recovery

The CCG's financial plan for 2018/19 recognised that it would not be able to meet its financial duties. The CCG was notified of its NHS England control total for 2018/19 which was a deficit of £28.4m before Commissioner Sustainability Funding (CSF) of £28.4m. The CCG commenced the year with the potential of delivering a breakeven financial outturn. The 2018/19 planned deficit before CSF was a £10.3m improvement on the 2017/18 reported £38.7 deficit.

The plan required savings of £11.2m to be delivered in 2018/19 to deliver the control total. In line with the Alliance Turnaround Board agreement the approach to delivering this position was by targeting efficiency savings and further savings on discretionary expenditure with an overall savings target of 4%. The CCG achieved £7.3m of savings (65%).

To support financial turnaround, our Financial Recovery Programme started in 2016/17 and will continue into 2019/20 and beyond. In 2019/20 the CCG will be required to deliver further savings and to also make investments to deliver the transformational changes as set out in the NHS Long Term Plan. We submitted a Financial Recovery Plan to NHS England in July 2018 which demonstrated how we planned to immediately stabilise our financial position and take steps to reduce the deficit over the next five years. The CCG is working on a refresh to this Financial Recovery Plan with STP CCGs and our main providers of acute, community, and mental health services.

The CCG has been notified of its 2019/20 control total which is a deficit of £31.3m before CSF. This control total is broadly consistent with the 2018/19 control total – a movement of £2.9m. The Commissioner Sustainability Funding available to the CCG is £11.6m leaving a year end deficit after CSF of £19.7m. The CCG has submitted a plan inclusive of £8.8m in efficiency savings for 2019/20.

At present the CCG is unable to constrain expenditure or find sufficient savings to deliver its control total for 2019/20 and is working closely with regulators, STP CCGs, and providers to develop a system-wide plan to enable the CCG to operate within the control total provided.

Our savings plan

Our savings plan has been worked up from opportunities identified in tackling unwarranted variation, which are identified from national benchmarking data.

We will focus on identifying and delivering savings by only commissioning proven and cost effective services. We will also put in place new ways of commissioning and paying for services that will incentivise improved outcomes for patients at an affordable cost. The plans are consistent with national planning guidance and contain broad assumptions about activity growth.

In developing our savings plans, we aim to eliminate waste and duplication, ensure delivery of quality and innovation plans addressing demand and supply, ensure our contracting process is robust and only when these have been exhausted we will explore clinically effective commissioning and making difficult choices including the prioritisation of services and expenditure.

Our financial report in section three carries more information.

Performance Analysis: A year in Performance

This section of the Annual Report provides a more detailed performance analysis and reports on key performance measures and how the CCG checks itself against them. The section is structured to cover our key activities into:

- A year in performance
- A year in quality and safety
- A year in commissioning: our programmes
- Engaging people and communities
- Reducing health inequalities
- Health and wellbeing strategy.

How the CCG measures performance

NHS Horsham and Mid Sussex CCG monitors performance through a monthly Integrated Performance and Quality Report. This comprehensive report has been developed in line with the CCG's ambition to create a health intelligence system to ensure that timely, accurate, and appropriate information is available to all relevant staff that will:

- Inform how the CCG commissions and delivers services by understanding about the health (and social) care needs and wants of patients and their experience of the services they use
- Provide an appropriate assurance framework to serve internal and external performance management regimes, and
- Support the CCG in delivering its constitutional requirements.

The report summarises performance and quality against the key areas of key performance indicators and operational standards outlined below and forms the basis of the NHS England assurance:

- CCG Operating Plan
- Continuing Healthcare
- Digital Targets
- Improvement and Assessment Framework
- NHS Constitution
- NHS Outcomes Framework, and
- Quality and Patient Safety.

It also contains other exceptional risks or issues at other providers. The bringing together of information, actions and risks allows the CCG to utilise this report at the monthly Quality and Performance Committee and at the Strategic Clinical Commissioning Group and Governing Body meetings. Specific risks against indicators are captured in programme risks registers and are also strategically reviewed through the Board Assurance Framework (BAF).

CCG Performance Rating

The Improvement and Assessment Framework (IAF) was introduced by NHS England in 2014. It provides a framework of measures against which CCGs are assessed.

Six areas were identified by NHS England and Public Health England as clinical priorities. They are listed in the table below along with the current rating for the CCG. This rating is based on published data (a number of measures are issued annually and a number of them are three year rolling averages such as the infant mortality figures).

IAF Ratings 2017/18

		NHS Horsham and Mid Sussex
Cancer	*2017/18*	Good
Mental health	*2017/18*	Requires Improvement
Dementia	*2017/18*	Requires Improvement
Diabetes	*2017/18*	Requires Improvement
Learning disabilities	*2017/18*	Requires Improvement
Maternity	*2017/18*	Outstanding

Each of the clinical priority areas are included in the Integrated Performance, Contracting, and Quality Report and scrutinised as part of the performance governance process described above.

NHS Constitution

The NHS Constitution establishes the principles and values of the NHS in England; it sets out the legal rights of patients, the public, and staff and further pledges that the NHS is committed to achieving these. It also sets out the responsibilities of public, patients and staff. There are a number of core standards against which we are measured which are shown in the next table.

Current Performance against NHS Constitution Standards

Measure	Target/ Threshold	NHS HMS CCG	Period of performance reported
RTT and Diagnosis			
RTT 18 weeks incomplete	>= 92.0%	81.2%	Mar-19
RTT 52+ week waiters	0	10	Mar-19
Diagnostic 6 weeks	<= 1.0%	8.7%	Mar-19
Cancer Access			
Cancer – 2 Week Wait	>= 93.0%	90.2%	Mar-19
Cancer - 2 Week Wait (Breast)	>= 93.0%	80.3%	Mar-19
Cancer - 31 Day First Treatment	>= 96.0%	95.4%	Mar-19
Cancer - 31 Day Surgery	>= 94.0%	97.0%	Mar-19
Cancer - 31 Day Drugs	>= 98.0%	99.1%	Mar-19
Cancer - 31 Day Radiotherapy	>= 94.0%	98.0%	Mar-19
Cancer - 62 Day GP Referral	>= 85.0%	70.2%	Mar-19
Cancer - 62 Day Screening	>= 90.0%	81.6%	Mar-19
Cancer - 62 Day Upgrade	>= 86.0%	86.7%	Mar-19
Mental Health and Dementia			
CPA 7 day follow-up	>= 95.0%	98.2%	Q4 18/19
Dementia Estimated Diagnosis Rate	>= 66.7%	70.0%	Mar-19
IAPT roll-out	>= 4.2%	4.3%	Rolling 3m (to Feb19)
IAPT Recovery	>= 50%	56.7%	Rolling 3m (to Feb19)
IAPT Waiting Times - 6 Weeks	>= 75%	96.4%	Feb-19
IAPT Waiting Times - 18 Weeks	>= 95%	100.0%	Feb-19
Psychosis treated within two weeks of referral	>= 53%	0.0%	Mar-19
Improve access rate to CYPMH	>= 32%	27.0%	18/19 YTD (to Feb19)

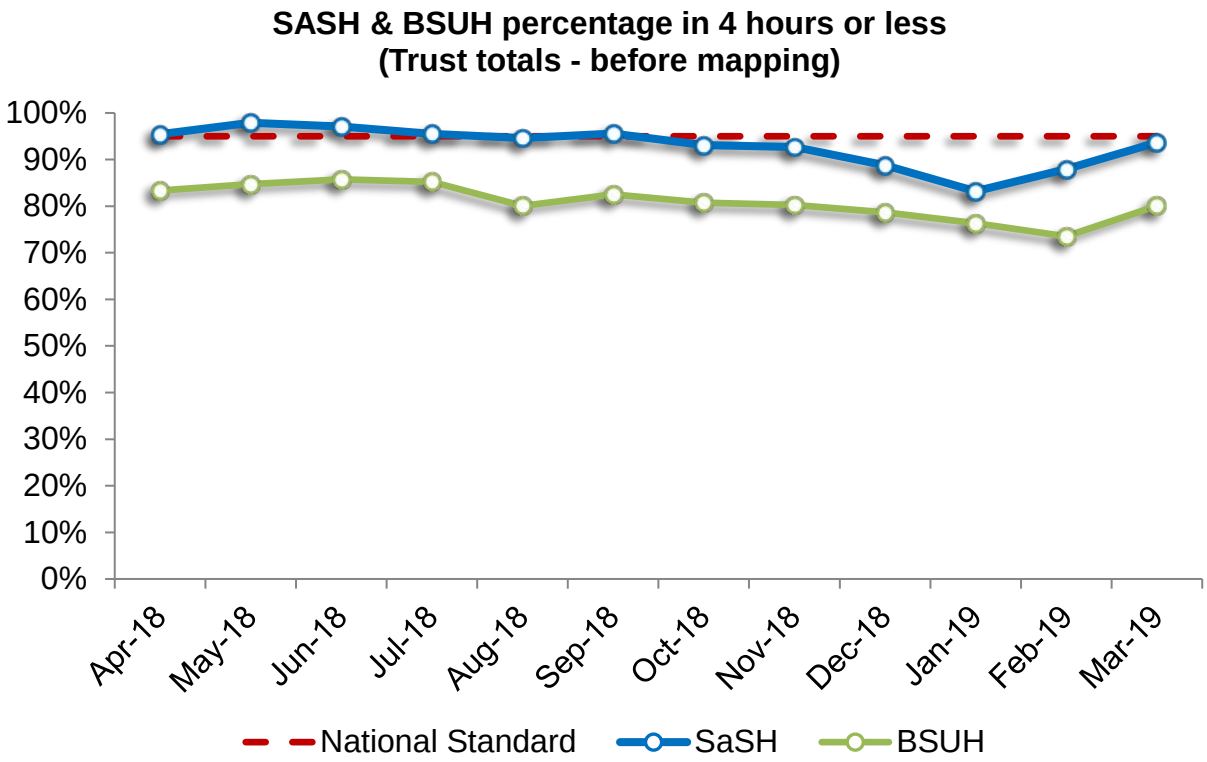
Measure	Target/ Threshold	NHS HMS CCG	Period of performance reported
Routine Referrals to CYP EDS (4 Weeks)	95% by 2020	n/a	Q4 18/19
Urgent Referrals to CYP EDS (1 Week)	95% by 2020	n/a	Q4 18/19
Urgent Care (provider BSUH)			
A&E 4hrs excluding mapped	>= 95.0%	80.0%	Mar-19
A&E 4hrs including mapped	>= 95.0%	83.6%	Mar-19
A&E 12hrs waiters	0	0	Mar-19
DToC bed days as a % of occupied beds	<=3.5%	4.7%	Feb-19
Urgent Care (provider SASH)			
A&E 4hrs excluding mapped	>= 95.0%	93.7%	Mar-19
A&E 4hrs including mapped	>= 95.0%	95.9%	Mar-19
A&E 12hrs waiters	0	0	Mar-19
DToC bed days as a % of occupied beds	<=3.5%	2.0%	Feb-19

There are a number of NHS Constitutional targets where the CCG has not achieved the required standards. These are described in the sections below.

Four-hour Accident & Emergency (A&E) Standard

The NHS Constitution standard states that 95 per cent of patients should be seen and either treated and discharged or admitted within a maximum four hours of arrival in A&E.

Whilst this measure focuses on time spent in A&E it is an excellent indicator of performance across a hospital. This is because where it is achieved it indicates good patient flow, bed management, and timely discharge. This target is the primary indicator used to assess and report the performance of a trust in the national performance tables.



Along with many other A&E departments across the country, Princess Royal Hospital (PRH) faces a huge challenge in trying to ensure staff see and treat patients as quickly as possible. A contributing factor to A&E performance is the volume of demand being seen at the Trusts, with PRH seeing a 5.6% growth in the number of A&E attendances compared to last year.

Surrey and Sussex Health Care NHS Trust (SASH) achieved the four hour standard for the first six months of 2018/19 but has experienced challenges to deliver since October 2018, reporting 88% February 2019.

The CCGs have been working closely with providers to ensure patients are assessed and treated by the right clinician at the right time improve our patients' experience of urgent care. These include:

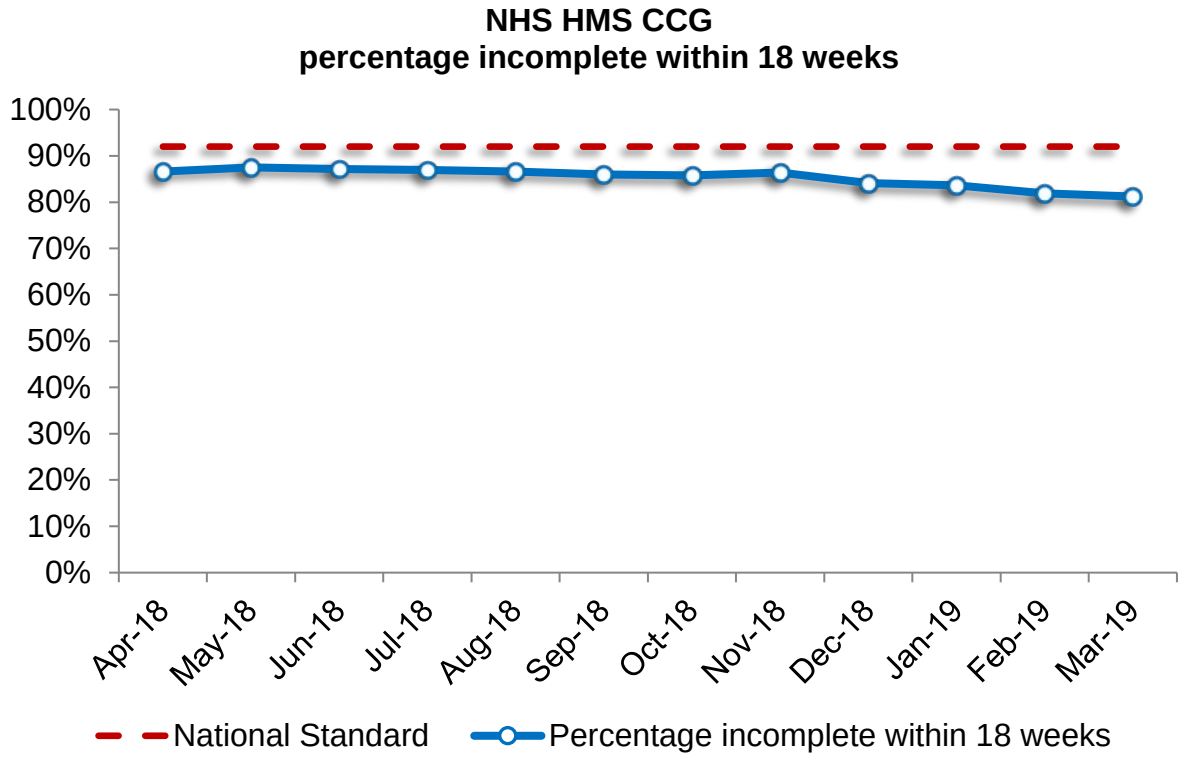
- Additional GP Streaming in A&E
- Additional spot purchase beds commissioned and all escalation areas opened to support safe management of patient pathways
- Daily system operational calls with all providers to ensure optimum flow out of hospital and use of the operational pressures system escalation framework (known as OPEL) to manage pressure. Continuation of Accountable Officer level twice weekly escalation calls
- GP practices commenced their extended access hubs across towns during December which has increased urgent access to primary care appointments
- Implementation of a live bed management system to ensure that every bed is allocated as soon as it is vacated, improving flow, minimising pressure and improving ambulance handover and patient experience

- Significant system-wide focus on Delayed Transfers Of Care and stranded patient reductions, and
- System-wide focus on supporting seven day flow with further development of our community responsiveness to support admission avoidance and early supported discharge.

Referral to Treatment (RTT)

The NHS Constitution states that 92% of patients should wait no longer than 18 weeks from a GP referral to starting treatment. This is known as the 18 week RTT standard and it has not been met locally during the last twelve months.

The CCG has been committed to meeting the RTT standard during 2018/19 and on the months leading up to the winter period, the performance has been above the agreed trajectory developed with NHS England and our local Acute Trusts, including BSUH. The winter period has brought significant pressures with more resources being used to care for those people who are in urgent need. In addition, NHS England asked acute Trusts to pause planned care procedures for the whole of January which meant that fewer patients waiting for routine care could be treated. Despite this, more patients this year are being treated within 18 weeks that there were at this time last year.



A number of practises and initiatives have been implemented across the CCG to improve waiting times for our population. The CCG has fully implemented the Referral Support Service (RSS), this supports reductions in waiting times for treatments by:

- Ensure referrals to secondary care are consistent with our commissioning policies and thresholds for treatment, and
- Promotes the use of Advice and Guidance and offers patient choice.

The services has also helped the successful roll out of the national Electronic Referral Service (ERS), all of our referrals are now made electronically meeting the national October 2018 deadline. Our patients have access to the right planned care services at the right time, reducing waiting times for clinically appropriate referrals.

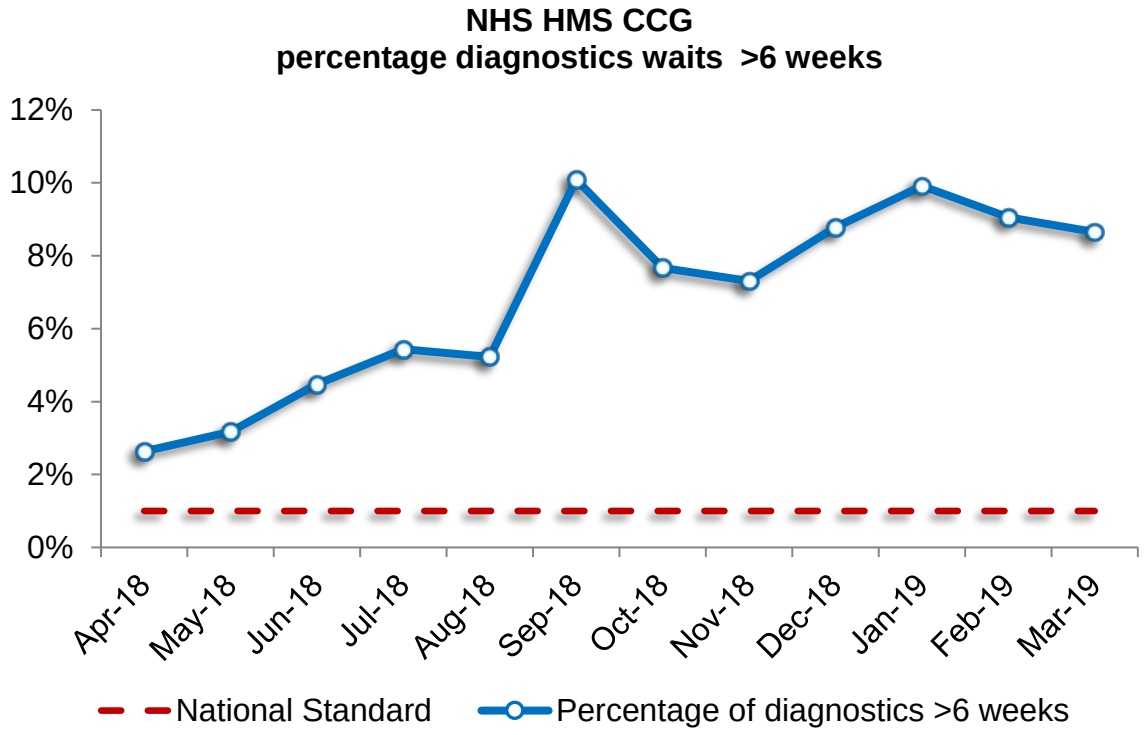
The CCG is also working with commissioning colleagues across the Sustainable Transformation Partnership (STP) on the Clinically Effective Commissioning (CEC) programme. Established in 2017 the programmes aims to improve the effectiveness and value for money of healthcare services by ensuring that commissioning decisions are consistent for all and follow the latest clinical evidence therefore making the most sensible use of limited resources.

The CCG has implemented a number of changes to improve patient pathways and support improvement against the RTT standard:

- Reviewed and improved patient appointment systems to improve booking and scheduling, maximising capacity and flow
- Teledermatology - Live from Jan 2019, pilot covers seven practices in NHS Crawley/ NHS Horsham and Mid Sussex CCG; the aim is to gain a rapid opinion on diagnosis and management of dermatology conditions and provides a useful alternative to a face-to-face clinic referral for selected patients
- We are part of a national First Contact Practitioner pilot for our musculoskeletal (MSK) services which aims to improve care for patients by providing earlier intervention by an MSK specialist, and
- We have rolled out a self-referral pathway for MSK patients to access physiotherapy.

Diagnostic waiting times

The diagnostic waiting time standard states that no more than 1% of patients should wait longer than six weeks for a diagnostic test.

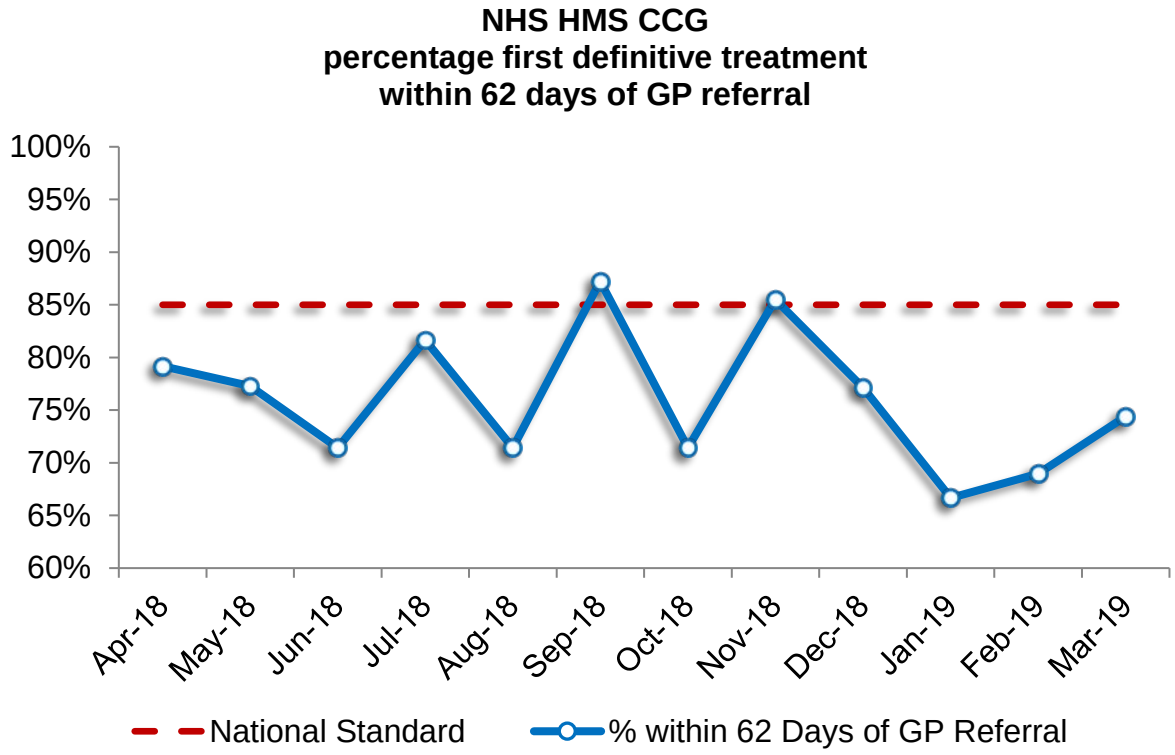


During the reporting period, the CCG has not met this standard, nor did QVH and BSUH which provide the majority of diagnostic tests for HMS patients. Work is in progress on improving NOUS Ultrasound pathways.

Cancer Access

The NHS Constitution standards for cancer treatment are:

- Patients should be seen by a specialist doctor within two weeks of a referral by their GP for suspected cancer
- Patients should be seen within 31 days from when a decision is made to treat, and
- Patients should be seen within 62 days from an urgent referral to the first definitive treatment for all cancers.



The CCG has not been consistently meeting the cancer access, diagnostic and treatment the standards described above. There are a number of contributing factors which include:

- Pathology services have continued to be a challenge but look to be improving, and
- Inter provider delays in referrals between SASH and other Trusts impacting on the number of shared breaches.

The CCG has been working with fellow commissioners in the Alliance and the Surrey and Sussex Cancer Alliance to support achievement of the eight national waiting time standards for cancer and address priority areas for improvement which include:

- Early Diagnosis
- Living with and Beyond Cancer
- Modernising Cancer Services and Commissioning
- Patient Experience, and
- Prevention.

More specifically the CCG have developed a SES Commissioning Plan. This describes what we will do to meet the national recommendations in the National Cancer Strategy. We have also:

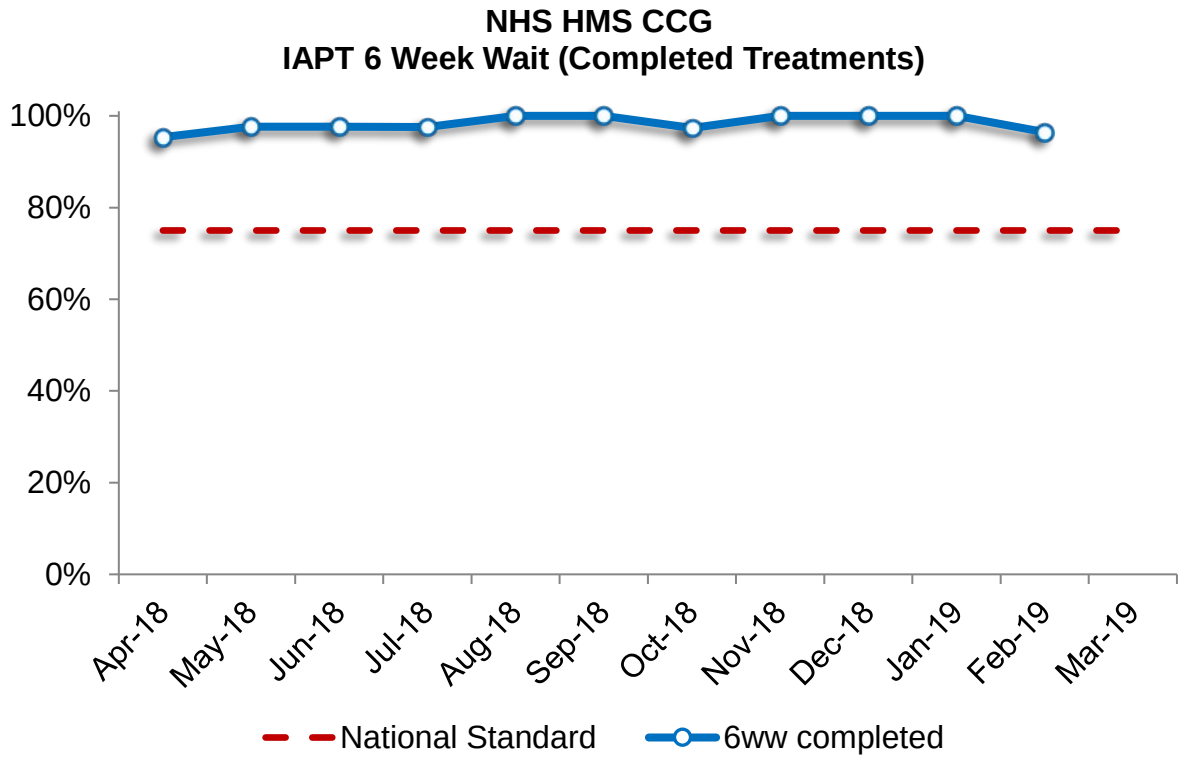
- Extended the scope of current Non-Obstetric Ultrasound (NOUS) contracts to include suspicion of cancer to reduce demand on diagnostics in acute hospitals (HMS and Crawley only)

- Fully implemented guidance for cancer referrals (which include lower thresholds for referral , new pathways and diagnostics, including straight to test)
- Implemented straight to test pathways for colorectal symptoms for BSUH and SASH
- Implemented the Accelerate, Coordinate, Evaluate pathway for lung cancer at BSUH and SASH
- Implemented the Faecal Immunochemical Test (FIT) at SASH to enable earlier diagnosis of bowel cancer, and
- Started a rolling programme of GP Practice visits to encourage uptake for screening and a GP education programme to raise awareness of signs and symptoms of cancer.

Mental Health Access Targets

The NHS Constitution requires CCGs to commission services to support people experiencing mental health illness. These include:

- Improving access to and recovery rates for psychological therapies (IAPT) so that at least 25% of people with common mental health conditions access services each year, and
- At least 50% of adults receiving therapy will achieve self-reported recovery following treatment.



The CCG has been performing well against the access and recovery standards for the year. The referrals to the service decreased leading to a dip in access rates, however, the provider is confident that they will meet the end of year target of 19%.

A year in quality and safety

The delivery of high quality care is at the centre of the CCG's Vision and Values. We are dedicated to ensuring all commissioned services on behalf of the resident populations are of the highest quality, delivered with respect and compassion and provide a positive experience for the patient and their family.

Our overarching aim is to ensure the services we commission deliver excellent care whilst driving forward quality and workforce improvements for the benefit of our local population

During 2018/19 we continued to focus on a wide range of activities to improve and assure safety, health outcomes and the patient and their family's experience of local services.

Improving quality and safeguarding vulnerable people is at the heart of what we do. We play a key leadership role in commissioning for quality. All existing and new services are assessed for their impact on the local population. In 2018/19 we implemented a revised Quality Impact Assessment Policy Sussex and East Surrey wide.

An essential component of our work is to provide robust assurance of services delivered to our patients. The eight CCG commissioning quality teams have been aligned as one team, led by the Chief Nurse for Sussex and East Surrey.

During the year a review of the existing Quality Committees was undertaken resulting in an aligned approach with strong leadership, public and Lay representation. Our terms of reference were reviewed to ensure quality assurance of services were subject to robust scrutiny and challenge in order to improve the care delivered to our local population.

These developments have enabled our staff to collectively use their extensive clinical knowledge and skills to influence service provision, inform the commissioning cycle with evidence based best practice and assure stakeholders of the quality of care.

Quality improvement

In line with our statutory duty, our vision for the CCG has always been to reach out to the communities we care for to understand how we could help them to improve their health. During 2018/19 a number of engagement events were held with local people to share our commissioning intentions and find out what we could do to improve local services. In the coming year we will build on these using our revised approach to quality improvement.

2018/19 saw the development of the Sussex and East Surrey Quality Assurance and Improvement framework. This framework will provide a structured approach to improving quality and escalating quality concerns using a risk based methodology.

This will enable the commissioning quality team to proactively safeguard people, using a consistent evidence based approach. Interventions to improve care delivery will be coordinated and delivered collaboratively with system partners.

Our focus on quality has played an essential role in helping us to ensure that we commission safe and effective, services which provide our patients with the best possible experience of the NHS. We continue to work with our provider organisations to ensure that patients, their families and carers are treated with compassion, respect and dignity, in safe environments and protected from harm.

As system leaders, we take an active role in a range of formal and informal reviews. These include ongoing dialogue with service providers, quality impact assessments, quality assurance visits, the use of contractual levers and the implementation of agreed quality improvement plans.

Additionally we work alongside our commissioning teams to:

- Carry out surveillance in line with the Care Quality Commission 'domains' (safety, effectiveness, patient experience, leadership, culture and responsiveness
- Monitor quality performance against agreed standards and outcomes
- Obtain assurance of commissioned service quality, and
- Use of the Commissioning for Quality and Innovation (CQUIN) payment framework to support local improvement.

During 2018/19 we refined our management of CQUIN and adopted an aligned approach throughout Sussex and East Surrey. Through these commissioned schemes the CCG is seeking to deliver improvements for example by improving services for people with mental health needs who present to A&E and by reducing the impact of serious infections (Antimicrobial Resistance and Sepsis).

The main CCG providers are:

- Brighton and Sussex University Hospital
- IC24
- MSK partnership
- Queen Victoria Hospital
- South East Coast Ambulance NHS Trust
- Surrey and Sussex Healthcare Trust
- Sussex Community Foundation Trust, and
- Sussex Partnership Foundation Trust.

During 2018/19 the quality team has worked with providers and partners to drive up the quality of services for our population. The following section provides details of some of our successes.

Early identification of patients reaching end of life

Working together with lead clinicians in partnership with a software company (Docobo), NHS Horsham Mid Sussex CCG and NHS Crawley CCG have grouped

multiple criteria used for decision making into a single system. This has enabled GPs and the wider primary care team to identify early those nearing the end of their life and better support the planning and coordination of their care. The CCGs, together with the local acute hospital, commissioned a Palliative Care Service in the Accident & Emergency Department and the acute assessment units. This supports patient choice of where they wish to die and is an example of partnership working across the CCGs.

Primary Care workforce

Our Primary Care workforce tutor and team have introduced a sustainable framework to enable:

- Advancing Clinical Practitioners to increase their scope of practice
- Health Care Assistants to develop their skills through health care apprenticeships
- New roles to be developed (such as Nurse Associates), and
- Practice Nurses to become clinical mentors to supervise students in training.

We have increased the number of student nurse placements in primary care leading to successful recruitment of qualified nurses in GP practices. To support this there has been a significant increase in the number of GP surgeries with nurse mentors.

Sepsis

Throughout the year a sepsis education program was delivered to primary care, enabling GP surgeries to identify sepsis leads for their practices, positively building on the 2017/18 national sepsis indicator. Bespoke training programmes for managing the deteriorating patient and sepsis awareness was delivered to the majority of care and nursing homes within East Surrey. This supported timely detection of deteriorating physical health and preventing the need for a hospital admission. This included raising awareness of the national tool for early recognition of the deteriorating patient.

Healthcare acquired infections

The quality team has supported our local acute hospital through a systematic review process which resulted in a reduction of total number of Clostridium difficile cases from 38 in 2017/18 to 27 in 2018/19.

Care Quality Commission ratings

Through our drive to improve quality as a system we have worked in partnership with our local providers enabling them to receive an improved Care Quality Commission rating with our local acute and community trusts being rated as ‘outstanding’.

