Wandsworth Clinical Commissioning Group Constitution

March 2015
Wandsworth Clinical Commissioning Group Constitution

Introduction

Dear Members

Wandsworth Clinical Commissioning Group has been created for and by its Member Practices. To achieve our vision of better care and a healthier future for Wandsworth, we will involve and engage our patients in designing services, support them to co-produce systems of care and empower them to look after their own health.

We will measure our success by the improvements we are able to secure in the health of local people and the range and quality of services provided. We will commission services based on evidence of need, clinical effectiveness, patient experience, and in response to defined local and national strategic priorities.

We are part of the NHS and will ensure that we uphold its principles and values as reflected in the NHS Constitution. We will demonstrate honesty and integrity in all of our work. We will be thoughtful and transparent in our decision-making and governance. We will be responsible stewards of public money, ensuring that we make adequate provision for adverse times.

We are responsible to our fellow Members, the Practices of Wandsworth. As members we will co-operate to ensure that local services are delivered to the highest standards and that we collectively commission services of high quality, the best value possible and which are responsive to patients' needs. We will work collaboratively with partner organisations to ensure that care is co-ordinated and patient-centred.

We have a responsibility to support our employees, and we will enable individuals and teams to experiment and succeed and to learn and develop. We will treat people with respect and value diversity. We will enable people to fulfil their responsibilities to their families. We will encourage innovation and experiment with new ways of working, learning from our experiences and celebrating successes.

This Constitution lays out the foundations on which Wandsworth Clinical Commissioning Group will build. It defines the rights and responsibilities of Members and establishes the systems of governance which will ensure that we make the right decisions. The Constitution is our commitment to working together.

Dr Nicola Jones MBE
MBChB DRCOG MRCGP MBA
Chair, Wandsworth CCG
# Wandsworth Clinical Commissioning Group Constitution

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Constitution

1.1 This Constitution

1.1.1 The National Health Service Act 2006 (the ‘Act’), as amended by the Health and Social Care Act 2012 requires that a Clinical Commissioning Group adopts a constitution.

1.1.2 This Constitution sets out the terms on which Wandsworth Clinical Commissioning Group (the “CCG”) shall exercise its statutory function of commissioning services for the purposes of the health service in England.

1.1.3 This Constitution shall have effect from 1 April 2013, being the date on which the NHS Commissioning Board established the CCG.

1.1.4 This Constitution has been made between the Members of the CCG and has been adopted by the Governing Body of Wandsworth CCG.

1.1.5 On becoming a Member of the CCG and on its signature of this Constitution each Member Practice confirms it will carry out its duties and responsibilities in respect of the CCG in accordance with the terms of this Constitution.

1.1.6 Words and expressions in this Constitution shall be interpreted in accordance with Schedule 1. Schedule 1 also sets out the general provisions that apply to this Constitution.

Further provisions in respect of the publication and variation of the Constitution are set out at Schedule 2.

1.1.7 This Constitution is supplemented by a number of documents which set out how the CCG will operate including:

1.1.8 the CCG’s Standing Orders which set out the arrangements for meetings and the appointment processes to elect the CCG’s representatives and appoint to the CCG’s committees, including the Governing Body;

1.1.9 the Scheme of Reservation and Delegation which sets out those decisions which are the responsibility of the CCG, its Governing Body, its committees and sub-committees, individual members and employees; and

1.1.10 Prime Financial Policies which sets out the arrangements for managing the CCG’s financial affairs.
2.1 Name
This Constitution sets out the governance arrangements adopted by Wandsworth Clinical Commissioning Group (the “CCG”).

2.2 Area
The CCG shall carry out its functions in respect of the geographical area known as the London Borough of Wandsworth as delineated on the map at Appendix 1: Wandsworth Borough.

2.3 Principal Purpose
2.3.1 The principal purpose of the CCG is the commissioning of services for the purposes of the health service in England.

2.3.2 The vision and strategic goals of the CCG are set out at paragraph 2.7.

2.3.3 The duties of the CCG are set out at paragraph 2.8 and Schedule 3.

2.4 Status
The legal status of the CCG is as follows:

2.4.1 The CCG is a body corporate established under the Act. The CCG is not a servant or agent of the Crown and does not enjoy the status, privilege or immunity of the Crown.

2.4.2 The property of the CCG is not regarded as property of, or property held on behalf of, the Crown.

2.4.3 The CCG is accountable to Parliament by way of the Secretary of State and the Commissioning Board.

2.4.4 The Secretary of State may arrange for the CCG to exercise any public health function of the Secretary of State in accordance with the Act.

2.4.5 Where the Secretary of State arranges for the Commissioning Board to exercise a function, the Commissioning Board may arrange for the CCG to exercise that function.

2.4.6 Where the CCG assumes responsibility for a function it shall be liable for any rights or liabilities arising in respect of the exercise by the CCG of that function.

2.5 Composition
2.5.1 The CCG is a statutory body constituted by the Practices in the Area.

Subject to the requirements set out in this Constitution:
All Practices in the Area shall be eligible to become members of the CCG in accordance with Part 3 of this Constitution;

2.5.2 The executive functions of the CCG shall be exercised by the Governing Body, which is composed of appointed, elected and nominated members;

2.5.3 The Members shall form an unincorporated association known as the Members’ Forum;

2.5.4 Each Member shall be represented on the Members’ Forum by a Member Representative nominated by each Member;

2.5.5 The Member Representatives shall be entitled to attend and vote at meetings of the Members’ Forum; and

2.5.6 The Members’ Forum with input from the Commissioning Board shall elect clinicians to the Governing Body’s clinical leadership team.

2.6 Diagram: Structure

2.7 Vision and Strategic Goals

2.7.1 The vision of the CCG is:
“Better care and a healthier future for Wandsworth.”

2.7.2 We will achieve this by being:

2.7.3 Patient focused:
Our first responsibility is to our patients, their carers and to the people and communities of Wandsworth. We will involve and engage them in designing services, support them to co-produce systems of care and empower them to look after their own health and help others to do the same.
2.7.4 Outcomes driven:
We will measure our success by the improvements we are able to secure in the health of local people and the range and quality of services provided. We will commission services based on evidence of clinical effectiveness, patient experience, and in response to defined local and national strategic priorities.

2.7.5 Principled:
We are part of the NHS and will ensure that we uphold its principles and values as reflected in the NHS Constitution. We will demonstrate honesty and integrity in all of our work. We will be thoughtful and transparent in our decision-making and governance. We will be responsible stewards of public money, ensuring that we make adequate provision for adverse times.

2.7.6 Collaborative:
We are responsible to our fellow Members, the Practices of Wandsworth. As Members we will co-operate to ensure that local services are delivered to the highest standards and that we collectively commission services of high quality, the best value possible and which are responsive to patients’ needs. We will work collaboratively with partner organisations to ensure that care is co-ordinated and patient-centred.

2.7.7 Progressive and Professional:
We are responsible to our employees, and will support individuals and teams to experiment and succeed, to learn and develop. We will treat people with respect and value diversity. We will enable people to fulfil their responsibilities to their families. We will encourage innovation and experiment with new ways of working, learning from mistakes and celebrating successes.

2.7.8 The CCG’s strategic goals are to:

2.7.9 Reduce health inequalities through helping people to live longer and healthier lives, particularly those living in Wandsworth’s most deprived communities.

2.7.10 Support young people to take control of their own health earlier, so they continue to make healthier choices throughout their lives.

2.7.11 Educate people about mental wellbeing, sexual health, drugs, alcohol and obesity. Help prevent and diagnose earlier and improve services.

2.7.12 Improve access, quality and choice of service provision across all care pathways and in appropriate settings.

2.7.13 Improve the quality of life of people living with long term and complex health conditions and their carers by improving the quality, range and choice of services and giving them information to better manage their own health.

2.7.14 The strategic goals are subject to annual checks and consultation with key partners to ensure fit for purpose to achieve the vision.

2.8 Duties

The duties of the CCG are described in the Act and are set out in Schedule 3 of this Constitution.
2.9 Functions

2.9.1 The CCG shall carry out the functions described in the NHS Act 2006, including, but not limited to:

2.9.1.1 Commissioning certain health services (where the Commissioning Board is not under a duty to do so) that meet the reasonable needs of:

2.9.1.2 all people registered with Member Practices; and

2.9.1.3 people who are usually resident within the Area and are not registered with a member of any other clinical commissioning group;

2.9.1.4 Commissioning emergency care for anyone present in the Area;

2.9.1.5 Determining the remuneration and travelling or other allowances of members of the Governing Body; and

2.9.1.6 Paying its employees remuneration, fees and allowance in accordance with the determinations made by the Governing Body and determining any other terms and conditions of service of the CCG’s employees.

2.9.2 In discharging its functions the CCG shall act consistently with the discharge by the Secretary of State and the Commissioning Board of their duty to promote a comprehensive health service and with the objectives and requirements placed on the NHS Commissioning Board through the mandate published by the Secretary of State before the start of each financial year as set out in this constitution.

2.10 Principles of Good Governance

2.10.1 The CCG shall conduct its business at all times in accordance with such generally accepted principles of good governance, including but not limited to:

2.10.1.1 the highest standards of probity involving impartiality, integrity and objectivity in relation to the stewardship of public funds;

2.10.1.2 the Nolan Principles (Schedule 8);

2.10.1.3 the Good Governance Standard for Public Services;

2.10.1.4 the seven key principles of the NHS Constitution; and

2.10.1.5 the Equality Act 2010.

2.11 Transparency

2.11.1 All communications issued by the CCG, including the Commissioning Plan, Annual Report, notices of procurements, public consultations, reports, Governing Body meeting dates, times, venues and papers will be published on the CCG’s website at http://www.wandsworthccg.nhs.uk/Pages/Home.aspx
2.11.2 The CCG may use other means of communication, including circulating information by post, or making information available in venues or services accessible to the public.
Members and Membership

The CCG is a membership body, comprising GP Practice Members. Those Members are entitled to nominate Member Representatives who may attend and vote at meetings of the Locality Members Forum. The Locality Members’ Forum will engage with the Governing Body to ensure commissioning decisions reflect the needs of the patients and the public in the Area via the election of clinicians to the CCG’s Governing Body.

3.1 Eligibility for Membership

A Practice may become a Member of the CCG if it is situated within the Area and is a provider of primary medical services. For the purposes of this provision, ‘provider of medical services’ shall have the meaning given to it in section 14A(3) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012).

3.2 New Applications for Membership

3.2.1 New applications for membership of the CCG (New members are defined as those Practices wanting to become members after 1st July 2012) should be made in writing to the Governing Body.

3.2.2 Changes in membership shall be subject to the consent of the NHS Commissioning Board.

3.2.3 A Practice shall become a member of the CCG if the Practice:

3.2.4 in the opinion of the Governing Body is eligible to become a Member;

3.2.5 has, to the satisfaction of the Governing Body completed the Membership application process determined by the Governing Body, including the submission to the Governing Body of a declaration, signed on behalf of the Practice, that the Practice shall comply and be bound by the terms of this Constitution for the period of its Membership;

3.2.6 has had its application approved by the Governing Body; and

3.2.7 has had its name entered on the Register of Members by the Governing Body.

3.3 Membership Conditions

3.3.1 A Member shall be entitled to retain its membership of the CCG as long as that Member:

- remains eligible for Membership under the Constitution;
- undertakes any remedial action requested by the Governing Body in accordance with this Agreement;
- commits to support the objectives of the CCG as including delivery of targets for which the CCG is accountable to the NHS CB
- contributes to the annual Operating Plan and Commissioning Strategy refresh of the CCG
- retains their GP contract with NHS Wandsworth for 2012/13 and the NHS Commissioning Board thereafter and acting in accordance with the responsibilities of that contract.
- complies with the Standing Orders and Standing Financial Instructions with regards to any delegated budgets that may be mutually agreed
3.4 Locality Commissioning Groups

3.4.1 The CCG has formed three Locality Commissioning Groups for the following geographical areas as shown on the map at Appendix 1:

3.4.1.1 West Wandsworth;

3.4.1.2 Battersea; and

3.4.1.3 Wandle.

3.4.2 The practice and procedure of the Locality Commissioning Groups are set out in the Locality Delegation Agreement, which is appended to this Constitution at Appendix 10.

3.5 Register of Members

3.5.1 The CCG shall establish and maintain a register of its Members (the “Register of Members”).

3.5.2 The Register of Members as amended from time to time by the Governing Body will be appended to this Constitution at Appendix 2.

3.6 Termination of Membership

3.6.1 The CCG and its Members will adhere to the termination criteria and process as set out by the NHS CB.

3.6.2 The decision of the NHS CB in consultation with the CCG, LMC and any other party shall be final.

3.7 Member Representatives

3.7.1 Each Member Practice shall nominate an individual who is a GP and a Deputy (who is a GP or other healthcare professional) to represent the Member on the Members’ Forum (the “Member Representative”).

3.7.2 A Member may replace its Member Representative from time to time by notice in writing to the Governing Body.

3.7.3 The CCG shall be entitled to consider that the Member Representative has the authority to act on behalf of a Member until it receives notification of the replacement of that Member.

3.7.4 Each Member shall authorise its Member Representatives to act on behalf of the Member as follows:

3.7.4.1 attend and receive notice of any meetings of the Members’ Forum;

3.7.4.2 vote at meetings of the Members’ Forum on behalf of the Member in accordance with this Constitution;

3.7.4.3 sign any written resolution on behalf of the Member;
3.7.4.4 receive any notices from the CCG on behalf of the Member and any notice delivered by the CCG to the Member Representative shall be deemed to have been made or served on the Member;

3.7.4.5 appoint a proxy; and

3.7.4.6 approve or provide any consent required of the Member by the CCG in respect of the powers and duties of the Member described in this Constitution.

3.8 Inter-Practice Agreement

3.8.1 Each Member Practice shall enter into an agreement (the “Inter-Practice Agreement”) setting out details of how the Members will work together to further the objectives of the CCG. The Inter-Practice Agreement will be appended to this Constitution at Appendix 3.

3.9 Engagement with Members

3.9.1 The CCG shall establish a strategy for engaging with its Members (the “Member Engagement Strategy”). The Member Engagement Strategy will include details of how the CCG will gather and collate information from its Members and how that information will be incorporated into commissioning decisions taken by the Governing Body.

3.9.2 A copy of the Member Engagement Strategy shall be published on the CCG’s website.

3.10 The Locality Members Forum

3.10.1 The Members Forum shall be composed of the Member Representatives nominated from time to time by each Member.

3.10.2 Each Locality shall have a Members’ Forum.

3.10.3 The Members’ Forum for each locality shall meet a minimum of ten times a year.

3.10.4 Meetings of the Members Forum shall be chaired by the Locality Clinical Lead or locally appointed lay person.

3.10.5 The practice and procedure of the Members’ Forum is set out in the Members’ Forum Terms of Reference from time to time reviewed by the Members’ Forum and appended to this Constitution at Appendix 4.

3.11 Joint Locality Members Forum

3.11.1 The three Locality groups will meet together bi-annually at a Wandsworth Joint Locality Members Forum (JLMF). This meeting will provide an opportunity for the LCGs to share learning and raise any common issues. The Wandsworth Joint Locality Members Forum meetings are in addition to the ten regular members Forums meetings per year do not include the CCG Annual General Meeting (a public meeting)

3.11.2 The Wandsworth Joint Locality Members Forum will be chaired by the CCG Clinical Chair.
3.11.3 The agenda will be established via the LCG Leads in conjunction with the CCG Chair.

3.11.4 Additionally, should 20% of the total member practices wish to set an agenda item then this must be included on the agenda.

3.11.5 Should a vote be required on such an issue, support from 51% of Member Practices will constitute a pass of the proposal. A Practice must be represented at the JLMF meeting in order to vote.

3.11.6 The result will be passed to the Governing Body as a recommendation for the Governing Body to consider.

3.11.7 Papers will be circulated two weeks in advance, with Minutes being recorded.
4.1 The Governing Body

4.1.1 The CCG must have a governing body to oversee the delivery of the CCG’s Commissioning Plan, lead and set the strategy for the CCG and to be accountable for the delivery by the CCG of its functions as a statutory body. Member Practices will be entitled, through their Member Representatives, to elect members to the Governing Body to ensure the Members are represented and can contribute clinical expertise at the highest level within the CCG.

4.1.2 The NHS Act 2006 requires the CCG to establish a Governing Body. The CCG’s Governing Body shall be known as the Wandsworth CCG Governing Body.

4.1.3 The Governing Body has the power to create those committees it feels is necessary for it to fulfill its functions and carry out duties effectively.

4.1.4 The practice and procedure of the Governing Body is set out in the Governing Body Terms of Reference appended to this Constitution at Appendix 6.

4.2 Composition

4.2.1 The CCG shall have a Governing Body comprising eleven voting members, with one vote each, comprising:

4.2.1.1 Chief Officer (as Accountable Officer);

4.2.1.2 Clinical Chair;

4.2.1.3 Chief Finance Officer;

4.2.1.4 At least two Lay Members [including one patient and public lead member and one governance lead member which will include responsibilities for Audit, Remuneration and Conflicts of Interest]

4.2.1.5 Secondary Care Doctor

4.2.1.6 Registered Nurse

4.2.1.7 Locality Clinical Leads from Battersea, West Wandsworth and two from Wandle

4.2.1.8 The composition of the Governing Body is set out in Schedule 4.

4.3 Members of the Governing Body

4.3.1 The following may become members of the Governing Body:

4.3.1.1 a Member of the CCG who is an individual;

4.3.1.2 an individual appointed by virtue of Regulations in the Act;
4.3.1.3 individuals who are Health care Professionals; and

4.3.1.4 individuals who are Lay Persons;

4.3.2 Further provisions detailing the eligibility requirements for membership of the Governing Body and the circumstances in which membership of the Governing Body may be terminated are described in Schedule 5.

4.3.3 The CCG shall ask the Local Medical Committee (LMC) to assure the process for the election of the Chair to the CCG.

4.3.4 Disqualification of members of the Governing Body

4.3.4.1 Members of the Governing Body shall vacate their office if any of the following occurs:

4.3.4.2 if an elected Locality Clinical Lead ceases to work within the Area for a minimum of two clinical sessions per week;

4.3.4.3 if an elected Clinical Lead is suspended from providing primary medical services;

4.3.4.4 If the member has behaved in a manner that is inconsistent with the NHS Code of Conduct and the terms and conditions of their employment.

4.3.4.7 If the member becomes ineligible to stand for a position as a result of the declaration of any conflict of interest.

