ANNUAL REPORT AND ACCOUNTS 2017 TO 2018
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PERFORMANCE REPORT
2017 to 2018

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Amanda Philpott  
Chief Officer (Accountable Officer) 
25 May 2018
SECTION 1 – Overview

1 Introduction

1.1 This Annual Report and Accounts provides information on the performance of the Clinical Commissioning Group (CCG) across our fifth year of commissioning health services for people in area of East Sussex.

1.2 As a statutory body we follow the NHS model for our annual reporting and meet the requirements of the National Audit Office. Included in this document are a performance report, an accountability report, the financial statements and the independent auditor’s report.

1.3 The Performance Report, of which this is part, reviews performance against our key duties as a commissioner and our other statutory duties. It also analyses our performance, making sense of 2017-18 in relation to previous years.

1.4 Crucial to our performance has been our planning and delivery of integrated health and care under East Sussex Better Together (ESBT). It is recognised nationally that this integration is the best way in which to address the significant funding gap facing health and social care.

1.5 The Accountability Report is in three parts. In the first we describe our membership (the general practices in our area) and the delegation of duties to our governing body, senior executives and committees. The auditors and our audit committee have important roles in overseeing this accountability and providing assurance. Our Chief Officer (the accounting officer of the CCG who signs these reports) has specific responsibilities which are explained. The Annual Governance Statement then confirms how we have ensured robust governance during the year and sought to meet all our statutory duties through identifying and managing risk. We have reviewed the economy, efficiency and effectiveness of our use of resources and indicated the actions being taken in the few instances where our internal auditors have indicated that they are only able to provide limited assurance in a particular area.

1.6 The second part of the Accountability Report discloses information about payments (remuneration) to individuals and to the arrangements in place for and benefits available to our staff.

1.7 The final part addresses the subject of Parliamentary Accountability and Audit Reports and, whilst the CCG is not required to produce such a report we have opted to include a number of disclosures.

1.8 Our Financial Statements are included in the regulated format. They provide supporting detail for the financial part of in the performance analysis section.
1.9 Finally, we have included the Independent Auditor’s Report to the Members of the Governing Body.

1.10 These are immensely challenging times across the NHS but we remain committed to providing high quality, safe care for all of our patients. Demand for services has increased at a far greater rate than anticipated growth and this has placed pressure on our providers in both primary and secondary care. After four years of delivering a surplus control total, 2017/18 was a challenging year when the CCG went into financial deficit. We have developed and are implementing a recovery plan that will help us address the CCG’s financial deficit. Notwithstanding this, the quality of services has been maintained and we have achieved improvements in a number of key areas which are detailed in the analysis section of the Performance Report.

2 The Nature of the CCG

2.1 NHS Hastings and Rother Clinical Commissioning Group (CCG) is a GP led organisation responsible for commissioning the majority of health services for local people.

2.2 The CCG was licensed from 1 April 2013 under provisions enacted in the Health and Social Care Act 2012, which amended the National Health Service Act 2006. It is a membership organisation that brings together over 100 GPs, working in 25 practices, and which looks after over 183,000 local people using a budget of £310 million.

2.3 Every local GP practice is a member of the CCG and has a say in how healthcare services are provided for the local patients and community. Our GP members are well placed to make decisions about what healthcare services our local communities need.

2.4 Our staff work jointly across this CCG and the neighbouring NHS Eastbourne, Hailsham and Seaford CCG, and operate from premises in Lewes, Bexhill and Eastbourne. These offices are shared with other NHS organisations. The CCG also works in close partnership with East Sussex County Council to support an integrated approach to health and social care commissioning and in the wider context of the Sussex and East Surrey Sustainability and Transformation Partnership.

2.5 The CCG is responsible for the strategic and operational aspects of primary medical services commissioning and contract management. The additional flexibility this offers helps with the future developments in general practice which are key to how health and care transformation is being delivered as part of East Sussex Better Together (ESBT).
Demographics and Population Needs

3.1 The CCG has an older population compared to other areas of England. It has a significantly higher percentages of people aged 65 years and over, and aged 85 years and over. Population projections predict that the proportions of older people will continue to increase:

- 21% of the population are aged 0-19 years (23% for England);
- 26% are aged 65 years and over (17% for England);
- 4% are aged 85 years and over (2% for England).

3.2 Within the CCG area the Bexhill locality has the oldest population profile (34% aged 65 years and over and 6% aged 85 years and over) and the Hastings and St Leonards locality has the youngest (23% aged 0-19 years). 32% of patients are aged 65 years or over, and in West Hastings 15% are aged 65 years or over.

Source: GP registered populations as at 1st April 2017, NHS Digital
3.3 Twenty five percent of CCG residents live in those areas that are classed as being among the most deprived 20% of areas in England. These areas are concentrated in Hastings, St Leonards, Bexhill and Eastern Rother.

3.4 The leading causes of death for persons aged under 75 years in the CCG area are cancers (42% of deaths) and circulatory disease (22% of deaths).

3.5 Health and social care economies are facing challenges as populations continue to grow and people are living longer. This is felt particularly keenly in East Sussex, which has a high proportion of older residents:

- More people are developing multiple long term conditions, thus the demand for local health and care services is growing faster than our budget. More and more people need long-term health and social care support so we’re working to ensure these services are provided in a joined-up way. Chronic and lifestyle diseases are becoming more common. Our Joint Strategic Needs and Assets Assessment (JSNAA)\(^1\) details the size of the health challenges we must address as a whole economy.
- Developments in diagnosis, treatment and assistive technology mean we can do far more to support people at home and in the community rather than provide care in traditional bed based settings.
- A shift to more self-care, targeted prevention, early intervention and care outside of hospitals, where appropriate, will better provide integrated health and social care that meets the needs within available resources.
- We’re doing more to promote and enable proactive health and wellbeing, prevent illness and improve population health.
- Partnership working across primary, community health and social care and the third sector is pivotal to improving access, quality and capacity to deliver the right care outside hospital.
- We are transforming and integrating the way health and social care services are commissioned and provided in order to meet local need and deliver the ‘Triple Aims’ as set out in the NHS Five Year Forward View:
  - Improved population health and wellbeing
  - Transformed quality of care
  - Sustainable finances.

3.6 We are working locally as part of East Sussex Better Together (ESBT) to address these challenges.

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4 Transformation in 2017/18: ESBT delivering the CCG Strategy

4.1 East Sussex Better Together is our whole system (£860 million) health and care transformation. ESBT is about making sure we use our combined £860 million annual budget to achieve the best possible services for local people. It encompasses everything we do and our entire population – spanning acute and community care, mental health, prevention, specialist services, social care provision and our GP localities.

4.2 Our shared ambition is that by 2020/21, there will be an integrated, sustainable health and care system in East Sussex that ensures people receive proactive, joined up care which supports them to live as healthily and independently as possible. This strongly aligns our CCG’s vision to the collective ESBT vision which is:

‘To create a sustainable health and social care system that promotes health and wellbeing whilst addressing quality and safety issues, in order to prevent ill health and deliver improved patient experience and outcomes for our population. This will be delivered through a focus on population needs, better prevention, self-care, improved detection, early intervention, proactive and joined-up responses to people that require care and support across traditional organisational and geographical boundaries’.

4.3 The first 150 week phase of our ESBT whole system programme came to an end in June 2017, and during 2017/18 we formally entered into an ESBT Alliance with our ESBT partners to take us onto the next phase of the ESBT Alliance test bed year to help deliver our ESBT vision.

4.4 We expect to see most local community health and social care services, together with some local hospital services, join up as part of this new way of working. This joined up service will have close links to more specialist services and other hospital services so people can be referred into them when clinically needed, and then return back to their local community.

4.5 Our learning from ESBT, and from evidence elsewhere, tells us that this way of working is the best way of securing excellent local services that keep people independent and as well as possible, so that people only go to hospital when it is the only place that can provide their care.

4.6 The CCG has worked closely throughout the year with GP member practices, local patients and the public, as well as strategic partners such as ESCC and ESHT, to develop plans and strategies for how we will work to improve the health of local people.
4.7 All our plans are publicly available on our website².

These include:
- Our two-year Operating Plan 2017/19 – which details our objectives for the year and the activities we planned to undertake to deliver our objectives.
- Five Year Strategic Plan 2014-2019 – this plan includes the work we are delivering through ESBT³, in partnership with NHS Eastbourne, Hailsham and Seaford CCG⁴, East Sussex County Council⁵ and East Sussex Healthcare NHS Trust⁶.

4.8 All information about the ESBT programme can be found on our website⁷.

4.9 Sometimes for clinical reasons people need to be cared for in a clinical network which stretches beyond the ESBT area, for example for specialist services. So whilst, for the majority of services, we have been working to make sure local health and care services are joined up in a way that makes sense to local people and fits with the way we live our lives today, we are also contributing to work outside our local communities.

4.10 We are working as part of the Sussex and East Surrey Sustainability and Transformation Partnership* (STP) to do this. Working as part of the STP helps us ensure we have access to the best workforce and facilities, and make the best investments in things like digital communications, to improve services for all the people we serve. This plan is aligned to the progress and ambitions of ESBT, which in turn are designed to deliver the NHS Five Year Forward View⁸.

4.11 Our CCG and partner organisations within our ESBT footprint have come together to take forward how we will, collectively as a system:
- Improve health outcomes for our local populations, closing the health and wellbeing gap.
- Drive transformation to improve quality and patient experience, closing the care and quality gap.
- Seek to reduce the per capita cost of care, closing the finance and efficiency gap.

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* There are 24 organisations in our Sussex and East Surrey STP⁹ – local authorities, health and care providers and clinical commissioning groups. It is the first time we have all worked together in this way and it gives us an opportunity to bring about significant

² http://www.hastingsandrotherccg.nhs.uk/about-us/plans-and-strategies/
⁴ https://www.eastbournehailshamandseafordccg.nhs.uk/
⁵ http://www.eastsussex.gov.uk/
⁶ http://www.esht.nhs.uk/
⁷ https://news.eastsussex.gov.uk/east-sussex-better-together/
⁸ https://www.england.nhs.uk/five-year-forward-view/
⁹ http://www.seshealthandcare.org.uk/
improvements in health and care over the next five years, over and above those already underway in local areas.

The STP is not one single separate plan. It is a way of making sure that the plans of all the partners across the area are joined up and working together. It aims to ensure that no part of the health and care system operates in isolation. ESBT is our local contribution to the wider Sussex and East Surrey STP.

The STP is a partnership and a way of working. It has no powers to make decisions on behalf of the individual partner organisations. These powers continue to sit with each partner organisation’s board.

4.12 In 2017/18 ESBT has continued to build on our successful partnership working over the previous three years to begin to bend the curve in demand.

4.13 As acknowledged in a positive Local System Review carried out by the Care Quality Commission in November 2017, a range of initiatives continue to be successfully implemented and embedded to support people to remain in their own home and maintain their wellbeing:

- **Integrated Support workers (ISWs)** To build further the capacity of our community-based services, and in response to a shortfall of home carers to provide care in people’s own homes, we developed a programme to bolster resilience in the community. This has involved the recruitment of a large team of ISWs (100 in the first phase). Their role is to provide direct personal care into people’s home as an alternative to hospital admission, if appropriate, or to support people to be discharged from hospital sooner.

- **NHS 111 and Clinical Assessment service (CAS)** The new NHS 111 and CAS service aims to provide care closer to people’s homes and to help tackle the increasing demands on all urgent care services (primary care and hospitals) and emergency admissions.

  The new service will provide the 24/7 gateway into an integrated urgent care service providing access to clinical advice where required, incorporating call handling from the old NHS 111 model and elements of the former GP Out of Hours (GP OOH) service. The service model has been developed on the basis of the national mandated requirements with local requirements built into the service model for NHS 111 across Sussex and ESBT. The new service will go live in April 2019.

- **Urgent Treatment Centres (UTCs)** UTCs will provide an improved service offer by streamlining access to and improving a currently confusing array of urgent care services. Following nationally mandated requirements from NHS England, Eastbourne, Hailsham and Seaford and Hastings and Rother CCGs
have designated one UTC per area to provide a consistent and standardised urgent care offer for patients. These services will be open for a minimum of 12 hours per day, seven days per week and are integrated with other urgent care services. These services will be staffed by clinicians providing access to treatment and access to diagnostics where required and accessible by directly booked appointments through NHS 111. This service will be available from April 2019 to align with the provision of the new NHS 111 service.

- **Primary Care Extended Access** As nationally mandated by NHS England, the CCG is commissioning Primary Care Extended Access to improve access to primary care for patients. There are seven core national requirements for the delivery of primary care extended access to improve the hours of access available for local patients up to 8pm in the evenings and with appointments available on Saturdays and Sundays. These appointments will be offered on an easily accessible basis with choice as to evening or weekend appointments. These developments will be supported by digital technology to support new models of care in general practice. The service will work in an integrated way with the providers of integrated urgent care services across NHS 111 and Urgent Treatment Centres, primary care and ambulance services. Access to primary care extended access will be available in October 2018.

- **Enhanced Hospital Intervention Team (HIT)** The HIT team is a successful existing service working within hospitals to identify people who have come to A&E, but who did not really need to be admitted into hospital. Their role is to arrange and coordinate home care support to allow people to be looked after in their own homes. The team has now been expanded to provide an extended service into the community.

- **Take Home and Settle** is another service aimed at supporting elderly people being discharged from hospital. It provides transport for patients and ensures they are settled and have everything they need to remain in their own homes.

- **Medicines Optimisation Strategy** This is the second year of a strategy aimed at delivering sustainable improvements in patient outcomes from the £74m investment in primary care prescribing across Eastbourne, Hailsham and Seaford and Hastings and Rother CCGs. Highlights for 2017-18 include:
  
  - Roll out of a comprehensive medicines optimisation service for care homes
  - Recruitment of a prescribing support dietitian to improve outcomes for patients prescribed oral nutrition
  - National recognition for our work in improving the quality of prescribing for pain management
Improvements in repeat prescribing processes by increasing the use of more efficient electronic systems and better integration of community pharmacy and GP services.

- **Locality Link Workers** work with partners to develop strong and resilient communities across East Sussex. Locality Link Workers encourage and establish strong connections between local assets (people, places and resources), and health and social care teams to improve the health, wellbeing and resilience of local communities. There is one in each of the CCG’s three locality areas who have created a network of information about local projects, clubs and initiatives, which have supported people to keep well, by being active and feeling less isolated.

5 Our ESBT Alliance: Developing new models of care

5.1 Following on from our 150-week programme, 2017/18 has been our test bed year of operating as an integrated (accountable) care system. In April 2017 the members of the ESBT Programme Board moved formally into an ESBT Alliance arrangement for a test bed year, in order to enable us to develop rapidly our capacity to manage the health and social care system collectively as an ESBT Alliance partnership. This arrangement was underpinned by an ESBT Alliance Agreement which provided the framework to operate ‘as if’ we were an accountable care system, in order to test ways of working, configure resources more flexibly, and improve services for the population in 2017/18 and in the longer-term.

5.2 To support our ambition to work as one system in 2017/18 we put in place a system-wide governance structure, to support our ESBT Alliance to cover the following areas during the test bed year:

- The commissioning and delivery of health and care services to the local population and with an annual budget of approximately £860m (2017/18), focussing on what matters to local people. This has included continuing our programme of transformation and service change and raising the profile and investment in prevention and proactive care while reducing reliance on secondary care (hospital) services;

- Collaboration to deliver our integrated Strategic Investment Plan and further development of integration plans and practice; and

- The alignment of our budgets so we can design a payment mechanism that incentivises population health outcomes more than activity and invest appropriately across our health and care system to best benefit local people.

5.3 Part of the purpose of the test bed year was to create the space and time to undertake the necessary learning and development, with support from NHS
Improvement (NHSI) and NHS England (NHSE) as the system regulators, to design our ESBT Alliance integrated care model.

5.4 Our formal ESBT Alliance arrangement in 2017/18 has enabled a system-wide approach and focus on operational delivery. The indications are that this has enabled us to continue to build on our successful ESBT partnership working over the previous three years to begin to bend the curve in demand, including in the following ways:

- For those aged over-65 there has been a sustained reduction in A&E attendance, unplanned admissions, acute referrals, and admissions from care homes that demonstrates how we have produced a bend in the demand curve to be much better than regional and national average.

- Consequently, system performance has significantly improved for key national standards, including Referral to Treatment Time (RTT), Accident and Emergency (A&E) and Delayed Transfers of Care (DTsOC).

- A&E is now regularly in the upper quartile of performance nationally and DTsOC have reduced from approximately 8% to as low as 2%. RTT regularly performs at over 90%.

- Over and above this, by working together we have reduced serious incidents, and improved stroke measures and outcomes.

5.5 This positive picture of collaboration was recognised at the 2017 Health Service Journal (HSJ) Awards, where the ESBT Alliance won the ‘Improved Partnerships between Health and Local Government’ award in recognition of the hard work and commitment to integrating health and care services in East Sussex.

5.6 The Care Quality Commission (CQC) Local System Review of East Sussex, undertaken in November 2017 has been equally instructive. This reported that ESBT system leaders in East Sussex had a clear and aligned purpose and vision for providing health and social care services, with strong commitment and a high level of trust between the system leaders. The CQC Local System Review was also extremely positive about our preventative approaches to health and social care delivery, acknowledging that we have embedded a wide range of effective initiatives that are supporting people to remain in their own home and maintain their wellbeing.