Learning from Serious Incidents (SIs)

The CCG has a statutory responsibility for management of serious incidents reported by commissioned services. This process is hosted by a Patient Safety Team based at NHS Brighton and Hove CCG who provide oversight and effective management of serious incidents for all providers across Sussex and East Surrey. This includes a fortnightly Serious Incident Scrutiny Panel. In 2018/19 the service was awarded a rating of ‘significant assurance’ by Internal Audit.

In addition, the CCG received positive feedback from its external partners (including NHS England) on the robustness of the scrutiny process.

During 2018/19 in partnership with providers the commissioning quality team strengthened its assurance that valuable lessons learned from serious incidents have been widely shared embedded in individual, team, organisation and system practice. This will continue to be a priority for 2019/20.

Infection Prevention and Control

The CCGs with provider organisations continue to drive improvements that reduce the incidence of healthcare acquired infections. The commissioning quality team have taken a proactive approach to achieving its reduction targets including the development of a two year clinical strategy.

For *Clostridium difficile (*CDI) infections in 2018/19 the CCGs can report a reduction in the number of cases year on year. East Surrey's local acute hospital, Surrey and Sussex Hospitals NHS Trust has implemented 'lessons learned' to improve patient care. This has seen improved outcomes for our patients.

In line with the national vision, there remains a zero tolerance approach locally for methicillin resistant *Staphylococcus aureus* blood stream infections (MRSA BSI).

A number of infectious outbreaks have affected local services especially during the winter period, resulting in ward or bay closures in acute and, community in patient areas and nursing homes. To manage this effectively CCGs have agreed with health providers throughout Sussex and East Surrey a system wide approach to managing infectious outbreaks during periods of escalation. This includes the management of influenza in and out of season.

During an influenza outbreak, when appropriate, antivirals are given as prophylaxis treatment to high risk patients, residents and staff. In 2018/19 the uptake of staff and the public receiving the flu vaccination has improved from last year's trajectories.

Workforce development

Whilst 2018/19 has seen an overall increase in the number of nursing, midwifery, and health visitors (registered and support workers) clinical staff in post, the NHS workforce continues to be under real pressure. Causal factors include the increasing number of people accessing the service coupled with the complexity of their condition.

Some geographies and types of job have proved been hard to recruit to and this has been exacerbated further by ongoing uncertainties around pay and international recruitment. Despite these well understood pressures, frontline NHS staff say their experience at work continues to improve, with overall employee engagement scores now at a five-year high.

The commissioning quality team continues to work with providers to ensure they have effective retention plans in place that focus on engaging and empowering the workforce, understanding insights such as the reasons why people leave and are taking sustainable action to retain staff.

Contract Quality Review Meetings regularly receive progress updates on a number of initiatives. For example:

- Apprenticeships: Assistant practitioners, Nurse associates
- International recruitment programme, and
- Retention: 'Best Place to Work' initiatives (supported by Health Education England).

The commissioning quality team continue to work closely with Trusts to ensure safer staffing levels are maintained through robust clinical risk assessment.

Primary and Community Care Workforce Development

The beginning of 2019 saw a key development in Primary and Community Care workforce, the first is an agreement to establish the SES Primary and Community Care Workforce Group.

The purpose of the group will be to develop a SES primary and community care workforce plan by the autumn of 2019, agree an implementation plan that will be delivered locally and at scale by Community Education Provider Networks (CEPN) and monitor progress and drive delivery.

A significant achievement for the CCG in 2018/19 has been the production of a handbook for care workers in Care Homes and for home carers called the Stop Look Care tool which is an educational tool to support care staff undertaking the National Care Certificate, as well as being a reference guide for families and carers to increase awareness of health needs and identify when referrals may be needed if concerns are identified.

The Stop Look Care project won the Nursing times award in 2018. This project serves to support the unregistered workforce to ensure they are competent and confident to deliver great care.

Following on from this prestigious award this work has been combined with the Sussex and East Surrey clinical skills project. During 2019/20 the teams will embed the nationally recognised Stop, Look, Care brand throughout Sussex and East Surrey through the roll out of a tailored core package of training and competencies which will form a staff passport recognised in any practice setting.

Patient experience

Complaints are taken very seriously by the CCGs and are managed within an established process. Soft intelligence is triangulated with other data and shared across providers, commissioners and external stakeholders. The commissioning quality team ensure any learning is widely shared and informs our commissioning intentions.

We work closely with the Patient advice and liaison service (PALS) to understand patient's feedback on the services we commission. Each person's view is taken into account so we can ensure we do everything possible to ensure every patient's experience is positive and their expectations met.

Safeguarding adults, children and looked after children

The STP-wide safeguarding team holds statutory responsibilities in relation to safeguarding adults, children and looked after children within our local populations. The CCGs are committed to fulfilling our statutory responsibilities by seeking assurance around the safety and effectiveness of the services we commission. The work undertaken by the safeguarding team includes taking into account national changes, influencing local activity and developments and maintaining oversight of any actions being taken to mitigate any significant safeguarding risks.

The safeguarding team have continued to develop processes to work as one aligned team across the STP area during 2018/19 and significant progress has been made with the identified team objectives and the NHS England priorities.

Key actions taken in 2018/19

- An external review of the safeguarding processes and structure across Sussex has been undertaken; an action plan is in place to address the identified recommendations which will help inform the future improvements and transformation of the safeguarding systems for adults, children and looked after children
- An audit was undertaken by NHS England of CCG compliance with statutory safeguarding duties. NHS England were fully assured that all statutory duties were being met and all the key lines of enquiry were RAG rated green
- Increased provision of supervision for designated professionals has been put in place
- Safeguarding stocktake feedback identified priorities for the safeguarding team including embedding safeguarding within the commissioning cycle, engaging primary care in safeguarding assurance and training and developing a recovery plan to enable initial health assessments for looked after children to be completed within 20 days
- Work continues to support the multi-agency large scale safeguarding enquiry with an independent provider (Sussex Healthcare). The West Sussex team continue to work with the Local Authority around safeguarding enquiries and support the services to mitigate known safeguarding risks.

Key team priorities for 2018/19

- Development of a Safeguarding dashboard to include data capture for adult and child safeguarding, across the STP: a working group made up of designated professionals are updating the standards and agreeing a data-set. The new safeguarding dashboard will form part of the assurance and data gathering from Quarter 1 2019/20

- Aligning the governance, processes and paperwork for safeguarding across the STP: a programme of work is currently being carried out to align business support processes, policies, and paperwork
- Development and implementation of Safeguarding Standards across the care home sector: the standards have been agreed by CCGs across Kent, Sussex and Surrey and wider stakeholder engagement is due to take place; events will be arranged in each of the areas to roll out the standards
- Standardising training across the STP, in terms of content, length, audience and levels (as per intercollegiate documents): standardised training will be rolled out across the STP from April 2019.

NHS England priorities for 2018/19

Mandatory staff safeguarding training: NHS Coastal West Sussex, NHS Crawley, and NHS Horsham and Mid Sussex CCGs have made significant improvement with the training completion rates for both safeguarding adults and children training over the last year. In the first quarter the CCGs were reporting an average of 77% of staff completing the training compared to 86% in the third quarter.

Summary of Planned Actions in the coming year

- Domestic abuse learning events for primary care clinicians are due to be delivered by the end of May 2019 (NHS England funding)
- Looked after children professionals away day and networking event planned to take place in Q1 to progress the looked after children agenda
- Continue to address actions from external safeguarding review within the identified timescales
- Continue to progress with the team priorities, and
- Since the publication of the Working Together to Safeguard Children 2018 guidance in May, the CCGs have increased statutory responsibilities to make arrangements to work together with relevant agencies to safeguard and protect the welfare of children; work will continue to implement the reforms.

The STP-wide safeguarding team holds statutory responsibilities in relation to safeguarding adults, children and looked after children within our local populations. The CCGs are committed to fulfilling our statutory responsibilities by seeking assurance around the safety and effectiveness of the services we commission. The work undertaken by the safeguarding team includes taking into account national changes, influencing local activity and developments and maintaining oversight of any actions being taken to mitigate any significant safeguarding risks.

The safeguarding team have continued to develop processes to work as one aligned team across the STP area during 2018/19 and significant progress has been made with the identified team objectives and the NHS England priorities.

Improving Care for people with Learning Disabilities

In response to the Winterbourne Scandal in 2011, NHS England published 'Building the Right Support' (BRS) and **'The New Service Model'** in October 2015, prescribing national guidance for the support and rights of people with learning disabilities. The programme was three years in length and ends in March 2019. The NHS Long Term Plan 2019 demonstrates an ongoing commitment to the programmes principles and tackling wider health inequalities for people with learning disabilities and/or autism. The new assurance framework is under development within NHSE.

We support the national ambition to transform the treatment, care and support available to people of all ages with a learning disability, autism or both so that they can lead longer, happier, healthier lives in homes not hospitals. As a result we have committed to continuing the Transforming Care Programme until NHSE set trajectories (currently under review) are achieved and the model of care in the community can be demonstrated as robust in admission prevention via community interventions.

Summary of NHS Horsham Mid Sussex CCG Performance January 2018 vs January 2019

Inpatient numbers	
Over the course of the past 12 months the total number of Transforming Care (TC) inpatients for NHS Horsham Mid Sussex CCG has increased marginally by one inpatient, from four to five	
In January 2018 the CCG had a total of 4 inpatients	0 CCG inpatients
	4 Specialised Commissioned (SC) inpatients
In January 2019 the CCG had a total of 5 inpatients	0 CCG inpatients
	5 SC inpatients
Care Treatment Reviews	
The number of people who have been offered a Care Treatment Review (CTR) has increased significantly over the course of the past twelve months, reflecting increased focus and targeted resource towards this initiative	
January 2018	14% of CCG inpatients had a CTR
	71% of SC inpatients had a CTR
January 2019	NA due to now having no patients
	100% of SC inpatients had a CTR
Annual Health Checks	
The number of people in the CCG over the age of 14, with a learning disability on a GP register who have been offered an AHC has increased marginally from 17% to 20%	
January 2018	17% had an AHC
January 2019	20% had an AHC

Summary of key actions taken in previous year

- Sussex has made significant progress this year, the rate of admissions has slowed and complex discharges enabled, this has not yet been sufficient to achieve the inpatient bed rate targets primarily due to a changing cohort with corresponding changes in need, compounded by a lack of willing and able community providers

- There has been a reduction in those with learning disability accessing inpatient provision but an increase in those with Autism and no learning disability
- CTR delivery now surpassing NHSE targets
- Increased governance and monitoring of patient data, ensuring more timely discharges, and
- Increased leadership to drive programme objectives forward.

The following outcomes have been prioritised

- To reduce inappropriate hospitalisation of people with a learning disability, autism or both: In Sussex this translates as a reduction from 85 to 56 beds
- To continue to improve access to healthcare for people with a learning disability with increase in Annual Health Check: Locally, Annual Health Checks (AHCs) are to be offered to 75% of people with learning disability on a GP register by 2020
- Further investment in intensive community support to avoid hospitalisation
- To ensure more children with a learning disability, autism or both get a Community Care, Education and Treatment Review (CETR) to consider other options before they are admitted to hospital, and
- The Learning Disabilities Mortality Review (LeDeR) Programme: To continue the work on tackling premature mortality by supporting the review of deaths of patients with learning disabilities, as outlined in the National Quality Board 2017 guidance and ensuring learning is embedded.

Summary of Planned Actions in the coming year

The following outcomes will be delivered:

a) Continue to Reduce Inappropriate Hospitalisation:

- Ensuring Care and Treatment Reviews (CTRs) continue to be completed in line with the CTR policy (April 2017) timescales. With added focus on children and young people in east Sussex
- Reducing admissions with a focus upon the impact of pre-admission CTRs
- Ensuring that discharges are safe and timely for each individual including fortnightly discharge planning meetings with commissioners to ensure best practice is applied and provide support for any blocks to discharge
- Continuing to ensure the local standard that 90% of CCG inpatients have discharge dates and plans
- Active participation in the roll out of new care models for mental health
- Investment in prevention measures, Stopping Overmedication of People with a Learning Disability (STOMP), Autism Awareness and Training, Positive Behaviour Support and training
- Commissioner training for Personal Health Budgets, and
- Increased engagement of those with lived experience to inform commissioning strategies.

b) Increase the Annual Health Checks (AHCs) offer

- Ensuring AHCs are offered to 75% of people with a learning disability in Sussex on a GP register by 2020
- Quarter 2 performance this year has fallen marginally from 16.13% in 2017/18 to 16.4% in 2018/19, and
- A review of Annual Health Checks, including current levels of resource, capacity, to uptake and gaps has commenced and will inform refreshed improvement plan.

c) Community Development

- Develop and deliver commissioning strategy to increase willing and capable community providers to increase rate of discharges and increase quality of community provision
- Deliver 14 new housing and support options via NHSE capital funds
- Increase community provision to prevent admission and maintain discharges
- Pan Sussex Transforming Care Autism team
- Establishment of an Intensive Support Service in East Sussex
- Additional Capacity in Sussex wide forensic team (Learning Disability specific), and
- Children's LD Services in West Sussex.

d) Increase Care, Education & Treatment Reviews for Children (CeTRs)

- Continue standardisation and improved quality of CeTRs and risk registers across the Transforming Care Partnership (TCP), including children. This will enable individual escalation support is in place to prevent admission.

e) Tackle Premature Mortality

- Continuing to implement the Learning Disabilities Mortality Review (LeDeR) Programme across Sussex, driving improvement in care and treatment of Learning Disabilities/ (LD/LSD) individuals
- recruit to LeDeR programme manager role, and
- Collation of LeDeR review findings, identifying key themes arising from early death, learning lessons and determining required actions and areas for change (LeDeR Programme Work Stream) in Sussex.

A year in commissioning

Our programmes

Transforming primary and community care

Throughout 2018/19 the CCG has been working with key partners across primary and community services to develop the building blocks to an Integrated Care Partnership. This has included further work in developing primary care networks and multi-disciplinary teams that fit around networks so that patients' needs are met in a holistic, joined up way. This way of working is further supported through the recently published NHS Long Term Plan that focuses on a network model of general practice with a range of health care services wrapped around them. We have also been working with our community providers to ensure that patients at risk of hospital admission, or after a stay in hospital, have timely access to the care they need within their own home or usual place of residence.

We have made good progress this year around a number of areas, but specifically:

Resilience of GP Practices

General practices in the area face challenges of recruitment, resilience, and workload pressures which are no different from other areas. The practices have been involved in schemes to support their sustainability and resilience which include those schemes linked to the 10 High Impact Actions particularly active signposting and document management.

There are number of housing developments taking place in the Horsham and Mid–Sussex area particularly north of Horsham. This has the potential to put increased pressure into the area with regards to new patient registrations. A plan is being developed to take advantage of developer funding to support premises development so practices will have the capacity to take these new patients.

Improving care for people with Long Term Conditions

The CCG has improved its care for patients that are diagnosed with diabetes so that more people get the right care and treatment at the right time. We have been working with primary care to improve the number of newly diagnosed diabetic patients are referred to, and complete, a structured education programme to support them to manage their diabetes more effectively.

The National Diabetes Prevention Programme, which targets those people who are pre-diabetic, remains a focus for the CCG and work has taken place to ensure that all eligible patients are offered access to the programme.

The CCG has a growing number of its population who have a respiratory condition, for example chronic obstructive pulmonary disease (COPD) or asthma. We have been working with our community provider; the hospital Trust, and general practice to develop an integrated and streamlined pathway for patients. The CCG has also been using technological solutions to help patients with COPD manage their

condition more effectively with the implementation of the digital application, MyCOPD.

Improving Care at the end of life

The CCG has worked with partners from across health and social care, including hospices, hospital Trusts, adult social care, the voluntary sector, and community providers to develop an End of Life Care Strategy. The strategy includes:

- Developing a nationally recognised digital way to identify patients who may benefit from the above
- Improving the way those patients who at the end of their lives are identified and supported which include enhanced care coordination, the wrapping of care around the patient. We are working with GP practices to implement this approach throughout the next year, and
- Trialling a new way to ensure that patients at the end of life can decide how and where they die. This is called 'ReSPECT'.

Improving the coordination of care for the patients with the most complex needs

The CCG has continued to focus work on developing services that meet the needs of those patients who are most frail, and may have complex needs. We have done this in a number of ways:

- Building on the success of multi-disciplinary team operating at a town based level across Crawley, Horsham and Mid Sussex. This has included the inclusion of hospital consultants who specialise in older adults being part of the MDT 'daily huddles'; and
- Developing a single point of access for those at risk of falls which has helped reduce the number of people who need to go to A&E, or being admitted to hospital, as a result of a fall. Increased investment over the winter has seen a further increase in home hazard assessments (identifying potential fall hazards) and specialist falls interventions.

Improving coordination for the most complex and frail patients

Across Crawley, Horsham, and Mid Sussex we have introduced Communities of Practice (COP) which are multidisciplinary teams based around groups of GP practices. These Communities of Practice bring together the care resources of community and mental health services, social care, community pharmacy, and the third sector (Community Link Workers) around a registered population enabling the delivery of shared outcomes and care organised around individuals and their needs.

To enable caring for complex patients these multi-disciplinary teams communicate and coordinate efforts among the members on a regular basis. The Communities of Practice host a 'daily huddle' facilitated by a Senior Clinician which allows general practice staff, pharmacists, paramedics, and the wider community services to dial in on the day and discuss patients of concern. The health and care professionals then use this information to prioritise and allocate their work based on patient need throughout the day and into the week ahead.

The team meets with primary care colleagues on a monthly basis. These meetings provide a forum to discuss patients about whom the practices and / or the COP teams have concerns and to agree appropriate care and management plans.

With complex patient care the team are focused on admissions avoidance whilst recognising these patients are unlikely to avoid all admissions to hospital therefore they work in partnership with responsive services to support rapid discharge home to reduce length of stay and ensure the patients can remain in their usual play of residence whenever possible. To this aim the COP teams work closely with responsive services teams in Crawley, Horsham and Mid Sussex, other specialist nursing teams, and the Falls Prevention teams.

Improving primary care access

The Improved Access Service (IAS) has been commissioned according to national timescales and has been delivering additional weekday evenings and weekend GP appointments across Crawley, Horsham and Mid Sussex, and East Surrey since October 2018. The IAS delivers an additional 30 minutes of capacity per 1,000 head of population per week and is run via a hub model at various locations across each CCG with the local GP Federation as the provider. The service has been well received by local practices and patients in terms of providing much needed additional capacity.

We have also been implementing a number of general practice specific measures during 2018/19 in recognition of the increasing challenges primary care faces with an ageing local population and the national requirement to prepare for the implementation of Primary Care Networks:

- Use of GP Transformation Fund to stimulate Primary Care Network development and support projects developing solutions to common issues regarding workforce, managing demand and releasing time to care
- Wrap around community services provided via Communities of Practice teams, including community link workers, social care and mental health input a key part of the GPFV and LTP
- Social prescribing interventions accessible by all practices commissioned at scale well ahead of the LTP deadline of 21/22
- Improved Access service in place delivering additional appointment capacity on weekday evenings and at weekends
- Wider workforce developments including GP Assistant role, Paramedic Practitioner, Physicians Associates and practices employing Pharmacists and also accessing CCG commissioned ‘town’ based pharmacist support
- Successful roll out of 10 High Impact Actions across practice populations.
- Care Coordinators / link workers in place in each practice
- PCN developing project for Group based consultations a first of a kind, and
- Emerging Primary Care Networks across the CCGs adopting Primary Care Home Model.

Improving mental health

During 2018/19, the CCG worked with colleagues across the STP, Sussex Partnership Foundation Trust, local authorities, and voluntary sector organisations to deliver the goals and aspirations for mental transformation that were set out in the Five Year Forward View for Mental Health.

During 2018/19, the CCG commissioned the development and expansion of the Improving Access to Psychological Therapies service to treat patients with long term conditions. Areas of prioritised need include people with diabetes, heart disease, and COPD. In addition, further specialisation has included patients with musculoskeletal pain, irritable bowel syndrome and asthma.

Two particular impacts from this development have been, firstly, that patient outcomes are really positive with 55.7% of those treated seeing both their anxiety and depression levels reduce to healthy levels by discharge, well beyond the national target of 50%. Secondly, healthcare utilisation rates have fallen from £5450 annual health care cost before treatment to £2295 after their treatment.

The CCG is developing a Locally Commissioned Service (LCS) to ensure that people with serious mental illness are able to access a comprehensive health assessment in primary care and follow-up support where that is needed. Those with severe mental illness (SMI) suffer huge health inequalities compared to the general population and are at risk of dying 15 -20 years earlier than other people.

The CCG has continued to deliver above the national target for its dementia diagnosis rate (the CCG has been highest in South East England). This has been supported further in 2018/19 by more efficient pathways in assessment and diagnosis, as well as expanded networks of community based support for patients, carers and families.

Children young people and maternity

Children's mental health and wellbeing

Children's and Young People's (CYP) mental health and community health services are commissioned jointly with West Sussex County Council and West Sussex CCGs.

We have recently refreshed our plans for improving services locally and implemented a range of new services (and expanded existing services that have been proven to make a significant impact on CYP).

Overall, we believe one of our strengths is our commitment to engaging local CYP in both developing, reviewing services and planning for the future. The CCG has acknowledged that the journey from childhood to adulthood through emotional health and wellbeing services has weaknesses.

Stakeholders, CYP, and their families said to us that what matters to them is:

- Being seen quickly and with high continuity of care
- Early identification of when help is needed (and such help being available)
- Easy access and simple pathways

- Greater capacity and choice for early support
- Greater coordination between all agencies (and in particular having no gaps between young people's and adult services)
- Having a great experience of care as well as the right medical intervention, and
- Recognition of the complexity of their lives.

Over the past year, CYP and their families have been involved in many ways. For example:

- Over 50 children and young people have contributed to the scoping of the counselling service for sexual abuse
- Free Your Mind, a group of 11-18 year olds, started as an action group to reduce the stigma around mental health which also provides a forum to influence commissioning plans and services
- Families have been involved in the development of the Sussex children and young people and Families Eating Disorders Service through the development of parents groups and the production of resources, and
- CYP and families have shaped the new neurodevelopmental pathway model including parents and carers as key members of the Steering Group.

In addition, with population growth and changes in the profile of need, demand for services are projected to increase. Although any description of the future is always subject to very high levels of variability, current capacity across the whole system will need to manage an increase in demand.

Based on previous assessments of children's needs (and growth in population) we have agreed new plans and implemented significant changes in 2018/19. These include:

- Over 30% increase in the numbers of CYP who have been supported through Child and Adolescent Mental Health Services (CAMHS) and emotional well-being services overall (and delivered in schools, local facilities and out of hospital environments). Locally, we saw one of the largest increases in access for patients in the South East
- Those CYP who do end up in A&E (and who are experiencing mental health problems) are also seen by enhanced CAMHS teams
- More and better training. Our successful mental health training programme for the whole workforce (from GPs and social workers to police officers and youth volunteers) has continued to expand and now includes a programme for parents and carers, and
- Increases in the Eating Disorder services to improve access for CYP who require more intensive mental health support.

Children's Community Health Services

Two NHS organisations, Sussex Community Foundation NHS Trust and Western Sussex Hospital NHS Foundation Trust, provide children's community services (including child development centres, therapies and community nursing). Both Trusts are committed to working in partnership with commissioners to prioritise waiting

times for those children waiting for an autism assessment. Although work in ongoing, we plan for over 100 more children to have been assessed through increased capacity.

We are also working closely with schools, and additional support has been available for community nurses to work with our local specialist schools. Additional community nurses are also available in the Mid Sussex area to ensure services are now more equitable across West Sussex.

Plans to create a new refurbished Child Development Centre at Crawley are progressing and final designs to be available for implementation in 2019/20 onwards. A lead clinician for CYP with special education needs has now been appointed within the team - which means those patients will get increased support and better coordination across all the different agencies.

There has also been a significant increase in performance for looked after children (LAC) children requiring health assessments. There has been a significant reduction in the average working days of completion for CYP under the care of Sussex Community Foundation Trust to now 75% being seen within 16 working days (up from 25%).

Local maternity system

The majority of women living in Horsham and Mid Sussex deliver at either East Surrey Hospital or the Princess Royal Hospital. The CCG has a higher than national average rural population and higher percentage of older mothers (over 40). It is acknowledged that rural populations have a higher risk of maternal morbidity, poor access to care including antenatal care, reduced choice in terms of birthplace, and increased risk of mental illness. Also older mothers have an increased risk of complications including gestational diabetes, eclampsia, miscarriage, growth restriction, and reduced choice. The CCG has been working with system partners to ensure that the needs of women accessing maternity services are met and with the same offer for all women to reduce in equality and unwarranted variation, as they are known to be linked to poor access and worse pregnancy outcomes.

The most recent Improvement and Assessment Framework rating of ‘outstanding’ was a significant improvement on the previous rating of ‘requires improvement’. Smoking at delivery and stillbirths/neonatal mortality are below the national average. Patient experience was above the national average. However choice of maternity services has been identified as an area for improvement and the CCG is working jointly with NHS Brighton and Hove CCG to scope the options for an alongside midwife led unit.

Maternity services are facing an increasing challenge of improving outcomes in the context of increasing prevalence of risk factors whilst endeavouring to meet the expectations of women and their families. Over the past couple of years the CCG has been an integral member of the Sussex and East Surrey Local Maternity System (LMS) working with other commissioning organisations, providers and service users to develop and deliver our long term transformation plans. These plans have been created to deliver the key outcomes identified in the Better Births: Five Year Forward

View for Maternity Services. The four core target improvements we are aiming to meet for women and their families are:

- Safety and perinatal mortality: reducing stillbirth and neonatal mortality rates by 20% by 2020
- Reducing Health inequalities and unwarranted variation: ensuring all women are offered high-quality care regardless of geography, circumstance or background
- Improving Access to perinatal mental health (PMH) services: early identification of women experiencing PMH problems and supporting the mental health and wellbeing of women and their families throughout the perinatal period
- Improving maternal experience: working with women and families to provide a kind, caring and personalised maternity journey and co-designing services to meet women's need.

Working with the LMS the CCG acknowledges the critical role that maternal involvement provides in supporting service improvements. To enable this the LMS has been strengthening links with women putting them and their families at the heart of the development of maternity services. Bringing service users, providers, and commissioners together across the LMS enables ongoing involvement and co-design of services with women and their families through Maternity Voice Partnerships (MVPs). The MVPs are the long-term forum for service user engagement playing a continued role in the development of maternity services guided by the needs of local families. The CCG has been working with locally with established Maternity Service Liaison Committees supporting them during their transition to MVPs.

The CCG is committed to delivering the future vision for maternity services in line with Better Births: Five Year Forward View for Maternity Services and through this the following benefits will be realised:

- Better staff and user satisfaction
- Better value maternity services
- Improved population health
- Improved safety and outcomes, and
- Increased service sustainability.

Working as part of the LMS will support the CCG vision to deliver transformative change. The end objective is to empower and enable all women to make real choices about their care, supported by collaborative relationships with healthcare staff, access to care in the community, and ultimately services which are co-designed to meet their needs.

Medicines management

Over the last financial year the Medicine Management Team have worked to improve patient care and optimise their medicines through evidence based, patient centred and cost effective medicines. The CCG team of pharmacists and pharmacy technicians have worked closely with all colleagues within and outside the CCG to work on an ambitious and innovative approaches to deliver quality and efficiency in the health economy. We worked to reduce inappropriate polypharmacy, admission reduction through optimising patient medications, monitoring medicine's safety and efficacy and assisting clinicians with their workload.

The team have worked to expand partnerships with all stakeholders and have welcomed new colleagues to provide medicine review in care/nursing homes in addition to building on the success of the team working with communities of practice teams and networks in a multidisciplinary integrated model.

We have had many successes last year. From managing stock problems such as recent global shortages in Epipen® to implementing national policies such the NHS England low value items, we have supported everyone involved and worked towards the best outcome for the patient. The implementation of a new repeat management policy within the CCG has supported in reducing medicine wastage significantly by empowering patients to manage the ordering of their medicines. The support of colleagues in community pharmacy has been fundamental to the success of this. Empowering patients has been an essential part of the CCG's work and the CCG has achieved great success in implementing the national self-care policy. This will help our patients lead healthier lifestyle and prevent ill health.

With respect to high cost drugs, the CCG has successfully completed the implementation of a number of best value biologics. The CCG has established a joint working relationship with Kent, Surrey, and Sussex to embed change consistently on a bigger geographical footprint and is working in partnership with NHS England and the regional procurement teams to improve the management and procurement of high cost drugs for the future.

Technology to empower patients

Online Consultation Project

The CCG is supporting GP practices in reaching 20% of patients registered for patient online services, by providing training and support. Online services are being offered in addition to the traditional telephone and face-to-face means of interacting with a GP practice. Patients can choose the route they prefer.

These services include:

- Booking and cancelling appointments
- Ordering repeat prescriptions, and
- Viewing their GP record (which includes coded information about allergies, immunisations, diagnoses, and medication and test results).

Extended Access Hubs

We are supporting the Additional Access and Extended Access Hubs, providing and supporting IT solutions for improving access to general practice. This is to ensure everyone has improved access to services, such as routine appointments at evening and weekends.

This involves working with local practices and practice federations in setting up hubs, to ensure a joined-up service approach for patients, which is connected to the wider system of urgent care.

Public Wi-Fi

We are working on providing a free, secure and consistent Wi-Fi services at practices. This will allow patients to be connected to the internet to access health and care information such as:

- Access Health Apps such as the new NHS App
- Access personal health records
- Interact with patient support networks
- Manage appointments and medication
- Manage conditions online, and
- Use health-based information services.

The project is being completed jointly as a single approach across Central Alliance CCGs with a selected IT provider.

As the range of digital services available increases, this will enable patients to take control of their own health and care online.

Urgent care

During 2018/19 the CCG has commissioned a ‘GP in Emergency Department service’ at Princess Royal Hospital. The GPs work as part of an integrated team at the hospital supporting emergency flows and assessing patients with ambulatory care sensitive conditions.

Due to the increase in the number of children presenting to A&E (as reported in the CCG inequalities report) GP practices across areas seeing growth have implemented a same day paediatric assessment process enabling parents with sick children to access an appointment at the practice rather than having to potentially wait for an appointment on another day or seek alternatives.

The CCG has an ageing population (projected to increase to over 53,000 people in the next five years) and a high ratio of care home beds within its geography. The population cohort with one or more long-term condition is also increasing.

Development of contingency plans for care home residents, end of life care, and patients with known long-term conditions and at risk of hospitalisation has been supported by community and GP practices. The contingency plan information is made available to ambulance crews and GP Out of Hours services to enable informed decision making and prevent conveyance and hospital admission where possible. The information being available to ambulance crews has helped to reduce the conveyance rate for the targeted population.

Stroke

Although nationally deaths caused by stroke have halved in the last two decades, the growing and ageing population in the CCG area will increase the number of people having a stroke by almost 50% by 2035 and the numbers of people living with disability will increase as a result. The CCG has focussed on primary and secondary prevention through a proactive approach to reducing high blood pressure, improved cholesterol control and the detection and management of atrial fibrillation (AF). The gap between the number expected in the population and those identified has closed with 5,394 detected above the national average and above the Kent, Surrey, and Sussex average. The numbers on anti-coagulation are 92%, above the national and local South East Region performance.

A number of national developments will continue to provide a focus on cardiovascular management through changes in the GP contract that underpin the ambitions in the NHS Long Term Plan for secondary prevention. In 2019/20, further progress is expected through changes to blood pressure and control and the detection of AF. A new cardio-vascular disease national prevention audit and benchmark tool for primary care will support continuous improvement.

For those residents unfortunate enough to have a stroke they will go to either Royal Sussex County Hospital (RSCH) or Surrey and Sussex Hospitals Trust (SASH). The quality of the service delivered as measured by a national audit (Sentinal Stroke National Audit Programme) has improved with RSCH performing at the highest level of ‘A’. SASH have achieved a ‘B’ rating and our focus this year will be on working with them to continuously improve to be able to achieve consistently better outcomes.

In 2018 the CCG has monitored the embedding of the Early Supported Discharge service delivered by our Community Service provider (Sussex Community NHS Foundation Trust). The pathway delivers rehabilitation and re-ablement services to enable more people to leave hospital earlier and make a faster recovery at home. The pathway was commissioned to take patients with an increased level of complexity of rehabilitation needs. Last year on average 33% of discharged patients were on this pathway and the trend has been growing with the ambition to consistently reach 40%. Community pathways are supported by the Stroke Association Recovery Service which also carries out six month review after strokes.

In 2019 the CCG’s focus will be on enabling the NHS Long Term Plan’s stroke ambitions for Acute- and Community-based stroke rehabilitation services. These include further improvements in access to 24/7 high quality specialist diagnostic pathways to detect the type of stroke and new treatments for example clot extraction for appropriate patients.

Planned care

The priorities for the Planned Care Team for 2018/19 were to manage demand for planned care services and ensure that pathways are clinically effective and delivered in a timely and affordable way thereby reducing waiting times for patients.

Demand Management

Our demand management programme has been focussed on reducing variation in GP referrals not always easily explained by different demographics, health needs, or practice populations. We have now fully implemented a Referral Support Service (RSS) which helps ensure referrals to secondary care are consistent with our commissioning policies and thresholds for treatment, promotes the use of Advice and Guidance, and offers patient choice.

The RSS has also helped to ensure the successful roll out of the national Electronic Referral Service (ERS) and 100% of our referrals are now made electronically meeting the national October 2018 deadline. All of this means our patients have access to the right planned care services at the right time, reducing waiting times for clinically appropriate referrals.

Clinically Effective Commissioning programme (CEC)

The CCG has been working with our commissioning colleagues across the STP on the Clinically Effective Commissioning (CEC) programme. CEC is a programme established in 2017, which aims to improve the effectiveness and value for money of healthcare services by ensuring that commissioning decisions are consistent, are in line with the latest clinical evidence and represent the most sensible use of limited resources. It is anticipated CEC will bring the following:

Expected outcomes and benefits of the CEC Programme

Benefits	Outcomes
• Reduced variation in clinical practice	• Improving outcomes (reducing rate of complications, readmissions; improvement in benchmarked position in terms of Right Care outcomes)
• Maximise use of resource and focus interventions which have the highest health benefits	• reducing resource utilisation (overall reduction in the number of interventions not routinely commissioned;
• Improved joint working across STP/Sussex CCGs	• improved adherence to clinical policies where we have thresholds in place- measurable by clinical audit or other tools

A review of current CCG Clinical Policies was concluded in July 2018 and some changes have already been implemented this year. Our current clinical policies are available on the CCG website.