4.4 Appointment/Nomination/Election of members to the Governing Body

4.4.1 Appointed Members

The Commissioning Board on the recommendation of the Members shall appoint individuals to the following positions on the Governing Body:

4.4.1.1 Chair;

4.4.1.2 Chief Officer (as Accountable Officer);

4.4.1.3 Chief Finance Officer;

4.4.1.4 Together referred to as the ‘Appointed Members’.

4.4.1.5 Provisions outlining the appointment and roles of the Appointed Members are set out in Schedule 5.

4.4.2 Elected Members

Four Locality Clinical Leads shall be elected by the Members of the Localities in a manner of the Localities choosing. Candidates are only eligible if they are a practicing GP in the Locality which they will represent, work a minimum of two clinical sessions per week, not be a director of a Federation and be subject to assessment for suitability by the Chair of the CCG and the CCG Chief Officer.
4.4.3 Nominated Members

4.4.3.1 Director of Public Health (Wandsworth Borough Council)

4.4.3.2 Director of Education and Adult Social Services (Wandsworth Borough Council)

4.4.3.3 Director of Primary Care Development

4.4.3.4 Director of Commissioning and Planning

4.4.3.5 Director of Corporate Affairs, Performance and Quality

4.4.3.6 Wandsworth HealthWatch

4.4.3.7 Any other nominees at the discretion of the Governing Body

4.5 Meetings of the Governing Body

Meetings of the Governing Body must be held in public, except where the CCG has resolved that it would not be in 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 to permit members of the public to attend a meeting or part of a meeting. Further provisions describing the practice and procedure of the Governing Body are set out in the Governing Body’s Terms of Reference appended to this Constitution at Appendix 6.

4.6 Voting Rights of Appointed, Elected and Nominated members

Subject to the provisions of the Governing Body Terms of Reference, Appointed Members and Elected Members shall each be entitled to vote at meetings of the Governing Body. Nominated Members shall be entitled to attend but shall not be entitled to vote at meetings of the Governing Body.

4.7 Functions

4.7.1 The core functions of the Governing Body are to:

4.7.2 ensure that the CCG has made appropriate arrangements to:

4.7.2.1 exercise its functions effectively, efficiently and economically; and

4.7.2.2 comply with such generally accepted principles of good governance as are relevant to it. In particular, the Governing Body shall ensure that appropriate arrangements are put in place to ensure the CCG complies with the Seven Principles of Public Life as described by the Nolan Committee (the ‘Nolan Principles’) which are set out at Schedule 6 to this Constitution.

4.7.2.3 Through the Remuneration Committee, determine the remuneration, fees and allowances payable to the employees of the CCG or to other persons providing services to it;

4.7.2.4 determine the allowances payable under a pension scheme established under the Act; and
4.7.2.5 such other functions connected with the exercise of its main function as may be determined by the CCG and set out in this Constitution at Schedule 7.

4.7.2.6 The Governing Body shall have regard to any Guidance published by the Commissioning Board in respect of the exercise by the Governing Body of the functions described at paragraphs 4.7 and 4.7.4 above.

**4.8 Exercise of Functions**

4.8.1 The functions of the Governing Body may be exercised by any of the following on behalf of the Governing Body:

4.8.1.1 any committee or sub-committee of the Governing Body;

4.8.1.2 a member of the Governing Body; or

4.8.1.3 a Member of the CCG who is an individual (but is not a member of the Governing Body).

4.8.1.4 In discharging its functions the Governing Body (and its committees and individuals) must:

4.8.1.5 comply with the principles of good governance described in this Constitution;

4.8.1.6 operate in accordance with the CCG’s Scheme of Reservation and Delegation;

4.8.1.7 comply with the CCG’s Standing Orders;

4.8.1.8 comply with the CCG’s arrangements for discharging its statutory duties; and

4.8.1.9 where appropriate ensure that Member Practices have had the opportunity to contribute to the CCG’s decision making process.
Committees

The CCG may appoint committees and sub-committees to assist it in carrying out its functions. A CCG committee may be composed of individuals from outside the CCG enabling the CCG to benefit from the expertise of individuals with a broad range of skills and experience.

5.1 Committees

5.1.1 The CCG may appoint committees or sub-committees. The committees or sub-committees may consist of or include persons other than Members or employees of the CCG.

5.1.2 The CCG shall ensure that each committee or sub-committee adopts and complies with terms of reference detailing the duties and responsibilities of the committee or sub-committee and the procedure of that committee or sub-committee.

5.1.3 The CCG shall ensure that any duties and responsibilities delegated to a committee of the CCG are described in the CCG’s Scheme of Delegation and Reservation.

5.1.4 The Governing Body shall delegate responsibilities to committees or subcommittees, as laid out in the relevant Appendices to this Constitution. The Governing Body shall have at least the following three Committees:

5.1.4.1 Audit Committee (Appendix 7);

5.1.4.2 Remuneration Committee (Appendix 8); and

5.1.4.3 Integrated Governance Committee (Appendix 9).

5.1.5 Nothing in this paragraph 5.1 will prejudice or affect the CCG’s or the Governing Body’s rights, powers or duties under the Act.

5.2 Audit Committee

5.2.1 The Governing Body shall establish an Audit Committee, which shall be directly accountable to it. The composition of the Audit Committee will accord with any published national guidance.

5.2.2 The Audit Committee is accountable to the Governing Body, shall be chaired by a Lay-Member and shall perform such financial monitoring, reviewing and other functions as are considered appropriate by the Governing Body. The duties and responsibilities of the Audit Committee shall include:

5.2.3 assisting the CCG in discharging its functions under paragraph 4.7 above;

5.2.4 carrying out such other functions connected with the exercise of its main function at paragraph 4.7 above as may be determined by the Governing Body and which are set out in the Audit Committee Terms of Reference which are appended to this Constitution at Appendix 7 and (where necessary) delegated to the Audit Committee under the CCG’s Scheme of Delegation and Reservation;

5.2.5 identifying strategic risks;

5.2.6 monitoring compliance; and
5.2.7 providing assurance.

5.2.8 overseeing and assessing the functions of the Accountable Officer and Chief Finance Officer and report on any aspects of their duties.

5.2.9 providing independent reports to the Governing Body as and when required.

5.2.10 overseeing the CCG’s financial systems including budgetary and other financial information with regard to any of the CCG’s functions.

5.3 Remuneration Committee

5.3.1 The Governing Body shall establish a Remuneration Committee, which shall be directly accountable to it. The composition of the Remuneration Committee shall accord with any published national guidance.

5.3.2 The Remuneration Committee shall be chaired by the Lay Member with a responsibility for governance and the duties and responsibilities of the Remuneration Committee shall include:

5.3.3 Making recommendations to the Governing Body as to the discharge of its functions under paragraphs 4.7;

5.3.4 Carrying out such other functions connected with the exercise of the functions described at paragraph 4.7 above as may be determined by the Governing Body and which are set out in the Remuneration Committee Terms of Reference which is appended to this Constitution at Appendix 8 and (where necessary) are delegated to the Remuneration Committee under the CCG’s Scheme of Delegation and Reservation.

5.3.5 The Remuneration Committee must comply with any Regulations setting out provisions in respect of its functions.

5.3.6 The Remuneration Committee shall be responsible for the recommendations by way of written reports to the Governing Body on any remuneration, fees, benefits and any other types of allowances in respect of person(s) who provide services to the CCG.

5.4 Integrated Governance Committee

5.4.1 The Integrated Governance Committee (Appendix 9) shall be chaired by the CCG Chair (with the Deputy Chair being the Nurse Member of the Governing Body) and have responsibility for:

5.4.1.1 ensuring the Board is aware of the implications with regards to adopting a particular approach to clinical care;

5.4.1.2 clinical governance of commissioned services for assurance of patient safety;

5.4.1.3 quality outcomes and embedding a quality culture in all services;

5.4.1.4 combined approach to performance and delivery inclusive of clinical quality and financial control.
5.5 If there is any conflict between the terms of reference for any committee or the Governing Body and this Constitution, this Constitution shall prevail.
The CCG must have regard to any guidance published by the Commissioning Board in respect of the exercise by the CCG of its commissioning functions.

6.1 Commissioning Plan

6.1.1 The CCG shall prepare a commissioning plan before the start of each financial year in accordance with the Act (the “Commissioning Plan”) and any guidance published by the NHS Commissioning Board. The Commissioning Plan must set out how the CCG proposes to exercise its functions during the relevant Financial Year. The Commissioning Plan must, in particular, explain how the CCG proposes to discharge its responsibilities in relation to its duties to: improve the quality of the services; reduce inequalities; ensure public involvement and consultation, its financial duties in relation to expenditure; and additional controls on resource use.

6.1.2 The CCG shall publish the Commissioning Plan and supply a copy to the NHS Commissioning Board before any date specified by the NHS Commissioning Board in a direction and to any relevant Health and Wellbeing Board.

6.1.3 The CCG may revise the Commissioning Plan after it has been published. Following a revision, the CCG must prepare and publish a document detailing the changes it has made to the Commissioning Plan. The CCG shall supply a copy of the revised Commissioning Plan to the NHS Commissioning Board before any date specified by them and to any relevant Health and Wellbeing Board. If the CCG revises the Commissioning Plan in a way in which the CCG considers to be significant, the CCG must also publish a copy of the revised Commissioning Plan.

6.1.4 A copy of the Commissioning Plan as amended from time to time shall be available at the CCG’s place of business and shall be published on the CCG’s website.

6.2 Consulting on Commissioning Plans

6.2.1 Where the CCG is preparing a Commissioning Plan or revising a Commissioning Plan in a way which the CCG considers significant, the CCG must:

6.2.1.1 consult individuals for whom it has responsibility for the purposes of Section 3 of the NHS Act 2006; and

6.2.1.2 involve any relevant Health and Wellbeing Board in revising or preparing the Commissioning Plan.

6.3 In particular, the CCG shall:

6.3.1 give the Wandsworth Health and Wellbeing Board a draft of the Commissioning Plan or, as the case may be, a copy of the revised Commissioning Plan; and

6.3.2 consult the Wandsworth Health and Wellbeing Board on whether the draft Commissioning Plan takes proper account of each Joint Health and Wellbeing Strategy published by the Wandsworth Health and Wellbeing Board which relates to the period (or any part of the period) to which the Commissioning Plan relates.
6.3.3 include in the published Commissioning Plan or, in circumstances where the CCG revises a published plan in a way in which the CCG considers significant, the revised Commissioning Plan:

6.3.4 a summary of the views expressed by individuals consulted under 6.2 above;

6.3.5 an explanation of how the CCG took account of those views; and

6.3.6 a statement of the final opinion of each relevant Health and Wellbeing Board consulted in relation to the Commissioning Plan under paragraphs 6.2 and 6.3 above.

6.3.7 have regard to any guidance published by the Commissioning Board in relation to drafting, revising and consulting on the contents of the Commissioning Plan.

6.4 Any Qualified Provider (“AQP”)

6.4.1 In drafting the Commissioning Plan, the CCG must have regard to:

6.4.1.1 the ‘Procurement Guide for Commissioners of NHS-funded Services’ published on 30 July 2010 and any document which supersedes it;

6.4.1.2 ‘Operational Guidance to the NHS - Extending Patient Choice of Provider’ published on 19 July 2011 and any document which supersedes it; and

6.4.1.3 any other documentation setting out how the AQP model is to function.

6.4.2 When commissioning services from those providers who are qualified to do so under the national list of services the CCG must ensure that those qualified still meet the requirements, namely that they:

6.4.2.1 are registered with the Care Quality Commission and licensed by Monitor where required, or meet equivalent assurance requirements;

6.4.2.2 will meet the Terms and Conditions of the NHS Standard Contract which includes a requirement to have regard to the NHS Constitution, relevant guidance and law;

6.4.2.3 accept NHS prices;

6.4.2.4 can provide assurances that they are capable of delivering the agreed service requirements and comply with referral protocols; and

6.4.2.5 reach agreement with local commissioners on supporting schedules to the standard contract including any local referral thresholds or patient protocols.

6.4.2.6 The CCG will carry out procurement activity in accordance with relevant legislation and having regard to relevant guidance, including the NHS Procurement Policy.
7.1 Annual Report

7.1.1 In every financial year, save for its first financial year, the CCG shall prepare an Annual Report in accordance with the Act and any directions given to the CCG by the NHS Commissioning Board on how it has discharged its functions in the previous financial year.

7.1.2 Provisions describing the contents of and the procedures in respect of the publication of the Annual Report are set out in Schedule 8.
8.1 Permitted Disclosures of Information

8.1.1 The CCG may disclose information obtained by it in the exercise of its functions if the disclosure is:

8.1.2 made under or pursuant to regulations under Sections 113 or 114 of the Health and Social care (Community Standards) Act 2003 (Complaints About Health Care and Social Services);

8.1.3 made in accordance with any enactment or court order;

8.1.4 necessary or expedient for the purposing of protecting the welfare of an individual;

8.1.5 made to any person in circumstances where it is necessary or expedient for the person to have the information for the purposes of exercising functions of that person under any enactment;

8.1.6 made for the purposes of facilitating the exercise of any of the CCG’s functions;

8.1.7 made in connection with the investigation of a criminal offence (whether or not in the United Kingdom);

8.1.8 made for the purpose of criminal proceedings (whether or not in the United Kingdom); or

8.1.9 if the information has previously been lawfully disclosed to the public.

8.1.10 The CCG’s right to disclose information under paragraphs 8.1.1.2, 8.1.1.3, 8.1.1.6 and 8.1.1.8 above may be exercised notwithstanding any rule of common law which would otherwise prohibit or restrict the disclosure.

8.1.11 No member of the Governing Body or any authorised committee of the Governing Body shall make or permit or authorise the making of any press release or other public statement and/or any disclosure concerning any commissioning aspect of the CCG or any members without the prior written consent of the Governing Body. For the avoidance of doubt, this clause is not intended to override any NHS policy of ‘whistleblowing’ and individual members must comply with any current applicable General Medical Council guidance.
Third Party Engagement/Collaborative Working

9.1 The Commissioning Board

9.1.1 The CCG shall work with the NHS Commissioning Board to improve the quality of primary care services; ensuring that local service re-design promotes innovation and reducing health inequalities.

9.1.2 The CCG will be accountable to the NHS Commissioning Board.

9.2 Patients and the Public

9.2.1 The Governing Body shall make arrangements to ensure that patients and the public are involved in the planning and development of the Commissioning Plan. Such arrangements shall include service commissioning in accordance with its duty at paragraph 13 of Schedule 3 of this constitution.

9.2.2 The CCG shall apply the following principles when implementing the arrangements described at paragraph 9.2 above

9.3 Local Authority

9.3.1 The CCG will work in partnership with Wandsworth Borough Council to reduce health and social inequalities. This may include entering into formal arrangement for the pooling of budgets.

9.4 Health and Wellbeing Boards

9.4.1 From April 2013 the CCG, as a member of the Health and Wellbeing Board for the Area shall work with the Local Authority to develop a Joint Strategic Needs Assessment for the Area and will hold the local authority to account for the delivery of the Joint Health and Wellbeing Strategy.

9.4.2 The CCG shall act in partnership with the Local Authority, Public Health and other agencies with a commitment to promoting the health and well-being of the Wandsworth population to develop a shared vision and ambition for health improvement and health and social care services.

9.5 Wandsworth Local Medical Committee

9.5.1 The CCG recognises the unique role of the Wandsworth Local Medical committee (LMC) in representing the professional interests of GPs in the Borough. The LMC and the CCG share a common membership. The CCG shall build and maintain a strong, open and effective collaborative relationship with the LMC.

9.5.2 The CCG shall:

9.5.2.1 Commit to senior level representation (Chair, Chief Officer or other Directors) attending each meeting of the standing joint committee with Wandsworth LMC as the main forum for collaborative work.

9.5.2.2 Strive to keep the LMC fully briefed on professional issues related to the delivery of services by GPs arising from the commissioning activities of the CCG.
9.5.2.3 share the CCG Governing Body agenda and papers with the LMC prior to each meeting held in public and welcome the attendance by representatives of the LMC at such meetings. The LMC Chair or a representative of the Londonwide LMC office will be afforded the opportunity to raise any issues pertaining to items on the agenda with the CCG Chair or Chief Officer prior to the meeting. LMC representatives may also comment or question any aspects of the work of the CCG in the ‘Open Space’ section of each meeting of the CCG held in public.

9.5.2.4 Ask the LMC to oversee the process for the election of the Clinical Chair and other elections as mutually agreed.

9.6 Not used

9.7 Public Health

9.7.1 The CCG will develop a Memorandum of Understanding with Public Health Wandsworth that outlines:

9.7.2 Public Health input into the Joint Commissioning Unit with the Local Authority/CCG with regards to core Public Health functions.

9.7.3 Public Health specialist support and capacity into the CCG.

9.7.4 CCG support and capacity into the commissioning elements of Public Health core functions.

9.8 Joint commissioning arrangements with other Clinical Commissioning Groups

9.8.1 The clinical commissioning group (CCG) may wish to work together with other CCGs in the exercise of its commissioning functions.

9.8.2 The CCG may make arrangements with one or more CCG in respect of:

9.8.2.1 delegating any of the CCG’s commissioning functions to another CCG;

9.8.2.2 exercising any of the commissioning functions of another CCG; or

9.8.2.3 exercising jointly the commissioning functions of the CCG and another CCG

9.8.3 For the purposes of the arrangements described at paragraph 9.8.2, the CCG may:

9.8.3.1 make payments to another CCG;

9.8.3.2 receive payments from another CCG;

9.8.3.3 make the services of its employees or any other resources available to another CCG; or

9.8.3.4 receive the services of the employees or the resources available to another CCG.

9.8.4 Where the CCG makes arrangements which involve all the CCGs exercising any of their commissioning functions jointly, a joint committee may be established to exercise those functions.

9.8.5 For the purposes of the arrangements described at paragraph 9.8.2 above, the CCG may establish and maintain a pooled fund made up of contributions by any of the CCGs working together pursuant to
paragraph 9.8.2.3 above. Any such pooled fund may be used to make payments towards expenditure incurred in the discharge of any of the commissioning functions in respect of which the arrangements are made.

9.8.6 Where the CCG makes arrangements with another CCG as described at paragraph 9.8.2 above, the CCG shall develop and agree with that CCG an agreement setting out the arrangements for joint working, including details of:

- How the parties will work together to carry out their commissioning functions;
- The duties and responsibilities of the parties;
- How risk will be managed and apportioned between the parties;
- Financial arrangements, including, if applicable, payments towards a pooled fund and management of that fund;
- Contributions from the parties, including details around assets, employees and equipment to be used under the joint working arrangements.

