NHS
West Hampshire
Clinical Commissioning Group

NHS WEST HAMPSHIRE

CLINICAL COMMISSIONING GROUP

CONSTITUTION

APPENDICES

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Individual appendices have been updated to reflect changes approved by the CCG Board and its Committees since the Constitution was last approved by NHS England.

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APPENDIX A: DEFINITIONS OF KEY DESCRIPTIONS USED IN THIS CONSTITUTION

2006 Act	National Health Service Act 2006
2012 Act	Health and Social Care Act 2012 (this Act amends the 2006 Act)
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Area	the geographical area that the group has responsibility for, as defined in Chapter 2 of this constitution
Board	the body appointed under section 14L of the NHS Act 2006 (as inserted by section 25 of the 2012 Act), with the main function of ensuring that a clinical commissioning group has made appropriate arrangements for ensuring that it complies with: • its obligations under section 14Q under the NHS Act 2006 (as inserted by section 26 of the 2012 Act), and such generally accepted principles of good governance as are relevant to it.
Board member	any member appointed to the Board of the group
Chairman of the Board	the individual appointed by the group to act as Chairman of the Board
Chief finance officer	the qualified accountant employed by the group with responsibility for financial strategy, financial management and financial governance
Chief Officer	an individual, as defined under paragraph 12 of Schedule 1A of the 2006 Act (as inserted by Schedule 2 of the 2012 Act), appointed by NHS England, with responsibility for ensuring the group: • complies with its obligations under: o sections 14Q and 14R of the 2006 Act (as inserted by section 26 of the 2012 Act), o sections 223H to 223J of the 2006 Act (as inserted by section 27 of the 2012 Act), o paragraphs 17 to 19 of Schedule 1A of the NHS Act 2006 (as inserted by Schedule 2 of the 2012 Act), and o any other provision of the 2006 Act (as amended by the 2012 Act) specified in a document published by the Board for that purpose; exercises its functions in a way which provides good value for money.
Clinical commissioning group	a body corporate established by NHS England in accordance with Chapter A2 of Part 2 of the 2006 Act (as inserted by section 10 of the 2012 Act)
Committee	a committee or sub-committee created and appointed by: • the membership of the group • a committee / sub-committee created by a committee created / appointed by the membership of the group • a committee / sub-committee created / appointed by the Board
Financial year	this usually runs from 1 April to 31 March, but under paragraph 17 of Schedule 1A of the 2006 Act (inserted by Schedule 2 of the 2012 Act), it can for the purposes of audit and accounts run from when a clinical commissioning group is established until the following 31 March
Group	NHS West Hampshire Clinical Commissioning Group, whose constitution this is

Lay member	a lay member of the Board, appointed by the group. A lay member is an individual who is not a member of the group or a healthcare professional (i.e. an individual who is a member of a profession regulated by a body mentioned in section 25(3) of the National Health Service Reform and Health Care Professions Act 2002) or as otherwise defined in regulations
Member	a provider of primary medical services to a registered patient list, who is a member of this group (see tables in Chapter 3 and Appendix B)
Practice representatives	an individual appointed by a practice (who is a member of the group) to act on its behalf in the dealings between it and the group, under regulations made under section 89 or 94 of the 2006 Act (as amended by section 28 of the 2012 Act) or directions under section 98A of the 2006 Act (as inserted by section 49 of the 2012 Act)
Registers of interests	registers a group is required to maintain and make publicly available under section 140 of the 2006 Act (as inserted by section 25 of the 2012 Act), of the interests of: • the members of the group; • the members of its Board; • the members of its committees or sub-committees and committees or sub-committees of its Board; and • its employees.

APPENDIX B: LIST OF MEMBER PRACTICES

Practice Name	Address
Andover Locality	
The Adelaide Medical Centre	Adelaide Road, Andover SP10 1HA
The Andover Hc Medical Practice	Charlton Road, Andover SP10 3LD
Charlton Hill Surgery	Charlton Rd, Andover SP10 3JY
Two Rivers Medical Partnership (also known as Whitchurch Surgery and Derrydown Clinic)	Derry Down Clinic, Derry Down, St Marys Otterbourne, Andover SP11 BS Whitchurch Surgery, Bell Street, Whitchurch, Hampshire RG28 7AE
Shepherd Spring Medical Centre	The Oval, Andover SP10 5DE
St Mary's Surgery	Church Close, Andover SP10 1DP
Eastleigh North and Test Valley South Locality	
Abbeywell Surgery	Abbey Mead Surgery, The Abbey, Romsey SO51 8EN Nightingale Surgery, Great Well Drive, Romsey SO51 7QN
Alma Road Surgery	Alma Road, Romsey, SO51 8ED
The Archers Practice	Eastleigh Health Centre/Newtown Road, Eastleigh SO50 9AG
Boyatt Wood Surgery	Boyatt Shopping Centre, Shakespeare Road, Eastleigh SO50 4QP
The Fryern Surgery	Oakmount Road, Chandler's Ford, Eastleigh SO53 2LH
North Baddesley Health Centre	Norton Welch Close, Fleming Avenue, North Baddesley, Southampton SO52 9EP Knightwood Surgery, Pilgrims Close, Chandlers Ford, Eastleigh SO53 4SD
Park & St Francis Surgeries	Chandlers Ford, Eastleigh SO53 2ZH
Parkside Family Practice	Eastleigh Health Centre, Newtown Road, Eastleigh SO50 9AG
St Andrew's Surgery	166 Market Street, Eastleigh SO50 5PT
Eastleigh Southern Parishes Locality	
Blackthorn Health Centre	Satchell Lane, Hamble, Southampton SO31 4NQ
Bursledon Surgery	7 Manor Crescent, Bursledon, Southampton SO31 8DQ
Hedge End Medical Centre	24 Lower Northam Road, Hedge End, Southampton SO30 4FQ
St Luke's & Botley Surgery	St Lukes Close, Hedge End, Southampton SO30 2US
West End Surgery	Moorgreen Road, Southampton SO30 3PY
Totton & Waterside Locality	
Forestgate Surgery	Hazel Farm Road, Totton, Southampton SO40 8WU
Forestside Medical Centre	Beaulieu Road, Dibden Purlieu, Southampton SO45 4JA
The Red & Green Practice	Blackfield Health Centre Hampton Lane, Blackfield, Southampton SO45 1XA
Testvale Surgery	12 Salisbury Road, Totton, Southampton SO40 3PY

Practice Name	Address
Totton Health Centre	Testwood Lane, Totton, Southampton SO40 3ZN
Waterfront and Solent Surgery	Jones Lane, Hythe, Southampton SO45 6AW
West New Forest Locality	
The Arnewood Practice	Avenue Road, New Milton BH25 5JP
Barton and Web-Peploe Partnership	Barton Surgery, 1 Edmunds Close, Barton-on-Sea BH25 7EN
Chawton House Surgery	St Thomas Street,Lymington,SO41 9ND
Cornerways Medical Centre	5 Parkers Close Ringwood BH24 1SD
The Fordingbridge Surgery	Bartons Road, Fordingbridge SP6 1RS
Lyndhurst Surgery	2 Church Lane, Lyndhurst SO43 7EW
New Forest Central Medical Group	Brockenhurst Surgery Highwood Road, Brockenhurst SO42 7RY
New Milton Health Centre	Spencer Road, New Milton BH25 6EN,
Ringwood Medical Centre	The Close, Ringwood BH24 1JY
Twin Oaks Medical Centre	Ringwood Road, Bransgore BH23 8AD
Wistaria Surgery and Milford Medical Centre	Wistaria Court, 18 Avenue Road, Lymington SO41 9GJ
Winchester Locality	
Alresford Surgery	Station Road, Alresford SO24 9JL
Bishops Waltham Surgery	The Surgery, Lower Lane, Bishops Waltham SO32 1GR
The Friarsgate Practice	Stockbridge Road (corner of Stoney Lane) Weeke, Winchester SO22 6EL
Gratton Surgery	Gratton Close, Sutton Scottney, Winchester SO21 3LE
St Clements Surgery	Tanner Street, Winchester SO23 8AD
St Paul's Surgery	Alison Way, Winchester SO22 5DD
Stockbridge Surgery	New Street, Stockbridge SO20 6HG
Stokewood & Old Anchor Surgeries	Fair Oak Road, Eastleigh SO50 8AU Riverside, Eastleigh SO50 6LQ
Twyford Surgery	Hazeley Road, Twyford, Winchester SO21 1QY
Watercress Medical Group	Mansfield Park Surgery, Lymington Bottom Road, Medstead GU34 5EW
West Meon Surgery	Lane West Meon Petersfield GU32 1LR
Wickham Group Surgery	Station Road, Wickham, Fareham PO17 5JL

APPENDIX C: STANDING ORDERS

1. STATUTORY FRAMEWORK AND STATUS

1.1. Introduction

1.1.1. These standing orders have been drawn up to regulate the proceedings of the NHS West Hampshire Clinical Commissioning Group so that group can fulfil its obligations, as set out largely in the 2006 Act, as amended by the 2012 Act and related regulations. They are effective from the date the group is established.

1.1.2. The standing orders, together with the group's scheme of reservation and delegation[1] and the group's prime financial policies[2], provide a procedural framework within which the group discharges its business. They set out:

a) the arrangements for conducting the business of the group;

b) the appointment of member practice representatives;

c) the procedure to be followed at meetings of the group, the Board and any committees or sub-committees of the group or the Board;

d) the process to delegate powers,

e) the declaration of interests and standards of conduct.

These arrangements must comply, and be consistent where applicable, with requirements set out in the 2006 Act (as amended by the 2012 Act) and related regulations and take account as appropriate[3] of any relevant guidance.

1.1.3. The standing orders, scheme of reservation and delegation and prime financial policies have effect as if incorporated into the group's constitution. Group members, employees, members of the Board, members of the Board's committees and sub-committees, members of the group's committees and sub-committees and persons working on behalf of the group should be aware of the existence of these documents and, where necessary, be familiar with their detailed provisions. Failure to comply with the standing orders, scheme of reservation and delegation and prime financial policies may be regarded as a disciplinary matter that could result in dismissal.

1.2. Schedule of matters reserved to the clinical commissioning group and the scheme of reservation and delegation

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[1] See Appendix D

[2] See Appendix E

[3] Under some legislative provisions the group is obliged to have regard to particular guidance but under other circumstances guidance is issued as best practice guidance.

1.2.1. The 2006 Act (as amended by the 2012 Act) provides the group with powers to delegate the group's functions and those of the Board to certain bodies (such as committees) and certain persons. The group has decided that certain decisions may only be exercised by the group in formal session. These decisions and also those delegated are contained in the group's scheme of reservation and delegation (see Appendix D).

2. THE CLINICAL COMMISSIONING GROUP: COMPOSITION OF MEMBERSHIP, KEY ROLES AND APPOINTMENT PROCESS

2.1. Composition of membership

2.1.1. Chapter 3 of the group's constitution provides details of the membership of the group (also see Appendix B).

2.1.2. Chapter 6 of the group's constitution provides details of the governing structure used in the group's decision-making processes, whilst Chapter 7 of the constitution outlines certain key roles and responsibilities within the group and its Board, including the role of practice representatives (section 7.1 of the constitution).

2.2. Clinical accountability

2.2.1. The Board is accountable to the membership. Each member practice is represented by an individual from the practice and this group of individuals, will meet twice yearly as the Membership Group.

2.2.2. Two-thirds of this group, 33 members, can among other things take a vote of no confidence in the elected members of the Board and expect a process of election to take place. There will also be the opportunity to call additional meetings if required (see Section 3 of the Standing Orders).

2.2.3. The CCG area is divided into 6 localities and there is a lead from each of these localities who is a voting member of the Clinical Cabinet and Board representing the patient population and membership within that locality.

2.3. Key Roles

2.3.1. Paragraph 6.9.2 of the group's constitution sets out the composition of the group's Board whilst Chapter 7 of the group's constitution identifies certain key roles and responsibilities within the group and its Board. These standing orders set out how the group appoints individuals to these key roles.

2.3.2. The **Clinical Chairman** as listed in paragraphs 3.3 and 6.9.2 of the group's constitution, is subject to the following appointment process:

a) *Nominations* – the Clinical Chairman will be nominated by written confirmation of support from a West Hampshire CCG member practice, and submitted to the Chief Officer (or his/her nominated individual).

b) *Eligibility* – The Chairman shall be general practitioner practising in West Hampshire CCG member practices, whether as a partners, non-partner or locum. Further detail regarding the eligibility for Clinical Board members is set out in paragraph 3.4 of the group's constitution.

c) *Appointment process* – all nominations for Clinical Chairman will subject to a pre-selection process to ensure that they have the required skills and experience to be a Board member and to undertake the role of Chairman. The selection process will involve an interview with an appropriately constituted panel including the CCG Chief Officer, a lay member of the Board and an external GP assessor. The nominees would also need to meet national guidance on the selection process for appointment. Once this process has been completed elections to the Board shall be conducted by the Local Medical Committee (LMC).

d) *Term of office* – the Chairman shall remain in post for a period of five years.

e) *Eligibility for reappointment* – The Chairman is eligible for reappointment.

f) *Grounds for removal from office* – the Chairman could be removed from office by NHS England and:

– if they are, or subsequently become:

i) retired from the practice or primary care service provider;
ii) suspended by either the GMC or the CCG or any successor body;
iii) subject to serious misconduct proceedings;
iv) subject to a vote of no confidence by members of the group, in line with section 2.2.2 of these standing orders;
v) the Nominating Practice ceases to be eligible for membership;
vi) that Member ceases to hold a contract for the provision of primary medical services within the Area of the Clinical Commissioning Group;
vii) not eligible to work in the UK;
viii) subject to a bankruptcy restrictions order or an interim bankruptcy restrictions order;
ix) in the last five years been dismissed from employment by a health service body otherwise than because of redundancy;
x) a person who has received a prison sentence or suspended sentence of three months or more in the last five years;
xi) a person who has been dismissed by a former employer (within or outside the NHS) on the grounds of misconduct within the last 5 years;
xii) a person who has at any time been removed from the management or control of a charity

xiii) a person who is under a disqualification order under the Company Directors Disqualification Act 1986 or the Company Directors Disqualification (Northern Ireland) Order 2002, or an order made under section 429(2) of the Insolvency Act 1986 (disabilities on revocation of administration order against an individual);
xiv) any other circumstances described in the HR policies.

g) *Notice period* – six months prior written notice to the Board.

2.3.3. The **Chief Officer** as listed in paragraph 6.9.2 of the group's constitution, is subject to the following appointment process:

a) *Nominations* – The Chief Officer shall not be subject to election but shall be appointed subject to a formal application and interview process, meeting national guidance on the selection process for appointment.

b) *Eligibility* – The Chief Officer shall be either a GP who is a member of the CCG or an employee or member of the CCG. Where the Chief Officer is a clinician, the Board will appoint a very senior manager to take operational responsibility to ensure that robust systems and processes are in place. Where the Chief Officer is a manager, the senior clinical lead shall take the role of Chairman of the Board ensuring that the CCG is clinically led and clinically accountable.

c) *Appointment process* – selection and nomination by the Board, for approval by NHS England.

d) *Term of office* – not applicable

e) *Eligibility for reappointment* – not applicable

f) *Grounds for removal from office* – the Chief Officer can be removed from office by the Board of the CCG:

- If they are or subsequently become:

i) retired from the practice or primary care service provider (if the Chief Officer is a GP);
ii) the Practice ceases to be eligible for membership (if the Chief Officer is a GP);
iii) that Member ceases to hold a contract for the provision of primary medical services within the Area of the Clinical Commissioning Group (if the Chief Officer is a GP);
iv) suspended by either the GMC (if the Chief Officer is a GP), the CCG or any successor body;
v) subject to serious misconduct proceedings;
vi) not eligible to work in the UK;
vii) subject to a bankruptcy restrictions order or an interim bankruptcy restrictions order;

viii) in the last five years been dismissed from employment by a health service body otherwise than because of redundancy;
ix) a person who has received a prison sentence or suspended sentence of three months or more in the last five years;
x) a person who has been dismissed by a former employer (within or outside the NHS) on the grounds of misconduct within the last 5 years;
xi) a person who has at any time been removed from the management or control of a charity
xii) a person who is under a disqualification order under the Company Directors Disqualification Act 1986 or the Company Directors Disqualification (Northern Ireland) Order 2002, or an order made under section 429(2) of the Insolvency Act 1986 (disabilities on revocation of administration order against an individual);
xiii) any other circumstances described in the HR policies.

g) *Notice period* – six months prior written notice to the Board.

2.3.4. The **Locality Clinical Directors** (GP Clinical Board Members**),** comprising one elected member from within each of the six CCG Localities (as listed in paragraphs 3.3 and 6.9.2 of the group's constitution), are subject to the following appointment process:

a) *Nominations* – Nominations for Locality Clinical Directors must be submitted to the Clinical Chairman, accompanied by written confirmation of support from a West Hampshire CCG member practice located within their respective locality.

b) *Eligibility* – GPs practising in West Hampshire CCG member practices, whether they be partners, non-partners or locums. The GP must meet prevailing revalidation standards.

c) *Appointment process* – all nominations for Locality Clinical Director roles will be interviewed to ensure that they have the required skills and experience to be a Board member. This interview will take place with an appropriately constituted panel including the CCG Chief Officer, a lay member of the Board and the Clinical Chairman. All nominees successfully completing this process will be confirmed as candidates for an election within their respective locality, administered by the respective Director of Commissioning. , ..;

d) *Term of office* – shall remain in post for a period of three years;

e) *Eligibility for reappointment* – A Locality Clinical Director is eligible for reappointment.

f) *Grounds for removal from office* – Locality Clinical Directors will be removed from office if they are, or subsequently become:

i) retired from the practice or primary care service provider,
ii) suspended by either the GMC or the CCG or any successor body;
iii) subject to serious misconduct proceedings;
iv) subject to a vote of no confidence by members of the group, in line with section 2.2.2 of these standing orders;
v) the Practice ceases to be eligible for membership;
vi) that Member ceases to hold a contract for the provision of primary medical services within the Area of the Clinical Commissioning Group;
vii) not eligible to work in the UK;
viii) subject to a bankruptcy restrictions order or an interim bankruptcy restrictions order;
ix) in the last five years been dismissed from employment by a health service body otherwise than because of redundancy;
x) a person who has received a prison sentence or suspended sentence of three months or more in the last five years;
xi) a person who has been dismissed by a former employer (within or outside the NHS) on the grounds of misconduct within the last 5 years;
xii) a person who has at any time been removed from the management or control of a charity;
xiii) a person who is under a disqualification order under the Company Directors Disqualification Act 1986 or the Company Directors Disqualification (Northern Ireland) Order 2002, or an order made under section 429(2) of the Insolvency Act 1986 (disabilities on revocation of administration order against an individual);
xiv) any other circumstances described in the HR policies.

g) *Notice period* – six months prior written notice to the Board.

h) *Deputising for the Clinical Chairman* – occasionally one of the Locality Clinical Directors will be asked to undertake the role of Vice Clinical Chairman. This is an ad-hoc arrangement, performed only in the absence of the Clinical Chairman

2.3.6 The **Lay Members** as listed in paragraph 6.9.2 of the group's constitution, is subject to the following appointment process:

a) *Nominations* – this will be open competition, with an interview process;

b) *Eligibility* – the lay members shall reside or work within the area covered by the West Hampshire CCG. One lay member will have recent financial and audit experience and another member will have expertise and knowledge of the local community. One of the lay members will have the additional role of Deputy Chairman of the Board and include the role of Conflicts of Interest Guardian

c) *Appointment process* – formal application and interview by an appropriately constitutedpanel which includes the CCG Chairman and Chief Officer.

d) *Term of office* - the lay members shall serve on the Board of the CCG for a period of no more than three Years.

e) *Eligibility for reappointment* - The lay members are eligible for reappointment.

f) *Grounds for removal from office* – if they are, or subsequently become:

   i) a serving civil servant within the Department of Health, or members/ employees of the Care Quality Commission;
   ii) intending to serve as a Chair or non-executive of another NHS body beyond the formal establishment of the relevant CCG;
   iii) not eligible to work in the UK;
   iv) subject to a bankruptcy restrictions order or an interim bankruptcy restrictions order;
   v) in the last five years been dismissed from employment by a health service body otherwise than because of redundancy;
   vi) a person who has received a prison sentence or suspended sentence of three months or more in the last five years;
   vii) a person who has been dismissed by a former employer (within or outside the NHS) on the grounds of misconduct within the last 5 years;
   viii) a health care professional whose registration is subject to conditions, or who is subject to proceedings before a fitness to practise committee of the relevant regulatory body, or who is the subject of an allegation or investigation which could lead to such proceedings;
   ix) a person who has at any time been removed from the management or control of a charity;
   x) a person who is under a disqualification order under the Company Directors Disqualification Act 1986 or the Company Directors Disqualification (Northern Ireland) Order 2002, or an order made under section 429(2) of the Insolvency Act 1986 (disabilities on revocation of administration order against an individual);
   xi) any other circumstances described in the HR policies.

g) *Notice period* – six months prior written notice to the Board.