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10 East Sussex Local System Review November 2017 Report (Care Quality Commission, January 2018)
5.7 In 2017/18 we have continued to build our locality model to shift to a proactive, community-based model of care. This includes continued implementation of integrated locality teams, frailty practitioners, crisis response and proactive care teams. In addition, Health and Social Care Connect has become fully embedded and operational as our streamlined single point of access for all adult health and social care enquiries and assessments. Progress has been made with building the locality planning and delivery model in 2017/18 in order to facilitate stronger partnerships across the health and care system to support delivery in our six ESBT localities.

5.8 Our integrated ESBT Alliance Outcomes Framework was also agreed, adopted and owned by ESBT Alliance partners in June 2017, following local engagement and research into what matters to local people about their health and care services. The agreed outcomes have been developed into a framework which has ten strategic objectives and eighteen desired outcomes set out within four domains:

- Population health and wellbeing;
- Experience of local people;
- Transforming services for sustainability; and
- Quality care and support.

5.9 Work to identify appropriate test performance measures and data sources for each of the agreed outcomes within the framework has also been completed, and these have been used, tested and further refined during the ESBT Alliance test bed phase.

5.10 Although it is too soon to measure comparative performance against previous years' performance, the indications are that our new ESBT Alliance Outcomes Framework for 2017/18 will show measurable improvements in the areas that local people have told us are important.

5.11 We have also been able to undertake an options appraisal of future ESBT delivery models in the test bed year, using design criteria co-produced with our stakeholders. As a result, all ESBT Alliance partner organisations have agreed that we want to further strengthen our ESBT Alliance in 2018/19 as a stepping stone to our preferred option of more formal integration of our care system provision by 2020/21. This has put us in a strong position to move forward with developing the business case for our integrated care provider model, which is due to be brought to the sovereign governing bodies of ESBT partner organisations in July 2018.

5.12 Our learning in the test bed phase has put us in a strong position to move forwards as an ESBT Alliance in 2018/19, recognising that we need to have a stronger grip
on improving system performance and finances and a more flexible, responsive governance structure to move at the pace our system requires to do this. In keeping with this we have developed proposals to further strengthen our ESBT Alliance, initially concentrating on integrated commissioning and transformation in early 2018/19, and then focusing on the development of our ESBT business case for the integrated care provider model.

5.13 The business case is being developed in the context of the Sussex and East Surrey Sustainability Transformation Partnership to set out how our integrated care provision locally can best support prevention and manage demand, as well as deliver quality services and integrated care. Reflecting our original principles and characteristics for integrated (accountable) care, the business case will consider all parts of the provider map including community, hospital, mental health and social care services for children and adults along the spectrum of primary, secondary and tertiary care. Considerations will also include what will be core delivery for the integrated care provider model, and what will be commissioned from other providers.

5.14 We believe that an integrated (accountable) care system model is the best vehicle to help us deliver sustainable services locally. Integrated (accountable) care is about investing for services based on quality outcomes, or results, for patients and services users, rather than through volumes of patients or clinical activity alone. We have used the learning from various international models, as well as the learning from our test bed phase of working ‘as if’ we are an ‘accountable care system’ to help us research what system would provide the best solutions for local people. Moving towards a bespoke integrated (accountable) care system model in East Sussex is the best way to achieve the triple aims of improving patient experience, improving population health and financial sustainability.

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SECTION 2 - Analysis

1 Financial Performance and the Better Care Fund

1.1 In 2017/18 the CCG received an in year revenue budget from NHS England of £310.1m which included an allocation of £26.7m for Primary Care commissioning, delegated by NHS England from 1 April 2015. The net operating expenditure was £320.2m. The CCG therefore did not meet its statutory financial duty to ensure that expenditure in the year did not exceed the allocated budget, ending the year with a £10.1m deficit.

1.2 Within the operating expenditure the CCG spent £4m on administrative costs which was within the running costs allowance set by NHS England.

1.3 We remained within the annual cash limit set by NHS England and managed our cash position during the year to ensure that there was always sufficient cash to meet needs. The cash flow statement included in the Annual Accounts provides detailed analysis of the net cash movements.

1.4 As set out in the 2017/18 NHS Planning Guidance, CCGs were required to hold a 0.5 percent reserve uncommitted from the start of the year, created by setting aside the monies that CCGs were otherwise required to spend non-recurrently. This was intended to be released for investment in Five Year Forward View transformation priorities to the extent that evidence emerged of risks not arising or being effectively mitigated through other means.

1.5 In the event, the national position across the provider sector has been such that NHS England has been unable to allow CCGs’ 0.5% non-recurrent monies to be spent. Therefore, to comply with this requirement, NHS Hastings and Rother CCG has released its 1% reserve to the bottom line, resulting in an improvement in the deficit for the year of £1.4m. This has been offset against other cost pressures from the current financial year.

1.6 The chart below shows how the £320.2m expenditure was shared across the services that the CCG commissioned in 2017/18.
1.7 The CCG will receive £7.4m Growth in 2018/19. Demand growth and cost pressures for 2018/19 plus the requirement of the CCG to contribute £13.8m to the Better Care Fund (BCF) means that a net savings target of £16.5m is required to deliver a control total deficit of £6m.

1.8 The East Sussex Better Together (ESBT) interventions are designed to ensure that each pound spent is used to bring maximum benefit and quality of care to patients. These are a fundamental part of the ESBT programme and are designed to contribute to the transformation objectives of ESBT.

1.9 The Strategic Investment Plan (SIP) sets the overall financial context for the ESBT programme and this will be refreshed in the opening months of 2018/19 to update the forecast financial position for the next planning cycle.

1.10 The transformation of services described by the SIP will inform the intervention plans over the coming years to return the local health economy to a financially sustainable position. In many cases the interventions to be delivered in 2018/19 have their origins in developments which began in 2015/16, focused inevitably on the main acute contract with East Sussex Healthcare NHS Trust (ESHT). The CCG is drawing on benchmarking and best practice work done across the country to identify opportunities to improve the quality of services available to the public while working towards remaining within the financial resources available.
1.11 The CCG will contribute £13.8m to the BCF, the purpose of which is to improve the experience and outcomes of people who use our services by integrating health and social care to meet the needs of our population in an integrated, joined up way. The BCF is an integral part of the East Sussex Better Together transformation programme delivering service redesign and contingency planning in partnership with all of our health and social care providers.

1.12 From 1 April 2016 the Section 75 BCF Pooled Budget has operated between: Eastbourne, Hailsham and Seaford CCG, Hastings and Rother CCG and East Sussex County Council. The ESBT Programme Board reports to the East Sussex Health and Wellbeing Board, which receives updates on health and social care transformation through reports on the ESBT programme, including, when appropriate, details about the BCF. The pooled budgets are approved by the Health and Wellbeing Board (HWB) and national reporting of the BCF is via HWB areas, so information is combined with the High Weald, Lewes and Havens CCG Section 75 BCF Pooled Budget to meet reporting requirements.

1.13 For 2017-19, there are four national conditions in the BCF:
   - Plans to be jointly agreed.
   - NHS contribution to adult social care is maintained in line with inflation
   - Agreement to invest in NHS commissioned out-of-hospital services, which may include 7 day services and Adult Social Care.
   - Managing Transfers of Care (a new condition to ensure people’s care transfers smoothly between services and settings).

2 CCG Assurance Framework

2.1. In 2016 NHS England (NHSE) introduced a new CCG Improvement and Assessment Framework (IAF) which was refreshed for the 2017/18 financial year.

2.2. The IAF is designed to provide a focus on assisting improvement, alongside providing a structure for the statutory duty NHSE has, which requires it to carry out an annual assessment of each CCG.

2.3. There are four domains within the CCG Improvement and Assessment Framework; (1) better health, (2) better care, (3) sustainability and (4) leadership. The content of these domains is summarised in the diagram below.
2.4. Each of the domains then contains a number of indicators which the CCG is measured against, totalling 51. The outcomes for each of these indicators are routinely published as part of a ‘dashboard’ of CCG performance publicly available.

2.5. Some of the data indicators are not solely within a CCG’s control, in recognition that care is delivered through place-based partnerships which span NHS commissioners, local government, providers, patients, communities and the voluntary and independent sectors – and the role we play as a CCG within this local system.

2.6. For 2017/18 the statutory annual assessment by NHSE was a judgement reached by taking into account the CCG’s performance in each of the indicator areas over the full year, balanced against the financial position and a further qualitative assessment of each CCG’s leadership. The latest published indicator data for our CCG can be found on the NHS Choices website11.

3 Outcomes Framework and local indicators

3.1 Contract management is provided by NHS South, Central and West Commissioning Support Unit (SCWCSU) and the CCG works closely with the CSU in order to understand the performance of these contracts.

11 [www.nhs.uk/service-search/performance/search](http://www.nhs.uk/service-search/performance/search)
3.2 The CCG is the designated lead commissioner for East Sussex Healthcare NHS Trust (ESHT).

3.3 The full list of acute services where the CCG is either the designated lead or a nominated associate commissioner can be found in section 3.15, below.

**East Sussex Healthcare NHS Trust (ESHT)**

3.4 We commission the provision of acute and community services from ESHT. We have actively monitored the Trust’s performance each month against its quality and contract targets including NHS Constitutional Standards, and various levels of action have been taken to address a range of performance issues:

a. **Key performance indicator - Referral to treatment time**
   92% of patients to be treated within 18 weeks (for incomplete pathways):
   - At the end of February 2018 ESHT had achieved 89.74% for Hastings and Rother patients. This is a 1.2% improvement compared to February 2017.
   - The current number of patients waiting for treatment on an 18 week pathway has continued to reduce and at February 2018 sits at 12787 patients on the waiting list, compared to 13372 patients in February 2017 – a 4.37% improvement.

b. **Key performance indicator – Accident & Emergency Access standard**
   Percentage of A&E attendances where the patient spent four hours or less in A&E from arrival to transfer, admission or discharge (95%):
   - Throughout 2017/18, performance has improved at ESHT with year to date performance now at 87.4%. This is more than 7% higher than last year. However this is still significantly below the national target.
   - A whole-system recovery plan has been developed by the CCGs in partnership with ESHT, Adult Social Care and SECAmb. This plan has been implemented and will be monitored through the Local A&E delivery board.
   - A working group known as the Operational Executive (OpEx) has been fully embedded for the past year. This group is made up of senior directors from the CCGs, ESHT, Adult Social Care and is supported by members of SECAmb and Mental Health services. The group meets on a weekly basis with the aim to address any urgent operational system issues, monitor Urgent Care recovery plans whilst also focusing on forward planning items such as Winter planning.

c. **Key performance indicator – Delayed Transfers of Care (DTOCs)**
   Total delayed days per 100,000 18+ populations (less than 3.5%).
   - Our formal ESBT Alliance arrangement in 2017/18 has enabled a system-wide approach, closer working with social care and focus on operational delivery.
   - There has been a sustained continued improvement equating to a 78% reduction in average daily rates of delays since April 2017.
By January 2018 1.3% had been achieved with four consecutive months achieving the national target.

d. **Key performance indicator - Cancer targets**
85% of patients to wait no longer than 62 days from urgent referral to first treatment.
- At the end of December 2017 ESHT had achieved 80.2%
- The 62 day urgent referral to treatment target compliance continues to be a challenge but has shown signs of improvement through the year.
- The CCG and ESHT continue to address the issues as detailed in their cancer waiting times action plan to ensure further improvement in performance.

e. **Key performance indicator - Diagnostic tests**
Less than 1% of patients should have to wait more than 6 weeks to receive their diagnostic test.
- At the end of February 2018 ESHT had achieved 2.11%
- There have been a number of challenges over the last year resulting in equipment failures and reduced workforce. These issues are being addressed through a Diagnostic Recovery Plan, which the CCG is monitoring with ESHT in order to deliver a sustainable and timely service.

3.5 **Improving Quality**

3.5.1 The CCG has discharged its duty under Section 14R of the National Health Service Act 2006 (amended legislation-S14R)\(^\text{12}\) to improve the quality of services. The following sections show how this has been achieved.

3.6 **Care Quality Commission (CQC Inspection)**

3.6.1 The Trust was again formally reviewed by the CQC as part of the regulator’s planned inspection regime during October 2016. The findings of this review were published during January 2017 with the Trust awarded a rating of “Requires Improvement”.

3.6.2 This is an improvement on the rating the Trust had received following the September 2015 CQC inspection whereby a rating of “Inadequate” had been given with the Trust subsequently placed in “Special Measures”.

3.6.3Whilst the Trust has now been awarded the rating of “Requires Improvement” the Chief Inspector of Hospitals decided that it must remain in “Special Measures” in order to allow for the leadership to fully stabilise, governance to become

\(^{12}\) [http://www.legislation.gov.uk/ukpga/2012/7/section/26/enacted](http://www.legislation.gov.uk/ukpga/2012/7/section/26/enacted)
embedded and the safety issues in the Emergency Department (ED) to be addressed.

3.6.4 Meetings continue to take place between the CCG, Trust, NHS Improvement and NHS England with specific focus upon the Quality Improvement Plan (QIP) in order to ensure patients receive optimal care and service.

3.6.5 The trust was reviewed by the CQC during March 2018 as part of the regulars planned inspection programme. The review view focused upon trust acute services across both the Eastbourne District General Hospital (EDGH) and Conquest Hospital sites. The findings of this review had yet to be published by the regulator at the time of writing.

3.7 Stroke

3.7.1 Following the single siting of trust stroke services to the Eastbourne District General Hospital (EDGH) during 2013 the quality of services has improved in many areas and these improvements have been sustained.

3.7.2 The CCG has worked with the trust to improve performance against Stroke Sentinel National Audit Programme (SSNAP) indicators and a joint locally agreed improvement metrics have been agreed. The trust’s SSNAP position has now improved from an overall “C” position to “B” based upon latest information available in line with an “A” to “E” scoring scale.

3.7.3 Whilst the quality of care in relation to Stroke services has improved there remains scope for further improvement in areas relating to therapies and thrombolysis. The trust and CCG are sighted on the issues in these areas and are working together to resolve them.

3.8 Maternity

3.8.1 In May 2017 the CCG briefing on ESHT Maternity Services (2016/17), reflected the sustained progress made in terms of quality and safety for mothers and babies.

3.8.2 Key improvements identified over the previous 12 months were sustained reductions in the number of Serious Incidents (SIs) since the services were reconfigured, improvement in Maternity Staffing levels including newly qualified Midwives, maintained 72 hour consultant presence on labour ward and Maternity Dashboard now fully live and shared with commissioners.

3.8.3 The Trust worked with the CCGs in an open and transparent way in relation to providing assurance around the quality and effectiveness of maternity services. The key areas where ongoing assurance was required included how the
organisation learns from, and embeds required learning following SIs (particularly in relation to the interpretation and acting on the outcome of Cardiotocographs (CTGs)), arrangements for the implementation of the named safeguarding role and implementation and changes to practice as a result of clinical audit.

3.8.4 The mechanisms to ensure that the quality and safety of ESHT maternity services were of the required standard. Maternity Services had identified continued areas of improvement of services and outcomes for women.

3.8.5 Maternity staffing levels had improved over the previous 12 months; and the CCG had an effective structure in place to support ESHT maternity services in ensuring safe, effective commissioned services.

3.9 Infection Control

3.9.1 The trust’s Clostridium Difficile Infection (CDI) rates are below the national NHS England objective for 2017/18. The CCG reviews all CDI root cause analysis to determine if there is a lapse in care that may have contributed or caused the CDI.

Improvements in relation to CDI were seen during the 2017/18 year relating to the adoption of revised antimicrobial prescribing by trust staff and an improvement in national cleaning scores.

3.9.2 The trust reported four cases of trust acquired Methicillin-Resistant Staphylococcus Aureus (MRSA) bacteraemia during 2017/18 whereas one case was reported during the 2016/17 year.

Of the MRSA bacteraemia cases reported, three have been investigated as being related to contaminated samples where the patients were no treated for an active infection but contamination occurred at the time of blood sampling. The Trust has developed an action plan and improvements with blood sampling technique.

The CCG and Trust have agreed to agree a local procedure for the investigation of MRSA bacteraemia following the change to NHS England guidance in 2018/19.

3.9.3 The CCG continues to work with the trust to identify learning and ensure required actions are embedded into practice in order to ensure that patients continue to receive safe and effective care.
3.10 **Falls**

3.10.1 The trust has continued to implement improvement strategies to ensure that the risks to those patients who may be likely to experience a fall are reduced over the 2017/18 year which have proven to be successful.

3.10.2 As a result of the implementation of these improvement strategies the following conclusions can be drawn:
- The rise in the number of falls occurring has declined;
- The number of falls resulting in patient harm have been reduced; and,
- The overall number of falls resulting in patient harm per 1,000 bed days has decreased.

3.11 **Pressure Damage**

3.11.1 The trust has continued to implement improvement strategies to ensure that the risks to those patients who may be likely to experience trust acquired grade three or four pressure damage are reduced over the 2017/18 year.

As a result of the implementation of these improvement strategies the following conclusions can be drawn:
- The total number of pressure damage cases per 1,000 bed days has reduced; and,
- The number of all grades of hospital acquired pressure damage has decreased.