9.8.7 The liability of the CCG to carry out its functions will not be affected where the CCG enters into arrangements pursuant to paragraph 9.8.2 above.

9.8.8 The CCG will act in accordance with any further guidance issued by NHS England on co-commissioning.

9.8.9 Only arrangements that are safe and in the interests of patients registered with member practices will be approved by the governing body.

9.8.10 The Governing Body of the CCG shall require, in all joint commissioning arrangements, that the lead clinician and lead manager of the lead CCG make a quarterly written report to the Governing Body and hold at least annual engagement events to review aims, objectives, strategy and progress and publish an annual report on progress made against objectives.

9.8.11 Should a joint commissioning arrangement prove to be unsatisfactory the governing body of the CCG can decide to withdraw from the arrangement, but has to give six months’ notice to partners, with new arrangements starting from the beginning of the next new financial year.

9.9 Joint commissioning arrangements with NHS England for the exercise of CCG functions

9.9.1 The CCG may wish to work together with NHS England in the exercise of its commissioning functions.

9.9.2 The CCG and NHS England may make arrangements to exercise any of the CCG’s commissioning functions jointly.

9.9.3 The arrangements referred to in paragraph 9.9.2 above may include other CCGs.

9.9.4 Where joint commissioning arrangements pursuant to 9.9.2 above are entered into, the parties may establish a joint committee to exercise the commissioning functions in question.

9.9.5 Arrangements made pursuant to 9.9.2 above may be on such terms and conditions (including terms as to payment) as may be agreed between NHS England and the CCG.
9.9.6 Where the CCG makes arrangements with NHS England (and another CCG if relevant) as described at paragraph 9.9.2 above, the CCG shall develop and agree with NHS England a framework setting out the arrangements for joint working, including details of:

- How the parties will work together to carry out their commissioning functions;
- The duties and responsibilities of the parties;
- How risk will be managed and apportioned between the parties;
- Financial arrangements, including, if applicable, payments towards a pooled fund and management of that fund;
- Contributions from the parties, including details around assets, employees and equipment to be used under the joint working arrangements; and

9.9.7 The liability of the CCG to carry out its functions will not be affected where the CCG enters into arrangements pursuant to paragraph 9.9.2 above.

9.9.8 The CCG will act in accordance with any further guidance issued by NHS England on co-commissioning.

9.9.9 Only arrangements that are safe and in the interests of patients registered with member practices will be approved by the governing body.

9.9.10 The Governing Body of the CCG shall require, in all joint commissioning arrangements that the Accountable Officer of the CCG make a quarterly written report to the Governing Body and hold at least annual engagement events to review aims, objectives, strategy and progress and publish an annual report on progress made against objectives.

9.9.11 Should a joint commissioning arrangement prove to be unsatisfactory the governing body of the CCG can decide to withdraw from the arrangement, but has to give six months’ notice to partners, with new arrangements starting from the beginning of the next new financial year after the expiration of the six months’ notice period.

9.10 Joint commissioning arrangements with NHS England for the exercise of NHS England’s functions

9.10.1 The CCG may wish to work with NHS England and, where applicable, other CCGs, to exercise specified NHS England functions.

9.10.2 The CCG may enter into arrangements with NHS England and, where applicable, other CCGs to:

9.10.3 Exercise such functions as specified by NHS England under delegated arrangements;

9.10.4 Jointly exercise such functions as specified with NHS England.

9.10.5 Where arrangements are made for the CCG and, where applicable, other CCGs to exercise functions jointly with NHS England a joint committee may be established to exercise the functions in question.

9.10.6 Arrangements made between NHS England and the CCG may be on such terms and conditions (including terms as to payment) as may be agreed between the parties.
9.10.7 For the purposes of the arrangements described at paragraph 9.10.2 above, NHS England and the CCG may establish and maintain a pooled fund made up of contributions by the parties working together. Any such pooled fund may be used to make payments towards expenditure incurred in the discharge of any of the commissioning functions in respect of which the arrangements are made.

9.10.8 Where the CCG enters into arrangements with NHS England as described at paragraph 9.10.2 above, the parties will develop and agree a framework setting out the arrangements for joint working, including details of:

- How the parties will work together to carry out their commissioning functions;
- The duties and responsibilities of the parties;
- How risk will be managed and apportioned between the parties;
- Financial arrangements, including payments towards a pooled fund and management of that fund;
- Contributions from the parties, including details around assets, employees and equipment to be used under the joint working arrangements.

9.10.9 The liability of NHS England to carry out its functions will not be affected where it and the CCG enter into arrangements pursuant to paragraph 9.10.2 above.

9.10.10 The CCG will act in accordance with any further guidance issued by NHS England on co-commissioning.

9.10.11 Only arrangements that are safe and in the interests of patients registered with member practices will be approved by the Governing Body.

9.10.12 The Governing Body of the CCG shall require, in all joint commissioning arrangements that the Accountable Officer of the CCG make a quarterly written report to the Governing Body and hold at least annual engagement events to review aims, objectives, strategy and progress and publish an annual report on progress made against objectives.

9.10.13 Should a joint commissioning arrangement prove to be unsatisfactory the Governing Body of the CCG can decide to withdraw from the arrangement, but has to give six months’ notice to partners, with new arrangements starting from the beginning of the next new financial year after the expiration of the six months’ notice period.
Conflicts of Interest

10.1 Conflicts of Interest

10.1.1 The Governing Body shall develop and maintain a conflicts of interest policy (the “Managing Conflicts of Interest Policy”).

10.1.2 A copy of the Managing Conflicts of Interest Policy as amended from time to time by the Governing Body will be published on the CCG’s website.

10.2 Registers of Interest

10.2.1 The CCG shall create and maintain registers of the interests of:

10.2.1.1 Members;

10.2.1.2 Members of the Governing Body;

10.2.1.3 The members of committees or sub-committees or of committees or sub-committee of the Governing Body; and

10.2.1.4 CCG employees.

10.2.2 (the “Registers of Interest”) recording all declarations of interest as set out below and in the CCG’s Managing Conflicts of Interest Policy.

10.2.3 The Registers of Interest shall be available for public inspection on written request.

10.2.6 The CCG shall have regard to guidance published by the NHS Commissioning Board on the discharge of CCG functions in respect of conflicts of interest.

10.2.7 Conflicts of Interest shall be managed in accordance with the CCG’s Managing Conflicts of Interest Policy, which is available on the Wandsworth CCG website.
Employment, Remuneration and Expenses

11.1 Staff

11.1.1 The CCG may appoint such persons to be employees of the CCG as it considers appropriate.

11.1.2 The CCG must:

11.1.2.1 employ its employees on such terms and conditions as the CCG considers appropriate; and

11.1.2.2 pay its employees, remuneration and travelling or other allowances as determined by the Remuneration Committee.

11.1.3 The Remuneration Committee may, for or in respect of such of its employees as it may determine, make arrangements for providing pensions, allowances or gratuities. Such arrangements may include the establishment and administration, by the CCG or another party, of one of more pension schemes.

11.1.4 The arrangements described at paragraph 11.1.3 above include arrangements for the provision of pensions, allowances or gratuities by way of compensation to or in respect of employees who suffer loss of office or employment or loss or diminution of emoluments.

11.2 Governing Body

11.2.1 The CCG sets the rates of pay for Governing Body members and may pay members of the Governing Body such remuneration and travelling or other allowances, pensions and/or gratuities as it considers appropriate.

11.2.2 The arrangements described at paragraph 11.1.3 above may include the establishment and administration, by the CCG or another party, of one or more pension schemes of which the members of the Governing Body may become members.

11.2.3 The arrangements described at paragraph 11.1.3 include arrangements for the provision of pensions, allowances or gratuities by way of compensation to or in respect of any members of the Governing Body who suffer loss or diminution of emoluments.

11.2.4 Paragraph 11.1.3 does not apply to Members or employees of Members of the CCG.

11.2.5 For the avoidance of doubt, the Remuneration Committee may make arrangements for the provision of pensions for employees in accordance with paragraph 11.1.3 and such employees shall not also be entitled to become members of any pension scheme established pursuant to paragraph 11.1.3 by virtue of their membership of the Governing Body.

11.3 Accountable Officer

11.3.1 The CCG must have an Accountable Officer.

11.3.2 The Accountable Officer is to be appointed by the NHS Commissioning Board.
11.3.3 The Remuneration Committee may, for or in respect of its Accountable Officer, make arrangements for providing remuneration and travelling or other allowances, pensions, allowances or gratuities, including arrangements for the provision of pensions, allowances or gratuities by way of compensation to or in respect of the Accountable Officer where that Accountable Officer suffers loss of office or loss or diminution of emoluments.

11.4 Additional Powers in Respect of Payment of Allowances

11.4.1 The Remuneration Committee may pay such travelling or other allowances as it considers appropriate to any of the following:

11.4.1.1 Members of the CCG who are individuals;

11.4.4.2 Individuals, including Member Representatives, authorised to act on behalf of a Member in dealings between the Member and the CCG; and

11.4.1.3 Members of any committee or sub-committee of the CCG or the Governing Body.
This document contains 10 Schedules
Schedule 1
Definitions

1.1. The following words and phrases shall be interpreted as set out below:

**Accountable Officer**
An individual who is appointed to be accountable for the exercise by the CCG of any of its functions by the NHS Commissioning Board in accordance with the Act and whose duties and responsibilities are set out in this Constitution.

**Annual Report**
The report prepared by the CCG at the end of each financial year, save for its first financial year, describing how the CCG has discharged its functions in the previous financial year.

**Appointed Members**
Members appointed to the Governing Body in accordance with paragraph 4.4.

**Area**
The geographical area to be covered by the CCG described in paragraph 2.2.

**Audit Committee**
The committee established by the Governing Body in accordance with paragraph 5.2.

**Commissioning Board**
The body established by the NHS Act 2006 (as amended by the Health and Social Care Act 2012).

**Commissioning Functions**
The functions of Clinical Commissioning Groups in arranging for the provision of services as part of the Health Service (including the function of making a request to the NHS Commissioning Board for the purposes of Section 1427).

**Commissioning Plan**
The plan for commissioning prepared by the CCG in accordance with the NHS Act 2006 and pursuant to paragraph 6.1.

**Conflicts of Interest Policy**
The policy developed and maintained by the Governing Body pursuant to paragraph 10.

**Financial Year**
Includes the period which begins on the day the CCG is established and ends on the following 31 March.

**Governing Body**
The CCG Governing Body appointed pursuant to having the responsibilities set out in Part 4.

**GP**
Means a general practitioner registered on a performers list of that NHS Commissioning Board.

**Guidance**
Measuring applicable health or social care guidance, direction or determination which the CCG has a duty to have regard to.

**Health and Wellbeing Board**
A committee of the Local Authority established by the NHS Act 2006 (as amended by the Health and Social Care Act 2012), on which the CCG will be represented.
**Health Care Professional**
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.

**Health-Related Services**
Services that may have an effect on the health of individuals but are not health services or Social Care Services.

**Inter-Practice Agreement**
The Inter-Practice Agreement described in paragraph 3.8 setting out how the Member Practices will work together to further the objectives of the CCG.

**Joint Health and Wellbeing Strategy**
A strategy under Section 116A of the Local Government and Public Involvement in Health Act 2007 which is prepared and published by a Health and Wellbeing Board by virtue of Section [195 of the Health and Social Care Act 2010].

**Lay Person**
An individual who is not:
(a) a member of the CCG;
(b) a Healthcare Professional; or
(c) an individual of prescribed description.

**Legislation**
Laws statutes, statutory instruments, regulations and directions issued from time to time in respect of the CCG.

**Locality Clinical Lead**
A GP or other Health Care Professional [elected] by the Members in each Locality Commissioning Group in accordance with paragraph 4.4.2 of this Constitution who will represent the Members in that locality and who will each be a member of the Governing Body.

**Locality Delegation Agreement**
The Locality Delegation Agreement described in paragraph 3.4.2 setting out the practice and procedure of the Locality Commission Groups.

**Locality Commissioners**
Committees of the CCG for West Wandsworth, Battersea and Wandle whose duties and responsibilities are described in the Locality Delegation Agreement.

**Locality Members Forum**
A committee of members per locality that meet eight times per year and participate in two Wandsworth Joint Members’ Forums.

**Member**
A Practice which has successfully completed the application process for Membership of the CCG and whose name is recorded in the Register of Members in accordance with paragraph 3.5 of this Constitution (and “Membership”) shall be construed accordingly.

**Member Engagement Strategy**
A strategy established by the CCGs for engaging with its Members in accordance with paragraph 3.9 of this Constitution.
<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
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<tbody>
<tr>
<td>Member Representative</td>
<td>An individual nominated by a Member to represent that Member on the Members Forum in accordance with paragraph 3.7.1 of this Constitution.</td>
</tr>
<tr>
<td>Members Forum</td>
<td>The collective term for the Member Representatives.</td>
</tr>
<tr>
<td>Practice</td>
<td>An individual or organisation that is a provider of primary medical services pursuant to: a general medical services contract; arrangements under section 83(2) of the Act; or arrangements under section 92 of the Act, for the provision of primary medical services of a prescribed description.</td>
</tr>
<tr>
<td>Prime Financial Policies</td>
<td>The Prime Financial Policies described in paragraph 1.1.10.3 and set out in Appendix 12.</td>
</tr>
<tr>
<td>Register of Interests</td>
<td>A written register as amended from time to time of the interests of each member of the Governing Body or Members Forum as described in paragraph 10.2 of this Constitution.</td>
</tr>
<tr>
<td>Register of Members</td>
<td>A written register as amended from time to time of the names and addresses of the Members of the CCG established and maintained in accordance with paragraph 3.5 of this Constitution and appended to this Constitution at Appendix 2.</td>
</tr>
<tr>
<td>Regulations</td>
<td>Any applicable delegated or subordinate legislation or regulation.</td>
</tr>
<tr>
<td>Relevant Health and Wellbeing Board</td>
<td>A Health and Wellbeing Board established by a Local Authority whose area is co-terminus with, or includes the whole or any part of the Area of the CCG.</td>
</tr>
<tr>
<td>Remuneration Committee</td>
<td>The committee established by the Governing Body in accordance with paragraph 5.1.4.</td>
</tr>
<tr>
<td>Social Care Services</td>
<td>Services that are provided in pursuance of the social services functions of local authorities (within the meaning of the Local Authority Social Services Act 1970).</td>
</tr>
<tr>
<td>Standing Orders</td>
<td>The Standing Orders described in paragraph 1.1.8 and set out in Appendix 11.</td>
</tr>
<tr>
<td>The Local Government Act</td>
<td>The Local Government and Public Involvement in Health Act 2007 as amended from time to time.</td>
</tr>
<tr>
<td>The NHS Constitution</td>
<td>The NHS Constitution published on 21 January 2009 as amended from time to time.</td>
</tr>
<tr>
<td>The Nolan Principles</td>
<td>The Seven Principles of Public Life expounded by the Nolan Committee and set out at Schedule 6 of this Constitution.</td>
</tr>
</tbody>
</table>
Wandsworth Joint Members Forum

1.2. Unless the context otherwise requires, words in the singular shall include the plural and in the plural shall include the singular.

1.3. Unless the context otherwise requires, a reference to one gender shall include a reference to the other gender.

1.4. A reference to a statute or statutory provision is a reference to it as amended, extended or re-enacted from time to time.

1.5. A reference to a statute or statutory provision shall include all subordinate legislation made from time to time under that statute or statutory provision.

1.6. A reference to ‘writing’ or ‘written’ includes faxes and e-mail, but not text messages or messages conveyed by way of social media websites.

1.7. Any words following the terms ‘including’, ‘include’, ‘in particular’ or any similar expression shall be construed as illustrative and shall not limit the sense of the words, description, definition, phrase or term preceding those terms.

2. General Provisions

2.1. Confidential Information

2.1.1. “Confidential Information” means any information which any Member may have or acquire in relation to the CCG or another Member. Information shall not be considered Confidential Information if it becomes public knowledge other than as a direct or indirect result of a breach of this provision.

2.1.2. Each Member shall at all times use all reasonable endeavours to keep confidential any Confidential Information and each Member agrees:

2.1.2.1. to use Confidential Information only for the use for which the Confidential Information was disclosed to it; and

2.1.2.2. not to disclose the Confidential Information to any third party or use it to the detriment of the CCG or any other Member.

2.1.3. A Member may disclose Confidential Information in the following circumstances:

2.1.3.1. where it is reasonably required by the Member’s professional advisors where such disclosure is for a purpose related to the operation of the CCG; or

2.1.3.2. with the consent in writing of the Member to which the Confidential Information relates; or

2.1.3.3. where it is reasonably required by IW or regulation, in which case the Member shall supply a copy of the required disclosure to the Governing Body in sufficient time to enable the Governing Body to suggest and incorporate amendments to it; or

2.1.3.4. to comply with the law; or
2.1.3.5. to any tax authority; or

2.1.3.6. if the Confidential Information is disclosed within the public domain otherwise than as a breach of this provision.

2.1.4. The obligations of each of the Members under this provision shall continue without limit of time. The Members agree that they shall not make or permit or authorise the making of any press release or other public statement or disclosure concerning the CCG or any of the Members without the prior consent in writing of the Governing Body.

2.2. Notices

2.2.1. A notice given to a party under or in connection with this Constitution shall be:

2.2.1.1. in writing;

2.2.1.2. in English; and

2.2.1.3. for the CCG sent to the address or to the fax number, or, in the case of a Member or the Member Representative, for that Member, the address set out from time to time in the Register of Members.

2.2.2. The following table sets out methods by which a notice may be sent and, if sent by that method, the corresponding deemed delivery date and time:

<table>
<thead>
<tr>
<th>Delivery method</th>
<th>Deemed delivery date and time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delivery by hand.</td>
<td>At the time the notice is left at the address.</td>
</tr>
<tr>
<td>Pre-paid first class, recorded delivery post or other next working day delivery service.</td>
<td>48 hours after the date of posting.</td>
</tr>
<tr>
<td>Fax.</td>
<td>2 hours after the time of transmission.</td>
</tr>
</tbody>
</table>

2.2.3. For the purpose of this clause and calculating deemed receipt:

2.2.3.1. all references to time are to local time in the place of deemed receipt; and

2.2.3.2. if deemed receipt would occur on a Saturday or Sunday or a public holiday when banks are not open for business, or outside normal business hours (meaning 9.00am to 5.00pm) on a business day, deemed receipt will take place at 9.00 am on the day when business next starts in the place of receipt.

