Report to the Merton
Clinical Commissioning Group Governing Body

Date of Meeting: Thursday 27 September 2012
Agenda No: 6.2 – 6.6
ATTACHMENT Att 03

Title of Document:
Merton CCG Authorisation Evidence

Purpose of Report:
For Approval

Report Author:
Merton Clinical Commissioning Group (MCCG)

Lead Director:
Eleanor Brown, Chief Officer

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Executive Summary:
By April 2013 each Clinical Commissioning Group will be established as a statutory body. Approval is sought for the attached documents and to agree that they be submitted as evidence to support the authorisation of Merton CCG.

The NHS Commissioning Board must be satisfied that Merton CCG is able to commission safely; discharge responsibly their stewardship for the NHS budget they are accountable for; and exercise their functions in relation to improving quality, reducing inequality and delivering improved outcomes within available resources.

Key sections for particular note (paragraph/page), areas of concern etc:
Assurance is sought through the process of CCG authorisation, requiring submission of evidence against a series of criteria. The attached documents form a part of that evidence which will be submitted to the NHS Commissioning Board on 1st October 2012. For approval:

- Item 6.2 Merton CCG Constitution
- Item 6.3 Commissioning Support:
  - Item 6.4 Committees of the CCG's Terms of Reference
- Item 6.5 CCG Organisational Working Arrangements, including terms of reference.
- Item 6.6 Equality and Diversity Strategy 2012/13

Recommendation(s):
The Merton Clinical Commissioning Group Governing Body is requested to:

1. Review and approve the attached documents.
2. Agree that amendments made as a result of this meeting, or subsequently, be approved by Chair’s Action.
3. Agree that Chair’s Action be taken on any other documents required for submission by the 1st October deadline. These will be presented to the next board meeting for ratification. .
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<td>Equality Analysis: Where appropriate already included in the documents and the framework for Equality Impact Assessment (Equality Delivery System) is set out in item 6.6 Equality and Diversity Strategy 2012/13</td>
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Dear Members

CHAIR’S STATEMENT

Merton Clinical Commissioning Group has been created for and by its Member Practices. To achieve our vision of better care and a healthier future for Merton, 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 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 Merton. 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 mistakes and celebrating successes.

This Constitution lays out the foundations on which Merton 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 Howard Freeman
Chair, Merton CCG
# Merton Clinical Commissioning Group Constitution

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Part 1
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 Merton 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 Authority 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 Merton 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.

1.1.7 This Constitution reflects the values and rights set out in the NHS Constitution.

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

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

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;

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

Prime Financial Policies which sets out the arrangements for managing the CCG’s financial affairs.
Part 2
The CCG

2.1 Name

This Constitution sets out the governance arrangements adopted by Merton 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 Merton as delineated on the map at Appendix 1: Merton 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 2.7 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 Authority.

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 Authority to exercise a function, the Commissioning Board Authority 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;
The executive functions of the CCG shall be exercised by the Governing Body, which is composed of appointed and elected and other members;

The Members shall form an unincorporated association known as the Practice Leads Forum;

Each Member shall be represented on a Practice Leads Forum by a Practice Lead nominated by each Member;

The Practice Leads shall be entitled to attend and vote at meetings of the Practice Leads Forum; and

The Practice Leads Forum shall elect clinicians to the Governing Body’s clinical leadership team as described in Part 4.

2.6 **Vision and Strategic Goals**

2.6.1 The vision of the CCG is to improve the health outcomes for the population of Merton by commissioning services *tailored* to the needs of individual patients whilst addressing the diverse health needs of the population.

2.6.2 The CCG aims to improve patient experiences and health outcomes in a financially and clinically sustainable way by:

2.6.3 Achieving better value through ensuring the people are able to access the right care they need, in the right setting, at the right time;

2.6.4 Acting with a view to securing that health services are provided in a way which promotes’ the NHS Constitution;

2.6.5 Using an understanding of patient needs to shape services and their experiences to drive performance improvement;

2.6.6 Acting with a view to securing continuous improvements in the quality of services for patients and in outcomes;

2.6.7 Working with local partners and providers to integrated services across health and social care and across different care settings, including the development of services in community and primary care settings;

2.6.8 Making ‘better healthcare closer to home’ real for delivering local population health outcomes;

2.6.9 Agreeing, communicating and implementing an achievable vision for patient-centred healthcare services across Merton; and