3.12 **Mortality**

3.12.1 The trust has improved its mortality position and as evidenced by performance across a range of performance indicators and is no longer considered an outlier in terms of the Hospital Standardised Mortality Ratio (HSMR) and the Summary Hospital Mortality Indicator (SHMI).

3.12.2 The two areas of key improvement work undertaken by the trust in relation to improving mortality outcomes during 2017/18 include:
- Improving the ability of staff to identify, manage and escalate those patients at risk of developing Sepsis; and,
- Ensuring that all deaths are reviewed within three months of the event occurring.

3.13 **Friends and Family Test (FFT)**

3.13.1 The trust significantly improved its position regarding inpatient FFT responses during the 2017/18 year; however, further assurance is required from the
organisation around how it intends to improve the Emergency Department FFT position.

3.13.2 Whilst the Emergency department has continued to receive a low rate of patient response during the 2017/18 year there continues to be favourable feedback for those that did respond in relation to services provided. Improving the response in this area of the FFT remains a trust priority in relation to patient experience.

3.14 **Patient Safety Incidents**

3.14.1 The trust has continued to foster a spirit of openness and transparency in the reporting of patient safety incidents which has been reflected in the number of reported occurrences declared.

3.14.2 The trust has identified a significant improvement in the number of patient safety incidents related to missing and unavailable patient documentation following the digitisation bar coding of these records and their current off site storage.

3.15 **Duty of Candour**

3.15.1 The trust has focused upon ensuring that the component parts of the Duty of Candour have been applied to all those who have incurred moderate harm or worse whilst under the care of the organisation.

3.15.2 The three component parts that compromise the core elements of the Duty of include:

- Patient / next of kin (NOK) should be verbally advised of what has occurred within 10 days;
- Patients / NOK should receive written acknowledgement of incident; and,
- Patients / NOK should receive formal feedback/report.

3.15.3 The trust has been successful in improving adherence to the Duty of Candour where required.

3.16 **Other Acute Providers**

3.16.1 The CCG also commissions services from a number of other acute healthcare providers, both independent and NHS. These include:

- British Pregnancy Advisory Service (BPAS);
- Brighton and Sussex University Hospitals NHS Trust;
- East Sussex Out Patient Service (ESOPS);
- Esperance Hospital (BMI Healthcare);
- Great Ormond Street Hospital;
- Guys and St Thomas’ Hospital NHS Foundation Trust;
• Horder Centre;
• Imperial College London;
• Kings College Hospital NHS Foundation Trust;
• Maidstone and Tunbridge Wells NHS Trust;
• Moorfields Eye Hospital NHS Foundation Trust;
• Queen Victoria Hospital NHS Foundation Trust;
• Royal Brompton and Harefield NHS Foundation Trust;
• Royal Marsden NHS Foundation Trust;
• Royal National Orthopaedic Hospital NHS Trust;
• Royal Surrey County Hospital NHS Foundation Trust;
• St George’s Hospital NHS Trust;
• Surrey and Sussex Healthcare NHS Trust;
• Sussex MSK Partnership 2 Ltd;
• Spire Healthcare Ltd (Hastings);
• University College London Hospitals NHS Foundation Trust; and,
• Western Sussex Hospital NHS Trust.

3.17 South East Coast Ambulance Service NHS Foundation Trust

3.17.1 The CCG has a contract with South East Coast Ambulance Service NHS Foundation Trust (SECAmb) for 999 services.

3.17.2 The trust received a planned and routine inspection visit by the regulator during May 2016 and following review was subsequently awarded a rating of “Inadequate” and placed in special measures with two Sections 29a Warning Notices issued. A subsequent planned follow up inspection by the regulator during May 2017, recognised significant improvement in some areas, however the trust did not improve their overall rating.

3.17.3 An updated improvement plan with a commitment to increase the speed of improvement has been developed and continues to be monitored by commissioners.

3.17.4 On 22 November 2017, SECAmb was the last of the 10 ambulance trusts in England to adopt the new national ambulance response standards. These new standards change the way ambulance services take and respond to emergency calls.
3.17.5 The new standards aim to:
- Provide the right resources to the right patients meeting clinical needs in an appropriate timeframe;
- Treat more people by phone or at home;
- Increase early recognition of cardiac arrest;
- Ensure patients with life-threatening conditions receive a faster response;
- Reduce lengthy waits, even for less urgent calls.

3.17.6 Until 22 November 2017, SECAmb worked to the following key performance indicators (Ambulance response times):
+ Cat A Red 1 calls in 8 minutes (Standard is 75%)
+ Cat A Red 2 calls in 8 minutes (Standard is 75%)
+ Cat A all calls in 19 minutes (Standard is 95%)

3.17.7 During the period 1 April to 22 November 2017, SECAmb achieved an average of 64.23%, 46.6% and 83.8% respectively against the above targets for Hastings and Rother CCG.

3.18 Sussex Partnership NHS Foundation Trust

3.18.1 Hastings and Rother CCG is party to the Sussex-wide contract with Sussex Partnership Foundation Trust (SPFT) for Mental Health services in 2017/18.

3.18.2 The CQC published an updated and comprehensive inspection report into the Trust in January 2018 when improvements were acknowledged and the Trust was awarded an overall rating of “Good”.

3.18.3 As a Foundation Trust, SPFT is obliged to meet standards set both by the NHS Constitution and by Monitor. These standards include:
- patient follow-up within 7 days of discharge from in-patient care;
- home-treatment team-based gate-keeping of access to in-patient beds;
- prevention of avoidable admissions;
- effective evidence-based treatment provision for first episodes of psychosis; and
- annual reviews of all patients on case-loads managed under the care programme approach.
3.18.4 The trust is continuing to work well in achieving these standards and develop and implement action plans to address areas where and when further improvement is required.

4 Reducing Inequality

4.1 The Health and Social Care Act 201213 introduced the first legal duties on health inequalities, with specific duties on NHS England and CCGs, as well as duties on the Secretary of State for Health. These duties took effect from 1 April 2013.

4.1.1 The CCG has duties to:

- have regard to the need to reduce inequalities between patients in access to health services and the outcomes achieved;
- exercise its functions with a view to securing that health services are provided in an integrated way, and are integrated with health-related and social care services, where it considers that this would improve quality, reduce inequalities in access to those services or reduce inequalities in the outcomes achieved;
- include in an annual commissioning plan an explanation of how it proposes to discharge its duty to have regard to the need to reduce inequalities;
- include in an annual report an assessment of how effectively it has discharged its duty to have regard to the need to reduce inequalities.

4.2 Health and Wellbeing Board

4.2.1 The CCG’s Chief Officer has continued to be an active participant at all meetings of this Board. During the year the Board reviewed and discussed CCG activities in support of the Health and Wellbeing Strategy and achievements, including:

- East Sussex Better Together (ESBT) Strategic Investment Plan (SIP) for 2017/18;
- Local arrangements for diagnosis and post diagnosis support for people with dementia in the East Sussex Better Together (ESBT) area of East Sussex including a new Dementia Post Diagnostic Support Service delivering practical support to carers and patients across the ESBT area;
- The improvement of quality, safety and access to services in the ESBT area, in particular the performance of the A&E Departments at East Sussex Healthcare NHS Trust and a letter from the Secretary of State for Health informing the Trust that it had the most improved A&E performance in the country. On the evidence of this system-wide improvement in the ESBT area,

some additional funding was secured to help the system during the winter period and used in the A&E Departments and in GP practices;

- The material improvements to patient experience and outcomes in the acute sector as a result of the ESBT programme leading to increased costs, albeit from a low cost base;
- ESBT winning of the Health service Journal’s (HSJ) Improved partnership between health and local government award;
- Significant investment in primary care to ensure that the practices are resilient and can treat people in the community; in line with all national evidence that points towards integration of health and social care, and investment in this area; and
- The challenge to the health economy resulting in both CCGs in the ESBT area predicting deficits for the 2017/18 financial year, along with five of the other six CCGs in the STP area.

4.2.2 The Care Quality Commission’s Local System Review Report of the Health and Wellbeing Board confirmed that governance structures were aligned around the ESBT strategic transformation programme with shared membership of health and social care representatives which also ultimately reported to the Health and Wellbeing Board and East Sussex County Council cabinet members.

4.2.3 The Health and Wellbeing Board will continue to develop the necessary rigour and to hold to account the leaders of the local transformation strategies.

4.3 Health Inequalities Programme

4.3.1 The Healthy Hastings and Rother (HHR) programme was launched in 2014, as part of East Sussex Better Together (ESBT), to reduce health inequalities in the most deprived communities of Hastings and Rother (HR). It has been developed and implemented collaboratively with the CCG’s key stakeholders including local people, target population groups and communities, GP practices, East Sussex Healthcare NHS Trust (ESHT), East Sussex County Council (ESCC), Sussex Partnership NHS Foundation Trust (SPFT), Hastings Borough Council, Rother District Council, Sussex Police, the local voluntary sector and businesses.

4.3.2 The table below summarises HHR’s Investment plan for its key objectives from November 2014 to March 2018:

<table>
<thead>
<tr>
<th>Ref</th>
<th>Healthy Hastings and Rother’s (HHR’s) objectives</th>
<th>Total Investment 2014/15 to 2017/18</th>
<th>% of total investment 2014/15 to 2017/18</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Reduce variation in access to or quality of services</td>
<td>£3,218,403</td>
<td>25%</td>
</tr>
</tbody>
</table>

"Hastings and Rother Clinical Commissioning Group Annual Report and Accounts 2017/18"
2. Empower individuals to improve health and wellbeing £3,043,516 24%
3. Empower communities to improve health and wellbeing £1,790,293 14%
4. Enhance support for the health needs of vulnerable population groups £2,609,567 20%
5. Improve the social determinants of health £1,845,289 14%
6. Co-ordinate, measure the impact of projects and the programme, evaluate and share the learning £373,581 3%

Total £12,880,649 100%

4.3.3 There has been significant progress against the programme’s 2017-2019 action plan, which was approved by the Governing Body in March 2017. Projects of particular note this year which have received national recognition are:

- September 2017 – ESCC’s Support of patients with long term conditions / dementia and their carers project that was shortlisted in the “Innovation for Dementia Services” category at the National Dementia Care awards.

- December 2017 – ESCC’s Positive Parenting Programme (Triple P) that was highly commended for its commitment to developing and implementing a sustainable programme that reduces health inequalities at the New NHS Alliance’s awards.

- January 2018 – SPFT’s i-Rock project that won the “Partnership working and Co-production” award at the National Children and Young People’s Mental Health awards.

- March 2018 – Seaview that won a King’s Fund and GlaxoSmithKline award for its exceptional impact on addressing health inequalities amongst homeless people.

4.3.4 An evidence based approach will continue to be taken to commission services which reduce inequalities between patients in access to services and reduce health inequalities between patients in outcomes from services. As well as aiming to reduce the gaps in health outcomes and inequalities in healthy life expectancy between both the most and least deprived areas of Hastings and Rother and East Sussex; the HHR programme will contribute to the CCG’s plans to address the ‘must do’ priorities in the NHS Operational Planning and Contracting Guidance 2017 – 2019 of Cancer, Mental Health and People with Learning Disabilities.

5 Patient and Public Engagement

5.1 Our commitment
5.1.1 The CCG is committed to ensuring and implementing effective engagement and involvement opportunities for local people. This is enshrined in our two year Communications and Engagement Strategy (April 2016 – March 2018). The strategy is currently being refreshed for April 2018\textsuperscript{14}.

5.1.2 Our Governing Body includes three lay members who help with decisions on which health services to commission for local people.

5.1.3 Our key priorities for engagement this year have included structural work to integrate our activities and messages as part of our ESBT Alliance which has led to the formation of our ESBT Alliance Communications and Engagement Team. We have also further embedded our equality and diversity objectives into our engagement work to ensure we are talking to a diverse range of audiences.

5.1.4 Activity and feedback from patient and public engagement is embedded across our organisation at all levels and is reported to the Governing Body at all formal meetings as well as shared on the ‘Get Involved’ pages on our website. Our Quality and Governance Committee is chaired by our Lay Member for Patient and Public Involvement and includes two patient representatives. Furthermore, our Primary Care Co-Commissioning Group and GP Forward View committees include Healthwatch representation.

5.1.5 Our joint Reward and Recognition Policy\textsuperscript{15} ensures local people are rewarded appropriately for their contribution to the planning, delivery and evaluation of health and care services.

5.2 Our structures

5.2.1 In September 2017, we launched our new Collaborative Health and Wellbeing Stakeholder Group\textsuperscript{16} which was co-designed with local people and third sector partners and was created following a review of our participation structures. The group brings together 15 community representatives to work alongside senior decision makers from across the health and care system. The group has developed its priority work plans which include a focus on primary care, mental health, bedded care, housing/homelessness, substance misuse and winter

\textsuperscript{14} www.hastingsandrotherccg.nhs.uk/about-us/plans-and-strategies/east-sussex-better-together/

\textsuperscript{15} http://www.hastingsandrotherccg.nhs.uk/EasysiteWeb/getresource.axd?AssetID=453064&type=Full&servicetype=Attachment

\textsuperscript{16} http://www.eastsussex.gov.uk/socialcare/providers/stakeholder/
pressures. The partnership will also focus on how the community and voluntary sector can support ESBT Alliance in the design and achievement of its objectives.

5.2.2 We have increased our digital engagement activity by developing our newsletter for local people and building our profile on social media with our twitter accounts gaining an average of 20-25 new followers per week. To celebrate the end of our ESBT Alliance 150 week programme we created a video\(^\text{17}\) which was shared with our partners and stakeholders and was watched by over 850 people. We also rebranded and relaunched our ‘Local Voices Network’ which enables local people to sign up and receive regular information about opportunities to get involved in specific projects such as pathway reviews and designing cancer information leaflets.

5.2.3 We have continued to develop our regular engagement events – Shaping Health and Care – which we run twice a year. This year we held a number of co-design workshops with local people including the development of our ESBT model which was used to create our checklist for our options appraisal; building our locality planning arrangements which were used to inform the creation of our Locality Networks and Locality Planning Boards and our new care navigation programme which provided useful feedback for the Equalities Impact Assessment produced to support the work. This year we also took the opportunity to talk to our audiences about the format and content going forward to ensure that these events are meaningful and as far as possible respond to the issues local people consider to be important. Feedback from these sessions included a need to focus on feeding back the difference previous contributions have made and more time for networking. Our reports from these events can be found on our ESBT website\(^\text{18}\).

5.2.4 Building on our conversations at Shaping Health and Care, to ensure our engagement reaches grassroots groups, we established new Locality Networks. Networks have been established in Hastings and Rother and bring together local people, community groups, third sector organisations as well as representatives of the health and care system. The meetings are well attended with 20-40 people attending. Participative methods are used (such as speed dating) to ensure that everyone is able to have a say. The groups help to determine priorities and shape service improvements by feeding back to our Locality Planning and Delivery Groups who are driving change at a local level.

5.2.5 During the year we resumed responsibility for directly supporting our network of Patient Participation Groups (PPGs) and to ensure this is patient-led we have

\(^{17}\) http://www.youtube.com/watch?v=712_SvGeEHc
\(^{18}\) https://news.eastsussex.gov.uk/east-sussex-better-together/events/past-events/
co-created a PPG steering group and appointed patient chairs to our Hastings and Rother Area Forum. The steering group is empowered to support PPGs and Practices directly in growing their patient involvement work and plays an active role in the development of some of our key programmes such as our ESBT Alliance Outcomes Framework and health education.

5.2.6 This year we have also refreshed our ‘Get Involved’ web pages to ensure that we have clearly set out information about all of our involvement opportunities as well as details of our work and engagement updates 19.

5.3 Our key activities

5.3.1 Some examples of our engagement and the way it has informed our work are listed below:

- The results of our joint public consultation on the new model for the pan-Sussex NHS 111 was shared during September 2017. Over 1,000 people took part, 67% of whom had used the service. The results showed that 72% of respondents would recommend the service with 28% not recommending the service due to issues such as call back times, lack of access to clinicians and the number of ‘non’ relevant questions. This feedback has been captured and will inform the redesign and recommissioning of the new service.

- Our Personal and Community Resilience Programme continues to empower local people in relation to their health and wellbeing, for example through the development of a self-help network in Rother supported by Rother Voluntary Action. The network has 127 groups in its membership and they are supported to access training, promote their activities and access small grants through our Healthy Hastings and Rother Programme.

- During November 2017 we held our first PPG/Practice led sharing best practice event. Co-hosted with a local practice the event attracted staff and patients from practices across this and the neighbouring Eastbourne, Hailsham and Seaford CCG. The event provided an opportunity for PPGs and staff supporting them to learn from a successful PPG as well as think about and create action plans for improving patient participation in their practices. Event feedback was exceptionally good with most people rating the event as ‘excellent’ or ‘good’ overall as it enabled “good ideas to move forward with” and “lots of food for thought”.

19 [www.hastingsandrotherccg.nhs.uk/get-involved/](http://www.hastingsandrotherccg.nhs.uk/get-involved/)
As part of our commitment to making sure that everyone has easier access to GP services, during January and February 2018 we surveyed local people about when they would like to be able to access GP services outside the current opening hours. We received over 1,200 responses, many from working people who are less likely to engage with our formal engagement opportunities. The survey was promoted widely both online and in paper including ‘easy read’ versions. We have published this summary report\(^{20}\) of the survey results, which will be used to inform and shape our procurement of our new extended access for primary care.