We have also been working to strengthen the governance and formal decision-making arrangements for the CEC programme with a view to streamlining these and strengthening oversight and transparency of the CEC programme as a whole. A further programme of clinical areas for review has been developed for 2019/20.

Reducing Clinical Variation

The CCG has started working with our commissioning colleagues across the STP to address clinical variation in three clinical pathways including musculoskeletal, circulation, and falls.

The key aims of the programme are to gain a better understanding of clinical variation in these pathways and enable providers and commissioners to work together to deliver solutions to unwarranted variation and implement evidence based patient pathways that drive up the quality of care and value that our patients experience.

The CCG we have worked with fellow commissioners in the south to implement an evidence-based elective angina pathway with BSUH that is consistent with NICE Guidance. The programme has been endorsed as a key priority for the STP; a programme manager has been recruited and we have started a cycle of working groups for each of the pathways.

Improving patient pathways

The CCG has implemented a number of changes to improve patient pathways:

- In November 2018 we implemented a new service for patients with venous leg ulcers to ensure better outcomes and improved healing rates
- In January 2019 we started a tele dermatology pilot which means GPs are supported and upskilled to manage more patients in primary care and patients receive care closer to home without having to travel for specialist opinion, advice and care
- we are part of a national First Contact Practitioner pilot for our musculoskeletal (MSK) services which aims to improve care for patients by providing earlier intervention by an MSK specialist
- we have rolled out a self-referral pathway for MSK patients to access physiotherapy, and
- we have developed a new pathway for ear wax removal and this will be in place from April 2019.

Cancer

We have been working with our fellow commissioners in SES and the Surrey and Sussex Cancer Alliance to support achievement of the eight national waiting time standards for cancer. This includes addressing priority areas for improvement that include prevention, early diagnosis, patient experience, living with and beyond

cancer, modernising cancer services and commissioning, accountability and provision. Specifically we have:

- Developed a SES Commissioning Plan which describes what we will do to meet the national recommendations in the National Cancer Strategy and the NHS Long Term Plan
- Extended the scope of current Non-Obstetric Ultrasound (NOUS) contracts to include suspicion of cancer to reduce demand on diagnostics in acute hospitals
- Fully implemented NG12 guidance for cancer referrals (which include lower thresholds for referral , new pathways and diagnostics, including straight to test)
- Implemented straight to test pathways for colorectal for BSUH and SASH
- Implemented the ACE (accelerate, coordinate, evaluate) pathway for lung cancer at BSUH and SASH
- Implemented the Faecal Immunochemical Test (FIT) at SASH to enable earlier diagnosis of bowel cancer
- Started a rolling programme of GP Practice visits to encourage uptake for screening and a GP education programme to raise awareness of signs and symptoms of cancer, and
- Started work to scope delivery of the Recovery Package which supports people to self-manage the impact cancer and its treatment can have on all aspects of life, to meet national requirements that 'every person with cancer has access to the elements of the Recovery Package by 2020'.

South East Coast Ambulance NHS Foundation Trust

In October 2018 the CCGs across Kent, Surrey and Sussex came together with South East Coast Ambulance Service NHS Foundation Trust (SECAmb) to announce plans for a major programme of work that will improve care for patients across Kent, Surrey and Sussex, and North East Hampshire.

This followed an independent review (jointly commissioned by the CCGs and the ambulance service) that looked at demand for and capacity to deliver ambulance services and the need for a rolling programme of investment to help address a number of challenges and implement changes that will improve patient care and experience.

As a result commissioners committed to additional investment in ambulance services, starting with £10million in 2018/19, with similar levels of investment over the next two years. The additional investment will see an improvement plan in place that will:

- Ensure the service has the right number of staff, with the right skills, to meet the changing needs of its patients
- Improve the service's fleet of vehicles, to ensure we have the right number and type of vehicles available to respond to all categories of call, and significantly increase the number of front-line ambulance staff on the road and in its Emergency Operations Centres.

Part of these improvement will also see SECAmb working to improve response times including in rural areas. A Service Transformation and Delivery Group is overseeing implementation of the plan, which will enable the ambulance trust to meet key performance standards that have been introduced as part of the national Ambulance Response Programme.

We are also working closely with SECAmb to deliver a number of other improvements. These include:

- Continued focus on reducing hospital handover delays. We saw these increase over the winter period due to additional pressures but performance in this area has now improved
- Continued improvement in performance relating to how emergency calls are answered and handled, with 80% of calls now being answered within just five seconds and plans to achieve 95% by June 2019. This has been as a result of new Emergency Medical Advisors and also a new telephone system introduced at the end of last year
- Further work with the trust to support recruitment as part of the service transformation
- Updating the 2019/20 service specification (which sets out in detail what the service we buy must include) to ensure the same level of service is provided across the whole geography of the contract, ensuring a fair and equitable service for the whole population, and
- Working closely with the trust on the reporting of serious incidents, ensuring that these are reported to us and then working with the ambulance service to ensure action is taken where needed.

Patient transport service

The Patient Transport Service is a non-emergency service provided for medically-eligible residents of Sussex who require support in getting to their appointments.

A contract for patient transport with a former provider was terminated early in 2016/17 due to failure to perform the service adequately. Additional costs were incurred over and above the contract price of c£7m funding the continuation of the service until a replacement provider was in place. NHS High Weald Lewes Havens CCG, on behalf of the STP CCGs, is currently seeking to recover these additional costs by calling upon the former provider's parent company under a guarantee to remedy performance and / or to reimburse the costs. The matter is in the hands of the CCG's solicitors who have confirmed that all costs fall within the remit of the Parent Company Guarantee.

The current contract with South Central Ambulance Service (SCAS) is now in its second year and responsibility for its management transferred from NHS High Weald Lewes Havens CCG to NHS Coastal West Sussex CCG on behalf of all of the STP CCGs on 1 November 2018. The process is integrated through a Sussex-wide Programme Board and a contract review process involving all of the CCGs.

The operational and quality performance on the contract has been maintained and in some areas improved in 2018/19 compared with 2017/18. The levels of complaints and incidents remain relatively low for a contract of this size.

There are still challenging areas within the contract on which the CCGs are working with SCAS to improve further particularly around call answering, discharges, and transfers. Discussions are also underway regarding potential service improvement for the last year of the contract and the longer term procurement options.

Engaging people and communities

We have a duty to ensure the services we commission meet the needs of our local population. Therefore we engage with and involve patients, carers, and the public in our work in order to make sure the services we commission are responsive to their needs and deliver the best possible standards of care. We also build local networks and partnerships in order to extend reach and work collaboratively with communities and partners to ensure we seek as many views as possible.

Being part of the Alliance has brought the benefit of an extended engagement team across the five CCGs in the Alliance with resulting increased capacity, alignment of systems and processes, and shared good practice. We are also working with NHS Coastal West Sussex, NHS Hastings and Rother, and NHS Eastbourne, Hailsham and Seaford CCGs in order that all eight CCGs in the Sussex and East Surrey Sustainability and Transformation Partnership (STP) work together with a shared vision.

Big Health and Care Conversation

Over the past year we have extended the Big Health and Care Conversation to CCGs across the Alliance. In Horsham and Mid Sussex we held three town-based events where attendees had the opportunity to express views and ideas in relation to our key commissioning areas. We also took the Big Conversation out to the local communities to gather further feedback. We produced a summary report showing the main points and where we have taken, or plan to take, action as a result.

Our Health and Care, Our FUTURE

In January 2019 the NHS Long Term Plan was published and NHS England (NHSE) has asked CCGs to develop local plans that will deliver the aims of the NHS Long Term Plan for our local population. In addition the 'Population Health Check' was published in Sussex and East Surrey providing a diagnostic on the health needs of our populations. We have been engaging with local people and organisations across Sussex and East Surrey in a coordinated and aligned way about what this means for them and which areas they think should be prioritised. We are linking this in with the ten areas of focus highlighted within the NHS Long Term Plan. This will build on the feedback from the Big Health and Care Conversation and provide the foundation for further engagement to develop local plans later in 2019/20.

Engagement in commissioning

We have continued to ensure that we put the views of patients, carers, and the public at the centre of our commissioning. We systematically engage with patients, carers, and the public to inform our planning and commissioning work. We record all our engagement activities and listening events and proactively manage feedback to ensure it informs commissioning decisions and activity.
Over the past year, we have sought feedback on services including:

- Improved GP Access
- Maternity Services
- Online GP consultations
- Referral Support Service
- Sussex Musculo-skeletal pathway, and
- Time to Talk service.

We also heard from Dermatology service users and the carers of service users about their experiences, views, and suggestions which fed into the transformation of Dermatology services over the next five years. We also heard from users of Maternity services which fed into the creation of a new dashboard for patients and the organisation of a 'Dads Matter' Workshop. Feedback from our survey to understand local eye health needs has been used to enhance and improve community and hospital Ophthalmology services.

We recognise that it is important to support our staff to understand the need for engagement. We have appointed Engagement Champions within the commissioning teams across the CCG who support the embedding of high quality and appropriate engagement in our work.

Patient Participation Groups (PPGs) and Commissioning Patient Reference Group (CPRG)

The CCG continues to work closely with PPGs. Across Horsham and Mid Sussex there are 20 active Patient Participation Groups (PPGs) in the area. The representatives of Horsham and Haywards Heath PPGs come together in locality-based forums; in addition representatives from all PPGs are members of the Commissioning Patient Reference Group which also includes representatives from PPGs in Crawley in addition to clinicians, Healthwatch, and local voluntary and community sector members. The CPRG is chaired by our Governing Body Lay Member for Patient and Public Engagement.

Over the past year we have reshaped the CPRG to ensure that it is effective as a way of engaging on our commissioning plans and that there is a clear route for PPG members to feed into the CPRG and the CCG. The CPRG has contributed to various work areas including:

- Communications in relation to our Clinically Effective Commissioning programme
- Providing feedback on the Alliance's Communications and Engagement Strategy

- The creation of a digital self-management service for patients with chronic obstructive pulmonary disease
- The development of the Integrated Primary Urgent Care (IPUC) programme
- The introduction of social prescribing across the area, and
- The review of the Dementia Framework.

Communities, neighbourhoods, and partnerships

We have continued to build on existing work in communities across the area. We have expanded our network of contacts and have used this to seek feedback about health and wellbeing information and to extend invitations to be involved in our work.

We have built on our existing links with West Sussex County Council, Healthwatch West Sussex , local parish and district councils, and key local voluntary community groups in order to maximise opportunities for a collaborative approach to engagement and to extend our reach across the wide geography of the area.

Engaging with diverse groups

We know there are groups and communities in Horsham and Mid Sussex who do not engage with us through our regular methods. It is particularly important that we do take steps to seek these views as these groups often comprise people who have existing health inequalities or inequity of access to health and care services.

We work closely with groups and forums that can help us to reach and hear from those who do not engage through our usual methods. This builds upon our principle that we should ‘go to’ our communities to seek their views and feedback or work with trusted intermediaries to do so.

These groups include:

- 4Sight Group in Haywards Heath
- East Grinstead Rotary Club
- Forward Thinking Dementia Group.
- Local Carers’ forums
- Mental Health Forum
- Mid Sussex Older People’s Council, and
- Sangam Women’s Forum.

Keeping patients, carers, and the public informed

We continue to develop and grow our Health Network. This is a virtual group of local people who have expressed interest in working with us through sharing views and becoming more closely involved. This not only informs commissioners about the views of those using local health and care services but also provides active engagement in our ongoing work. We currently have approximately 500 members.

We produce our public newsletter ‘Patient Round-up’ each month which helps keep people informed about our work and provides information on engagement opportunities and wider community initiatives that support health and wellbeing.

We use a variety of other tools to keep patients and the public informed of our work and to promote involvement opportunities including our public website, newsletters, Facebook, Twitter, and YouTube.

Over the past year we have posted approximately 100 tweets on the CCGs' Twitter account promoting a range of campaigns including #HelpMyNHS and #StopOctober. We shared approximately 100 items on the CCGs' Facebook accounts raising awareness of Evening and Weekend GP Appointments, NHS 111, and Change4Life. We also produced two podcasts and six videos on ordering medicines, Bin Used Tissues, and Help Us Help You Stay Well This Winter in A&E.

Reducing health inequalities

The CCG has a duty to reduce health inequalities and our health needs analysis of the CCG's population seeks to understand the causes of health inequalities and to find ways of addressing these.

Inclusion has been a significant focus of work across all of the eight CCGs in the STP during 2018/19 with a high level of system development, staff engagement, and training regarding equalities and health inequalities taking place during the reporting period. The highlights of this are:

- Mandated staff engagement events to review organisational performance relating to equalities and culture
- Additional mandated face-to-face training for all staff focussing on health inequalities and equalities
- Leadership development via the hosting of a Compassionate and Inclusive Leadership Conference for all managers at Band 8a and above
- Participation in Inclusion Week 2018: The CCGs developed a range of corporate communications to promote inclusion throughout the CCGs during Inclusion Week 2018
- A corporate drive to encourage all employees to update their personal details on the Electronic Staff Record so that the organisations are more aware of the diversity of the workforce which will inform strategic planning, and
- The renewing of our organisational values by replacing historical local values with those expressed within the NHS Constitution.

Building on this good work, an Inclusion Strategy will be developed over the summer months which outlines the CCGs' collective strategic intent and outlines key priority areas for the period 2019-2023. In addition to the focus on developing an inclusive and diverse workforce, the strategy will also address how we optimise commissioning levers to address the inclusion agenda and health inequalities across our wider population.

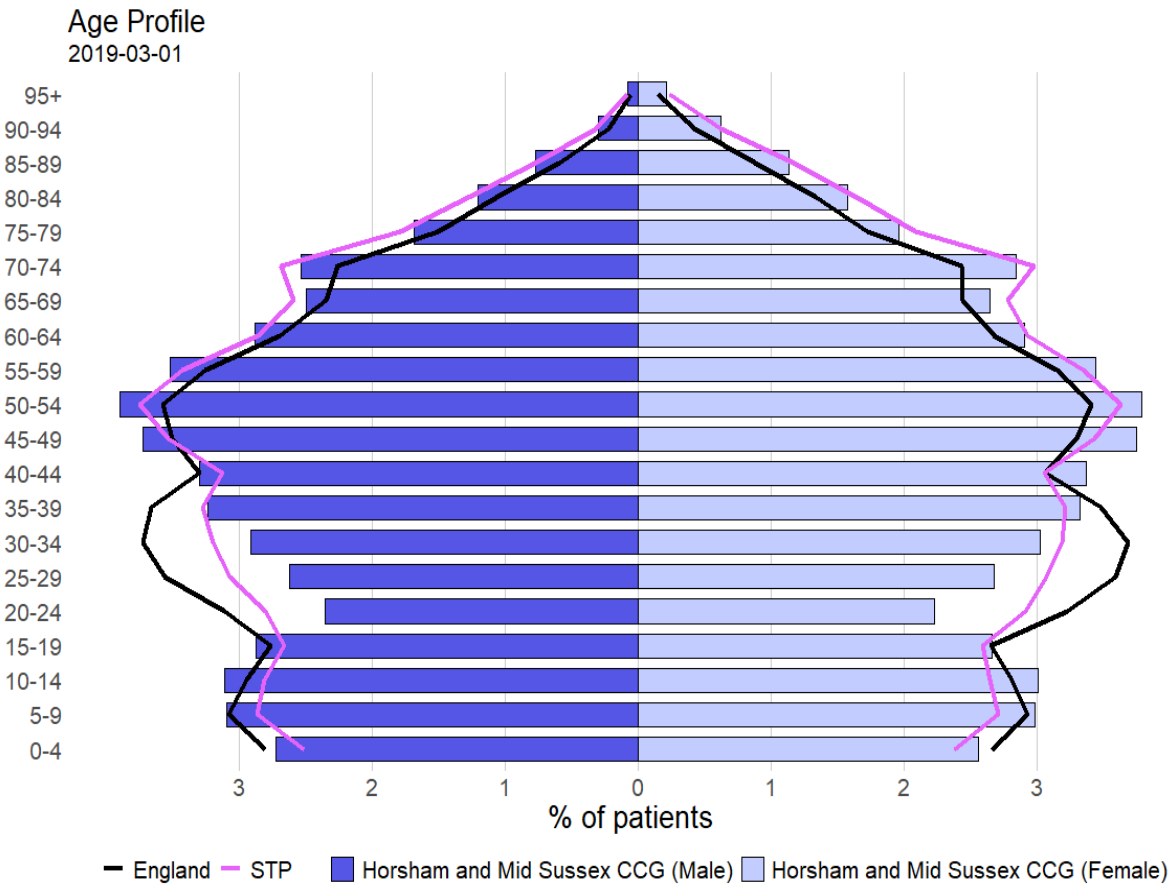
Population

The current population projections for NHS Horsham and Mid Sussex CCG are estimating an overall population increase of 7.9% over the next ten years and a 14.6% increase over the next two decades.

Higher percentage increases are expected in older age groups, specifically persons aged 65-84 years (+23.0% by 2026, and +43.4% by 2036) and aged 85 years or above (+33.8% by 2026, and +122.5% by 2036).

9% of Horsham and Mid Sussex population are from black and minority ethnic groups.

Age profile of population



When compared with other similar populations NHS Horsham Mid Sussex CCG is significantly better than England for the following:

- Life expectancy
- Deaths, all ages and all causes, and
- Incidence of some cancers.
- However NHS Horsham Mid Sussex CCG is significantly worse than England for the following:
- Incidence of prostate cancer
- Elective Coronary Heart Disease admissions.

Equality

The Health and Social Care Act 2012 introduced the first legal duties about health inequalities. It included specific duties for health bodies including the Department of Health, Public Health England, CCGs, and NHS England, which require the bodies to have due regard to reducing health inequalities between the people of England.

The Equality Act 2010 established equality duties for all public sector bodies which aim to integrate consideration of the advancement of equality into the day-to-day business of all bodies subject to the duty.

In particular, the Equality Act 2010 introduced a new, legal, Public Sector Equality Duty (PSED) requiring public bodies to declare their compliance with the duty on an annual basis. This means that as a CCG we must show compliance with both the general and specific duties of the PSED.
In the exercise of its functions, for the general duty we must have due regard to the need to:

- Eliminate discrimination, harassment and victimisation and any other conduct that is prohibited by or under the Equality Act 2010
- Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it, and
- Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

Protected characteristics – in the context of the PSED – are defined as age, disability, gender reassignment, pregnancy and maternity, race – this includes ethnic or national origins, colour or nationality, religion or belief – this includes lack of belief, sex (male and female), and sexual orientation.
For the specific duty we are required to:

- Publish information to demonstrate compliance with the general duty
- Publish data on the make-up of our workforce
- Publish data on those affected by our policies and procedures, and
- Publish one or more equality objectives covering a 4 year period.

We are committed to embedding equality and diversity values into our policies, procedures, employment practice and the commissioning processes that secure health and social care for our population.

Equality Impact Assessments

Equality Impact Assessments (EIAs) help demonstrate that an organisation is giving due regard to equality when developing and implementing changes to strategy, policy, and practice. The eight CCGs have reviewed the way in which EIAs are completed and managed and made significant improvements to the overall process during 2018/19. Further training will be delivered during 2019 to ensure all relevant managers are fully knowledgeable and skilled in applying the new processes.

Equality Delivery System 2 (EDS2)

The EDS2 is a framework that helps NHS organisations to improve the services they commission or provide for their local communities; it also considers health inequalities in our locality. EDS2 also provides evidence of better working environments, free of discrimination, for those who work in the NHS.

On receiving advice from NHS England the CCGs within the Alliance have undertaken a combined EDS2 assessment during Quarter 4 of 2018/19 when several services were assessed within domain 1 (Better Health Outcomes) and domain 2 (Improved Patient Access and Experience).

Investment in Inclusion Experts

The leadership team has stated that evidencing best practice inclusion and reducing health inequalities are key organisational priorities. To support this the organisation has invested in senior managerial leadership for the Inclusion programme and in an Equalities and Diversity Manager to ensure that best practice is developed throughout the organisation and that our reporting on our performance relating to legal obligations and NHS Standards is of the highest quality.

Workforce Race Equality Standard (WRES)

Workforce Race Equality Standard reports have been developed for all of the CCGs in 2018/19. For 2019/20 the CCGs will work to produce one single report and action plan covering all eight CCGs.

Workforce Disability Equality Standard (WDES)

The CCGs received a presentation from NHS Employers on the Standard which comes into effect on 1 April 2019. Although not statutorily obliged to do so for the period 2018/19, the eight CCGs have agreed to publish their collective WDES data and develop an action plan in response to the findings.

Gender Pay

Although individually CCGs were below the threshold of staff for mandatory reporting, five of the eight CCGs in 2018/19 committed to reviewing and publishing their gender pay differential during 2018/19. Staff were invited to workshops held in various sites to hear about the gender pay gap and to explore what the CCGs might do to understand and address this differential. It is planned that a cross-organisational network for women will be established and a more consistent approach to flexible and agile working rolled out across the CCGs during 2019/20.

Health and wellbeing strategy

The CCG has two seats on the West Sussex Health and Wellbeing Board (HWB) which has been established as a statutory committee of West Sussex County Council and is the body responsible for leading on improving the co-ordination of commissioning across NHS, social care, and public health services. The Board brings together elected council members, leaders from the NHS, social care, and the voluntary sector to work together and support one another to improve the health and wellbeing of the local population and reduce health inequalities. A major responsibility is the development of the health and social care needs assessment referred to as the Joint Strategic Needs Assessment (JSNA). The JSNA identifies the health and wellbeing needs of the people of West Sussex and the results are used to inform the local commissioning of services to create a more effective and responsive local health and care system.

We consult regularly on a formal and informal basis with the HWB, its membership, and its Chair. In particular we consult with the HWB on our strategies and plans and how these contribute to the delivery of the Health and Wellbeing Strategy for West Sussex. The West Sussex Director of Public Health formally presented the draft West Sussex Health and Wellbeing Strategy at the Governing Body meeting held in January 2019.

Joint Commissioning

The CCG continues to commission services in partnership with NHS Coastal West Sussex CCG, NHS Crawley CCG, and WSCC. Joint commissioning is delivered and managed through the Joint Commissioning and Partnerships Directorate that works across partner organisations and includes:

- Community Equipment Services
- Community and Mental Health services for children and young people
- Services for Learning Disabled adults, and
- The Better Care Fund (BCF).

The Partnership reports through the Joint Commissioning Strategy Group to the Health and Wellbeing Board as well as to the three West Sussex CCGs and WSCC.

Our partnership and joint commissioning arrangements across West Sussex are an important part of our journey towards Health and Social Care integration. We have many examples of jointly commissioned services delivering integrated care to patients and service users and strategic intent to develop further jointly commissioned, integrated services. This year, we have worked closely together as three CCGs and WSCC to review and strengthen the governance structure required to support the high-level joint commissioning strategy. New areas for collaboration and integration have been identified which, together with the use of the BCF, will support further system-wide collaboration and transformation.

Learning Disability

The services for Learning Disability (adults) are commissioned through a pooled budget between NHS Coastal West Sussex CCG, NHS Crawley CCG, NHS Horsham Mid Sussex CCG, and WSCC. The pooled budget funds packages of care for individually eligible customers and integrated clinical community services for people with learning disabilities (Community Learning Disability Teams). The increasing demand for the services and rising costs for the providers providing services in the community have placed considerable pressure on this service and presented challenges for commissioners and providers to respond to the increasing complexity of need and demand within resources available. Despite the volatility and vulnerability of the care market, the joint commissioning approach has continued to support services that are integrated at the point of delivery for people with learning disabilities and their families.

West Sussex Better Care Fund

The West Sussex Better Care Fund (BCF) footprint is a partnership across West Sussex CCGs and WSCC. In 2018/19 the pooled budget totalled £78.27m which included funding for Maintaining Social Care, Care Act, Reablement, Carers, and the Disabled Facilities Grant.

The West Sussex BCF programme continued to focus on three core areas of work: Crisis Management, Long Term Conditions, and Prevention. These themes align to the strategic direction of addressing a frailty plan overall without age boundaries. The BCF schemes continued to provide joined-up proactive care via multi-disciplinary teams, improve hospital discharge, and also support the specific needs of carers.

Sustainable development

During 2018/19 the eight CCGs in Sussex and East Surrey have begun to collaborate more deeply. This has enabled a greater scale of planning and purchasing, so that the more sustainable systems can be used by all.

There has been a move to rely heavily on teleconferencing, and Skype for Business is being rolled out to all areas. This is a piece of software, installed onto laptops which has not required the purchase of additional computers for staff. It allows meetings to be held from remote locations, so that staff no longer need to travel to attend, which is especially important on the larger footprint. It saves the travel time as well as reducing the need for fuel and transportation. The uptake of this technology will continue next year, when the software will be rolled out in to all areas and the cultural changes from remote working will become embedded.

The uptake of teleconferencing has also enabled a new approach to work to be developed with staff. This approach includes greater flexibility in working locations and times, to avoid staff needing to travel long distances if work can be done more locally or at home. It also allows staff to avoid peak periods, such as rush hours, which reduces travel times and pollution. The approach has been successfully used in this year and will be rolled out more formally in the year to come.
This move to new, digital technologies has continued with the Governing Bodies and the Committees. These used to be heavily paper-reliant, with large packs of papers sent out to Governing Body members on a monthly basis. During the year all CCGs have moved to a single digital system for organising and delivering the documents, with reports available immediately on line. This saves the cost of printing, the use of paper, and the expenditure of posting and transporting packs of documents around the patch. It provides a more sustainable approach to the administration of the CCGs and demonstrates the organisational intent to create streamlined, sustainable solutions for the organisations.

By working across the CCGs, we have been able to improve the use of the estate in two ways. Firstly, we have disposed of buildings that are no longer fit for healthcare purposes so they can be re-used or redeveloped by other sectors. Secondly, we have successfully been able to fill vacant space in under-occupied premises and better use the utilities that support these buildings.

Performance Report

Adam Doyle
Accountable Officer
28 May 2019

Section 2: Accountability Report

Corporate Governance Report: A year in Governance

This section of the Annual Report enables the CCG to meet key accountability requirements to Parliament. In this section you will find the Corporate Governance Report, which includes:

- The Members' Report
- The Statement of Accountable Officer's Responsibilities
- The Governance Statement
- The Remuneration and Staff Report
- The Parliamentary Accountability and Audit Report

Members' Report

The CCG membership is comprised of each of the 23 GP practices within the boundaries of NHS Horsham and Mid Sussex CCG. Each practice is grouped into one of the CCG's four towns or communities within the CCG: Burgess Hill, East Grinstead, Haywards Heath and Horsham, The table below shows the practices which make up the membership of the CCG.

Member Practices

Practice name	Address
Courtyard Surgery	London Road, Horsham, RH12 1AT
Holbrook Surgery	Bartholomew Way, Horsham, RH12 5JL
Orchard Surgery	Lower Tanbridge Way, Horsham, RH12 1PJ
Park Surgery	Albion Way, Horsham, RH12 1BG
Riverside Surgery	48 Worthing Road, Horsham, RH12 1UD
Rudgwick Medical Centre	Station Road, Rudgwick, RH12 3HB
The Village Surgery	Station Road, Southwater, RH13 9HQ
The Brow Medical Centre	The Brow, Burgess Hill, RH15 9BS
Cowfold	The Surgery, St Peters Close, Cowfold, RH13 8DN Branch Surgery: Partridge Green Surgery, Oakleigh, Partridge Green, RH13 8HX

Practice name	Address
Crawley Down Health Centre	Bowers Place, Crawley Down, RH10 4HY Branch Surgeries: West Hoathly Surgery, West Hoathly, RH19 4QF, and Turners Hill Surgery, The Ark, Turners Hill, RH10 4RA
Cuckfield Medical Practice	Glebe Road, Cuckfield, RH17 5BQ Branch Surgery: The Vale Surgery, Haywards Heath, RH16 4SY
Dolphins Practice	The Nightingale Primary Care Centre, Butlers Green Road, Haywards Heath, RH16 4BN
Judges Close Surgery	High Street, East Grinstead, RH19 3AA
Lindfield	The Medical Centre, High Street, Lindfield, RH16 2HX
The Meadow Surgery	Temple Grove, Gatehouse Lane, Burgess Hill, RH15 9XN
Mid Sussex Health Care	The Health Centre, Trinity Road, Hurstpierpoint, BN6 9UQ Branch Surgeries: Ditchling Health Centre, Lewes Road, Ditchling, BN6 8TT, and Hassocks Health Centre, Windmill Avenue, Hassocks, BN6 8LY
Moatfield Surgery	St Michaels Road, East Grinstead, RH19 3GW
Newtons Practice	The Health Centre, Heath Road, Haywards Heath, RH16 3BB
Northlands Wood Practice	7 Walnut Park, Haywards Heath, RH16 3TG
Ouse Valley Practice	Dumbledore Primary Care Centre, London Road Handcross, RH17 6HB Branch Surgery: Gilletts Surgery, Deanland Road, Balcombe, RH17 6PH
Park View Health Partnership	Sidney West Primary Care Centre, Leylands Road

Practice name	Address
	Burgess Hill, RH15 8HS
Ship Street Surgery	Ship Street, East Grinstead, RH19 4EE
Silverdale Practice	4 Silverdale Road, Burgess Hill, RH15 0EF Branch Surgery: The Avenue Surgery, 283 London Road, Burgess Hill, RH15 9QU

Details of the CCG's governance structures can be found in the constitution on the website at: http://www.horshamandmidsussexccg.nhs.uk/about-us/our-governing-body/ .

Details of the membership and attendance at committees are outlined in the annual governance statement. This includes the Audit Committee, which is a key part of the oversight and assurance functions of the CCG.

Our Governing Body

Our Governing Body oversees the decisions that the CCG makes about local health services, ensuring our activities meet the best standards of quality for the local population. The members of the Governing Body as at 31 March 2019 are as shown below. There is currently a vacancy for one Clinical Director GP post. Details of members during the year can be seen on pages 76 - 77 and in the Remuneration Report.

Dr Minesh Patel – Clinical Chair to 31 March 2019

Dr Patel qualified at the University of London in 1991 and has been a GP for 18 years and a GP Partner at Moatfield Surgery, East Grinstead since 1999. He was the Clinical Chair of the CCG until 31 March 2019.

Dr Patel is the Chair of the STP Clinical Board. He is an Executive Member of the National Association of Primary Care and also the Clinical Lead responsible for the current Sussex-wide Stroke Services Transformation Programme.

Dr Laura Hill – Clinical Chair Designate

Dr Laura Hill has worked in Primary Care in Crawley since August 2002, co-leading the national award-winning Crawley Dementia Alliance to make Crawley a Dementia Friendly Community. Dr Hill has held varied roles in General Practice since 2002 including as a GP Trainer until March 2014.

Dr Hill co-chairs the Sussex and East Surrey Sustainability and Transformation Partnership Clinical and Professional Cabinet which brings together local doctors, specialists and clinicians to clinically guide the priorities of the STP and has a seat on the National Board of NHS Clinical Commissioners representing the South East.

Adam Doyle – Chief Executive

Adam Doyle is Chief Executive Officer for NHS Horsham and Mid Sussex CCG and for the other seven CCGs in the Sussex and East Surrey Transformation Partnership area. Adam is also the Senior Responsible Officer for the Sussex and East Surrey Sustainability and Transformation Partnership.

Adam started his career as a physiotherapist and has held a number of senior healthcare roles over the past twelve years.

Before working in Sussex Adam was the Chief Accountable Officer at NHS Merton CCG in London, where he worked from its establishment in 2013. Prior to this, Adam was the Director of Private Care and Community Services at The Royal Marsden NHS Foundation Trust.

David Cryer – Strategic Director of Finance (interim)

David Cryer has worked in the NHS for ten years and was most recently the Finance Director for NHS England in the South West. In the South West David worked with four Sustainability and Transformation Partnerships and was part of the transformation of their financial positions. Prior to that David worked with the Vanguard Programme to develop payment mechanisms to support new care models. David joined this team following a three and a half year period as the Chief Officer of Camden Clinical Commissioning Group where he was instrumental in the delivery of innovative population segmented clinical teams with lead providers and reported patient outcomes. Before joining the public sector David had 10 years' experience working in the consumer goods industry and management consulting.

Dr David McKenzie – Clinical Director

Dr McKenzie is Co-Chair of the CCG Locality Group Meeting representing Horsham and GP practice representative for Rudgwick Surgery. He qualified from Otago University in New Zealand in 2000 and has worked in the UK since 2002. He initially worked in a surgical rotation, but he retrained as a GP from 2009. He is Co-Chair of the Locality Group, Clinical Lead responsible for adult functional mental health, and Chair of the Horsham GP Forum, and sits on the Finance and Contacting Committee and the Strategic Clinical Commissioning Group.

Dr Karen Eastman – Clinical Director

Dr Karen Eastman is Clinical Director member for the Governing Body Clinical Strategy Committee since April 2013. She is also the Sussex and East Surrey STP Lead for unwarranted clinical variation, a GP Partner at The Brow Medical Centre in Burgess Hill, and a GP with Special Interest in Pain Management. With a passion for high quality, person centred and innovative patient care and services, Dr Eastman leads the integration of Right Care, Getting it Right First Time and Clinically Effective Commissioning to understand and address unwarranted clinical variation in pathways of care. She is a RCGP Champion for collaborative Care and Support Planning and has been a GP since 1998.

Dr Stephen Bellamy – Clinical Director

Dr Bellamy is Mid Sussex Chair of the Locality Group and a member of the Delivery Group and the Commissioning Patient Reference Group.

He is a GP at Ship Street Surgery and has been a GP in East Grinstead since 1991, having completed his training in Worthing and Shoreham. He was involved in administering the GP-run Out Of Hours Co-Operative between 1996 and 2008.