2.6.10 Acting as a clinically-led and managerially efficient membership organisation.

2.6.11 We will achieve our vision and strategic goals by:

using a blend of clinical and managerial skill to ensure that we commission in a way that is better than and different from what has gone before. Our commissioning strategies will be evidence-based. We will capture ideas for population health improvement, blend these with local and national priorities and develop an annual business plan that has broad consensus. With a leaner and more fluid structure, we aim to be faster at converting good ideas into reality;
making holistic commissioning decisions alongside our commissioning and provider colleagues, reflecting the challenge of co-morbidities and promoting integrated responses to patient needs. We will achieve a better balance in the health system so we can justify where we spend our resources on health care services for population health improvement;

being open and transparent in how we work. We will strive to achieve consensus for clinical change and couple clinical priorities with local democracy, working with the local authority to ensure our population has confidence in our commissioning decisions.

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

2.7 Duties

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

2.8 Functions

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

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

all people registered with Member Practices; and

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

Commissioning emergency care for anyone present in the Area.

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

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.

In discharging its functions the CCG shall act consistently with the discharge by the Secretary of State and the Commissioning Board Authority 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.

2.9 Principles of Good Governance

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

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

the Nolan Principles (Schedule 8);

the Good Governance Standard for Public Services;

the seven key principles of the NHS Constitution; and
the Equality Act 2010.

2.10  Transparency

2.10.1 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.

2.10.2 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.
Part 3
Members and Membership

The CCG is a membership body, comprising GP Practice Members. Those Members are entitled to nominate representatives (Practice Leads) who may attend and vote at meetings of the Practice Leads Forum. The Practice Leads Forum will engage with the Governing Body to ensure commissioning decisions reflect the needs of the patients and the public in the Area.

3.1 Eligibility for Membership

A Practice may become a Member of the CCG if it is situated within the Borough of Merton and it holds a contract for the provision of primary medical services.

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 01st July 2012) should be made in writing to the Governing Body.

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

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

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;

has had its application approved by the Governing Body; and

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

3.3 Register of Members

3.3.1 The CCG shall establish and maintain a register of its Practice Leads in the Register of Interests

3.4 Termination of Membership

3.4.1 A Member may terminate its Membership of the CCG on giving 6 months’ notice to the Governing Body of such intention, in which case the Member’s Membership shall terminate at the expiry of such notice period, or such later date set out in the notice, and that Member shall be removed from the Register of Members by the Governing Body.

3.4.2 A Member shall immediately cease to be a Member and shall be removed from the Register of Members and their Practice Leads shall cease to be eligible to attend/vote at meetings of the Practice Leads Forum subject to approval by the National Commissioning Board (NCB) if:

the Practice ceases to be eligible to be a Member; and/or

in the opinion of the Governing Body that Member has failed to comply with any material provision of this Constitution.
Further provisions detailing the eligibility requirements for Membership and the circumstances in which Membership may be terminated are described in Schedule 4.

3.5 **Member Representatives**

3.5.1 Each Member Practice shall nominate an individual who is a GP to represent the Member as a Practice Lead on the Practice Leads Forum.

3.5.2 A Member may replace its Practice Lead from time to time by notice in writing to the Governing Body.

3.5.3 The CCG shall be entitled to consider that the Practice Lead has the authority to act on behalf of a Member until it receives notification of the replacement of that Practice Lead in accordance with paragraph 3.6.2 above.

3.5.4 Each Member shall authorise its Practice Lead to act on behalf of the Member as follows:

- attend and receive notice of any meetings of the Practice Leads Forum;
- vote at meetings of the Practice Leads Forum on behalf of the Member in accordance with this Constitution;
- sign any written resolution on behalf of the Member;
- receive any notices from the CCG on behalf of the Member and any notice delivered by the CCG to the Practice Lead shall be deemed to have been made or served on the Member;
- appoint a proxy; and
- 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.

3.6 **Communications and Engagement Strategy**

3.6.1 The CCG shall establish a strategy for communicating with its Members, patients and the public, and other stakeholders.

3.6.2 This strategy will include details of how the CCG will engage with all stakeholders, including Members, and how the CCG will gather and collate information to influence commissioning decisions and improve health services.