We have continued to commission our award winning Public Reference Forum which reaches a diverse range of local people in non-traditional settings such as shops and railway stations. The Forum has helped us to broaden our reach into parts of the community that we do not engage through their membership of groups and networks – to those people who are not already known to us – in order to build a much richer picture of what interests and concerns local people. This is shaping our priorities and informing our work streams in all our ESBT Alliance work going forward. Building on its work in 2016, during 2017/18, the Public Reference Forum was seen by over 15,066 people on Facebook, had over 125 responses to the online survey, and gathered six case studies to provide a narrative on the experiences of local people.

### 5.4 Complaints

#### 5.4.1
The organisation can receive complaints about both its own commissioning activities and about the services of the provider organisations which it commissions. Most complaints received are about the latter.

#### 5.4.2
The number of complaints received was relatively low and comparable with the previous year. The CCG publishes an Annual Complaints Report on its website\(^{21}\).

#### 5.4.3
If unhappy with the response from the Chief Officer a complainant may contact the Parliamentary Ombudsman. During 2017/18 the Ombudsman neither accepted any complaints about the CCG for investigation nor reported on any CCG complaints.

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\(^{21}\) [https://www.hastingsandrotherccg.nhs.uk/](https://www.hastingsandrotherccg.nhs.uk/)
6  **Equality and Diversity**

6.1 As a public sector body, the CCG has followed the requirements of the Equality Act 2010 and the General Duty within the Equality Act which requires us to:
- Eliminate unlawful discrimination, harassment and victimisation;
- Advance equality of opportunity between different groups; and
- Foster good relations between different groups.

6.2 Equality is embedded in the services we commission, delivering equal opportunities and equal health outcomes regardless of age, disability, ethnicity, sex, gender reassignment, marital status, pregnancy / maternity, religion or belief, sexual orientation and socio-economic status. In addition, we have continued to focus on addressing health inequalities associated with socio economic factors.

6.3 We published our Inclusion Action Plan 2017/18\(^{22}\) to set out our equality objectives for the year and describe our actions to achieve them. Progress on these is reported six monthly to our Quality and Governance Committee and the work is driven by our Inclusion Working Group which brings together staff representatives from across our organisation.

6.4 Our achievements through this plan, together with our wider equality and diversity work, is described in our separate Public Sector Equality Duty Report 2017\(^{23}\). This report also includes further information on the Equality and Diversity profile of Hastings and Rother.

6.5 We also published our Workforce Race Equality Report and Action Plan for 2017\(^ {24}\), setting out our objectives for workforce race equality.

6.6 We use ‘About You’ forms at all of our events and engagement activities to monitor diversity of experiences and voices, ensuring we tailor our approach to cater to all backgrounds. We also use this approach when carrying out surveying and wider consultation.

6.7 Our policies supporting equality of opportunity and employees with disabilities are detailed within section 8.2 of the Remuneration report (Section 2 Part 2 of these Annual Report and Accounts).

6.8 We have continued to ensure we achieve the requirements of the Accessible Information Standard. Our website now includes translation and text options and

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our ESBT video has received praise for presenting the ESBT Alliance in easy-to-understand formats. The ESBT website itself has benefitted from review and refresh, enabling sign up to the regular newsletter.

7 Membership Engagement

7.1 Our vision

7.1.1 As a membership organisation we recognise the value in building and developing relationships with our members (GPs). We know that a vibrant and engaged membership is vital in ensuring delivery of our ambition to create a sustainable health and social care system that promotes health and wellbeing, reduces health inequalities and supports stronger more resilient communities.

7.2 Our commitment

7.2.1 We are passionate about involving local people in our work and we continue to work with our member practices to support and develop their Patient Participation Groups (PPGs). Our engagement team have provided support to practices to establish a PPG and we held a PPG good practice event for practice staff and PPG members to share good practice, network and discuss innovative solutions to building and developing a PPG.

7.2.2 As part of our commitment to building resilient and sustainable general practice, we have invested and supported the creation of GP federations. Our GP federations allow member practices to begin working at scale and provide services for their combined patients.

7.3 Our key activities

7.3.1 Our GP locality meetings continue to take place every two months as an opportunity for discussion and engagement at a local level. These meetings are chaired by colleagues from our member practices with an assigned CCG Director and include updates on our developing integrated care system, new services and GP Five Year Forward View projects.

These meetings also allow for colleagues and the community and voluntary sector to attend and engage with members and share information on projects, schemes and new initiatives to support the health and wellbeing of local people. Our Governing Body GPs and those appointed as Clinical Leads play a vital part in these conversations.
7.3.2 **Locality Planning and Delivery Groups** have been established across our ESBT localities (Eastbourne, Hailsham and Polegate, Seaford, Hastings and St Leonards, Bexhill and Rural Rother) as a means to enable planning and clinically-led decisions at a local level.

7.3.3 Representatives from our member practices form a key part of these groups which bring together community health and social care, mental health, children’s services, community pharmacy the voluntary sector and others. The aim is that together, and with the right people in the room, we can begin to unpick and discuss what’s preventing our integrated health and care system working locally and what needs to be in place to allow that to happen.

7.3.4 Our **Membership Engagement and Learning Events (MELE)** took place in autumn 2017 and spring 2018 with a refreshed focus on a whole practice agenda and collaborative workshops from across our integrated health and social care system.

7.3.5 In the autumn we focussed on building resilience with sessions on influenza, diabetes, suicide prevention and our ESBT community services. For our spring 2018 events we worked with East Sussex Parent and Carers Council to co-design sessions on children and young people including mental health and emotional wellbeing, working with gender non-conforming young people and Special Educational Needs and Disabilities.

7.3.6 As part of our MELE events we include a marketplace with colleagues and services from across health and social care, showcasing the wide range of support and initiatives available to support local people.

7.3.7 We continue to distribute a monthly **GP newsletter** to our member practices which includes updates on clinical practice, new services, events and training. The newsletter also allows us to share news and information from our partners in social care and the community and voluntary sector.

7.3.8 Last summer we held **Information Management & Technology (IM&T) training events** as an opportunity for members to further their knowledge and learning of the latest systems and software including sessions on EMIS and MJOG as well an interactive marketplace.

7.3.9 We recognise the need to build better relationships between primary and secondary care. Working with Cancer Research UK we organised a **cancer speed dating** event where our members could spend a short amount of time with Consultants specialising in cancer treatment. We are currently working with our GP tutors to consider how we can use this model for other specialities.

*Hastings and Rother Clinical Commissioning Group Annual Report and Accounts 2017/18*
7.4 **Going forward together**

7.4.1 We recognise that together we need to empower local people to access services differently and to change the way services are delivered to ensure the sustainability of primary care. Across our ESBT Alliance we are developing a **primary care strategy** to set out the strategic intentions around the future role of primary care and its transformation in relation to the GP Forward View and ESBT Alliance priorities.

7.4.2 Set in the context of managing increasing demand and reducing resources, it includes a focus on promoting resilience, prevention and self-care, improving health outcomes and locality working. It will also seek to address the current challenges around workforce, resilience, quality and ensuring processes and systems support and enable transformation.

7.4.3 Our member practices are key partners in the development and delivery of this strategy and we have looked to involve members in the development of the strategy through our GP locality meetings and our Membership Engagement and Learning Events.

8 **Armed Forces Network**

8.1 The CCG (collectively with other CCGs across Sussex and Kent) is making significant progress in delivering against the NHS Constitution, NHS Contracts and the Armed Forces Covenant, through the CCG-funded Director for the Armed Forces Community (AFC) and support team who provide leadership to the system and are hosted by NHS Hastings and Rother CCG. We have engaged with this hard-to-reach population and have a good understanding of the needs of this community within East Sussex, resulting in moving towards an integrated armed forces community-friendly health economy. The outcomes from the programme of work have met many of the objectives from the Five Year Forward Plan\(^\text{25}\).

8.2 NHS Hastings and Rother and NHS Eastbourne, Hailsham and Seaford CCGs have both progressed in 2017/18 to receive the Silver Award from the Defence Employer Recognition Scheme. This recognises that the CCG demonstrates delivery of support to the armed forces community in line with the Armed Forces Covenant. The CCG has supported East Sussex County Council in their application for silver.

\(^\text{25}\) [https://www.england.nhs.uk/five-year-forward-view/]
8.3 The work being undertaken has been recognised nationally and a joint NHS and Local Authority bid to share this work across the county councils in Sussex, Kent and Medway, Surrey and Hampshire was achieved; resulting in over 35 Service champions being trained in East Sussex County Council in 2018.

8.4 Through engagement and collaborative working the team has delivered:

- direct engagement to over 2500 members of this hard-to-reach community and the professionals who support them;
- working with over 500 organisations including the military, charities and other statutory organisations;
- service champion training this year a further 173 people (total of >400), frontline training to 550 staff, Mental Health First Aid training a further 90 (total of 160), eLearning, and refresher sessions to existing champions;
- events – Working Together Can Make a difference 2018 (>150);
- pathways – There are 24 pathways across Sussex, Kent and Medway with further in production and the format being used in Surrey and Hampshire;
- raised awareness and undertaken training to GPs, providers and charities across both counties;
- directly signposting, advocacy and supporting over 50 contacts per quarter from the armed forces community and professionals;
- some of the outcomes have been lifesaving and an improvement of quality of life, health and social position and the experience of the support provided; and
- a Gurkha/Nepalese Health toolkit has been developed through collaboration with the community and national contents.

9 Sustainability

9.1 As an NHS organisation, and as a spender of public funds, we have an obligation to work in a way that has a positive effect on the communities for which we commission and procure healthcare services.

9.2 Sustainability means spending public money well, the smart and efficient use of natural resources and through building healthy, resilient communities. By making the most of social, environmental and economic assets, we can improve health both in the immediate and long term even in the context of the rising cost of natural resources.

9.3 As a commissioning and contracting organisation, the CCG requires effective contract mechanisms to deliver our ambitions for sustainable healthcare delivery. The NHS policy framework already sets the scene for commissioners and providers to operate in a sustainable manner. Crucially for the CCG, evidence of this commitment will need to be provided in part through contracting mechanisms.
More information on these measures is available at the Sustainable Development Unit.

9.4 The latest report for our NHS carbon footprint was published in January 2016 and is based on 2015 data. It shows that the NHS carbon footprint in England is 22.8 million tonnes of carbon dioxide equivalents (MtCO2e). Between 2007 and 2015 the carbon footprint has reduced by 11%.

9.5 Every action counts and we are a lean organisation trying to realise efficiencies across the board for cost and carbon (CO2) reductions. We support a culture for active travel to improve staff wellbeing and reduce sickness. Outlined below are some of the key areas which continue to help us contribute to a reduced carbon footprint.

- The CCG has invested in videoconferencing facilities. Staff are encouraged to use these wherever possible to save on travel time and prevent the use of transport. Tele-conferencing is also promoted to avoid unnecessary travel to meetings.
- The CCG has an electronic system for the distribution of meeting papers for its Governing Body and key committee meetings. Governing Body members and Senior Managers have access to documents via tablet computers where papers are uploaded within a secure environment. This has significantly reduces the time spent by staff copying and distributing papers, and in the resources involved in the production and destruction of paper.
- The main CCG printer has a ‘secure print/release’ feature that reduces excessive printing by requiring the use of a password before printing documents.
- The CCG is based in a town with good public transport links by bus and train. Staff are encouraged to use these or to car-share when travelling to meetings.
- The CCG encourages its staff through its Health and Wellbeing Directorate to be mindful of ways to improve our environment and to recycle wherever possible. The staff are provided with regular updates by way of noticeboards and staff briefings.

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ACCOUNTABILITY REPORT
2017 to 2018

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Amanda Philpott
Chief Officer (Accountable Officer)
25 May 2018
SECTION 1 – Corporate Governance Report:

Part A – Members' Report

1. Introduction

1.1 Our Clinical Commissioning Group is formed of local GP practices. These are termed “the Membership” and are listed below:

<table>
<thead>
<tr>
<th>Practice Name</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Bexhill</strong></td>
<td></td>
</tr>
<tr>
<td>Collington Surgery</td>
<td>23 Terminus Road, Bexhill-on-Sea, TN39 3LR</td>
</tr>
<tr>
<td>Little Common / Old Town</td>
<td>82 Cooden Sea Road, Little Common, Bexhill-on-Sea TN39 4SP</td>
</tr>
<tr>
<td>Pebsham Surgery</td>
<td>119 Seabourne Road, Bexhill-on-Sea, TN40 2SD</td>
</tr>
<tr>
<td>Sidley Medical Practice</td>
<td>44 Turkey Road, Bexhill-on-Sea, TN39 5HE</td>
</tr>
<tr>
<td><strong>Rural Rother Locality</strong></td>
<td></td>
</tr>
<tr>
<td>Fairfield Surgery</td>
<td>High Street, Burwash, TN19 7EU</td>
</tr>
<tr>
<td>Ferry Road Health Centre</td>
<td>Ferry Road, Rye, TN31 7DN</td>
</tr>
<tr>
<td>Martins Oak Surgery</td>
<td>36 High Street, Battle, TN33 0EA</td>
</tr>
<tr>
<td>Northiam &amp; Broad Oak Surgeries</td>
<td>Main Street, Northiam, Rye, TN31 6ND</td>
</tr>
<tr>
<td>Oldwood Surgery, Robertsbridge</td>
<td>Station Road, Robertsbridge, TN32 5DG</td>
</tr>
<tr>
<td>Rye Medical Centre</td>
<td>Kiln Drive, Rye Foreign, Rye, TN31 7SQ</td>
</tr>
<tr>
<td>Sedlescombe and Westfield Surgeries</td>
<td>Brede Lane, Sedlescombe, Nr Battle TN33 0PW</td>
</tr>
<tr>
<td><strong>Hastings Locality</strong></td>
<td></td>
</tr>
<tr>
<td>Beaconsfield Surgery</td>
<td>21 Beaconsfield Road, Hastings, TN34 3TW</td>
</tr>
<tr>
<td>Harold Road Surgery</td>
<td>164 Harold Road, Hastings, TN35 5NH</td>
</tr>
<tr>
<td>Hastings Medical Practice &amp; Walk-in Centre <em>(Practice operated by Integrated Care 24 (IC24)</em> &amp;</td>
<td>Station Plaza Health Centre, Station Approach, Hastings, TN34 1BA</td>
</tr>
<tr>
<td>Hastings Old Town Surgery</td>
<td>High Street, Hastings, TN34 3EY</td>
</tr>
</tbody>
</table>
1.2 Our membership has reserved a small number of functions to itself. However, the day-to-day duties of the CCG are delegated to the Governing Body. Our Governing Body has further delegated some functions to individuals or committees of the CCG. These arrangements are detailed in our Scheme of Reservation and Delegation. This document is appended to the CCG Constitution and is available on the our website.

1.3 In summary, our Governing Body has responsibility for:

1.3.1 Ensuring that the group has appropriate arrangements in place to exercise its functions effectively, efficiently and economically and in accordance with the group’s principles of good governance (its main function).

1.3.2 Determining the remuneration, fees and other allowances payable to employees or other persons providing services to the group and the allowances payable under any pension scheme it may establish under paragraph 11(4) of Schedule 1A of the 2006 National Health Service Act, inserted by Schedule 2 of the 2012 Act.

1.3.3 Approving any functions of the group that are specified in regulations.

1.3.4 The functions attributed to it in the Prime Financial Policies, including, but not limited to:

27 [Link](www.hastingsandrotherccg.nhs.uk/about-us/vision-and-values)
a) The approval of budgets;
b) Receiving the reports of the Chief Financial Officer relating to the monitoring of financial performance against budget and plan; and
c) The approval of the consultation arrangements for the group’s commissioning plan.

1.3.5 All other functions and general duties of the group.

1.3.6 During 2017/18 our Governing Body was chaired by Dr David Warden. Amanda Philpott was the Chief Officer.

2. Members of the Governing Body

<table>
<thead>
<tr>
<th>Dr David Warden</th>
<th>Amanda Philpott</th>
<th>Barbara Beaton</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chair</td>
<td>Chief Officer</td>
<td>Lay member, Patient and Public Involvement</td>
</tr>
<tr>
<td>Dr Binodh Bhaskaran</td>
<td>GP member</td>
<td></td>
</tr>
<tr>
<td>Dr Rajeev Dhar</td>
<td>Rose Durban</td>
<td></td>
</tr>
<tr>
<td>Independent member, Secondary Care Doctor</td>
<td>Lay member</td>
<td></td>
</tr>
<tr>
<td>Karen Keane</td>
<td>Dr Rob McNeilly</td>
<td>Dr Craig Namvar</td>
</tr>
<tr>
<td>Independent member, Registered Nurse</td>
<td>GP member</td>
<td>(until 31/03/2018)</td>
</tr>
</tbody>
</table>
3. **Members of the Audit Committee**

3.1 The members of our Audit Committee in 2017/18 were:

- Alan Rummins (Chair);
- Barbara Beaton;
- Rose Durban.

4. **Membership of Other Committees**

4.1 The Governance Statement section of our Annual Report and Accounts contains further details, including membership of our committees and sub-committees.