2.2.4. To prove service it is sufficient to prove that:

2.2.4.1. where a notice was delivered by hand, that the notice was delivered and left at the correct address;

2.2.4.2. where a notice was posted, that the envelope containing the notice was properly addressed and posted; and

2.2.4.3. where a notice was sent by fax, a fax delivery report showing that the notice was properly addressed and despatched to the correct fax number.
A notice given under this Constitution is not valid if sent by e-mail.

2.3. **No Partnership or Agency**

Nothing in this Constitution is intended to, or shall be deemed to, establish any partnership or joint venture between any of the parties, constitute any party the agent of another party, nor authorise any party to make or enter into any commitments for or on behalf of any other party.
Schedule 2
Constitution

Guidance

The CCG must have regard to any Guidance published by the NHS Commissioning Board, including Guidance on the form, content or publication.

Publication

The CCG shall publish this Constitution on the CCG’s website - http://www.wandsworthccg.nhs.uk/aboutus/Our-Plans/Pages/Strategies-and-Plans.aspx. If this Constitution is varied, the CCG must publish the Constitution as so varied.

The CCG must have regard to any Guidance published by the NHS Commissioning Board in respect of the publication of the Constitution.

Variation

The CCG may apply to the NHS Commissioning Board to vary this Constitution. Such variation may include varying the CCG’s Area or its list of members. The CCG shall have regard to any Guidance published by the NHS Commissioning Board and comply with any Regulations made in respect of varying this Constitution.

The Act sets out further circumstances in which this Constitution may be varied otherwise than by an application by the CCG to the NHS Commissioning Board.

The CCG can amend the appendices of the constitution at its discretion, subject to Governing Body approval. The CCG will notify members of any amendments made.

For the avoidance of doubt, content included within the main body of the Constitution will override any contradictory content included within the appendices.
The Members (appointed, elected and nominated) of the CCG shall ensure that their conduct in the exercise of their duties to the CCG complies with such generally accepted principles of good governance as are relevant to it, in particular, the Nolan Principles.

The following is a list of the statutory duties of the CCG under the Act. The CCG shall put in place arrangements to ensure it exercises its duties in accordance with Legislation and directions by the NHS Commissioning Board and having regard to any Guidance documenting them as necessary in this constitution, the CCG’s Scheme of Reservation and Delegation and other relevant CCG policies and procedures.

The CCG shall in exercising these duties act consistently with the Secretary of State’s duty to promote a comprehensive health service.

1 Duty to promote the NHS Constitution

1.1 The CCG shall adhere to the NHS Constitution’s seven principles which are as follows:

1.1.1 The NHS provides a comprehensive service, available to all;

1.1.2 Access to NHS services is based on clinical need, not an individual’s ability to pay;

1.1.3 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 the patient experience;

1.1.4 NHS services must reflect the needs and preferences of patients, their families and their carers;

1.1.5 The NHS works across organisational boundaries and in partnership with other organisations in the interest of patients, local communities and the wider population;

1.1.6 The NHS is committed to providing best value for taxpayers’ money and the most cost-effective, fair and sustainable use of finite resources; and

1.1.7 The NHS is accountable to the public, communities and patients it serves.

1.2 The CCG shall, in the exercise of its functions:

1.2.1 act with a view to securing that health services are provided in a way which promotes the NHS Constitution; and

1.2.2 promote awareness of the NHS Constitution amongst patients, staff and members of the public.
In this paragraph “patients” and “staff” have the same meanings as in Chapter 1 of Part 1 of the Health Act 2009.

2  **Duty as to Efficiency**

The CCG must exercise its functions effectively, efficiently and economically.

3  **Duty as to Improvement in Quality of Services**

3.1 The CCG must exercise its functions with a view to securing continuous improvement in the quality of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness. In particular the CCG must act with a view to securing continuous improvement in the outcomes that are achieved from the provision of the services. These outcomes include, in particular, outcomes which show the:

3.1.1 effectiveness of the services;

3.1.2 safety of the services; and

3.1.3 quality of the experience undergone by patients.

4  **Duty in relation to Quality of Primary Medical Services**

The CCG must assist and support the NHS Commissioning Board in discharging its duty under Section 13 E of the Act (NHS Commissioning Board’s duty as to improvement in quality of services) so far as it relates to securing continuous improvement in the quality of primary medical services.

5  **Duties as to Reducing Inequalities and the Equality Duty**

5.1 The CCG must, in the exercise of its functions, have regard to the need to:

5.1.1 reduce inequalities between patients with respect to their ability to access health services;

5.1.2 reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services;

5.1.3 eliminate discrimination; harassment, victimisation and any other conduct that is prohibited under the Equality Act 2010;

5.1.4 advance equality of opportunity between persons who share a relevant protected characteristic (under the Equality Act 2010) and persons who do not share it;

5.1.5 foster good relations between persons who share a relevant protected characteristic (under the Equality Act 2010) and persons who do not share it; and

5.1.6 report annually on the CCG’s progress in respect of paragraphs 5.1.1 and 5.1.2 above.

5.2 The Equality Delivery System (“EDS”) or future variation shall be used to enable the CCG to meet its requirements in relation to the public sector Equality Duty and aspects of the NHS Constitution and the NHS Outcomes Framework.

5.3 The CCG shall champion the use of the EDS to embed areas for improvement within commissioned services.
5.4 The Board will agree a number of equality objectives for the CCG to implement annually, which will be derived from stakeholder consultation. These will be published on the CCG’s website and will form the basis of an action plan for the CCG to improve performance against equality standards and outcomes.

6 Duty to Promote Involvement of each Patient

6.1 The CCG shall in the exercise of its functions, promote the involvement of patients, and their carers and representatives (if any), in decisions which relate to:

6.1.1 the prevention or diagnosis of illness in the patients, or

6.1.2 their care or treatment.

6.2 The CCG shall have regard to any guidance published by the NHS Commissioning Board in respect of its duty under paragraph 6.1 above.

6.3 The CCG must have regard to any Guidance issued by the NHS Commissioning Board in respect of this duty.

6.4 All Clinical Reference Groups terms of reference and subsequent plans for re-design will include Tier Zero – patient education and self management.

6.5 Outcomes to achieve in respect of self management will be included within service specifications and be monitored according to the contract.

7 Duty as to Patient Choice

7.1 The CCG must, in the exercise of its functions, act with a view to enabling patients to make choices with respect to aspects of health services provided to them.

7.2 The CCG will uphold the principles of patient choice in ensuring that every service it directly commissions promotes patient choice.

7.3 The CCG will ensure its Complaints function supports patients with issues over patient choice.

8 Duty to obtain Appropriate Advice

8.1 The CCG must obtain advice appropriate for enabling it effectively to discharge its functions from persons who together have a broad range of professional expertise in the prevention, diagnosis and treatment of illness and the protection or improvement of public health.

8.2 The CCG must have regard to any Guidance issued by the NHS Commissioning Board in respect of this duty.

8.3 The CCG will obtain appropriate specialist (e.g. legal) advice when required in order to execute its legislative requirements fully.

9 Duty to Promote Innovation

9.1 The CCG must, in the exercise of its functions, promote innovation in the provision of health services (including innovation in the arrangements made for their provision).
9.2 The CCG will promote continuous improvement in its commissioned services. This will ensure better health outcomes are attained.

9.3 The CCG will promote health outcomes through a commitment to increasing the use of alternatives to block contracts, for example, payment by outcomes.

10 Duty in Respect of Research

10.1 The CCG must, in the exercise of its functions, have regard to the need to promote research on matters relevant to the health service and the use of the health service of evidence obtained from research.

10.2 The CCG will work with local providers and across organisational boundaries to understand how the latest evidence can be commissioned within its contracts.

11 Duty as to Promoting Integration

11.1 The CCG must exercise its functions with a view to securing that health services are provided in an integrated way where it considers that this would:

11.1.1 improve the quality of those services (including the outcomes that are achieved from their provision)

11.1.2 reduce inequalities between persons with respect to their ability to access those services; or

11.1.3 reduce inequalities between persons with respect to the outcomes achieved for them by the provision of those services.

11.2 The CCG will work with local stakeholders and across organisational boundaries to develop needs and evidence based services.

11.3 The CCG will ensure understanding of whole-system pathways and explore opportunities for integration to improve overall outcomes.

11.4 The CCG must exercise its functions with a view to securing that the provision of health services is integrated with the provision of Health-Related Services or Social Care Services where the CCG considers that such integration would:

11.4.1 improve the quality of the health services (including the outcomes that are achieved from the provision of those services);

11.4.2 reduce inequalities between persons with respect to their ability to access those services; or

11.4.3 reduce inequalities between persons with respect to the outcomes achieved for them by the provision of those services.

12 Duty as to promoting education and training

12.1 The CCG shall in exercising its functions, have regard to the need to promote education and training for persons who are employed, or who are considering becoming employed, in an activity which
involves or is connected with the provision of services as part of the health service in England so as to assist the Secretary of State of the duty under section 1F(1) of the Act.

13 Public Involvement

13.1 The CCG must make arrangements to secure that individuals to whom the services are being or may be provided are involved (whether by being consulted or provided with information in other ways):

13.1.1 in the planning of the CCG’s commissioning arrangements;

13.1.2 in the development and consideration of proposals by the CCG for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals or the range of health services available to them; and

13.1.3 in decisions of the CCG affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact.

13.2 The CCG must have regard to any Guidance issued by the NHS Commissioning Board in respect of this duty.

13.3 The CCG will develop and maintain annually a Patient and Public Involvement/Engagement plan. The plan will outline:

13.3.1 how the CCG will work with HealthWatch and other patient organisations; and

13.3.2 how the CCG will ensure that the views of patients and their carers will inform commissioning decisions

14 Financial Duties

14.1 Expenditure

The CCG shall perform its functions so as to ensure that the CCG’s expenditure does not exceed the aggregate of the CCG’s allocations for the financial year and expenditure which is attributable to the performance by the CCG of its functions in that financial year (including the CCG’s capital resource use and its revenue resource use) does not exceed the amounts specified in the Act and/or by the NHS Commissioning Board for the relevant financial year.

14.2 Quality Payments

The CCG shall publish an explanation of how the CCG spent any payment in respect of quality made to the CCG by the NHS Commissioning Board.

14.3 Use of Resources

The CCG must ensure that the use by it of its capital and revenue resources do not exceed the amount specified by any direction of the NHS Commissioning Board.
15 Additional Powers of the CCG

15.1 Mergers

The CCG may, together with one or more other Clinical Commissioning Group, make an application to the NHS Commissioning Board for the dissolution of the Clinical Commissioning Groups and the establishment of a new merged Clinical Commissioning Group. The requirements for such an application are described in the Act.

15.2 Dissolution

The CCG may make an application to the NHS Commissioning Board for the CCG to be dissolved.

15.3 Raising Additional Income

The CCG may do anything specified in Section 7(2)(a), (b) and (e) to (h) of the Health and Medicines Act 1988 (provision of goods etc.) for the purpose of making additional income available for improving the health service only to the extent that its exercise does not to any significant extent interfere with the performance by the CCG of its functions.

15.4 Grants

The CCG may make payments by way of grant or loan to a voluntary organisation which provides or arranges for the provision of services which are similar to the services in respect of which the CCG has functions.

The payments may be made subject to such terms and conditions as the group considers appropriate.

16 Emergency Planning

16.1 The CCG must take appropriate steps for securing that it is properly prepared for dealing with a relevant emergency.

17 Procurement, Patient Choice and Competition

17.1 The CCG shall:

- adhere to good practice in relation to procurement;
- protect the right of patients to make choices with respect to treatment or other healthcare services provided for the purposes of the health service; and
- put processes in place to ensure that the CCG does not engage in anti-competitive behaviour which is against the interests of people who use the service.
Schedule 4  
Composition of the Governing Body

1 The CCG shall have a Governing Body comprising eleven voting members:

1.1 Chief Officer (as Accountable Officer);

1.2 Clinical Chair;

1.3 Chief Finance Officer;

1.4 At least two Lay Members [including one patient and public lead member and one governance lead member which will include responsibilities for Audit, Remuneration and Conflicts of Interest]

1.5 Secondary Care Doctor

1.6 Registered Nurse

1.7 Locality Clinical Leads from Battersea, West Wandsworth and two from Wandle

2 The following may become members of the Governing Body:

2.1 a Member of the CCG who is an individual;

2.2 an individual appointed by virtue of Regulations in the Act;

2.3 individuals who are Health care Professionals; and

2.4 individuals who are Lay Members;

3 Appointed Members

3.1 The Commissioning Board on the recommendation of the Members shall appoint individuals to the following positions on the Governing Body:

3.1.1 Chair;

3.1.2 Chief Officer (as Accountable Officer);

3.1.3 Chief Finance Officer;

4 Four Locality Clinical Leads shall be elected by the Members of the Localities in a manner of the Localities choosing. Candidates are only eligible if they are a practicing GP in the Locality which they will represent, work a minimum of two clinical sessions per week, not be a director of a federation and be subject to assessment for suitably by the Chair of the CCG and the CCG Chief Officer.

5 Nominated members of the CCG are:

5.1.1 Director of Public Health (Wandsworth Borough Council)

5.1.2 Director of Education and Adult Social Services (Wandsworth Borough Council)

5.1.3 Director of Corporate Affairs, Performance and Quality
5.1.4 Director of Primary Care Development
5.1.5 Director of Commissioning and Planning
5.1.6 A nominated representative of the Wandsworth HealthWatch
5.1.7 Any other nominees at the discretion of the Governing Body
Schedule 5
Additional information for Governing Body Membership

CCG Governing Body Terms of Office

1.1 The Chair shall serve a three-year term, after which time an election will be held. The incumbent Chair shall be eligible for re-election.

1.2 The election shall be open to any GP within Wandsworth providing they are a Partner, a Sessional GP or Locum of a Practice within Wandsworth who works a minimum of two clinical sessions per week in a Wandsworth CCG Member Practice and is on the Wandsworth Performers List.

1.3 The CCG shall ask the LMC to assure the process for the election of the Chair to the CCG.

1.4 Those eligible to vote for the Chair are those GPs who meet the criteria of 1.2 above. Managing Partners in GP Practices are also entitled to vote. Each eligible GP and Managing partner are entitled to one vote each.

1.5 The quorum for Governing Body meetings will be six members of which three will be GPs and at least one Lay Member and one voting Director (either the Chief Officer or the Chief Finance Officer). No business shall be transacted at a meeting unless the following are present:

Chief Finance Officer or the Chief Officer; and
Chair or Vice Chair.

1.6 Detailed Governing Body terms of reference can be found at Appendix 6.

1.7 Terms of office for clinical and Lay Person members of the Governing Body:

1.6.1. Appointed Clinical and Lay Person members of the Governing Body shall serve for a term not exceeding four years and will be eligible for re-appointment following a public process;

Locality Clinical Lead Elections and Terms of Office

1.7.3 Locality Clinical Leads shall be elected to the Governing Body following a locality election;

1.7.4 The election process will be determined by each Locality Members’ Forum.

1.7.5 Locality Clinical Leads shall be eligible to stand for re-election.

1.7.6 To be eligible to stand for election as a Locality Clinical Lead a GP must be a GP on the Wandsworth Performers list and work a minimum of two Clinical Sessions a week in a Member Practice of that Locality.

1.7.7 The term of office will commence at a time stipulated by the Chair of the Governing Body, and this is expected to be communicated ahead of any appointments and/or election process for stated posts.
Disqualification of members of the Governing Body

1.8 Members of the Governing Body shall vacate their office if any of the following occurs:

1.8.3 if an elected Locality Clinical Lead ceases to work within the Area for a minimum of two clinical sessions per week;

1.8.4 if an elected Locality Clinical Lead is suspended from providing primary medical services;

1.8.5 if in the opinion of the Governing Body (having taken appropriate professional advice in cases where it is deemed unnecessary) the member becomes or is deemed to be of unsound mind; or

1.8.6 If the member has behaved in a manner or exhibited conduct which has or is likely to be detrimental to the honour and interest of the Governing Body or the CCG and is likely to bring the Governing Body or the CCG into disrepute. This includes but it is not limited to dishonesty, misrepresentation (either knowingly or fraudulently), defamation of any member of the Governing Body (being slander or libel), abuse of position, non declaration of a known conflict of interest, seeking to manipulate a decision of the Board in a manner that would ultimately be in favour of that member whether financially or otherwise.

1.8.7 If the member has behaved in a manner that is inconsistent with the NHS Code of Conduct and the terms and conditions of their employment.

1.8.8 If the member becomes ineligible to stand for a position as a result of the declaration of any conflict of interest.
Schedule 6
The Seven Principles of Public Life (the Nolan Principles)

1. 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 material benefits for themselves, their family, or their friends.

2. 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.

3. 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.

4. 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.

5. OPENNESS

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

6. 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.

7. LEADERSHIP

Holders of public office should promote and support these principles by leadership and example.
Schedule 7

CCG Functions

1. The statutory functions of the CCG to be exercised on behalf of the CCG by the Governing Body are as follows:

1.1. The Governing Body shall carry out the following functions:

1.1.1. ensuring the Register of Interests is reviewed regularly and updated as necessary;

1.1.2. ensuring that all conflicts of interest or potential conflicts of interest are declared

1.1.3. leading the settling of vision and strategy

1.1.4. approving commissioning plans

1.1.5. monitoring performance against plans

1.1.6. providing assurance of strategic risk.
Schedule 8

Annual Report: Contents and Publication

The Annual Report shall include the details required by the Act. In particular, the Annual Report must:

(a) explain how the CCG has discharged its duties under the Act in respect of improving the quality of the services and its duties under the Act in respect of public involvement and consultation; and

(b) having consulted any Relevant Health and Wellbeing Board, review the extent to which the CCG has contributed to the delivery of any Joint Health and Wellbeing Strategy to which it was required to have regard under Section 116B(1)(b) of the Local Government and Public in Health Act.

The CCG shall give a copy of the Annual Report to the NHS Commissioning Board before any date specified by the NHS Commissioning Board.

The CCG shall publish the Annual Report on the CCG website and present the Annual Report at the Annual General Meeting of the CCG.
1. **Provision of Documents to the Commissioning Board**

The Act gives the NHS Commissioning Board the power to request documents from the CCG in certain circumstances prescribed by the Act. The CCG shall ensure arrangements are in place to ensure the CCG or any of its Members or employees comply with any such request made by the NHS Commissioning Board, including, where requested by the NHS Commissioning Board, supplying any documents or records kept by means of computer in legible form.