2.3.7 The **Director of Quality Nursing (Board Nurse)**, as listed in paragraph 6.9.2 of the group’s constitution, is subject to the following appointment process:

a) *Nominations* – The Director of Quality & Safety (Board Nurse) will be appointed subject to a formal application and interview process.

b) *Eligibility* – a registered nurse who has developed a high level of professional expertise and knowledge and is suitably qualified.

c) *Appointment process* – formal application to the CCG and appointment by a CCG interview panel, including an external advisor.

d) *Term of office* – not applicable

e) *Eligibility for reappointment* – not applicable

f) *Grounds for removal from office* – the Director of Quality & Safety (Board Nurse) can be removed from office by the Board of the CCG

- if they are or subsequently become:

i) suspended by the NMC, or the CCG or any successor body;
ii) subject to serious misconduct proceedings;
iii) not eligible to work in the UK;
iv) subject to a bankruptcy restrictions order or an interim bankruptcy restrictions order;
v) in the last five years been dismissed from employment by a health service body otherwise than because of redundancy;
vi) a person who has received a prison sentence or suspended sentence of three months or more in the last five years;
vii) a person who has been dismissed by a former employer (within or outside the NHS) on the grounds of misconduct within the last 5 years;
viii) a person who has at any time been removed from the management or control of a charity;
ix) a person who is under a disqualification order under the Company Directors Disqualification Act 1986 or the Company Directors Disqualification (Northern Ireland) Order 2002, or an order made under section 429(2) of the Insolvency Act 1986 (disabilities on revocation of administration order against an individual);
x) any other circumstances described in the HR policies.

g) *Notice period* – three months prior written notice to the Board;

2.3.8 The **Secondary Care Specialist Doctor** as listed in paragraph 6.9.2 of the group's constitution, is subject to the following appointment process:

a) *Nominations* – formal application and interview process;

b) *Eligibility* – a doctor who is, or has been, a secondary care specialist, who has a high level of understanding of how care is delivered in a secondary care setting. Whilst the individual may well no longer practice medicine, they will need to demonstrate that they still have a relevant understanding of care in the secondary setting. The individual should have no conflicts of interest i.e. they should not be employed by any organisation from which the CCG secures any significant volume of provision.

c) *Appointment process* – formal application and an appropriately constituted panel with includes the CCG Chairman.

d) *Term of office* - shall serve on the Board of the CCG for a period of three Years.

e) Eligibility for reappointment – The secondary care specialist is eligible for reappointment.

f) Grounds for removal from office – if they are or subsequently become:

i) suspended by the GMC;
ii) subject to serious misconduct proceedings;
iii) the individual becomes employed in an organisation from which the CCG commissions;
iv) not eligible to work in the UK;
v) subject to a bankruptcy restrictions order or an interim bankruptcy restrictions order;
vi) in the last five years been dismissed from employment by a health service body otherwise than because of redundancy;
vii) a person who has received a prison sentence or suspended sentence of three months or more in the last five years;
viii) a person who has been dismissed by a former employer (within or outside the NHS) on the grounds of misconduct within the last 5 years;
ix) a person who has at any time been removed from the management or control of a charity;
x) a person who is under a disqualification order under the Company Directors Disqualification Act 1986 or the Company Directors Disqualification (Northern Ireland) Order 2002, or an order made under section 429(2) of the Insolvency Act 1986 (disabilities on revocation of administration order against an individual);
xi) any other circumstances described in the HR policies.

g) *Notice period* – three months prior written notice to the Board;

2.3.9 The **Chief Finance Officer** as listed in paragraph 6.9.2 of the group's constitution, is subject to the following appointment process:

a) *Nominations* – formal application, meeting national guidance on the selection process for appointment.

b) *Eligibility* – someone with a recognised professional accounting qualification

c) *Appointment process* – formal application and an appropriately constituted panel with includes the CCG Chief Officer and Clinical Chairman;

d) *Term of office* – not applicable;

e) *Eligibility for reappointment* – not applicable

f) *Grounds for removal from office* – the Chief Finance Officer can be removed from office by the Board of the CCG

- if they are or subsequently become:

i) suspended by the CCG or any successor body;
ii) subject to serious misconduct proceedings;
iii) not eligible to work in the UK;
iv) subject to a bankruptcy restrictions order or an interim bankruptcy restrictions order;
v) in the last five years been dismissed from employment by a health service body otherwise than because of redundancy;
vi) a person who has received a prison sentence or suspended sentence of three months or more in the last five years;
vii) a person who has been dismissed by a former employer (within or outside the NHS) on the grounds of misconduct within the last 5 years;
viii) a person who has at any time been removed from the management or control of a charity;
ix) a person who is under a disqualification order under the Company Directors Disqualification Act 1986 or the Company Directors Disqualification (Northern Ireland) Order 2002, or an order made under section 429(2) of the Insolvency Act 1986 (disabilities on revocation of administration order against an individual);
x) any other circumstances described in the HR policies.

g) *Notice period* – six months prior written notice to the Board;

2.3.10 The **Representative of Hampshire County Council (HCC)** as listed in paragraph 6.9.2 of the group's constitution, is subject to the following appointment process:

a) *Nominations* – from the Local Authority;

b) *Eligibility* – senior officer in the Local Authority;

c) *Appointment process* – not applicable;

d) *Term of office* – not applicable;

e) *Eligibility for reappointment* – not applicable;

f) *Grounds for removal from office* – if they are or subsequently become:

i) ceases to be an employee of Hampshire County Council
ii) subject to serious misconduct proceedings
iii) not eligible to work in the UK;
iv) subject to a bankruptcy restrictions order or an interim bankruptcy restrictions order;
v) in the last five years been dismissed from employment by a health service body otherwise than because of redundancy;

vi) a person who has received a prison sentence or suspended sentence of three months or more in the last five years;
vii) a person who has been dismissed by a former employer (within or outside the NHS) on the grounds of misconduct within the last 5 years;
viii) a person who has at any time been removed from the management or control of a charity;
ix) a person who is under a disqualification order under the Company Directors Disqualification Act 1986 or the Company Directors Disqualification (Northern Ireland) Order 2002, or an order made under section 429(2) of the Insolvency Act 1986 (disabilities on revocation of administration order against an individual);
x) any other circumstances described in the HR policies;

g) *Notice period* – three months prior written notice to the Board

2.3.11 The **Representative of Healthwatch** as listed in paragraph 6.9.2 of the group's constitution, is subject to the following appointment process:

a) *Nominations* – from the local branch of Healthwatch

b) *Eligibility* – a member of Healthwatch

c) *Appointment process* – not applicable

d) *Term of office* – not applicable;

e) *Eligibility for reappointment* – not applicable;

f) Grounds for removal from office – if they are or subsequently become:

i) a serving civil servant within the Department of Health, or members /employees of the Care Quality Commission;
ii) intending to serve as a Chairman or non-executive of another NHS body beyond the formal establishment of the relevant CCG;
iii) not eligible to work in the UK;
iv) subject to a bankruptcy restrictions order or an interim bankruptcy restrictions order;
v) in the last five years been dismissed from employment by a health service body otherwise than because of redundancy;
vi) a person who has received a prison sentence or suspended sentence of three months or more in the last five years;
vii) a person who has been dismissed by a former employer (within or outside the NHS) on the grounds of misconduct within the last 5 years;
viii) a health care professional whose registration is subject to conditions, or who is subject to proceedings before a fitness to practise committee of the relevant regulatory body, or who is the

subject of an allegation or investigation which could lead to such proceedings;

ix) a person who has at any time been removed from the management or control of a charity;

x) a person who is under a disqualification order under the Company Directors Disqualification Act 1986 or the Company Directors Disqualification (Northern Ireland) Order 2002, or an order made under section 429(2) of the Insolvency Act 1986 (disabilities on revocation of administration order against an individual);

xi) any other circumstances described in the HR policies.

g) *Notice period* – three months prior written notice to the Board;

2.3.12 The **Director of Public Health** as listed in paragraph 6.9.2 of the group's constitution, will be the appointed Director of Public Health employed by Hampshire County Council.

2.3.13 The roles and responsibilities of each of these key roles are set out either in paragraph 6.9.2 or Chapter 7 of the group's constitution.

3 MEETINGS OF THE CLINICAL COMMISSIONING GROUP

3.1 Calling meetings

3.1.1 Meetings of the group shall be held at regular intervals at such times and places as the group may determine.

3.1.2 The Chairman of the committees and sub committees can call any additional meetings as required. Other members of the committees may request additional meetings from the appropriate chair person.

3.1.3 The meetings of the Board shall be held at least six times per annum and shall be open to the public.

3.1.4 The date, time and venue of all meetings of the Board will be made public with at least 7 days' notice on the CCG website.

3.1.5 The group shall hold an Annual General Meeting (AGM) of the Board once in each year provided that not more than 15 months shall elapse between the date of one Annual General Meeting and that of the next.

3.1.6 The AGM of the Board shall be held in publically accessible premises within the geographical area of the CCG.

3.1.7 No Observer shall carry a vote.

3.1.8 In the case of an equality of votes, the Chairman shall carry the casting vote.

3.1.9 A special meeting may be called at any time by the Chairman or any two members of the Board upon not less than three clear days written notice given to the other members of the Board of matters to be discussed.

3.2 Agenda, supporting papers and business to be transacted

3.2.1 Items of business to be transacted for inclusion on the agenda of a meeting need to be notified to the Chairman of the meeting at least fourteen working days (i.e. excluding weekends and bank holidays) before the meeting takes place. The agenda and supporting papers will be circulated to all members of a meeting five working days before the date the meeting will take place.

3.2.2 The names of the Chairman and Members present at the meeting shall be recorded.

3.2.3 Agendas and certain papers for the group's Board – including details about meeting dates, times and venues - will be published on the group's website at www.westhampshireccg.nhs.uk and will be available on request either in person, by letter or email to the CCG's headquarters at:

- post – Omega House
  112 Southampton Road
  Eastleigh
  Hampshire
  SO50 5PB

  email – whccg.info@nhs.net

3.3 Petitions

3.3.1 Where a petition has been received by the group, the Chairman of the Board shall include the petition as an item for the agenda of the next meeting of the Board.

3.4 Chairman of a meeting

3.4.1 At any meeting of the group or its Board or of a committee or sub-committee, the Chairman of the group, Board, committee or sub-committee, if any and if present, shall preside. If the Chairman is absent from the meeting, the Deputy Chairman, if any and if present, shall preside.

3.4.2 If the Chairman is absent temporarily on the grounds of a declared conflict of interest the Deputy Chairman, if present, shall preside. If both the Chairman and Deputy Chairman are absent, or are disqualified from participating, or there is neither a Chairman or Deputy a member of the group, Board, committee or sub-committee respectively shall be chosen by the members present, or by a majority of them, and shall preside.

3.5 Chairman's ruling

3.5.1 The decision of the Chairman of the Board on questions of order, relevancy and regularity and their interpretation of the constitution, standing orders, scheme of reservation and delegation and prime financial policies at the meeting, shall be final.

3.6 Quorum

3.6.1 The Board meetings will be quorate when there are at least 3 GP Clinical Board members (Clinical Chairman and Locality Clinical Directors) and 2 other voting members as described in section 6.9.2, including 1 lay member and 1 executive officer (Chief Officer or Chief Finance Officer).

3.6.2 The Board must be quorate when any decisions are made or votes taken.

3.6.3 Deputies may attend meetings in the absence of members but may not vote or be included in the quorum numbers unless a formal acting up arrangement is in place.

3.6.4 Where any of the positions are occupied on a shared basis by more than one individual that position shall only exercise one vote.

3.6.5 Others may be invited to attend for specific items with the prior agreement of the Chairman or the Nominated Director.

3.6.6 For all other of the group’s committees and sub-committees, including the Board’s committees and sub-committees, the details of the quorum for these meetings and status of representatives are set out in the appropriate terms of reference

3.7 **Decision making**

3.7.1 Chapter 6 of the group’s constitution, together with the scheme of reservation and delegation, sets out the governing structure for the exercise of the group’s statutory functions. The Chairman will work to establish consensus as the basis for decisions of the Board. If, exceptionally, the Board cannot reach a decision, the Chairman will put the matter to a vote usually by a show of hands. The process for which is set out below:

- **Eligibility** – only designated members of the Board (as in chapter 6 of the constitution) may vote. Deputies for members may not vote unless a formal acting up arrangement is in place.

- **Majority necessary to confirm a decision** – majority of one.

- **Casting vote** -The Chairman or Vice Clinical Chairman shall have a second vote as described in chapter 6

- **Dissenting views** – all dissenting views to be recorded in the minutes.

3.7.2 Should a vote be taken the outcome of the vote, and any dissenting views, must be recorded in the minutes of the meeting.

3.7.3 For all other of the group's committees and sub-committees, including the Board's committees and sub-committee, the details of the process for holding a vote are set out in the appropriate terms of reference.

3.8 Emergency powers and urgent decisions

3.8.1 A member of the Board may give written notice of an emergency motion after the issue of the notice of meeting and agenda, at least one hour before the time fixed for the meeting, subject to the agreement of the Chairman, and provided the motion is seconded by another member of the Board. The notice shall state the grounds of urgency. If in order, it shall be declared to the Board at the commencement of the business of the meeting as an additional item included in the agenda. The Chairman's decision to include the item shall be final.

3.8.2 The Chairman may call an emergency meeting.

3.8.3 Urgent decisions may be taken by the Chairman, the Chief Officer and one other clinical member of the Board. Any decisions of this nature will immediately be conveyed to the Board members via email and a record made of the decision, the rationale and the communications.

3.9 Suspension of Standing Orders

3.9.1 Except where it would contravene any statutory provision or any direction made by the Secretary of State for Health or NHS England, any part of these standing orders may be suspended at any meeting, provided five members of the Board are in agreement.

3.9.2 A decision to suspend standing orders together with the reasons for doing so shall be recorded in the minutes of the meeting.

3.9.3 A separate record of matters discussed during the suspension shall be kept. These records shall be made available to the Board's audit committee for review of the reasonableness of the decision to suspend standing orders.

3.10 Record of Attendance

3.10.1 The names of all members of the meeting present at the meeting shall be recorded in the minutes of the group's meetings.

3.10.2 The names of all members of the Board present shall be recorded in the minutes of the Board meetings.

3.10.3 The names of all members of the Board's committees / sub-committees present shall be recorded in the minutes of the respective Board committee / sub-committee meetings.

3.10.4 Where a member is representing a member practice the name of the practice shall also be recorded.

3.11 Minutes

3.11.1 The minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting where they shall be signed by the person presiding at it.

3.11.2 No discussion shall take place upon the minutes except upon their accuracy or where the Chairman considers discussion appropriate.

3.11.3 Minutes shall be circulated in accordance with members' wishes. Where providing a record of a public meeting the approved minutes shall be made available to the public as required by Code of Practice on Openness in the NHS.

3.11.4 The name of the person recording and drafting the minutes shall also be recorded in the minutes.

3.11.5 The minutes will be published on the group's website at www.westhampshireccg.nhs.uk group's website address] and will be available on request either in person, by letter or email to the CCGs' headquarters at:

post – Omega House
112 Southampton Road
Eastleigh
Hampshire
SO50 5PB

email – whccg.info@nhs.net

3.11.6 Members will receive the minutes via email and will also have access via the CCG's website.

3.12 Admission of public and the press

3.12.1 Admission and exclusion on grounds of confidentiality of business to be transacted:

3.12.1.1 The public and representatives of the press may attend all meetings of the Board, but shall be required to withdraw upon the Board as follows:

'that representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest', Section 1 (2), Public Bodies (Admission to Meetings) Act 1960'

3.12.2 General disturbances:

3.12.2.1 The Chairman or the person presiding over the meeting shall give such directions as he/she thinks fit with regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the business shall be conducted without interruption and disruption and, without prejudice to the power to exclude on grounds of the confidential nature of the business to be transacted, the public will be required to withdraw upon the Board resolving as follows:

`That in the interests of public order the meeting adjourn for (the period to be specified) to enable the Board to complete its business without the presence of the public'. Section 1(8) Public Bodies (Admissions to Meetings) Act 1960.

3.12.3 **Business proposed to be transacted when the press and public have been excluded from a meeting**:

3.12.3.1 Matters to be dealt with by the Board following the exclusion of representatives of the press, and other members of the public, as provided in (3.12.1) and (3.12.2) above, shall be confidential to the members of the Board.

3.12.4 **Use of Mechanical or Electrical Equipment for Recording or Transmission of Meetings**:

3.12.4.1 Permission for the introduction by the public, or press representatives, of recording, transmitting, video or similar apparatus into meetings of the Board or committee thereof shall be granted upon resolution of the Board or committee by request to the Chairman.

4 APPOINTMENT OF COMMITTEES AND SUB-COMMITTEES

4.1 Appointment of committees and sub-committees

4.1.1 The group may appoint committees and sub-committees of the group, subject to any regulations made by the Secretary of State[4], and make provision for the appointment of committees and sub-committees of its Board. Where such committees and sub-committees of the group, or committees and sub-committees of its Board, are appointed they are included in Chapter 6 of the group's constitution.