4.2 Our Remuneration Report contains further information on the membership of the Remuneration Committee.

5. **Register of Interests**

5.1 The Governing Body Register of Interests can be accessed via the CCG’s website\(^\text{28}\).

6. **Disclosure of ‘Serious Incidents’**

6.1 There were no serious incidents during the 2017/18 year. Disclosures required for incidents involving data loss or confidentiality breaches (Information Governance incidents) are contained in the Data Security statement in Section 12 of the Annual Governance Statement. This confirms that there were no such incidents reported this year.

7. Statement as to Disclosure to Auditors

7.1 Each of those persons listed below (which includes all members of the Governing Body at the time that the Governing Body Report was approved) confirms:

So far as the member is aware, that there is no relevant audit information of which the Clinical Commissioning Group’s external auditor is unaware; and,

That the member has taken all the steps that they ought to have taken as a member in order to make themselves aware of any relevant audit information and to establish that the Clinical Commissioning Group’s auditor is aware of that information.

- Dr David Warden, Chair
- John O’Sullivan, Chief Finance Officer
- Barbara Beaton, Lay Member
- Dr Binodh Bhaskaran GP member
- Dr Rajeev Dhar, Secondary Care Doctor member
- Rose Durban, Lay member
- Karen Keane, Registered Nurse member
- Dr Robert McNeilly, GP member
- Dr Craig Namvar, GP member
- Dr Milan Radia, GP member
- Dr Susan Rae, GP member
- Alan Rummins, Lay Member

7.2 The Chief Officer confirmation of these statements is set out separately in the next part of this report.

8. Modern Slavery Act

8.1 Hastings and Rother CCG fully supports the Government’s objectives to eradicate modern slavery and human trafficking. The size of the CCG is insufficient to trigger the requirement for an Annual Statement as set out in the Modern Slavery Act 2015.29

SECTION 1 – Corporate Governance Report:
Part B – Statement of the Accountable Officer’s Responsibilities

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

2. 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 Section 14R of the National Health Service Act 2006 (as amended)),
- Ensuring that the CCG complies with its financial duties under Sections 223H to 223J of the National Health Service Act 2006 (as amended).

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

4. In preparing the financial statements, the Accountable Officer is required to comply with the requirements of the Group Accounting Manual issued by the Department of Health and in particular to:
• Observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
• Make judgements and estimates on a reasonable basis;
• State whether applicable accounting standards as set out in the Group Accounting Manual issued by the Department of Health have been followed, and disclose and explain any material departures in the financial statements; and,
• Prepare the financial statements on a going concern basis.

5. To the best of my knowledge and belief, 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.

6. I also confirm that:

• as far as I am aware, there is no relevant audit information of which the CCG’s auditors are unaware, and that as Accountable Officer, I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the CCG’s auditors are aware of that information.
• that the annual report and accounts as a whole is fair, balanced and understandable and that I take personal responsibility for the annual report and accounts and the judgments required for determining that it is fair, balanced and understandable.
SECTION 1 – Corporate Governance Report:
Part C – Annual Governance Statement

1 Introduction and context

1.1 The Clinical Commissioning Group was licensed from 1 April 2013 under provisions enacted in the Health and Social Care Act 2012, which amended the National Health Service Act 2006. As at 31 March 2018, the clinical commissioning group was licensed without conditions (and had been throughout the year).

2 Scope of responsibility

2.1 As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the Clinical Commissioning Group’s policies, aims and objectives, whilst safeguarding the public funds and assets for which I am personally responsible, in accordance with the responsibilities assigned to me in Managing Public Money. I also acknowledge my responsibilities as set out in my Clinical Commissioning Group Accountable Officer Appointment Letter.

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

3 Compliance with the UK Corporate Governance Code

3.1 The CCG is not required to comply with the UK Corporate Governance Code. Our corporate governance arrangements draw on best practice available, including those aspects of the Code we consider to be relevant to the CCG given its size and nature. Our arrangements are as follows:

Leadership

The Role of the Governing Body:
The types of decisions taken by the Governing Body, or delegated to committees or management, are detailed in the published scheme of delegation and reservation.

Division of Responsibilities:
The roles of Chair and Chief Officer (Accountable Officer) are separate appointments.
Non-executive Directors:
Senior Independent Directors not formally designated but fulfilled through the Lay members’ and Independent members’ roles on committees, particularly with reliance on audit chair and performance and delivery committee chair.

Effectiveness
The Composition of the Board:
The CCG has the nationally required Governing Body membership.

Appointments to the Board:
All appointments are as a result of transparent appointment processes. The Chair, Accountable Officer, and Chief Finance Officer were also subject to NHS England assessment and approval.

Commitment:
All Governing Body members allocate time as per contract; for lay and independent members this is in line with national guidance.

Development:
Mandatory and Governing Body development training is provided, together with an on-going programme of organisational development.

Information and Support:
Adequate resources are available under the guidance of the Accountable Officer and Directors.

Evaluation:
Individual performance reviews for Governing Body members and Directors are undertaken; the operation of the Governing Body has been reviewed as part of the programme of organisational development; internal Key Performance Indicators have been reported to Governing Body at each of its formal meetings.
There is also review and performance management by the NHS England Local Team in place.

Re-election:
The composition of the Governing Body is based on statute and follows NHS guidance. This allows for GP election to the Governing Body by the membership. Arrangements for this are set out in the CCG constitution.
Accountability
The CCG has dual accountability i.e. the governing body is accountable ‘upwards’ to NHS England and ‘sideways’ to its constituent practices (as well as maintaining its on-going accountability to patients and the public).

Remuneration
The Level and Components of Remuneration:
Remuneration is paid in line with agreed NHS reward schemes.

Remuneration Procedure:
Remuneration for executives is fixed by the remuneration committee, not by individual directors.

Relations with Stakeholders
Dialogue with Stakeholders:
Whilst there are no shareholders; the organisation is accountable to the public for its activities and engages patients, stakeholder organisations and the public in planning its objectives; particularly when considering larger scale service changes where it has a duty to consult.

Constructive use of the AGM:
There are no investors. However, patients, stakeholder organisations and the public are encouraged to participate in the Annual General Meeting of the member practices.

4 The Clinical Commissioning Group Governance Framework
4.1 The National Health Service Act 2006 (as amended), at paragraph 14L (2)(b) states:

‘The main function of the governing body is to ensure that the group has made appropriate arrangements for ensuring that it complies with such generally accepted principles of good governance as are relevant to it’.

4.2 The NHS Hastings and Rother CCG Constitution sets out the arrangements made by CCG to meet its responsibilities for commissioning care for the people for whom it is responsible. It describes the governing principles, rules and procedures that the group will establish to ensure probity and accountability in the day-to-day running of the CCG, to ensure that decisions are taken in an open and transparent way and that the interests of patients and the public remain central to the goals of the group.
4.3 The constitution also sets out the **Principles of Good Governance** to which the CCG adheres, as follows:

In accordance with section 14L (2) (b) of the 2006 Act, the Group will at all times observe ‘such generally accepted principles of good governance’ in the way it conducts its business. These include:

- the highest standards of propriety involving impartiality, integrity and objectivity in relation to the stewardship of public funds, the management of the organisation and the conduct of its business;
- the **Good Governance Standard for Public Services**;
- the standards of behaviour published by the **Committee on Standards in Public Life (1995)** known as the ‘**Nolan Principles**’;\(^{30}\);
- the seven key principles of the **NHS Constitution**\(^{31}\);
- the **Equality Act 2010**.

4.4 Our Governing Structure is clearly defined and includes the framework for decision-making, arrangements for the management of conflicts of interest, the functions discharged by the CCG and the scheme of delegation and reservation which sets out those decisions that are reserved for our membership as a whole and those decisions that are the responsibilities of our Governing Body, the Governing Body’s committees and sub-committees, the Group’s committees and sub-committees, individual members and employees.

4.5 In line with national guidance the Chair of the Audit Committee takes on the role of ‘Conflicts of Interest Guardian’ providing, among other things, a conduit for GP practice staff, members of the public and healthcare professionals who have any concerns with regards to conflicts of interest as well as providing independent advice and judgment where there is any doubt about how to apply conflicts of interest policies. Being a Lay member of the Governing Body provides sufficient authority as well as the necessary independence of management.

5 The Governing Body

5.1 The Governing Body has 13 members and is constituted as follows:

- The Chair, who is a general practitioner (GP)
- The Accountable Officer, known as the Chief Officer
- The Chief Finance Officer

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*Hastings and Rother Clinical Commissioning Group Annual Report and Accounts 2017/18*
• Three other GP Governing Body members (and two vacancies)
• A secondary care specialist doctor
• A registered nurse
• A lay member to lead on governance
• A lay member to lead on patient and public involvement
• A lay member to lead on primary care commissioning, procurement and delivery

5.2 Each GP member provides a direct liaison point with a CCG locality as well as providing functional leadership for a clinical area.

5.3 Under the Health and Social Care Act 2012, it was established that Clinical Commissioning Groups should have a local GP (i.e. drawn from the membership of the CCG) in either or both the Chair and / or Accountable Officer roles. The CCG has a clinical Chair (a GP) and a non-clinical Accountable Officer (Chief Officer).

5.4 The CCG works in close collaboration with NHS Eastbourne, Hailsham and Seaford Clinical Commissioning Group and shares a Senior Management Team that comprises the Chief Officer, Chief Finance Officer, Chief Operating Officer, Director of Localities and Primary Care, Chief Nurse and Director of Delivery and Performance.

5.5 Highlights from the Governing Body meetings during 2017/18 include:

5.5.1 Achieving a successful end to our 150 week East Sussex Better Together programme, the decision on the future delivery model for our Integrated Care System and driving the move into its implementation phase to fully realise the vision of better health and social care – the profile of this initiative continues to be raised nationally as a model for local cooperation and integration.

5.5.2 Development of a system wide Strategic Investment Plan.

5.5.3 Active contribution to the Sussex and East Surrey Sustainability and Transformation Partnership and work undertaken around Clinically Effective Commissioning pathways to ensure that the best care possible is being delivered in the right way, according to best clinical evidence.

5.5.4 The CCGs receiving the Health Service Journal (HSJ) award in the ‘Improved Partnerships between Health and Local Government’ category.

5.5.5 A significant and sustained reduction in Delayed Transfers of Care (an NHS Constitutional Standard) alongside the meeting of targets for Improving Access to
Psychological Therapies (IAPT) and Early Intervention in Psychosis (EIP) (mental health).

5.5.6 Leadership of well attended Shaping Health and Care, and Integrated Locality Engagement events and many patient and public engagement event during the year.

5.5.7 Sustained reductions in the numbers of Serious Incidents since the reconfiguration of maternity services.

5.5.8 The significant amount of resource utilised in support of patients affected by the dissolution of a practice within the CCG area.

5.5.9 The development of the Urgent Care Service model.

5.6 The Governing Body has highlighted some performance issues including:

5.6.1 The challenging position against the Strategic Investment Plan during the part of the year due to cost pressures for both the CCG and ESHT. The progress against the Financial Recover Plan and the reporting of a 2017/18 CCG deficit following an initial four years of surplus.

5.6.2 Whilst there were significant and sustained improvements in some areas of performance against the NHS Constitutional Standards there continued to be issues in meeting some of the standards.

5.6.3 Activity volumes for Musculoskeletal referrals and the lower than expected use of alternative pathways.

5.6.4 Concerns over performance against the Cancer 62 day targets at ESHT.

5.6.5 Actions taken by the CCG are described in Section 2 of the Performance Report.

5.7 Attendance at CCG Governing Body meetings during 2017/18 is shown below, with (number of attendances / number of meetings held during their individual membership).

5.7.1 General Practitioner members:
- Dr David Warden (attendance 4/6)
- Dr Binodh Bhaskaran (attendance 6/6)
- Dr Craig Namvar (attendance 4/6)
- Dr Rob McNeilly (attendance 5/6)
- Dr Milan Radia (attendance 5/6)
- Dr Susan Rae (attendance 6/6)
5.7.2 Lay members:
- Barbara Beaton: Lay member, patient and public involvement (attendance 5/6)
- Rose Durban, Lay member (attendance 6/6)
- Alan Rummins, Lay member, governance (attendance 6/6)

5.7.3 Independent clinician members:
- Karen Keane: Registered Nurse member (attendance 6/6)
- Dr Rajeev Dhar (attendance 5/6)

5.7.4 Executive members:
- Amanda Philpott: Chief Officer (attendance 6/6)
- John O'Sullivan: Chief Finance Officer (attendance 4/6) the Deputy Chief Finance Officer attended the other 2 meetings which were during a period of absence

5.8 Minutes of Governing Body meetings are available on the CCG website.

6 Assessment of the effectiveness of the Governing Body

6.1 During the year the domains for assurance of organisational health and capability continued to be assessed by NHS England. Further information is available within Section 2 of the Performance Report.

7 CCG Committees

7.1 The CCG Governing Body has six committees, which are:

- Audit Committee;
- Remuneration committee;
- Primary Care Commissioning Committee;
- Quality and Governance Committee
- Performance and Delivery Committee
- Procurement Committee

These committees meet together with the same committees established by NHS Eastbourne, Hailsham and CCG and have been operating throughout the reporting period. In this way wider and richer discussion is possible and through a reciprocal arrangements, Lay members of each CCG may contribute to the quorums of both CCG committees.
7.2 During the course of the year the committees have met as prescribed and have reviewed their work in line with their terms of reference to confirm that they have fully discharged their functions.

7.3 Nominated members of the Governing Body also attend the East Sussex Better Together (ESBT) Alliance meetings. The ESBT Alliance is delivering our shared ambition of a fully integrated health and social care system locally that will ensure every patient or service user receives proactive, joined up care that supports them to live as independently as possible and achieve the best possible outcomes.

7.4 A joint Reference Group, established with the neighbouring Eastbourne, Hailsham and Seaford CCG, meets as necessary to review specific areas.

7.5 The CCG committee structure, which clearly shows the reporting lines from the various committees to the Governing Body, is shown within the diagram below:
7.6  A summary of the functions of each of the committees of the Governing Body is given below.

7.6.1  Function of the Audit Committee
To assist the CCG to deliver its responsibilities for the conduct of public business and the stewardship of funds under its control. In particular, the Committee will seek to provide assurance to the Governing Body that an appropriate system of internal control is in place to ensure that:

- Business is conducted in accordance with the law and proper standards;
- Public money is safeguarded and properly accounted for;
- Financial Statements are prepared in a timely fashion, and give a true and fair view of the financial position of the CCG for the period in question;
- Affairs are managed to secure economic, efficient and effective use of resources; and
- Reasonable steps are taken to prevent and detect fraud and other irregularities.

7.6.2  Function of the Remuneration Committee
To assist the Governing Body in meeting its responsibilities as statutory employer to ensure appropriate remuneration, allowances and terms of service for all formal Governing Body members and other individuals who are engaged by the CCG but also not on Agenda for Change (AfC) Terms and Conditions, having proper regard to the organisation’s circumstances and performance and to the provisions of any national arrangements where appropriate.

7.6.3  Function of the Primary Care Commissioning Committee
To be a corporate decision-making body for the management of the delegated functions and the exercise of the delegated functions relating to the commissioning of primary medical services under section 83 of the NHS Act in accordance with Section 13z of the NHS Act. The Committee is subject to any directions made by NHS England or by the Secretary of State.

To make collective decisions on the review, planning and procurement of primary care services Hastings and Rother under delegated authority from NHS England. In performing its role the Committee will exercise its management of the functions in accordance with the agreement entered into between NHS England and NHS Hastings and Rother CCG, which will sit alongside the delegation and terms of reference.

7.6.4  Function of the Quality and Governance Committee
To provide assurance that corporate responsibilities and duties are discharged, including:

Hastings and Rother Clinical Commissioning Group Annual Report and Accounts 2017/18
• assurance on the systems and processes by which organisational objectives and compliance, and the safety and quality of clinical services, are achieved;
• assurance regarding risk, including organisational risk and risks related to the delivery of commissioned services;
• assurance regarding external contractors delivering administrative and management functions to the CCG;
• assurance regarding the delivery of equality and engagement duties;
• assurance on compliance with information governance duties;
• assurance that responsibilities with regard to the NHS Constitution are discharged;
• assurance that other statutory and legal requirements are met.

7.6.5 Function of the Performance and Delivery Committee
To provide oversight and assurance on the integrated performance of all commissioned services and on delivery against internal Quality, Innovation, Productivity and Prevention (QIPP) targets and related change management programmes.

7.6.6 Function of the Procurement Committee
To ensure a strategic approach to procurement management and to provide oversight and assurance on the procurement process and on the delivery against the annual Procurement Plan.

7.6.7 Function of the Joint Reference Group
To advise both Hastings and Rother and Eastbourne, Hastings and Seaford CCG Governing Bodies, to review specific areas that require a joint view with a level of Lay oversight such as incentive schemes to ensure:

• genuine stretch;
• fairness to all;
• levels of funding available;
• appropriate balance between incentives for effort and achievement / performance;
• strong performance management / measurement;
• principles for withholding payments;
• contributes to strategic priorities i.e. QIPP;
• no double counting/ payments; and
• transparency.

This Group does not replace formal arrangements around Remuneration Committees or provide a decision making forum. The Joint Reference Group is in existence to support Governing Bodies in assuring themselves of fairness of processes for incentive schemes across the CCGs.