3.6.3 A copy of the Communications and Engagement Strategy shall be published on the CCG’s website.

3.7 **Members’ Duties and Responsibilities**

3.7.1 The duties of each Member are follows:

3.7.2 Duty to co-operate;

- Duty to act in good faith;
- Compliance with Standing Orders and Standing Financial Instructions;
- Attendance at meetings;
- Improving quality, innovation, prevention and productivity across the Merton health economy;
Provide input into the Commissioning Strategy Plan (CSP);

Provide input into the Annual Report;

Adhering to Commissioning and Delegated Budgets; and

Supporting Public/Patient Engagement.

3.7.3 Members will receive support from the CCG to fulfil these duties and when asked to take on specific functions delegated to them by the CCG Governing Body. Practice leads and others working for Members will also receive support to carry out these duties on behalf of the CCG.
Part 4

Governing Body

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 Practice Lead, 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 Merton CCG Governing Body.

4.1.3 The practice and procedure of the Governing Body is set out in the Governing Body Terms of Reference appended to this Constitution at Appendix 5.

4.2 Composition

4.2.1 The CCG shall have a Governing Body comprising of no more than 12 voting members, comprising initially the following 10 members:

Clinical Chair;
Chief Officer;
Chief Financial Officer;
At least 2 lay members [including one to chair the Audit Committee, and one to act as Deputy Chair and to represent the interests of patients and the public]
2 GPs who currently practice within Merton
Secondary Care Consultant
Registered Nurse
Director of Public Health

Up to two other members may be appointed if deemed necessary for the Governing Body to carry out its functions.

The Chair of Merton LMC will attend meetings in public of the governing body as a non-voting participant and non-public meetings of the governing body, subject to the agreement of the CCG chair and/or accountable officer, as a non-voting participant.

4.2.2 The Governing Body will have a clinical majority and be chaired by a GP.

4.2.3 The Composition of the Governing Body is set out in Schedule 5.
4.3 **Members of the Governing Body**

4.3.1 The following may become members of the Governing Body:

- a Member of the CCG who is an individual;
- an individual appointed by virtue of Regulations in the Act;
- individuals who are Health Care Professionals; and
- 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 6.

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

4.4.1 Appointed Members

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

- Chair;
- Chief Operating Officer (as Accountable Officer);
- Chief Financial Officer;

Together referred to as the ‘Appointed Members’.

Provisions outlining the appointment and roles of the Appointed Members are set out in Schedule 7.

4.4.2 Elected Members

Members of the CCG shall elect the Chair and two GPs, all of whom shall be GPs from Merton. Each member practice will have one vote per role.

4.4.3 Other Members

4.4.4 Director of Public Health

4.4.5 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 5.
4.6 Voting Rights of Members of the Governing Body

Subject to the provisions of the Governing Body Terms of Reference, all members of the Governing Body shall 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:

- exercise its functions effectively, efficiently and economically; and
- 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 7 to this Constitution.

4.7.3 determine the remuneration, fees and allowances payable to the employees of the CCG or to other persons providing services to it;

4.7.4 determine the allowances payable under a pension scheme established under the Act; and

4.7.5 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 8.

4.7.6 The Governing Body shall have regard to any Guidance published by the Commissioning Board Authority in respect of the exercise by the Governing Body of the functions described at paragraph 4.7.3 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:

- any committee or sub-committee of the Governing Body;
- a member of the Governing Body; or
- a Member of the CCG who is an individual (but is not a member of the Governing Body).

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

- comply with the principles of good governance described in this Constitution;
- operate in accordance with the CCG’s Scheme of Reservation and Delegation;
- comply with the CCG’s Standing Orders;
- comply with the CCG’s arrangements for discharging its statutory duties; and
- where appropriate ensure that Member Practices have had the opportunity to contribute to the CCG’s decision making process.
Part 5
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 two Committees:

Audit and Governance Committee (Appendix 6)
Remuneration Committee (Appendix 7)
Quality Committee (Appendix 6b)

5.2 Audit and Governance Committee

5.2.1 The Governing Body shall establish an Audit and Governance Committee. The composition of the Audit and Governance Committee will accord with any published national guidance.

5.2.2 The Audit and Governance Committee is accountable to the Governing Body, shall be chaired by a Lay Person 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 and Governance Committee shall include:

assisting the CCG in discharging its functions under paragraph 4.7.1 above;
carrying out such other functions connected with the exercise of its main function at paragraph 4.7.1 above as may be determined by the Governing Body and which are set out in the Audit and Governance Committee Terms of Reference which are appended to this Constitution at Appendix 5 and (where necessary) delegated to the Audit and Governance Committee under the CCG’s Scheme of Delegation and Reservation;
identifying strategic risks;
monitoring compliance;
providing assurance; and

assuring adherence to the principles of good governance, as described in paragraph 2.10.1.