4.1.2 Other than where there are statutory requirements, such as in relation to the Board's audit committee, remuneration committee or primary care commissioning committee, the group shall determine the membership and terms of reference of committees and sub-committees and shall, if it requires, receive and consider reports of such committees at the next appropriate meeting of the group.

4.1.3 The provisions of these standing orders shall apply where relevant to the operation of the Board, the Board's committees and sub-committee and all

[4] See section 14N of the 2006 Act, inserted by section 25 of the 2012 Act

committees and sub-committees unless stated otherwise in the committee or sub-committee's terms of reference.

4.2 Terms of Reference

4.2.1 Terms of reference shall have effect as if incorporated into the constitution and shall be added to this document as an appendix.

4.3 Delegation of Powers by Committees to Sub-committees

4.3.1 Where committees are authorised to establish sub-committees they may not delegate executive powers to the sub-committee unless expressly authorised by the group.

4.4 Approval of Appointments to Committees and Sub-Committees

4.4.1 The group shall approve the appointments to each of the committees and sub-committees which it has formally constituted including those of the Board. The group shall agree such travelling or other allowances as it considers appropriate.

5 DUTY TO REPORT NON-COMPLIANCE WITH STANDING ORDERS AND PRIME FINANCIAL POLICIES

5.1 If for any reason these standing orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the Board for action or ratification. All members of the group and staff have a duty to disclose any non-compliance with these standing orders to the Chief Officer as soon as possible.

6 USE OF SEAL AND AUTHORISATION OF DOCUMENTS

6.1 Clinical Commissioning Group's seal

6.1.1 The group may have a seal for executing documents where necessary. The following individuals or officers are authorised to authenticate its use by their signature:

6.1.1.1 the Chief Officer;

6.1.1.2 the Chairman of the Board;

6.1.1.3 the Chief Finance Officer;

6.1.1.4 other CCG Directors are authorised to authenticate documents only if a second signatory is required.

6.2 Use of the Seal – general guide

6.2.1 The Seal shall be used in the following circumstances. This may not be a complete list:

6.2.1.1 All contracts for the purchase/lease of land and/or building

6.2.1.2 All contracts for capital works exceeding £100,000

6.2.1.3 All lease agreements where the annual lease charge exceeds £100,000 per annum and the period of the lease exceeds beyond five years

6.2.1.4 Any other lease agreement where the total payable under the lease exceeds £100,000

6.2.1.5 Any contract or agreement with organisations other than NHS or other government bodies including local authorities where the annual costs exceed or are expected to exceed £100,000

6.3 Execution of a document by signature

6.3.1 The following individuals are authorised to execute a document on behalf of the group by their signature.

6.3.1.1 the Chief Officer

6.3.1.2 the Chairman of the Board

6.3.1.3 the Chief Finance Officer

6.3.1.4 other CCG Directors are authorised to authenticate documents only if a second signatory is required.

7 OVERLAP WITH OTHER CLINICAL COMMISSIONING GROUP POLICY STATEMENTS / PROCEDURES AND REGULATIONS

7.1 Policy statements: general principles

7.1.1 The group will from time to time agree and approve policy statements / procedures which will apply to all or specific groups of staff employed by NHS West Hampshire Clinical Commissioning Group. The decisions to approve such policies and procedures will be recorded in an appropriate group minute and will be deemed where appropriate to be an integral part of the group's standing orders.

APPENDIX D: SCHEME OF RESERVATION & DELEGATION

1. SCHEDULE OF MATTERS RESERVED TO THE CLINICAL COMMISSIONING GROUP AND SCHEME OF DELEGATION

1.1. The arrangements made by the group as set out in this scheme of reservation and delegation of decisions shall have effect as if incorporated in the group's constitution.

1.2. The clinical commissioning group remains accountable for all of its functions, including those that it has delegated.

1.3. The following table shows those matters which are reserved and delegated for the discharge of the groups' functions.

		Reserved to the Members	Board	Audit Committee	Clinical Cabinet	Clinical Governance Committee	Finance & Performance Committee	Remuneration Committee	Primary Care Commissioning Committee
1. REGULATION & CONTROL									
1.1	Determine the arrangements by which the members of the group approve those decisions that are reserved for the membership.	✓							
1.2	Consideration and approval of applications to NHS England on any matter concerning changes to the group's constitution	✓							
1.3	Prepare the group's overarching scheme of reservation and delegation, which sets out those decisions of the group <u>reserved</u> to the membership and those <u>delegated</u> to the o group's Board o committees and sub-committees of the group, or o its members or employees and sets out those decisions of the Board <u>reserved</u> to the Board and those <u>delegated</u> to the o Board's committees and sub-committees, o members of the Board, o an individual who is member of the group but not the Board or a specified person for inclusion in the group's constitution.	✓							
1.4	Approve the arrangements for o identifying practice members to represent practices in matters concerning the work of the group; and o appointing clinical leaders to represent the group's membership on the group's Board.	✓							
1.5	Approve the appointment of Board members, the process for recruiting and removing elected members to the Board (subject to any regulatory requirements) and succession planning.	✓							
1.6	Approve arrangements for identifying the group's proposed accountable officer		✓						

		Reserved to the Members	Board	Audit Committee	Clinical Cabinet	Clinical Governance Committee	Finance & Performance Committee	Remuneration Committee	Primary Care Commissioning Committee
1.7	Approval of the group’s overarching scheme of reservation and delegation.	✓							
1.8	Approval of the group’s operational scheme of delegation that underpins the group’s ‘overarching scheme of reservation and delegation’ as set out in its constitution.		✓						
1.9	Prepare detailed financial policies that underpin the clinical commissioning group’s prime financial policies.						✓		
1.10	Approve detailed financial policies.		✓						
1.11	Approve arrangements for managing exceptional funding requests		✓						
1.12	Set out who can execute a document by signature / use of the seal		✓						
1.13	Prepare the group’s operational scheme of delegation, which sets out those key operational decisions delegated to individual employees of the clinical commissioning group, not for inclusion in the group’s constitution.		✓						
2. STRATEGY AND PLANNING									
2.1	Agree the vision, values and overall strategic direction of the group.	✓							
2.2	Approval of the group’s operating structure.		✓						
2.3	Approval of the group’s commissioning plan.		✓						
2.4	Approval of the group’s corporate budgets that meet the financial duties as set out in section 5.3 of the main body of the constitution.		✓				✓		

		Reserved to the Members	Board	Audit Committee	Clinical Cabinet	Clinical Governance Committee	Finance & Performance Committee	Remuneration Committee	Primary Care Commissioning Committee
2.5	Approval of variations to the approved budget where variation would have a significant impact on the overall approved levels of income and expenditure or the group's ability to achieve its agreed strategic aims.		✓				✓		
2.6	Approve common commissioning strategies and approaches and provider proposals, clinical specifications for business cases, clinical priority statements and locality constitutions				✓				
2.7	Agree clinical priorities for the CCG in terms of commissioning and QIPP				✓				
2.8	Review, plan and commission primary medical care services under delegated authority from NHS England.								✓
3. ANNUAL REPORTS AND ACCOUNTS									
3.1	Approval of the group's annual report and annual accounts.		✓						
3.2	Approval of the arrangements for discharging the group's statutory financial duties		✓				✓		
4. HUMAN RESOURCES									
4.1	Approve the terms and conditions, remuneration and travelling or other allowances for Board members, including pensions and gratuities.							✓	
4.2	Approve terms and conditions of employment for all employees of the group including, pensions, remuneration, fees and travelling or other allowances payable to employees and to other persons providing services to the group.							✓	
4.3	Approve any other terms and conditions of services for the group's employees							✓	
4.4	Determine the terms and conditions of employment for all employees of the group.							✓	

		Reserved to the Members	Board	Audit Committee	Clinical Cabinet	Clinical Governance Committee	Finance & Performance Committee	Remuneration Committee	Primary Care Commissioning Committee
4.5	Determine remuneration, fees and allowances payable to employees and to other persons providing services to the group.							✓	
4.6	Recommend pensions, remuneration, fees and allowances payable to employees and to other persons providing services to the group.							✓	
4.7	Approve disciplinary arrangements for employees, including the accountable officer (where he/she is an employee or member of the clinical commissioning group) and for other persons working on behalf of the group.		✓						
4.8	Review disciplinary arrangements where the accountable officer is an employee or member of another clinical commissioning group		✓						
4.9	Approval of the arrangements for discharging the group's statutory duties as an employer.		✓						
4.10	Approve human resources policies for employees and for other persons working on behalf of the group		✓ via Policy Sub Group						
4.11	Determine arrangements for termination of employment and other contractual terms.							✓	
5. QUALITY AND SAFETY									
5.1	Approve arrangements, including supporting policies, to minimise clinical risk, maximise patient safety and to secure continuous improvement in quality and patient outcomes					✓			
5.2	Approve arrangements for supporting the NHS England in discharging its responsibilities in relation to securing continuous improvement in the quality of general medical services.					✓			
5.3	Approve arrangements to drive improvements in healthcare assurances within the providers from whom the CCG commissions care so that providers demonstrate year on year improvements, identifying and managing risk and underperformance.					✓			

		Reserved to the Members	Board	Audit Committee	Clinical Cabinet	Clinical Governance Committee	Finance & Performance Committee	Remuneration Committee	Primary Care Commissioning Committee
5.4	Provide assurance to the Board and member practices that appropriate systems and processes are in place to realise continuous improvement in the quality of commissioned services and to ensure wider system learning from any emergent issues relating to poor quality service provision.					✓			
5.5	Receive and scrutinise independent investigation reports relating to patient safety issues and agree publication plans.					✓			
5.6	Ensure there are effective early warning systems which draw on a range of quality indicators and other sources of information to identify gaps in assurance about providers					✓			
5.7	Respond to specific clinical governance and healthcare assurance issues identified by the Clinical Cabinet, Board and external regulatory bodies.					✓			
6. OPERATIONAL AND RISK MANAGEMENT									
6.1	Prepare and recommend an operational scheme of delegation that sets out who has responsibility for operational decisions within the group.						✓		
6.2	Approve arrangements for risk sharing and or risk pooling with other organisations (for example arrangements for pooled funds with other clinical commissioning groups or pooled budget arrangements under section 75 of the NHS Act 2006).		✓						
6.3	Approval of the group's risk management arrangements.			✓					
6.4	Approve proposals for action on litigation against or on behalf of the clinical commissioning group.			✓					
6.5	Approve the group's arrangements for business continuity and emergency planning.			✓					
6.6	Approve the group's arrangements for managing potential conflict of interest.			✓					
6.7	Approve the group's arrangements for managing dispute resolution.	✓							

		Reserved to the Members	Board	Audit Committee	Clinical Cabinet	Clinical Governance Committee	Finance & Performance Committee	Remuneration Committee	Primary Care Commissioning Committee
6.8	Approval of a comprehensive system of internal control, including budgetary control, that underpin the effective, efficient and economic operation of the group.			✓					
6.9	Approve the group's counter fraud and security management arrangements.			✓					
7. FINANCE AND PERFORMANCE									
7.1	Review and approve the annual budget setting guidance and oversee the development of the Finance Plan and estimates						✓		
7.2	Undertake detailed scrutiny of • monthly, quarterly and year to date financial information, including performance against the cost improvement programme • financial forward projections • the Finance & Recovery Programme						✓		
7.3	Oversee the development, implementation and delivery of the Quality, Innovation, Productivity and Prevention Plans (QIPP) and the Commissioning for Quality and Innovation Plans (CQUIN)						✓		
7.4	Test investments, programmes and projects against agreed prioritisation frameworks, and recommend prioritisation to the CCG Board with regard to agreed business case processes.						✓		
7.5	Review the Integrated Performance Report						✓		
7.6	Support the CCG Quarterly Assurance process and the development of an action plan to respond to issues as required.						✓		
7.7	To agree the CCG Contracting Strategy, oversee the negotiation of contracts with local providers and receive regular contract updates.						✓		

		Reserved to the Members	Board	Audit Committee	Clinical Cabinet	Clinical Governance Committee	Finance & Performance Committee	Remuneration Committee	Primary Care Commissioning Committee
7.8	Oversee the development processes for producing and delivering commissioning intentions in line with the CCG's Strategic / Operating Plans						✓		
7.9	To consider business case proposals: • included in the Board approved CCG Operating Plan and which request an investment of up to £300k for the life time costs of the contract and approve • developed in year (and are not included in the Board approved CCG Operating Plan) up to a maximum of £2,000,000 and approve for onward ratification by the Board • which request an investment exceeding £2,000,000 and recommend for onward approval by the Board						✓		
7.10	Regularly scrutinise the schedule of approved business cases to ensure delivery against key milestones and schemes are being delivered within financial limits.						✓		
7.11	Approve Tender Ratification documents within delegated limits and approve Tender Ratification documents for onward transmission to the Board.						✓		
7.12	Scrutinise forward view of Procurement Schemes including understanding and engagement with the supplier market.						✓		
8. INFORMATION GOVERNANCE									
8.1	Approve the group's arrangements for handling complaints.					✓			
8.2	Approval of the arrangements for ensuring appropriate and safekeeping and confidentiality of records and for the storage, management and transfer of information and data.		✓						
9. TENDERING AND CONTRACTING									

		Reserved to the Members	Board	Audit Committee	Clinical Cabinet	Clinical Governance Committee	Finance & Performance Committee	Remuneration Committee	Primary Care Commissioning Committee
9.1	Approval of the group's contracts for any commissioning support.		✓						
9.2	Approval of the group's contracts for corporate support (for example finance provision).		✓						
10. PARTNERSHIP WORKING									
10.1	Approve decisions that individual members or employees of the group participating in joint arrangements on behalf of the group can make. Such delegated decisions must be disclosed in this scheme of reservation and delegation.		✓						
10.2	Approve decisions delegated to joint committees established under section 75 of the 2006 Act.		✓						
11. COMMISSIONING AND CONTRACTING FOR CLINICAL SERVICES									
11.1	Approval of the arrangements for discharging the group's statutory duties associated with its commissioning functions, including but not limited to promoting the involvement of each patient, patient choice, reducing inequalities, improvement in the quality of services, obtaining appropriate advice and public engagement and consultation.		✓						
11.2	Approve arrangements for co-ordinating the commissioning of services with other groups and or with the local authority(ies), where appropriate		✓						
11.3	Undertake the functions relating to the commissioning of primary medical services under section 83 of the NHS Act, under delegated authority from NHS England. This includes the following: • GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action such as issuing branch/remedial notices, and removing a contract); • Newly designed enhanced services ("Local Enhanced Services" and								✓

		Reserved to the Members	Board	Audit Committee	Clinical Cabinet	Clinical Governance Committee	Finance & Performance Committee	Remuneration Committee	Primary Care Commissioning Committee
	"Directed Enhanced Services"); • Design of local incentive schemes as an alternative to the Quality Outcomes Framework (QOF); • Decision making on whether to establish new GP practices in an area; • Approving practice mergers; and • Making decisions on 'discretionary' payment (e.g., returner/retainer schemes.								
12. COMMUNICATIONS									
12.1	Approving arrangements for handling Freedom of Information requests.		✓						
12.2	Determining arrangements for handling Freedom of Information requests			✓					

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APPENDIX E: PRIME FINANCIAL POLICIES

1. INTRODUCTION

1.1. General

1.1.1. These prime financial policies and supporting detailed financial policies shall have effect as if incorporated into the group's constitution.

1.1.2. The prime financial policies are part of the group's control environment for managing the organisation's financial affairs. They contribute to good corporate governance, internal control and managing risks. They enable sound administration, lessen the risk of irregularities and support commissioning and delivery of effective, efficient and economical services. They also help the Chief officer and chief finance officer to effectively perform their responsibilities. They should be used in conjunction with the scheme of reservation and delegation found at Appendix D.

1.1.3. In support of these prime financial policies, the group has prepared more detailed policies, approved by the Board.

1.1.4. These prime financial policies identify the financial responsibilities which apply to everyone working for the group and its constituent organisations. They do not provide detailed procedural advice and should be read in conjunction with the detailed financial policies. The chief finance officer is responsible for approving all detailed financial policies.

1.1.5. A list of the group's detailed financial policies will be published and maintained on the group's website at www.westhampshireccg.nhs.uk.

1.1.6. Should any difficulties arise regarding the interpretation or application of any of the prime financial policies then the advice of the chief finance officer must be sought before acting. The user of these prime financial policies should also be familiar with and comply with the provisions of the group's constitution, standing orders and scheme of reservation and delegation.

1.1.7. Failure to comply with prime financial policies and standing orders can in certain circumstances be regarded as a disciplinary matter that could result in dismissal.

1.2. Overriding Prime Financial Policies

1.2.1. If for any reason these prime financial policies are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next formal meeting of the Board's audit committee for referring action or ratification. All of the group's members and employees have a duty to disclose any non-compliance with these prime financial policies to the chief finance officer as soon as possible.

1.3. Responsibilities and delegation

1.3.1. The roles and responsibilities of group's members, employees, members of the Board, members of the Board's committees and sub-committees, members of the group's committee and sub-committee (if any) and persons working on behalf of the group are set out in chapters 6 and 7 of this constitution.

1.3.2. The financial decisions delegated by members of the group are set out in the group's scheme of reservation and delegation (see Appendix D).

1.4. Contractors and their employees

1.4.1. Any contractor or employee of a contractor who is empowered by the group to commit the group to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Chief officer to ensure that such persons are made aware of this.

1.5. Amendment of Prime Financial Policies

1.5.1. To ensure that these prime financial policies remain up-to-date and relevant, the chief finance officer will review them at least annually. Following consultation with the Chief officer and scrutiny by the Board's audit committee, the chief finance officer will recommend amendments, as fitting, to the Board for approval.

2. INTERNAL CONTROL

POLICY – the group will put in place a suitable control environment and effective internal controls that provide reasonable assurance of effective and efficient operations, financial stewardship, probity and compliance with laws and policies

2.1. The Board is required to establish an audit committee with terms of reference agreed by the Board (see paragraph 6.6.5.1 of the group's constitution for further information).

2.2. The Chief officer has overall responsibility for the group's systems of internal control.

2.3. The chief finance officer will ensure that:

a) financial policies are considered for review and update annually;

b) a system is in place for proper checking and reporting of all breaches of financial policies; and

c) a proper procedure is in place for regular checking of the adequacy and effectiveness of the control environment.

3. AUDIT

POLICY – the group will keep an effective and independent internal audit function and fully comply with the requirements of external audit and other statutory reviews

3.1. The person appointed by the group to be responsible for internal audit and the Audit Commission appointed external auditor will have direct and unrestricted access to audit committee members and the Chairman of the Board, Chief officer and chief finance officer for any significant issues arising from audit work that management cannot resolve, and for all cases of fraud or serious irregularity.

3.2. The person appointed by the group to be responsible for internal audit and the external auditor will have access to the audit committee and the Chief officer to review audit issues as appropriate. All audit committee members, the Chairman of the Board and the Chief officer will have direct and unrestricted access to the head of internal audit and external auditors.