2. **Power to Require Explanation**

The CCG must comply with any request by the NHS Commissioning Board under the NHS Act 2006 for the CCG to provide it with an explanation of any matter which relates to the exercise by the CCG of its functions, including an explanation of how the CCG is proposing to exercise any of its functions.

3. **Intervention Powers of the Commissioning Board**

The Commissioning Board has powers under the Act to direct and dissolve the CCG. In particular, the Commissioning Board may direct the CCG or the Accountable Officer of the CCG to cease to perform any functions for such period as may be specified by the Commissioning Board in any direction. In such circumstances, and where the Commissioning Board is exercising a function of the CCG or has directed another CCG to do so, the CCG must co-operate with the Commissioning Board or, as the case may be the other CCG or its Accountable Officer as required by the Act.
Clinical Commissioning Group Constitution

Appendices

This document contains 12 Appendices
Appendix 1

Area
## Register of Members

The Wandsworth Clinical Commissioning Group comprises of the following members:

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<table>
<thead>
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<tbody>
<tr>
<td>1</td>
<td>St John's Hill Practice</td>
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<tr>
<td>2</td>
<td>Battersea Fields Practice</td>
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<tr>
<td>3</td>
<td>Clapham Junction Medical Practice</td>
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<tr>
<td>4</td>
<td>Queenstown Road Surgery</td>
</tr>
<tr>
<td>5</td>
<td>Lavender Hill Group Practice</td>
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<tr>
<td>6</td>
<td>Balham Hill Medical Practice</td>
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<td>7</td>
<td>Falcon Road Medical Practice</td>
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<td>8</td>
<td>Thurleigh Road Practice</td>
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<td>9</td>
<td>The Heritage Medical Practice</td>
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<td>10</td>
<td>Bridge Lane Group Practice</td>
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<td>11</td>
<td>Battersea Rise Group Practice</td>
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<tr>
<td>12</td>
<td>The Junction Medical Centre</td>
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<td>13</td>
<td>The Alton Practice</td>
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<td>14</td>
<td>The Heathbridge Practice</td>
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<td>15</td>
<td>The Mayfield Surgery</td>
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<td>The Roehampton Lane Surgery</td>
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<td>The Danebury Avenue Surgery</td>
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<td>Chartfield Surgery</td>
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<td>Putneymead Group Medical Practice</td>
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<td>21</td>
<td>Tudor Lodge Health Centre</td>
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<td>22</td>
<td>Balham Health Centre</td>
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<td>23</td>
<td>Tooting Bec Surgery</td>
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<td>Wandsworth Medical Centre</td>
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<td>Balham Park Surgery</td>
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<td>Nightingale Practice</td>
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<td>Elborough Street Surgery</td>
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<td>28</td>
<td>Chatfield Health Centre</td>
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<tr>
<td>29</td>
<td>Dr Howard Freeman and Partners</td>
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<tr>
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<td>Streatham Park Surgery</td>
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<td>31</td>
<td>Earlsfield Surgery</td>
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<td>32</td>
<td>The Surgery</td>
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<td>Brocklebank Group Practice</td>
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<td>St Paul’s Cottage</td>
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Appendix 3
Inter Practice Agreement

WANDSWORTH Clinical Commissioning Group

Inter-Practice Agreement

Draft Version 5.3
To be reviewed and re-issued by 31st March 2013
Wandsworth Clinical Commissioning Group

Inter-Practice Agreement

1. Introduction

It is the intention of WCCG to become a statutory body by the 01st April 2013. The 45 Wandsworth GP practices have already taken strides to establish a clinical commissioning group which covers the entire borough, working with NHS Wandsworth, Wandsworth Council and local patient groups.

The commissioning group will now begin testing the new commissioning arrangements to ensure they are working well before more formal arrangements come into place by April 2013. This Inter-Practice Agreement is for 2012/13 and will be replaced in 2013/14 with a new Inter-Practice Agreement.

The WCCG is a membership organisation. GP Practices can become members of the WCCG provided they meet the membership criteria as outlined in section 3 of this document as well as in the CCG Constitution. The members mandate the CCG governing body to provide commissioning functions, performance monitoring functions (where relevant), financial management (including delegated budgets as appropriate) and engagement with stakeholders on their behalf. The members in turn will commit to engaging with the CCG and abiding by the membership conditions set out in the CCG constitution and related documents (such as the Locality Delegation Agreement, CCG Standing Orders, and committee terms of reference). The diagram below describes the current structure for the CCG.

2. Definitions and Interpretation:

In this Agreement, the following words shall have the meanings given to them below:

2.1 Constitution means the governance document that is being developed by the CCG and which describes how the CCG will carry out its duties and responsibilities.
2.2 **Members Forum** is the collective term for the Member Representatives of each Locality Commissioning Group.

2.3 **Governing Body** means the group of individuals responsible for the strategic direction of the CCG and whose functions will be described in the Constitution and in the CCG’s Scheme of Reservation and Delegation.

2.4 **Local Clinical Commissioning Groups/Localities** means the committees of the CCG for West Wandsworth, Battersea and Wandle whose duties and responsibilities will be described in the Locality Development Agreement.

2.5 **Locality Clinical Lead** means the GP or other healthcare professional elected by the Members (as described in paragraph 12 of this Agreement) in each Locality who will represent the Members in that Locality and who will be each be a member of the Governing Body.

2.6 **Member** means the GP practice which has become a member of the CCG [as evidenced by its signature to this Agreement and to the Constitution [and whose name has been entered on the Register of Members in accordance with the Constitution].

2.7 **Member Representative** means the GP nominated by each Member Practice to represent that Member on the Members Forum.

3. **Purpose of the Agreement**

3.1 **This is an Agreement for financial year 2012/13 between:**

- each of the GP Practices listed in Appendix 2 (the “Members”); and
- the Members and NHS Wandsworth as host of Wandsworth Clinical Commissioning Group (the “CCG”).

The CCG is a membership organisation and will be a statutory body. It cannot meet its objectives without the commitment and contributions of the GP practices which make up its membership.

This Agreement describes how the Members, the CCG as a whole and NHS Wandsworth will work together to ensure that the CCG develops into an organisation that has the capability to commission safe, high quality and cost effective services that meet the needs of the patients in its area.

The CCG has developed a constitution (the “Constitution”) which sets out how the CCG will function. This Inter-Practice Agreement explains how the Members, as individual GP practices, will contribute to the design, development and business of the CCG as it develops from an organisation headed up through a committee hosted within NHS Wandsworth (its shadow form) to a statutory body accountable to the Secretary of State (its authorised form). That transition will require input from all the Members to some extent and this Agreement sets out how the Members will support the CCG’s application for authorisation during this interim period.

4. **Term of the Agreement**

The Members agree that this Agreement supports the CCG Constitution. The CCG Constitution is legally binding on each of the Members for as long as they remain Members of the CCG and until 31st March
2013 or, if later, the date on which the CCG is authorised as a statutory body corporate. It will then be replaced by a new Inter-Practice Agreement.

5. Membership

5.1 Who may become a Member of the CCG?

Section 3.1 of the Constitution describes the eligibility criteria for Membership of the CCG.

5.2 Membership Conditions

A Member shall be entitled to retain its membership of the CCG as long as that Member complies with Section 3.3 of the CCG Constitution.

5.2.1 Termination of Membership

Section 3.6 of the Constitution describes the conditions under which termination could occur.

5.3 Engagement with Members

Engagement with members is vital to the CCG’s development, authorisation and success. As such, the CCG’s strategy, expectations and responsibilities for engagement with its Members is set out in (but not limited to) the following initiatives:

- The CCG Operating Plan
- The GP Engagement scheme
- Quality Innovation Productivity Performance Scheme (QIPP)
- Patient and Public Involvement schemes
- Through Locality Commissioning Groups
- Through member representatives
- Through Clinical Reference Groups via Pathway Locality Leads
- Via Stakeholder engagement events

6. The CCG

6.1 CCG Structure

The CCG currently operates as a committee of NHS Wandsworth. The internal structure and practice and procedure of the CCG is set out in the Constitution. Each Member shall have one named Member Representative (as defined in Section 8). The Member shall comply, and ensure that its Member Representative and any other person working on behalf of the Member, complies with any relevant provisions of the Constitution. The Constitution sets out the parameters of how the CCG will work and it is expected that members familiarise themselves with the terms therein.

6.2 Objectives/Vision

The objectives of the CCG are described in the Constitution and are listed below. Each Member agrees to co-operate in good faith with other Members, the CCG and NHS Wandsworth to contribute to the furtherance of these objectives. The CCG objectives are:

- To:
• Reduce health inequalities through helping people to live longer and healthier lives, particularly those living in Wandsworth’s most deprived communities
• Support young people to take control of their own health earlier, so they can continue to make healthier choices throughout their lives
• Educate people about mental well being, sexual health, drugs, alcohol and obesity. Help prevent and diagnose earlier and improve services
• Improve access, quality and choice of service provision across all are pathways and in appropriate settings
• Improve the quality of life of people living with long term and complex health conditions and their carers by improving the quality, range and choice of services and giving them information to better manage their own health
• The commissioning outcomes that relate to the CCG objectives described above can be found in (but are not limited to)
  • Joint Strategic Needs Assessment (JSNA)
  • Commissioning Strategy Plan (CSP)
  • Locality delivery plans
  • Local enhanced services
  • GP Engagement Scheme
  • Shift of Care initiatives
  • Joint health and social care initiatives
• Patient and Public Involvement Strategy documents (Including the Expert Patient Program)
6.3 **Locality Commissioning Groups**

6.3.1 **Localities**

The CCG have formed three local groups known as Locality Commissioning Groups for the following geographical areas.

- West Wandsworth
- Battersea; and
- Wandle

6.4 **Locality Clinical Lead**

Locality Clinical Leads (GPs) will be elected for each locality by its Member practices to represent the Locality. In the case of Battersea and West Wandsworth there will be one lead, in Wandle there will be two. Candidates must be a practicing GP in the Locality they wish to represent and working a minimum of 2 clinical sessions per week and must not be a Director of a Federation.

Candidates must also go through an interview process with the Chair and Accountable Officer of the CCG to determine their suitability to sit on the governing body. The Chair and Accountable Officer may determine the candidate is either a suitable potential member of the governing body, suitable with a development plan, or unsuitable. In this situation the candidate is then withdrawn from the process.

The Locality Clinical Leads shall be entitled to attend and vote at meetings of the Governing Body. The practice and procedure of the Locality Commissioning Groups is set out in the Locality Delegation Agreement.

Each Locality Lead shall be entitled to one vote each at meetings of the Governing Body. The Governing Body terms of reference will describe the practice and procedure of the Governing Body. Locality Leads shall act in their corporate capacity as members of the Governing Body when attending meetings and voting at meetings of the Governing Body – however they will bring the unique understanding of member practice groups to the discussion and decision making of the Governing Body as their particular contribution.

6.5 **Locality Members Forum**

Member Representatives together shall be referred to as the Locality Members Forum. Member representatives shall be entitled to attend and vote at meetings of the Locality Members Forum. The practice and procedure of the Locality Members Forum is set out in the Locality Delegation Agreement at [Appendix 11] of the Constitution.

6.6 **Member Representatives**

Each Member shall appoint a named individual who is a GP as a Member Representative to represent the Member on the Members Forum. The Members shall also appoint an individual who is a GP or other Healthcare Professional as a Deputy Member Representative to act with the full authority of the Member where the Member representative is unavailable. Each Member shall notify the Governing Body of the names of its Member representative and Deputy Member representative appointed from time to time and
update the CCG when changes are made. The Member Representative and Deputy Member Representative must not be Director of a Federation.

6.7 Voting at Meetings of the Members Forum

The Member representative for each Practice shall be entitled to vote as determined by their Locality Clinical Commissioning Group. This will be determined at a future meeting.

6.8 Duties and responsibilities of Members

As described in Section 3.3.1 of the Constitution.

6.9 Re-investment scheme

- The Freed Up Resources (FUR’s) scheme was borne out of the desire to fund future investments in a local and meaningful way.
- It is imperative that WCCG maintain adequate levels of surplus and contingency funding for future investment and to manage and mitigate risk associated with delivering National Priorities, the Commissioning Strategy Plan (CSP) goals and meeting the cost of changes in the financial regime.
- As such, future savings including FURs will be made available to practices and Locality Clinical Commissioning Group subject to the Clinical Commissioning Group achieving recurrent financial balance and savings
- Practice recurrent FURs schemes that have been approved under the previous Freed up Resources scheme will be reviewed in light of national policy in April 2013.
- Where it is appropriate FUR’s schemes will be subject to contract variation on existing Personal Medical Services (PMS) and General Medical Services (GMS) contracts.

6.10 LCG Local Enhanced Service (LES)

- The aim of the LCG LES is to encourage and resource practice participation and engagement in areas that underpin the work of the Wandsworth Clinical Commissioning Group.
- A focus of the LCG LES is to support the delivery of the Quality Innovation Productivity and Prevention (QIPP) plan
- GP attendance at 80% of the Locality Members Forums is an entry criterion for the LCG LES
- In addition, Practices will also be required to undertake two clinical audits to be determined by the CCG. These audits seek to promote further understanding of specific clinical pathways and clinician behaviour and to promote positive changes to both of these

6.11 GP Engagement scheme (GES)

- The GP Practice Commissioning Engagement Scheme is a scheme that assists practices in developing internal systems and processes for monitoring agreed objectives at practice level.
- The CCG recognises the importance of engaging and supporting the establishment of strong commissioning processes as GPs prepare for their future roles. The Wandsworth Clinical Commissioning Group is committing significant investment to GP engagement through the GP Practice Commissioning Engagement Scheme.
• The GP Practice Commissioning Engagement Scheme reflects the move to GP-led clinical commissioning and is aimed at shaping and strengthening future commissioning at GP practice level.

• The scheme itself involves different levels of engagement that will support the delivery of key areas of activities over the next year. The levels of engagement will be supported by a GP Engagement Support Monitoring Framework that will ensure that practices receive timely support at practice, locality and WCCG level.

• GP practices signing up to this agreement will identify a Named GP Practice Lead who will undertake specific activities and manage the interface between the practice, locality and the WCCG.

• Practices will, through their named Leads, agree three areas of improvement that the practice will focus on over an agreed time period with their Locality Clinical Commissioning Lead.

• Selection of areas for improvement will be linked to local need and current performance. NHS Wandsworth Performance and Information Team will provide practice and Locality level performance data for the above work streams.

6.12 Performance Management of the GP Engagement Scheme

Members are expected to agree areas of improvement with their Locality Clinical Commissioning Lead and their Locality Management Teams. Selection of priorities will be linked to local need and current performance. The Governing Body shall develop and adopt a policy for appraising Members’ compliance with this scheme and for resolving instances where Member’s fail to meet the Membership Conditions. Performance concerns will be addressed in a supportive manner and in line with the following practical stages:

Stage 1

• Members will be supported by their respective Locality Management Team to identify the causes for under-performance and produce a remedial plan with appropriate timeframes for review.

• If upon review the plan has delivered the required sufficiently altered behaviours agreed outcomes the matter is deemed to be closed.

• If however, upon review, the plan has not altered behaviour and/or produced the required outcomes, stage 2 will be implemented

Stage 2

• The Locality Clinical Commissioning Lead will meet with the member and agree a plan for a limited time period.

• This plan will be taken to the Members Forum for discussion and agreement. The Member may also be offered additional peer support to help affect any changes required.

• If upon review, (within the agreed timescale) the plan has still not altered behaviour and/or produced the required result, stage 3 will be implemented.

Stage 3

• The Locality Clinical Lead, by mandate of the Members Forum, will inform the Governing Body of any unresolved issues from the review with the Member practice in relation to areas for improvement.

• The Chair of the Governing Body to make direct contact with the member.
• Formal written objectives will be given to the Member by the Governing Body via the Chair of the Governing Body.
• Peer support may be provided by the Governing Body if appropriate.
• The Member has a one quarter period in which to clearly demonstrate they have implemented the objectives and have started to deliver improved performance.
• If improvement is seen at this stage, the Member will revert to stage 2 and performance will be closely monitored for a further 3 months by the Locality Clinical Lead.
• If improvement is not seen, then payment will be withdrawn until such time that improvement is evidenced.

6.13 Management Support

The CCG will produce a Development Plan which describes the development support to be provided to Members. Members shall be notified by the CCG of the support, events and leadership development training available. The Members acknowledge the importance of ongoing training and development in building the success of the CCG and shall use all reasonable endeavours to ensure that relevant Member representatives attend or engage with the programme of support provided for the benefit of the Members.
6.14 Conflicts of Interest

Each Member shall comply, and ensure that its Member representative and any other person working on behalf of the Member, complies with the provisions of the CCG’s Conflicts of Interest policy as stated in the CCG Constitution. All conflicts of interest must be openly declared and added to the CCG Conflicts of Interests register.

6.15 Dispute Resolution

The Governing Body has developed a disputes policy to deal with any disputes between the Members, the CCG, the Locality Commissioning Groups. The Members agree to act reasonably and in good faith in respect of any disagreement arising from their membership of the CCG and shall use all reasonable endeavours to promote the resolution of any dispute as swiftly as possible and to mitigate any impact on the resources of the Member, the CCG, NHS Wandsworth and/or NHS South West London. Please refer to the CCG Constitution for the CCG dispute resolution policy.

The Governing Body will utilise the Anti-Fraud policy within the CCG Constitution in relation to potential fraud or misconduct.

6.16 Information Governance

Each Member shall at all times use all reasonable endeavours to keep confidential any confidential information relating to the CCG or its business. Each Member agrees to comply, and ensure that its Member representatives and any other person working on behalf of the Member, complies with the provisions around confidential information set out in the Constitution. For the purposes of this section, the term “Confidential Information” shall be defined in accordance with the Constitution.

6.17 Notices

A notice given to a party under or in connection with this Agreement shall be in writing, in English and in the case of a Member or the Member representative for that Member, the address set out from time to time in the CCG Register of Members. The notice required is 6 months.

6.18 No Partnership or Agency

Nothing in this Agreement is intended to, or shall be deemed to, establish any partnership or joint venture between any of the parties, constitute any party the agent of another party, nor authorise any party to make or enter into any commitments for or on behalf of any other party.
Signatures

Each party hereby confirms its agreement to the terms contained in this Agreement.