Hastings and Rother Clinical Commissioning Group Annual Report and Accounts 2017/18
7.7 The following form our East Sussex Better Together (ESBT) Alliance Governance Structure and are not statutory committees:

7.7.1 Function of the ESBT Strategic Commissioning Board

The ESBT Strategic Commissioning Board is made up of Councillors from East Sussex County Council and General Practitioners and Lay Members from the Governing Bodies of Eastbourne, Hailsham and Seaford and Hastings and Rother Clinical Commissioning Groups.

They are responsible for addressing the health needs of the population and for commissioning health and social care through oversight of the ESBT Strategic Investment Plan (SIP) which sets the outcomes to be delivered by the ESBT Alliance to meet the needs of the population, reflecting national policy where this is appropriate, and ensures that local people are engaged in discussions to understand local needs and the outcomes to be delivered. The Board monitors and evaluates the meeting of needs and the delivery of outcomes.

7.7.2 Function of the ESBT Alliance Governing Board

The ESBT Alliance Governing Board is made up of the Chief Officers, Board Directors and Governing Body Members who direct and lead the ESBT Alliance and operate the ESBT Alliance Agreement.

They are responsible for developing and agreeing the delivery of the Strategic Investment Plan, and holding the ESBT Alliance Executive to account for delivery of agreed plans, management of risk and any changes to proposed service arrangements, performance and resource allocations. They will also lead the development of proposals for the full ESBT Alliance integrated care model.

8 Attendance at Committees

8.1 The table below details the attendance of our Governing Body members and attendees at committees, indicating committee chairs (C), members (M) and ‘in attendance’ (A) during the year. It is shown in the form of (number of attendances / number of meetings held during their membership). Where a person is not a member of a particular committee the area is shaded in grey.

<table>
<thead>
<tr>
<th>Committee Member</th>
<th>Role</th>
<th>Audit Committee</th>
<th>Remuneration Committee</th>
<th>Quality and Governance Committee</th>
<th>Performance and Delivery Committee</th>
<th>Primary Care Commissioning Committee</th>
<th>Procurement Committee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barbara Beaton</td>
<td>Lay member, Patient and Public Involvement</td>
<td>M (5/6)</td>
<td>C (2/2)</td>
<td>C (5/6)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jessica Britton</td>
<td>Chief Operating Officer</td>
<td>A (4/6)</td>
<td></td>
<td>M (5/6)</td>
<td></td>
<td></td>
<td>A (5/5)</td>
</tr>
<tr>
<td>Committee Member</td>
<td>Role</td>
<td>Audit Committee</td>
<td>Remuneration Committee</td>
<td>Quality and Governance Committee</td>
<td>Performance and Delivery Committee</td>
<td>Primary Care Commissioning Committee</td>
<td>Procurement Committee</td>
</tr>
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</tr>
<tr>
<td>Allison Cannon</td>
<td>Chief Nurse</td>
<td></td>
<td></td>
<td>M (6/6)</td>
<td>M (4/5)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr Rajeev Dhar</td>
<td>Secondary Care Doctor Member (from September 2017)</td>
<td>M (1/2)</td>
<td></td>
<td></td>
<td>M (3/5)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rose Durban</td>
<td>Lay member</td>
<td>M (4/6)</td>
<td></td>
<td>C (5/6)</td>
<td>M (5/5)</td>
<td>C (5/6)</td>
<td></td>
</tr>
<tr>
<td>Garry East</td>
<td>Acting Director of Delivery and Performance (from November 2017)</td>
<td></td>
<td></td>
<td></td>
<td>M (3/3)</td>
<td></td>
<td>M (3/3)</td>
</tr>
<tr>
<td>Paula Gorvett</td>
<td>ESBT Programme Director (now Director of Localities and Primary Care)</td>
<td></td>
<td></td>
<td>M (1/2)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Karen Keane</td>
<td>Registered Nurse member</td>
<td>M (2/2)</td>
<td>M (6/6)</td>
<td></td>
<td>M (3/5)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Representative</td>
<td>Local Authority Public Health</td>
<td></td>
<td></td>
<td>A (5/6)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>John O’Sullivan</td>
<td>Chief Finance Officer (represented by the Deputy Chief Finance Officer during a period of absence)</td>
<td>A (6/6)</td>
<td>A (2/2)</td>
<td>M (6/6)</td>
<td>M (3/5)</td>
<td>M (6/6)</td>
<td></td>
</tr>
<tr>
<td>Amanda Philpott</td>
<td>Chief Officer</td>
<td>A (4/6)</td>
<td>A (1/2)</td>
<td>A (5/6)</td>
<td>M (5/5)</td>
<td>M (5/5)</td>
<td></td>
</tr>
<tr>
<td>Milan Radia</td>
<td>GP member</td>
<td></td>
<td></td>
<td>M (4/6)</td>
<td></td>
<td></td>
<td>M (4/5)</td>
</tr>
<tr>
<td>Susan Rae</td>
<td>GP member</td>
<td></td>
<td></td>
<td>M (6/6)</td>
<td></td>
<td></td>
<td>M (4/5)</td>
</tr>
<tr>
<td>Alan Rummins</td>
<td>Lay member, Governance</td>
<td>C (6/6)</td>
<td>M (2/2)</td>
<td>M (6/6)</td>
<td>M (5/5)</td>
<td>M (6/6)</td>
<td></td>
</tr>
</tbody>
</table>

8.2 The Governing Body has reviewed the effectiveness of its committees through a two part process:

a) an annual checklist review to ensure Committees meet their Terms of Reference and function as designed; and

b) our Governing Body and Committees have checked that arrangements are in place for the discharge of statutory functions and that they are legally compliant.

The committees also submit mid-year and annual reports to the Governing Body.
9 The Clinical Commissioning Group Risk Management Framework

9.1 The Governing Body is committed to ensuring that good corporate governance and risk management are integral to the organisation’s philosophy, practice and planning rather than being viewed or practiced as separate programmes, and to ensuring that responsibility for implementation is accepted at all levels of the organisation.

9.2 The Governing Body reviews the Risk Management Strategy annually, regularly reviews its assurance framework and receives reports on the governance, internal control, risk and assurance work of its committees. Deployment of the CCG Risk Management Strategy and its supporting policy and procedures are managed within each directorate with expert support from a dedicated Risk and Business Planning Manager. The Strategy sets out the structure, system and accountabilities for risk management within the CCG, promoting high quality, safe, accountable healthcare, minimising risks to the organisation and our staff, and maximising available resources.

9.3 The Governing Body receives details of the extreme risks, their potential impact on the Key Objectives, the controls and assurances in place and the actions scheduled to further mitigate the risks in the form of an Assurance Framework. This is submitted for discussion and approval at each formal meeting of the Governing Body along with the reports arising from the regular scrutiny of the risks and the risk system by the committees.

9.4 There are particular responsibilities for the Governing Body, committees and individuals. New risks are assessed and appropriate measures put in place to manage those risks within a pre-determined timescale. Each risk is scored against the CCG Model Risk Matrix, adapted from the National Patient Safety Agency (NPSA) model matrix, and is reviewed at least bi-monthly by the manager who is nominated as the ‘owner’ of the risk. High level risks; those with high impact, high likelihood or both are overseen by the Senior Management Team. Extreme risks are assessed for their potential impact upon the Governing Body’s Key Objectives, controls are designed to ensure that the management actions are undertaken and assurances on the effect of those actions are also detailed.

9.5 The Quality and Governance Committee scrutinises each of the high level and extreme risks at each of its meetings. Where there is insufficient assurance available members will direct that actions are taken to ensure that this is remedied.

9.6 Risk management training is made available to all staff and is mandatory. All staff must attend an update every year. A full range of health and safety and other mandatory training packages are made available to all relevant staff. Records of attendance are kept and collated for reporting purposes.
9.7 The extreme risks reported on the Governing Body’s Assurance Framework during 2017/18 are shown in the following table:

<table>
<thead>
<tr>
<th>Risks</th>
<th>Original score</th>
<th>Mitigation target</th>
<th>Residual level</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Risk 1701</strong> - Targets from central regulators including Constitutional Standards.</td>
<td>3x5=15</td>
<td>Reduce likelihood from 5 to 4</td>
<td>3x4=15</td>
</tr>
<tr>
<td><strong>Risk 1702</strong> - Brighton and Sussex University Hospitals NHS Trust (BSUH) financial and operation challenges.</td>
<td>4x4=16</td>
<td>Reduce likelihood from 4 to 3</td>
<td>4x3=12</td>
</tr>
<tr>
<td><strong>Risk 1703</strong> - Resources for GP Out of Hours service.</td>
<td>4x4=16</td>
<td>Reduce likelihood from 4 to 3</td>
<td>4x3=12</td>
</tr>
<tr>
<td><strong>Risk 1704</strong> - Focus on Individual organisational investment.</td>
<td>4x5=20</td>
<td>Reduce likelihood from 5 to 4</td>
<td>4x4=12</td>
</tr>
<tr>
<td><strong>Risk 1705</strong> - Primary care workforce recruitment.</td>
<td>4x4=16</td>
<td>Reduce likelihood from 4 to 3</td>
<td>4x3=12</td>
</tr>
<tr>
<td><strong>Risk 1706</strong> - East Sussex Healthcare NHS Trust (ESHT) financial and operational challenges.</td>
<td>5x3=15</td>
<td>Reduce likelihood from 3 to 2</td>
<td>5x2=15</td>
</tr>
<tr>
<td><strong>Risk 1707</strong> - Operational delivery of East Sussex Better Together (ESBT) plans.</td>
<td>4x5=20</td>
<td>Reduce likelihood from 5 to 4</td>
<td>4x4=20</td>
</tr>
<tr>
<td><strong>Risk 1720</strong> - South East Coast Ambulance NHS Trust’s ability to deploy appropriate resources.</td>
<td>5x3=15</td>
<td>Reduce likelihood from 3 to 2</td>
<td>5x2=10</td>
</tr>
<tr>
<td><strong>Risk 1723</strong> - Delivery of the main outcomes of the National Transforming Care Programme.</td>
<td>4x4=16</td>
<td>Reduce likelihood from 4 to 3</td>
<td>4x3=12</td>
</tr>
<tr>
<td><strong>Risk 1724</strong> - NHS 111 procurement to secure a provider to successfully deliver the specification required.</td>
<td>4x4=16</td>
<td>Reduce impact from 4 to 3</td>
<td>3x4=12</td>
</tr>
</tbody>
</table>

9.8 The Risk Management System is examined by internal auditors and this contributes to the Annual Head of Internal Audit Opinion.

10 The Clinical Commissioning Group Internal Control Framework

10.1 The 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.

10.2 The Governing Body is responsible for determining the nature and extent of the significant risks it is willing to take in achieving its strategic objectives and has agreed a statement of Risk Appetite. The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to
achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness.

10.3 The CCG ensures that effective governance and risk management systems are in place for meeting all statutory requirements and adhering to guidance issued by the Department of Health in respect of governance. The Chief Operating Officer is accountable for the strategic development and implementation of organisational risk management and governance controls. All the Senior Managers are accountable to the Chief Officer for risk management and governance across the breadth of their functions.

10.4 The Audit Committee reports to the Governing Body and reviews the establishment and deployment of an effective system of integrated governance, risk management and internal control across the whole of the organisation’s activities that supports the achievement of the organisation’s objectives. It reviews the system of risk at each of its meetings to ensure that it remains robust and is sufficiently deployed.

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

11.1 The Governing Body identified the principal risks to its Key Objectives. Staff have identified risks during the year and these were assessed and escalated as appropriate. These two sets of risks formed the extreme risks that were regularly reported as part of the Assurance Framework document. Actions were set to mitigate these risks and they were reviewed at least bi-monthly.

11.2 Individual risks were scrutinised at each meeting of the Quality and Governance Committee and the Governing Body reviewed and approved the mitigating actions and controls for each risk on the Assurance Framework as well as the assurances that had been received for each. The Audit Committee scrutinised the system of risk and its deployment across the organisation at each of its meetings and reported to the Governing Body. In this way, the scrutiny, review and reporting requirements were met.

11.3 Risks in relation to Governance, Risk Management and Internal Control have been identified and managed. There are no extreme risks in these areas and the overall level of risk to these systems is assessed as low.

12 Information Governance

12.1 The NHS Information Governance Assurance Framework sets the processes and procedures by which the NHS handles information about patients and employees, in particular personal confidential data. The Framework is supported by an
Information Governance Toolkit and the annual submission process provides assurances to the Clinical Commissioning Group, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively.

12.2 The CCG places a high importance on ensuring that there are robust information governance systems and processes in place to help protect patient and corporate information. The CCG has an Information Governance Management Framework with supporting policies and procedures in line with the national Information Governance Toolkit. We have ensured that staff undertake annual information governance training and were able to report that in excess of 95% of them had completed training in the year to 31st March 2018.

12.3 Subject Access Requests are dealt with effectively, within the time constraints set out by the Data Protection Act 1998. A ‘Subject Access Request’ (SARs) log is maintained. The Caldicott Guardian also maintains his own log of decisions made. In this way the CCG keeps track of requests from members of the public and any queries that are raised by staff about the management of personal information.

12.4 There are processes in place for incident reporting and investigation of serious incidents and an information risk culture continues to be embedded throughout the organisation.

12.5 An internal Information Governance Steering Group (IGSG), with membership including the Senior Information Risk Owner, Caldicott Guardian and subject matter specialists is accountable to the Quality and Governance Committees. Its purpose is to support and drive the broader information governance agenda and provide the Quality and Governance Committee with assurance that effective information governance best practice mechanisms are in place within the organisation.

12.6 The CCG has made appropriate preparations for the introduction of the General Data Protection Regulations in May 2018.

13 Review of economy, efficiency & effectiveness of the use of resources

13.1 Monthly finance reports are produced through the Integrated Single Financial Environment (ISFE) which are consistent in terms of information extracted from the ledgers and reported to budget holders and the governing body. The annual budget was set to ensure the delivery of the financial framework that underpins the annual operating plan and variations from this plan are closely monitored.

13.2 Each month there is a review of financial ledger information, contract monitoring information and reports from the QIPP programme all of which are reported to, and
discussed by, the Governing Body. The delivery of savings from the QIPP programme is a key component of the assurance given to the Governing Body on effectiveness of use of resources.

13.3 Each month the finance report gives the Governing Body information on the delivery of the control total surplus and sets out what intervention has been made to address any shortfall in the QIPP savings and any other financial pressures in the overall forecast outturn.

14 Feedback from Delegation Chairs Regarding Business, use of resources and responses to risk

14.1 Our Operational Scheme of Delegation describes the level to which authority, for a matter, may be delegated with no further action required. It specifies that all financial limits in the Schedule of matters delegated to officers are subject to sufficient budget being available. Our Schedule was reviewed at the Audit Committee on 24 May 2017 and it was decided that it required no amendments at that time.

15 Capacity to Handle Risk

15.1 The Quality and Governance Committee scrutinises all corporate risks at each of its meetings. It notes the totality of risk and raises issues on individual risks which are communicated to risk owners and addressed. The Senior Management Team agrees the revised register and the resulting Assurance Framework report prior to submission to Governing Body.

15.2 The Primary Care Commissioning Committee reviews risks related to this area of work and any risks outside of this area which may, likewise, impact on our primary care commissioning.

15.3 The Governing Body scrutinises and approves the Assurance Framework at each meeting. It notes the actions in place to mitigate risks and the controls and assurances planned to manage the mitigation. The Governing Body has considered both its tolerance of risk and its risk appetite. It has directed a level of authority that senior management has (under the Accountable Officer) to take risk and has mandated that this may only be done when the totality of risk on the Assurance Framework is below a certain level. In this way the organisation’s capacity to manage risk is not overstretched.

15.4 The Audit Committee scrutinises the system of risk management ensuring that it is fit for purpose and that it is robustly and consistently deployed across the organisation. The internal auditors the CCG risk system giving ‘Substantial Assurance’ – the highest of the available ratings.
16 Review of the effectiveness of Governance, Risk Management and Internal Control

16.1 As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors and the executive managers and clinical leads within the 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 management letter and other reports.

16.2 Assurance on the operation of internal controls is also obtained through the Service Auditor Reports provided by the Commissioning Support Units which provide services to the CCG.

16.3 The CCG has been provided with a Service Auditor Report on South, Central and West CSU and North East London CSU. These reports state that, except for a small number of matters described, in all material respects, the controls related to the control objectives were suitably designed to provide reasonable assurance that the specified control objectives be achieved if the described controls operated as at the reporting date. The CCG is also able to take assurance from the reasonable assurance opinion provided by our Internal Auditors, TIAA Ltd, on the Key Financial Systems Review.

16.4 I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Governing Body, the Audit Committee and Quality and Governance Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

16.5 The Audit Committee scrutinises the system of risk management ensuring that it is fit for purpose and that it is robustly and consistently deployed across the organisation.

16.6 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 (TIAA Ltd) concluded that:
“The overall Head of Internal Audit Opinion for 2017/18 is ‘Reasonable Assurance’, except for the CCG’s ability to deliver their planned financial control total.

I am satisfied that sufficient internal audit work has been undertaken to allow me to draw a ‘reasonable assurance’ conclusion as to the adequacy and effectiveness of CCG’s risk management, control and governance processes. In my opinion the CCG has adequate and effective management, control and governance processes to manage the achievement of its objectives, except for delivery of its planned financial control total.”