Dr Riz Miarkowski – Clinical Director

Dr Miarkowski is a GP practice representative for Park View Surgery on the Locality Group and member of the Delivery Group. He has also been a member of the Clinical Policy and Medicines Approval Panel since it formed in July 2013.

He is senior partner in Park View Health Partnership in Burgess Hill, where he has been a partner since 2002. He was previously on the Mid Sussex PCT PEC in 2004-2008, and has been GP Prescribing Lead for Mid Sussex from 2008 until 2013. His current main clinical areas of interest include Pro-active Care and Medicines Management.

Dr Mark Lythgoe – Clinical Director

Dr Lythgoe is GP practice representative for Judges Close Surgery on the Locality Group, and a member of the Delivery Group and the Quality and Performance Committee. He has also been a member of the Clinical Policy and Medicines Approval Panel since it formed in July 2013.

Dr Lythgoe, a GP Trainer, has worked in East Grinstead since 2002 and was involved in Practice Based Commissioning before the formation of CCGs.

Debbie Stubberfield, Independent Nurse Member

Debbie Stubberfield is a registered nurse and health visitor with a broad range of experience as a senior clinical leader and practitioner. She joined the Surrey Downs CCG board in November 2015, and the NHS East Surrey CCG board in August 2017. As part of her CCG role, she attends the Quality, Finance and Delivery Committee.

She has held Director of Nursing roles in both provider and commissioning organisations, most recently working at the Trust Development Authority (now NHS Improvement) as Clinical Quality Director for London. Debbie has a first degree in nursing and a master's degree gained from St. George's Hospital Medical School.

Hugh McIntyre, Secondary Care Clinician

Dr McIntyre was appointed as consultant physician at East Sussex Healthcare Trust (ESHT) in 1995. He has held various clinical lead roles in Medicine including as Trust Medical Director for Strategy. He is an Hon. Clinical Reader in Medicine at BSMS and a Fellow of the Royal College of Physicians, European Society of Cardiology and Royal Society of Arts.

He has developed a nationally recognised integrated heart failure service with national and international publications, and has contributed to international and NICE guidelines. Dr McIntyre is a member of the South East Clinical Senate Council and is Chair of the NICE Quality Standards.

Adrian Brown, Lay Member for Governance

Adrian Brown is Chair of the Audit Committee and Remuneration Committee, Chair of the Clinical Policy and Medicines Approval Panel, and Chair of the Individual Funding Requests Panel. Following a career in the international engineering and construction industry where he held a number of board level positions including Commercial Director and Group Managing Director. Adrian was previously Chairman of Surrey and Sussex NHS Trust and is a Justice of the Peace.

Carol Pearson, Lay Member for Finance and Performance

Carol Pearson is an experienced chartered accountant. After graduating from Oxford, she qualified with Ernst & Young and spent 13 years working in international development for CDC Group plc, where she was Group Financial Controller for many years. Carol has also been a charity trustee since 2008 and has won awards for her work in the charity sector from the Institute of Chartered Accountants (ICAEW) and from the Royal Surrey County Hospital for her patient support work.

Simon Chandler, Lay Member for Patient and Public Engagement

Simon Chandler is a professional Engineer and Programme Manager who spent 25 years in Unilever in the UK and overseas before joining the Strategy and Operations team of a leading Professional Services firm. The last seven years in this role he spent coordinating the Public Sector Health team in the UK. He is particularly interested in innovation and the future opportunities of using innovative technology to improve the management of health conditions. He has been a resident of Horsham for the past 20 years.

John Steele, Lay Member

John Steele is a retired senior civil servant with a career in criminal justice and has wide experience of strategic and financial management. Following retirement he was the Chair of the Sussex Probation Board and then the Surrey and Sussex Probation Trust for seven years. He has been the lay member for the Primary Care Commissioning Committee since 2015 and is a member of the Audit Committee.

Composition of the Governing Body during 2018/19

Name	Position	Terms of appointment
Mark Baker	Strategic Director of Finance (Joint with Brighton and Hove CCG, NHS East Surrey CCG, High Weald Lewes Havens CCG, and NHS Crawley CCG)	Appointed 1 January 2018 Left CCG 31 December 2018
Dr Stephen Bellamy	Locality Group Chair/GP Member of the Governing Body	Appointed 1 April 2015 to 31 March 2018 Extended to 31 March 2020
Adrian Brown	Lay Member (Governance) Also a member of NHS Crawley CCG and NHS East Surrey CCG	Appointed 24 July 2012 Current third term of office (24 July 2018 to 23rd July 2019)
Simon Chandler	Lay Member (PPE) and Vice Chair of the Governing Body	Current third term of office (1 October 2018 to 30 September 2019)
David Cryer	Interim Strategic Director of Finance (Joint with Brighton and Hove CCG, NHS Crawley CCG, NHS East Surrey CCG, Hastings and Rother CCG, NHS Eastbourne, Hailsham and Seaford CCG and High Weald Lewes Havens CCG)	Appointed 1 January 2019
Adam Doyle	Chief Executive Officer (Joint with Brighton and Hove CCG, High Weald Lewes Havens CCG, and NHS Crawley CCG)	Appointed 1 January 2018 From 1 April 2018 AO for NHS East Surrey CCG and Coastal West Sussex CCG From 17 September 2018 AO for NHS Eastbourne, Hailsham and Seaford CCG and Hastings and Rother CCG
Dr Karen Eastman	Clinical Director/GP Member of the Governing Body	Current (second) term of office (1 April 2018 to 31 March 2020)
Dr Laura Hill	Clinical Chair (Designate). Joint with NHS Crawley CCG.	Current term of office 1 April 2019 to 31 March 2020

Name	Position	Terms of appointment
Dr Terry Lynch	Clinical Director/GP Member of the Governing Body	Left CCG 19 October 2018
Dr Mark Lythgoe	Clinical Director/GP Member of the Governing Body	Current (second) term of office (1 April 2018 to 31 March 2020)
Dr Hugh McIntyre	Secondary Care Clinician (joint appointment with NHS Crawley CCG)	Current (second) term of office (1 April 2019 to 31 March 2020)
Dr David McKenzie	Clinical Director/GP Member of the Governing Body	Current term of office 1 April 2017 to 31 March 2020
Dr Riz Miarkowski	Clinical Director/GP Member of the Governing Body	Current (second) term of office (1 April 2019 to 31 March 2020)
Carol Pearson	Lay Member (Finance) Also a member of NHS Crawley CCG and NHS East Surrey CCG	Previously Co-opted member, formally member 20 August 2018 to 19 August 2019
Dr Minesh Patel	CCG Clinical Chair	Term of office 1 April 2016 to 31 March 2019. Left CCG 31 March 2019
John Steele	Lay Member Primary Care	Appointed 1 January 2018 Current term of office to 31 March 2020
Debbie Stubberfield	Independent Nurse (joint appointment with NHS Crawley CCG and NHS East Surrey CCG)	Appointed 1 August 2018 to 31 July 2019
Sally Thomson	Independent Nurse (joint appointment with NHS Crawley CCG)	Appointed 26 June 2012 Left CCG 23 July 2018

Emergency preparedness resilience and response

The Civil Contingencies Act 2004 and the NHS Act 2006 (NHSA) (as amended) place responsibilities on Clinical Commissioning Groups in relation to Emergency Planning, Resilience, and Response (EPRR) as described below.

The Civil Contingencies Act 2004 (CCA) defines CCGs as a Category 2 responder organisation. This means the CCG has a legal obligation to support, co-operate, and share information with other responding organisations in planning for and responding to emergencies.

Section 252A of the NHS Act 2006 (NHSA) requires that CCGs take appropriate steps to prepare for and respond to emergencies. In this regard, I can confirm that the CCG has in place suitable plans enabling it to respond to major incidents and emergencies as they may arise. These plans are consistent with the NHS England Emergency Preparedness Framework and are regularly reviewed and exercised.

The NHS Act 2006 requires NHS England to establish processes to monitor and seek assurance that each CCG is properly prepared for dealing with emergencies. In order to ensure that CCGs are meeting their responsibilities under the CCA and the NHSA NHS England has created a framework for Emergency Planning, Resilience, and Response including a robust annual assurance process under which NHS organisations are obliged to demonstrate their compliance. This process identifies a series of core standards for EPRR against which commissioner and provider organisations are assessed. As a commissioner of services CCGs use these core standards to seek assurance from service providers and in turn provide assurance to NHS England that the CCG and its local health economy are meeting their obligations in relation to EPRR.

Under the last annual assurance process, concluded in October 2018, NHS Horsham Mid-Sussex CCG was assessed as ‘Partially’ compliant with the NHS England National Core Standards for EPRR. This means that during the assurance process there were a minority of areas where we were able to provide sufficient evidence that the CCG had met and exceeded the core standards. Although we are confident that our organisation’s response to arising emergencies is effective we are working with our partner CCGs in Sussex and East Surrey to ensure that we will be able to provide greater assurance going forward. The CCGs in Sussex are now working together and aligning our resources to provide a consistent aligned response to any arising emergency affecting Sussex.

The CCG’s providers of clinical services, in accordance with CCA, NHSA, and the terms of the NHS Standard Contract have their own responsibilities in respect of EPRR for which the CCG seeks assurance. The seven CCGs in Sussex collectively sought assurance from their provider organisations against the national core standards. For the most part the Sussex CCGs were assured that the providers were adequately meeting their EPRR responsibilities. However, where it was evident that a provider had not met the required standard in their EPRR responsibilities, they will continue to work with their local CCG to improve their performance against the national core standards.

As the Chief Accountable Officer for NHS Horsham Mid-Sussex CCG I have chosen to delegate the responsibility for EPRR to an Accountable Emergency Officer (AEO), responsible for ensuring that the CCG is compliant with its EPRR obligations. The AEO represents the CCG at the Local Health Resilience Forum, taking a strategic coordinated view of EPRR activity amongst health organisations in Sussex. Terry Willows, Director of Corporate Affairs, has been appointed AEO for the CCG, supported by Adrian Brown, Lay Member for Governance, and CCG staff with responsibilities for EPRR.

Personal data related incidents

There have been no personal data related incidents requiring formal reporting to the Information Commissioner's Office.

Register of interests

The CCG keeps a register of interests and a register of gifts and hospitality on its website. The register for the Governing Body and Senior Managers (as defined in the remuneration report) for the year can be found on our website here http://www.horshamandmidsussexccg.nhs.uk/about-us/how-we-work/.

Statement of disclosure to auditors

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

- So far as the member is aware, there is no relevant audit information of which the CCG's auditor is unaware that would be relevant for the purposes of their audit report; and

- The member has taken all the steps that they ought to have taken in order to make him or herself aware of any relevant audit information and to establish that the CCG's auditor is aware of it.

Modern Slavery Act

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

Statement of Accountable Officer's responsibilities

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

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

- The propriety and regularity of the public finances for which the Accountable Officer is answerable
- For keeping proper accounting records (which disclose with reasonable accuracy at any time the financial position of the Clinical Commissioning Group and enable them to ensure that the accounts comply with the requirements of the Accounts Direction)
- For safeguarding the Clinical Commissioning Group's assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities)
- The relevant responsibilities of accounting officers under Managing Public Money
- Ensuring the CCG exercises its functions effectively, efficiently, and economically (in accordance with Section 14Q of the National Health Service Act 2006 (as amended)) and with a view to securing continuous improvement in the quality of services (in accordance with Section14R of the National Health Service Act 2006 (as amended)), and
- Ensuring that the CCG complies with its financial duties under Sections 223H to 223J of the National Health Service Act 2006 (as amended).

Under the National Health Service Act 2006 (as amended), NHS England has directed each Clinical Commissioning Group to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts 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 income and expenditure, Statement of Financial Position, and cash flows for the financial year.

In preparing the accounts, the Accountable Officer is required to comply with the requirements of the Government Financial Reporting Manual for the relevant financial year taking account of the application guidance contained in the Department of Health and Social Care Group Accounting Manual for the relevant financial year 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 Government Financial Reporting Manual for the relevant financial year have been followed, taking account of the application guidance contained in the Department of Health and Social Care Group Accounting Manual for the relevant financial year, and clinical commissioning group specific guidance issued by the National Health Service Commissioning Board, and disclose and explain any material departures in the accounts
- Prepare the accounts on a going concern basis, and
- Confirm that the Annual Report and Accounts as a whole is fair, balanced and understandable and take personal responsibility for the Annual Report and Accounts and the judgements required for determining that it is fair, balanced and understandable.

To the best of my knowledge and belief, and subject to the disclosures set out below (e.g. directions issued, s30 letter issued by external auditors), I have properly discharged the responsibilities set out under the National Health Service Act 2006 (as amended), Managing Public Money and in my Clinical Commissioning Group Accountable Officer Appointment Letter.

Disclosures:

- NHS England Legal Directions issued 13 November 2018
- Our external auditors have issued a Section 30 referral to the Secretary of State for Health and Social Care.

I also confirm that:

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

Adam Doyle
Accountable Officer
28 May 2019

Governance statement

Introduction and Context

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

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

As at 1 April 2018 the CCG was subject to directions from NHS England which came into effect from November 2017, (issued under Section 14Z21 of the National Health Service Act 2006). These directions were replaced with revised directions which were issued on 13 November 2018. The current legal directions now focus on:

- Production and delivery of a credible financial recovery plan, and
- Production of a credible financial plan for 2019/20.

The full directions can be found on the NHS England website here https://www.england.nhs.uk/wp-content/uploads/2018/11/ccg-directions-18-horsham-mid-sussex.pdf.

I was appointed as NHS Horsham and Mid Sussex CCG's Accountable Officer with effect from 1 January 2018. Additionally, I also became the Accountable Officer for NHS Coastal West Sussex CCG and NHS East Surrey CCG on 1 April 2018, and for NHS Eastbourne, Hailsham and Seaford CCG and NHS Hastings and Rother CCG on 17 September 2018. This is a role that is shared across the eight CCGs in the Sussex and East Surrey Sustainability and Transformation Partnership, which encompasses the five CCGs of the Central Sussex and East Surrey Commissioning Alliance.

During the period I have been the Accountable Officer for NHS Horsham and Mid Sussex CCG, I have held the same position across the other CCGs in Sussex and East Surrey. In this period I have been especially mindful of the need to ensure that the individual statutory responsibilities of each CCG are not in any way undermined by my wider responsibilities. The governance structure of NHS Horsham and Mid Sussex CCG has been fully utilised and adhered to at all times to ensure decision making is taken in the best interest of the CCG. Conflicts of interest where they have arisen have been declared and managed in the appropriate way.

Building on 2017/18 and having now completed a full financial year with the CCG I have, with the support of the Governing Body, continued to develop the governance processes and commissioning functions of the CCGs for which I am responsible. I

have not only effectively discharged my duties but have moved the CCG forward and addressed the key aspects of the legal directions. Demonstrable progress has been made through the change in legal directions, removing the qualifications with respect to leadership.

Financial Turnaround

The CCG ended 2017/18 in a challenging financial position in common with all the CCGs that comprise the Alliance delivering a £38.7m deficit. The Strategic Chief Finance Officer for the Alliance and I agreed with the Clinical Chairs to place all of the CCGs within the Alliance into financial turnaround. I took this necessary action to ensure the appropriate level of focus and application across our organisations to manage expenditure and to establish and deliver a clear plan to work within the available resources. This has helped us to co-ordinate the approach to financial recovery and balance across the CCGs. This was further strengthened during 2018/19 through the formation of an Alliance Turnaround Board (ATB) that has driven a rigorous approach to achieving in-year savings alongside long term sustainability.

The 2018/19 outturn financial position shows considerable improvement on the 2017/18 year end delivering a £3.6m deficit (after receipt of CSF). Adding this to the brought forward cumulative deficit of the CCG means the CCG carries forward a historic deficit of £57.1m into 2019/20. A detailed financial recovery plan has been developed in response to the revised legal directions of which the Governing Body has had full ownership and visibility.

Consistent with previous years, reporting a deficit requires that the CCG's external auditors make a Section 30 referral to the Secretary of State to advise that the CCG has breached its statutory duty to operate within allocated financial resources. This was done in May 2018 covering both 2017/18 and 2018/19 financial years.

Our Strategic Director of Finance moved on during the financial year but was replaced by an experienced interim appointment in David Cryer, who was already working with the CCG as Director of Financial Delivery. This key appointment provides continuity of approach and stability so that the CCG can continue to consolidate its journey towards financial equilibrium.

Governance Review

I commissioned PricewaterhouseCoopers LLP in March 2018 to undertake a governance review to appraise the financial scrutiny and oversight, leadership, and governance arrangements across all five CCGs in the Alliance. The purpose of this review was to test whether the CCGs were robust, fit for purpose, and would meet the expectations of NHS England.

For the CCG the completion of this review marked the discharge of one element of the legal directions that were in place at that time. A full action plan was prepared by the executive team responding to the recommendations and this plan was reviewed by the Governing Body and NHS England, who both agreed the action plan. The action plan has been progressed during the course of the year with a regular review of progress by the Local Management Team alongside detailed scrutiny by the Audit

Committee and has then been reported up to the Governing Body and thereafter to NHS England.

During the year our governance structures have further developed with the Governing Bodies of the three CCGs in the North of the Alliance increasingly working collectively and in common to make the most of our leadership resources and to 'do things once' for the benefit of our populations.

Clinical Leadership

During 2018/19 I have worked with the CCG Clinical Chairs across the STP area to develop our model of clinical leadership and engagement to ensure that the vision for CCGs as clinically-led organisations is not lost while we address the considerable financial challenges.

As noted elsewhere in this annual report Dr Minesh Patel has decided not to re-stand as Clinical Chair and I am extremely grateful for the support, insight, and enthusiasm he has shown during this financial year and indeed from the very start of the CCG's formation. I am also delighted that Dr Laura Hill assumed the role in April 2019, alongside her role in NHS Crawley CCG, thus further cementing our commitment to joint working.

Staff Engagement and Inclusion Programme

I have held three Staff Conferences during 2018 in February, June, and November. The final conference of the year focussed on putting patients at the heart of everything we do. As part of this all teams across the Alliance were asked to make individual pledges regarding what they felt they could do to achieve this. Staff are also working hard to embed the NHS values across the CCGs and the Alliance that were agreed at an earlier staff conference in the year, making clear their intention to play their part in the changes and challenges we will continue to face over the coming months.

A Compassionate and Inclusive Leadership conference was also held for staff across the CCGs. The essence of the conference related to how we can better develop organisational and professional relationships with staff and stakeholders to enhance our potential for reducing health inequalities and providing outstanding healthcare services to all of our communities.

I am determined that we become an exemplar amongst CCGs that value the diverse backgrounds, heritages, and skills of our teams and harness this collective talent to commission the best care we can for patients. This conference was another step forward on what will be a long journey for us.

Conclusion

Working as part of the Alliance, I have appointed an executive team to provide greater leadership and executive resilience across the CCGs which enables me to ensure that the full benefits of collective working are realised. In my new role across the eight CCGs of the STP I will be further developing our structures to ensure that the CCG has the right executive and clinical leadership to enable it to meet the challenge of commissioner reform and of moving to Integrated Care Systems in line with the national direction outlined in the NHS Long Term Plan.

Taken together the above actions have given me sources of assurance that I have been able to reference as part of this Governance Statement.

Scope of responsibility

As Accountable Officer I have responsibility for maintaining a sound system of internal control that supports the achievement of the CCG's policies, aims, and objectives whilst safeguarding the public funds and assets for which I am personally responsible in accordance with the responsibilities assigned to me in Managing Public Money. I also acknowledge my responsibilities as set out under the National Health Service Act 2006 (as amended) and in my Clinical Commissioning Group Accountable Officer Appointment Letter.

I am responsible for ensuring that the CCG is administered prudently and economically and that resources are applied efficiently and effectively, safeguarding financial propriety and regularity. I also have responsibility for reviewing the effectiveness of the system of internal control within the CCG as set out in this governance statement.

Governance arrangements and effectiveness

The Governing Body

The main function of the Governing Body is to ensure that the group has made appropriate arrangements for ensuring that it exercises its functions effectively, efficiently, and economically and complies with such generally accepted principles of good governance as are relevant to it. The main features of the governance of NHS Horsham and Mid Sussex CCG are described below.

In accordance with the Health and Social Care Act 2012 the CCG was formed as a membership organisation with the constituent GP practices as its members.

The CCG Governing Body has responsibility for ensuring good governance arrangements and as well as its main function the membership has assigned the following specific duties to the Governing Body:

- Approving the annual strategic commissioning plans
- Approving the annual budget
- Ensuring that all conflicts of interest or potential conflicts of interest are declared and appropriate management plans are in place

- Ensuring that the registers of interest are reviewed regularly, and updated as necessary
- Leading the setting of vision and strategy, and
- Monitoring performance against plans and providing assurance of strategic risk.

The five CCGs of the Alliance are divided into North Place and South Place. The CCGs that sit in the North Place are NHS Crawley CCG, NHS Horsham and Mid Sussex CCG, and NHS East Surrey CCG. Those that sit in the South Place are NHS Brighton and Hove CCG and NHS High Weald Lewes Havens CCG.

The Governing Body meets in common as the North Place Governing Bodies with a common agenda, meeting in a common venue, but taking individual CCG decisions.

The Governing Body meets formally in public. The Governing Body also meets informally to discuss matters that arise and to give an opportunity for development and training. This is part of an ongoing process which will be further strengthened through the organisational development activities of the Alliance.
As a clinically-led organisation it is necessary for there to be strong clinical representation on the Governing Body and on the committees of the CCG and the Constitution of the CCG provides for strong clinical representation.

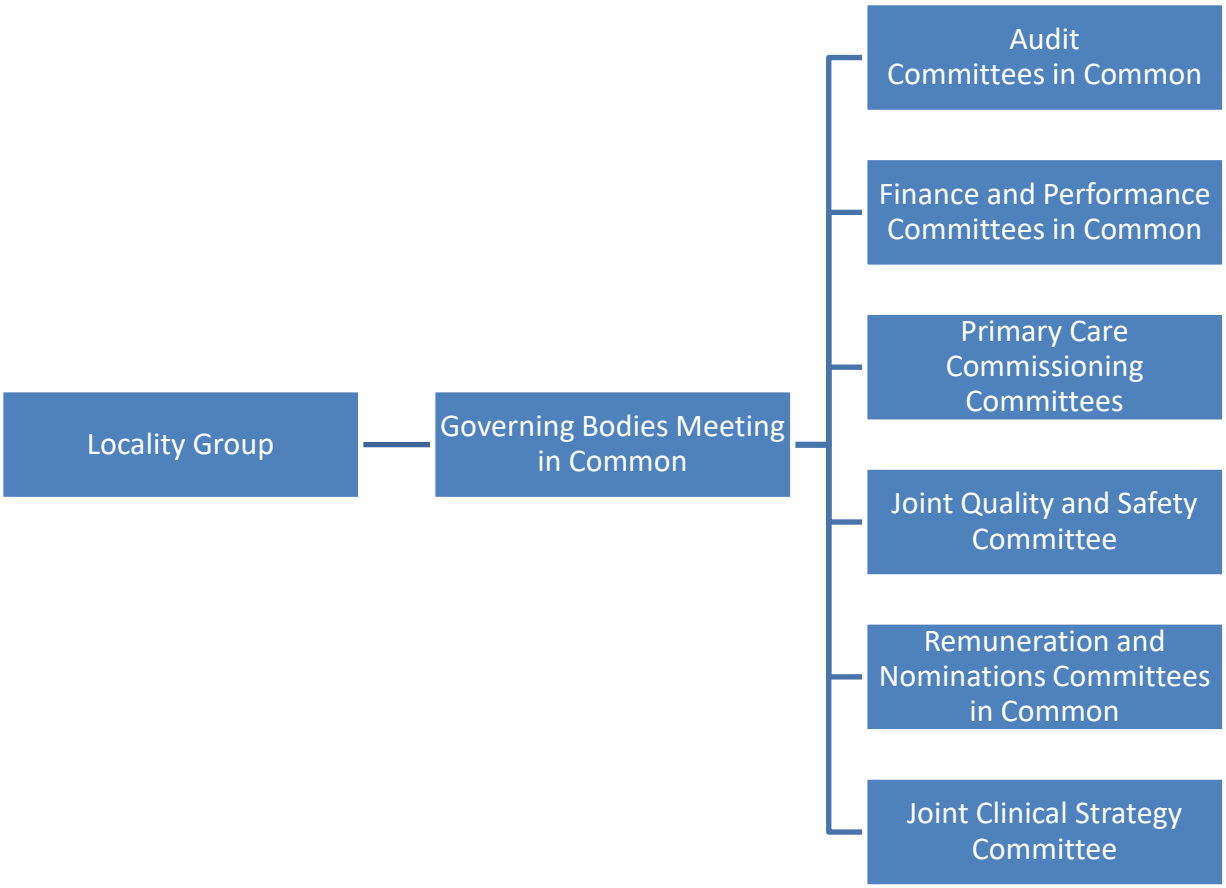
During the course of the year there have been some changes to the Governing Body. Sally Thomson resigned from her role as Governing Body Nurse in July 2018 and was replaced by Debbie Stubberfield as Independent Governing Body Nurse. Debbie fulfils this role for the three North Place CCGs.

CCG Committee Structure

The CCG and the Governing Body have established committees for the running of CCG business and details of these governance structures can be found in the CCG Constitution on the CCG's website at https://www.horshamandmidsussexccg.nhs.uk/about-us/our-governing-body/.

During 2018/19 the CCG implemented a change in Governance Committee structures so as to reflect closer working across the North Place CCGs to reduce duplication and to improve resilience in its operations. The North Place CCGs have a joint management team and committees work 'in common' unless otherwise indicated. The table below shows the revised structure and the remainder of this section describes the committees in more detail.

CCG Governance structure



The CCG membership body: Locality Group

In accordance with the Health and Social Care Act 2012 the CCG was formed as a membership organisation with the constituent GP practices as its members. The composition of the membership is outlined at the opening of this Accountability Report.

Clinical commissioning has been developed around the principle of clinical leadership which is demonstrated in CCGs by their status as membership bodies. The membership voice in NHS Horsham and Mid Sussex CCG is expressed through the Locality Group.

The Locality Group is made up of the statutory GP practice representative or nominated GP deputy from each practice (voting) and a practice manager representative from each locality (Horsham and Mid Sussex), the Lay Member who is the Chair of the Commissioning Patient Reference Group, two other Lay Members representing each locality, and a pharmacist (all non-voting). The Locality Group may also invite other individuals, including professional advisers, to attend meetings periodically if required although such individuals will not have voting rights.

The Locality Group met four times during 2018/19. The Locality Group has reserved to itself decisions on the CCG's operational structure, clinical pathways, and decisions on changes to the Constitution.

North Audit Committees in Common

As part of closer working relations between the North CCGs from May 2018 the Audit Committee for NHS Horsham and Mid Sussex CCG started North Audit Committee meetings in common with NHS Crawley CCG and NHS East Surrey CCG with aligned terms of reference.

The Audit Committee critically reviews the CCG's governance and internal control principles. The Committee ensures that an appropriate relationship with both internal and external auditors is maintained. It approves a comprehensive system of internal control that underpins the effective, efficient, and economic operation of the CCG.

In 2018/19 the Audit Committee provided assurance to the Governing Body on the effectiveness of the CCG's systems of integrated governance, risk management, and internal control to support the achievement of the organisation's objectives.

In addition to this the Audit Committee reviewed the work and findings of the external and internal auditors considering the implications of, and management response to, their work. The Committee satisfied themselves that the organisation has taken appropriate steps to meet the new conflicts of interest guidance, to be in line with the whistleblowing guidance, and that procurement processes are reviewed and lessons are learnt.

The Audit Committee undertook a self-assessment exercise during 2019; four questionnaires were completed which included by both internal and external audit. The results highlighted the need for training of both new members of the committee and ongoing members. The committee members advised that there doesn't appear to be sufficient time to discuss in depth the business relating to all three separate CCGs now that the meetings are held in common. It was suggested that a way to mitigate this would be to raise any issues of concern to the Chair prior to the meeting to allow for conversations to be had in more depth.

North Finance and Performance Committee in Common

In July 2018 the final Finance and Contracting Committee was held and, from August 2018, the Horsham and Mid Sussex Finance and Performance Committee met in common with those of NHS Crawley CCG and NHS East Surrey CCG using aligned terms of reference.

The Committee has subjected the North CCGs' financial reporting to detailed scrutiny and review. This has included reports and presentations on the Financial Recovery Plan, improving the forecasting methodology, the content, presentation, and timeliness of financial reporting, and strengthening the methodology and governance for setting and signing off annual budgets aligned to clear framework of accountability, risk identification, and mitigations.

In addition to this the Lay Chairs have had regular updates with the Chief Finance Officer and Strategic Director of Finance on the current financial position.

Delivery Programme Board

The Delivery Programme Board has been established by the Governing Body to drive and assure the delivery of the 2018/19 Financial Recovery Plans (FRP) and Programmes and to design and drive the delivery of future year's QIPP (Quality, Innovation, Productivity, and Prevention) Programmes. The Board meets weekly and a key responsibility during the financial year has been to oversee the production of the medium term FRP developed in response to the CCG's legal directions. Scrutiny of QIPP delivery is undertaken monthly and new schemes' business cases are approved within delegated financial limits or recommended to the Finance and Performance Committee for sign off.

Joint North Clinical Strategy Committee (replacing the Strategic Clinical Commissioning Group)

The Strategic Clinical Commissioning Group (SCCG) had principal responsibilities for developing and overseeing the necessary programme and project arrangements to effectively inform the development of clinical strategy and to oversee production of the operating plan in response to national guidelines, local priorities, and the joint strategic needs assessment (JSNA).

Due to the change in Governance Committee structures in 2018 the SCCG was superseded by the Joint North Clinical Strategy Committee (CSC). The final SCCG meeting was held in August 2018. The Joint North Clinical Strategy Committee met from September 2018.

The committee ensures regular linkage between the CCG executive and the representatives of the Members. As a committee of each of the respective North Place Governing Bodies the North Clinical Strategy Committee provides more detailed clinical input and assurance relating to clinical strategy and the clinical components of the Operating Plan, major cases of change, and clinical performance measures.

Quality and Performance Committee

With the closer working nature of the CCGs, the Quality and Performance Committee became the Joint North Quality and Safety Committee. The Quality and Performance Committee met for the final time in May 2018 and from July 2018 the Joint North Quality and Safety Committee met.

The purpose of the Joint Quality and Safety Committee is to provide the Governing Bodies of NHS Crawley, NHS East Surrey, and NHS Horsham and Mid Sussex CCGs with assurance that people are in receipt of safe and effective care in relation to quality and safety. The Committee also works to ensure the effectiveness of clinical care and that the patient is at the heart of clinical commissioning.

Primary Care Commissioning Committee

NHS Horsham and Mid Sussex CCG has assumed delegated responsibility for primary care commissioning. The Primary Care Commissioning Committee (PCCC) is in place to oversee the commissioning of primary care services. The Committee also manages any actual or potential conflicts of interests in those areas where CCG commissioning does impact on member practices.

In 2018/19 the PCCC met seven times. During this time the committee reviewed locally commissioned services around diabetes, chronic obstructive pulmonary disorder, care homes, and sustainable general practice.

UK Corporate Governance Code

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

For the financial year ended 31 March 2019 and up until the date of signing this statement we have complied with the provisions of the Code as would be expected of a CCG.

Leadership

The CCG is headed by an effective Governing Body which is collectively responsible for the long-term success of the CCG. There is a clear division of responsibilities between the running of the Governing Body and the executive responsibility for the running of the CCG's business. No one individual has unfettered powers of decision and decision-making powers are clearly governed by the CCG's Standing Orders and Prime Financial Instructions.

NHS England's evaluation of the quality of the CCG's leadership can be found on the My NHS website at https://www.nhs.uk/service-search/Performance/Search . The latest published evaluation (from summer 2018) is 'requires improvement'. As detailed in this annual report the CCG has taken a series of actions to strengthen the governance arrangements and leadership of the CCG during 2018/19. The next evaluation will be published in summer 2019.

Effectiveness

The Governing Body and its committees have the appropriate balance of skills, experience, independence, and knowledge to enable them to discharge their respective duties and responsibilities effectively. During 2018/19 there has been a review of the training and developmental needs of the Governing Body and there will be a training programme implemented in the coming year.

Arrangements for appointments to key roles are outlined in the CCG's Constitution and in the case of the Accountable Officer, Chair, and Chief Finance Officer subject to the NHS England appointments process. The CCG directions mean that no senior or executive appointment can be made without NHS England approval.

Executive members of the Governing Body set objectives annually and their performance is reviewed by the Accountable Officer. Governing Body papers are supplied in a timely manner with minimum timescales for receipt of papers set out in the CCG's Constitution and committee terms of reference. The Governing Body meeting reports are prepared with information in a form and of a quality appropriate to enable the Governing Body to discharge its duties.

Accountability

The Governing Body considers that it presents a balanced and understandable assessment of the CCG's position and prospects. The CCG's management of risk and arrangements for the Audit Committee are outlined elsewhere in the Governance Statement.

The CCG does not have shareholders but is accountable to the public for its activities. The CCG engages patients, stakeholder organisations, and the public in planning its objectives particularly when considering larger scale service changes where it had a duty to consult. Elsewhere in this Annual Report there are further details on our work for patient and public engagement.

Discharge of Statutory Functions

In light of recommendations of the 2013 Harris Review the CCG has reviewed all of the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated legislative and regulations. As a result I can confirm that the CCG is clear about the legislative requirements associated with each of the statutory functions for which it is responsible including any restrictions on delegation of those functions.

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

Risk management arrangements and effectiveness

The CCG recognises that risk management is an integral part of good management practice and to be most effective it must be embedded within the organisation's culture.

All five CCGs that are part of the Alliance share a single Risk Management Strategy which sets out the aligned structure and system within which the Alliance CCGs manage their risks.

The Risk Management Strategy was agreed by all five Governing Bodies at a meeting held in common on 25 September 2018. It aims to:

- Drive a standardised, strategic and accessible approach to risk management
- Ensure that risk management is an integral part of organisational culture
- Improve safety by addressing and effectively prioritising risk treatment plans, and
- Identify risks to achieving the Alliance's objectives requiring intervention.