5.3 **Remuneration Committee**

5.3.1 The Governing Body shall establish a Remuneration Committee. The composition of the Remuneration Committee shall accord with any published national guidance.

5.3.2 The Remuneration Committee shall be chaired by a Lay member, and the duties and responsibilities of the Remuneration Committee shall include:

- making recommendations to the Governing Body as to the discharge of its functions under paragraphs 4.7.3 and 4.74 above; and
- carrying out such other functions connected with the exercise of the functions described at paragraph 4.7.1 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 6 and (where necessary) are delegated to the Remuneration Committee under the CCG’s Scheme of Delegation and Reservation.

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

5.4 **Quality Committee**

5.4.1 The Governing Body shall establish a Quality Committee. The composition of the Quality Committee shall accord with any published national guidance.

5.4.2 The Quality Committee shall be chaired by the Chair of the Governing Body, and the duties and responsibilities of the Quality Committee shall include:

- making recommendations to the Governing Body as to the quality and safety of the providers from which services have been commissioned by the Governing Body;
- reviewing any Serious Untoward Incidents (SUIs) and Never Events; and
- seeking assurance that providers have robust risk management and mitigation plans in place
Part 6
Commissioning

The CCG must have regard to any guidance published by the Commissioning Board Authority 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 Authority. The Commissioning Plan must set out how the CCG proposes to exercise its functions during the relevant Financial Year.

6.1.2 The Commissioning Plan must, in particular, explain how the CCG proposes to discharge its responsibilities in relation to its duties to:

6.1.3 Act 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.

6.1.4 Have regard to the need to reduce inequalities between patients with respect to their ability to access health services and the outcomes achieved for them.

6.1.5 Promote the involvement of individual patients, and their carers and representatives where relevant, in decisions relating to the prevention or diagnosis of illness in them or their care and treatment.

6.1.6 Act with a view to enabling patients to make choices about aspects of health services provided to them.

6.1.7 Promote innovation in the provision of health services.

6.1.8 Promote research on matters relevant to the health service, and the use of evidence obtained from research.

6.1.9 Act with a view to securing that health services are provided in an integrated way, and that provision of health services is integrated with provision of health-related or social care services, where the CCG considers that this would improve quality of services or reduce inequalities.

6.1.10 Have regard to the need to promote education and training of current or future health service staff.

6.1.11 Ensure that appropriate facilities are made available to any university which has a medical or dental school in connection with clinical teaching or research.

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

6.1.13 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 Authority 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.

6.1.14 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:

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

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 Merton 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 Merton Health and Wellbeing Board on whether the draft Commissioning Plan takes proper account of each Joint Health and Wellbeing Strategy published by the Merton 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:

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

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

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.

6.3.4 have regard to any guidance published by the Commissioning Board Authority 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:

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

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

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

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;

accept NHS prices;

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

reach agreement with local commissioners on supporting schedules to the standard contract including any local referral thresholds or patient protocols.
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 Authority 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 9.
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:

- 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);
- made in accordance with any enactment or court order;
- necessary or expedient for the purposing of protecting the welfare of an individual;
- 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;
- made for the purposes of facilitating the exercise of any of the CCG’s functions;
- made in connection with the investigation of a criminal offence (whether or not in the United Kingdom);
- made for the purpose of criminal proceedings (whether or not in the United Kingdom); or
- if the information has previously been lawfully disclosed to the public.

8.1.2 The CCG’s right to disclose information under paragraphs 8.1.1 above may be exercised notwithstanding any rule of common law which would otherwise prohibit or restrict the disclosure.
Part 9
Third Party Engagement/Collaborative Working

9.1 The Commissioning Board Authority

9.1.1 The CCG shall work with the Commissioning Board Authority 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 Commissioning Board Authority.

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.