16.7 During 2017/18, three limited assurance opinion reports out of a total of fifteen which were issued, and a fourth had an opinion split between ‘Limited’ and ‘Reasonable’:
- Cyber Security;
- Looked After Children;
- Quality Premium; and
- Strategic Investment Plan (part)

Actions with timescales have been agreed that are designed to correct the weaknesses identified.

17 Annual Audit of Conflicts of Interest Management

17.1 Internal Audit has reported ‘Reasonable Assurance’ in the area of Conflicts of Interest. This showed clear improvements on the previous year with a fully robust filing and processing system for those declarations being maintained.

17.2 The CCG is implementing recommendations to increase the clarity of policies, committee terms of reference of relevant committees and public registers. It will also issue guidance to senior managers regarding the point during the recruitment processes when it is appropriate to seek declarations of interests.

17.3 In line with all other NHS organisations, the CCG has identified key staff for whom the recently launched conflict of interest training will be mandatory and will ensure compliance.

18 Data Quality

18.1 A range of data is made available to the Governing body. Our Commissioning Support Unit, Central and South West CSU, produces our standard Performance and Delivery reports and responds to our ad-hoc data queries. These outputs are checked; and any outlying or unexpected values questioned. The reports are further cross-matched against the area team reports, and other widely available
national information sources such as Public Health Observatories, Quality Observatories, Better Care Better Value indicators, NHS Comparators, Health and Social Care Information Centre indicators, and iView.

18.2 The content and layout of the performance report has evolved over time not only to provide information regarding the national and local targets, but also to provide useful contextual information relating to trends, overall national performance, and total patient volumes where relevant.

19 Business Critical Models

19.1 There is an appropriate framework and environment in place to provide quality assurance of business critical models, in line with the recommendations of the MacPherson Report.

19.2 All business critical models have been identified and information about quality assurance processes for those models has been provided to the Analytical Oversight Committee, chaired by the Chief Analyst in the Department of Health.

20 Data Security

20.1 We have submitted a satisfactory level of compliance with the Information Governance Toolkit Assessment. The process was audited at two stages and learning from the reports was incorporated into the remainder of the process.

20.2 There have been no Serious Incidents reported relating to data security breaches during the year.

21 Emergency Planning, Resilience and Response

21.1 During the reporting year the CCG was assessed against the NHS England Core Standards for Emergency Planning. This takes the form of a self-assessment that is subject to peer review and challenge followed by a formal scrutiny by the Local Health Resilience Partnership (Chaired by NHS England). The CCG improved its compliance from ‘substantial compliance’ in 2016/17 to ‘full compliance’ in 2017/18.

22 Discharge of Statutory Functions

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

Hastings and Rother Clinical Commissioning Group Annual Report and Accounts 2017/18
22.2 In light of the Harris Review, the Clinical Commissioning Group has reviewed all of the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated legislative and regulations. As a result, I can confirm that the Clinical Commissioning Group is clear about the legislative requirements associated with each of the statutory functions for which it is responsible, including any restrictions on delegation of those functions.

22.3 Responsibility for each duty and power has been clearly allocated to a lead Director. The directorates have confirmed that their structures provide the necessary capability and capacity to undertake all of the Clinical Commissioning Group’s statutory duties.

23 Counter Fraud Arrangements

23.1 The CCG is supported by an accredited counter fraud specialist through contract with its internal auditors. This individual is a regular attendee at Audit Committee meetings.

23.2 The CCG Audit Committee receives a report against each of the standards for commissioners. The Chief Finance Officer is the executive lead in this area and ensures that NHS Protect quality assurance recommendations are implemented.

23.3 The CCG is committed to taking all necessary steps to counter Fraud, Bribery and Corruption and has a specific policy which is referenced from a range of other policies and published on its website. To meet their objectives, they have adopted the four key principles which are set out in the NHS Counter Fraud Agency strategy:

- Inform and involve;
- Prevent and deter crime;
- Investigate, sanction and seek redress; and
- continuously review and hold to account.

23.4 The CCG has conducted risk assessments in line with Ministry of Justice guidelines to assess how Fraud, Bribery and Corruption may affect the organisation, and to implement proportionate procedures to mitigate identified risks.

32 http://www.hastingsandrotherccg.nhs.uk/search/?q=fraud
23.5 Awareness of counter fraud is included in the staff induction programme. Counter fraud measures are a regular feature at staff briefings and counter fraud training forms a part of mandatory training for all staff.

23.6 There is a specific section of the staff intranet giving definitions and examples, dos and don’ts, and copies of the Fraudstop Newsletter.

23.7 Hastings and Rother CCG was selected for a focused assessment against the requirements of the 13 NHS Protect Standards for Commissioners 2017-18, fraud, bribery and corruption.

23.8 Requirement 1.5 examines whether the organisation reports annually on how it has met the standards. Although this work was reported on in detail the document did not include a full summary of ratings against each standard of the CCG’s most recent self-review tool (SRT) and the CCG was therefore non-compliant in this area alone.

23.9 The Counter Fraud Agency report concluded that the CCG had strong management and awareness of anti-fraud work at a senior level and adopted a risk based approach to work conducted. In addition, contract management arrangements in place were comprehensive as were the code of conduct implementation and declarations of interest.

23.10 In line with national guidance the CCG has appointed the Independent Clinician (Registered Nurse) member of the Governing Body as its ‘Freedom to Speak Up Guardian’. In this role she works alongside the CCG leadership team to support the organisation in becoming a more open and transparent place to work, where all staff are actively encouraged and enabled to speak up safely.
SECTION 2 – The Remuneration and Staff Report

1 Introduction

1.1 This Remuneration Report discloses all relevant information with respect to Senior Managers in NHS Hastings and Rother CCG. The definition of ‘Senior Manager’ in the guidance is:

“Those persons in senior positions having authority or responsibility for directing or controlling the major activities of the Clinical Commissioning Group: This means those who influence the decisions of the Clinical Commissioning Group as a whole rather than the decisions of individual directorates or departments. Such persons will include advisory and lay members.”

1.2 Our Chief Officer has confirmed that the definition of Senior Manager does not extend beyond the members of our Governing Body and the remuneration of any additional regular attendees at Governing Body meetings is disclosed via the employee benefits expenditure tables in the annual accounts.

1.3 This CCG and NHS Eastbourne, Hailsham and Seaford CCG are two separate statutory bodies working with a shared management team and arrangements are governed by a memorandum of understanding. Where a Senior Manager, as defined for the purposes of the report, works across both CCGs the appropriate proportion of remuneration is reported and their total remuneration across both CCGs is shown separately in order to ensure full disclosure.

Remuneration Report

2 Details of the Remuneration Committee

2.1 Our Remuneration Committee is established in accordance with our CCG Constitution, Standing Orders and Scheme of Reservation and Delegation. It has delegated authority from our Governing Body to ensure appropriate remuneration, allowances and terms of services for our Chief Officer and Chief Financial Officer, having proper regard to the organisation's circumstances and performance and to the provisions of any national arrangements where appropriate, pension contributions for senior employees and from the Membership via the Constitution, to determine the remuneration, including allowances, for members of our Governing Body who are not employees.

2.2 The membership of our Remuneration Committee consists of:

• Barbara Beaton, Lay Member (Patient and Public Engagement)
• Alan Rummins, Lay Member (Governance)
• Karen Keane, Independent Clinical Member (Registered Nurse)
2.3 Our Remuneration Committee meets together with the Remuneration Committee of Eastbourne, Hailsham and Seaford CCG. There were two Meetings of the Remuneration Committees during the period. Attendance for Hastings and Rother CCG at the meetings was as follows:

Members:
- Barbara Beaton, attended 19 July 2017 and 24 January 2018
- Alan Rummins, attended 19 July 2017 and 24 January 2018
- Karen Keane, attended 19 July 2017 and 24 January 2018
- Dr Rajeev Dhar, attended 19 July 2017 and 24 January 2018

Attendees:
- Amanda Philpott, Chief Officer, attended 19 July 2017 and 24 January 2018
- John O’Sullivan, Chief Finance Officer, attended 19 July 2017
- Alison Gale, Deputy Chief Finance Officer, attended 24 January 2018

2.4 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 Principal Associate, employed by the CCG’s HR provider; South, Central and West CSU (SCW). The Committee retained the services of the named HR resource ensuring continuity of advice for the remuneration committee. 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.

2.5 Our Remuneration Committee was satisfied that the advice received was objective and independent due to the objective nature of the data provided and the fact that the service provider had no other association or involvement with our CCG Officers or Senior Employees.

3 Policy Statement on Remuneration of Senior Managers for current and future years

3.1 In setting levels of remuneration, the Remuneration Committee takes into account national guidance for CCGs, CCG benchmarking, locally prevailing employment conditions and the levels of responsibility associated with each post. In addition, the Committee has access to, and takes advice from, a named HR Specialist, employed by South, Central and West CSU.

3.2 The current remuneration policy does not specify performance related awards or targets and amendments to remuneration are considered and determined annually by the Committee.
3.3 In determining the payment made to Office Holders on the Governing Body, the Remuneration Committee considered the rates for comparable NHS organisations as well as the best practice terms of appointment for Lay Members provided by the NHS Commissioning Board. In determining the pay and conditions for the Senior Employees, consideration was given to NHS Very Senior Managers and Agenda for Change Terms and Conditions.

4 Methods Used to Assess Whether Performance Conditions were met, and why those methods were chosen

4.1 The performance of Executives is monitored through an annual appraisal process based on organisational and individual objectives. Any recommendations for remuneration review are submitted to our Remuneration Committee prior to any decision being taken. The committee, in reaching a decision, ensures equitable methodology is applied.

4.2 The performance of other Governing Body Members is the responsibility of the CCG Chair and is based on an annual review process.

4.3 No elements of the remuneration packages for our Chief Officer, or other Governing Body members, are directly linked to performance.

5 Policy on Duration of Senior Manager Contracts; notice periods and termination payments

5.1 Our Chief Officer and Chief Finance Officer on the CCG Governing Body are substantive employees and have permanent contracts which mirror the national terms and conditions of service of the national Very Senior Manager contracts and provide for a notice period of six months from the employee and six months from the employer. The contracts include the ability for our CCG to enact a 'pay in lieu of notice' clause and there are no special contractual compensation provisions or any other form of termination payment.

5.2 The GP, Lay and Independent Clinical Members on our Governing Body are Office Holders and their terms of appointment provide that the individual may step down from Office at any time with the expectation of three months' notice (with the exception of the Chair for whom the notice period is six months). In the event of disqualification from holding Office, or a motion of no confidence from the membership, the CCG may terminate the appointment with no specified minimum notice period. There are no special contractual compensation provisions for early termination or any other form of termination payment.

6 Senior Managers Service Contracts (Current)
6.1 Below are the contractual details of the employees on our Governing Body who served in 2017/18:

**Amanda Philpott, Chief Officer for NHS Hastings and Rother CCG (Joint Appointment with NHS Eastbourne, Hailsham and Seaford CCG)**

Appointed 1 April 2013, permanent contract, six month notice period, no special contractual compensation provisions for early termination.

**John O'Sullivan, Chief Finance Officer for NHS Hastings and Rother CCG (Joint Appointment with NHS Eastbourne, Hailsham and Seaford CCG)**

Appointed 1 April 2013, permanent contract, six month notice period, no special contractual compensation provisions for early termination.

6.2 Below are the contractual details of the Office Holders on our Governing Body who served in 2017/18.

**Dr David Warden, GP member of the Governing Body and CCG Clinical Chair**

Appointed 1 April 2013, term of office until 31 March 2016. Appointed for a further term, and appointed as Clinical Chair, 1 April 2016, term of Office until 31 March 2019. Three months' notice period, no special contractual compensation provisions for early termination.

**Barbara Beaton, Lay Member on the Governing Body**

Appointed 1 April 2013, term of office until 6 January 2016. Term extended to 30 April 2016. Appointed for a further term 1 May 2016 to 30 April 2019. Three months' notice period, no special contractual compensation provisions for early termination.

**Dr Binodh Bhaskaran, GP Member of the Governing Body**

Appointed 1 April 2016, term of office until 31 March 2019. Three months’ notice period, no special contractual compensation provisions for early termination.

**Rose Durban, Lay Member (joint appointment with NHS Eastbourne, Hailsham and Seaford CCG)**

Appointed 3 October 2016, term of office until 2 October 2019. Three month notice period, no special contractual compensation provisions for early termination.

**Dr Rajeev Dhar, Secondary Care Doctor on the Governing Body (joint appointment with NHS Eastbourne, Hailsham and Seaford CCG from 1 September 2017)**

Appointed 1 April 2013, term of office until 6 January 2016. Term extended from 1 to 31 January 2016. Appointed for a further term 1 February 2016 to 31/01/2019. Three months’ notice period, no special contractual compensation provisions for early termination.

**Karen Keane, Independent member - Registered Nurse on the Governing Body (joint appointment with NHS Eastbourne, Hailsham and Seaford CCG)**
Appointed 1 April 2013, term of office until 31 March 2016. Term was extended until 30 June 2016, and then until 31 July 2016 Appointed for a further term 1 August 2016 to 31 July 2019. Three months' notice period, no special contractual compensation provisions for early termination.

**Dr Rob McNeilly, GP Member of the Governing Body**

Appointed 1 April 2013, term of office until 31 March 2015. Appointed for a further term 1 April 2015 to 31 March 2018. Three months' notice period, no special contractual compensation provisions for early termination.

**Dr Craig Namvar, GP Member of the Governing Body**

Appointed 1 April 2015 term of office until 31 March 2018. Three months' notice period, no special contractual compensation provisions for early termination.

**Dr Milan Radia, GP Member of the Governing Body**

Appointed 1 April 2013, term of office until 31 March 2015 Appointment extended until 31 March 2017. Appointed for a further term 1 April 2017 to 31 March 2020. Three months' notice period, no special contractual compensation provisions for early termination.

**Dr Susan Rae, GP Member of the Governing Body**

Appointed 1 April 2013, term of office until 31 March 2015 Appointment extended until 31/03/2017, 3 months' notice period, no special contractual compensation provisions for early termination. Appointed for a further term 1 April 2017 to 31 March 2020. Resigned with effect from 31 March 2018.

**Alan Rummins, Lay Member on the Governing Body**


7 **Senior Managers Service Contracts (past)**

7.1 There are no past Senior Managers who served on the Governing Body in 2017/18.

8 **Remuneration of Very Senior Managers**

8.1 There are no senior managers of the CCG who are paid more than £142,500 per annum.

9 **Remuneration Tables**

*This section falls within the auditable part of the remuneration report*
No senior managers received benefits in kind or waived remuneration in the financial year.

The amount included in the column headed "all pension related benefits" represents the increase in pension entitlement and lump sum over 20 years. It is calculated using the method set out in the Finance Act 2004 (1) and is expressed in bands of £2,500.

Pension benefits as at 31 March 2018

This section falls within the auditable part of the remuneration report

Hastings and Rother Clinical Commissioning Group Annual Report and Accounts 2017/18

---

<table>
<thead>
<tr>
<th>Name and title</th>
<th>Shared Staff Full salary (bands of £5,000)</th>
<th>Salary &amp; Fees (bands of £5,000)</th>
<th>Taxable Benefits (rounded to nearest £000)</th>
<th>Annual Performance Related Bonuses (bands of £5,000)</th>
<th>Long-term Performance Related Bonuses (bands of £5,000)</th>
<th>All Pension Related Benefits (bands of £2,500)</th>
<th>Total (bands of £5,000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amanda Philpott, Chief Officer (shared)</td>
<td>140 - 145</td>
<td>70 - 75</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>7 - 10</td>
<td>50 - 55</td>
</tr>
<tr>
<td>John O’Sullivan, Chief Finance Officer (shared)</td>
<td>110 - 115</td>
<td>55 - 60</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>2.5</td>
<td>55 - 60</td>
</tr>
<tr>
<td>Dr David Warden, Chair</td>
<td>55 - 60</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>55 - 60</td>
</tr>
<tr>
<td>Dr Susan Rae, GP Governing Body member</td>
<td>35 - 40</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>35 - 40</td>
</tr>
<tr>
<td>Dr Milan Radia, GP Governing Body member</td>
<td>50 - 55</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>50 - 55</td>
</tr>
<tr>
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<td>50 - 55</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>50 - 55</td>
</tr>
<tr>
<td>Dr Craig Namvar, GP Governing Body member</td>
<td>25 - 30</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>25 - 30</td>
</tr>
<tr>
<td>Dr Chanath Bhaskar, GP Governing Body member</td>
<td>25 - 30</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>25 - 30</td>
</tr>
<tr>
<td>Barbara Beaton, Lay member</td>
<td>15 - 20</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>15 - 20</td>
</tr>
<tr>
<td>Alan Rummins, Lay member</td>
<td>10 - 15</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>10 - 15</td>
</tr>
<tr>
<td>Dr Rajeev Dhar, Secondary care doctor, shared post from 01/09/17</td>
<td>5 - 10</td>
<td>5 - 10</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>5 - 10</td>
</tr>
<tr>
<td>Karen Keane, Nurse member (shared)</td>
<td>5 - 10</td>
<td>0 - 5</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>0 - 5</td>
</tr>
<tr>
<td>Rose Durban, Lay member (shared), joined 03/10/16</td>
<td>10 - 15</td>
<td>5 - 10</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>5 - 10</td>
</tr>
</tbody>
</table>

---

<table>
<thead>
<tr>
<th>Name and title</th>
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<td>Nil</td>
<td>Nil</td>
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<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>5 - 10</td>
</tr>
</tbody>
</table>
Note 1 – Where a senior manager is shared between organisations the pension details included in the table above are the gross amounts rather than the CCG’s share.