The strategy is supported by a Risk Management Policy which is formatted as a Risk Management Guide to ensure that it is readable and user-friendly for staff. The purpose of this guide is to set out the process for risk management for the CCGs within the Alliance including how each CCG's risks are identified, assessed, recorded, and managed within the Alliance.

As well as the directorate and team risk registers each programme has a risk register which is reviewed and managed by the Programme Directors and Clinical Directors at the programme boards. When directorate, team, or programme risks are assessed as having significant risk to the CCG/s' or the Alliance goals they are escalated to the North or South Place Risk Register (as appropriate) or to the Alliance Strategic Risk Register.

These risks are identified from a variety of internal and external sources such as staff resource issues, workforce recruitment problems, incompatibility of IT systems, lack of assurance on areas of quality and performance data, or information from staff and or patients.

The consequences of some risks, or the action needed to mitigate them, can be such that it is necessary to escalate the risk to a higher management level. During 2018/19 the Alliance CCGs had a single integrated Strategic Risk Register and Assurance Framework both aligned to the Alliance goals:

- Alliance Strategic Goal One: To take control of, and lead, our system by being stronger commissioners in order to deliver better outcomes for our population
- Alliance Strategic Goal Two: To enable the development of new local models of care for the benefit of our patients and public
- Alliance Strategic Goal Three: To deliver the best outcomes for our population and the individual within our allocated resources, and through the effective engagement of patients, staff, and stakeholders.

As at 1 April 2019, this was superseded by an integrated risk register, assurance framework, and set of Strategic Goals across all eight Sussex and East Surrey CCGs.

The Alliance Assurance Framework provides the Governing Body with assurance through an overview of the key risks identified under each Alliance Strategic Goal, the actions in place to mitigate the risks, and the trend over time.

Capacity to Handle Risk

The Alliance Chief Executive Officer (CEO) has overall responsibility for ensuring effective risk management systems are in place and the Director of Corporate Affairs has delegated responsibility for managing the development and implementation of risk systems. The Alliance Strategic Finance Director is answerable to the Chief Executive Officer (CEO) and is responsible for ensuring (and reporting to the Governing Body, Audit Committee, and the Finance and Performance Committee) that systems are in place for the effective management of financial risk and organisational controls.

The CCG's Clinical Leads each have an identified portfolio of clinical responsibilities. They oversee the management of risks to programme delivery working with the executive team and heads of department all of whom are accountable for the management of risks related to their areas of responsibility. Staff are supported to manage risk as appropriate to their level of authority and duties and the CCG's policies and procedures are available on the CCG's website. There is a programme of mandatory training for staff that includes equality and diversity, fire safety, information governance, conflicts of interest, health and safety, manual handling, safeguarding children and adults, and Prevent (safeguarding people and communities from the threat of terrorism).

In early 2019 a single online risk management system was adopted by all five Alliance CCGs. Technical training on the use of the system, and training in risk management, was delivered across all five CCGs to staff involved in recording and managing risks.

Further risk management training and support is available to all staff and can be conducted at a team level on request.

The Governing Body's oversight of risk is underpinned by a number of systems of control. The Governing Body reviews risk principally through the following four related mechanisms:

- The Alliance Assurance Framework (AAF) sets out the Alliance Strategic Goals, identifies risks in relation to each strategic goal along with the controls in place and assurances available on their operation
- The integrated Alliance Strategic Risk Register is the corporate high level strategic risk register used as a tool for managing risks and monitoring actions and plans against them. Used correctly it demonstrates that an effective risk management approach is in operation within the five Alliance CCGs
- The integrated Alliance Risk Register incorporates strategic risks at the following levels:
    - Alliance-wide
    - North Place
    - South Place
    - Individual CCG
- In this way, each CCG retains the ability to monitor and manage its own risk as a statutory body
- The Governing Body receives assurance from those delegated the operational responsibility to individual programme boards overseen by the following committees which scrutinise risks relating to their own remit:
    - Clinical Strategy Committee
    - Finance and Performance Committee
    - Primary Care Commissioning Committee, and
    - Quality and Safety Committee.

The Governing Body receives assurance from the Audit Committee on the soundness and effectiveness of the overall risk management process.

The Alliance Assurance Framework and the integrated Alliance / Place / CCG Strategic Risk Register are updated on an ongoing basis with a formal review undertaken monthly. This formal review is led by the Governance Team which meets with each risk owner to review changes in the score, controls, and assurances and progress against actions agreed since the previous review. From April 2019 reviews will take place online which will allow for a more streamlined and live approach to risk management across the Alliance.

Following each monthly review the overall risk profile is then considered by the North or South Place Local Management Team. Risks rated at twelve and above and relating to the specific portfolios are reviewed monthly at the Finance and Performance Committee, Quality and Safety Committee, Clinical Strategy Committee, and Primary Care Commissioning Committee. All risks are reported to the Governing Body to enable them to consider their own assessment of the risks in question.

The Alliance Assurance Framework and Alliance Risk Summary document are also reviewed as a standing item at the Audit Committee. The Audit Committee's focus is on providing assurance to the Governing Body that the agreed system is robust and being appropriately applied.

Risk Assessment

The CCG recognises that it is impossible to eliminate all risk and that the aim of risk management is to mitigate risks using control measures and an action plan. As part of risk assessment risks are given an initial risk score and a target risk score. The target risk score represents the level of risk that remains after existing control measures and actions have been taken into account; it is the level of risk that is acceptable to the CCG.

The Alliance has determined a 'risk appetite' which sets the level at which the CCG is prepared to tolerate the risk although the risk appetite is not necessarily static and may change depending on the circumstances. The Alliance CCGs have agreed the following Risk Appetite Statement in common with each other:

- *"The Alliance and its member CCGs will not accept risks that materially impact on patient safety. It has zero tolerance for fraud and an aspiration for zero tolerance for regulatory breaches. It has a low risk appetite for financial risk but recognises that in some circumstances the taking of considered and managed risks is necessary. The Alliance supports well-managed risk taking and will ensure that the skills, ability, and knowledge are in place to manage risks appropriately and to maximise the sustainability of the services it commissions."*

At year end, the corporate risk register contained the following risks with an initial score of 15 and above:

Risks with a score of 15 and above as at 31 March 2019

Objective AG1: To take control of, and lead our system by being stronger commissioners in order to deliver better outcomes for our population			
Reference	Risk Description	Initial Score (Impact x Likelihood)	Current Score (Impact x Likelihood)
Alliance level risks			
AL0001	If Alliance providers failing to deliver key constitutional standards, including RTT/52 weeks/ Cancer 62 days, resulting in poor patient care.	5x4=20	5x4=20
AL0002	If commissioned providers are unable to recruit sufficient qualified and unregistered workforce to meet current demand	4x4=16	4x4=16
AL0003	If workforce pressures in General Practice and Primary care impact on GPs ability to maintain current levels of patient care.	5x4=20	5x4=20
AL0005	If the Sussex TCP national target is not met, this may impact on patient care and avoid unnecessary extended stays in hospital.	4x4=16	4x4=16
AL0006	If CCGs within the Alliance do not deliver the core and mandated requirements of the GP IT Operating Model or does not comply with the data security standards, this may impact on cyber security protection to GP systems	4x4=16	4x4=16
AL0007	If in the event of a major healthcare provider being compromised by a successful cyber attack the Alliance CCGs will be subject of an unfavourable media coverage, reputational damage and significant cost pressures as a result of unplanned community and secondary care activity.	5x5=25	4x4=16

Objective AG1: To take control of, and lead our system by being stronger commissioners in order to deliver better outcomes for our population			
Reference	Risk Description	Initial Score (Impact x Likelihood)	Current Score (Impact x Likelihood)
AL0011	If QVH ability to monitor and manage patient treatment lists and impact on key key constitutional standards, including RTT/52 weeks/ Cancer 62 days, resulting in poor patient care.	4x5=20	4x4=16
AL0029	If CQC inspections rate commissioned Nursing/Care Homes as inadequate or requires improvement, this may lead to poor quality of care received by patients	4x4=16	4x4=16
North place risks			
NP0001	If QVH fails to meet its constitutional targets in relation to RTT and >52 week waiters it will thereby result in Alliance CCG patients not accessing elective treatment within the 18 week period.	3x3=9	4x4=16
NP0003	If the emerging ABC Federation are not set up and developed as an effective service provider with robust ties into constituent GP practices, there is a risk that it will be unable to support CCG efforts to increase overall primary care resilience and deliver services at scale	5x4=20	5x4=20
NP0016	If there is not sufficient innovation or market development there is then a risk that the reprocurement of the CAMHS service does not deliver the transformational change that is required.	5x3=15	5x3=15
NP0029	If the community bed unit, Kleinwort at Haywards Heath (part of Sussex Community Foundation Trust) is not able to remain open due to significant staffing pressures, this would then mean a loss of up to 31 community step down beds for patients leaving acute hospital care	4x4=16	4x4=16

Objective AG1: To take control of, and lead our system by being stronger commissioners in order to deliver better outcomes for our population			
Reference	Risk Description	Initial Score (Impact x Likelihood)	Current Score (Impact x Likelihood)
	resulting in an inability to provide the level of care required to patients.		
NHS Horsham and Mid Sussex Clinical Commissioning Group risks			
No risks identified under AG2 at risk score 15+			
Total current level of risk against the objective		**209**	**203**

Objective AG2: To enable the development of new local models of care for the benefit of our patients and public			
Ref	Risk Description	Initial Score (Impact x Likelihood)	Current Score (Impact x Likelihood)
Alliance level risks			
No risks identified under AG2 at risk score 15+			
North place risks			
NP0009	If there continues not to be a clear articulation of the type of relationship and interface we wish to nurture with Surrey County Council and West Sussex County Council, there is a risk that we will not be able support each other to mutual benefit in areas where we need to work closely together	5x3=15	5x3=15
NP0019	If the development and adoption of new whole system models of care (e.g. Integrated Care Partnerships) is not fast enough there is a risk it will then lead to continued misalignment of system priorities resulting in continued financial unbalanced across systems and the inability to further improve patient outcome and experience with services	5x4=20	5x4=20
NP0022	There is a risk that ABC Ltd as the local GP Federation have insufficient capacity and capability infrastructure to deliver on the requirements of their current contracts.	4X4=16	4X4=16
NHS Horsham and Mid Sussex Clinical Commissioning Group risks			
No risks identified under AG2 at risk score 15+			
Total current level of risk against the objective		**51**	**51**

Objective AG3: Deliver the best outcomes for our population and the individual within our allocated resources, and through the effective engagement of staff and stakeholders.			
Reference	Risk Description12	Initial Score (Impact x Likelihood)	Current Score (Impact x Likelihood)
Alliance level risks			
AL0019	If the Alliance does not secure financial reductions as per NHS England financial recovery plan, the Alliance will fail to achieve break even position and not meet its statutory duties.	5x4=20	5x4=20
AL0023	If CCGs within the Alliance do not meet their statutory duties in relation to the Equality Act and Health and Social Care Act then the effectiveness of the organisation's commissioning processes may be limited and fail to meet statutory duties.	4x4=16	4x4=16
AL0027	If a lack of scheme of delegation surrounding financial decisions continues this will lead to confusion, duplication and may result in the wrong committee making a decision.	4x4=16	4x4=16
AL0028	If the procurement process for new models of care delivery is not robust then this would result in suboptimal delivery of service that doesn't deliver value for money.	4x4=16	4x4=16
North place risks			
NP0002	If there are continued cuts and reductions in services across adult and children's social care, there is a risk that these will impact on the effectiveness and outcomes for services and also potentially leading to increased costs to the NHS as a whole and commissioners in particular	4x4=16	4x4=16
NP0024	Insufficient paediatric capacity to manage activity peaks within SASH continues throughout winter this may then have an	4x4=16	4x4=16

Objective AG3: Deliver the best outcomes for our population and the individual within our allocated resources, and through the effective engagement of staff and stakeholders.			
Reference	Risk Description12	Initial Score (Impact x Likelihood)	Current Score (Impact x Likelihood)
	impact upon patient safety resulting in non-delivery of clinical outcomes.		
NP0025	There is a risk that with the number of GPs and nurses approaching retirement age or leaving their profession without being replaced that resilience and sustainability of Primary Care is more vulnerable.	5x4=20	5x4=20
NHS Horsham and Mid Sussex Clinical Commissioning Group risks			
No risks identified under AG3 at risk score 15+			
Total current level of risk against the objective		120	**120**

Other sources of assurance

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 has an Integrated Governance Framework (available at https://www.horshamandmidsussexccg.nhs.uk/), which describes the CCG's systems and processes for:

- Building robust corporate governance within its own structures
- Emergency preparedness, resilience and response
- Ensuring the CCG is commissioning for quality
- Ensuring the CCG is operating within the law and adhering to appropriate legislation
- Managing clinical and non-clinical risk

- Managing financial risk, and
- Managing information risk.

The Governing Body arrangements, including the Governing Body Assurance Framework, are outlined above. The financial controls are outlined in more detail in the annual accounts.

The CCG has adopted a set of Standing Orders (annex C of the Constitution) and Standing Financial Instructions/ Prime Financial Policies (annexes D and E of the Constitution) as well as more detailed financial policies approved by the Audit Committee and a detailed financial scheme of delegation.

The Continuing Healthcare Services for the CCG are hosted by NHS Coastal West Sussex CCG under a memorandum of understanding. During 2018/19 the Head of Continuing Healthcare at NHS Coastal and West Sussex CCG has attended the Quality and Safety Committee to provide information and assurance of the service being provided.

The Governing Body receives assurance that the organisation and commissioned providers are meeting the defined set of standards across domains of performance, safety, quality, and patient experience through the Integrated Performance, Delivery and Quality Report (PDQ) that is presented to Strategic Clinical Commissioning Group, Quality and Performance Committee, and the Governing Body. The PDQ consists of a review of, and exception reporting on, performance and quality issues in key areas of provider activity.

Annual audit of conflicts of interest management

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

During 2018 /19 the CCG has not identified any breaches of its policy on conflicts of interest.

The annual internal audit of conflicts of interest was carried out in January 2019 and provided an assessment of ‘reasonable assurance’.

The CCG carries out a Conflicts of Interest Indicator quarterly and annual self-assessment as part of the adherence to the national managing conflicts of interest guidance.

Data quality

The CCG Governing Body has in place comprehensive reporting through which it can monitor the result of commissioning initiatives. The Integrated Performance, Contracting and Quality Report provides assurance to the Governing Body and to the Finance and Performance Committee that the organisation and commissioned providers are meeting the quantitatively defined set of standards across the domains

of performance, safety, quality, and patient experience. It is broken into themes including constitutional targets, activity, and quality.

The annual contract model is built on Secondary User Service (SUS) and Service Level Agreement (SLAM) data. We continue to work with our providers to reconcile SUS data to their contract monitoring. We have included a Data Quality Improvement Plan (DQIP) within the contract with both Surrey and Sussex Hospitals Trust and Brighton and Sussex University Hospitals NHS Trust to improve data quality in a number of areas. 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. Throughout the year the data outputs from the CSU and the in-house Performance and Intelligence team are checked and any outlying or unexpected values are questioned. The reports are further checked against other available data sources such as NHS England reports, Improvement Assessment Framework indicators, and Public Health data.

Information Governance (IG)

The NHS Information Governance Framework identifies requirements in relation to policy and procedure dictating how the NHS and associated organisations handle information about patients and employees, in particular personal identifiable information.

The NHS Information Governance Framework is supported by the Data Security & Protection Toolkit (DSPT). Annual submission of evidence to this Framework provides assurance to the CCG, other organisations, and to individuals that personal information is dealt with legally, securely, efficiently, and effectively.

In 2018/19 all Alliance CCG's achieved a complete assessment against all 'Mandatory' criteria across the ten identified assertions of the framework. In order to address both GDPR requirements and the consolidation of processes and procedures across all of the five Alliance CCGs an extensive review of policy and procedure has taken place to bring the organisation into line with Data Protection Legislation as well as to align all systems into a single modus operandi. A revised IG training provision was delivered to over 60 key identified staff across the Alliance ensuring all staff are aware of IG and integrate it into working practice.

For 2018/19 and to date the CGG has received no level 2 or above Serious Incident Requiring Investigation reports (SIRIs). We continue to monitor both root and cause of low level IG breaches to inform training needs and potential operational review.

General Data Protection Regulations (GDPR) came into effect May 2018, the outcome of which allowed the organisation to review processes and practices in order to ensure compliance with Data Protection Legislation requirements. Some immediate impacts of this on service delivery have been observed, most notably, an increase in the number, and complexity, of Subject Access Requests under strengthened Individual Rights Requests Laws. The impact on processing SARS, will be reviewed as part of a wider IG Team staffing review.

To support legislative changes as a result of the new General Data Protection Regulation law (UK GDPR and DPA 18) NHS Digital have made changes to data sharing processes applying an approval process to Data Privacy Impact Assessments (DPIAs). We have been working closely with teams to streamline the DPIA process for all CCGs across the Alliance for direct projects as well as the implementation of a DPIA review process for funded projects.

A number of key service tasks have been completed this year that were a result of the structural changes implemented across the Alliance.

There remain a number of areas within the IG service that still require review and development. The key areas for consideration for the next financial year include:

- The integration and embedding of GP IG services team ensuring the increased demand for IG services both within and outside the CCG can be matched with suitably qualified, experience staff
- Streamlining of IG processes including the adoption of bespoke digital solutions to assist with IAO tasks, centralise incident reporting, and provide more comprehensive visibility of data sharing and associated risk
- Profile raising of the IG Team – ensuring IG is embedded in every day practice and that IG is viewed as a critical friend, providing solutions to facilitate the delivery of exceptional care.

Business critical models

The CCG recognises the principles reflected in the Macpherson report as a direction of travel for business modelling in respect of service analysis, planning, and delivery. An appropriate framework and environment is in place to provide quality assurance of business critical models within the clinical commissioning group.

The CCG's business critical models primarily rely on activity and finance data produced by the South Central and West Commissioning Support Unit (CSU) which is assured through their own processes. The CCG reviews CSU data regularly and its use is checked internally by the executive team and externally through audit of key systems and processes. The output of business critical models is validated by NHS England through their assurance process of the CCG.

Third party assurances

In 2018/19, the CCG commissioned support services from the following Commissioning Support Units (CSUs):

- South Central and West (SCW CSU) provide Human Resources, Financial , Business Intelligence, Information Governance, Complaints and Freedom of Information request support
- North East London (NEL CSU) provides Information Technology services, Individual Funding Requests, and clinical policies support.

The CCG obtains assurance regarding CSU provided services through Service Auditor Reporting. Service Auditor Reporting is undertaken by an independent auditor (Deloitte) to review the key business process controls of a service

organisation and to give an opinion on whether control activities are designed and operating effectively for control objectives to be achieved. The CSUs provide the CCG with letters outlining the scope and findings of the audits and these, together with CCG management controls for monitoring the performance of the CSU, provide coverage for a significant portion of the year in relation to CSU activities.

The CCG receives activity and finance data produced from SCW CSU which is assured through their own processes. The CCG also employs its own analysts who review the data and reports provided by CSU and may comment on their accuracy. The CCG also has its own processes for checking the quality of information received by third parties, recognising the importance of reliable information both in terms of commissioning services and efficient management of the CCG's day-to-day business and resources.

Where the CCG relies on third party providers (for example NHS Digital who provide IG training modules, payroll services which are provided by ESHT), built into the contract are mechanisms regarding assurances that the CCG requires throughout the life of the contract. The contract with the CSU is monitored by senior managers within the CCG and any issues reported to the senior management team.

Control Issues

The CCG notes a control issue relating to its financial position in 2018/19.

The financial position across the Alliance has improved during 2018/19 following the development of a comprehensive medium-term financial recovery plan which was presented to NHS England in July 2018. An Alliance Turnaround Board was formed to oversee the implementation of the plan.

The CCG position has improved during the year and the CCG almost reached its agreed control total of £28.4m deficit. The CCG missed this control total by £1.7m and its Commissioner Sustainability Funding was therefore reduced by £1.9m resulting in the final deficit position of £3.6m. Actions which have contributed to this improvement include:

- Development of a comprehensive medium-term financial recovery plan which was presented to NHS England in July 2018
- The work of the Alliance Turnaround Board to oversee implementation of plans, and
- PricewaterhouseCoopers LLP undertook a governance review in May 2018 which resulted in a comprehensive action plan.

Review of economy, efficiency, and effectiveness of the use of resources

As described above, the membership has delegated authority to the Governing Body and its committees to act effectively, efficiently, and economically. The Quality and Safety Committee oversees provider performance management across the CCG. The Delivery Programme Board oversees QIPP development and CCG performance and delivery. The Finance and Performance Committees oversee financial performance including scrutiny of financial planning and ensuring transparency of underlying assumptions in building financial plans and budgets. During 2018/19 there has been additional scrutiny of financial planning and in-year performance monitoring through the appointment of an interim Director of Financial Delivery, providing an independent assessment of the CCG plans.

The delivery of savings from the QIPP programme is always a key component of the assurance given to the Governing Body on the effective use of resources. The Audit Committee has been delegated responsibility for providing assurance that the CCG is acting effectively, efficiently, and economically and this includes receiving and processing all recommendations made by Internal Audit. Formal reports on financial performance are presented at every Governing Body meeting and Finance and Performance Committee meetings.

The Accountable Officer has responsibility for reviewing the effectiveness of the system of internal control within the clinical commissioning group.

The CCG rating for the Quality of Leadership indicator of the CCG Improvement and Assessment Framework 2018/19 was ‘requiring improvement’. The CCG has addressed this in a number of ways and a key theme of the improvement and assurance plan is leadership which is monitored through the executive team with oversight of the Audit Committee.

Delegation of functions

The CCG has not delegated decision-making on any aspects of its expenditure or functions. Where it works collaboratively with partners the decisions still need to be taken in a CCG decision-making committee.

A formal Memorandum of Understanding exists between the CCGs in the Alliance. The CCG has formal Section 75 agreements in place with West Sussex County Council and neighbouring CCGs in West Sussex. These arrangements are monitored through the Joint Commissioning Strategic Group (JCSG) and through the provisions of the Section 75 agreement. This includes arrangements for the Better Care Fund and JCSG monitor performance and budget reports monthly.

Counter fraud arrangements

The CCG takes its responsibilities towards fraud, bribery, and corruption very seriously and has in place thorough systems and practices to ensure that the organisation does not become a victim of fraud. We have appointed a Local Counter Fraud Specialist (LCFS) who works with the CCG to ensure that our policies are appropriate and up-to-date with the necessary legislation and to provide our staff with annual counter-fraud training.

The LCFS is a regular attendee of the CCG's Audit Committee where they report to the Committee on progress made against active fraud investigations where the CCG is a potential victim. The LCFS's report to the Audit Committee also includes the CCG's progress against national standards and the compliance of the CCG's providers against their counter fraud reporting requirements under the standard NHS contract.

The LCFS undertakes proactive work to detect abuse or fraud as well as investigates suspicions of fraud. There is a full set of policies and procedures in place and contact information via posters on staff notice boards, local intranet, and fraud newsletters. During 2018/19 the activities of the fraud service included:

- Fraud Awareness presentations to all staff and members
- Issuing a staff Fraud Survey annually which enables Counter Fraud to focus on areas where awareness is low
- Issuing national and local Fraud Alerts to the CCG and GP Practices
- Monitoring the National Fraud Initiative for the CCG
- Registration concerns at GP surgeries
- Supporting the CCG to complete its Self-Review Tool (SRT) to evidence how the CCG approaches and tackles fraud (this is required annually by NHS England and the NHS Counter Fraud Authority), and
- Thematic reviews into Purchasing Cards and Personal Health Budgets.

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:

> *Except for the CCG's ability to deliver their planned financial control total,* ***'Reasonable'*** *assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weakness in the design and/or inconsistent application of controls, put the achievement of particular objectives at risk.*

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

Internal Audit Reports 2018/19

Area of Audit	Level of Assurance Given
Delivery of Clinical Outcomes	Reasonable
Contract Management	Reasonable
Commissioning Support Services	Reasonable
Cybersecurity Maturity	n/a (advisory)
Conflicts of Interest (Draft)	Reasonable
Locally Commissioned Services	Reasonable
GDPR Compliance	Limited
GDPR Compliance (Follow Up)	Reasonable
Data Security and Protection Toolkit – Interim Report	n/a
Data Security and Protection Toolkit – Final Report	Substantial
Assurance Framework and Risk Management – Interim Report	n/a
Assurance Framework and Risk Management – Final Report	Reasonable
Core Financial Assurance (CFA) - Financial Accounting, Procurement & Non-Pay	Reasonable
CFA - Payroll and HR systems (Draft)	Reasonable
Non-Contract Activity	n/a (advisory)

There was one area reviewed by internal audit where it was assessed that the effectiveness of some of the internal control arrangements provided 'limited' assurance. Recommendations were made to further strengthen the control environment in these areas and the management responses indicated that the recommendations had been accepted

The CCG will monitor completion of all actions through the Audit Committee.

Review of the effectiveness of governance, risk management, and internal control

My review of the effectiveness of the system of internal control is informed by the work of PricewaterhouseCooper's governance review in May 2018, internal auditors, 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 Board 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 this review by:

- The Governing Body
- The Audit Committee
- The Delivery Programme Board
- External Consultants appointed to review the CCG's governance
- The Finance and Performance Committee
- Internal audit, and
- The Quality and Safety Committee.

This has been a challenging year for the CCG, having seen significant changes to the organisation's leadership both through changes in the Governing Body membership and the development of the Alliance and remaining under directions. I have put in place a series of actions to address these issues which are discussed in more detail in the introduction and context to the Governance Statement. The conclusions highlighted that apart from the financial balance there were no other significant control issues identified.

Conclusion

In 2019/20, working with colleagues in the Alliance, the CCG will continue to strengthen its governance structures and financial controls and build on the Head of Internal Audit Opinion stating that the CCG can take 'reasonable assurance' that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently.

The CCG recognises the challenging financial situation in which it is operating and which is evidenced in the Head of Internal Audit Opinion being 'reasonable assurance…except for the CCG's ability to deliver their planned financial control total…' , by the qualified regularity opinion provided by the external auditors, and by the section 30 referral to the Secretary of State. In 2019/20 I will continue to work with the executive team to address this challenge.

The factors described in this statement have given me increased assurance and I am therefore satisfied that the CCG operates effective and sound systems of internal control and that these will be further improved during 2019/20.

Adam Doyle
Accountable Officer
28 May 2019

Attendance at committees 2018/19

Governing Body

The Governing Bodies of NHS Crawley CCG, NHS Horsham and Mid Sussex CCG, and NHS East Surrey CCG meet 'in common' as the North Place Governing Bodies. This involves having a common agenda and meeting in a common venue at the same time but taking individual CCG decisions.

Name	Position	Attended / Eligible to attend
Mark Baker	Strategic Director of Finance up to 31.12.18	6/6
Stephen Bellamy	Locality Group Chair	5/8
Adrian Brown	Lay Member Audit	8/8
Simon Chandler	Lay Member PPE and Vice Chair	7/8
Adam Doyle	Accountable Officer	6/8
Karen Eastman	Clinical Director	4/8
Terry Lynch	Clinical Director	1/3
Mark Lythgoe	Clinical Director	3/8
Hugh McIntyre	Secondary Care Clinician	7/8
David McKenzie	Clinical Director	3/8
Riz Miarkowski	Clinical Director	2/8
Minesh Patel	Clinical Chair	7/8
John Steele	Lay Member	5/8
Sally Thomson	Independent Nurse	1/3
Debbie Stubberfield	Independent Nurse	5/5
Carol Pearson	Lay Member Finance and Performance	8/8

Audit Committee

Name	Position	Attended / Eligible to attend
Adrian Brown	Chair	7/7
Simon Chandler	Lay Member	7/7
Dr Matthew Greenwood	CCG Member Representative	3/6
John Steele	Lay Member	5/7
Carol Pearson	Lay Member Finance and Performance	7/7
Dr Paul Vinson	Clinical Lead (from 1.01.19)(NHS Crawley CCG)	2/2

Joint North Clinical Strategy Committee (replacing Strategic Clinical Commissioning Group)

Due to the change in governance committee structures in 2018 the SCCG was superseded by the Joint North Clinical Strategy Committee (CSC). The final SCCG meeting was held in August 2018. The Joint North Clinical Strategy Committee met from September 2018 onwards.

Name	Position	Attended / Eligible to attend
Stephen Bellamy	Locality Group Co Chair	4/7
Karen Eastman	Locality Group Co Chair	5/7
Rachel Harrington	Director of Commissioning Operation	2/3
Geraldine Hoban	Managing Director (North Place)	3/7
Mark Lythgoe	Clinical Director	6/7
David McKenzie	Clinical Director	4/7
Riz Miarkowski	Clinical Director	5/7
Minesh Patel	Clinical Chair	4/7
Barry Young	Chief Finance Officer (North)	1/3
Rory Church	Deputy Finance Officer (North)	3/4
Terry Lynch	Clinical Director	1/1

Locality Group

Practice	Attended / Eligible to attend
The Brow Medical Centre	5/5
Courtyard Surgery	5/5
Cowfold Medical Group	4/5
Crawley Down Health Centre	3/5
Cuckfield Medical Practice and Vale Surgery	4/5
Dolphins Practice	4/5
Holbrook Surgery	3/5
Judges Close Surgery	4/5
Lindfield Medical Centre	5/5
The Meadows Surgery	4/5
Mid Sussex Healthcare	3/5
Moatfield Surgery	4/5
Newtons Practice	4/5
Northlands Wood Practice	4/5
Orchard Surgery	4/5
Ouse Valley Practice	5/5
Park Surgery	3/5
Park View Health Partnership	4/5
Riverside Surgery	3/5
Ship Street Surgery	5/5
Silverdale Practice	4/5
Village Surgery	4/5

Primary Care Commissioning Committee

The CCG has assumed delegated responsibility for primary care commissioning. A Primary Care Commissioning Committee (PCCC) is in place in order to manage conflicts of interests in those areas where CCG commissioning does impact on member practices. In 2018/19 the committee reviewed locally commissioned services around diabetes, chronic obstructive pulmonary disorder, care homes, and sustainable general practice.

Name	Position	Attended / Eligible to attend
Stephen Bellamy / Mark Lythgoe	GP Governing Body Member	3/6
Adrian Brown	Governing Body Lay Member (Governance)	4/6
Simon Chandler	Governing Body Lay Member (PPE) - Chair	6/6
Matt Greenwood	GP Member	4/5
Sheryl Knight	GP Member	0/1
Sally Thomson	Independent Nurse	3/6
John Steele	Lay Member - Vice Chair	6/6
Barry Young	Chief Finance Officer (North)	4/6

Finance and Performance Committee

In July 2018 the final Finance and Contracting Committee was held and from August 2018 the Crawley Finance and Performance Committee met 'in common' with those of NHS Horsham and Mid Sussex CCG and of NHS East Surrey CCG using aligned terms of reference.

Name	Position	Attended / Eligible to attend
Mark Baker	Strategic Director of Finance until 31.12.18	7/9
Stephen Bellamy	Locality Group Co Chair	5/11
Adrian Brown	Governing Body Lay Member (Audit)	10/13
Simon Chandler	Governing Body Lay Member (PPE) - Chair	2/2
David Cryer	Director of Financial Delivery from 1.10.18 to 21.12.18 Strategic Director of Finance from 01.01.19	6/7
Adam Doyle	Accountable Officer	2/13
Rachel Harrington	Director of Commissioning Operation	10/13
David King	Director of Joint Commissioning and Partnerships	4/8
Peter Kottlar	Deputy Director North	7/10
David McKenzie	GP Member	9/13
Carol Pearson	Lay Member Finance and Performance Chair	11/13

Quality and Safety Committee

With the closer working nature of the CCG with NHS Crawley CCG, the Quality and Performance Committee became the Joint North Quality and Safety Committee. The Quality and Performance Committee met for the final time in May 2018 and from July 2018 the Joint North Quality and Safety Committee met.

Name	Position	Attended / Eligible to attend
Debbie Stubberfield	Independent Nurse	7/7
Geraldine Hoban	Managing Director (North Place)	4/7
Hugh McIntyre	Secondary Care Clinician	1/7
Simon Chandler	Lay Member PPE (NHS Horsham and Mid Sussex CCG)	6/7
Arif Syed	Lay Member (PPE)(NHS Crawley CCG)	1/7
Yvette Robbins	Lay Member PPE (NHS East Surrey CCG)	7/7
Patricia Brayden	Clinical Lead End of Life Care	3/5
Allison Cannon	Director of Quality and Chief Nurse	2/7
Adrian Bryan	Head of Quality	4/7
Karen Devanny	Head of Nursing	6/7
Selvi Bangalore	Clinical Director / GP Member of the Governing Body (NHS East Surrey CCG)	1/7
Paul Vinson	Clinical Director / GP Member of the Governing Body (NHS Crawley CCG)	6/7
David Hill	Clinical Director/GP Member of the Governing Body (NHS East Surrey CCG)	0/7

Remuneration and Nominations Committee

Name	Position	Attended / Eligible to attend
Adrian Brown	Lay Chair	5/5
Simon Chandler	Governing Body Lay Member	5/5
Hugh McIntyre	Secondary Care Clinician	2/5
Carol Pearson	Lay Chair	5/5
Debbie Stubberfield	Independent Nurse	3/3
Sally Thompson	Independent Nurse	1/2

There is a Remuneration and Nominations Committees in Common covering NHS Brighton and Hove CCG, NHS Crawley CCG, NHS East Surrey CCG, NHS High Weald Lewes Havens CCG, and NHS Horsham and Mid Sussex CCG. In addition to these meetings ‘in common’ the Remuneration and Nominations Committee of each CCG can choose to meet individually. Both individual and ‘in common’ meetings are included in the above table.

Remuneration and staff report

Remuneration Report

Remuneration Committee

The Remuneration Committee is a formally appointed committee of the Governing Body. It has delegated authority from the Governing Body to determine the terms and conditions of engagement, remuneration including fees, allowances and the appropriate administration of pension contributions for senior employees on the Governing Body and from the Membership via the Constitution, to determine the remuneration, including allowances, for members of the Governing Body who are officers.