3.3. The chief finance officer will ensure that:

a) the group has a professional and technically competent internal audit function; and

b) the Board's audit committee approves any changes to the provision or delivery of assurance services to the group.

4. FRAUD AND CORRUPTION

POLICY – the group requires all staff to always act honestly and with integrity to safeguard the public resources they are responsible for. The group will not tolerate any fraud perpetrated against it and will actively chase any loss suffered

4.1. The Board's audit committee will satisfy itself that the group has adequate arrangements in place for countering fraud and shall review the outcomes of counter fraud work. It shall also approve the counter fraud work programme.

4.2. The Board's audit committee will ensure that the group has arrangements in place to work effectively with NHS Protect.

5. EXPENDITURE CONTROL

5.1. The group is required by statutory provisions[5] to ensure that its expenditure does not exceed the aggregate of allotments from NHS England and any other sums it has received and is legally allowed to spend.

[5] See section 223H of the 2006 Act, inserted by section 27 of the 2012 Act

5.2. The Chief officer has overall executive responsibility for ensuring that the group complies with certain of its statutory obligations, including its financial and accounting obligations, and that it exercises its functions effectively, efficiently and economically and in a way which provides good value for money.

5.3. The chief finance officer will:

a) provide reports in the form required by NHS England;

b) ensure money drawn from NHS England is required for approved expenditure only is drawn down only at the time of need and follows best practice;

c) be responsible for ensuring that an adequate system of monitoring financial performance is in place to enable the group to fulfil its statutory responsibility not to exceed its expenditure limits, as set by direction of NHS England.

6. ALLOTMENTS[6]

6.1. The group's chief finance officer will:

a) periodically review the basis and assumptions used by NHS Englandfor distributing allotments and ensure that these are reasonable and realistic and secure the group's entitlement to funds;

b) prior to the start of each financial year submit to the Board for approval a report showing the total allocations received and their proposed distribution including any sums to be held in reserve; and

c) regularly update Board on significant changes to the initial allocation and the uses of such funds.

7. COMMISSIONING STRATEGY, BUDGETS, BUDGETARY CONTROL AND MONITORING

POLICY – the group will produce and publish an annual commissioning plan[7] that explains how it proposes to discharge its financial duties. The group will support this with comprehensive medium term financial plans and annual budgets

7.1. The Chief officer will compile and submit to the Board a commissioning strategy which takes into account financial targets and forecast limits of available resources.

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6 See section 223(G) of the 2006 Act, inserted by section 27 of the 2012 Act.

7 See section 14Z11 of the 2006 Act, inserted by section 26 of the 2012 Act.

7.2. Prior to the start of the financial year the chief finance officer will, on behalf of the Chief officer, prepare and submit budgets for approval by the Board.

7.3. The chief finance officer shall monitor financial performance against budget and plan, periodically review them, and report to the Board. This report should include explanations for variances. These variances must be based on any significant departures from agreed financial plans or budgets.

7.4. The Chief officer is responsible for ensuring that information relating to the group's accounts or to its income or expenditure, or its use of resources is provided to NHS England as requested.

7.5. The Board will approve consultation arrangements for the group's commissioning plan[8].

8. ANNUAL ACCOUNTS AND REPORTS

POLICY – the group will produce and submit to NHS England accounts and reports in accordance with all statutory obligations[9], relevant accounting standards and accounting best practice in the form and content and at the time required by NHS England

8.1. The chief finance officer will ensure the group:

a) prepares a timetable for producing the annual report and accounts and agrees it with external auditors and the Board;

b) prepares the accounts according to the timetable approved by the Board:

c) complies with statutory requirements and relevant directions for the publication of annual report;

d) considers the external auditor's management letter and fully address all issues within agreed timescales; and

e) publishes the external auditor's management letter on the group's website at www.westhampshireccg.nhs.uk.

9. INFORMATION TECHNOLOGY

POLICY – the group will ensure the accuracy and security of the group's computerised financial data

[8] See section 14Z13 of the 2006 Act, inserted by section 26 of the 2012 Act

[9] See paragraph 17 of Schedule 1A of the 2006 Act, as inserted by Schedule 2 of the 2012 Act.

9.1. The chief finance officer is responsible for the accuracy and security of the group's computerised financial data and shall

a) devise and implement any necessary procedures to ensure adequate (reasonable) protection of the group's data, programs and computer hardware from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 1998;

b) ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;

c) ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment;

d) ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as the chief finance officer may consider necessary are being carried out.

9.2. In addition the chief finance officer shall ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy must be obtained from them prior to implementation.

10. ACCOUNTING SYSTEMS

POLICY – the group will run an accounting system that creates management and financial accounts

10.1. The chief finance officer will ensure:

a) the group has suitable financial and other software to enable it to comply with these policies and any consolidation requirements of NHS England;

b) that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

10.2. Where another health organisation or any other agency provides a computer service for financial applications, the chief finance officer shall periodically seek assurances that adequate controls are in operation.

11. BANK ACCOUNTS

POLICY – the group will keep enough liquidity to meet its current commitments

11.1. The chief finance officer will:

a) review the banking arrangements of the group at regular intervals to ensure they are in accordance with Secretary of State directions[10], best practice and represent best value for money;

b) manage the group's banking arrangements and advise the group on the provision of banking services and operation of accounts;

c) prepare detailed instructions on the operation of bank accounts.

11.2. The audit committee shall approve the banking arrangements.

12. INCOME, FEES AND CHARGES AND SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS.

POLICY – the group will
- operate a sound system for prompt recording, invoicing and collection of all monies due
- seek to maximise its potential to raise additional income only to the extent that it does not interfere with the performance of the group or its functions[11]
- ensure its power to make grants and loans is used to discharge its functions effectively[12]

12.1. The Chief Finance Officer is responsible for:

a) designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, and collection and coding of all monies due;

b) establishing and maintaining systems and procedures for the secure handling of cash and other negotiable instruments;

c) approving and regularly reviewing the level of all fees and charges other than those determined by the NHS England or by statute. Independent professional advice on matters of valuation shall be taken as necessary;

d) for developing effective arrangements for making grants or loans.

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[10] See section 223H(3) of the NHS Act 2006, inserted by section 27 of the 2012 Act
[11] See section 14Z5 of the 2006 Act, inserted by section 26 of the 2012 Act.
[12] See section 14Z6 of the 2006 Act, inserted by section 26 of the 2012 Act.

13. TENDERING AND CONTRACTING PROCEDURE

POLICY – the group:

- will ensure proper competition that is legally compliant within all purchasing to ensure we incur only budgeted, approved and necessary spending
- will seek value for money for all goods and services
- shall ensure that competitive tenders are invited for
  - the supply of goods, materials and manufactured articles;
  - the rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the Department of Health); and
  - for the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens) for disposals

13.1. The group shall ensure that the firms / individuals invited to tender (and where appropriate, quote) are among those on approved lists or where necessary a framework agreement. Where in the opinion of the chief finance officer it is desirable to seek tenders from firms not on the approved lists, the reason shall be recorded in writing to the Chief officer.

13.2. The Board may only negotiate contracts on behalf of the group, and the group may only enter into contracts, within the statutory framework set up by the 2006 Act, as amended by the 2012 Act. Such contracts shall comply with:

a) the group's standing orders;

b) the Public Contracts Regulation 2006, any successor legislation and any other applicable law; and

c) take into account as appropriate any applicable NHS England or the Independent Regulator of NHS Foundation Trusts (Monitor) guidance that does not conflict with (b) above.

13.3. In all contracts entered into, the group shall endeavour to obtain best value for money. The Chief officer shall nominate an individual who shall oversee and manage each contract on behalf of the group.

14. COMMISSIONING

POLICY – working in partnership with relevant national and local stakeholders, the group will commission certain health services to meet the reasonable requirements of the persons for whom it has responsibility

14.1. The group will coordinate its work with the NHS England, other clinical commissioning groups, local providers of services, local authority(ies), including

through Health & Wellbeing Boards, patients and their carers and the voluntary sector and others as appropriate to develop robust commissioning plans.

14.2. The Chief officer will establish arrangements to ensure that regular reports are provided to the Board detailing actual and forecast expenditure and activity for each contract.

14.3. The chief finance officer will maintain a system of financial monitoring to ensure the effective accounting of expenditure under contracts. This should provide a suitable audit trail for all payments made under the contracts whilst maintaining patient confidentiality.

15. RISK MANAGEMENT AND INSURANCE

POLICY – the group will put arrangements in place for evaluation and management of its risks

15.1 The West Hampshire CCG will manage risk by:

- Clarifying strategic objectives, management and delivery arrangements
- Identifying strategic and operational risks and challenges to those objectives
- Assessing risks
- Managing risks and issues
- Reviewing and reporting on risks and issues

15.2 A guide has been produced for WH CCG that explains the supporting processes and methodology used in each of these stages.

15.3 WH CCG will operate an assurance framework. This is a structure of recording identified risks at all levels of the CCG's activities using a Risk Register. At the CCG Board level this includes a summary of the Significant Risks to the Strategic Objectives of the CCG. This public facing summary incorporates a description of the CCG Board's assurances that they receive to confirm whether or not these risks are effectively controlled

15.4 All significant corporate risks will link to the CCG Strategic Risk Register which will also reference the sources of information that satisfy the CCG Board that effective control measures are in place

16. PAYROLL

POLICY – the group will put arrangements in place for an effective payroll service

16.1. The chief finance officer will ensure that the payroll service selected:

a) is supported by appropriate (i.e. contracted) terms and conditions;

b) has adequate internal controls and audit review processes;

c) has suitable arrangements for the collection of payroll deductions and payment of these to appropriate bodies.

16.2. In addition the chief finance officer shall set out comprehensive procedures for the effective processing of payroll

17. NON-PAY EXPENDITURE

POLICY – the group will seek to obtain the best value for money goods and services received

17.1. The Board will approve the level of non-pay expenditure on an annual basis and the Chief officer will determine the level of delegation to budget managers

17.2. The chief officer shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

17.3. The chief finance officer will:

a) advise the Board on the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in the detailed financial policies;

b) be responsible for the prompt payment of all properly authorised accounts and claims;

c) be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable.

18. CAPITAL INVESTMENT, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

POLICY – the group will put arrangements in place to manage capital investment, maintain an asset register recording fixed assets and put in place polices to secure the safe storage of the group’s fixed assets

18.1. The Chief officer will

a) ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon plans;

b) be responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost;

c) shall ensure that the capital investment is not undertaken without confirmation of purchaser(s) support and the availability of resources to finance all revenue consequences, including capital charges;

d) be responsible for the maintenance of registers of assets, taking account of the advice of the chief finance officer concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted once a year.

18.2. The chief finance officer will prepare detailed procedures for the disposals of assets.

19. RETENTION OF RECORDS

POLICY – the group will put arrangements in place to retain all records in accordance with NHS Code of Practice Records Management 2006 and other relevant notified guidance

19.1. The Chief officer shall:

a) be responsible for maintaining all records required to be retained in accordance with NHS Code of Practice Records Management 2006 and other relevant notified guidance;

b) ensure that arrangements are in place for effective responses to Freedom of Information requests;

c) publish and maintain a Freedom of Information Publication Scheme.

20. TRUST FUNDS AND TRUSTEES

POLICY – the group will put arrangements in place to provide for the appointment of trustees if the group holds property on trust

20.1. As an inherently management organisation, it is not expected that the CCG will hold any charitable funds, and if any such donations should be made, the CCG will liaise with the donator regarding a more appropriate beneficiary.

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APPENDIX F: NOLAN PRINCIPLES

1. The 'Nolan Principles' set out the ways in which holders of public office should behave in discharging their duties. The seven principles are:

   a) **Selflessness** – Holders of public office should act solely in terms of the public interest. They should not do so in order to gain financial or other benefits for themselves, their family or their friends.

   b) **Integrity** – Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties.

   c) **Objectivity** – In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit.

   d) **Accountability** – Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.

   e) **Openness** – Holders of public office should be as open as possible about all the decisions and actions they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

   f) **Honesty** – Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

   g) **Leadership** – Holders of public office should promote and support these principles by leadership and example.

Source: *The First Report of the Committee on Standards in Public Life* (1995)[13]

[13] Available at http://www.public-standards.gov.uk/

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APPENDIX G: NHS CONSTITUTION

The NHS Constitution sets out seven key principles that guide the NHS in all it does:

1. **the NHS provides a comprehensive service, available to all** - irrespective of gender, race, disability, age, sexual orientation, religion or belief. It has a duty to each and every individual that it serves and must respect their human rights. At the same time, it has a wider social duty to promote equality through the services it provides and to pay particular attention to groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population

2. **access to NHS services is based on clinical need, not an individual's ability to pay** - NHS services are free of charge, except in limited circumstances sanctioned by Parliament.

3. **the NHS aspires to the highest standards of excellence and professionalism** - in the provision of high-quality care that is safe, effective and focused on patient experience; in the planning and delivery of the clinical and other services it provides; in the people it employs and the education, training and development they receive; in the leadership and management of its organisations; and through its commitment to innovation and to the promotion and conduct of research to improve the current and future health and care of the population.

4. **NHS services must reflect the needs and preferences of patients, their families and their carers** - patients, with their families and carers, where appropriate, will be involved in and consulted on all decisions about their care and treatment.

5. **the NHS works across organisational boundaries and in partnership with other organisations in the interest of patients, local communities and the wider population** - the NHS is an integrated system of organisations and services bound together by the principles and values now reflected in the Constitution. The NHS is committed to working jointly with local authorities and a wide range of other private, public and third sector organisations at national and local level to provide and deliver improvements in health and well-being

6. **the NHS is committed to providing best value for taxpayers' money and the most cost-effective, fair and sustainable use of finite resources** - public funds for healthcare will be devoted solely to the benefit of the people that the NHS serves

7. **the NHS is accountable to the public, communities and patients that it serves** - the NHS is a national service funded through national taxation, and it is the Government which sets the framework for the NHS and which is accountable to Parliament for its operation. However, most decisions in the NHS, especially those about the treatment of individuals and the detailed organisation of services, are rightly taken by the local NHS and by patients with their clinicians. The system of responsibility and accountability for taking decisions in the NHS should be transparent and clear to the public, patients and staff. The Government will ensure that there is always a clear and up-to-date statement of NHS accountability for this purpose

Source: *The NHS Constitution: The NHS belongs to us all* (March 2012)[14]

[14] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_132961

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APPENDIX H: TERMS OF REFERENCE FOR THE AUDIT COMMITTEE

AUDIT COMMITTEE

TERMS OF REFERENCE

1 Constitution

1.1 The Audit Committee (the Committee) is a Committee of the Clinical Commissioning Group (CCG) Board and has those executive powers specifically delegated to it by the CCG Board within the Scheme of Delegation and in these Terms of Reference.

1.2 In line with the requirements and guidelines of the NHS Audit Committee Handbook, NHS Code of Conduct and Accountability, the Audit Committee is established to provide the CCG with an independent, critical and objective view of its systems and processes and compliance with laws that regulate and govern the NHS.

1.3 The Committee is accountable to the CCG Board.

1.4 These Terms of Reference will be reviewed annually by the Committee and submitted to the CCG Board for approval.

2 Purpose

2.1 The Committee's primary purpose is to support the CCG Board to discharge its functions relating to CCG financial duties and its main function of overseeing efficiency, effectiveness, economy and governance.

2.2 It will work to deliver and support an integrated governance, assurance and scrutiny process covering all the objectives of the CCG and any risks to them being achieved, including corporate and clinical governance, information governance, financial control and internal control.

2.3 The Committee will, for those aspects of corporate, clinical and information governance associated, particularly, with internal control procedures:

- support the CCG Board in its governance and oversight role
- provide assurance and scrutiny on objectives and risks
- review the effectiveness of systems and controls
- review the Assurance Framework
- oversee external audit, internal audit, local counter fraud services and other external assurance functions
- review and approve the CCG's Annual Accounts on behalf of the CCG Board
- review the register of gifts and hospitality
- review the register of interests
- accountable for ensuring the effective management, accountability, resources, improvements and compliance in all aspects of information governance (IG)

3 Responsibilities

3.1 The Committee has a number of principal duties: the key aims are to;

- ensure effective governance
- risk management, and
- internal controls.

3.2 Whilst not losing the focus on financial control and risk, the Committee shall monitor and, where necessary, review the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the CCGs' activities that support the achievement of its objectives.

3.3 In particular, the Committee will review the adequacy of:

- financial planning, reporting and controls established within the CCG
- integrated governance systems and processes within the CCG
- all risk and control related disclosure statements, in particular the Annual Governance Statements, together with any accompanying Head of Internal Audit statement, and declarations of compliance with External Audit Opinion and any other appropriate independent assurances, and approve them on behalf of the CCG Board
- the underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements
- the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and
- the policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by NHS Protect.
- The compliance in all aspects of information governance.

3.4 In carrying out this work the Committee will primarily utilise the work of external audit, internal audit, the local counter fraud specialist, CSU Information Governance Lead and other assurance functions but will not be limited to these audit functions. It will also seek reports and assurances from CCG employees as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness. This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

3.5 External Audit

3.5.1 The Committee shall review the work and findings of its external auditor and consider the implications and the management's responses to their work. This will be achieved by:

- consideration of the performance of the external auditor as far as the rules governing the appointment permit
- discussion and agreement with the external auditor, before the audit commences, of the

nature and scope of the audit as set out in the Annual Plan, and ensure coordination, as appropriate, with other external auditors in the local health economy

- discussion with the external auditors of their local evaluation of audit risks and assessment of the CCG and associated impact on the audit fee

- review of all external audit reports, including agreement of the Annual Audit Letter before submission to the CCG Board and any work carried outside the Annual Audit Plan, together with the appropriateness of management responses

- discussing any problems and reservations arising from the external auditor's work and any other matters the external auditor may wish to discuss (in the absence of CCG officers, as necessary).

3.5.2 In addition, there are certain required communications between the External Auditors and Audit Committee and these include

Fraud

- Enquiries to determine whether the Audit Committee has knowledge of any actual, suspected or alleged fraud affecting the CCG
- Disclosure of any fraud the Audit Committee has identified or information it has obtained that indicates a fraud may exist
- A discussion of any other matters related to fraud

Going concern

- Events or conditions identified that may cast significant doubt on the CCG's ability to continue as a going concern, including:
  - Whether the events or conditions constitute a material uncertainty
  - Whether the use of the going concern assumption is appropriate in the preparation and presentation of the financial statements
- The adequacy of related disclosures in the financial statements

3.6 **Internal Audit**

3.6.1 The Committee shall ensure that there is an effective internal audit function established by the CCG which meets mandatory NHS internal audit standards and provides appropriate independent assurance to the Committee, Chief Officer and the CCG Board. This will be achieved by:

- consideration of the provision of the internal audit service, the cost of the audit and any questions of resignation and dismissal

- review and approval of the Internal Audit medium term Strategic Plan and Annual Audit Plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework

- consideration of the major findings of internal audit work (and management's response), and ensure co-ordination between the Internal and external auditors to optimise audit resources

- ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation; and

- undertaking an annual review of the effectiveness of internal audit.