9.3 Local Authority

9.3.1 The CCG will work in partnership with Merton Borough Council to reduce health and social inequalities.

9.3.2 Partnership working between the CCG and Merton Borough Council might include joint commissioning. In this instance, the CCG may make arrangements with Merton Borough Council in respect of:

9.3.3 Delegating any of the CCG’s commissioning functions to the Council;

9.3.4 Exercising any of the commissioning functions jointly

9.3.5 For purposes of the arrangements described in 9.3.2., the CCG may:

9.3.6 Agree formal and legal arrangements to make payments to, or receive payments from the Council, or pool funds for the purpose of joint commissioning;

9.3.7 Make the services of its employees or any other resources available to the Council; and

9.3.8 Receive the services of the employees or the resources from the Council.

9.3.9 Where the CCG makes an agreement with the Council as described in 9.3.2., the agreement will set out the arrangements for joint working, including details of:

9.3.10 how the parties will work together to carry out their commissioning functions;

9.3.11 the duties and responsibilities of the parties;

9.3.12 how risk will be managed and apportioned between the parties’

9.3.13 financial arrangements, including payments towards a pooled fund and management of that fund;
9.3.14 contributions from both parties, including details of assets, employees and equipment to be used under the joint working arrangements; and

9.3.15 the liability of the CCG to carry out its functions will not be affected where the CCG enters into arrangements pursuant to 9.3.2; and similarly, the liability of the Council to carry out its functions will not be affected where the Council enters in said arrangements.

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 Merton population to develop a shared vision and ambition for health improvement and health and social care services.

9.5 **Merton Local Medical Committee**

9.5.1 The CCG recognises the unique role of the Merton 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 aim to build and maintain a strong, open and effective collaborative relationship with the LMC.

9.5.2 In discharging its functions, the CCG, through its Governing Board and committees, shall consult the Local Medical Committee on decisions that impact on practices in their delivery of Primary Care Services, and individual general practitioners in their professional role; this will include regular attendance at meetings, by agreement.

9.6 **Other Clinical Commissioning Groups**

9.6.1 The CCG may wish to work together with other Clinical Commissioning Groups in the exercise of its Commissioning Functions.

9.6.2 The CCG may make arrangements with one or more Clinical Commissioning Groups in respect of:

- delegating any of the CCG’s Commissioning Functions to another Clinical Commissioning Group;
- exercising any of the Commissioning Functions of another Clinical Commissioning Group; or
- exercising jointly the Commissioning Functions of the CCG and another Clinical Commissioning Group.

9.6.3 For the purposes of the arrangements described at paragraph 9.6.2, the CCG may:

- make payments to another Clinical Commissioning Group
- receive payments from another Clinical Commissioning Group; or
- make the services of its employees or any other resources available to another Clinical Commissioning Group; or
- receive the services of the employees or the resources available to another Clinical Commissioning Group.
For the purposes of the arrangements described at paragraph 9.6.2 above, the CCG may establish and maintain a pooled fund made up of contributions by any of the Clinical Commissioning Groups working together pursuant to paragraph 9.6.2 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.

Where the CCG makes arrangements with another Clinical Commissioning Group as described at paragraph 9.6.2. above, the CCG shall develop and agree with that Clinical Commissioning Group 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 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

The liability of the CCG to carry out its functions will not be affected where the CCG enters into arrangements pursuant to paragraph 9.6.2 above.

9.7 Public Health

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

- Public Health input into joint commissioning with the Local Authority/CCG with regards to core Public Health functions.
- Public Health specialist support and capacity into the CCG.
- CCG support and capacity into the commissioning elements of Public Health core functions.
Part 10
Conflicts of Interest

10.1 Conflicts of Interest

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

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

10.2 Registers of Interest

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

Practice Leads

Members of the Governing Body;

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

CCG employees

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

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

10.2.2 The CCG shall make arrangements to ensure that:

- a person referred to in paragraph 10.2.1 above declares any conflict or potential conflict of interest that the person has in relation to a decision to be made in the exercise of the commissioning functions of the CCG;

- any such declaration is made as soon as practicable after the person becomes aware of the conflict or potential conflict and, in any event within 28 days; and

- any such declaration is included in the Registers of Interests.

10.2.3 The CCG shall make arrangements for managing conflicts and potential conflicts of interest in such a way as to ensure that it does not, and does not appear to, affect the integrity of the CCG’s decision making processes.

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

10.3 Governing Body

10.3.1 The CCG shall collate and maintain a Register of Interests of each Member of the Governing Body. The Register of Interests shall include all relevant personal or business interests as defined by the CCG’s Conflicts of Interest Policy, held by a Governing Body Member.
10.3.2 All Members of the Governing Body must comply with the provisions of the Conflicts of Interest Policy, which includes a provision requiring Members of the Governing Body to notify the CCG of a relevant interest or a change to an existing interest noted on the Register of Interests. Failure by a Governing Body Member to so notify the CCG or to comply with the Conflicts of Interest Policy, may lead to the suspension and/or removal of the Governing Body Member from the Governing Body.