The information in the Remuneration Report that is subject to external audit, includes:

- The table of salaries and allowances of senior managers and related narrative notes from pages 120
- The table of pension benefits of senior managers and related narrative notes from page 124
- The narrative disclosure of pay multiples on page 129, and
- Employee staff numbers outlined the Accounts at Appendix B and on page 130

The Committee is appointed by the CCG from amongst its Lay and Independent Governing Body Members and comprises the Lay Member for Governance, the Lay member for Patient and Public Engagement (PPE), the Independent Secondary Care Clinician and the Independent Nurse. The Chair of the Committee is usually the Lay Member for Governance except when the remuneration of the Lay Members is being discussed, at which point one of the independent clinicians takes the chair.

The Committee is quorate if any two members are present, and a member of the Committee is not permitted to be present if their remuneration is being discussed.

The Committee has met no less than twice a year, as provided in its terms of reference. Details of Remuneration Committee membership and attendance is shown in the annual governance statement.

The CCG contracts with a Commissioning Support Unit (CSU) under a service level agreement to deliver HR services. This includes provision of specialist HR advice to its Remuneration Committee. The Committee therefore has access to and takes advice from a named HR Lead, employed by the CCG's HR provider; South, Central and West CSU (SCW). Specialist advice covered employment law, 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 work of the Remuneration Committee and decisions made

The Committee has worked to its agreed annual work plan over the past year and has reached decisions on the following:

- The Committees agreed the proposed responsibilities for Committees in common
- The Committees agreed that each CCG should keep the same information with regard to Conflicts of Interest
- The Committees agreed in principle that there should be a pay review but not until after the Governance Review has reported and the scope of the Terms of Reference need to be refined
- The Committees agreed the Deputy Managing Director role should be a Very Senior Manager (VSM) role subject to approval from the relevant clinical chair
- Agreement to set up a Benchmarking Pay review sub group (a sub-committee of the Remuneration Committees in common) to consider the benchmarking of Governing Body members, Clinical leads, VSMs, and B9s
- Agreed payment of a complexity allowance to the interim Accountable Officer across the eight CCGs
- Agreed to paying an equal share across the eight SES CCGs of a non-consolidated complexity allowance for the Director of Corporate Affairs and Director of Corporate Programmes
- Agreed to SES CCGs CEO salary (pending approval from NHS E)
- Agreed to VSM terms & conditions, and
- Agreed to the nomination and remuneration of an interim Alliance Strategic CFO.

In reaching decisions, the Committee was provided with relevant benchmarking and up to date guidance from its specialist HR provider to ensure all decisions are robust.

Policy on the remuneration of senior managers

The definition of 'senior manager' within 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 decision of individuals, directorates or departments'.*

For the purposes of this report, this definition has been taken to include employee and officer voting members of the Governing Body and all members of the Central Sussex Commissioning Alliance Executive Team. The Accountable Officer has confirmed that the definition of senior manager does not extend beyond this and that regular (but non-voting) attendees at the Governing Body and Clinical Strategy Committee are covered by nationally negotiated NHS Pay scales and are disclosed via the employee benefits table in these annual accounts.

The CCGs that are part of the Central Sussex Commissioning Alliance (NHS East Surrey CCG, NHS Horsham and Mid Sussex CCG, NHS Crawley CCG, NHS Brighton and Hove CCG and NHS High Weald Lewes Havens CCG) are separate statutory bodies working with shared management team and arrangements since 1

January 2018 are governed by a Memorandum of Understanding. Where a senior manager and member of the Governing Body works across more than one CCG, the appropriate proportion of remuneration is reported and their total remuneration across both CCGs is shown separately in order to ensure full disclosure.

Remuneration of very senior managers

The CCG has a number of individuals whose total remuneration (when pro-rated) exceeds £150,000pa. The CCG is satisfied that this remuneration is reasonable based on the benchmarking data and analysis undertaken by the Remuneration Committee.

Senior manager remuneration (including salary and pension entitlements)

[Note: The disclosures in the salary and pensions tables are auditable]

Salary Disclosure Table (1 of 2)

Name and Title	2018/19	2018/19	2017/18
	Total Salary (bands of £5,000)	CCGs Share Salary (bands of £5,000)	Salary (bands of £5,000)
	£0	£0	£0
	(note 10)	(note 10)	(note 10)
Dr Minesh Patel, CCG Chair to 31.3.2019	100-105	100-105	100-105
Adam Doyle, Chief Executive Officer (Note 1)	160-165	20-25	5-10
Mark Baker, Strategic Director of Finance to 31.12.2018 (Note 3)	90-95	20-25	5-10
David Cryer, Strategic Director of Finance from 1.1.2019 (Note 5 and Note 15)	25-30	0-5	
Geraldine Hoban Managing Director North to 31.3.2019 (Note 3)	130-135	30-35	110-115
Wendy Carberry Managing Director South to 31.3.2019 (Note 3)	120-125	25-30	-

Name and Title	2018/19	2018/19	2017/18
	Total Salary (bands of £5,000)	CCGs Share Salary (bands of £5,000)	Salary (bands of £5,000)
	£0	£0	£0
	(note 10)	(note 10)	(note 10)
Terry Willows, Director of Corporate Affairs (Note 4 and Note 13)	105-110	20-25	5-10
Glynn Dodd, Programme Director of Commissioning Reform (Note 4)	105-110	20-25	5-10
Sarah Valentine, Director of Commissioning and Performance (Note 2)	110-115	10-15	0-5
Allison Cannon, Director of Quality and Chief Nurse (Note 2)	100-105	10-15	5-10
Dr Karen Eastman, Clinical Director/GP Member of the Governing Body	80-85	80-85	80-85
Dr Mark Lythgoe, Clinical Director/GP Member of the Governing Body	65-70	65-70	65-70
Dr Riz Miarkowski, Clinical Director/GP Member of the Governing Body	65-70	65-70	65-70
Dr Terry Lynch, Clinical Director/GP Member of the Governing Body to 19 October 2018	35-40	35-40	65-70
Dr Stephen Bellamy Clinical Director/GP Member of the Governing Body	65-70	65-70	65-70

Name and Title	2018/19	2018/19	2017/18
	Total Salary (bands of £5,000)	CCGs Share Salary (bands of £5,000)	Salary (bands of £5,000)
	£0	£0	£0
	(note 10)	(note 10)	(note 10)
Carol Pearson, Lay Member (Governance) from 20.08.2018 (Note 7)	15-20	10-15	n/a
Adrian Brown, Lay Member (Governance) (Note 7)	15-20	10-15	15-20
Simon Chandler, Lay Member (PPE) of the Governing Body	10-15	10-15	10-15
Sally Thomson, Independent Nurse to 23.7.2018 (Note 7)	0-5	0-5	5-10
Debbie Stubberfield - Independent Nurse from 01.08.2018 (Note 8 and Note 16)	5-10	0-5	n/a
Dr Hugh McIntyre, secondary care clinician (Note 7)	10-15	5-10	10-15
John Steele, Lay Member Primary Care (Note 7)	0-5	0-5	0-5
The individuals below are not considered as Senior Managers in 2018/19 as defined in the Annual Report			
Barry Young, Chief Finance Officer for NHS Crawley CCG (Note 6)	n/a	n/a	65-70
Rachel Harrington, Director of System Transformation (Note 6)	n/a	n/a	60-65

Salary Disclosure Table (2 of 2)

For the joint appointments, total salary is shown. All pension related benefits are calculated with respect to total for the joint appointment	2018/19			2017/18		
	Salary	All pension related benefits	Total	Salary	All pension related benefits	Total
	(Bands of £5,000)	(Bands of £2,500)	(Bands of £5,000)	(Bands of £5,000)	(Bands of £2,500)	(Bands of £5,000)
	£0	£0	£0	£0	£0	£0
		(Note 11)			**(Note 11)**	
Adam Doyle	160-165	50-52.5	220-215	35-40	57.5-60	90-95
Mark Baker	90-95	25-27.5	120-125	30-35	70-72.5	100-105
David Cryer	25-30	7.5-10	37.5-40			
Geraldine Hoban	130-135	-	130-135	130-135	65-67.5	195-200
Terry Willows (Note 14)	105-110	n/a	105-110			
Glynn Dodd	105-110	45-47.5	155-160	25-30	20-22.5	45-50
Sarah Valentine	110-115	-	135-140	25-30	110-112.5	135-140
Allison Cannon	100-105	67.5-70	170-175			
Rachel Harrington	n/a	n/a	n/a	95-100	55-57.5	150-155
Barry Young	n/a	n/a	n/a	105-120	25-27.5	130-135

Pension Disclosure Table (1 of 2)

In salary disclosure table 2 and the pension disclosure table, all pension related benefits are calculated with respect to the total for the joint appointment.

2018/19								
Name and title	Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March (bands of £5,000)	Cash Equivalent Transfer Value at 1 April	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March previous year	Employer's contribution to stake-holder pension
	£000	£000	£000	£000	£000	£000	£000	£000
Adam Doyle	2.5-5	0	15-20	0	85	33	144	0
Mark Baker	0-2.5	0	5-10	0	39	21	75	0
David Cryer	0-2.5	0	20-25	0	207	49	266	0
Geraldine Hoban	0-2.5	0	40-45	95-100	707	69	817	0
Terry Willows	0	0	0	0	0	0	0	0
Glynn Dodd	2.5-5	0-2.5	30-35	75-80	476	101	606	0
Alison Cannon	2.5-5	5-7.5	35-40	85-90	515	116	660	0
Sarah Valentine	0-2.5	0-2.5	50-55	155-160	1015	98	1161	0
Barry Young	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
David King	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a

Pension Disclosure Table (2 of 2)

2017/18								
Name and title	Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March (bands of £5,000)	Cash Equivalent Transfer Value at 1 April	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March previous year	Employer's contribution to stake-holder pension
	£000	£000	£000	£000	£000	£000	£000	£000
Adam Doyle	0-2.5	-	10-15	-	85	59	27	1
Mark Baker	0-2.5	-	2.5-5	-	39	-	39	1
Terry Willows								
Glynn Dodd	0-2.5	(2.5)-0	25-30	70-75	476	446	30	1
Sarah Valentine	0-2.5	0-2.5	50-55	150-155	1,015	864	151	-
Allison Cannon								
Rachel Harrington	0-2.5	2.5-5	25-30	70-75	514	442	72	14
Geraldine Hoban	0-2.5	0-2.5	35-40	90-95	688	596	92	3
Barry Young	0-2.5	(2.5)-0	35-40	90-95	569	514	55	5

Notes relating to tables

Note 1: Joint appointment between NHS Brighton and Hove CCG, NHS High Weald Lewes Havens CCG, NHS East Surrey CCG, NHS Horsham and Mid Sussex CCG, NHS Crawley CCG, and NHS Coastal West Sussex CCG. At this point the salary shares were based upon each CCG's registered population. The total salary for the joint appointment is as shown in salary disclosure table 1 followed by the CCG's share. In salary disclosure table 2 and the pension disclosure table, all pension related benefits are calculated with respect to the total for the joint appointment contribution. From 17 September 2018 also Accountable Officer for NHS Eastbourne, Hailsham and Seaford CCG and NHS Hastings and Rother CCG. Shares have been subsequently divided equally across all eight CCGs. Formally

appointed as Chief Executive Officer in January 2019 and holds Accountable Officer status for each of the CCGs.

Note 2: Joint appointment to the eight CCGs in the STP (NHS Brighton and Hove CCG, NHS High Weald Lewes Havens CCG, NHS Coastal West Sussex CCG, NHS Horsham & Mid Sussex CCG, NHS East Surrey CCG, NHS Eastbourne Hailsham and Seaford CCG, NHS Hastings and Rother CCG, and NHS Crawley CCG). The total salary for the joint appointment is as shown in in salary disclosure table 1 followed by the CCG's share of the salary. In salary disclosure table 2 and the pension disclosure table all pension related benefits are calculated with respect to the total for the joint appointment. The STP percentage split agreed is 15.7% NHS Brighton and Hove CCG, 8.4% NHS High Weald Lewes Havens CCG, 11.1% NHS Horsham & Mid Sussex CCG, 6.5% NHS Crawley CCG, 27.7% NHS Coastal West Sussex CCG, 8.9% NHS East Surrey CCG, 10.8% NHS Eastbourne, Hailsham and Seaford CCG, and 10.9% NHS Hastings and Rother CCG.

Note 3: Joint appointment to the five CCGs in the Alliance (NHS Brighton and Hove CCG, NHS High Weald Lewes Havens CCG, NHS Horsham & Mid Sussex CCG, NHS East Surrey CCG, and NHS Crawley CCG). Shared posts between NHS East Surrey CCG, NHS Horsham and Mid Sussex CCG, NHS Brighton and Hove CCG, NHS High Weald Lewes Havens CCG, and NHS Crawley CCG). The total salary for the joint appointment is as shown in salary disclosure table 1 followed by the CCG's share. In salary disclosure table 2 and the pension disclosure table, all pension related benefits are calculated with respect to total for the joint appointment. The Alliance percentage split agreed is 30% NHS Brighton and Hove CCG, 16% NHS High Weald Lewes Havens CCG, 23% NHS Horsham and Mid Sussex CCG, 17% NHS East Surrey CCG and 12% NHS Crawley CCG.

Note 4: Joint appointment to NHS East Surrey CCG, NHS Horsham and Mid Sussex CCG, NHS Brighton and Hove CCG, NHS High Weald Lewes Havens CCG, and NHS Crawley CCG. At this point the salary shares were based upon each CCG's registered population. The total salary for the joint appointment is as shown in salary disclosure table 1 followed by the CCG's share. In salary disclosure table 2 and the pension disclosure table, all pension related benefits are calculated with respect to the total for the joint appointment. The percentage split agreed is 30% NHS Brighton and Hove CCG, 16% NHS High Weald Lewes Havens CCG, 23% NHS Horsham & Mid Sussex CCG 17% East Surrey CCG, and 12% NHS Crawley CCG. From 7 November 2018 also appointed to NHS Coastal West Sussex CCG, NHS Eastbourne, Hailsham and Seaford CCG, and NHS Hastings and Rother CCG; costs shared equally across the CCGs.

Note 5: Joint appointment to the seven of the eight CCGs in the STP (NHS Brighton and Hove CCG, NHS High Weald Lewes Havens CCG, NHS East Surrey CCG, NHS Eastbourne Hailsham and Seaford CCG, NHS Hastings and Rother CCG, NHS Horsham and Mid Sussex CCG, and NHS Crawley CCG).

Note 6: Positions from 1.4.2018 no longer considered as Senior Managers as defined in this report.

Note 7: Joint appointment between NHS Horsham and Mid Sussex CCG and NHS Crawley CCG .The total salary for the joint appointment is as shown in salary disclosure table 1 followed by the CCG share. The MOU between NHS Crawley CCG and NHS Horsham and Mid Sussex CCGs is for 36% of the salary cost to be recharged from NHS Horsham and Mid Sussex CCG (the employer) to NHS Crawley CCG.

Note 8: Joint appointment between NHS Horsham and Mid Sussex CCG, NHS East Surrey CCG and NHS Crawley CCG .The total salary for the joint appointment is as shown in in salary disclosure table 1 followed by the CCG share.

Note 9: Lay Members, the Governing Body Independent Nurse, and Governing Body Secondary Care Consultant remuneration are non-pensionable and therefore there are no entries in respect of pensions for these members. The Clinical Directors are office holders of the CCG and are self-employed GPs. The employment status is as an 'off payroll worker' for NHS statutory accounting purposes, although the individual is paid via payroll. In accordance with HMRC guidance, they are deemed 'office holders' of the organisation requiring the organisation to deduct income tax and National Insurance at source. The practitioner pension information cannot be obtained by the CCG in respect of CETV or lump sum. As the role carried out by the GPs at the CCGs will only form a part of their overall work it is also considered inappropriate to disclose information on CETV or lump sum even if the CCGs were party to the information.

Note 10: There are nil entries for annual performance related bonuses, long term performance related bonuses and all pension related benefits for those senior managers shown in salary disclosure table 1 except for employees of the CCG. (See salary disclosure table and pension table for pension related benefits for employees).

Note 11: All Pension Related Benefits: This will apply to those receiving pension contributions only. The amount included here comprises all pension related benefits, including:

- The cash value of payments (whether in cash or otherwise) in lieu of retirement benefits, and
- All benefits in year from participating in pension schemes.

For defined benefit schemes, the amount included here is the annual increase in pension entitlement determined in accordance with the 'HMRC' method. In summary, this is as follows:

Increase = ((20 x PE) +LSE) - ((20 x PB) + LSB) less employee contributions
Where:

- PE is the annual rate of pension that would be payable to the director if they became entitled to it at the end of the financial year
- PB is the annual rate of pension, adjusted for inflation, that would be payable to the director if they became entitled to it at the beginning of the financial year

- LSE is the amount of lump sum that would be payable to the director if they became entitled to it at the end of the financial year; and
- LSB is the amount of lump sum, adjusted for inflation, that would be payable to the director if they became entitled to it at the beginning of the financial year.

Note 12: The inflation applied to the accrued pension, lump sum (where applicable) and CETV is the percentage (if any) by which the Consumer Prices Index (CPI) for the September before the start of the tax year is higher than it was for the previous September. For 2018/19 the difference in CPI between September 2017 and September 2018 was 3%. Therefore for transfers and benefit calculation purposes in 2018/19 CPI is 3%. Applying this inflation adjustment to the 31 March 2018 value has in some cases resulted in an adjusted value which exceeds the 31 March 2019 value.

Note 13: Seconded from NHS England; Pension disclosure information not available from host organisation. Total Salary value is full cost to the CCGs, as split of Employer Cost is not available.

Note 14: Seconded from NHS England

Note 15: Role is Sussex wide and on NHS Hastings and Rother CCG payroll.

Note 16: Post holder is recharged from NHS Surrey and Downs CCG

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 (or other allowable beneficiary'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.

Real increase in CETV

This reflects the increase in CETV that is funded by the employer. It does not include the increase in accrued pension due to inflation or contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement).

Exit packages, including special (non-contractual) payments

There has been one exit package in 2018/19 for an agreed redundancy for a post shared with NHS Horsham and Mid Sussex CCG and NHS Coastal West Sussex CCG. The total termination benefit was £47k; the CCGs share is £12k. (2017/18: nil)

Pay multiples

[Note: The pay multiples disclosure is auditable]
Reporting bodies are required to disclose the relationship between the remuneration of the highest paid member in their organisation and the median remuneration of the organisation's workforce.

The banded remuneration of the highest paid member in NHS Horsham and Mid Sussex CCG in the financial year 2018/19 was £100,000-£104,000 (2017/18: £130,000-£135,000). The full time equivalent (FTE) value for the highest member remuneration is £175,000-£180,000 (2017/18: £225,000-£230,000). This was 4.1 times (2017/18: 5.0) the median remuneration of the workforce, which was £42,457 (2017/18: £45,519). The increase in pay multiples is due to a number of posts within the CCG filled on an interim basis with consultants; especially with the assurance of the Financial Recovery Programme.

In 2018/19, sixteen employees received remuneration in excess of the highest-paid member. Remuneration (calculated on a full time equivalent basis) ranged from £12,000–£290,000 (2017/18: £15,000–£226,000).

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

Staff Report

Following a period of change affecting the way staff work across a broader footprint, the CCG has continued to seek different ways to engage with its workforce. This includes regular and varied communications channels to share information and also networks to enable an additional means for staff to have their voices heard on the full range of issues. The CCG took part in the NHS national staff survey and is working with staff to ensure everyone has the opportunity to influence how the CCG can improve its employee experience to increase staff engagement, staff wellbeing and staff morale.

The CCG is participating in the national Regional Talent Board and is also developing plans to work at a local level; introducing integrated organisational development interventions across partner organisations in the STP to ensure that wherever possible talent is retained within the STP.

The HR provision is delivered through the lead provider framework, by South, Central and West Commissioning Support Unit.

Number of senior managers, staff numbers and composition

Staff details disclosed are permanently employed staff with a permanent (UK) employment contract with the CCG and includes the relevant CCG share of any shared posts.

The Governing Body members' composition is shown below. The table below shows the staff composition by band. This includes those GPs working as clinical leads, and paid through the payroll, but who are not employees or officers.

	Total	
	Head-count in 2018/19	Average WTE
Governing Body		
Chair	1.00	1.00
Chief Executive Officer	0.19	0.19
Managing Director	0.46	0.43
Strategic Finance Director	0.23	0.17
Clinical Directors	7.64	4.37
Lay Members	2.79	1.26
Governing Body Total	**12.30**	**7.43**

	Total	
	Head-count in 2018/19	Average WTE
Employees of the CCG		
Apprentice	0.46	0.15
Band 2	0.23	0.13
Band 3	0.92	0.49
Band 4	7.41	4.12
Band 5	14.44	7.76
Band 6	15.69	10.29
Band 7	21.08	12.99
Band 8a	27.63	15.79
Band 8b	11.44	6.15
Band 8c	10.18	6.80
Band 8d	6.15	3.42
Band 9	1.98	1.46
VSM	1.14	0.79
Chief Finance Officer	0.69	0.52
Clinical Lead	2.46	0.59
Employees Total	**121.91**	**71.47**
Grand Total	**134.21**	**78.89**

Staff Costs

[(Note: This disclosure is auditable]

The tables below show the total employee benefits.

2018/19 Employee Benefits	2018/19 total			Admin			Programme		
	Total	Perm	Other	Total	Perm	Other	Total	Perm	Other
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Employee Benefits									
Salaries and wages	5,524	4,983	541	2,736	2,437	299	2,788	2,545	242
Social security costs	456	456	0	284	284	0	172	172	0
Employer contributions to the NHS Pension Scheme	474	474	0	300	300	0	175	175	0
Apprenticeship Levy	12	12	0	12	12	0	0	0	0
Termination benefits	47	47	0	47	47	0	0	0	0
Net Employee Benefits	**6,513**	**5,972**	**541**	**3,379**	**3,080**	**299**	**3,135**	**2,892**	**242**

2017/18 Employee Benefits	2017/18 total			Admin			Programme		
	Total	Perm	Other	Total	Perm	Other	Total	Perm	Other
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Employee Benefits									
Salaries and wages	4,861	4,579	282	2,184	2,034	150	2,677	2,545	132
Social security costs	402	402	0	228	228	0	175	175	0
Employer contributions to the NHS Pension Scheme	431	431	0	264	264	0	166	166	0
Apprenticeship Levy	12	12	0	12	0	0	0	0	12
Termination benefits	0	0	0	0	0	0	0	0	0
Net Employee Benefits	**6,513**	**5,972**	**541**	**3,379**	**3,080**	**299**	**3,135**	**2,892**	**242**

Sickness absence data

[Note: This sickness absence disclosure is not auditable. The information is provided by the Department of Health and Social Care]

Sickness absence rates for the calendar year to December 2018, show average days lost per FTE employee of 8.2 days (6.2 days in 2017/18), equating to sickness absence rate of 3.64% (2.78% in 2017/18). The underlying figures have been converted to the Cabinet Office measurement base by applying a factor of 225/365 to convert from calendar days to working days lost. Because of the shared management team (with all employee payments made through NHS Horsham and Mid Sussex CCG) the figure shown is combined with NHS Crawley CCG. There is a sickness absence policy in place and support in managing absence is provided by a human resources service.

Staff policies

Part of the HR Provision by South, Central and West Commissioning Support Unit ensures that all CCG Human Resources policies are agreed in partnership with Trade Union representatives, are complaint with UK employment law, follow up to date guidance and provide a backdrop of equality for all staff.

The CCG in discharging its obligation as a responsible employer has HR policies, procedures and practices in place that are inclusive of diversity and equal treatment of its workforce. Each policy is equality impact assessed for the effect on different groups protected from discrimination by the Equality Act (2010) to ensure the policy is fully effective for all target groups.

The CCG works with its HR provider to ensure training and development is accessible to all staff and where appropriate will seek the advice of Occupational Health specialists. The CCG is a member of a Sussex wide Health and Safety Committee which enables the CCG to discharge its responsibility for the safety and wellbeing of its workforce.

Staff Equality Network

A staff equality network has been formed during the reporting period. This network covers all of the CCGs within Sussex and East Surrey. The network has strong leadership support and commitment, and is beginning to achieve progress.

We are proud to note that on 30 January 2019 the Sussex and East Surrey Commissioners (DCS012299) was certified as 'disability confident committed' employer.

As a Disability Confident Committed Employer we have committed to:

- Anticipating and providing reasonable adjustments as required
- At least one activity that will make a difference for disabled people
- Communicating and promoting vacancies
- Ensure our recruitment process is inclusive and accessible
- Offering an interview to disabled people
- Supporting any existing employee who acquires a disability or long term health condition, enabling them to stay in work.

Trade Union facilities

Senior managers and the HR leads in the CCG meet formally with recognised Trade Union representatives and engage with staff through this mechanism. The CCG is a relevant public sector employer as defined by the Trade Union (Facility Time Publication Requirements) Regulations 2017. There are three employees to report who, between them, serve the joint management team of the Sussex and East Surrey CCGs. They each spent between 1% and 50% of their working hours on facility time representing less than 1% of total pay bill.

Expenditure on consultancy

During the year the CCG spend on consultancy services was £876,000 (£1,336,000 in 2017/18) as can be seen in note 4 of the Annual Accounts.

Off-payroll engagements

Off-payroll engagements are defined as those at rates of more than £245 per day and lasting more than six months. In this category there have been a number of engagements with individuals undertaking interim roles for the CCG, outlined below.

The majority of these roles are shared with the Sussex and East Surrey CCGs as part of the shared management arrangements.

Off-payroll engagements longer than 6 months

For all off-payroll engagements as at 31 March 2019, for more than £245 per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2019	**15**
Of which, the number that have existed:	
for less than one year at the time of reporting	10
for between one and two years at the time of reporting	5
for between 2 and 3 years at the time of reporting	0
for between 3 and 4 years at the time of reporting	0
for 4 or more years at the time of reporting	0

In 2018/19 the establishment control process required approval at weekly management meeting for all changes to the CCGs establishment; including recruitment of interims.

New off-payroll engagements

Where the reformed public sector rules apply, entities must complete Table 2 for all new off-payroll engagements, or those that reached six months in duration, between 1 April 2018 and 31 March 2019, for more than £245 per day and that last for longer than 6 months:

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2018 and 31 March 2019	**18**
Of which:	
Number assessed as caught by IR35	1
Number assessed as not caught by IR35	17
Number engaged directly (via PSC contracted to department) and are on the departmental payroll	0
Number of engagements reassessed for consistency / assurance purposes during the year	1
Number of engagements that saw a change to IR35 status following the consistency review	0

Off-payroll engagements / senior official engagements

For any off-payroll engagements of Board members and / or senior officials with significant financial responsibility, between 01 April 2018 and 31 March 2019.

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year (1)	3
Total no. of individuals on payroll and off-payroll that have been deemed “board members, and/or, senior officials with significant financial responsibility”, during the financial year. This figure should include both on payroll and off-payroll engagements (2).	3

The individuals reported as off-payroll Senior Management Engagements are Sussex and East Surrey CCG positions that are recharged from NHS England and NHS Hastings and Rother CCG.

Parliamentary accountability and audit report

NHS Horsham and Mid Sussex CCG is not required to produce a Parliamentary Accountability and Audit Report. Disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges are included as notes in the Financial Statements at Appendix B of this report. An audit certificate and report is also included in this Annual Report at Appendix A.

Accountability Report

Adam Doyle
Accountable Officer
28 May 2019

Section 3: Annual Accounts

Finance report

Managing a challenging financial agenda

Overall summary of the financial position

NHS Horsham and Mid Sussex CCG delivered a deficit of £3.6m after Commissioner Sustainability Funding (CSF) in 2018/19. The key results are:

- The CCG delivered a greater deficit than planned (planned deficit £0.0m after CSF: actual deficit of £3.6m) against a Revenue Resource Limit of £340m
- Cash was managed within the resource limits available, and
- The CCG, as a result of its many joint working arrangements, stayed within its running cost target of £21.90 per head of population, restricting costs to £21.86 per head.

Finance report

In 2018/19 the CCG was required to set its financial plan in accordance with the planning requirements laid down by NHS England. This plan included 0.5% contingency, and a challenging savings target requiring a QIPP efficiency saving as well as identifying other savings on discretionary expenditure with an overall savings target of 3.1%.

The CCG faced a number of financial pressures in 2018/19 leading to an increase in deficit above plan. These included:

- A contractual difference with the main acute provider that had been included as a unmitigated risk in the plan and was resolved close to year end resulting in the crystallising of some of the risk, and
- Failure to fully identify and deliver QIPP savings targets.

Quality, Innovation, Productivity and Prevention (QIPP)

The NHS as a whole has to improve efficiency to offset the rising cost of healthcare from new technologies, population growth, inflation, and other pressures. A national programme is now well established to release savings by improving quality, driving innovation in healthcare, improving productivity, and preventing ill-health.

The CCG plan for 2018/19 included a savings target of £11.2m (4% of allocation). This is significantly above the CCG national average for delivery over the last three years. The actual delivery of savings was £7.3m (65% of plan).

Running costs

Each CCG is set a limit on how much it can spend on its administrative and management costs. The 'running costs' threshold approximates to £21.90 per head of population, and we were able to manage our business within this limit with a running cost of £21.86 per head of population. The CCG manages its running cost allowance as efficiently as possible through significant joint working with NHS Crawley CCG and NHS East Surrey CCG in particular and with other Sussex CCGs.

Looking ahead

The financial prospects for 2019/20 and subsequent years remain challenging, with significant savings targets to be met and rising demand for services, coupled with an ageing population with increasingly complex health needs.

The CCG will be over its funding target, sometimes known as the 'fair shares' place based target, compared with other local CCGs by 2019/20. The CCG's funding allocation, in terms of distance from target, will be under target by 0.03% at the end of 2019/20.

The CCG has received an additional programme allocation of £15.7m (5.76%) in 2019/20. The CCG has to fund tariff uplift of £11.1m (net 3.3%), forecast growth in activity of £16.1m (net 4.8%) including Operating Plan investments required to deliver the national guidance around Mental Health, Community and Primary Care services, and cost pressures.

The CCG has produced a financial plan for 2019/20 in line with the guidance produced by NHS England. The CCG's current plans do not deliver the statutory financial duty of breakeven in 2019/20 nor the NHS England control total of a deficit of £31.3m in year. The CCG is developing saving plans to meet this control total and will provide an updated Financial Recovery Plan to NHS England by 30 June 2019.

Glossary

3VA	Council for Voluntary Services
AAF	Alliance Assurance Framework
ACCA	Association of Chartered Certified Accountants
ADHD	Attention Deficit Hyperactivity Disorder
AEO	Accountable Emergency Officer
AfC	Agenda for Change
AFC	Armed Forces Community
AHC	Annual Health Check
ATB	Alliance Turnaround Board
BME	Black and Minority Ethnic
BSI	Blood Stream Infections
BSUH	Brighton and Sussex University Hospitals NHS Trust
CAMHS	Child and Adolescent Mental Health Services
CCA	Civil Contingencies Act 2004
CCG	Clinical Commissioning Group
CEC	Clinically Effective Commissioning
CEO	Chief Executive Officer
CEPN	Community Education Provider Networks
CETR	Care, Education and Treatment Review
CETV	Cash Equivalent Transfer Value
CDI	Clostridium Difficile Infection
COI	Conflict of Interest
CPA	Care Programme Approach
CQC	Care Quality Commission

CSU	Commissioning Support Unit
CTR	Care Treatment Review
CYP	Children and Young People
DPIAs	Data Privacy Impact Assessments
DQIP	Data Quality Improvement Plan
DToC	Delayed Transfers of Care
EBI	Evidence Based Interventions
E. Coli	Escherichia coli
ED	Emergency Departments
EHIA	Equality and Health Inequalities Impact Assessment
EMU	East Sussex Better Together
EPRR	Emergency Planning, Resilience, and Response
ESBT	East Sussex Better Together
ESCIS	East Sussex Community Information Service
ESHT	East Sussex Healthcare NHS Trust
EU	European Union
EXPaCC	East Sussex Parent Carer Council
FFT	Friends and Family Test
FReM	Government Financial Reporting Manual
FRP	Financial Recovery Plan
GDPR	General Data Protection Regulations
HEE	Health Education England
HFMA	Healthcare Financial Management Association
HIUS	High Intensity User Service
HOSC	Health Overview and Scrutiny Committee
HPG	Health Policy Group

HSCC	Health and Social Care Connect
IAF	Improvement and Assessment Framework
ICDC	Integrated Community Diabetes Care
ICS	Integrated Care Systems
IGSG	Information Governance Steering Group
JMT	Joint Management Team
KSS	Kent, Surrey and Sussex
LD	Learning Disability
LeDeR	Learning Disabilities Mortality Review (LeDeR)
LMC	Local Medical Committee
LMS	Local Maternity System
MARS	Mutually agreed resignations
MRSA	Meticillin or Methicillin Resistant Staphylococcus Aureus
MDT	Multidisciplinary Team
MLU	Midwife Led Unit
MSK	Musculoskeletal Service
MTW	Maidstone and Tunbridge Wells NHS Trust
NHSA	NHS Act 2006 as amended
OpEx/OPEX	Operational Executive
PPG	Patient Participation Groups
PSC	Patient Safety Collaborative
QIPP	Quality, Innovation, Productivity and Prevention
QOF	Quality and Outcomes Framework
RAG	Red Amber Green
SARs	Subject Access Requests
SCAS	South Central Ambulance Service

SCRs	Summary Care Records
SECAmb	South East Coast Ambulance Service NHS Foundation Trust
SEND	Special Education Needs and Disability
SHMI	Summary Hospital Mortality Indicator
SIP	Strategic Investment Plan
SLAM	Service Level Agreement
SPFT	Sussex Partnership Foundation Trust
SRO	Senior Responsible Officer
SSNAP	Stroke Sentinel National Audit Programme
STOMP	Stopping Overmedication of People with a Learning Disability
SUS	Secondary User Service
STP	Sustainability and Transformation Partnership
TCP	Transforming Care Partnership
UTCs	Urgent Treatment Centres
WTE	Whole Time Equivalent

Appendix A:
Independent Auditor's Report

INDEPENDENT AUDITOR'S REPORT TO THE MEMBERS OF THE GOVERNING BODY OF NHS HORSHAM AND MID SUSSEX CLINICAL COMMISSIONING GROUP

Opinion

We have audited the financial statements of NHS Horsham and Mid Sussex Clinical Commissioning Group (the CCG) for the year ended 31 March 2019 under the Local Audit and Accountability Act 2014. The financial statements comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes 1 to 19. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the 2018/19 HM Treasury's Financial Reporting Manual (the 2018/19 FReM) as contained in the Department of Health and Social Care Group Accounting Manual 2018/19 and the Accounts Direction issued by the NHS Commissioning Board with the approval of the Secretary of State as relevant to the National Health Service in England (the Accounts Direction).