3.6.2 The Committee shall receive a report from the Head of Internal Audit on any internal audit reports completed and the management response to these. It shall also review an Annual Report from the Head of Internal Audit.

3.7 **Other Assurance Functions**

3.7.1 The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications to the governance of the organisation.

3.7.2 These will include, but will not be limited to, any reviews by Department of Health or regulators/inspectors, for example, the Care Quality Commission, NHS Litigation Authority, and professional bodies with responsibility for the performance of staff or functions such as the Royal Colleges, or other accreditation bodies.

3.7.3 In addition, the Committee will review the work, function and terms of reference of other committees within the CCG, whose work can provide relevant assurance to the Audit Committee's own scope of work.

3.7.4 The Committee shall also be informed by the work and reports of other internal and external scrutiny, review and enquiry bodies.

3.7.5 The Committee shall satisfy itself that the CCG has adequate arrangements in place for countering fraud and will review the outcomes of counter fraud work. It will also approve the counter fraud work programme.

3.8 **Financial Reporting**

3.8.1 The Committee shall review and approve the Annual Accounts and, where possible, the Annual Report on behalf of the Board, focusing particularly on:

- the wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee
- changes in, and compliance with, accounting policies and practices and estimation techniques
- unadjusted mis-statements in the financial statements
- significant judgmental areas in the preparing of the financial statements
- significant adjustments resulting from the audit
- letter of representation
- quantitative aspects of financial reporting.

3.8.2 The Committee should also ensure that the systems for financial reporting to the CCG Board, including those of budgetary control, are subject to review - as to completeness and accuracy of the information provided to the CCG Board.

3.9 **Information Governance**

3.9.1 Ensuring the effective management, accountability, resources, improvements and compliance in all aspects of information governance including:

- developing, providing direction and maintaining an Information Governance (IG) management framework strategy and supporting corporate/directorate policies.

- ensuring Board awareness and support for IG resourcing and implementation of improvements.
- establishing coordinated working groups for the information asset owners and information asset custodians.
- ensuring annual assessments and audits and policy reviews are undertaken where required.
- ensuring the annual assessment and associated improvement plans are prepared for approved on behalf of the Board prior to 31 March each year.
- ensuring that the CCG is in line with the requirement in respect to the training of its staff as stated within the Information Governance Toolkit.
- receiving outcomes of investigations into IG Serious Incidents Requiring Investigation (SIRIs).
- receiving quarterly updates on progress with IG audits, training and toolkit evidence requirements, together with updates on any incidents that may have occurred.
- identifying and allocate resource implications incurred by the implementation of the Information Governance framework, policy and improvement plan.

3.10 Conflicts of Interest

3.10.1 The chair of the Audit Committee has a lead role in ensuring that the CCG Board and the wider CCG behaves with the utmost probity at all times. The Chair of Audit Committee oversees key elements of governance including the appropriate management of conflicts of interest. This includes ensuring that:

- The Standards of Business Conduct and conflicts of interest policy is regularly reviewed, and meets statutory guidance.
- The regular CCG self-assessments (annual and quarterly) are completed and submitted to NHS England, in line with assurance requirements, including the publication of the register of declared interest, the register of procurement decisions and the register of gifts and hospitality.

3.10.2 The Chair of the Audit Committee will act as the Conflicts of Interest Guardian. The conflicts of interest guardian should in collaboration with the Board Secretary:

- Act as a conduit for GP practice staff, members of the public and healthcare professionals who have any concerns with regards to conflicts of interest
- Be a safe point of contact for employees or workers of the CCG to raise any concerns in relation to this policy
- Support the rigorous application of conflict of interest principles and policies
- Provide independent advice and judgment where there is any doubt about how to apply conflicts of interest policies and principles in an individual situation
- Provide advice on minimising the risks of conflicts of interest.

4 Scope of authority and decision-making

4.1 The Committee is required to work in accordance with these Terms of Reference and the CCG's Standing Orders, Standing Financial Instructions and Scheme of Reservation and Delegation.

4.2 The Committee will work to the professional and legal standards required of its members.

4.3 The Committee will ensure that it reports to the CCG Board on any matters which properly fall within the Board's 'Schedule of Matters Reserved to the CCG Board'.

4.4 The Committee is authorised by the CCG Board to investigate any activity within its terms of reference.

4.5 It is authorised to seek any information it requires from any employee of the CCG and all employees are required to co-operate with any request made by the Committee.

4.6 Matters for consideration by the Committee may be nominated by any member of the CCG Board or the Accountable Officer, or the Chief Finance Officer of the CCG.

4.7 The Committee is authorised by the CCG Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

4.8 The following actions can be undertaken on behalf of the CCG Board:

- receive the External Audit Plan with the external auditor before the Audit commences and agree the extent of reliance to be placed upon the Annual Internal Audit Report

- review the external audit Annual Audit Letter and management response

- agree, on an annual basis, the programme of internal audit review for the coming year and endorse any subsequent variation in this programme

- review the Annual Governance Statement which should reflect the findings of relevant self assessments or inspections for example, Care Quality Commission reports, internal audit reports and the Assurance Framework

- review the work plan and periodic reports of the local counter fraud service and consider actions necessary by the CCG to combat fraud and corruption

- consider any other issues relating to internal control, such as variations to Standing Orders and Standing Financial Instructions, schedules of losses & compensations, and receive details pertaining to the use of CCG's official Seal

- a review of every decision to suspend Standing Orders, as required by Standing Orders.

5 Membership and attendance

5.1 The Committee will comprise all Lay members of the Board and one GP Board member (not the Clinical Chair).

5.2 The Committee will be Chaired by the Lay member for Governance.

5.3 The Accountable Officer, Chief Finance Officer and appropriate external and internal auditors and local counter fraud service representatives shall normally attend meetings. However, at least once a year the Committee should meet privately with the external and internal auditors.

5.4 The Committee has the power to invite others to attend (including other CCG employees) when it believes this would provide it with relevant and necessary expertise and experience that otherwise would not be available to it.

5.5 The meeting will be quorate when there are two Lay members of the CCG Board present.

5.6 The Chair of the CCG Board will not be a member of the Committee, but may attend meetings of the Committee.

6 Frequency

6.1 Meetings shall be held a minimum of four times a year.

6.2 The external auditor, internal audit or local counter fraud service may request a meeting if they consider that one is necessary.

6.3 Additional meetings may be called by the Committee Chair if required.

7 Management

7.1 Decisions will generally be made on the basis of consensus.

7.2 In the case of an equality of votes, the chair shall have a second vote which will be the casting vote.

7.3 The Committee Chair will provide reports on the work of the Committee to Part I or Part II of the CCG Board meeting according to the nature of the business to be reported.

7.4 The agenda and any papers shall normally be circulated to members five working days before the date of the meeting.

7.5 The Committee will be permitted to meet, for the whole or part of any meeting, without any officers being present. The Chair of the Committee will raise any issues with the CCG Board and this could mean excluding anyone normally present from that meeting.

7.6 The Committee shall request and review reports and positive assurances from the Accountable Officer and Chief Finance Officer on the overall arrangements for governance, risk management and internal control. They may also request specific reports from individual functions within the organisation.

8 Reporting

8.1 The minutes of Committee meetings shall be formally recorded and be submitted to the CCG Board.

8.2 The Chair of the Committee shall draw to the attention of the CCG Board any issues that require disclosure to the full Board.

8.3 The Committee will ensure that it monitors the adequacy and effectiveness of its work in support of the Annual Governance Statement, specifically commenting on the fitness for purpose of the Assurance Framework, the completeness and embeddedness of risk management in the organization and the integration of governance arrangements.

8.4 The Committee Chair will submit an Audit Committee Annual Report to the CCG Board covering the principal areas of responsibilities and any other matters that of note.

8.5 The Committee will be supported administratively by the CCG to include agreement of agendas, meeting dates, meeting venues, listing of attendees, collation of papers, minute taking, action tracking and advising the Committee on pertinent areas for inclusion into agendas or meetings.

Date Last Approved: March 2017
Date for Review: March 2018
Reviewed:

Date Revision to be approved by Board:

APPENDIX I: TERMS OF REFERENCE FOR THE REMUNERATION COMMITTEE

REMUNERATION COMMITTEE

TERMS OF REFERENCE

1. Constitution

1.1 The Remuneration Committee (the Committee) is a Committee of the CCG Board and has those executive powers specifically delegated to it by the CCG Board within the Scheme of Reservation and Delegation and in these Terms of Reference, which will be reviewed annually by the CCG Board.

2. Purpose

2.1 The Remuneration Committee, which is accountable to the CCG's Board, makes recommendations to the Board on determinations about the;

- allowances under any pension scheme the group might establish as an alternative to the NHS Pension Scheme
- Remuneration fees and other allowances for CCG employees
- Remuneration fees and other allowances for people who provide services to the group.

3. Responsibilities

3.1 The responsibilities of the Committee are to:

- review and approve pay arrangements for employees of the CCG
- review and approve remuneration for Board members
- consider national guidance and requirements in relation to pay and remuneration
- scrutinise any termination payments, taking account of advice and guidance as appropriate and seek advice from the National Commissioning Board on any significant proposed termination payments.
- review alternative pension scheme arrangements the group might establish
- as required assist the CCG Chair evaluate the performance of the Accountable Officer and, through the Accountable Officer, the Chief Finance Officer, and advise on and oversee appropriate contractual arrangements for such staff

4. Scope of authority and decision-making

4.1 The Committee is required to work in accordance with these Terms of Reference and the CCG's Standing Orders, Standing Financial Instructions and Scheme of Reservation and Delegation.

4.2 The Committee will work to the professional and legal standards required of its members.

4.3 The Committee will ensure that it reports to the CCG Board on any matters which properly fall within the CCG Board's 'Schedule of Matters Reserved to the Board'.

4.4 In order to facilitate the achievement of good governance the Committee is authorised by the CCG Board to help the CCG Board discharge its functions relating to CCG financial duties and its main function of overseeing efficiency, effectiveness, economy and governance to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

4.5 Matters for consideration by the Committee may be nominated by any member of the Committee or the Chair of the CCG Board.

4.6 The Committee is authorised by the CCG Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

5. Membership and attendance

5.1 The Committee will consist of

- Four lay members of the CCG Board.
- Two elected GP members, one of which will be the CCG Chair.

5.2 The Committee will be chaired by the Lay Member for Governance.

5.3 The meeting will have a quorum of four members present, except when lay members' remuneration is discussed. In the event of lay member remuneration, the two elected GP members in conjunction with the Chief Officer shall meet and make recommendations for any changes to terms and conditions and/or remuneration to the CCG Board for approval, if necessary.

5.4 The Committee must be quorate when any decisions are made or votes taken.

5.4 No member of the Committee should be present to discuss their own Remuneration or Terms of Services and Conditions.

5.5 The Accountable Officer will normally be in attendance – but no executive officer will be present for discussions about their own remuneration and terms of service.

5.6 Other attendees may be invited to attend for specific items with the prior agreement of the Chair.

6. Frequency

6.1 Meetings shall normally be held twice a year. Additional meetings may be called by the Chair if deemed necessary, including telephone conferences and virtual decision-making where urgent decisions are required.

7. Management

7.1 The Committee shall operate in line with the requirements of the NHS Codes of Conduct and Accountability, the NHS Constitution and the CCG Constitution, reflecting the Nolan Principles.

7.2 Decisions will generally be made on the basis of consensus. In certain circumstances it may be necessary for all members to vote, normally by a show of hands.

7.3 In the case of an equality of votes, the chair shall have a second vote, which will be the casting vote.

7.4 The Committee will report in writing to the CCG Board the basis for any recommendations, which require Board decision. The CCG Board will use that report as the basis for their decisions but will remain accountable for taking decisions on the remuneration, allowances and terms of service of the Accountable Officer and the Chief Finance Officer.

7.5 Minutes of the CCG Board's meetings should record such decisions. Where reports to the CCG Board contain confidential information about individuals, these should be considered in Part 2 of the CCG Board meeting.

7.6 The Committee shall receive support services from the Governance team.

7.7 The agenda and any papers shall normally be circulated to members five working days before the date of the meeting.

7.8 The Committee will receive expert HR advice via Commissioning Support South or an alternative HR Specialist.

8. Reporting

8.1 The Committee will report to the CCG Board. The approved minutes of the Committee shall be formally recorded and made available to the Board.

8.2 The Committee Chair may provide reports on the work of the Committee to Part I or Part II of the CCG Board meeting according to the nature of the business to be reported.

8.3 The Committee Chair shall draw to the attention of the CCG Board any issues which require full disclosure to the CCG Board.

8.4 The Committee's annual report forms the Remuneration Report section contained in the CCG's Annual Report and Accounts.

Date for CCG Board Approval: September 2017
Date for Review: March 2018
Date of previous reviewed: March 2017
Date Last Approved by Board: 26 May 2016

Draft 5

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APPENDIX J: TERMS OF REFERENCE FOR THE CLINICAL GOVERNANCE COMMITTEE

CLINICAL GOVERNANCE COMMITTEE

TERMS OF REFERENCE

1. CONSTITUTION

1.1 The West Hampshire Clinical Commissioning Group (CCG) Clinical Governance Committee is a sub-committee of the CCG Board. The Clinical Governance Committee is established in accordance with West Hampshire CCG's Constitution, Standing Orders and Scheme of Delegation. These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the Committee and shall have effect as if incorporated into the CCG's Constitution and Standing Orders.

2. PURPOSE

2.1 The CCG Clinical Governance Committee will seek assurance that the population of West Hampshire receives safe and high quality care and that services deliver health benefits, positive clinical outcomes and patient experience.

2.2 To provide the CCG Board with an assurance and scrutiny function in relation to quality of commissioned services relating specifically to patient safety, patient experience and clinical effectiveness, and to ensure appropriate action is taken where such assurance is lacking.

2.3 The Committee will also drive improvements in healthcare assurances within the providers from whom the CCG commissions care so that providers demonstrate year on year improvements, identifying and managing risk and underperformance.

2.4 To enable West Hampshire CCG as the lead for safeguarding to have oversight and scrutiny of governance mechanisms in place around safeguarding children within Hampshire in order to provide assurance to the five Hampshire CCGs (West Hampshire CCG, North Hampshire CCG, North East Hampshire & Farnham CCG, Fareham & Gosport CCG and South East Hampshire CCG).

2.5 To enable West Hampshire CCG as the lead for safeguarding to have oversight and scrutiny of governance mechanisms in place around safeguarding adults within Hampshire in order to provide assurance to the three Hampshire CCGs (West Hampshire CCG, North Hampshire CCG and North East Hampshire & Farnham CCG).

3. RESPONSIBILITIES

3.1 The responsibility of the Committee is to provide an assurance to the CCG Board on all matters concerning duties, obligations and responsibilities relating to patient safety, patient experience and clinical effectiveness.

3.2 To provide assurance to the CCG Board that the process and compliance issues concerning Serious Incidents (SIs) and Never Events is robust.

3.3 Receive and scrutinise independent investigation reports relating to patient safety issues and agree publication plans.

3.4 To ensure that all sub-optimal professional and organisational clinical performance within commissioned services is effectively identified and performance managed via contract mechanisms and that the wider implications and trends are addressed.

3.5 To ensure there are effective early warning systems which draw on a range of quality indicators and other sources of information to identify gaps in assurance about providers.

3.6 Respond to specific clinical governance and healthcare assurance issues identified by the Clinical Executive, Clinical Cabinet, the Finance and Assurance Committee, Primary Care Commissioning Committee, other Clinical Commissioning Groups or external regulatory bodies

3.7 To ensure that decisions made by the Individual Funding Request (IFR) Panel for both adults and children on behalf of the CCG are appropriate and that, where an individual appeals the decision of the IFR Panel, that an IFR appeals panel is established.

3.8 To approve the CCG's arrangements for handling complaints.

3.9 To approve arrangements to minimise clinical risk, maximise patient safety and to secure continuous improvement in quality and patient outcomes.

3.10 To support the CCG and NHS England in discharging its responsibilities in relation to securing continuous improvement in quality of general medical services.

3.11 To review new / updated national guidance relating to quality and safety, together with any implications for the CCG.

3.12 To seek assurance on the performance of NHS organisations in terms of the Care Quality Commission, NHS Improvement and any other relevant regulatory bodies.

On behalf of Hampshire CCG's

3.13 To provide assurance to each of the five Hampshire CCGs' Quality / Governance Committees on all matters concerning duties, obligations and responsibilities relating to safeguarding children and looked after children.

3.13 To provide assurance to North Hampshire and North East Hampshire CCGs' Quality / Governance Committees on all matters concerning duties, obligations and responsibilities relating to safeguarding adults.

3.14 To receive assurance that safeguarding adults and children processes for NHS commissioned services are robust and work in collaboration with other statutory partners. This will include the progress of providers against the respective quality assurance frameworks.

3.15 To ensure there are annual work plans for safeguarding adults, safeguarding children and children in care.

3.16 To review CCG policies for safeguarding children and adults and make recommendations to the Hampshire CCGs on their approval.

3.17 To receive assurance on the quality of health checks, including subsequent health outcomes for looked after children.

3.18 To receive the minutes of the Hampshire Local Safeguarding Children Board (HSCB), HSCB Health Sub Group, Hampshire Care Matters Board, Hampshire Safeguarding Adults Board (HSAB), HSAB Health Sub Group and review each annual action plan and the CCGs' role within it.

4. MEMBERSHIP, QUORUM AND ATTENDANCE

4.1 The Committee shall have the following core membership:

- 2 x Lay Members (one of which is the Chair)
- Director of Quality and Nursing (Board Nurse)
- Deputy Director of Quality & Nursing (Deputy Board Nurse)
- CCG Chairman
- CCG Clinical Executive Director or another GP to deputise
- Chief Officer
- Director of Commissioning: Mid Hampshire
- Director of Commissioning: West
- Director of Commissioning: South
- Director of Strategy & Service Improvement
- Director of Performance & Delivery
- Public Health Representative
- Local Authority Representative

4.2 In addition to the above core membership, there will also be Patient Representatives in attendance at each Committee.

4.3 The following will also be in attendance at the Committee to provide regular reports as detailed within the Committee Annual Work Plan:

- Senior Quality Manager: South & West
- Senior Quality Manager: Mid Hampshire
- IPC Specialist / Primary Care Quality Lead
- Quality Manager: South
- Quality Manager: West
- Designated Nurse: Safeguarding Children
- Designated Nurse: Looked After Children / Children in Care
- Consultant Nurse: Safeguarding Adults
- Associate Director: Medicines Management
- Named GP Safeguarding Children

4.4 The CCG Clinical Governance Committee will identify a Chairman and Deputy Chairman for the Committee.

4.5 The meetings will be quorate when there are at least five of the members appointed present, of whom there should be a Board lay representative and at least two General Practitioners.

4.6 The Committee must be quorate when any recommendations are made or votes taken.

4.7 Only members of the Committee are entitled to be present at its meetings. Others may be invited to attend for specific items with the prior agreement of the Chair or Deputy Chair of the Committee.