10.3.3 Where the business of the Governing Body requires a decision on an area in which a member holds a significant conflict of interest, the Chair of the Governing Body shall ensure that the Member Representative in question takes no part in the discussion or subsequent decision making. The CCG’s Conflicts of Interest Policy states what could be considered a conflict of interest and the procedure for evaluating proposals where more than one member of the Governing Body holds a significant interest pertaining to the business of the Governing Body.

10.3.4 Should the Chair of the Governing Body have a conflict of interest, then the Chair shall take no part in the discussion or subsequent decision making, and the Deputy Chair (Lay Member) shall chair the discussion and subsequent decision making.

10.4 Practice Leads Forum

10.4.1 The CCG shall collate and maintain a Register of Interests of each member of the Members Forum. The register of interests shall include all relevant personal or business interests as defined by the CCG’s Conflicts of Interest Policy, held by a Practice Lead on the Practice Leads Forum.

10.4.2 All Practice Leads of the Practice Leads Forum must comply with the provisions of the Conflicts of Interest Policy, which includes a provision requiring members of the Practice Leads Forum to notify the CCG of a relevant interest or a change to an existing interest noted on the register. Failure by a Practice Lead to so notify the CCG or to fail to comply with the Conflicts of Interest Policy, may lead to the suspension and/or removal of the Practice Lead from the Practice Leads Forum.

10.4.3 Where the business of the Practice Leads Forum requires a decision on an area in which a Practice Lead holds a significant conflict of interest, the Chair of the Governing Body, working with the chair of the Practice Leads Forum, shall ensure that the Practice Lead in question takes no part in the discussion or subsequent decision making. The CCG’s Conflicts of Interest Policy describes examples of interests that are likely to be considered ‘significant’.

10.5 Declaration of Interests

10.5.1 Each Governing Body member, Practice Lead, CCG employee or any other person working on behalf of the CCG shall declare any personal or business interest as defined in the CCG’s Conflicts of Interest Policy immediately on becoming aware of such interest. The CCG’s Conflicts of Interest Policy shall set out the procedure for making the declaration. Such declaration shall include details of the nature and extent of the interest, including details of any benefit already received or which is expected to be received.

10.5.2 Any question of whether an interest is a conflict of interest or potential conflict of interest as defined by the CCG’s Conflicts of Interest Policy or whether an interest should be recorded or removed from the Register of Interests shall be for the consideration of the Accountable Officer.

10.5.3 Any member of the Governing Body or Practice Lead, CCG employee or any other person working on behalf of the CCG must absent themselves from any meeting or part of a meeting in which any personal or business interests conflicts, or has the potential to conflict, with the business of the CCG in accordance with the CCG’s Conflicts of Interest Policy. In such circumstances the
individual shall not be counted as part of the quorum for the meeting and shall not be entitled to vote.
Part 11
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:

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

pay its employees remuneration and travelling or other allowances as determined by the Governing Body.

11.1.3 The CCG may, for or in respect of its employees, make arrangements for providing pensions, allowances or gratuities. Such arrangements may include the establishment and administration, by the CCG or another party, or 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 11.2.2 does not apply to Members or employees of Members of the CCG.

11.2.5 For the avoidance of doubt, the CCG 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 11.2.3 by virtue of their membership of the Governing Body.

11.3 Chief Officer

11.3.1 The CCG must have an Chief Officer.

11.3.2 The Chief Officer is to be appointed by the NHS Commissioning Board Authority.

11.3.3 The CCG may, for or in respect of its Chief 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 Chief Officer where that Chief Officer suffers loss of office or loss or diminution of emoluments.

11.4  **Finance Officer**

11.4.1 The CCG must have a Finance Officer.

11.4.2 The Finance Officer is to be appointed by the NHS Commissioning Board Authority.

11.4.3 The CCG may, for or in respect of its Finance 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 Finance Officer where that Finance Officer suffers loss of office or loss or diminution of emoluments.