In our opinion, the financial statements:

- give a true and fair view of the financial position of NHS Horsham and Mid Sussex Clinical Commissioning Group as at 31 March 2019 and of its net operating costs for the year then ended; and
- have been properly prepared in accordance with the Health and Social Care Act 2012 and the Accounts Directions issued thereunder.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of our report below. We are independent of the clinical commissioning group in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard and the Comptroller and Auditor General's AGN01, and we have fulfilled our other ethical responsibilities in accordance with these requirements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

We have nothing to report in respect of the following matters in relation to which the ISAs (UK) require us to report to you where:

- the Accountable Officer's use of the going concern basis of accounting in the preparation of the financial statements is not appropriate; or
- the Accountable Officer has not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the Clinical Commissioning Group's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from the date when the financial statements are authorised for issue.

Other information

The other information comprises the information included in the annual report set out on pages 3 to 140, other than the financial statements and our auditor's report thereon. The Accountable Officer is responsible for the other information.

Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in this report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of the other information, we are required to report that fact.

We have nothing to report in this regard.

Opinion on other matters prescribed by the Health and Social Care Act 2012

In our opinion the part of the Remuneration and Staff Report to be audited has been properly prepared in accordance with the Health and Social Care Act 2012 and the Accounts Directions issued thereunder.

Matters on which we are required to report by exception

We are required to report to you if:

- in our opinion the governance statement does not comply with the guidance issued by the NHS Commissioning Board; or
- we issue a report in the public interest under section 24 of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the CCG under section 24 of the Local Audit and Accountability Act 2014.

We have nothing to report in these respects.

In respect of the following, we have matters to report by exception:

Referral to the Secretary of State

We refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the CCG, or an officer of the CCG, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

On 2 May 2018 we made a referral to the Secretary of State under section 30a of the Local Audit and Accountability Act 2014 in relation to the CCG being set a deficit control total by NHS England for 2018/19, therefore in excess of the limits set under the National Health Service Act 2006 (as amended) section 223I (3) in breach of its statutory financial duties.

Proper arrangements to secure economy, efficiency and effectiveness

We report to you, if we are not satisfied that the CCG has put in place proper arrangements to secure economy efficiency and effectiveness in its use of resources.

Basis for qualified conclusion

The CCG reported a deficit of £3.6 million in its financial statements for the year ending 31 March 2019, thereby breaching its duty under the National Health Service Act 2006, as amended by paragraphs 223I (2) and (3) of Section 27 of the Health and Social Care Act 2012, to break even on its commissioning budget.

The CCG has not yet succeeded in addressing the underlying deficit in its budget and is forecasting a further deficit of £31.3 million for 2019/20.

This issue is evidence of weaknesses in proper arrangements for planning finance effectively to support the sustainable delivery of strategic priorities and maintain statutory functions.

Qualified conclusion (Except for)

On the basis of our work, having regard to the guidance issued by the Comptroller and Auditor General in November 2017, with the exception of the matters reported in the basis for qualified conclusion paragraph above, we are satisfied that, in all significant respects, NHS Horsham and Mid Sussex Clinical Commissioning Group put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2019.

Responsibilities of the Accountable Officer

As explained more fully in the Statement of Accountable Officer's Responsibilities set out on page 80, the Accountable Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view and is also responsible for ensuring the regularity of expenditure and income.

In preparing the financial statements, the Accountable Officer is responsible for assessing the Clinical Commissioning Group's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Accountable Officer either intends to cease operations, or have no realistic alternative but to do so.

As explained in the Annual Governance Statement the Accountable Officer is responsible for the arrangements to secure economy, efficiency and effectiveness in the use of the CCG's resources. We are required under Section 21(1)(c) of the Local Audit and Accountability Act 2014 to be satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. Section 21(5)(b) of the Local Audit and Accountability Act 2014 requires that our report must not contain our opinion if we are satisfied that proper arrangements are in place.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at https://www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Scope of the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in November 2017, as to whether the CCG had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the CCG put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2019.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to form a view on whether, in all significant respects, the CCG had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

We are required under Section 21(1)(c) of the Local Audit and Accountability Act 2014 to be satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. Section 21(5)(b) of the Local Audit and Accountability Act 2014 requires that our report must not contain our opinion if we are satisfied that proper arrangements are in place.

We are not required to consider, nor have we considered, whether all aspects of the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

Report on Other Legal and Regulatory Requirements

Qualified Regularity opinion

We are responsible for giving an opinion on the regularity of expenditure and income in accordance with the Code of Audit Practice prepared by the Comptroller and Auditor General as required by the Local Audit and Accountability Act 2014 (the "Code of Audit Practice").

We are required to obtain evidence sufficient to give reasonable assurance that the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

In our opinion, in all material respects the expenditure and income reflected in the financial statements have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them, except for the £3.6 million expenditure in excess of statutory limits. We referred this matter to the Secretary of State on 2 May 2018 under section 30a of the Local Audit and Accountability Act 2014.

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Certificate

We certify that we have completed the audit of the accounts of NHS Horsham and Mid Sussex Clinical Commissioning Group in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Use of our report

This report is made solely to the members of the Governing Body of NHS Horsham and Mid Sussex Clinical Commissioning Group in accordance with Part 5 of the Local Audit and Accountability Act 2014 and for no other purpose. Our audit work has been undertaken so that we might state to the members of the Governing Body of the CCG those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the members as a body, for our audit work, for this report, or for the opinions we have formed.

Helen Thompson *(Key Audit Partner)*
for and on behalf of Ernst & Young LLP (Local Auditor)
Southampton
28 May 2019

[The following foot note should be added to the audit report when it is published or distributed electronically:
The maintenance and integrity of the NHS Horsham and Mid Sussex Clinical Commissioning Group web site is the responsibility of the members; the work carried out by the auditors does not involve consideration of these matters and, accordingly, the auditors accept no responsibility for any changes that may have occurred to the financial statements since they were initially presented on the web site. Legislation in the United Kingdom governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.]

Appendix B:
Financial statements 2018/19

NHS Horsham & Mid Sussex CCG

Financial Statements as at 31st March 2019

Contents

Statement of Comprehensive Net Expenditure for the year ended 31st March 2019

	Note	2018-19 £'000	2017-18 £'000
Income from sale of goods and services	2	(552)	(1,833)
Other operating income	2	(145)	(591)
Total operating income		**(697)**	**(2,424)**
Staff costs	3	6,435	5,706
Purchase of goods and services	4	336,116	330,814
Provision expense	4	211	(72)
Other Operating Expenditure	4	157	7,456
Total operating expenditure		**342,919**	**343,904**
Total Net Expenditure for the Financial Year		**342,222**	**341,479**
Comprehensive Expenditure for the year		**342,222**	**341,479**
Of which:			
Administration Income and Expenditure			
Employee Benefits	3	3,300	2,688
Operating Expenses	4	1,707	1,947
Other Operating Revenue	2	-	(25)
Net Administration Costs before Interest		**5,007**	**4,610**
Programme Income and Expenditure			
Employee Benefits	3	3,134	3,018
Operating Expenses	4	334,778	336,250
Other Operating Revenue	2	(697)	(2,399)
Net Programme Expenditure before Interest		**337,215**	**336,869**

Surplus / Deficit for Year

	2018-19 Total £000	2018-19 Admin £000	2018-19 Programme £000
The CCG's performance for the year ended 31 March 2019 is as follows:			
Total Net Operating Cost for the Financial Year	342,222	5,008	337,212
Revenue Allocation	338,611	5,017	333,594
(Under)/Overspend Against Revenue Resource Limit (RRL)	**3,611**	**(9)**	**3,620**

Statement of Financial Position as at 31st March 2019

	Note	2018-19 £'000	2017-18 £'000
Non-current assets:			
Property, plant and equipment	7	219	293
Total non-current assets		**219**	**293**
Current assets:			
Trade and other receivables	8	28,742	27,692
Cash and cash equivalents	9	96	44
Total current assets		**28,838**	**27,736**
Total assets		**29,057**	**28,030**
Current liabilities			
Trade and other payables	10	(23,815)	(25,643)
Provisions	11	(245)	(253)
Total current liabilities		**(24,060)**	**(25,896)**
Non-Current Assets plus/less Net Current Assets/Liabilities		**4,997**	**2,134**
Financed by Taxpayers' Equity			
General fund		4,997	2,134
Total taxpayers' equity:		**4,997**	**2,134**

The notes from page 6 form part of this statement

The financial statements on pages 2 to 5 were approved by the Governing Body on 23rd May 2019 and signed on its behalf by:

Adam Doyle
Accountable Officer

Statement of Changes In Taxpayers Equity for the year ended 31st March 2019

	31 March 2019 General fund £'000	31 March 2018 General fund £'000
Changes in taxpayers' equity for 2018-19		
Balance at 01 April	2,134	3,878
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2018-19		
Net operating expenditure for the financial year	(342,222)	(341,479)
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(342,222)**	**(341,479)**
Net funding*	345,085	339,735
Balance at 31 March	**4,997**	**2,134**

*The Net funding represents the cash drawdown received from NHS England.

The notes from page 6 form part of this statement

Statement of Cash Flows for the year ended 31st March 2019

	Note	2018-19 £'000	2017-18 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(342,222)	(341,479)
(Increase)/decrease in trade & other receivables	8	(1,050)	(1,121)
Increase/(decrease) in trade & other payables	10	(1,735)	3,015
Provisions utilised	11	(219)	(222)
Increase/(decrease) in provisions	11	211	(72)
Net Cash Inflow (Outflow) from Operating Activities		**(345,015)**	**(339,879)**
Cash Flows from Investing Activities			
(Payments) for property, plant and equipment		(158)	(103)
Proceeds from disposal of assets held for sale: property, plant and equipment		140	-
Net Cash Inflow (Outflow) from Investing Activities		**(18)**	**(103)**
Net Cash Inflow (Outflow) before Financing		**(345,033)**	**(339,982)**
Cash Flows from Financing Activities			
Net Funding Received		345,085	339,735
Net Cash Inflow (Outflow) from Financing Activities		**345,085**	**339,735**
Net Increase (Decrease) in Cash & Cash Equivalents	9	**52**	**(246)**
Cash & Cash Equivalents at the Beginning of the Financial Year		**44**	**290**
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**96**	**44**

Note: Capital Payables balances from Note 8- Trade & Other Payables are included within the **(Payments) for property, plant and equipment** of the Statement of Cash Flow not within **Increase/ (decrease) in trade & other payables**.

The notes on pages 7 to 55 form part of this statement

Notes to the financial statements

1. Accounting Policies

NHS England has directed that the financial statements of clinical commissioning groups shall meet the accounting requirements of the Department of Health and Social Care (DHSC) Group Accounting Manual (GAM) issued by the Department of Health and Social Care. Consequently, the following financial statements have been prepared in accordance with the DHSC Group Accounting Manual 2018-19 issued by the Department of Health. The accounting policies contained in the DHSC Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to clinical commissioning groups, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the DHSC Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the clinical commissioning group for the purpose of giving a true and fair view has been selected. The particular policies adopted by the clinical commissioning group are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Going Concern

These accounts have been prepared on the going concern basis. In accordance with Section 30 of the Local Audit and Accountability Act 2014 our auditors issued a referral to the Secretary of State for Health in relation to the CCG's breach of its financial duty to operate within its revenue resource limit for the year ended March 2019.

Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.

Where a clinical commissioning group ceases to exist, it considers whether or not its services will continue to be provided (using the same assets, by another public sector entity) in determining whether to use the concept of going concern for the final set of financial statements. If services will continue to be provided the financial statements are prepared on the going concern basis.

The following is clear evidence that the Clinical Commissioning Group meets the requirements as set out in the DHSC Group Accounting Manual issued by the Department of Health:

- The Clinical Commissioning Group was established on the 1st April 2013 as a separate statutory Body;
- The Clinical Commissioning Group has an agreed constitution which it is operating to for the governance of its activities;
- The Clinical Commissioning Group has a notified allocation from NHS England to 2019-20 and an indicative allocation to 2022-23;
- The Clinical Commissioning Group has a notified control total from NHS England in 2019-20;
- The Clinical Commissioning Group has an agreed plan for 2019-20 and NHS England have agreed to provide cash funding as required;
- The Clinical Commissioning Group is part of the Central Sussex and East Surrey Commissioning Alliance and has worked to achieve a combined total.

1.2 Accounting Convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment and certain financial assets and financial liabilities.

1.3 1.1 Joint arrangements

Arrangements over which the clinical commissioning group has joint control with one or more other entities are classified as joint arrangements. Joint control is the contractually agreed sharing of control of an arrangement. A joint arrangement is either a joint operation or a joint venture.

A joint operation exists where the parties that have joint control have rights to the assets and obligations for the liabilities relating to the arrangement. Where the clinical commissioning group is a joint operator it recognises its share of, assets, liabilities, income and expenses in its own accounts.

A joint venture is a joint arrangement whereby the parties that have joint control of the arrangement have rights to the net assets of the arrangement. Joint ventures are recognised as an investment and accounted for using the equity method.

The CCGs Pooled Budgets are Joint Operations as detailed in Note 15

1.4 Pooled Budgets

The Clinical Commissioning Group has entered into a pooled budget arrangement with West Sussex County Council, NHS Crawley CCG and NHS Coastal West Sussex CCG [in accordance with section 75 of the NHS Act 2006]. The arrangements relate to the Better Care Fund and Joint Commissioning Unit and note 15 to the accounts provides details of the income and expenditure.

The Clinical Commissioning Group accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement.

1.5 Operating Segments

Income and expenditure are analysed in the Operating Segments note and are reported in line with management information used within the clinical commissioning group.

1.6 Revenue

The transition to IFRS 15 has been completed in accordance with paragraph C3 (b) of the Standard, applying the Standard retrospectively recognising the cumulative effects at the date of initial application. There is no material impact for the CCG on the transition to IFRS 15.

In the adoption of IFRS 15 a number of practical expedients offered in the Standard have been employed. These are as follows;

- As per paragraph 121 of the Standard the clinical commissioning group will not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less,
- The clinical commissioning group is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date.
- The Government Financial Reporting Manual (FReM) has mandated the exercise of the practical expedient offered in C7(a) of the Standard that requires the clinical commissioning group to reflect the aggregate effect of all contracts modified before the date of initial application.

The CCG's main source of revenue is cash received from NHS England as part of an annual resource allocation. This is drawn down directly into the bank account of the CCG and credited to the General Fund. The revenue is not included in note 2 of the accounts. Revenue is totally from the supply of services. The CCG receives no revenue from the sale of goods.

Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer, and is measured at the amount of the transaction price allocated to that performance obligation.

Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred.

Payment terms are standard reflecting cross government principles.

1.7 Employee Benefits

1.7.1 Short-term Employee Benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees, including bonuses earned but not yet taken.

The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

1.7.2 Retirement Benefit Costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the clinical commissioning group of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period. The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

1.8 Other Expenses

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

1.9 Property, Plant & Equipment

1.9.1 Recognition

Property, plant and equipment is capitalised if:

- It is held for use in delivering services or for administrative purposes;
- It is probable that future economic benefits will flow to, or service potential will be supplied to the clinical commissioning group;
- It is expected to be used for more than one financial year;
- The cost of the item can be measured reliably; and,
- The item has a cost of at least £5,000; or,
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or,
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

1.9.2 Measurement

All property, plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at valuation.

The CCG does not own any land or buildings.

Plant and Machinery and IT equipment are carried at depreciated historic cost as this is not considered to be materially different from current value in existing use.

1.9.3 Subsequent Expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

1.9.4 Depreciation, Amortisation & Impairments

Depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the clinical commissioning group expects to obtain economic benefits or service potential from the asset. This is specific to the clinical commissioning group and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognized on a prospective basis. Assets held under finance leases are depreciated over their estimated useful lives.

At each reporting period end, the clinical commissioning group checks on where there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is an indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

1.10 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

1.10.1 The Clinical Commissioning Group as Lessee

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate on interest on the remaining balance of the

liability. Finance charges are recognised in calculating the clinical commissioning group's surplus/deficit.

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

1.11 Cash & Cash Equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the clinical commissioning group's cash management.

1.12 Provisions

Provisions are recognised when the clinical commissioning group has a present legal or constructive obligation as a result of a past event, it is probable that the clinical commissioning group will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rates below. Early retirement provisions are discounted using HM Treasury's pension discount rate of positive 0.29% (2017-18: positive 0.10%) in real terms. All general provisions are subject to four separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:

- A nominal short-term rate of 0.76% (2017-18: negative 2.42% in real terms) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.
- A nominal medium-term rate of 1.14% (2017-18: negative 1.85% in real terms) for inflation adjusted expected cash flows over 5 years up to and including 10 years from the Statement of Financial Position date.
- A nominal long-term rate of 1.99% (2017-18: negative 1.56% in real terms) for inflation adjusted expected cash flows over 10 years and up to and including 40 years from the Statement of Financial Position date.
- A nominal very long-term rate of 1.99% (2017-18: negative 1.56% in real terms) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.

All 2018-19 percentages are expressed in nominal terms with 2017-18 being the last financial year that HM Treasury provided real general provision discount rates.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

1.13 Clinical Negligence Costs

NHS Resolution operates a risk-pooling scheme under which the clinical commissioning group pays an annual contribution to NHS Resolution, which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with clinical commissioning group.

1.14 Non-clinical Risk Pooling

The clinical commissioning group participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the clinical commissioning group pays an annual contribution to the NHS Litigation Authority and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

1.15 Contingent Liabilities

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the clinical commissioning group, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

Where the time value of money is material, contingencies are disclosed at their present value.

1.16 Financial Assets

Financial assets are recognised when the clinical commissioning group becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are classified into the following categories:

- Financial assets at amortised cost;
- Financial assets at fair value through other comprehensive income and;
- Financial assets at fair value through profit and loss.

The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and is determined at the time of initial recognition.

There is no material impact for the CCG on the transition to IFRS 9.

1.16.1 Financial Assets at Amortised cost

Financial assets measured at amortised cost are those held within a business model whose objective is achieved by collecting contractual cashflows and where the cash flows are solely payments of principal and interest. This includes most trade receivables and other simple debt instruments. After initial recognition these financial assets are measured at amortised cost using the effective interest method less any impairment. The effective interest rate is the rate that exactly discounts estimated

future cash receipts through the life of the financial asset to the gross carrying amount of the financial asset.

1.16.2 Impairment

For all financial assets measured at amortised cost or at fair value through other comprehensive income (except equity instruments designated at fair value through other comprehensive income), lease receivables and contract assets, the clinical commissioning group recognises a loss allowance representing the expected credit losses on the financial asset.

The clinical commissioning group adopts the simplified approach to impairment in accordance with IFRS 9, and measures the loss allowance for trade receivables, lease receivables and contract assets at an amount equal to lifetime expected credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2) and otherwise at an amount equal to 12 month expected credit losses (stage 1).

HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds, and Exchequer Funds' assets where repayment is ensured by primary legislation. The CCG therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally, the Department of Health and Social Care provides a guarantee of last resort against the debts of its arm's length bodies and NHS bodies (excluding NHS charities), and the CCG does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of the estimated future cash flows discounted at the financial asset's original effective interest rate. Any adjustment is recognised in profit or loss as an impairment gain or loss.

1.17 Financial Liabilities

Financial liabilities are recognised on the statement of financial position when the clinical commissioning group becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

1.17.1 Other Financial Liabilities

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health and Social Care, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.18 Value Added Tax

Most of the activities of the clinical commissioning group are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.19 Losses & Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the clinical commissioning group not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

The CCG has no Critical Accounting Judgements & Key Sources of Estimation Uncertainty to disclose.

1.20 Accounting Standards That Have Been Issued but Have Not Yet Been Adopted

The Department of Health and Social Care (DHSC) GAM does not require the following IFRS Standards and Interpretations to be applied in 2018-19. These Standards are still subject to HM Treasury FReM adoption, with IFRS 16 being for implementation in 2020-21, and the government implementation date for IFRS 17 still subject to HM Treasury consideration.

- IFRS 16 Leases – Application required for accounting periods beginning on or after 1 January 2020, but not yet adopted by the FReM: early adoption is not therefore permitted.
- IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.
- IFRIC 23 Uncertainty over Income Tax Treatments – Application required for accounting periods beginning on or after 1 January 2019.

2. Other Operating Revenue

	2018-19 Total £'000	2017-18 Total £'000
Income from sale of goods and services (contracts)		
Education, training and research	52	-
[1]Non-patient care services to other bodies	20	1,832
[2]Prescription fees and charges	480	259
Total Income from sale of goods and services	**552**	**2,091**
Other operating income		
[3]Charitable and other contributions to revenue expenditure: non-NHS	145	-
Other non contract revenue	-	333
Total Other operating income	**145**	**333**
Total Operating Income	**697**	**2,424**

Admin Revenue is revenue received that is not directly attributable to the provision of healthcare or healthcare services.
Revenue arose totally from the supply of services. The Clinical Commissioning Group (CCG) receives no revenue from the sale of goods.

[1]2017-18 Included within the **Non-patient Care Services to Other Bodies** £1,022k relating to s117 income from West Sussex County Council; part of the Joint Commissioning Unit s75.

[2]**Prescription Fees and Charges** – In 2018-19 the CCG received more rebates from pharmaceutical companies, £480k (2017-18 £259k)

[3]**Charitable and other contributions to revenue expenditure: non-NHS**: Children and Young People (CYP) Waiting list allocation received via NHS Coastal West Sussex CCG £145k.

2.1. Disaggregation of Income - Income from sale of good and services (contracts)

	Education, training and research	Non-patient care services to other bodies	Prescription fees and charges
	£'000	£'000	£'000
Source of Revenue			
NHS	52	-	-
Non NHS	-	20	480
Total	**52**	**20**	**480**

	£'000	£'000	£'000
Timing of Revenue			
Point in time	52	20	480
Total	**52**	**20**	**480**

2.2. Transaction price to remaining contract performance obligations

The CCG has no Contract revenue expected to be recognised in the future periods relating to contract performance obligations not yet completed at the reporting date

3. Employee benefits and staff numbers

3.1. Employee benefits

	Total Permanent Employees £'000	Other £'000	2018-19 Total £'000
Employee Benefits			
Salaries and wages	4,940	541	5,481
Social security costs	456	-	456
Employer Contributions to NHS Pension scheme	474	-	474
Other pension costs	-	-	-
Apprenticeship Levy	12	-	12
Termination benefits	12	-	12
Net employee benefits excluding capitalised costs	**5,894**	**541**	**6,435**

	Total Permanent Employees £'000	Other £'000	2017-18 Total £'000
Employee Benefits			
Salaries and wages	4,579	282	4,861
Social security costs	402	-	402
Employer Contributions to NHS Pension scheme	431	-	431
Apprenticeship Levy	12	-	12
Net employee benefits excluding capitalised costs	**5,424**	**282**	**5,706**

3.2. Average number of people employed

	2018-19			2017-18		
	Permanently employed Number	Other Number	Total Number	Permanently employed Number	Other Number	Total Number
Total	**76**	**9**	**85**	**67**	**8**	**75**

NHS Horsham & Mid Sussex CCG is a member of the Sussex and East Sussex CCGs. The disclosures incorporate the CCGs share of the establishment in 2018-19. The "Other" Headings refer to Agency spend.

3.3. Exit packages agreed in the financial year

The CCG has one exit package agreed in the year. The total payment made was £47k and this cost of this was shared with NHS Crawley CCG and NHS Coastal West Sussex CCG. The Share for NHS Horsham & Mid Sussex CCG is £12k.

Redundancy and other departure costs were paid in accordance with the provisions of the employee contract.

Analysis of Other Agreed Departures

	2018-19		2017-18	
	Other agreed departures		Other agreed departures	
	Number	£	Number	£
Voluntary redundancies including early retirement contractual costs	1	11,947	-	-
Total	**1**	**11,947**	**-**	**-**

3.4. Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions.

These schemes are unfunded, defined benefit schemes that cover NHS employers, General Practices and other bodies allowed under the direction of the Secretary of State in England and Wales. The schemes are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities.

Therefore, the schemes are accounted for as though they were defined contribution schemes: the cost to the clinical commissioning group of participating in a scheme is taken as equal to the contributions payable to the scheme for the accounting period.

The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

3.5. Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2018, is based on valuation data as 31 March 2017, updated to 31 March 2018 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

3.6. Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and employee and employer representatives as deemed appropriate.

The next actuarial valuation is to be carried out as at 31 March 2016 and is currently being prepared. The direction assumptions are published by HM Treasury which are used to complete the valuation calculations, from which the final valuation report can be signed off by the scheme actuary. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

For 2018-19, employers' contributions of £474k were payable to the NHS Pensions Scheme (2017-18: £431k) were payable to the NHS Pension Scheme at the rate of 14.38% of pensionable pay. The scheme's actuary reviews employer contributions, usually every four years and now based on HMT Valuation Directions, following a full scheme valuation. The latest review used data from 31 March 2012 and was published on the Government website on 9 June 2012. These costs are included in the NHS pension line of note 3.1.

As part of the Memorandum of Understanding between Crawley and Horsham and Mid Sussex the pension contributions are paid over by NHS Horsham and Mid Sussex CCG on behalf of Crawley CCGs.

4. Operating expenses

	2018-19 Total £'000	Restated 2017-18 Total £'000
Purchase of goods and services		
Services from other CCGs and NHS England	1,511	1,482
[7]Services from foundation trusts	73,878	79,622
[5]Services from other NHS trusts	123,817	118,684
Services from Other WGA bodies	143	-
[6/7]Purchase of healthcare from non-NHS bodies	56,829	48,199
Purchase of social care	4,242	4,459
Prescribing costs	30,887	34,443
Pharmaceutical services	47	92
General Ophthalmic services	195	188
GPMS/APMS and PCTMS	32,124	30,455
Supplies and services – clinical	37	7
Supplies and services – general	9,277	9,327
[4]Consultancy services	876	1,336
Establishment	558	889
Transport	4	584
Premises	1,484	886
[2]Audit fees	57	68
Other non statutory audit expenditure		
· Other services	1	-
[3]Other professional fees	98	28
Legal fees	14	13
Education, training and conferences	37	51
Total Purchase of goods and services	**336,116**	**330,813**
Provision expense		
Provisions	211	(72)
Total Provision expense	**211**	**(72)**
Other Operating Expenditure		
Chair and Non Executive Members	108	75
[1]Expected credit loss on receivables	20	7,305
Other expenditure	29	75
Total Other Operating Expenditure	**157**	**7,456**
Total operating expenditure	**336,484**	**338,197**

*Additional Information provided for these notes below.

Notes on Operating Expenses

The **Restatement** of 2017-18 relates to the reclassification of BCF Expenditure. In 2018-19 it was identified that the Protecting Adult Social Care scheme and Carers expenditure with West Sussex County Council should classify as Purchase of social care**.**

	2017-18	Reclassification	Restated
Supplies and services – general	13,475	-4,148	9,327
Purchase of social care	312	4,148	4,459

[1]**Expected credit loss on receivables:** In 2017-18 the CCG provided for a receivable balance, in relation contract payments to providers, that at the time were doubtful in its recovery; £7,305k. An independent audit completed in 2018-19 to assure the balance sheet reporting provided information to confirm that the receivable and prepayment balances were overstated by £8,420k; an additional adjustment of £1,115k was derecognised within **Purchase of healthcare from non-NHS bodies** to move to the values reporting in Note 8 Trade and other receivables.

The 2018-19 balance £20k is the current value of the Expected Credit Loss calculation for potential risk of impairment on current outstanding receivables.

[2]**Audit fees** relates to statutory audit services and the amount in note 4 includes VAT payable. Net audit fees amount to £42k in 2018-19 (£58k in 2017-18). The balance is the CCG assurance audit of the Mental Health Investment Standard £10k (£0 2017-18)

[3]Internal Audit spend of £38k was included within **Other professional fees** in 2018-19 (£28k in 2017-18).

[4]**Consultancy services** relates to the collaborative working across Surrey and East Sussex CCGs for off payroll Consultants including covering senior resource requirements in shared CCG teams and contributions to the Sussex and East Surrey Sustainability and Transformation Partnership (STP) programme of work.

[5]**Services from other NHS trusts**: majority increase due to final contract positon agreed with main providers Surrey and Sussex Healthcare NHS Trust 2018-19 £52,128k (2017-18 £49,998k) and Brighton & Sussex University Hospitals NHS Trust £67,126k (2017-18 £65,142k).

[6]**Purchase of healthcare from non-NHS bodies**: Includes increased expenditure following contract variation of the Musculoskeletal Service with prime provider £3,861k.

[7]Also in **Purchase of healthcare from non-NHS bodies** the cost of Mental Health Specialist Placements in 2018-19 moved from **Services from foundation trusts** under Sussex Partnership NHS Foundation Trust previously now being spend in Non NHS Providers 2018-19 £2m.

Limitation on auditor's liability
Limitation on auditor's liability for external audit work carried out in 2018/19 is £2 million.

5. Better Payment Practice Code

Measure of compliance	2018-19 Number	2018-19 £'000	2017-18 Number	2017-18 £'000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	9,525	159,498	7,779	162,258
Total Non-NHS Trade Invoices paid within target	9,224	156,066	7,618	159,230
Percentage of Non-NHS Trade invoices paid within target	**96.84%**	**97.85%**	**97.93%**	**98.13%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	3,115	317,071	2,934	299,902
Total NHS Trade Invoices Paid within target	3,033	315,793	2,862	297,819
Percentage of NHS Trade Invoices paid within target	**97.37%**	**99.60%**	**97.55%**	**99.31%**

The Better Payment Practice Code requires the CCG to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later. The target percentage to be reached is 95% and in 2018-19 the CCG achieved this across all measures.

6. Operating Leases

6.1. Payments recognised as an Expense

	2018-19			2017-18		
	Buildings	**Other**	**Total**	**Buildings**	**Other**	**Total**
	£'000	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Payments recognised as an expense						
Minimum lease payments	1,450	4	**1,454**	853	6	**859**
Total	**1,450**	**4**	**1,454**	**853**	**6**	**859**

Whilst our arrangements with NHS Property Services Limited fall within the definition of operating leases, rental charge for future years has not yet been agreed. Consequently this note does not include future minimum lease payments for the arrangements.

7. Property, plant and equipment

2018-19	2018-19 Assets under construction and payments on account £'000	2017-18 Assets under construction and payments on account £'000
Cost or valuation at 01 April 2018	293	165
Additions purchased	65	129
Additions reversed	(140)	-
Cost/Valuation at 31 March 2019	**219**	**293**
Depreciation 01 April 2018	-	-
Charged during the year	-	-
Depreciation at 31 March 2019	**-**	**-**
Net Book Value at 31 March 2019	**219**	**293**
Purchased	219	293
Total at 31 March 2019	**219**	**293**
Asset financing:		
Owned	219	293
Total at 31 March 2019	**219**	**293**

7.1. Additions to assets under construction

	2018-19 £'000	2017-18 £'000
Information technology	8	129
Total	**8**	**129**

7.2. Economic lives

	Minimum Life (years)	**Maximum Life (Years)**
Plant & machinery	1	10
Information technology	1	5

8. Trade and other receivables

	Current 2018-19 £'000	Current 2017-18 £'000
[6]NHS receivables: Revenue	5,331	1,032
[1]NHS prepayments	649	428
[4/5/6]NHS accrued income	2,485	5,839
[6]NHS Contract Receivable not yet invoiced/non-invoice	3,949	-
NHS Non Contract trade receivable (i.e pass through funding)	315	-
Non-NHS and Other WGA receivables: Revenue	556	336
[3]Non-NHS and Other WGA prepayments	7,847	14,150
[3]Non-NHS and Other WGA accrued income	7,057	13,184
Non-NHS and Other WGA Contract Receivable not yet invoiced/non-invoice	548	-
[2]Expected credit loss allowance-receivables	(20)	(7,305)
VAT	12	22
Other receivables and accruals	13	6
Total Trade & other receivables	**28,742**	**27,692**

The majority of the Clinical Commissioning Group's trade is with NHS England. As NHS England is funded by Government to provide funding to clinical commissioning groups to commission services, no credit scoring of them is considered necessary.

Non-NHS and Other WGA refers to Non NHS organisations including those that are consolidated into the Whole of Government Accounts (WGA) for example Local Authorities.

[1]**NHS prepayments**: Maternity Pathway prepayments £162k (2017-18 £162k).

[2]**Expected credit loss allowance-receivables:** In 2017-18 the CCG provided for a receivable balance, in relation contract payments to providers, that were at the time doubtful in its recovery; £7,305k. An independent audit completed in 2018-19 to assure the balance sheet reporting provided information to confirm that the receivable and prepayment balances were overstated by £8,420k; an additional adjustment of £1,115k in 2018-19.

The 2018-19 balance £20k is the current value of the Expected Credit Loss calculation for potential risk of impairment on current outstanding receivables.

[3]**Non-NHS and Other WGA prepayments** includes £5,876k and Non-NHS and **Other WGA accrued income** £4,063k for Care Unbound for the MSK Service relating to transitional arrangements. Values confirmed following independent audit.

[4]Included in the **NHS Accrued Income** balance is £689k with NHS High Weald Lewes Havens with regards to the outstanding action on the parent company guarantee submitted as part of a non-emergency patient transport services (PTS) contract.