4.8 All core members of the Committee are expected to attend all of the meetings and by exception nominate a fully briefed deputy to be 'in attendance' on their behalf.

4.9 For the avoidance of doubt CCG representatives who serve as members of the Committee do not do so to specifically represent or advocate for their own General Practice or service area but to act in the interests of the CCG as a whole as part of the overarching Governance structure.

5. FREQUENCY

5.1 Meetings will normally be held every two months.

5.2 Additional meetings of the Committee may be held on an exceptional basis at the request of the Chair, deputy Chair or any three members of the Committee.

6. MANAGEMENT

6.1 Decisions will generally be made on the basis of consensus. In certain circumstances it may be necessary for all members to vote, normally by a show of hands.

6.2 In the case of an equality of votes, the chair shall have a second vote which will be the casting vote.

6.3 The majority of the Committee's business shall be conducted in an open and transparent way. Matters of a particularly confidential nature will be reserved to a confidential part two of the meeting.

6.4 Members of the Committee who have any direct or indirect financial or personal interest in a specific agenda item, or if the practitioner is interested in providing a service in relation to that agenda item, they should declare such an interest to the Chair. The individual or individuals must abstain from the discussion and take no part in, or influence, the decision. It will be at the discretion of the Chair to decide whether exclusion from the discussion/decision or from the meeting would be appropriate. The minutes will record all declarations of interest and actions taken in mitigation.

6.5 The Committee shall determine an annual work plan and schedule of regular reports for the Committee.

6.6 The Committee shall identify regular secretarial support for the Committee to ensure consistency of format of Committee records.

6.7 The agenda and any papers shall normally be circulated to members a minimum of 5 working days before the date of the meeting.

7. REPORTING ARRANGEMENTS

7.1 The CCG Clinical Governance Committee will report to the Board.

7.2 The minutes of the Committee will also be received by the CCG Board and Audit Committee.

7.3 The Business Services Manager will ensure that an accurate record of meetings is published on the website: www.westhampshireccg.nhs.uk.

8. SUB-COMMITTEES

8.1 The CCG Clinical Governance Committee may at times create sub-committees to deal with agenda items needing more detailed attention and that these sub-committees will be constituted by, dissolved when necessary and report to the Clinical Governance Committee.

8.2 The following sub-committee will report to the Clinical Governance Committee:

- Individual Funding Request Appeals Panel
- Commissioners Infection Prevention Group (CIPG)
- Clostridium Difficile Infection (CDI) Appeals Panel
- Continuing Healthcare Operational Group
- Care Home Monitoring Group

8.3 The following groups will also feed into the Clinical Governance Committee:

- Quality Monitoring Group: Primary Care (sub-committee of Primary Care Steering Group)
- Performance, Issues and Risks Group (sub-committee of Finance & Assurance Committee)

9. KEY RELATIONSHIPS

9.1 The Committee will establish and maintain relationships with the following key stakeholders:

- NHS South, Central & West Commissioning Support Unit (CSU)
- NHS England: Wessex Area Team
- Quality and Surveillance Group
- Care Quality Commission
- NHS Improvement
- Other Clinical Commissioning Groups
- Constituent General Practitioners
- Other independent Contractors
- Provider Clinical Quality Review Groups
- Local Authorities
- Local Safeguarding Children Board
- Local Safeguarding Adults Board
- Health Overview Scrutiny Committes
- Health and Wellbeing Boards
- Healthwatch
- Local Medical Committee
- Voluntary Services

10. REVIEW

10.1 The Committee will undertake an annual review of its performance in order to evaluate the achievement of its duties.

10.2 The Terms of Reference shall be reviewed as a minimum annually and at any time at the discretion of the Chair associated with necessary changes in CCG Governance arrangements such as those relating to full formal authorisation.

Date Reviewed by Committee:	14 March 2017
Date Approved:	30 March 2017
Approved by:	CCG Board
Date for Next Review:	One year from date of approval or as and when determined to be appropriate by the Chair of the Committee.

APPENDIX K: TERMS OF REFERENCE FOR THE CLINICAL CABINET

1. Constitution and Accountability

1.1. The West Hampshire Clinical Commissioning Group (WHCCG) Clinical Cabinet (the "Cabinet") is a sub-committee of the WHCCG Board.

1.2. The Cabinet is responsible for exercising those executive powers specifically delegated to it by the WHCCG Board in accordance with the Scheme of Delegation and as set out in these Terms of Reference, which will be reviewed annually by the WHCCG Board.

2. Purpose

2.1. The purpose of the Committee is to bring together all clinical leads (elected Board GPs, locality and specialty clinical leads) and senior management (Board directors) to:

- approve –
  - common commissioning strategies and approaches and provider proposals
  - clinical specifications relating to outline and full business cases
  - clinical policies and priority statements
  - locality constitutions
- agree –
  - clinical priorities for the CCG
  - priorities for CCG commissioning and operating plans
  - QIPP proposals
- promote –
  - clinical and wider stakeholder engagement in commissioning
  - good practice in clinical commissioning
  - equity of access in commissioning services
  - innovation
- maintain –
  - an overview of all commissioning by the CCG, including activities undertaken by localities and the implementation of new models of care
  - an overview and understanding of the CCG's financial position and key quality and performance indicators, via standing exception reports, for escalation to the Board and other CCG Committees as required
- align –
  - portfolios of the clinical directors and localities and support the development and operation of the locality commissioning structure.
- engage –
  - with the wider clinical community – within CCG membership and other commissioners and providers

3. Responsibilities

3.1. The responsibilities of the Clinical Cabinet are to:

- approve strategy and policy as delegated by the Board
- make recommendations to the Board across all the business of the CCG
- provide an opportunity for collective working and sharing of intelligence and learning;
- develop a common approach to commissioning strategies
- maintain an overview of all commissioning, including activities undertaken by localities and the implementation of new models of care
- facilitate engagement with the wider clinical body
- provide timely clinical commissioning consideration of key work programmes
- maximise clinical engagement in commissioning and QIPP and Reform plans
- provide a forum for decisions relating to clinical networks

4. Scope of authority and decision-making

4.1 The Cabinet will recommend matters for consideration by the WHCCG Board and ensure that it works in accordance with the terms of the CCG's Standing Orders, Standing Financial Instructions and Scheme of Delegation and reports to the Board on any matters which properly fall within the 'Schedule of Matters Reserved to the Clinical Commissioning Group'.

5. Membership and attendance

5.1 Membership of the Cabinet shall consist of the following voting members:

- Clinical Locality Leads
- Clinical Directors (clinical specialty leads)
- Board Executive Directors

5.2 Deputies may attend on behalf of members but only where they have the full authority of the members, (i.e. they are present in an "acting" capacity)

5.3 The following will also be invited to the meeting on a standing basis in a non-voting capacity:

- Director of Contracting and Performance
- Associate Director of Corporate Affairs and Communications / Head of Communications
- Public Health representative
- Board Secretary and nominated Governance Manager

5.4 Members are reminded of the importance of ensuring that they review all agenda items, consider the implications for any conflicts of interest and to make these are known to the Chair, either before the meeting or the item under consideration.

5.5 The Chair and Deputy Chair of the Clinical Cabinet shall be clinicians employed by the CCG, appointed and approved by the Board. The Chief Officer is executive lead for the Cabinet and will support the Chair and Deputy Chair in planning the programme of meetings

5.6 The Cabinet must be quorate when any formal decisions are made or votes taken. A quorum shall comprise the attendance of members from the following groups:

- 2 x Clinical Locality Leads
- 2 x Clinical Directors (specialties)
- 3 x Board Executive Directors, of which one must be the Chief Officer or the Chief Finance Officer/Deputy Chief Officer

5.7 Others may be invited to attend for specific items with the prior agreement of the Chair, Deputy Chair and/or Chief Officer.

5.8 There will be provision within the Cabinet meeting timetable for informal briefings and workshop discussions on pre-agreed topics. The following will normally be invited to attend and contribute to this part of the meeting:

- Deputy Directors of Commissioning
- Deputy Chief Finance Officer
- Deputy Director of Quality
- Deputy Director, Service Development
- Associate Director, Medicines Management
- Associate Director, Children's Services
- Associate Director, Strategy
- Head of Vulnerable Adults

6. Frequency of Meetings

6.1 The Cabinet will normally meet on a monthly basis, with at least 10 meetings a year.

6.2 The Chair and Deputy Chair of the Cabinet may convene special meetings, in line with the Standing Orders of the CCG

6.3 Meetings will normally be programmed to last one half-day – to cover both formal business and informal briefings/workshops

7. Management and Decision Making

7.1 The Cabinet Chairman will work to establish consensus as the basis of decisions. If exceptionally, the Cabinet cannot reach a decision, the Cabinet Chairman will put the matter to a vote, usually by a show of hands.

7.2 The Cabinet Chairman in conjunction with Directors of Commissioning will provide reports on the work of the Cabinet to Part I or Part II of the West Hampshire CCG Board meeting according to the nature of the business to be reported

7.3 The Governance Team will be responsible for the organisation of the Clinical Cabinet meetings.

7.4 The agenda and any papers shall normally be circulated to members five working days before the date of the meeting.

8. Reporting arrangements

8.1 The Cabinet will report to the CCG Board. The approved Minutes of the Cabinet will be submitted to the CCG Board.

Date Board Approved: 28 January 2016 (scheduled)

Date for Review: September 2016

Reviewed:

Date Revision Approved:

APPENDIX L: TERMS OF REFERENCE FOR THE PRIMARY CARE COMMISSIONING COMMITTEE

1. INTRODUCTION

1.1 Simon Stevens, the Chief Executive of NHS England, announced on 1 May 2014 that NHS England was inviting CCGs to expand their role in primary care commissioning and to submit expressions of interest setting out the CCG's preference for how it would like to exercise expanded primary medical care commissioning functions. One option available was that NHS England would delegate the exercise of certain specified primary care commissioning functions to a CCG.

1.2 In accordance with its statutory powers under section 13Z of the National Health Service Act 2006 (as amended), NHS England has delegated the exercise of the functions specified in Schedule 2 to these Terms of Reference to West Hampshire CCG. The delegation is set out in Schedule 1.

1.3 The CCG has established the West Hampshire CCG Primary Care Commissioning Committee ("Committee"). The Committee will function as a corporate decision-making body for the management of the delegated functions and the exercise of the delegated powers.

1.4 It is a committee comprising representatives of the following organisations:

- West Hampshire CCG – Lay, Executive and Clinical Members of the Board, including the Secondary Care Consultant member.
- Hampshire County Council – local authority representative from the Hampshire Health and Well-being Board (non-voting)
- Healthwatch Hampshire (non-voting)

2. STATUTORY FRAMEWORK

2.1 NHS England has delegated to the CCG authority to exercise the primary care commissioning functions set out in Schedule 2 in accordance with section 13Z of the NHS Act.

2.2 Arrangements made under section 13Z may be on such terms and conditions (including terms as to payment) as may be agreed between the Board and the CCG.

2.3 Arrangements made under section 13Z do not affect the liability of NHS England for the exercise of any of its functions. However, the CCG acknowledges that in exercising its functions (including those delegated to it), it must comply with the statutory duties set out in Chapter A2 of the NHS Act and including:

a) Management of conflicts of interest (section 14O);
b) Duty to promote the NHS Constitution (section 14P);
c) Duty to exercise its functions effectively, efficiently and economically (section 14Q);
d) Duty as to improvement in quality of services (section 14R);
e) Duty in relation to quality of primary medical services (section 14S);
f) Duties as to reducing inequalities (section 14T);
g) Duty to promote the involvement of each patient (section 14U);
h) Duty as to patient choice (section 14V);
i) Duty as to promoting integration (section 14Z1);
j) Public involvement and consultation (section 14Z2).

2.4 The CCG will also need to specifically, in respect of the delegated functions from NHS England, exercise those set out below:

- Duty to have regard to impact on services in certain areas (section 13O);
- Duty as respects variation in provision of health services (section 13P).

2.5 The Committee is established as a committee of the Board of West Hampshire CCG in accordance with Schedule 1A of the “NHS Act”.

2.6 The members of the CCG and its Board acknowledge that the Committee is subject to any directions made by NHS England or by the Secretary of State.

3. ROLE OF THE COMMITTEE

3.1 The Committee has been established in accordance with the above statutory provisions to enable the members to make decisions on the review, planning, commissioning and procurement of primary care services in West Hampshire, under delegated authority from NHS England. Decisions will be made within the context of the overall commissioning strategy of West Hampshire CCG.

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

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

3.4 This includes the following:

- GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action such as issuing branch/remedial notices, and removing a contract);
- Newly designed enhanced services (“Local Enhanced Services” and “Directed Enhanced Services”);
- Design of local incentive schemes as an alternative to the Quality Outcomes Framework (QOF);
- Decision making on whether to establish new GP practices in an area;
- Approving practice mergers; and
- Making decisions on ‘discretionary’ payment (e.g., returner/retainer schemes).

3.5 The CCG will also carry out the following activities:

- To undertake strategic planning, (including local needs assessment) of primary medical care services in West Hampshire and the identification of key objectives for delivery;
- To ensure meaningful engagement of patients and the public in decision making;
- To undertake reviews of primary medical care services in West Hampshire;
- To co-ordinate a common approach to the commissioning of primary care services;
- The development and investment in primary care services as a core CCG responsibility, affording primary care equal weighting with other sectors;
- To ensure access to consistently high quality care, with improved health outcomes, equity of access and reduced health inequalities; and

- To manage the budget for commissioning of primary medical care services in West Hampshire.

4. GEOGRAPHICAL COVERAGE

4.1 The Committee will comprise the area of West Hampshire CCG, as defined in the CCG's Constitution.

5. MEMBERSHIP

5.1 The Committee shall consist of:

- The Lay Members from the CCG Board
- Chief (Accountable) Officer
- Chief Finance Officer and Deputy Chief Officer
- Director of Quality and Safety (Board Nurse)
- Secondary Care Specialist
- Director of Commissioning (Mid Hampshire Directorate)
- Director of Commissioning (South Directorate)
- Director of Commissioning (West Directorate)
- Director of Strategy and Service Development
- Clinical Vice Chair / Clinical Executive Director (Primary and Community Care)

5.2 The Chair of the Committee shall be a Lay Member from the CCG Board (but not the Lay Member for Governance).

5.3 The Vice Chair of the Committee shall be a Lay Member from the CCG Board.

5.4 The following are invited to meetings of the Committee as non-voting attendee:

- Local Authority representative from the Hampshire Health and Wellbeing Board (Director of Public Health)
- Healthwatch representative
- Clinical Director, Primary Care
- Associate Director, Corporate Affairs and Communication
- Board Secretary/Head of Business Services ('Secretary to the Committee')
- NHS England Wessex representative

6. MEETINGS AND VOTING

6.1 The Committee will operate in accordance with the CCG's Standing Orders. The Secretary to the Committee will be responsible for giving notice of meetings. This will be accompanied by an agenda and supporting papers and sent to each member representative no later than five working days before the date of the meeting. When the Chair of the Committee deems it necessary in light of the urgent circumstances to call a meeting at short notice, the notice period shall be such as s/he shall specify.

6.2 Each member of the Committee shall have one vote. The Committee shall reach decisions by a simple majority of members present, but with the Chair having a second and deciding vote, if necessary. However, the aim of the Committee will be to achieve consensus decision-making wherever possible.

7. QUORUM

7.1 The quorum for a meeting of the Committee shall be five members, and must include at least one Lay Member (the Chair and/or Vice Chair of the Committee).

8. FREQUENCY OF MEETINGS

8.1 Meetings will normally be held every two months.

8.2 Additional meetings of the Committee may be held on an exceptional basis at the request of the Chair, supported by any three members of the Committee.

8.3 Meetings of the Committee shall:

a) be held in public, subject to the application of 8.2(b);
b) the Committee may resolve to exclude the public from a meeting that is open to the public (whether during the whole or part of the proceedings) whenever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time.

8.4 Members of the Committee have a collective responsibility for the operation of the Committee. They will participate in discussion, review evidence and provide objective expert input to the best of their knowledge and ability, and endeavour to reach a collective view.

8.5 The Committee may delegate tasks to such individuals, sub-committees or individual members as it shall see fit, provided that any such delegations are consistent with the parties' relevant governance arrangements, are recorded in a scheme of delegation, are governed by terms of reference as appropriate and reflect appropriate arrangements for the management of conflicts of interest.

8.6 The Committee may call additional experts to attend meetings on an ad hoc basis to inform discussions.

8.7 Members of the Committee shall respect confidentiality requirements as set out in the CCG's Constitution and Standing Orders.

8.8 The Committee will present its minutes to the Wessex Area Team of NHS England and the Board of West Hampshire CCG at each meeting for information, including the minutes of any sub-committees to which responsibilities are delegated under paragraph 8.5 above.

8.9 The CCG will also comply with any reporting requirements set out in its constitution.

8.10 It is envisaged that these Terms of Reference will be reviewed from time to time, reflecting experience of the Committee in fulfilling its functions – initially six months and then on an annual basis. NHS England may also issue revised model terms of reference from time to time.

9. ACCOUNTABILITY OF THE COMMITTEE

9.1 The Primary Care Commissioning Committee is a delegated committee of the Clinical Commissioning Group Board, and its powers are set out in the CCG's Constitution, including revised Standing Financial Instructions and Standing Orders.

9.2 For the avoidance of doubt, in the event of any conflict between the terms of this Scheme of Delegation (Terms of Reference) and the CCG's Standing Orders or Standing Financial Instructions, the latter will prevail.

10. PROCUREMENT OF AGREED SERVICES

10.1 The detailed arrangements for procurement of agreed services will follow the Standing Financial Instructions and Standing Orders of the Clinical Commissioning Group. These reflect the arrangements within the CCG's constitution and the delegation agreement with NHS England. The Committee will adhere to these arrangements.

11. DECISIONS

11.1 The Committee will make decisions within the bounds of its remit.

11.2 The decisions of the Committee shall be binding on NHS England and West Hampshire CCG.

11.3 The Committee will produce an executive summary report which will be presented to the Wessex Area Team of NHS England and the Board of West Hampshire CCG at each meeting for information.

11.4 The CCG will publish a register of procurement decisions on its website

Version 5

15 April 2016

Date Reviewed by Committee: **28 April 2016**

Date Approved:

Approved by:

Date for Next Review: Twelve months from date of approval or as and when determined to be appropriate by the Chair of the Committee.

Schedule 1: Scheme of Delegation

Available on request.

Schedule 2: Delegated Commissioning Functions

Delegated commissioning functions are as follows:

- GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action such as issuing branch/remedial notices, and removing a contract);
- Newly designed enhanced services ("Local Enhanced Services" and "Directed Enhanced Services");
- Design of local incentive schemes as an alternative to the Quality Outcomes Framework (QOF);
- Decision making on whether to establish new GP practices in an area;
- Approving practice mergers; and
- Making decisions on 'discretionary' payment (e.g., returner/retainer schemes).