11.5  **Additional Powers in Respect of Payment of Allowances**

11.5.1 The CCG may pay such travelling or other allowances as it considers appropriate to any of the following:

- Members of the CCG who are individuals;
- Individuals, including Member Representatives, authorised to act on behalf of a Member in dealings between the Member and the CCG; and
- Members of any committee or sub-committee of the CCG or the Governing Body.
Clinical Commissioning Group Constitution

Schedules

This document contains 10 Schedules
1.1. The following words and phrases shall be interpreted as set out below:

- **Accountable Officer**
  - See Chief Officer

- **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.

- **Chief 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 Authority in accordance with the Act and whose duties and responsibilities are set out in this Constitution.

- **Commissioning Board Authority**
  - 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 Authority 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.

- **Conflicts of Interest Policy**
  - The policy developed and maintained by the Governing Body pursuant to paragraph 10 and appended to this Constitution at Appendix 9.

- **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 Authority.
<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Guidance</td>
<td>Measuring applicable health or social care guidance, direction or determination which the CCG has a duty to have regard to.</td>
</tr>
<tr>
<td>Health and Wellbeing Board</td>
<td>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.</td>
</tr>
<tr>
<td>Health Care Professional</td>
<td>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.</td>
</tr>
<tr>
<td>Health-Related Services</td>
<td>Services that may have an effect on the health of individuals but are not health services or Social Care Services.</td>
</tr>
<tr>
<td>Joint Health and Wellbeing Strategy</td>
<td>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].</td>
</tr>
<tr>
<td>Lay Person</td>
<td>An individual who is not: (a) a member of the CCG; (b) a Healthcare Professional; or (c) an individual of prescribed description.</td>
</tr>
<tr>
<td>Legislation</td>
<td>Laws statutes, statutory instruments, regulations and directions issued from time in respect of the CCG.</td>
</tr>
<tr>
<td>Member</td>
<td>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 3.4 of this Constitution (and “Membership”) shall be construed accordingly).</td>
</tr>
<tr>
<td>Member Engagement Strategy</td>
<td>A strategy established by the CCGs for engaging with its Members in accordance with paragraph 3.8 of this Constitution.</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>Practice Lead</td>
<td>An individual nominated by a Member to represent that Member on the Practice Leads Forum.</td>
</tr>
<tr>
<td>Practice Leads Forum</td>
<td>A committee composed of Practice Leads that meets at least 2 times per year.</td>
</tr>
<tr>
<td>Prime Financial Policies</td>
<td>The Prime Financial Policies described in paragraph 1.1.9.3 and set out in Appendix 12.</td>
</tr>
</tbody>
</table>
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 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 required by law 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 then 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. **Legal Notices**

2.2.1. Any legal 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 CCGs 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 legal notice given under this Constitution is not valid if sent by e-mail. However, to conduct its regular daily business, the CCG may correspond with its Members using email so long as such correspondence does not constitute a legal notice in connection with the Constitution.

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 Authority, including Guidance on the form, content or publication.

Publication

The CCG shall publish this Constitution on the CCG’s website. If this Constitution is varied, the CCG must publish the Constitution as so varied. The CCG shall develop its own website for April 1st 2013.

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

Variation

The CCG may apply to the NHS Commissioning Board Authority 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 Authority 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 Authority.
The CCG’s Duties

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 Authority 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 Authority in discharging its duty under Section 13 E of the Act (NHS Commissioning Board Authority’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 Authority 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 Authority in respect of this duty.

6.4 All Clinical Reference Groups terms of reference and subsequent plans for re-design will include 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 Authority 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 Authority 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 Authority 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 Authority.

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 Authority.

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 Authority 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 Authority 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 services.
Schedule 4
Membership: Eligibility and Termination of Membership

1. Who may become a Member of the CCG?

CCG Membership will be composed of GP practices and not individual GPs. To become a member of the CCG, a GP practice must hold a contract with NHS Sutton and Merton for 2012/13 and thereafter the NHS Commissioning Board for the provision of primary care services such as a GMS, PMS, APMS contract or another Primary Care contract and must have their Primary site located within the Borough of Merton. For further details on eligibility for membership of the CCG and the process for approval of Members by the Governing Body of the CCG please see the CCG Constitution.

2. Membership Conditions

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

- is eligible for Membership under the Constitution;
- carries out the Member Responsibilities described in 3.7;
- operates within the delegated budgets described in 3.7; and
- undertakes any reasonable remedial action requested by the Governing Body in order for the CCG to meet its statutory duties

Membership is dependent on Practices retaining their GP contract with NHS Sutton and Merton for 2012/13 and the NHS Commissioning Board thereafter and acting in accordance with the responsibilities of that contract.