Date:..............................
Signature: ............................... ,
duly authorised for and on behalf of [Insert name of Member]

Date:..............................
Signature: ............................... ,
duly authorised for and on behalf of the emerging CCG
1. Scope and Purpose

The Wandsworth Clinical Commissioning Group has taken on full delegated responsibility since 1 October 2011 for all services and resources excluding public health budgets and resources that will be transferring to the National Commissioning Board. It is also the aspiration of the WCCG to achieve full Authorisation by April 2013.

Wandsworth CCG has three Locality Commissioning Groups. The Locality Commissioning Groups meet regularly in their Localities at Members Forum meetings. In addition to this the 3 Localities meet bi-annually at the Joint Locality Members Forum.

2. Objectives

The Locality Members Forum will:

- Develop and coordinate the delivery of the Locality Delivery Plan.
- Ensure Patient Public Engagement is central to commissioning at practice and Locality level.
- To deliver the responsibilities as set out in the Locality Delegation Agreement.
- Where needed facilitate multidisciplinary and partnership solutions to CCG priorities.
- Be responsible for monitoring practice level and collective Locality performance of the GP engagement scheme and further performance indicators as agreed by the WCCG.
- Share and disseminate good practice to GP practices as required
- Coordinate practice level and locality input into service redesign and care pathway projects as required.
- Manage the interface between GP practices and the WCCG via the Member Practices Communication Strategy.
• Where relevant, work closely with other stakeholders to deliver shared priorities and delegated responsibilities.

3. Membership

The core membership of the Locality Members Forum will comprise:

- Locality GP Clinical Lead or Lay person (Chair)
- GP Practices within the Locality
- Practice Nurse Lead (To be agreed)
- Patient Public Representative
- Wandsworth Borough Team Senior Manager (deputising for Managing Director)
- Consultant in Public Health (deputising for Director of Public Health)
- Wandsworth Borough Local Authority – Adult Social Services
- Wandsworth Borough Local Authority – Children’s Services

In attendance:

- Locality Manager
- Locality Administrator

4. Meeting Frequency

Meetings will be held monthly, with a total of 10 meetings held per year. Members are expected to attend a minimum of 8 out of 10 meetings. Agenda’s and circulation of papers to be determined locally.

5. Voting

To be determined locally.

The Chair may deem it necessary to have a confidential Part 2 of the meeting with membership restricted to Member Practices.

6. Minutes

The Locality administrator will, via the LCG Clinical Lead, circulate minutes within one week. The agenda will be circulated one week in advance.

7. Accountability and Review

The Locality Members Forum reports to Wandsworth CCG via the Management Team.

8. Review
The Terms of Reference will be reviewed annually.
Appendix 5

Joint Locality Members Forum Terms of Reference

Joint Locality Members Forum

Terms of Reference

1. Background

Wandsworth CCG has three Locality Commissioning Groups. The Locality Commissioning Group members meet regularly in their Localities at Members Forum meetings. Locality Members Forums are held 10 times per year with members expected to attend a minimum of 8 out of the 10. In addition to this the 3 Localities meet bi-annually at the Joint Locality Members Forum.

2. Objectives

The Joint Locality Members Forum will meet twice a year. These meetings are in addition to Locality Members Forums and the WCCG statutory Annual General Meeting. The aims of these meetings are to:

- Share good practice amongst members
- To share information between the CCG, Localities and Members
- To raise any issues that the Localities feel are pertinent
- To feedback on commissioning issues in the Localities to the WCCG as appropriate

3. Membership

The core membership of the Joint Locality Members Forum will comprise:

- WCCG Chair (Chair of the meeting – non-voting)
- Locality Clinical Leads (non-voting)
- A Member representative who has delegated authority from their Practice (i.e. a mandate from their Practice to vote on issues on their Practice’s behalf) for each Member practice

In attendance (non-voting):

- Locality Manager for each Locality
- Locality Administrator (minute taker)
- Senior WCCG officers
- Additional representatives from Member practices as determined by each
- Up to 2 Patient Public Representatives from each Locality, including up to 4 from Wandle

4. Meeting Frequency

The Joint Locality Members forum will meet 2 times per year at the end of January and the end of September. Included in the meetings will be the opportunity to approve annual plans and plan for winter pressures if necessary.
In exceptional circumstances the Chair can call a confidential part 2 of the meeting which will comprise a restricted membership as determined by the Chair.

5. Agenda

The agenda will be established via the LCG Leads in conjunction with the CCG Chair.

Additionally, should 20% of the total member practices wish to set an agenda item then this must go onto the agenda.

6. Voting

Should a vote be required an issue, support from a majority (51%) of the member practices present will constitute a pass of the proposal. A practice must be represented at the JLMF meeting in order to vote. The result will be passed to the CCG’s Governing Body (the ‘Board’) as a recommendation for the Governing Body to consider.

One vote per Practice is permitted.

7. Minutes

Accurate minutes will be recorded and circulated no later than one week after the meeting.

8. Accountability and Review

The Joint Locality Members Forum reports to the Governing Body of Wandsworth CCG.

9. Review

The Terms of Reference will be reviewed annually.
Appendix 6
Governing Body Terms of Reference

WANDSWORTH CLINICAL COMMISSIONING GROUP

Governing Body – Terms of Reference

1. **Aim and Purpose**
   The main function of the Governing Body is to ensure that Clinical Commissioning Group (CCG) has appropriate arrangements in place to ensure it exercises its functions effectively, efficiently and economically and in accordance with any generally accepted principles of good governance that are relevant to it.

   The Governing Body shall carry out the duties and responsibilities set out in the CCG’s Constitution and should ensure business is conducted in accordance with Standing Orders (SOs) and Standing Financial Instructions (SFIs).

   These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the Governing Body.

2. **Authority**
   The Governing Body may establish sub-committees to assist with the delivery of its delegated responsibilities and to progress its work as appropriate. Such sub-committees do not have executive powers, unless this has been agreed in advance by the Governing Body.

   The Governing Body will establish appropriate reporting arrangements for Sub-Committees.

   The Chair of the Governing Body will work to establish unanimity as the basis for decisions. If, exceptionally, the Governing Body cannot reach a unanimous decision, the Chair will put the matter to a vote, with decisions confirmed by a simple majority of those voting members present, subject to the meeting being quorate. In the case of equality of votes the Chair will have the casting vote.

3. **Relationship with Professional Executive Committee for 2012/13 only**
   The Governing Body subsumes the statutory obligations of the Professional Executive Committee (PEC) and in recognition that Wandsworth Primary Care Trust is the statutory body for 2012/13. The PEC chair will be a voting member of the Wandsworth Clinical Commissioning Group Governing Body for 2012/13 only, before PEC, as a statutory PCT function ceases on 1st April 2013.

4. **Duties**
   The role of the Governing Body is to commission health services, affect health inequalities and to deliver the vision and strategic goals of the CCG as specified in the Constitution. This includes any duties outlined in the Health and Social Care Act 2012 and in any subsequent amendments to the Act or as requested by the National Commissioning Board.

   Specific responsibilities include:
   - Exercise its functions in relation to the provision or securing the provision of healthcare.
   - Ensure effective systems are in place for ensuring the quality and effectiveness (including cost-effectiveness) of commissioned services.
   - Put in place proposed structures and systems to safeguard transparency, accountability and good governance.
   - Ensure accountability, probity and openness of its business at all times in line with the NHS Code of Conduct.
• Lead strategic direction and setting of corporate objectives
• Be responsible for the delivery of financial balance and performance indicators.
• Be responsible for the Board Assurance Framework
• Review risks rated 15 and above and ensure effective mitigations are in place.
• Ensure strong and effective clinical involvement in all aspects of commissioning.
• Receive and note reports and minutes from subgroups.

5. Membership and Quoracy
The Governing Body will comprise the following voting members, which reflects a clinical majority:

• CCG Chair (Chair)
• 4 x GP Locality Leads
• Chief Officer
• Chief Financial Officer
• Lay Member for Governance
• Lay Member for Patient and Public Involvement
• Secondary Care Doctor
• Registered Nurse

The Governing Body will be chaired by the Clinical Lead.

The Vice-Chair of the Governing Body will be the Lay Member with responsibilities for Governance.

In addition, the following are non-voting roles:

• Local Authority (nominated as the Director of Adult Social Services)
• Joint Director of Public Health
• Director of Delivery and Development
• Director of Commissioning and Planning
• Director of Corporate Affairs and Performance
• Wandsworth HealthWatch

Additional non-voting attendees may be co-opted on to the Governing Body from time to time at the discretion of the Chair. Part II of the meeting will be attended by all voting attendees, and others may be invited to attend at the discretion of the Chair.

The quorum will be six members of which three will be GPs and at least one Lay Member and one voting Director (either the Chief Officer or the Chief Financial Officer). No business shall be transacted at a meeting unless the following are present:

Chief Financial Officer or the Chief Officer; and
Chair or Vice Chair.

6. Frequency
The meetings will be held monthly with the exception of August and January.

The principle to be adopted is that the meetings will be held in public with, where necessary, a Part II in private for confidential items.

At any meeting of the Governing Body or a sub-committee, the Chair of the Governing Body or sub-committee, if present, shall preside. If the Chair is absent from the meeting, the Vice Chair shall preside.

If the Chair is absent temporarily (i.e. for a specific agenda item) on the grounds of a declared conflict of interest the Vice Chair, if present, shall preside. If both the Chair and Vice Chair are absent, are disqualified from participating, or there is neither a Chair or Vice Chair, a member of the Governing Body, shall be chosen by the members present, or by a majority of them, and shall preside for that agenda item only. The quoracy arrangements described above apply for meetings as a whole.
The Governing Body will arrange for an Annual General Meeting to be held each year, which will be open to members of the public.

Members are expected to maintain regular attendance at meetings. If circumstances make this impossible, this will be addressed by the Chair with the individual member concerned and alternative arrangements will be determined.

7. **Conduct of the committee**
   The Committee will conduct its business in accordance with the codes of conduct set out for all Governing Body members and good governance practice as laid out in the Constitution.

   Members of the Governing Body are required to adhere to the Wandsworth CCG Conflicts of Interest Policy.

   The Governing Body will keep a Register of Members’ interests, and interests relevant to items under discussion will be declared at each meeting as required in line with Standing Orders.

8. **Administration**
   The meeting will be administered by the Business Manager. The Business Manager will draft the Agenda for approval by the Chair. All Agenda items and relevant papers will be published one week prior to CCG meetings. The Business Manager will maintain Minutes of all meetings and a log of decisions made. Meetings will be held in public in an accessible venue within Wandsworth. Papers for discussion will be made available on the CCG website at least five working days in advance of the meeting. Papers should be considered by Management Team or a sub-committee of the Governing Body before being submitted to the Governing Body.

9. **Review**
   The terms of reference for the Governing Body will be reviewed at least annually, and may be reviewed before that date to reflect changes in national or local policy or guidance as required.
Appendix 7

Audit Committee Terms of Reference

WANDSWORTH CLINICAL COMMISSIONING GROUP

Audit Committee – Terms of Reference

1. Aim and Purpose
The Wandsworth Clinical Commissioning Group (CCG) hereby resolves to establish a Committee of the Governing Body to be known as the Audit Committee (the Committee). The Committee is a non-executive committee of the Governing Body and has no executive powers, other than those specifically delegated in these Terms of Reference.

2. Authority:
The Committee is authorised by the Governing Body to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

The Committee is authorised by the Governing Body 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.

3. Duties
The responsibilities of the Committee are categorised as follows:

3.1 Internal Control
3.1.1 The Committee shall review the establishment and maintenance of an effective system of internal control, across the whole of the organisation’s activities that supports the achievement of the CCG’s objectives. It will review the adequacy and effectiveness of the work of the Integrated Governance Committee, who will oversee specific actions and controls to deal with corporate and clinical governance, risk, and the quality and performance of commissioned services.

3.1.2 The Committee will specifically review the adequacy of:

- All risk and control related disclosure statements (in particular the Statement on Internal Control and declarations of compliance), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Governing Body.

- 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 systems of internal control, ensuring they are subject to review and adequate assurance is received on their operation.

- The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements.

- The policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the Counter Fraud and Security Management Service.

3.1.3 In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances on the overarching systems of integrated governance, risk management and internal control.
3.1.4 This will be evidenced through the Committee’s use of an effective Board Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

3.2 Internal Audit

3.2.1 The Committee shall ensure that there is an effective internal audit function established by management that meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Committee, Chief Officer and Governing Body. 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 strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Board 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.
- Annual review of the effectiveness of internal audit.

3.3 External Audit

3.3.1 The Committee shall review the work and findings of the External Auditor appointed by the Audit Commission and consider the implications and management’s responses to their work. This will be achieved by:

- Consideration of the appointment and performance of the External Auditor, as far as the Audit Commission’s rules 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 co-ordination, 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 organisation and associated impact on the audit fee.
- Review all External Audit reports, including agreement of the annual audit letter before submission to the Governing Body and any work carried outside the annual audit plan, together with the appropriateness of management responses.

3.4 Other Assurance Functions

3.4.1 In addition, the Committee will review the work of other committees within the organisation, to provide assurance to the Governing Body that responsibilities are being fulfilled.

3.5 Management

3.5.1 The Committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control. They may also request specific reports from individual functions within the organisation as they may be appropriate to the overall arrangements, for example, scrutinising a decision made by the Governing Body to ensure adherence to its key principles as established in the Constitution.

3.6 Financial Reporting

3.6.1 The Committee shall review the Annual Report and Financial Statements before submission to the Governing Body, focusing particularly on:

- The wording in the Statement on Internal Control and other disclosures relevant to the Terms of Reference of the Committee.
- Changes in, and compliance with, accounting policies and practices.
- Unadjusted mis-statements in the financial statements.
- Major judgemental areas.
- Significant adjustments resulting from the audit.
- Letter of representation.
- Qualitative aspects of financial reporting.
4. Membership:
The Committee shall be appointed by the Governing Body from amongst the Lay Members of the CCG and shall consist of not fewer than four members. Two additional Associate Lay Members will be recruited to be members of the committee. The Associate lay Members will not be members of the Governing Body. A quorum shall be two members, including at least one CCG Governing Body Lay Member. The Lay Member with responsibility for Governance will be appointed Chair of the Committee by the Governing Body. The Chair of the Governing Body shall not be a member of the Committee.

5. Attendance:
The Chief Finance Officer (CFO) and appropriate Internal Audit, External Audit and Counter Fraud representatives shall normally attend the meetings. At least once a year the Committee shall meet privately with the Internal and External Auditors.

The Chief Officer and Chair must be in attendance at least once a year, to review the Year End accounts plus the Statement of Internal Control.

The Chief Officer (COO), as the Accountable Officer, and other directors shall be invited to attend, particularly when the Committee is discussing areas of risk or operation that are the responsibility of that director.

The COO shall be invited to attend, at least annually, to discuss with the Committee the process for assurance that supports the Statement on Internal Control.

The CFO will provide appropriate support to the Chair and Committee members.

The Chair of the Governing Body may be invited to form a view on Committee operations.

Members are expected to maintain regular attendance at meetings. If circumstances make this impossible, this will be addressed by the Chair with the individual member concerned and alternative arrangements will be determined.

6. Frequency
Meetings shall be held not less than four times a year. The Head of Internal Audit or External Auditor may request a meeting if they consider that one is necessary.

The Committee Chair has discretion to call additional meetings if there is sufficient business to transact.

7. Reporting
The Minutes of the Committee meetings shall be formally recorded and submitted to the Governing Body. The Chair of the Committee shall draw to the attention of the Governing Body any issues that require disclosure or require executive action.

The Committee will report to the Governing Body annually on its work in support of the Statement on Internal Control, specifically commenting on the fitness for purpose of the Assurance Framework, the completeness and embeddedness of risk management in the organisation, and the integration of governance arrangements.

8. Conduct of the committee
The Committee will conduct its business in accordance with the codes of conduct set out for all Governing Body members and good governance practice as laid out in the Constitution.

9. Administration
The Committee shall be supported administratively by the Business Manager, whose duties in this respect will include:

- Agreement of Agenda with Chair and attendees and collation of papers.
- Taking the Minutes and keeping a record of matters arising and issues to be carried forward.

The Chief Finance Officer will advise the Committee on pertinent areas.

10. Review
The Committee will review its performance, membership and Terms of Reference annually. Any resulting changes to be approved by the Governing Body.
Appendix 8
Remuneration Committee Terms of Reference

WANDSWORTH CLINICAL COMMISSIONING GROUP

Remuneration Committee – Terms of Reference

1. **Aim and Purpose**
The Remuneration Committee (the Committee) is established in accordance with Wandsworth Clinical Commissioning Group’s Constitution, Standing Orders and Scheme of Delegation. These Terms of Reference set out the membership, remit, responsibilities and reporting arrangements of the Committee.

The purpose of the Committee is to advise and assist the Governing Body in meeting their responsibilities to ensure appropriate allowances and terms of service for the Chief Officer, directors or any other senior manager remunerated under the Very Senior Manager Pay Framework having proper regard to the organisation’s circumstances and performance and to the provisions of any national agreements and NHS Commissioning Board guidance where appropriate.

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 clinical commissioning groups’ constitution and standing orders.

2. **Authority**
The Committee will apply best practice to the decision making process. When considering remuneration the Committee will:

- Comply with disclosure requirements regarding Conflicts of Interests and will adhere to the WCCG Conflicts of Interest policy
- On occasion seek independent advice about remuneration for individuals
- Ensure that decisions are based on clear and transparent procedures.

The Committee will have the full authority to commission any reports or surveys it deems necessary to help fulfil its obligations.

3. **Duties**
The purpose of the Committee is to:

- Make recommendations to the Governing Body for appropriate remuneration and terms of service for the Chief Officer, Chair and other executive officers, including GPs and directors, of the Governing Body including:
  - Any aspects of salary (including any performance related aspects/bonuses)
  - Payments for additional responsibilities
  - Provisions for other benefits
  - Conditions of service
  - Monitoring and evaluating performance
  - Arrangements for termination of employment and other contractual terms
- Ensure proper calculation and scrutiny of termination payments taking account of appropriate national guidance, advise on and oversee appropriate contractual arrangements for such staff
- Report in writing to the Governing Body the basis for its decisions for ratification.

4. **Membership and Quoracy**
Fulltime employees or individuals who claim a significant proportion of their income from members of the Remuneration Committee are not eligible to be members of the Remuneration Committee.