Delegated commissioning arrangements exclude individual GP performance management (medical performers' list for GPs, appraisal and revalidation). NHS England to retain responsibility for the administration of payments and list management

APPENDIX M: TERMS OF REFERENCE FOR THE FINANCE AND PERFORMANCE COMMITTEE

1. Introductory Statement

It is proposed that this Committee is refocused from a Finance and Assurance Committee into a Finance and Performance Committee to:

- Strengthen and support the finance and assurance functions of the CCG for as long as the CCG is subject to a financial turn-around regime and to make a difference to the longer term financial sustainability.
- Facilitate the Committee to:
  - Seek a specific managerial response in terms of delivery of Directors own areas of responsibility.
  - Identify best practice and innovations and to seek ways to access expertise and bring this into the work of the CCG
- Ensure a cost effective best practice evidence based approach is applied rigorously to the CCG's business.
- Recognise and identify constraints and opportunities for driving improvements.
- Interface and engage with clinical business management.

1. Constitution

1.1 The Finance and Performance Committee (Committee) has powers limited to those specifically delegated to it in the Board's Scheme of Delegation and in these Terms of Reference.

1.2 Due to the developing nature of the CCG and the role of the Committee, its terms of reference need to be kept under review to reflect the on-going requirements to progress the development of the CCG.

2. Purpose

2.1 The Committee is responsible for:

- Establishing a performance framework which enables the CCG to proactively manage its Financial, Performance and Quality Innovation, Productivity and Prevention agenda.
- Providing the Board with assurance that the risks to the CCG's finances and operational performance are being appropriately managed.
- Reporting key issues and concerns to the Board for information or further consideration.
- Supporting the objectives of the CCG and its Governing Body, and the provision of assurance to the Governing Body and the Audit Committee.
- Hold to account the Management Team of the Clinical Commissioning Group for delivery in their areas of responsibility.

3. Authority

3.1 The Committee is authorised by the WHCCG Board to undertake the activities described in these terms of reference.

3.2 The Committee will ensure that it works in accordance with the terms of the CCG's Standing Orders, Standing Financial Instructions and Scheme of Delegation.

3.3 The Committee has delegated powers from the WHCCG Board to investigate any matter within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made. The Committee must have due regard for the use of personal health information and the CCG's duty of care to its employees when exercising its authority.

3.4 Whilst individual Directors will be responsible for regular reporting relevant matters to the Committee, the Committee may establish such sub-committees and task groups as it feels necessary in order to undertake its role.

4 Membership and Meeting Arrangements

4.1 **Members** The following post-holders or nominated deputies are voting members of the Committee:

- Chief Officer
- Chief Finance Officer
- Director of Quality and Nursing and Board Nurse
- Director of Commissioning Mid Hampshire
- Director of Commissioning South
- Director of Commissioning West
- Director of Strategy and Service Development
- Director of Performance and Delivery
- Clinical Executive Director : Clinical Chairman
- Clinical Executive Director : Vice Clinical Chairman
- Clinical Executive Director x3
- Lay Members x 4
- Secondary Care Consultant

The following post-holders or nominated deputies are non-voting members of the Committee:

- Associate Director of Communication and Development **or** Head of Communication and Engagement

The Chair of the Committee is a nominated Lay Member of the Board (not the Lay Member, Governance). Another Lay Member shall agree to deputise for the Chair in their absence.

4.2 **Attendance**

The Chair of the Committee may also extend invitations to other managers or advisers with relevant skills, experience or expertise as necessary to deal with the business on the agenda.

An attendance record will be recorded for each meeting which will be published within the Annual Report Accounts.

4.3 **Frequency of Meetings**

The Committee shall meet at such intervals as the Chair shall judge necessary to discharge its delegated responsibilities but shall normally meet on a monthly basis, with at least ten meetings a year.

The Chair of the Committee may convene special meetings in accordance with the Standing Orders of the CCG.

4.4 **Quorum**

A meeting of the Committee shall be quorate where there are a minimum of six members present to include

- Chair or Deputy Chair
- Two Directors
- One Lay Member (excluding Chair or Deputy Chair)
- Clinical Chair or Vice Chair
- One Clinical Executive Director

4.5 **Deputies**

Deputies may attend on behalf of members, but only where they have full authority of the members, (i.e. they are present in an “acting” capacity).

4.6 **Voting**

The Committee Chair shall determine whether any matter should be put to the vote for a decision. Voting will normally be effected by a show of hands and the outcome of the vote recorded in the minutes of the meeting. The vote will transfer to deputies in line with their acting responsibilities.

In the absence of a majority vote, the Chair (or Deputy Chair) may wish to exercise a casting vote.

4.7 **Reporting**

The confidential and main business minutes of the Committee will be submitted to the West Hampshire CCG Board after each meeting. The Chair of the Committee shall liaise with the Chief Finance Officer to provide a summary of hot topics/issues arising from meetings of this Committee within the Chief Finance Officer’s Report to the Board and draw to the attention of the Board and/or Audit Committee any issues that require disclosure or require executive action. The

Chair is required to inform the Board and Audit Committee on any exceptions to the annual work plan or strategy. The Chief Finance Officer will report any specific financial or service quality issues relating to the Trust Risk Register to the Audit Committee Chair for onward reporting to the Audit Committee.

Where necessary, part of the meeting will be reserved for the discussion of items of a confidential or commercial in confidence nature. The Committee will resolve to meet in closed session with members present, plus any others required by the nature of the business to be considered. The Minutes will be reported to the next available private meeting of the Board.

4.8 **Relationships With Other Committees**

The Committee receives information and assurances from the CCG's internal financial performance review processes and meetings, such as the Directorate Financial Recovery Plan meetings and the Performance Issues and Risks Group.

4.9 **Sub-Committees**

This Committee may at times create sub-committees or task and finish groups to deal with agenda items needing more detailed attention and that these sub-committees will be constituted by, dissolved when necessary and report to the Finance and Performance Committee.

The following sub-committee will report to the Committee ensuring that the Committee is focused on a forward look/strategic overview of procurement schemes and market management issues:

- Procurement Group
- Performance Issues and Risks Group

5. Duties

5.1 The Committee will provide assurance and raise concerns and make recommendations as required to the West Hampshire CCG Board, Audit Committee or Clinical Governance Committee, in respect of the systems and processes for financial and performance stewardship, contracting and commissioning governance, Financial Recovery Programme, QIPP plans, clinical business cases.

5.2 The Committees roles and responsibilities are:

1. Financial Matters

    a) Review and approve the annual budget setting guidance.
    b) Oversee the development of the Finance Plan and estimates.
    c) Undertake detailed scrutiny of monthly, quarterly and year to date financial information, including performance against the cost improvement programme.
    d) Undertake detailed scrutiny of the financial forward projections.
    e) Scrutinize the Finance and Recovery Programme.

2. Performance Management

a) Oversee the development, and implementation and delivery of the Quality, Innovation, Productivity and Prevention Plans (QIPP).
b) Oversee the development and implementation of the Commissioning for Quality and Innovation Plans and receive updates on both the financial and activity performance of each scheme.
c) Test investments, programmes and projects against agreed prioritisation frameworks, and recommend prioritisation to the WHCCG Board with regard to agreed business case processes.
d) Review the Integrated Performance Report.
e) Support the CCG Quarterly Assurance process and the development of an action plan to respond to issues as required.

3. Contract Negotiation

a) Agree the CCG Contracting Strategy.
b) Oversee the negotiation of contracts with local providers.
c) Receive regular contract updates.

4. Corporate Risk Register and Business Assurance Framework

a) Highlight to the Audit Committee and the Risk Review Group any risks and issues for review, escalation or inclusion on the Corporate Risk Register.

5. Clinical Service Procurement

a) Oversee the development processes for producing and delivering commissioning intentions in line with the CCG's Strategic/Operating Plans.
b) Ensure that Clinical engagement is harnessed within the business case development process and strengthen responsibilities around decision making for the commitment/re-commitment of resources.
c) To consider and approve clinical business case proposals, which are included in the Board-approved CCG Operating Plan and which request an investment of up to 300k for the life time costs of the contract.
d) To consider and approve all new clinical business case proposals developed in year (and are not included in the Board-approved CCG Operating Plan) up to a maximum of £2,000,000 for onward ratification by the Board.
e) To consider and recommend business case proposals (which are either included in the Board-approved CCG Operating Plan or are new and have been developed in year) and which request an investment exceeding £2,000,000, for onward approval by the Board.
f) Scrutinize on a quarterly basis the schedule of approved business cases to ensure delivery against key milestones and schemes are being delivered within financial limits
g) Evaluate and approve the Transformation Fund proposals.
h) Approve Tender Ratification documents within delegated limits and approve Tender Ratification documents for onward transmission to

WHCCG Board.

i) Scrutinize forward view of Procurement Schemes including understanding and engagement with the supplier market

6. Code of Conduct

   The Committee shall conduct its business in accordance with national guidance, relevant codes of practices including the Nolan Principles and The Conflict of Interest Policy

7. Process for Monitoring the Effectiveness of the Committee

   Annually, the Committee will review its performance against the requirements of the Terms of Reference and assess its effectiveness.

6. Administration

6.1 The Governance Team will be responsible for the organisation of the Finance and Performance meetings.

6.2 Meetings of the Committee shall be set by the start of the financial year.

6.3 The agenda and papers shall normally be circulated to members five calendar days before the date of the meeting. Timing is subject to the regular monthly reporting schedule, and so a level of flexibility of one to two days may be required in some months, subject to agreement with the Chair of the meeting.

7. Approval and Review

7.1 The Terms of Reference shall be reviewed at the first meeting of the Finance and Performance Committee and reviewed annually or earlier if indicated by the Chair. The initial Terms of Reference and any subsequent changes are to be approved by the West Hampshire CCG Board.

Approved at Finance and Performance Committee:
Date CCG Board Approved: 20 March 2017 (V2)
Date for Review: March 2018

APPENDIX N: TERMS OF REFERENCE FOR THE LOCALITY COMMITTEES

1. Constitution and Accountability

1.1 There are 6 Locality Committees (the "Committees") within the West Hampshire Clinical Commissioning Group (WHCCG) to whom these terms of reference apply.

1.2 The 49 practices within the West Hampshire CCG are divided between 6 localities:

- Andover 6 practices
- Winchester 12 practices
- West New Forest 11 practices
- Totton & Waterside 6 practices
- Eastleigh Southern Parishes 5 practices
- Eastleigh North & Test Valley South 9 practices

1.3 Each locality is a sub-committees of the WHCCG Clinical Cabinet who reviews and annually approves these terms of reference.

2. Purpose

2.1. To provide clinical leadership and advice, to locality practices for the programme of work relating to the locality.

2.2. Develop common commissioning strategies and approaches and provider proposals

2.3. Develop outline and final business cases within agreed limits

2.4. Develop clinical policies

2.5. Develop Locality constitutions

2.6. To support and inform the development and delivery of CCG objectives and associated plans in the locality.

2.7. Discuss the implications of specific issues raised by the Clinical Cabinet for the locality.

2.8. Support and inform the CCG Board via the Clinical Cabinet, on the development of CCG objectives and delivering on associated plans.

2.9. To engage with the locality clinical community

2.10. To identify local priorities for commissioning

2.11. To identify local QIPP proposals

2.12. To advise on or approve matters relating to primary care contracting

2.13. To promote clinical and locality stakeholder engagement in commissioning

2.14. To promote good practice in clinical commissioning

2.15. To promote equity of access in commissioning services

2.16. To maintain an overview of locality commissioning activities

3. Membership and attendance (to be discussed)

3.1 Membership of the Locality Committee(s) shall consist of:

- Locality Clinical Director (Chair)
- Practice representative(s)
- Patient representative

3.2 Members are reminded of the importance of ensuring that they review all agenda items, consider the implications for any conflicts of interest and to make these known to the Chair, either before the meeting or the item under consideration.

3.3 Others may be invited to attend for specific items with the prior agreement of the Chair.

4. Frequency of Meetings

4.1 The Locality Committee will normally meet on a monthly basis, with at least 10 meetings a year.

5. Management and Decision Making

5.1 The Locality Committee Chairman will provide reports on the work of the Locality Committee to the Clinical Cabinet meeting.

5.2 The agenda and any papers shall normally be circulated to members six working days before the date of the meeting.

6. Reporting arrangements

6.1 The Locality Committee will provide reports to the Clinical Cabinet meeting.

6.2 The approved minutes of the Locality Committee will be submitted to the WHCCG Clinical Cabinet.

The following template locality constitution has been adopted by the Winchester, Andover, New Forest and Totton & Waterside localities

X LOCALITY

LOCALITY CONSTITUTION
January 1st 2017

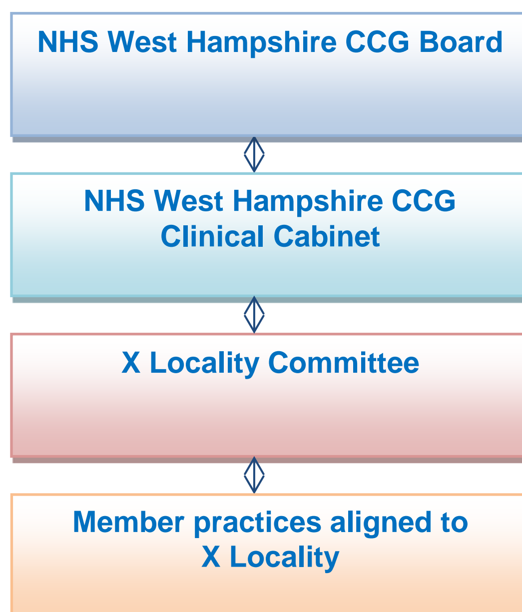
1. INTRODUCTION

1.1 Member practices of NHS West Hampshire Clinical Commissioning Group ("the CCG") are each aligned to one of six localities of the CCG ("the Localities"). The six Localities are known as:

- Andover
- Winchester
- West New Forest
- Totton and Waterside
- Eastleigh Southern Parishes
- Eastleigh North and Test Valley South

1.2 Member practices forming a Locality contribute to the governance and decision making processes of the CCG via meetings of a Committee established to represent their Locality ("the Locality Committee"); there being one Locality Committee to represent each Locality.

1.3 The Locality Committees are individually constituted as a sub-committee of the CCGs Clinical Cabinet; which is itself a committee of the CCG Board. These relationships are described in the following diagram:



1.4 The CCGs Clinical Cabinet shall approve the constitution of each Locality and review annually each constitution.

1.5 This Constitution establishes the arrangements under which **X** Locality shall convene and conduct the business of a Locality Committee, nominate suitable candidates to act as Chair of the Locality Committee in the role of a Locality Clinical Director and meet the Locality Committees responsibilities to the CCGs Clinical Cabinet.

2. PURPOSE

2.1 The aim of the **X** Locality is to act in the best interests of the registered patient population it serves in order to further the health & wellbeing of patients in line with the annual operating plan approved by the Board of the CCG.

2.2 This includes, wherever possible working to tackle health inequalities, to make evidence based decisions, to commission high quality patient centred care, to ensure value for money and attach a high priority to sustainability of local health services.

3. RESPONSIBILITIES

3.1 Each member practice of the CCG has a responsibility to represent the best interests of its patient population in commissioning decisions. This should be done from a position of knowledge and understanding both of the issue and of the views of those being represented.

3.2 Each practice within the locality has a responsibility as a member of the CCG to contribute to the development of strategic direction, management of associated change and delivery of specific areas of work, negotiated and agreed within the CCG structures.

3.3 Each member GP and practice is responsible for working within the framework set out by the annual operating plan of the CCG, working to ensure the effective and efficient use of the CCG resources and engaging in the CCG commissioning agenda recognising that the CCG has a statutory responsibility to ensure best value for money and operate within its financial resources.

3.4 Each member practice is responsible for their representation at meetings of the Locality Committee as agreed annually within the locality to deliver its responsibilities as outlined in 3.1, 3.2 & 3.3.

3.5 The **X** Locality is responsible for agreeing an annual work programme with the CCG which takes into account the CCGs annual operating plan and local needs.

4. MEMBERSHIP

4.1 The **X** member practices in the **X** Locality are:

- **INSERT ALL PRACTICE NAMES**

4.2 Each member practice shall nominate its own GP representative (“the practice lead”).

4.3 The Practice Leads will be the voting members of the **X** Locality Committee, representing their practice population at agreed meetings and events and in all locality decisions and taking into account the views of:

- all clinicians working within their practice (including salaried & locum GPs, and practice nurses, and
- patients registered with their practice

4.4 Practice leads (and representatives) will participate fully in decision making as commissioners of local health services and will be mindful of any potential conflicts of interest in views and discussion at practice level.

4.5 Practice leads are expected to attend 80% of locality meetings. If in exceptional circumstances the practice lead is unable to attend a meeting the practice can put forward at alternative GP to attend on the leads behalf. The practice will need to inform the Locality Clinical Director in advance of the meeting to allow the representative to participate actively in any decisions and to vote on behalf of their practice

4.6 It is the responsibility of the Practice Lead to ensure that all important and relevant commissioning matters are discussed within the practice (including GP locums, salaried GPs and nurses), with the practice's Patient Participation Group ("the PPG") and any other relevant stakeholders and the views of each represented at locality committee.

4.7 Other clinical or senior management members of a member practice may attend meetings on an *ad hoc* or regular basis but do not have a vote.

4.8 Other non-voting members of the locality may attend or be invited to provide support and/or education, and may include representatives from WHCCG, service providers, local partners, stakeholders or patient and public representatives.

5. LOCALITY MEMBERSHIP/WITHDRAWAL

5.1 Member Practices wishing to apply to join the **X** Locality should initially contact the Locality Clinical Director with an expression of interest.

5.2 Member Practices wishing to accept an offer to join the **X** Locality will need to formally accept the Locality Constitution and may join the locality, subject to 70% of all X Locality practices approving entry by vote.

5.3 Any Member Practice can voluntarily leave the **X** Locality by giving three months notice in writing addressed to the Locality Clinical Director informing them of their decision. Prior to giving formal notice any practice may contact the Locality Clinical Director and/or the Locality Director of Commissioning regarding issues relating to the decision and attempts will be made to resolve such issues if appropriate.

5.4 If a member practice leaves the **X** Locality and later wishes to re-join the Locality, then it will need to repeat the application process as set out in 5.1 and 5.2 above; as if it were a member practice that had no previous relationship to the Locality.

6. THE LOCALITY CLINICAL DIRECTOR

6.1 Each Locality will be led by a Locality Clinical Director; a GP from a member practice within the Locality who has been nominated by the member practices and who has subsequently been appointed to the post of Locality Clinical Director by the CCG.

6.2 The Locality Clinical Director will Chair meetings of the Locality Practice Leads and work to deliver the terms of the Locality Clinical Director Job Description. The Locality Clinical Director will work alongside and will be supported by the Locality Director of Commissioning.

6.3 The Locality Clinical Director is a voting member of the CCG Clinical Cabinet and is authorised by the **X** Locality to represent the majority opinion and decisions of the Locality at meetings of the Clinical Cabinet.

6.4 It is the responsibility of the Locality Clinical Director to ensure that Practice Leads receive timely and useful information to support necessary decision making.