Note 2 – GP Governing Body members are not classed as officers of the CCG, they are instead paid for service and therefore no pension contributions are paid.

10 Cash Equivalent Transfer Values

10.1 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.

10.2 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.

10.3 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.

11 Real Increase in CETV

11.1 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) and uses common market valuation factors for the start and end of the period.

12 Compensation on Early Retirement or for Loss of Office

This section falls within the auditable part of the remuneration report

12.1 In the Year 2017-18 there has been no compensation paid for early retirement or loss of office paid by the CCG.
13 Payments to Past Directors

This section falls within the auditable part of the remuneration report

13.1 In the Year 2017-18 there have been no payments made to past directors.

14 Pay Multiples

This section falls within the auditable part of the remuneration report

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

14.2 The banded remuneration of the highest paid director/member in Hastings and Rother CCG in the financial year 2017/18 was £140,000 – £145,000 (2016/17: £140,000 – £145,000). This was 4.01 times (2016/17: 4.05) the median remuneration of the workforce, which was £35,577 (2016/17: £35,225). This small decrease reflected the greater increase in pay for staff on lower bands.

14.3 In 2017/18, no employees received remuneration in excess of the highest-paid director/member. Remuneration ranged from £15,671 to £141,831 (2016/17: £9,557 to £137,700).

14.4 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

15 Senior Managers by Band

<table>
<thead>
<tr>
<th>Agenda for Change (AfC) Staff Band</th>
<th>Number of staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>AfC 7</td>
<td>34</td>
</tr>
<tr>
<td>AfC 8a</td>
<td>17</td>
</tr>
<tr>
<td>AfC 8b</td>
<td>15</td>
</tr>
<tr>
<td>AfC 8c</td>
<td>6</td>
</tr>
<tr>
<td>AfC 8d</td>
<td>7</td>
</tr>
<tr>
<td>AfC 9</td>
<td>3</td>
</tr>
<tr>
<td>VSM</td>
<td>2</td>
</tr>
</tbody>
</table>

16 Staff Numbers

This section falls within the auditable part of the remuneration report

16.1 On 31 March 2018 there were 179 staff employed by the CCG (each working for both this and Eastbourne, Hailsham and Seaford CCG).

Note: The figures in this report count individual staff members. Figures in the table below from note 4.2 of the Accounts show whole time equivalents.
17 Staff Composition

17.1 The gender breakdown of our Governing Body and other employees, again on 31 March 2017, is shown in the table below:

<table>
<thead>
<tr>
<th>Group</th>
<th>Female</th>
<th>Percentage</th>
<th>Male</th>
<th>Percentage</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Governing Body</td>
<td>6</td>
<td>42%</td>
<td>8</td>
<td>58%</td>
<td>14</td>
</tr>
<tr>
<td>CCG Staff and senior managers*</td>
<td>136*</td>
<td>78.61%</td>
<td>37*</td>
<td>21.38%</td>
<td>173*</td>
</tr>
</tbody>
</table>

*Fully shared with Eastbourne, Hailsham and Seaford CCG

18 Sickness Absence Data

18.1 The sickness rate is described in the table below:

<table>
<thead>
<tr>
<th>Total Staff Absence (in days)</th>
<th>Total Staff Years Worked</th>
<th>Average Days Lost (Per Staff Year Worked)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1728</td>
<td>178</td>
<td>9.7</td>
</tr>
</tbody>
</table>

18.2 Across the joint staffing team, with Eastbourne, Hailsham and Seaford CCG, 1728 days were lost in 2017/18.

- 930 days (53%) resulted from 15 episodes of long term sick (+28 days)
- 14 episodes lasted 14 days or longer; accounting for at least 324 days (18%)

18.3 The remaining absences (less than 474 days or 27%) comprised individual episodes of sickness.

19 Disabled Employees

19.1 All recruitment is carried out in line with policy, so that all protected characteristics as defined by the Equality Act 2010, including disabilities, are taken into account.

Hastings and Rother Clinical Commissioning Group Annual Report and Accounts 2017/18
and any reasonable adjustments made. All new appointees are required to be cleared by Occupational Health and are offered an appointment if necessary, to address any specific issues which will allow our CCG to put any reasonable adjustments in place to support an employee whilst at work. Throughout the employee’s time with the CCG, any new or on-going health issues are also addressed with the Occupational Health provider. This is to ensure that appropriate support is in place for the employee throughout their career with our CCG.

19.2 Our Human Resources policies are updated through a managed process in partnership with the Joint Staff Committee. This is led by our HR provider. The following policies have been in place throughout the year. Of the policies listed below (including relevant Health and Safety policies), those with an asterisk either assist us in its support of applicants and employees who have disabilities or assist us in identifying and combatting any discriminatory behaviour:

- Absence and Attendance Management *
- Annual leave
- Development Review (Appraisal)
- Dignity at Work (Bullying and Harassment) *
- Disciplinary *
- Display Screen Equipment *
- Equality and Diversity
- Family leave (maternity, maternity support (paternity), shared parental leave, adoption)
- Fire Safety *
- Flexible working *
- Freedom to Speak Up (Whistleblowing) *
- Individual Grievance *
- Learning and development *
- Leavers
- Lone Worker
- Management of organisational change
- Pay protection
- Performance and Capability
- Professional registration
- Recruitment and selection (inc DBS checks and recruitment of ex-offenders, starting salaries and pay progression, job evaluation process guidance and prevention of illegal working) *
- Recognition and facilities agreement with staff organisations
- Remote working
- Secondment (includes acting up)
- Special leave *
- Substance misuse
- Supervision
- Work experience
20 Trade Union (Facility Time Publication Requirements)

20.1 The CCG acknowledges that it is to the mutual benefit of the CCG and its staff for them to be represented by Trade Unions / Staff Organisations and encourages its employees to belong to an appropriate staff organisation, although membership is not a condition of employment.

20.2 The Recognition and Facilities Agreement (available to all staff on the Intranet) sets out the arrangements for consultation and negotiation on matters of common interest, with due regard for the ACAS Codes of Practice\(^{35}\).

20.3 As a small organisation the CCG works with other Clinical Commissioning Groups through a Joint Staffing Committee where union representation from across Sussex meets with management in a constructive and collaborative way to ensure that, in the absence of any representation from within the CCG staff group, representatives of those unions are still involved in the consultation arrangements.

20.4 The following information is published in accordance with the Statutory Instrument 2017 No. 328, The Trade Union (Facility Time Publication Requirements) Regulations 2017.

20.5 The total number of employees who were relevant union officials during the relevant period (Table 1):

<table>
<thead>
<tr>
<th>Number of employees who were relevant union officials during the relevant period</th>
<th>Full-time equivalent employee number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nil</td>
<td>Nil</td>
</tr>
</tbody>
</table>

20.6 The percentage of their working hours spent on facility time (Table 2):

<table>
<thead>
<tr>
<th>Percentage of time</th>
<th>Number of employees</th>
</tr>
</thead>
<tbody>
<tr>
<td>0%</td>
<td>Nil</td>
</tr>
<tr>
<td>1-50%</td>
<td>Nil</td>
</tr>
<tr>
<td>51-99%</td>
<td>Nil</td>
</tr>
<tr>
<td>100%</td>
<td>Nil</td>
</tr>
</tbody>
</table>

20.7 Percentage of pay bill spent on facility time (Table 3):

<table>
<thead>
<tr>
<th>Total cost of facility time</th>
<th>Nil</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total pay bill</td>
<td>£4,287,000</td>
</tr>
</tbody>
</table>


Hastings and Rother Clinical Commissioning Group Annual Report and Accounts 2017/18
20.8 The number of hours, as a percentage of total paid facility time, spent by employees who were relevant union officials on paid trade union activities (Table 4):

<table>
<thead>
<tr>
<th>Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as:</th>
</tr>
</thead>
<tbody>
<tr>
<td>(total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) x 100</td>
</tr>
<tr>
<td>Nil</td>
</tr>
</tbody>
</table>

21 Whistleblowing

21.1 The CCG has adopted the standard integrated policy on Whistleblowing as recommended in the Freedom to Speak Up review by Sir Robert Francis into whistleblowing in the NHS. The policy is available on the intranet for all staff to access.

21.2 In accordance with the duty of candour, CCG senior managers and the governing body are committed to an open and honest culture. The CCG will look into what its staff say and staff will have access to any support needed. To protect staff who make disclosures, any person who victimises someone who has raised genuine concerns under this policy will be subject to disciplinary action.

21.3 CCG local processes have been integrated into the policy and adhere to the principles of the policy.

21.4 There are prominent contact details for:

- CCG Freedom to Speak Up Guardian;
- National Freedom to Speak Up Guardian;
- Director with responsibility for Whistleblowing;
- Lay members with responsibility for Whistleblowing;
- CCG Caldicott Guardians for safeguarding patient information;
- Counter Fraud Manager;
- Staff Counselling Services; and
- Occupational Health.

21.5 During 2017/18 there were no whistleblowing incidents.

22 Expenditure on Consultancy (greater than £220 per day and longer than 6 months)

<table>
<thead>
<tr>
<th>Consultancy</th>
<th>£</th>
</tr>
</thead>
</table>

Hastings and Rother Clinical Commissioning Group Annual Report and Accounts 2017/18
Table 1: Off-payroll engagements longer than 6 months

For all off-payroll engagements as at 31 March 2018, for more than £220 per day and that last longer than six months:

<table>
<thead>
<tr>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of existing engagements as of 31 March 2018</td>
</tr>
<tr>
<td>Of which, the number that have existed:</td>
</tr>
<tr>
<td>for less than one year at the time of reporting</td>
</tr>
<tr>
<td>for between one and two years at the time of reporting</td>
</tr>
<tr>
<td>for between 2 and 3 years at the time of reporting</td>
</tr>
<tr>
<td>for between 3 and 4 years at the time of reporting</td>
</tr>
<tr>
<td>for 4 or more years at the time of reporting</td>
</tr>
</tbody>
</table>

Table 2: New off-payroll engagements

For all new off-payroll engagements between 01 April 2017 and 31 March 2018, for more than £220 per day and that last longer than six months:

<table>
<thead>
<tr>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of new engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018</td>
</tr>
<tr>
<td>Number of new engagements which include contractual clauses giving Hastings and Rother CCG the right to request assurance in relation to income tax and National Insurance obligations</td>
</tr>
<tr>
<td>Number for whom assurance has been requested</td>
</tr>
<tr>
<td>Of which:</td>
</tr>
<tr>
<td>assurance has been received</td>
</tr>
<tr>
<td>assurance has not been received</td>
</tr>
<tr>
<td>engagements terminated as a result of assurance not being received.</td>
</tr>
</tbody>
</table>

Table 3: 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 2017 and 31 March 2018.

<table>
<thead>
<tr>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year.</td>
</tr>
<tr>
<td>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.</td>
</tr>
</tbody>
</table>
23.4 Our GP Governing Body members are not classed as officers of the CCG, they are instead paid for service and are therefore classed as ‘off-payroll’. The CCG assures itself of the regularity of tax arrangements for our GP Governing Body members by making payment for service with tax and National Insurance deducted at source.

24 **Exit Packages, including special (non-contractual) payments**

*This section falls within the auditable part of the remuneration report*

24.1 In the Year 2017/18 there were no exit payments or severance packages.
SECTION 3 – Parliamentary Accountability and Audit Report

1.1. Hastings and Rother CCG is not required to produce a Parliamentary Accountability and Audit Report but has opted to include disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges in this Accountability Report at paragraphs 1.2 to 1.5 below. An audit certificate and report is also included in this Annual Report.

1.2. The CCG does not have any remote contingent liabilities in 2017/18,

1.3. The CCG did not have any losses and special payments in 2017/18,

1.4. The CCG publishes a register of gifts and hospitality on the internet on a quarterly basis.\footnote{http://www.hastingsandrotherccg.nhs.uk/search/?q=gifts}

1.5. The CCG did not have any fees and charges to disclose in 2017/18.
The Independent Auditor’s Report to the Members of the Governing Body
INDEPENDENT AUDITOR’S REPORT TO THE MEMBERS OF THE GOVERNING BODY OF NHS HASTINGS & ROTHER CCG

Opinion on financial statements

We have audited the financial statements of NHS Hastings & Rother Clinical Commissioning Group (the CCG) for the year ended 31 March 2018 which 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 notes to the financial statements, including a summary of significant accounting policies. 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 2017-18 Government Financial Reporting Manual as contained in the Department of Health and Social Care Group Accounting Manual 2017-18 and the Accounts Directions issued by NHS England (the Accounts Directions).

In our opinion the financial statements:

• give a true and fair view of the financial position of NHS Hastings & Rother CCG as at 31 March 2018 and of its net expenditure for the year then ended; and

• have been properly prepared in accordance with the Accounts Directions.

Basis for opinion on financial statements

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. We are independent of the CCG 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 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.

Use of our report

This report is made solely to the Members of the Governing Body of NHS Hastings & Rother CCG, as a body, in accordance with part 5 of the Local Audit and Accountability Act 2014 and as set out in paragraph 43 of the Statement of Responsibilities of Auditors and Audited Bodies published by the National Audit Office in April 2015. Our audit work has been undertaken so that we might state to the Members of the Governing Body 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 CCG and the Members of the Governing Body of the CCG, as a body, for our audit work, this report, or for the opinions we have formed.

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 CCG’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 Accountable Officer is responsible for the other information. The other information comprises the information included in the annual report, other than the financial statements and our auditor’s report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our 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 this other information, we are required to report that fact.

We have nothing to report in this regard.

Qualified opinion on regularity

In our opinion, except for the matters described in the Basis for qualified opinion on regularity section of our report, in all material respects the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions in the financial statements conform to the authorities which govern them.

Basis for qualified opinion on regularity

NHS Hastings & Rother CCG has a number of duties under the National Health Service Act 2006 (as amended) and in 2017/18 it did not meet the following three financial duties:

1. Expenditure not to exceed income;
2. Revenue resource use does not exceed the amount specified in Directions; and
3. Revenue resource use on Primary Care Co-Commissioning does not exceed the amount specified in Directions.

Opinion on information in the Remuneration and Staff Report

We have also audited the information in the Remuneration and Staff Report that is subject to audit, being:

- the table of salaries and allowances of senior managers and related narrative notes;
- the table of pension benefits of senior managers, and related narrative notes;
- the analysis of staff numbers; and
- the table of pay multiples.

In our opinion the parts of the Remuneration Report to be audited have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2017-18.

Matters on which we are required to report by exception

Adverse conclusion on use of resources

On the basis of our work, having regard to the guidance issued by the Comptroller & Auditor General in November 2017, because of the significance of the matters referred to in the Basis for adverse conclusion on use of resources section of our report, we are not satisfied that, in all significant respects, NHS Hastings & Rother CCG put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018.
**Basis for adverse conclusion on use of resources**

NHS Hastings & Rother CCG reported a deficit of £10.1 million in its financial statements for the year ending 31 March 2018, indicating a breach of 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 ensure that expenditure did not exceed income and that revenue resource used on specified matters did not exceed the amount specified in Directions.

The failure of the CCG to meet its financial targets and the scale of the task it faces to bring the CCG to a position of financial sustainability is evidence of significant weaknesses in arrangements to ensure that the CCG deployed its resources to achieve planned and sustainable outcomes for taxpayers and local people.

**Report to the Secretary of State**

On 18 April 2018 we reported to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 that NHS Hastings & Rother CCG had advised us that it had incurred unlawful expenditure above its allotted funding and that revenue resource used exceeded the amount specified in Directions for 2017/18.

**Other matters**

We have nothing to report in respect of the following other matters in relation which the Local Audit and Accountability Act 2014 requires us to report to you if:

- in our opinion the Governance statement does not comply with the guidance issued by the NHS England; or
- except as reported above 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; 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.

**Responsibilities of the Accountable Officer**

As explained more fully in the Statement of Accountable Officer Responsibilities, 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 for such internal control as the Accountable Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Accountable Officer is responsible for assessing the CCG’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 liquidate the CCG or to cease operations, or have no realistic alternative but to do so.

As explained in the Statement of the Accountable Officer Responsibilities, the Accountable Officer is also responsible for the propriety and regularity of the public finances for which the Accountable Officer is answerable and for ensuring the CCG exercises its functions effectively, efficiently and economically.
Auditor’s responsibilities for the audit of the financial statements

In respect of our 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 at the Financial Reporting Council’s website at: https://www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor’s report.

Auditor’s other responsibilities

In addition to our audit of the financial statements 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 statements conform to the authorities which govern them.

We are also required under section 21(3)(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.

As set out in the Matters on which we report by exception section of our report there are certain other matters which we are required to report by exception.

Certificate

We certify that we have completed the audit of the accounts of NHS Hastings & Rother CCG in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice issued by the National Audit Office.

Greg Rubins

For and on behalf of BDO LLP, Appointed Auditor
Southampton, UK
24 May 2018

BDO LLP is a limited liability partnership registered in England and Wales (with registered number OC305127).
FINANCIAL STATEMENTS