[5]Also within **NHS Accrued Income** are Contract reconciliation Accruals for 2018-19 £1,935k (2017-18 £836k) that await final reconciliation of the Activity information.

[6]**NHS Receivables** has £1,403k increase net recharges between Sussex and East Surrey CCGs for shared pay and non-pay expenditure £7,196k (2017-18 £5,793k).

8.1. Receivables past their due date but not impaired

	2018-19 DHSC Group Bodies £'000	2018-19 Non DHSC Group Bodies £'000	2017-18 DHSC Group Bodies £'000	2017-18 Non DHSC Group Bodies £'000
By up to three months	2,444	-	232	-
By three to six months	-	71	(26)	24
By more than six months	105	234	291	2
Total	**2,549**	**305**	**497**	**26**

DHSC Group Bodies are organisations consolidated in the Whole of Government Accounts.

8.2. Other financial assets: Expected Credit Losses on Financial Assets

	Trade and other receivables - Non DHSC Group Bodies £'000
Balance at 1st April 2018	(7,305)
Allowance for credit losses at 1st April 2018	(7,305)
Lifetime expected credit losses on trade and other receivables-Stage 3	(20)
Financial assets that have been derecognised	7,305
Allowance for credit losses at 31 March 2019	**(20)**

The Expected Credit loss on the £192k Financial Assets in scope of the Expected Credit Loss calculation is £20k.

9. Cash and cash equivalents

	2018-19 £'000	2017-18 £'000
Balance at 01 April	44	290
Net change in year	52	(246)
Balance at 31 March	**96**	**44**
Made up of:		
Cash with the Government Banking Service	96	44
Cash in hand	-	-
Current investments	-	-
Balance at 31 March	**96**	**44**

10. Trade and other payables

	Current 2018-19 £'000	Current 2017-18 £'000
[1/2]NHS payables: Revenue	3,511	7,448
NHS payables: Capital	73	-
[1]NHS accruals	4,881	2,992
Non-NHS and Other WGA payables: Revenue	4,149	3,752
Non-NHS and Other WGA payables: Capital	-	166
[3]Non-NHS and Other WGA accruals	10,632	10,167
Non-NHS and Other WGA deferred income	-	454
Social security costs	81	82
Tax	67	68
Other payables and accruals	421	514
Total Trade & Other Payables	**23,815**	**25,643**

Other payables include £288k outstanding pension contributions at 31 March 2019 (2017-18 £290k).

There are no liabilities shown above that are due in future years under arrangements to buy out the liability for early retirement over 5 years (31 March 2017: £0).

Non-NHS and Other WGA refers to Non NHS organisations including those that are consolidated into the Whole of Government Accounts (WGA) for example Local Authorities.

[1]**NHS payables** balance show reduced outstanding provider balance most significant following agreement of 2018-19 position with Surrey & Sussex Healthcare NHS Trust £321k (2017-18 £3,238k)

[2]**NHS Payables** has £515k reduced net recharges between Sussex and East Surrey CCGs for shared pay and non-pay expenditure £1,757k (2017-18 £1,241k).

[2]However, within **NHS Payables** there is an increase in the balances with Sussex Partnership NHS Foundation Trust due to increased Extra Contractual Referrals (ECR) balances to be reconciled 2018-19 1,471k (2017-18 £480k).

[2]Also included in the NHS balances is £1,096k (2017-18 £1,435k) for Partially Completed Spells.

[3]The **Non-NHS Accruals** balance includes an accrual for prescribing of £4,533k (2017-18 £5,224k). Also £2,037k accruals relating to the Delegated Primary Care Responsibility to payments to be made in 2019-20 relating to 2018-19; for example QOF (Quality and Outcomes Framework) Achievement.

11. Provisions

	Current 31 March 2019 £'000	Current 31 March 2018 £'000
Legal claims	9	36
Continuing care	236	217
Total	**245**	**253**

	Legal Claims £'000	Continuing Care £'000	Total £'000
Balance at 01 April 2018	**36**	**217**	**253**
Arising during the year	-	211	**211**
Utilised during the year	(27)	(192)	**(219)**
Balance at 31 March 2019	**9**	**236**	**245**
Expected timing of cash flows:			
Within one year	9	236	**245**
Balance at 31 March 2019	**9**	**236**	**245**

The CCG, in association with NHS Coastal West Sussex CCG and NHS Crawley CCG, has entered into a Memorandum of Understanding (MoU) for the provision Continuing Health Care. The agreement is accounted for under net accounting rules. Each CCG reflects in their own accounts the CHC provisions in respect of the MoU. The £236k shown above represents the CCG's share of the continuing health care provision.

Continuing care provisions relate to retrospective claims identified for periods after 1 April 2013.

For information on the legal provision refer to note 12 – Contingencies.

12. Contingent Liability

The seven Sussex CCGs are jointly taking legal steps to enforce the terms of a parent company guarantee submitted as part of a non-emergency patient transport services (PTS) contract which was terminated with effect from 31st March 2017. The case is being supported by NHS High Weald Lewes Havens CCG's (the host CCG's) solicitors who are currently engaged in negotiations with the parent company who provided the guarantee. The process is ongoing but may result in court proceedings At this stage, it is not possible to give an accurate quantification of the precise financial consequences of the legal steps initiated but it is considered that these will not have a material impact on the future reported financial position of the CCGs.

13. Commitments

13.1. Capital commitments

	2018-19 £'000	2017-18 £'000
Property, plant and equipment	73	166
Total	**73**	**166**

14. Financial instruments

14.1. Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities.

Because NHS clinical commissioning group is financed through parliamentary funding, it is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The clinical commissioning group has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the clinical commissioning group in undertaking its activities.

Treasury management operations are carried out by the finance department, within parameters defined formally within the NHS clinical commissioning group standing financial instructions and policies agreed by the Governing Body. Treasury activity is subject to review by the NHS clinical commissioning group and internal auditors.

14.2. Credit risk

Because the majority of the NHS clinical commissioning group and revenue comes parliamentary funding, NHS clinical commissioning group has low exposure to credit risk. The maximum exposures as at the end of the financial year are in receivables from customers, as disclosed in the trade and other receivables note

14.3. Liquidity risk

NHS clinical commissioning group is required to operate within revenue and capital resource limits, which are financed from resources voted annually by Parliament. The NHS clinical commissioning group draws down cash to cover expenditure, as the need arises. The NHS clinical commissioning group is not, therefore, exposed to significant liquidity risks.

14.4. Financial Instruments

As the cash requirements of NHS England are met through the Estimate process, financial instruments play a more limited role in creating and managing risk than would apply to a non-public sector body. The majority of financial instruments relate to contracts to buy non-financial items in line with NHS England's expected purchase and usage requirements and NHS England is therefore exposed to little credit, liquidity or market risk.

14.5. Financial assets

	2018-19 £'000	2017-18 £'000
Trade and other receivables with NHSE bodies	3,561	5,990
Trade and other receivables with other DHSC group bodies	15,577	14,087
Trade and other receivables with external bodies	1,103	314
Other financial assets	13	6
Cash and cash equivalents	96	44
Total at 31 March 2019	**20,350**	20,411

14.6. Financial liabilities

	2018-19 £'000	2017-18 £'000
Trade and other payables with NHSE bodies	2,223	1,455
Trade and other payables with other DHSC group bodies	11,667	14,222
Trade and other payables with external bodies	9,256	8,848
Other financial liabilities	421	514
Total at 31 March 2019	**23,667**	**25,039**

15. Operating segments

NHS Horsham & Mid Sussex CCG contributes to a Section 75 commissioning agreement between West Sussex County Council, Coastal West Sussex CCG and Crawley CCG for the joint commissioning and pooled funding of various services. Horsham and Mid Sussex CCG is the host CCG for the Section 75 which accounts for more than 10% of the CCGs consolidated total Revenue Resource and so is considered a separate operating segment.

	Gross expenditure £'000	Income £'000	Net expenditure £'000	Total assets £'000	Total liabilities £'000	Net assets £'000
Joint Commissioning Unit	30,205	-	**30,205**	1,001	(1,001)	**-**
Better Care Fund	13,483	-	**13,483**	-	-	**-**
Commissioning of Healthcare	299,230	(697)	**298,534**	28,056	(23,059)	**4,997**
Total	**342,918**	**(697)**	**342,222**	**29,057**	**(24,060)**	**4,997**

15.1. Reconciliation between Operating Segments and SoCNE

	2018-19 £'000
Total net expenditure reported for operating segments	342,222
Reconciling Items	-
Total net expenditure per the Statement of Comprehensive Net Expenditure	**342,222**

15.2. Reconciliation between Operating Segments and SoFP

	2018-19 £'000
Total assets reported for operating segments	29,057
Reconciling Items	-
Total assets per Statement of Financial Position	**29,057**

	2018-19 £'000
Total liabilities reported for operating segments	(24,060)
Reconciling Items	-
Total liabilities per Statement of Financial Position	**(24,060)**

16. Joint arrangements - interests in joint operations

NHS Horsham & Mid Sussex CCG is part of two section 75's with Pooled Budget Arrangements in 2018-19. Both section 75s are accounted for as Joint Operations. Breakdown of the areas within the two section 75 arrangements are detailed below. Parties for all arrangements are West Sussex County Council and the West Sussex CCGs: Coastal West Sussex, Horsham & Mid-Sussex and Crawley CCGs. Both section 75s principle activity is for the provision of health and social care schemes.

16.1. Interests in joint operations

	2018-19			
Name of arrangement	**Assets**	**Liabilities**	**Income**	**Expenditure**
	£'000	**£'000**	**£'000**	**£'000**
Better Care Fund Pooled Budget	-	-	-	13,483
Learning Disabilities	79	(79)	-	3,900
Mental Health Working Age Pool	236	(236)	-	15,251
Mental Health Older Adults Pool	686	(686)	-	5,964
Children & Young Peoples Services	-	-	-	4,230
Community Equipment Services	-	-	-	861
Telecare	-	-	-	-

	2017-18			
Name of arrangement	**Assets**	**Liabilities**	**Income**	**Expenditure**
	£'000	**£'000**	**£'000**	**£'000**
Better Care Fund Pooled Budget	-	-	-	13,232
Learning Disabilities	130	(130)	-	3,498
Mental Health Working Age Pool	140	(140)	-	14,707
Mental Health Older Adults Pool	180	(180)	(238)	5,502
Children & Young Peoples Services	2	(2)	-	4,084
Community Equipment Services	-	-	-	904
Telecare	-	-	-	35

Section 75 For the Joint Commissioning and Pooled Funding of Various Services

The NHS Horsham & Mid Sussex CCG has entered into a pooled budget with West Sussex County Council (WSCC), NHS Crawley CCG and NHS Coastal West Sussex CCG. Under the arrangement funds are pooled under Section 75 of the NHS Act 2006 for the following services: Working Age Adults Mental Health and Older Age Mental Health (hosted by Horsham & Mid Sussex CCG), Learning Difficulties and Telecare (hosted by WSCC).

There is a lead commissioning arrangement between the three Clinical Commissioning Groups, with Horsham and Mid Sussex CCG as the lead CCG for the Joint Commissioning Unit for both pooled and non-pooled funds for the other CCGs, and has accounted for this net in its financial statements. Due to this lead commissioning arrangement within the CCGs, the whole pool activity between the West Sussex County Council and the CCGs is shown in the Horsham & Mid Sussex CCG accounts, and then proportioned (according to weighted capitation income proportion) out to West Sussex County Council and the CCGs to give net accounting in each of the contributors accounts. Within the arrangement, there is a risk sharing agreement between the CCGs, whereby underspends and overspends are shared according to the CCG contributions.

Mental Health Working Age Pooled Memorandum Account for the period 01/04/18 to 31/03/19

	Services	Staff	TOTAL	
Contribution provided to the pooled budget	**£'000**	**£'000**	**£'000**	
NHS Horsham & Mid Sussex CCG	13,429	-	**13,429**	
Non-pooled Contribution provided				
NHS Horsham & Mid Sussex CCG	1,700	-	**1,700**	
Total Contribution (a)	**15,129**	**-**	**15,129**	**(a)**
Expenditure	**£'000**	**£'000**	**£'000**	
West Sussex County Council	2,384	-	**2,384**	
NHS providers	11,580	-	**11,580**	
Other Non NHS providers	1,229	58	**1,287**	
Total Expenditure (b)	**15,192**	**58**	**15,251**	**(b)**
Net deficit (a) - (b)			**(122)**	

Mental Health Older Age Pooled Memorandum Account for the period 01/04/18 to 31/03/19

	Services	Staff	TOTAL	
Contribution provided	**£'000**	**£'000**	**£'000**	
NHS Horsham & Mid Sussex CCG	5,843	-	**5,843**	
Total Contribution (a)	**5,843**	**-**	**5,843**	**(a)**
Expenditure				
NHS providers	4,775	-	**4,775**	
Other Non NHS providers	1,160	29	**1,189**	
Total Expenditure (b)	**5,935**	**29**	**5,964**	(b)
Net deficit (a) - (b)			**(121)**	

Learning Difficulties Pooled Budget Memorandum Account for the period 01/04/18 to 31/03/19

Contribution provided to the pooled budget	Services	Staff	TOTAL	
	£'000	**£'000**	**£'000**	
NHS Horsham & Mid Sussex CCG	3,860	-	**3,860**	
Total Contribution (a)	3,860	-	3,860	(a)
Expenditure				
West Sussex County Council	3,900	-	3,900	
Total Expenditure (b)	3,900	-	**3,900**	(b)
Net deficit (a) - (b)			**(40)**	

Children & Young People Aligned Budget Memorandum Account for the period 01/04/18 to 31/03/19

Contribution provided to the pooled budget	**Services**	**Staff**	**TOTAL**	
	£'000	**£'000**	**£'000**	
NHS Horsham & Mid Sussex CCG	4,268	-	**4,268**	
Total Contribution (a)	**4,268**	**-**	**4,268**	**(a)**
Expenditure				
NHS providers	4,186	44	**4,230**	
Total Expenditure (b)	**4,186**	**44**	**4,230**	(b)
Net surplus (a) - (b)			**38**	

Community Equipment Aligned Budget Memorandum Account for the period 01/04/18 to 31/03/19

Contribution provided	**Services**	**Staff**	**TOTAL**	
	£'000	**£'000**	**£'000**	
NHS Horsham & Mid Sussex CCG	861	-	**861**	
Total Funding (a)	**861**	**-**	**861**	(a)
Expenditure				
NHS providers	861	-	**861**	
Total Expenditure (b)	**861**	**-**	**861**	(b)
Net surplus/deficit (a) - (b)			**-**	

Better Care Fund

In 2018-19 the CCG continued a Pooled arrangement under a section 75 of the NHS Act agreement with West Sussex County Council for the Better Care Fund. West Sussex County Council is the host of this arrangement.

The principle of the BCF is a transition toward a healthier society supported by a more proactive care approach. The BCF utilises the section 75 agreement for Health and Social Care for pooling of resources with all commissioning partners to provide a joint programme of work to deliver better outcomes for patients, and improve services.. It is a mandated NHS England venture.

The aim is to streamline care services for the population of West Sussex that are supported by the CCG's (NHS Coastal West Sussex CCG, NHS Crawley CCG and NHS Horsham and Mid Sussex CCG) and West Sussex County Council.

For 2018-19 the committed funding for BCF has increased to £62.9m, and schemes are in place for the delivery of this funding in 2018-19. The Contingency was agreed by all parties to be set as the risk share; in recognition of the trend in Non Elective Admissions. The Contingency was applied to the Urgent Care activity in excess of planned expenditure.
The financial schedules are noted below:

	Committed Funding £'000	Maximum Contingency £'000	Total Funding £'000	2018-19 Expenditure £'000
Grant Funding				
Disabled Facilities Grant (West Sussex District and Boroughs)	7,690	-	**7,690**	**7,690**
iBCF	14,430	-	**14,430**	**14,430**
	22,120	**-**	**22,120**	**22,120**
Revenue Funding				
NHS Coastal West Sussex CCG	23,780	9,441	**33,221**	**33,221**
NHS Crawley CCG	5,422	2,152	**7,574**	**7,574**
NHS Horsham and Mid Sussex CCG	9,652	3,831	**13,483**	**13,483**
Total Revenue	**38,854**	**15,424**	**54,278**	**54,278**
West Sussex County Council additional contribution	1,878	-	**1,878**	**1,869**
Total Better Care Fund Budget	**62,852**	**15,424**	**78,276**	**78,267**
Underspend				**9**

For 2018-19, the pool has underspent by £9k on Telecare. The total expenditure was £62.8m of the £62.9m committed funds.
Details of Better Care Fund can be found at https://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/.

There is a cumulative underspend of £117k, including balances from 2017-18 and interest earned on balances. Use of the under spend on the pooled budget will be decided by the Joint Commissioning Strategy Group. It may be returned to partners or reinvested in new or other schemes.

	West Sussex Total	HMS Funding Share	HMS Spend Share
BCF Schemes	**£000**	**£000**	**£000**
Disabled Facilities Grant	7,690	-	-
Maintaining (Protecting) Social Care Services	16,822	4,090	4090
Meeting Adult Social Care needs	2,800	-	-
Reducing pressures on the NHS – hospital discharges	6,230	-	-
Supporting that the local social care provider network	5,400	-	-
Proactive Care / Communities of Practice	11,046	2,985	2985
Falls	270	67	67
Programme Support Care Homes	65	42	42
Programme Support BCF	180	45	45
Reablement	4,097	1,018	1018
Dementia	100	25	25
Wolfson (Docobo)	-	-	-
Integrated Hospital Discharge	600	-	-
Care Act Initiatives	2,056	500	500
Carers Advice, Information and Support	3,224	327	327
Carers Health Team	281	68	68
Carers Support in Hospitals	229	56	56
Social Care Reablement	428	104	104
Telecare	306	74	72
Community Equipment	663	161	161
Firefly	36	9	9
Managing delayed transfers of care initiatives	330	80	80
Total Funds	**62,852**	**9,651**	**9,649**
Contingency Fund	**15,424**	**3,831**	**3,831**
Total Better Care Fund Budget	**78,276**	**13,482**	**13,480**
Underspend			**2**

17. Related party transactions

The clinical commissioning group is required to disclose all transactions in the year with any parties that are related to or connected with members of the Governing Body or members of key management staff. The members of the Governing Body have declared an interest in the following organisations; these organisations are therefore regarded as related parties, and the details of the clinical commissioning group's transactions with these organisations are as follows:

Details of related party transactions with individuals are as follows:	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
	£'000	£'000	£'000	£'000
ABC Federation	940	-	-	-
Brighton and Sussex University Hospital Trust	67,966	-	803	5,608
Care Unbound Ltd (HERE)	20,129	-	311	4,248
Dorking Healthcare	59	-	-	-
East Sussex Healthcare NHS Trust	456	-	41	94
Epsom and St Helier Hospital Trust	653	-	225	-
Royal Surrey County Hospital NHS Trust	2,637	-	64	-
South East Coast Ambulance Service NHS Trust	9,164	-	275	-
Southgate Medical Group	42	-		-
Surrey Downs CCG	-	-	27	3
NHS Brighton and Hove CCG	-	21	348	193
NHS Coastal West Sussex CCG	230	-	193	1,463
NHS Crawley CCG	67	-	915	3,112
NHS East Surrey CCG	13	-	110	942
NHS Eastbourne, Hailsham and Seaford CCG	-	1	-	220
NHS Hastings and Rother CCG	26	-	4	219
NHS High Weald Lewes Havens CCG	-	-	187	1,046
Ship Street Surgery	2,655	-	59	-
Judges Close Surgery	1,762	-	45	-
Rudgwick Medical Centre	1,034	-	40	-
Moatfield Surgery	3,218	-	87	4
Brow Medical Centre	1,846	-	106	2
Park View Health Partnership	1,278	-	-	6

The Department of Health is regarded as a related party. During the year the clinical commissioning group has had a significant number of material transactions with entities for which the Department is regarded as the parent Department. The NHS organisations listed below are those where transactions over the year 2018/19 have exceeded £500k:

Material transactions with entities for which the Department is regarded as the parent Department are as follows:	**Payments to Related Party**	**Receipts from Related Party**	**Amounts owed to Related Party**	**Amounts due from Related Party**
	£'000	**£'000**	**£'000**	**£'000**
Brighton & Sussex University Hospitals NHS Trust	67,966	-	803	5,608
Epsom & St Helier University Hospitals NHS Trust	653	-	225	-
Maidstone & Tunbridge Wells NHS Trust	1,097	-	12	-
Surrey & Sussex Healthcare NHS Trust	52,060	-	321	1,478
Guy's & St Thomas' NHS Foundation Trust	1,810	-	161	-
Royal Surrey County Hospital NHS Foundation Trust	2,637	-	64	-
South Central Ambulance Service NHS Foundation Trust	2,141	-		-
South East Coast Ambulance Service NHS Foundation Trust	9,164	-	275	-
St George's University Hospitals NHS Foundation Trust	1,461	-	282	-
Sussex Community NHS Foundation Trust	26,522	-	940	-
Sussex Partnership NHS Foundation Trust	16,607	-	1,471	3,205
Queen Victoria Hospital NHS Foundation Trust	5,763	-	-	350
The Royal Marsden NHS Foundation Trust	745	-	14	-
University College London Hospitals NHS Foundation Trust	607	-	89	-
Western Sussex Hospitals NHS Foundation Trust	4,025	-	167	453

In addition, the CCG has had a number of material transactions with other government departments and other central and local government bodies. Transactions with other Government Departments over the year 2018/19 which have exceeded £500k:

Transactions with other Government Departments were as follows:	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
NHS Property Services	534	-	551	12
West Sussex County Council	12,588	-	273	3,282

Related Party with GP Member Practices

The CCG has 23 GP member practices:

Details of related party transactions with individuals are as follows:	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
	£'000	£'000	£'000	£'000
Meadows Surgery	2,215	-	53	4
Cowfold Surgery	1,603	-	87	1
Cuckfield Medical Centre	2,253	-	75	4
Ship Street Surgery	2,655	-	59	-
Judges Close Surgery	1,762	-	45	-
Park Surgery	6,440	-	206	-
Rudgwick Medical Centre	1,034	-	40	-
The Courtyard Surgery	2,783	-	86	4
Lindfield Medical Centre	2,744	-	87	-
Orchard Surgery	2,383	-	68	-
Crawley Down Health Centre PPG	2,390	-	82	7
Dolphins Practice	3,021	-	72	5
Newtons Practice	3,172	-	71	10
Mid Sussex Health Care	4,932	-	164	-
Moatfield Surgery	3,218	-	87	4
Silverdale Practice	3,023	-	93	-
Brow Medical Centre	1,846	-	106	2
Riverside Surgery	1,801	-	53	-
Village Surgery	2,838	-	50	6
Northlands Wood Surgery	1,808	-	51	3
Ouse Valley Practice	2,401	-	88	-
Park View Health Partnership	1,278	-	-	6
Holbrook Surgery	2,967	-	71	9

The list below highlights the relationships disclosed with the related party. Where the CCG has had a monetary relationship with these related parties, they are shown in Note 17 Related Party Transactions above:

Related Party	Name	Position within CCG	Relationship to Related Party
ABC Federation	Dr Stephen Bellamy	Clinical Director and Mid Sussex Locality Chair	GP Partner at Ship Street Surgery which has joined ABC Federation
	Dr Karen Eastman	Clinical Director	GP Partner at Brow Medical Centre which has joined ABC Federation
	Dr Terry Lynch	Clinical Director	Director
	Dr Mark Lythgoe	Clinical Director	GP Partner of Mid-Sussex Healthcare which has joined ABC Federation and shareholder
	Dr David McKenzie	Clinical Director and Horsham Locality Chair	GP Partner of Rudgwick Medical Centre which has joined ABC Federation
	Dr Riz Miarkowski	Clinical Director	GP Partner of Park View Health Partnership which is a member of ABC Federation
Brighton and Sussex University Hospital Trust	Dr Karen Eastman	Clinical Director	GPwSI in Pain Management
Care Unbound Ltd (HERE)	Allison Cannon	Chief Nurse	Husband is Director of Primary Care Development
Dorking Healthcare	Dr Karen Eastman	Clinical Director	Spouse is CEO and business director for Dorking Healthcare
East Sussex Healthcare NHS Trust	Dr Hugh McIntyre	Independent Secondary Care Clinician	Consultant Physician Senior Clinical Adviser to OOH Unit Consultant and Clinical Lead for Complex Care / Frailty
Epsom and St Helier Hospital Trust	Dr Hugh McIntyre	Independent Secondary Care Clinician	Member of Expert Group advising on the Pre Consultation Business Case for Trust Reconfiguration
	Dr Riz Miarkowski	Clinical Director	Shareholder

Royal Surrey County Hospital NHS Trust	Carol Pearson	Lay Member	Volunteer research assistant
South East Coast Ambulance Service NHS Trust	Adrian Brown	Governance Lay Member	Voting member Kent & Sussex 111/CAS Joint Committee
Southgate Medical Group	Dr Laura Hill	Clinical Chair (Designate)	Salaried GP
NHS Brighton and Hove CCG	Adam Doyle	Chief Executive Officer	Chief Executive Officer for NHS Brighton and Hove CCG
	Allison Cannon	Chief Nurse	Chief Nurse for NHS Brighton and Hove CCG
	Mark Baker	Strategic Director of Finance	Strategic Director for Finance of NHS Brighton and Hove CCG
	David Cryer	Strategic Director of Finance	Strategic Director for Finance of NHS Brighton and Hove CCG
	Glynn Dodd	Programme Director Of Commissioning Reform	Programme Director Of Commissioning Reform for NHS Brighton and Hove CCG
	Terry Willows	Director Of Corporate Affairs	Director Of Corporate Affairs for NHS Brighton and Hove CCG
	Geraldine Hoban	Managing Director (North)	Managing Director (North) for NHS Brighton and Hove CCG
	Wendy Carberry	Managing Director (South)	Managing Director (South) for NHS Brighton and Hove CCG
	Sarah Valentine	Director of Contracting and Performance	Director of Contracting and Performance for NHS Brighton and Hove CCG
NHS Coastal West Sussex CCG	Adam Doyle	Chief Executive Officer	Chief Executive Officer for NHS Coastal West Sussex CCG
	Terry Willows	Director Of Corporate Affairs	Director Of Corporate Affairs for NHS Coastal West Sussex CCG
	Allison Cannon	Chief Nurse	Chief Nurse for NHS Coastal West Sussex CCG
	Sarah Valentine	Director of Contracting and Performance	Director of Contracting and Performance for NHS Coastal West Sussex CCG

NHS Crawley CCG	Adam Doyle	Chief Executive Officer	Chief Executive Officer for NHS Crawley CCG
	Allison Cannon	Chief Nurse	Chief Nurse for NHS Crawley CCG
	Mark Baker	Strategic Director of Finance	Strategic Director for Finance of Crawley CCG
	David Cryer	Strategic Director of Finance	Strategic Director for Finance of NHS Crawley CCG
	Sarah Valentine	Director of Contracting and Performance	Director of Contracting and Performance for NHS Crawley CCG
	Wendy Carberry	Managing Director (South)	Managing Director (South) for NHS Brighton and Hove CCG
	Geraldine Hoban	Managing Director North	Managing Director North (NHS Crawley CCG, NHS Horsham and Mid-Sussex CCG, NHS East Surrey) member of Joint Management Team..
	Wendy Carberry	Managing Director (South)	Managing Director (South) (NHS Brighton & Hove CCG, High Weald Lewes and Havens CCG) member of Joint Management Team.
	Terry Willows	Director of Corporate Affairs	Director of Corporate Affairs for NHS Crawley CCG
	Carol Pearson	Lay Member	Lay Member for Crawley CCG
	Adrian Brown	Lay Member	Lay Member for Crawley CCG
	Glynn Dodd	Programme Director Of Commissioning Reform	Programme Director Of Commissioning Reform for NHS Crawley CCG
	Debbie Stubberfield	Independent Nurse	Independent Nurse at Crawley CCG
NHS East Surrey CCG	Carol Pearson	Lay Member	Audit Committee Chair of NHS East Surrey CCG
	Adrian Brown	Lay Member	Audit Committee Chair of NHS East Surrey CCG
	Adam Doyle	Chief Executive Officer	Chief Executive Officer for NHS East Surrey CCG
	Allison Cannon	Chief Nurse	Chief Nurse for NHS East Surrey CCG

	Mark Baker	Strategic Director of Finance	Strategic Director for Finance of NHS East Surrey CCG
	David Cryer	Strategic Director of Finance	Strategic Director for Finance of NHS East Surrey CCG
	Sarah Valentine	Director of Contracting and Performance	Director of Contracting and Performance for NHS East Surrey CCG
	Geraldine Hoban	Managing Director North	Managing Director North (NHS Crawley CCG, NHS Horsham and Mid Sussex CCG, NHS East Surrey) member of Joint Management Team.
	Wendy Carberry	Managing Director (South)	Managing Director (South) (NHS Brighton & Hove CCG, High Weald Lewes and Havens CCG) member of Joint Management Team.
	Carol Pearson	Lay Member	Audit Committee Chair of NHS East Surrey CCG
	Terry Willows	Director of Corporate Affairs	Director of Corporate Affairs for NHS East Surrey CCG
	Glynn Dodd	Programme Director Of Commissioning Reform	Programme Director Of Commissioning Reform for NHS East Surrey CCG
	Debbie Stubberfield	Independent Nurse	Independent Nurse at East Surrey CCG
NHS Eastbourne, Hailsham and Seaford CCG	Adam Doyle	Chief Executive Officer	Chief Executive Officer for NHS Eastbourne, Hailsham and Seaford CCG
	David Cryer	Strategic Director of Finance	Strategic Director for Finance of NHS Eastbourne, Hailsham and Seaford CCG
	Terry Willows	Director Of Corporate Affairs	Director Of Corporate Affairs for NHS Eastbourne, Hailsham and Seaford CCG
	Allison Cannon	Chief Nurse	Chief Nurse for NHS Eastbourne, Hailsham and Seaford CCG
	Sarah Valentine	Director of Contracting and Performance	Director of Contracting and Performance for Eastbourne, Hailsham and Seaford CCG

NHS Hastings and Rother CCG	Adam Doyle	Chief Executive Officer	Chief Executive Officer for NHS Hastings and Rother CCG
	David Cryer	Strategic Director of Finance 01/01/19 to date	Strategic Director for Finance of NHS Hastings and Rother CCG
	Terry Willows	Director Of Corporate Affairs	Director Of Corporate Affairs for NHS Hastings and Rother CCG
	Allison Cannon	Chief Nurse	Chief Nurse for NHS Hastings and Rother CCG
	Sarah Valentine	Director of Contracting and Performance	Director of Contracting and Performance for Hastings and Rother CCG
NHS High Weald Lewes Havens CCG	Adam Doyle	Chief Executive Officer	Chief Executive Officer for NHS High Weald Lewes Havens CCG
	Allison Cannon	Chief Nurse	Chief Nurse for NHS High Weald Lewes Havens CCG
	Mark Baker	Strategic Director of Finance	Strategic Director for Finance of NHS High Weald Lewes Havens CCG
	David Cryer	Strategic Director of Finance	Strategic Director for Finance of NHS High Weald Lewes Havens CCG
	Geraldine Hoban	Managing Director North	Managing Director North (NHS Crawley CCG, NHS Horsham and Mid Sussex CCG, NHS East Surrey) member of Joint Management Team.
	Wendy Carberry	Managing Director (South)	Managing Director (South) (NHS Brighton & Hove CCG, High Weald Lewes and Havens CCG) member of Joint Management Team.
	Glynn Dodd	Programme Director OfCommissioning Reform	Programme Director Of Commissioning Reform for NHS High Weald Lewes Havens CCG
	Terry Willows	Director Of Corporate Affairs	Director Of Corporate Affairs for NHS High Weald Lewes Havens CCG
	Sarah Valentine	Director of Contracting and Performance	Director of Contracting and Performance for NHS High Weald Lewes Havens CCG

NHS Surrey Downs CCG	Debbie Stubberfield	Independent Nurse	Independent Governing Body Nurse
Ship Street Surgery	Dr Stephen Bellamy	Clinical Director and Mid Sussex Locality Chair	GP Partner
Judges Close Surgery	Dr Mark Lythgoe	Clinical Director	GP Partner
Rudgwick Medical Centre	Dr David McKenzie	Clinical Director and Horsham Locality Chair	GP Partner
Mid Sussex Health Care	Dr Terry Lynch	Clinical Director	GP Partner
Moatfield Surgery	Dr Stephen Bellamy	Clinical Director and Mid Sussex Locality Chair	Spouse employed
	Dr Minesh Patel	Clinical Chair	
Brow Medical Centre	Dr Karen Eastman	Clinical Director	GP Partner
Park View Health Partnership	Dr Riz Miarkowski	Clinical Director	GP Partner

18. Events after the end of the reporting period

The CCG has no events after the end of the reporting period to disclose.

19. Financial performance targets

Clinical commissioning groups have a number of financial duties under the National Health Service Act 2006 (as amended).
The clinical commissioning group's performance against those duties was as follows:

		2018-19 Target	2018-19 Performance	2018-19 Duty Achieved	2017-18 Target	2017-18 Performance	2017-18 Duty Achieved
Expenditure not to exceed income	223I (1)	339,308	342,919	No	305,292	344,032	No
Capital resource use does not exceed the amount specified in Directions	223I (2)	65	65	Yes	129	129	Yes
Revenue resource use does not exceed the amount specified in Directions	223I(3)	338,611	342,222	No	302,739	341,479	No
Revenue administration resource use does not exceed the amount specified in Directions	223J(3)	5,017	5,008	Yes	4,985	4,610	Yes

The CCG has not achieved all of its set performance duties for 2018-19.

Note: For the purposes of 223H(1); expenditure is defined as the aggregate of gross expenditure on revenue and capital in the financial year; and, income is defined as the aggregate of the notified maximum revenue resource, notified capital resource and all other amounts accounted as received in the financial year (whether under provisions of the Act or from other sources, and included here on a gross basis).

*The difference between the two figures is the CCG's deficit of £3,611k (2017-18 £38,740k deficit) for the period as reported on the Statement of Comprehensive Net Expenditure on page 3.