6.4 It is the responsibility of Practice Leads to contribute to the discussion and decision making that informs Locality feedback represented to the Clinical Cabinet via the Locality Clinical Director.

6.5 It is the responsibility of the Locality Clinical Director to ensure that all member practices comprising the Locality have access to Clinical Cabinet minutes and to engage the locality team where specific CCG decisions require wider engagement.

6.6 Election of Locality Clinical Director - nominations will be invited from member practices comprising the Locality and GPs working in a member practice may self-nominate. Any GP accepting nomination will need to ensure that they have the support of their own practice.

6.7 Following nominations, the election of the Locality Clinical Director will follow a formal process of application. This will include an application by all candidates confirming the support of their GP Practice and a brief summary of less than 200 words outlining the contribution that they can make to the locality. This will be followed by a preliminary interview by representation of the CCG Board prior to recommending election to the membership. Election by the locality GP Practices will be via a voting system co-ordinated by the Primary Care Commissioning Manager. A majority vote will apply. In the circumstance of there being only one candidate, a majority vote of support will still be required. Votes will be submitted by Practices to a designated e-mail address. The voting process will be co-ordinated by the Commissioning Manager (Primary Care Development). The elected candidate (as a Director level post) will require ratification by the WHCCG Board prior to the formal contract offer and the candidate taking up the post.

6.8 The Locality Clinical Director will ordinarily serve in that post for a term of two years; subject to satisfactory performance in line with the CCGs terms and conditions of employment for this post. The term of service may be extended for a further period of up to one year subject to majority support for re-appointment of the incumbent post holder following a vote of the Locality Committee. In exceptional circumstances there may be a degree of flexibility to the period of this term of the extension with the agreement of the CCG.

6.9 In the event of no nominations being received from member practices constituting the Locality, it will be the responsibility the Clinical Cabinet to nominate suitable candidate(s) for the post of Locality Clinical Director for the **X** Locality.

7. VOTING STRUCTURE

7.1 The Locality will recommend matters for consideration by the Clinical Cabinet. The Locality will ensure that it works in accordance with the terms of the CCG's Standing Orders, Standing Financial Instructions and Scheme of Delegation and reports to the CCG Board on any matters which properly fall within the 'Schedule of Matters Reserved to the Clinical Commissioning Group'.

7.2 The Locality Clinical Director will work to establish consensus as the basis of decisions wherever possible.

7.3 Where consensus cannot be reached, a vote will be conducted. It is the responsibility of the Locality Clinical Director to call for a vote. All possible measures shall be taken by the Locality Clinical Director to ensure there is sufficient opportunity to inform and consult with member practices (and other stakeholders as appropriate) before a vote is taken.

7.4 Voting will take place at any ordinary meeting of the Locality Committee; votes will be cast by each Practice Lead. A vote will usually be conducted by a show of hands.

7.5 It is the responsibility of the member practices forming the locality to ensure their nominated Practice Lead, or nominated representative of the Practice Lead, is present at meetings of the Locality Committee.

7.6 In exceptional circumstances, and with the prior approval of the Locality Clinical Director, member practices can delegate voting to a named and nominated proxy, who can be a non-clinical representative of the member practice. Where necessary and appropriate, at the discretion of the Locality Clinical Director, votes may be accepted by email.

7.7 **VOTING STRUCTURE**

Voting for Locality Clinical Director and any other locality and commissioning matters will be on a practice capitation system as follows:

1 – 14,999	registered list size	1 vote
15,000 +	registered list size	2 votes

Quorum
>70% of practices need to be present for a meeting and vote to be quorate.

7.7 The Locality Clinical Director will not normally hold a vote. If the Locality Clinical Director is also the nominated Practice Lead for a member practice, they will be able to cast a vote with delegated authority by their practice, but not within their locality lead role.

7.8 In exceptional circumstances, but no more than once a year, e.g.: if there are urgent decisions that require practice/stakeholder consideration, an email vote will take place. This will be managed by the Locality Clinical Director/ Primary Care Commissioning Manager.

7.9 In a vote of censure, 80% of practices will be asked to vote;

7.10 Voting arrangements will be should any practice merge or membership group change.

8. DECLARATION OF INTERESTS

8.1 The CCG is a commissioning organisation and member practices comprising the **X** Locality must declare an interest and exclude themselves from decisions, but not necessarily discussions, on matters where they may benefit financially as individuals, or as a practice.

8.2 Any interests which conflict with the commissioning process need to be appropriately declared. All Locality Clinical Director and GP practice leads should be aware of their role in representing the population of **X** Locality, and should be bound by the Nolan Principles in Public Life.

8.3 A Register of Interests will be maintained by the appropriate CCG Commissioning Directorate for the Locality Clinical Directors, Practice leads and Practice Managers

Date of Clinical Cabinet Approval:

Date for Clinical Cabinet Review:

Date Revision Approved:

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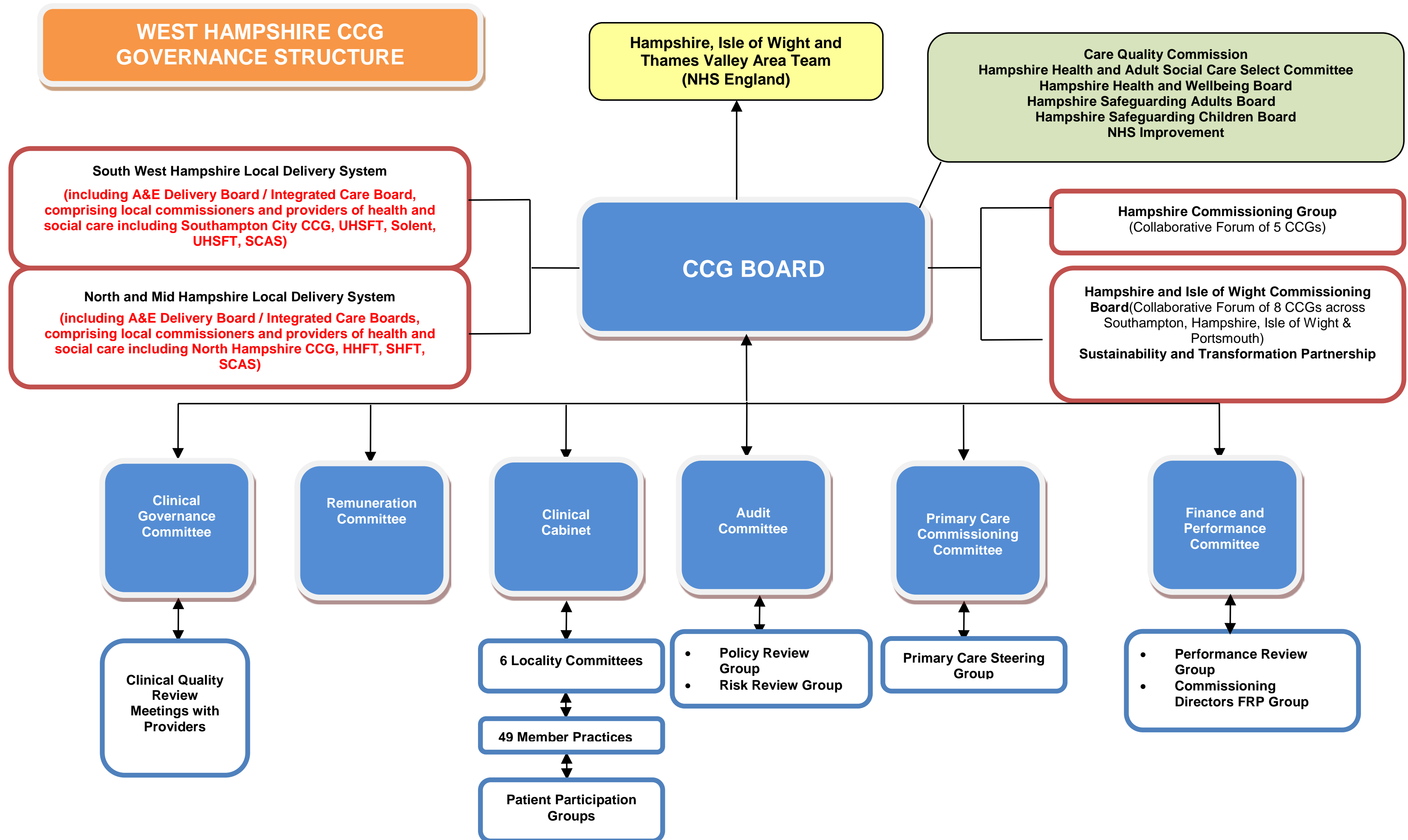
APPENDIX O: GOVERNANCE STRUCTURE



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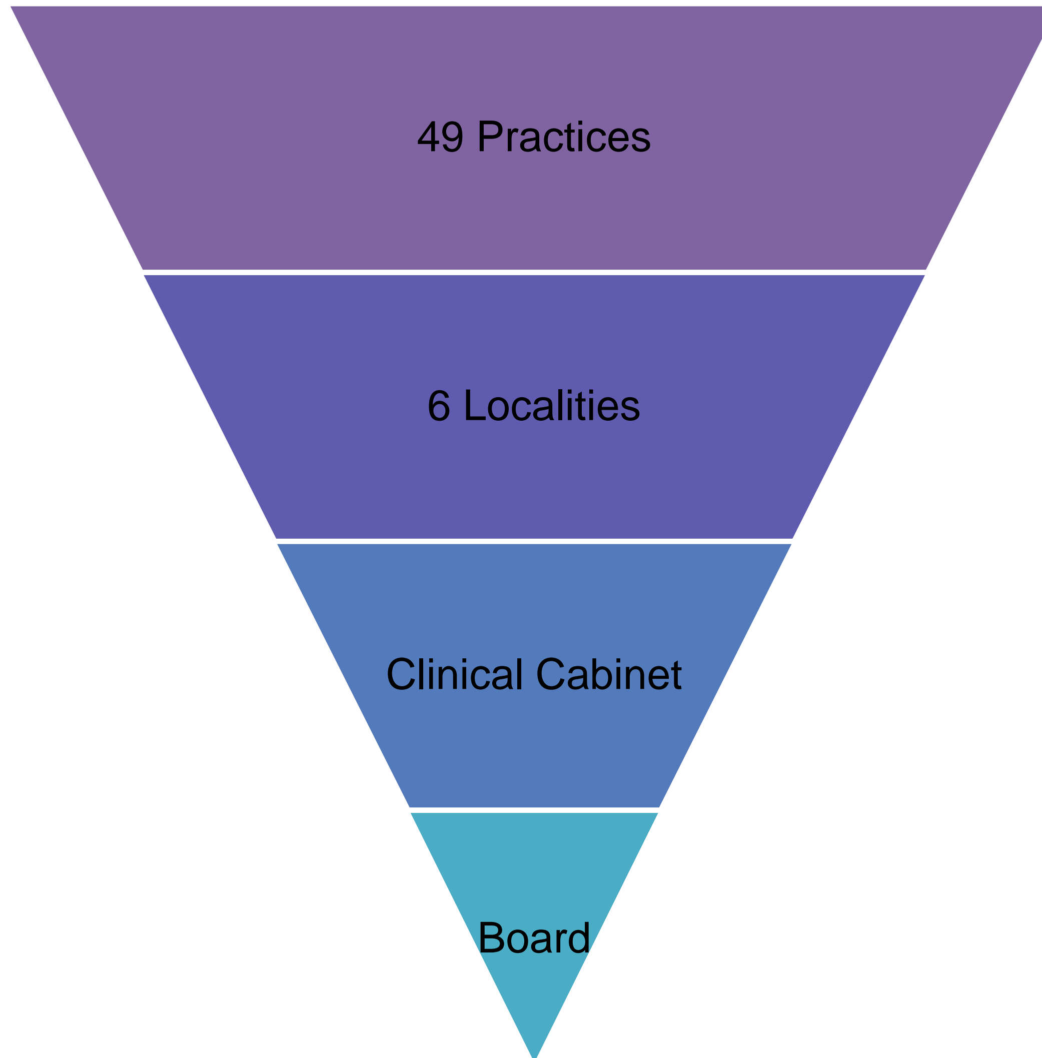
APPENDIX P: MEMBERSHIP MODEL

NHS
West Hampshire
Clinical Commissioning Group

Membership Model

- The 49 practices in the West Hampshire CCG area make up the membership of the CCG.
- A scheme of delegation identifies which decisions are reserved to the Board and which are reserved for the membership as a whole.
- Each individual practice is represented by an individual from the practice and the members group, will meet at least once per year. Two-thirds of this group, 33 members, can among other things take a vote of no confidence in the elected members and expect a process of election to take place. There will also be the opportunity to call additional meetings if required.
- The CCG has structured its membership into localities, each with a clinical lead (locality clinical director) who has a seat and vote on the Clinical Cabinet, a subcommittee of the Board, and the Board. Locality constitutions are set out in Appendix M
- The 49 practices are divided between 6 localities:
  - Andover 6 practices
  - Winchester 12 practices
  - West New Forest 11 practices
  - Totton & Waterside 6 practices
  - Eastleigh Southern Parishes 5 practices
  - Eastleigh North & Test Valley South 9 practices
- Each Locality has an elected Clinical Director who is a voting member of the Clinical Cabinet and who derives his/ her authority from the locality group.
- The membership advises, influences and works with the Board via these 6 Locality Clinical Directors.
- The Localities each have a written constitution indicating locality membership and rights of veto. Five Locality Constitutions have been developed as Winchester and Andover have elected to work together in partnership as combined localities under the terms of their constitution
- The Locality Leads each have a role specification agreed by the Locality members (attached).
- Communications between the Membership and the Board will be via the locality groups and Locality Clinical Directors. Both the locality groups and the member practice will have the opportunity to influence, engage with and cause to pause, proposed decisions of the CCG Board. A pause in the Board decision processes will come into effect when 2 or more localities vote against a decision or 50% of practices within each of the localities disagree with a decision.
- Cause to ‘pause’. A number of actions are possible at this point, ranging from a decision to elicit further feedback to overturning a decision which has been made. The membership who vote against a decision may indicate a preferred response. However, any subsequent decision will need to be ratified by the localities.

Membership Diagram



The 49 practices form a Membership Group with representation from each of the practices, meeting at least once per yearl.

Each of the localities has a lead clinician (Locality Clinical Directors) who is elected to serve on on the Clinical Cabinet and the Board.

The Clinical Cabinet comprises specialty Clinical Directors and the 6 Locality Clinical Directors elected by each locality, each with a vote.
The elected Locality Clinical Director from each locality are members of the CCG Board

Annex 1

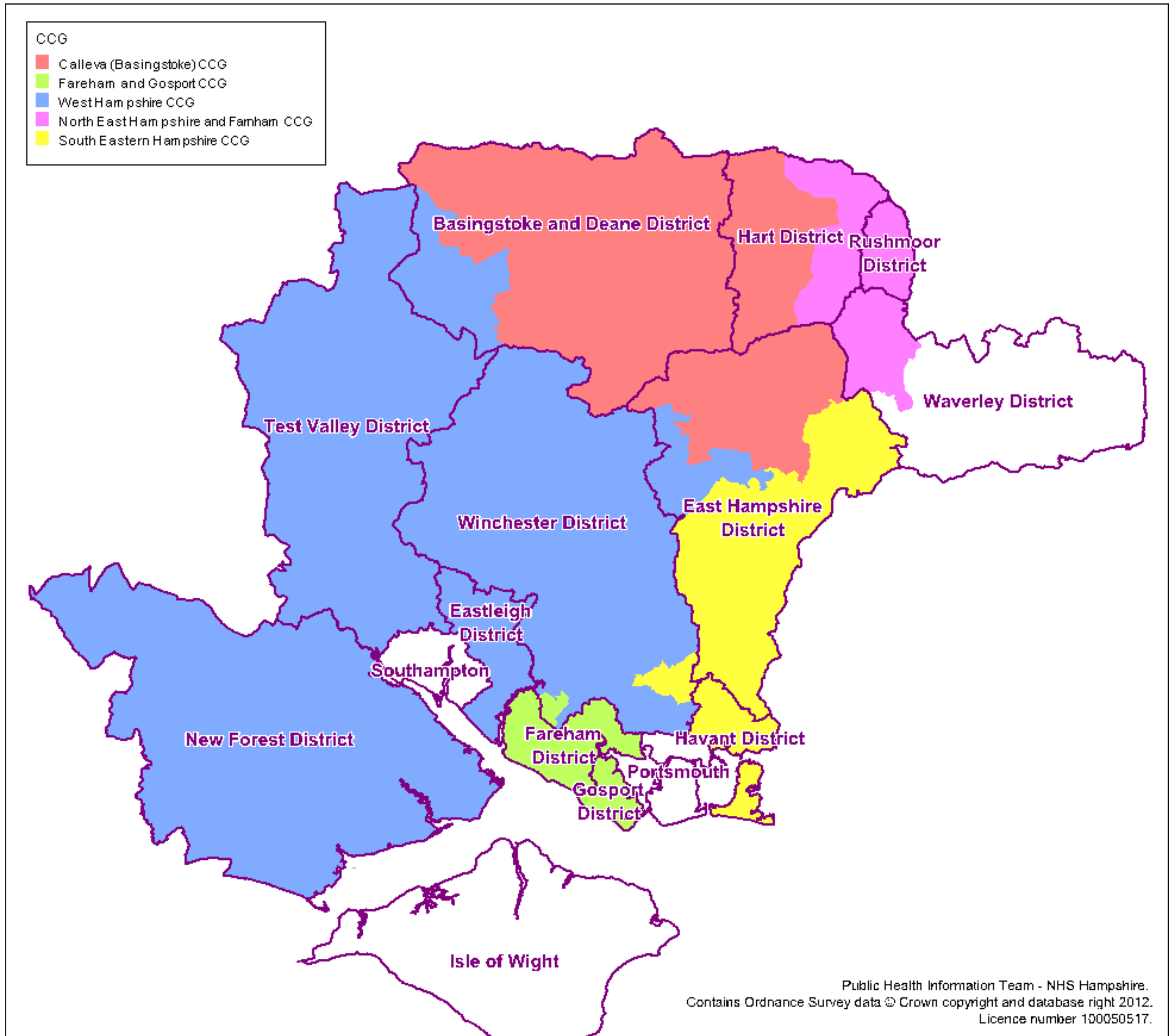
NHS West Hampshire Clinical Commissioning Group Boundaries at LSOA Level

NHS West Hampshire CCG is covered in its totality by Hampshire County Council. Hampshire County Council also covers North East Hampshire & Farnham CCG, North Hampshire CCG, Fareham & Gosport CCG & East Hampshire CCG.

NHS West Hampshire CCG is coterminous with Test Valley District Council, Winchester District Council, New Forest District Council and Eastleigh Borough Council.

The map below (excluding the white areas, which represent Portsmouth City Council, Southampton City Council and Waverly Council) represents the area covered by Hampshire County Council. NHS Hampshire CCG is blue in this map. The map also shows the areas within the CCG covered by Test Valley District Council, Winchester District Council, New Forest District Council and Eastleigh Borough Council.

We will also attach this to the CCG Constitution.



Geographically defined CCGs in the context of LAs