The Committee will be chaired by the Lay Member for Governance and will be attended by the Lay member for PPI. Two additional Associate Lay Members will be recruited to be members of the committee. The Associate Lay Members will not be members of the Governing Body. A quorum shall be two members, including at least one CCG Governing Body Lay Member. A senior HR representative from the Commissioning Support service will be an attendee.

5. **Attendance**
   The Chief Officer and Chief Financial Officer will attend to advise on any matters of risk or significant financial implications for the Governing Body.

Only members of the Committee have the right to attend Remuneration Committee meetings. Other individuals may be invited where relevant and appropriate, but they must not attend the part of a meeting where their own remuneration or terms of service are discussed.

Members are expected to maintain regular attendance at meetings. If circumstances make this impossible, this will be addressed by the Chair with the individual member concerned and alternative arrangements will be determined.

6. **Frequency**
   The Committee will meet at least bi-annually to fulfil its work plan. The Governing Body reserves the right to call a meeting at any time (with appropriate notice) if an urgent matter arises. Where urgent matters need to be decided, these can be made by the Chair of the Remuneration Committee and three Lay Members. All such actions will be reported back to the full Committee at its next meeting and any member of the Committee may request to see the full report and/or information that were considered when the decision was made.

Notice for meetings must be given two weeks in advance with the Agenda and supporting papers circulated by the Business manager one week prior to the meeting.

7. **Reporting**
   The Committee will submit its minutes to the Governing Body. Recommendations made by the Committee to the Governing Body on performance related pay must be approved by the NHS Commissioning Board.

8. **Conduct of the committee**
   The Committee will conduct its business in accordance with the codes of conduct set out for all Governing Body members and good governance practice as laid out in the Constitution.

9. **Administration**
   The Business Manager will attend to take Minutes, which will be approved by the Chair of the Committee before wider circulation to all members.

10. **Review**
    These Terms of Reference will be reviewed on an annual basis and any resulting changes must be approved by the Governing Body.
Appendix 9

Integrated Governance Terms of Reference

WANDSWORTH CLINICAL COMMISSIONING GROUP

Integrated Governance Committee – Terms of Reference

1. **Aim and Purpose**
   The Wandsworth Clinical Commissioning Group (CCG) hereby resolves to establish a committee of the Governing Body to be known as the Integrated Governance Committee (the Committee). The Committee has no executive powers, other than those specifically delegated in these Terms of Reference.

   These Terms of Reference set out the membership, remit, responsibilities and reporting arrangements of the committee and shall have affect as if incorporated into the CCGs constitution and standing orders.

   Integrated Governance provides the umbrella for all NHS governance approaches. It combines the principles of corporate and financial accountability, and moves to a single risk sensitivity process which covers all organisational objectives, supported by a coordinated source of collecting information. The primary aim of the Integrated Governance Committee is to provide assurance to the Governing Body that the governance systems, processes and behaviours by which the CCG leads, directs and controls functions in order to achieve organisational objectives, and the way in which they relate to patients and carers, the wider community and partner organisations, are integrated and effective.

2. **Authority**
   The Committee is directly accountable to the Governing Body and is authorised by it to investigate any activity within its Terms of Reference.

   The Committee 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.

   The Committee is authorised 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.

3. **Duties**
   The duties of the Committee are categorised as follows:

   3.1 Seek assurance that commissioned services are being delivered in a high quality, safe manner, including against criteria set by the Care Quality Commission, Monitor and other relevant regulatory bodies.

   3.2 Oversee the performance of commissioned services, taking into account performance against Key Performance Indicators and the NHS and Public Health Outcomes Frameworks, with a focus on areas rated Red or where there has been a deterioration in performance.

   3.3 Challenge, scrutinise and ensure that exception reports, action plans and risk assessments submitted by the Commissioning Support Service (or body that undertakes the function), Joint Commissioning Unit, Locality Commissioning Groups and subgroups include robust mitigating actions and controls that would effectively address identified risk.

   3.4 Review information of patient experience, including surveys, PALS queries and complaints to identify potential risks and issues.

   3.5 Consider reports from the finance committee, and the impact that the financial position has on the quality, safety and performance of commissioned services.
3.6 Regularly review the Integrated Governance Report before submission to the Governing Body ensuring data accuracy and that risks and issues have plans in place.

3.7 Oversee processes and compliance issues concerning serious incidents requiring investigation, receive notification of Never Events, and inform the governing body of any escalation or sensitive issue in good time.

3.8 Promote a culture of continuous improvement and innovation with respect to safety of services, clinical effectiveness and patient experience.

3.9 Ensure that the Governing Body undertakes an annual review of the organisation’s objectives and priorities in order to inform the development of the Commissioning Strategic Plan (CSP) and to align Governing Body agendas to the agreed annual cycle of business. Seek assurance that governance and quality principles are incorporated into the plan.

3.10 Oversee safeguarding arrangements for children and vulnerable adults.

3.11 Ensure that all corporate governance arrangements are robust, ensuring that the Governing Body is fully briefed on these matters and has regard to them when taking decisions.

3.12 Provide assurance to the Governing Body that the Board Assurance Framework is systematically reviewed against the Governance Framework and updated to cover activity, quality and resources, and is aligned to national and local targets and standards.

3.13 Ensure that the Assurance Framework action plan to address gaps in controls and assurance is effectively performance managed through regular performance management of Commissioning Support (or body that undertakes the function) and the Joint Commissioning Unit and review at Committee meetings.

3.14 Regularly review risks from the CCG’s Risk Register rated 12 or above, and ensure all risks that link to the achievement of corporate objectives are incorporated within the Assurance Framework.

3.15 Prepare the annual Statement on Internal Control and make recommendations for its approval to the Audit Committee.

3.16 Maintain a constant review of all governance and assurance arrangements to ensure all the threads of quality, activity and finance are aligned and integrated.

3.17 Oversee arrangements for information governance, ensuring that sufficient controls and appropriate policies and procedures are in place and that the CCG and commissioned services meet the requirements of the IG toolkit.

3.18 Approve operational policies prepared and recommended by subgroups.

3.19 Respond to requests for information and reports from the Governing Body and external organisations as required.

4. Membership and Quoracy
The membership of the Committee will be as follows:

- CCG Lead (Chair)
- Nurse Member on the CCG Board (Deputy)
- Chief Officer
- Director of Corporate Affairs and Performance
- Director of Commissioning and Planning
- Director of Delivery
- 2x Locality Clinical Leads
- Chief Financial Officer
- Lay member with lead for Governance

A quorum shall be three members, to include two directors and one clinical representative.

5. Attendance
The following members of staff will attend the meetings:
Clinical Governance Facilitator
Quality Outcomes Lead
Performance Manager
Senior Representatives of the Commissioning Support Service (or body that undertakes the function) and the Joint Commissioning Unit
When the Committee is discussing areas of risk or operation that are the responsibility of an Executive Director, any other manager or employee may also be required to attend in order to present papers or to provide additional information in support of discussions.

6. Frequency
Meetings shall be held on a monthly basis. Members are expected to maintain regular attendance at meetings. If circumstances make this impossible, this will be addressed by the Chair with the individual member concerned and alternative arrangements will be determined.

7. Reporting
The Committee will report directly to the Governing Body. Copies of all meeting Minutes will be submitted to the Governing Body for review and any necessary action.

A number of subgroups will provide reports to the Integrated Governance Committee: Performance Committees of JCU and CSS, integrated reporting subgroup, clinical governance subgroup, finance, performance, workforce committee.

8. Conduct of the committee
The Committee will conduct its business in accordance with the codes of conduct set out for all Governing Body members and good governance practice as laid out in the Constitution.

9. Administration
The Committee shall be supported administratively by the Business Manager, whose duties in this respect will include:

- Agreement of Agenda with Chair and attendees and collation of papers.
- Taking the Minutes and keeping a record of matters arising and issues to be carried forward.

Agenda items and relevant papers will be published one week prior to meetings. The Business Manager will maintain Minutes of all meetings and a log of decisions made.

10. Review
These Terms of Reference will be reviewed annually to ensure that the Committee is carrying out its functions effectively.
1. Background

Wandsworth Clinical Commissioning Group (CCG) consists of 44 GP Practices with over 368,000 registered patients. It is one CCG with three Localities namely; the Battersea Locality Commissioning Group (LCG), West Wandsworth Locality Commissioning Group (LCG) and Wandle Locality Commissioning Group (LCG).

This is an Agreement for financial year 12/13 between:

- each of the GP Practices listed in the Constitution
- The Locality Commissioning group
- the Members and NHS Wandsworth as host of Wandsworth Clinical Commissioning Group (the “CCG”).

This Agreement describes how the Members, the CCG as a whole and NHS Wandsworth will work together to ensure that the CCG develops into an organisation that has the capability to commission safe, high quality and cost effective services that meet the needs of the patients in its area.

2. Purpose

The objectives of the CCG are outlined within the Constitution. The purpose of the Locality Delegation Agreement (LDA) is:

- To set out the mechanics of how the LCG’s will conduct their business on a day to day basis, contributing to the overall CCG objectives.
- To outline and describe key relationships, responsibilities and accountabilities between the LCG and its related groups, such as the CCG
- To outline Locality commissioning, contracting, delivery and monitoring processes.
3. LCG member representatives and sub committees

- Members of the relevant LCG are responsible for holding each other to account where performance negatively impacts delegated responsibilities.

4. Objectives and Functions of the LCG

The following are key functions that the LCGs are required to deliver, contributing to CCG objectives. LCGs are expected to carry out functions effectively, efficiently and economically whilst maintaining quality.

4.1 Commissioning

- In line with the CCG operating plan to commission healthcare to the extent the LCG considers necessary to meet the unmet health need of patients registered and un-registered with the GP practices who are members of the LCG.

- In line with the CCG operating plan to commission healthcare for other groups of patients, which it is intended will include:
  - people who live within the LCG’s defined geographic area who are not registered with any GP practice
  - People present in the LCG’s geographic area who need access to emergency care.

- Demonstrate joint working in design of local services
• To exercise their functions with a view to securing continuous improvements in the quality of services for patients and in outcomes, with particular regard to clinical effectiveness, safety and patient experience.

• Focus on and assist the CCG with continuous improvement in quality of services through various initiatives including a Locality Pathway GP inputting to the CCG Clinical Reference Group.

• Work towards reducing health inequalities pan Wandsworth and at Locality level, with regard to healthcare and healthcare outcomes, promote patient and carer involvement in decisions about them (“no decision about me without me”) and enable patients to make choices with respect to aspects of their healthcare.

• The LCG may choose to commission and arrange for another health body to provide services, subject to the locality health priorities.

• Promote health service innovation and research; the LCG can conduct or commission research etc.

• Adhere to good procurement guidelines

4.2 Performance and Finance:

• Ensure good financial controls; responsible for devolved budgets and ensuring no overspend.

• Monitor locally enhanced contracts together with the Primary Care Development Manager.

4.3 Engagement

• **Patient and Public Representative groups;** To involve patients and the public in developing, considering and making decisions on any proposals that would have a significant impact on service delivery or the range of health services available.

Key Relationships

LCG are expected to work with the below forums and organisations to strengthened and enhance providing health services in an integrated way;
Delivering Joint Health and Social Care:

LCGs need strong shared leadership with Local authorities to commission services where integration of health and social care is vital. The LCG will also need to be able to access public health input when required, via the LCG forums and committees.

- The LCG may agree to commission some health improvement services jointly with local authority. The LCG may choose to buy in support from other external organisations including private and voluntary sector bodies within any delegated budget and subject to the LCGs procurement policy.

- To ensure that the LCG obtains advice from people with professional expertise in relation to the populations physical and mental health.

- The LCG can arrange for provision of services that aim to secure improvements in physical and mental health, or in the prevention, diagnosis and treatment of illness, for the people for whom the LCG is responsible.

- To co-operate with other NHS bodies and providers of NHS Commissioned Services

- The LCG may choose to enter local contracts and to arrange for another health body to provide services, subject to the locality priorities.

- The LCG can act jointly with another LCG in exercising commissioning functions or for one LCG to exercise such functions on behalf of another.

- NHS Commissioning Board Authority (NHS CBA) will provide assistance to the CCG to support them in the successful delivery of their commissioning functions. The CCG will provide the NHS CBA with specific information, if considered necessary by the Secretary of State for the purposes of carrying out his functions in relation to the health services (this is likely to be primarily financial information).
The LCG will act as the local arm of the CCG, helping it to carry out its functions at a local level and provide local services for its local population.

5. Responsible for implementation and delivery in the three key areas:

(i) COMMISSIONING

❖ Locality initiatives

The locality initiatives that are typically based on Public Health needs assessment that the Locality. For example, the implementation of a HIV screening programme within practices in Wards that have a high prevalence. The locality will detail action plans for a minimum of five local initiatives per year (the Locality will not be leading on any pan-Wandsworth initiatives).

Each practice along with Patient and Public, Local Authority and Public Health representatives should be involved in the development of the Locality Initiatives to address local health & well-being issues.

❖ Locally Enhanced Service contracts

The Wandsworth Clinical Commissioning Group (CCG) Board will retain responsibility for Local Enhanced Service budgets, approving expenditure, annual review, variation from plan and use of under and/or over spend on Local Enhanced Services budgets.

Delegation of the management, performance monitoring and review of Local Enhanced Services budgets and services to Locality Groups will build commissioning capacity and drive service improvements within primary care.

The Locality will be required to monitor LES activity levels and will be responsible for an annual review of some of the LES contracts, for the purpose of continuous quality improvement. See below locality responsibilities with regards to monitoring activity and review of all its practices.

LES monitoring and review of following contracts:

- Spirometry
- ECG
- Phlebotomy
- Anticoagulation
- Methotrexate
- Access
- Locality Commissioning Group
- 24 hour ABP

LES monitoring of Public Health contracts and input into the Public Health review process:

- Flu
- Chlamydia
Following LCG consultation, each Locality will agree which LES they will lead on reviewing on behalf of the other two Localities. This ensures that each Locality focuses on specific services and maximises resources, rather than have each Locality review all LESs. The CCG Management Team will formally ratify the reviews and recommendations.

**Recurrent Freed Up Resources (FUR)**

Practices will look to identify gaps in existing services and pathways that need improvement, Localities will support member practice with developing recurrent project bids which will be submitted to CCG approvals committee. Not all service improvements can be organised by one practice on their own, it is hoped that Practices will want to work together in the LCGs to achieve this.

Localities will also support practices with development of robust evaluation processes. Following approval of any FURs projects, the practices will be required to submit quarterly update report. The report will contain details of activity and qualitative analysis from patient surveys and internal practice peer review.

**(ii) PERFORMANCE and FINANCE**

**Performance targets**

Monitoring and managing performance is key to achieving various CCG objectives. This includes identifying key indicators of activity, quality and financial performance, regularly monitoring progress against them, and developing systems to deal with variations in performance.

The majority of performance targets have financial implications, and therefore through reducing activity levels where clinically appropriate, financial savings can be realised. Through this, the Locality will contribute to the Quality Innovation Prevention Productivity (QIPP) challenge.

Localities are well-placed to take a lead on monitoring and managing indicators which can be split at practice level, as they are close to the front-line and are building strong working relationships with their constituent members.

- Key Performance Acute Indicators devolved to localities:

1. Emergency admissions; Non-elective First Finished Consultant Episodes in general & acute (G&A) specialties
2. GP referrals to hospital
3. A&E attendances

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Definition</th>
<th>Rationale &amp; Success Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Non-elective First Finished Consultant</td>
<td>Number of non-elective emergency</td>
<td>To reduce the inappropriate use of expensive emergency care, and improve use of other</td>
</tr>
</tbody>
</table>
Localities will be expected to contribute to improved performance against these measures. Activities within the LDP may overlap to include committed resources, involvement of locality team and timescales. For example, the referral management programme would be a key activity linked to referral and outpatient indicators.

The locality management team will take the lead in managing and monitoring performance; they will be responsible of informing practices of indicators, plans and promoting schemes which will contribute to an improvement in performance.

GP Engagement Scheme performance indicators

The GP Engagement Scheme is an initiative that aims to have every practice in Wandsworth (delivered via Localities) designate a named clinical commissioning lead (two funded sessions per month).

Practices develop action plans for three areas of improvement (see the list below) and the Locality has the responsibility for ensuring plans for each practice is approved, implemented and monitored via approved the monitoring process outlined within the GP Engagement Scheme 2012-13.

- Childhood immunisations
- Breastfeeding
- NHS Health checks
- Smoking Quitters
- Cervical screening
- Flu Vaccinations
- Choose & Book

Budgetary responsibility
- **Re-investment budget** (previously known as Freed up Resources). The Locality will be expected to make rational decisions for re-investing any savings that occur into areas that will positively support the Locality to attain outcomes linked to key objectives.

- **QIPP:** the localities to support the CCG in the delivery of QIPP programme to generate cash releasing savings. The LDP will identify and specify the QIPP programmes localities take action to contribute to the overall delivery.

- **Prescribing budget,** the locality will be responsible for ensuring no overspend and that practices participate in annual review, development and adherence to use of scriptswitch.

(iii) ENGAGEMENT

- **PPI**
  
  Consult with patient group(s) to ensure they are central to (not an addition to) commissioning, and to work with the CCG Clinical Lead for PPI and central resource in ensuring this.

  To involve patients and the public in developing, considering and making decisions on any proposals that would have a significant impact on service delivery or the range of health services available.

  Annual Locality plan to be developed to strengthen PPI involvement from practice through to locality level.

- **Clinical Engagement**
  
  - Build active clinical engagement to improve local services and performance targets
  - Consult with practices as and when the need arises including their contribution to the LDP
  - Inform practices of wider CCG developments and to reflect practice views within the CCG Board
  - Encourage shared learning and development across the locality
  - Support to practices via the established practice managers forums

6. Planning, Reporting and Monitoring: The Locality Delivery Plan

The LCG will develop a Locality Delivery Plan (LDP) that will detail how the LCG intends to exercise its responsibilities outlined within the LDA. It will act as a means to monitor progress and report back to the LCG and CCG on a quarterly and year end basis.

There are specific monitoring and requirements for each of the responsibilities, outlined below. These must be captured within the LDP.

<table>
<thead>
<tr>
<th>Devolved tasks</th>
<th>Requirements</th>
<th>LCG Monitoring &amp; Reporting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local Initiatives</td>
<td>Agree local initiatives at the start of each financial year. For 2012/13 signed off by CCG before the end of Quarter 1 (June 2012).</td>
<td>LCG management teams (bi-monthly)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>LCG Members Forum (Bi monthly)</td>
</tr>
<tr>
<td>LES monitoring and review</td>
<td>As per delegation of Local Enhanced Services (LES) Budgets to Locality Groups. (appendix)</td>
<td>LCG management teams (bi-monthly)</td>
</tr>
<tr>
<td>Freed Up Resources</td>
<td>Be responsible for reviewing and monitoring locality FURs projects</td>
<td>LCG Members Forum (Bi monthly)</td>
</tr>
<tr>
<td>--------------------</td>
<td>---------------------------------------------------------------</td>
<td>-------------------------------</td>
</tr>
</tbody>
</table>
| (Managing A&E admission avoidance, GP referrals to secondary care) | Mapping: Assess likely impact of existing schemes, prioritise them and consider how locality could be more engaged and implement actions to improve performance. Consider evidence of best practice locally and further afield to determine whether any additional activities could be undertaken. | LCG management teams (bi-monthly)  
LCG Members Forum (Bi monthly) |
| GP Engagement Scheme performance indicators | As per the GP engagement contract | As per the GP engagement contract |
| Budget Responsibilities | Be responsible for devolved budgets and ensuring no overspend (Includes prescribing, Re-Investment, LES contracts) | To be agreed at LCG MF |
| PPI | Locality action plan to be developed. To be defined through PPI CRG. | Quarterly report to MT |
| Clinical Engagement | Locality action plan to be developed, supporting the CCG engagement strategy | To be agreed at LCG MF |

**Other functions of the LDP, to include**

Cycle of business of the LMF, in ensuring the LDP can be delivered with the support of all practices of the LCG.

**Other planning duties of the LCG**

The LCG is responsible for key planning, reporting and monitoring requirements. The planning duties of the LCG are:

- To contribute to the joint strategic needs assessment (JSNA) and the joint health and well-being strategy led by the relevant Health and Well-being Boards(s) (HWB(s)) and to have regard to the JSNA and the joint strategy in exercising any relevant functions.
- To take appropriate steps to ensure that it is prepared to deal with major incidents and emergency planning arrangements.
- To input into the annual commissioning intentions of the CCG.

**Other reporting duties of the LCG are:**

- To report as required on Locality Initiatives, e.g. quarterly reporting to CCG Management Team on progress v objectives.
7. Evaluation and Performance Escalation framework:

CCGs monitoring LCGs
The CCG will monitor the LCG against agreed objectives and commissioning responsibilities. The monitoring and resultant action will follow the escalation framework for delegated responsibilities as described within the CCG Performance Escalation Policy for the GP Engagement Scheme.

LCG’s monitoring Practice Members
As per IPA Performance Escalation framework for the GP Engagement Scheme.

8. Role of the LCG Locality Clinical Lead

The LCG Clinical Lead is elected for a 3 year period. The Locality Clinical Lead is line managed by the CCG’s Clinical Chair. The process for the appointment of the Locality Clinical Lead is to be determined locally, but applicants must be working in a practice within the Locality for a minimum 2 sessions per week.

The key responsibilities of the LCG Clinical Lead are:

- To ensure effective communication with all stakeholders
- To ensure the LCG is governed effectively and in line with legislative requirements
- To provide strong, effective and visible leadership of the Members Forum and Locality Management Team
- To act as a conduit between its GP member practices and the CCG
- To be accountable to the CCG to ensure delivery and implementation of key responsibilities outlined within the LDA
- To take ownership of the financial challenges at a Locality level
- To ensure that all members contribute to the development of the LCG
- To work closely with the Locality Manager to ensure outcomes from the Locality Delivery Plan are delivered
- To ensure all Practices are signed up to the GP Commissioning Engagement Scheme

9. Role of the LCG Locality Manager

The LCG Locality Manager is an appointed post. The Locality manager is line managed by the Director of Delivery & Development. The role of the LCG Locality Manager is to:

- Support the locality clinical commissioning lead in managing delivery and implementation of key responsibilities outlined within the LDA
- Input into service re-design at locality level
- Facilitate and co-ordinate local projects and initiatives
- Be responsible for supporting and managing the locality re-investment Scheme process
- Empower and enable practices to be involved in commissioning
- Assist, develop and deploy strategies for Patient and Public Involvement (PPI) at a local level under the support of the CCGs PPI Manager
- Develop capacity and competency in commissioning in the Locality
- Monitor Locality performance against agreed targets (such as the LDP, LESs and DESs and the GP engagement scheme)

10. Role of the General Practice Nurse (GPN) Lead for the Locality

A GPN Lead is required for each Locality to provide an active contribution to supporting the Locality in its delegated Commissioning and Performance targets. Nurses are important in delivering key targets and should be valued accordingly within Locality Management Teams. The GPN provides a nursing perspective on locality commissioning, practical expertise on achieving the performance indicators and represent the views of locality GPNs. The role of the GPN lead for the Locality is to:

- Represent the commissioning perspective and views of Locality General Practice nurses
- To lead on workstreams as delegated by the Locality team
- GPN with the Locality GP Lead will develop an action plan for each area of improvement in the LDP and agree specific key outcomes
- Improve GP/GPN communication and partnership working
- Strengthened GPN leadership with increased GPN engagement and contribution to commissioning.

11. Disclosure of information

Members Representatives are required to declare conflicts of interest, in line with the COI and dispute resolution policy of the CCG.

A register of interest for localities member’s forums will be held.

12. Voting and chairing of LCGs

Locality Members Forums will each need to agree a voting mechanism for how decisions are made, in particular for when a consensus is required for locality matters e.g. local initiatives within the LDP. Voting would relate to decisions being made would be in relation to the responsibilities devolved to localities.

A Locality chair should be determined by each Locality. This could include the appointment of a lay chair from a local PPI group who would be remunerated via travel expenses.

13. Duties and Responsibilities of Members
As defined in the Inter-Practice Agreement.

The Member Representative who attends Locality Members Forums must have the delegated authority to speak, and if necessary, to vote on behalf of their practice (i.e. the Member).

14. Appendices (available via separate request)
   - GP engagement scheme contract
   - Locality clinical commissioning lead Job Description
   - Locality Management lead Job Description
   - Role of the General Practice Nurse (GPN) Lead for the Locality
   - TOR LCG Management Teams
   - TOR Members Forum
Appendix 11

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 Wandsworth Clinical Commissioning Group ("CCG") so that the CCG 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 CCG is established.

1.1.2. The standing orders, together with the CCG’s scheme of reservation and delegation and the CCG’s prime financial policies, provide a procedural framework within which the CCG discharges its business. They set out:

   a) the arrangements for conducting the business of the CCG;
   b) the appointment of member practice representatives;
   c) the procedure to be followed at meetings of the CCG, the governing body and any committees or sub-committees of the CCG or the governing body;
   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 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 CCG’s constitution (the "Constitution"). CCG members, employees, members of the governing body, members of the governing body’s committees and sub-committees, members of the CCG’s committees and sub-committees and persons working on behalf of the CCG 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 CCG and the scheme of reservation and delegation

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

1.2.2. at

[http://www.southwestlondon.nhs.uk/About/clinicalcommissioninggroups/Pages/WandsworthClinicalCommissioningGroup.aspx].

1.3. Suspension of Standing Orders
1.3.1. Except where it would contravene any statutory provision or any direction made by the Secretary of State for Health or the NHS Commissioning Board, any part of these standing orders may be suspended at any meeting, provided [insert number] CCG members are in agreement.

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

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

1.4. Record of Attendance

1.4.1. The names of all members of the meeting present at the meeting shall be recorded in the minutes of the CCG’s meetings. The names of all members of the governing body present shall be recorded in the minutes of the governing body meetings. The names of all members of the governing body’s committees / sub-committees present shall be recorded in the minutes of the respective governing body committee / sub-committee meetings.

2. APPOINTMENT OF COMMITTEES AND SUB-COMMITTEES

2.1. Appointment of committees and sub-committees

2.1.1. The CCG may appoint committees and sub-committees of the CCG, subject to any regulations made by the Secretary of State and the Governing Body may appoint committees and sub-committees, subject to any regulations made by the Secretary of State. Where such committees and sub-committees of the CCG, or committees and sub-committees of its governing body, are appointed they will be included in Chapter 5 of the CCG’s Constitution.

2.1.2. Other than where there are statutory requirements, such as in relation to the Governing Body’s audit committee or remuneration committee: (a) the CCG shall determine the membership and terms of reference of committees and sub-committees which it has appointed and shall, if it requires, receive and consider reports of such committees at the next appropriate meeting of the CCG and (b) the Governing Body shall determine the membership and terms of reference of committees and sub-committees which it has appointed and shall, if it requires, receive and consider reports of such committees at the next appropriate meeting of the Governing Body.

2.1.3. The provisions of these standing orders shall apply where relevant to the operation of the Governing Body, the Governing Body’s committees and sub-committee and all committees and sub-committees unless stated otherwise in the committee or sub-committee’s terms of reference.

2.2. Terms of Reference

2.2.1. Terms of reference shall have effect as if incorporated into the Constitution and shall be added to this document as appendices.

2.3. Delegation of Powers by Committees to Sub-committees

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

2.4. Approval of Appointments to Committees and Sub-Committees

2.4.1. The CCG shall approve the appointments to each of the committees and sub-committees which it has formally constituted and the Governing Body shall approve the appointments to each of the committees and sub-committees which it has formally constituted. The CCG shall agree such travelling or other allowances as it considers appropriate.

3. DUTY TO REPORT NON-COMPLIANCE WITH STANDING ORDERS AND PRIME FINANCIAL POLICIES
3.1. 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 governing body for action or ratification. All members of the CCG and staff have a duty to disclose any non-compliance with these standing orders to the accountable officer as soon as possible.

4. **USE OF SEAL AND AUTHORISATION OF DOCUMENTS**

4.1. **CCG’s seal**

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

   a) the accountable officer;
   
   b) the chair of the governing body;
   
   c) the chief finance officer;
   
   d) [insert names of other individuals, or the titles/ roles of other individuals who are so authorised].

4.2. **Execution of a document by signature**

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

   a) the accountable officer
   
   b) the chair of the
   
   c) the chief finance officer
   
   d) [insert names of other individuals, or the titles/ roles of other individuals who are so authorised].

5. **OVERLAP WITH OTHER CLINICAL COMMISSIONING GROUP POLICY STATEMENTS / PROCEDURES AND REGULATIONS**

5.1. **Policy statements: general principles**

5.1.1. The CCG will from time to time agree and approve policy statements / procedures which will apply to all or specific groups of staff employed by Wandsworth Clinical Commissioning Group. The decisions to approve such policies and procedures will be recorded in an appropriate CCG minute and will be deemed where appropriate to be an integral part of the CCG’s standing orders.
Appendix 12
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 CCG’s Constitution.

1.1.2. The prime financial policies are part of the CCG’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 Accountable Officer and chief finance officer to effectively perform their responsibilities. They should be used in conjunction with the scheme of reservation and delegation.

1.1.3. In support of these prime financial policies, the CCG has prepared more detailed policies, approved by the [Accountable Officer / Chief Finance Officer], known as detailed financial policies. The CCG refers to these prime and detailed financial policies together as the CCG’s financial policies.

1.1.4. These prime financial policies identify the financial responsibilities which apply to everyone working for the CCG and its constituent organisations. They do not provide detailed procedural advice and should be read in conjunction with the detailed financial policies. The [Accountable Officer / Chief Finance Officer] is responsible for approving all detailed financial policies.

1.1.5. A list of the CCG’s detailed financial policies will be published and maintained on the CCG’s website at http://www.southwestlondon.nhs.uk/About/clinicalcommissioninggroups/Pages/WandsworthClinicalCommissioningGroup.aspx.

1.1.6. Should any difficulties arise regarding the interpretation or application of any of the prime financial policies then the advice of the [Accountable Officer / 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 CCG’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 governing body’s audit committee for referring action or ratification. All of the CCG’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 CCG’s members, employees, members of the governing body, members of the governing body’s committees and sub-committees, members of the CCG’s committee and sub-committee (if any) and persons working on behalf of the CCG are set out in Parts 3, 4 and 5 of this Constitution.

1.3.2. The financial decisions delegated by members of the CCG are set out in the CCG’s scheme of reservation and delegation.

1.4. Contractors and their employees

1.4.1. Any contractor or employee of a contractor who is empowered by the CCG to commit the CCG to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Accountable 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 Accountable Officer and scrutiny by the Governing Body’s audit committee, the Chief Finance Officer will recommend amendments, as fitting, to the [Governing Body] for approval. As these prime financial policies are an integral part of the CCG’s Constitution, any amendment will not come into force until the CCG applies to the NHS Commissioning Board and that application is granted.

2. INTERNAL CONTROL

POLICY – the CCG 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 Governing body is required to establish an audit committee with terms of reference agreed by the Governing Body.

2.2. The Accountable Officer has overall responsibility for the CCG’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 CCG will keep an effective and independent internal audit function and fully comply with the requirements of external audit and other statutory reviews

3.1. [In line with the terms of reference for the Governing Body’s audit committee], the person appointed by the CCG 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 chair of the governing body, Accountable 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 CCG to be responsible for internal audit and the external auditor will have access to the audit committee and the Accountable Officer to review audit issues as appropriate. All audit committee members, the chair of the governing body and the Accountable 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 CCG has a professional and technically competent internal audit function; and

b) the [Governing Body / Governing Body’s audit committee] approves any changes to the provision or delivery of assurance services to the CCG.

4. **FRAUD AND CORRUPTION**

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

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

4.2. The governing body’s audit committee will ensure that the CCG has arrangements in place to work effectively with NHS Protect.

5. **EXPENDITURE CONTROL**

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

5.2. The Accountable Officer has overall executive responsibility for ensuring that the CCG 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 the NHS Commissioning Board;
b) ensure money drawn from the NHS Commissioning Board 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 CCG to fulfil its statutory responsibility not to exceed its expenditure limits, as set by direction of the NHS Commissioning Board.

6. **ALLOTMENTS**

6.1. The CCG’s Chief Finance Officer will:

a) periodically review the basis and assumptions used by the NHS Commissioning Board for distributing allotments and ensure that these are reasonable and realistic and secure the CCG’s entitlement to funds;

b) prior to the start of each financial year submit to the [to be inserted, e.g. Governing Body] 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 the [to be inserted, e.g. Governing Body] on significant changes to the initial allocation and the uses of such funds.

7. **COMMISSIONING STRATEGY, BUDGETS, BUDGETARY CONTROL AND MONITORING**

<table>
<thead>
<tr>
<th>POLICY</th>
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<tbody>
<tr>
<td>the CCG will produce and publish an annual commissioning plan that explains how it proposes to discharge its financial duties. The CCG will support this with comprehensive medium term financial plans and annual budgets.</td>
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7.1. The Accountable Officer will compile and submit to the [Governing Body] a commissioning strategy which takes into account financial targets and forecast limits of available resources.

7.2. Prior to the start of the financial year the chief finance officer will, on behalf of the Accountable Officer, prepare and submit budgets for approval by the [to be inserted, e.g. Governing Body if delegated].

7.3. The Chief Financial Officer shall monitor financial performance against budget and plan, periodically review them, and report to the [to be inserted e.g. Governing Body]. 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 Accountable Officer is responsible for ensuring that information relating to the CCG’s accounts or to its income or expenditure, or its use of resources is provided to the NHS Commissioning Board as requested.

7.5. The [insert name] will approve consultation arrangements for the CCG’s commissioning plan.

8. **ANNUAL ACCOUNTS AND REPORTS**
POLICY – the CCG will produce and submit to the NHS Commissioning Board accounts and reports in accordance with all statutory obligations, relevant accounting standards and accounting best practice in the form and content and at the time required by the NHS Commissioning Board.

8.1. The Chief Finance Officer will ensure the CCG:

a) prepares a timetable for producing the annual report and accounts and agrees it with external auditors and the [to be confirmed e.g. Governing Body];

b) prepares the accounts according to the timetable approved by the [to be confirmed e.g. Governing Body];

c) 

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

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

f) publishes the external auditor’s management letter on the CCG’s website at http://www.southwestlondon.nhs.uk/About/clinicalcommissioninggroups/Pages/WandsworthClinicalCommissioningGroup.aspx.

9. INFORMATION TECHNOLOGY

POLICY – the CCG will ensure the accuracy and security of the CCG’s computerised financial data.

9.1. The Chief Finance Officer is responsible for the accuracy and security of the CCG’s computerised financial data and shall

a) devise and implement any necessary procedures to ensure adequate (reasonable) protection of the CCG’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 CCG will run an accounting system that creates management and financial accounts.

10.1. The Chief Finance Officer will ensure:

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

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 CCG will keep enough liquidity to meet its current commitments

11.1. The Chief Finance Officer will:

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

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

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

11.2. The [insert responsibility] shall approve the banking arrangements.

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

**POLICY** – the CCG 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 CCG or its functions

• ensure its power to make grants and loans is used to discharge its functions effectively

12.1. The Chief Financial 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 Commissioning Board 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.

13. **TENDERING AND CONTRACTING PROCEDURE**

**POLICY** – the CCG:

• 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
  o the supply of goods, materials and manufactured articles;
  o 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
  o for the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens) for disposals

13.1. The CCG 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 Accountable Officer or the CCG’s [to be confirmed e.g. Governing Body].

13.2. The [insert name of committee, e.g. Governing Body] may only negotiate contracts on behalf of the CCG, and the CCG 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 CCG’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 Commissioning Board 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 CCG shall endeavour to obtain best value for money. The Accountable Officer shall nominate an individual who shall oversee and manage each contract on behalf of the CCG.

14. **COMMISSIONING**

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

14.1. The CCG will coordinate its work with the NHS Commissioning Board, other clinical commissioning CCGs, 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 Accountable Officer will establish arrangements to ensure that regular reports are provided to the [insert who receives, e.g. Governing Body] 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 CCG will put arrangements in place for evaluation and management of its risks.

15.1. [Insert details describing how you will do this e.g. receiving the Governing Body receiving the assurance framework and the process used to populate/score the assurance framework]

16. **PAYROLL**

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

17.1. The [to be confirmed] will approve the level of non-pay expenditure on an annual basis and the Accountable Officer will determine the level of delegation to budget managers

17.2. The Accountable 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 [insert] 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 scheme of reservation and delegation;

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 CCG 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 CCG’s fixed assets

18.1. The Accountable 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 CCG 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 Accountable 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 CCG will put arrangements in place to provide for the appointment of trustees if the CCG holds property on trust.

20.1. The chief finance officer shall ensure that each trust fund which the CCG is responsible for managing is managed appropriately with regard to its purpose and to its requirements.