Members will need to commit to meeting the outcomes of the CCG’s Operating Plan

Failure by a Member to comply with any of the Membership Conditions may, at the absolute discretion of the Governing Body, result in the Member having sanctions imposed on it, the most severe being a Member losing its membership status from the Clinical Commissioning Group, subject to approval by the National Commissioning Board.
Schedule 5
Composition of the Governing Body

1. The CCG shall have a Governing Body comprising of no more than 12 voting members, comprising initially of the following 10 members:

   Clinical Chair;

   Chief Operating Officer (as Accountable Officer);

   Chief Financial Officer;

   At least 2 lay members [including one to chair the Audit Committee, and one to act as Deputy Chair and to represent the interests of patients and the public]

   2 GPs who currently practice within Merton

   Secondary Care Consultant

   Registered Nurse

   Director of Public Health

   Up to two other members may be appointed if deemed necessary for the Governing Body to carry out its functions.

2. The following may become members of the Governing Body:

   a Member of the CCG who is an individual;

   an individual appointed by virtue of Regulations in the Act;

   individuals who are Health care Professionals; and

   individuals who are Lay Persons;

3. Appointed Members

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

   Chair, who shall also be elected by the Members;

   Chief Operating Officer (as Accountable Officer); and

   Chief Financial Officer.

4. Elected members will be two GPs from Merton. Candidates are only eligible if they are a practicing GP in Merton, work a minimum of 2 clinical sessions per week.

5. Nominated members of the CCG are:

   Director of Public Health
Any other nominees at the discretion of the Governing Body

6. The Chair of Merton LMC will attend meetings in public of the governing body and other non-public meetings of the governing body to which he/she will be invited from time to time, as appropriate, as a non-voting participant.
Schedule 6
Additional information for Governing Body Membership
CCG Governing Body Terms of Office

1 Terms of Office

1.1 The Chair shall serve a two-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 Merton providing they are a Partner, a Sessional GP or Locum of a Practice within Merton who works a minimum of 2 clinical sessions per week in a Merton CCG Member Practice and is on the Merton Performers List.

1.3 Each member practice shall have one vote.

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

1.4.1 Appointed Clinical and Lay Person members of the Governing Body shall serve for a two two-year terms and will be eligible for re-appointment following a public process;

2 GPs on the Governing Board

2.1.1 Two GPs elected to the Governing Body by the membership shall each have a two-year term of office. Each will be eligible for re-election.

2.1.2 Each member practice shall have one vote for each GP role.

2.1.3 To be eligible to stand for election to the Governing Body a GP must be a GP on the Merton Performers list and work a minimum of 2 Clinical Sessions a week in a Member Practice.

2.1.4 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

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

2.2.1 if an elected GP ceases to work within the Area for a minimum of two clinical sessions per week;

2.2.2 if an elected GP is suspended from providing primary medical services;

2.2.3 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

2.2.4 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.
Schedule 7
The Seven Principles of Public Life (the Nolan Principles)

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.

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.

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.

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.

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.

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.

LEADERSHIP

Holders of public office should promote and support these principles by leadership and example.
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 9

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 Authority before any date specified by the NHS Commissioning Board Authority.

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 Authority**

The Act gives the NHS Commissioning Board Authority 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 Authority, including, where requested by the NHS Commissioning Board Authority, 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 Authority 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 Authority**

The Commissioning Board Authority has powers under the Act to direct and dissolve the CCG. In particular, the Commissioning Board Authority 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 Authority in any direction. In such circumstances, and where the Commissioning Board Authority is exercising a function of the CCG or has directed another CCG to do so, the CCG must co-operate with the Commissioning Board Authority 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 9 Appendices
Appendix 1

Area
## Appendix 2

### Register of Members

#### Merton CCG Practice List 2012

<table>
<thead>
<tr>
<th>No</th>
<th>Practice/Code</th>
<th>Practice Lead</th>
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<td>1</td>
<td>H85038: Cricket Green Medical Practice, 75-79 Miles Road, Mitcham, CR4 3DA</td>
<td>Dr Nav Chana</td>
<td>8,850</td>
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<td>2</td>
<td>H85634: Merton Medical Centre, 12-17 Abbey Parade, Merton High Street, SW19 1DG</td>
<td>Dr Nicola Waldman</td>
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<td>3</td>
<td>H85649: Colliers Wood Surgery/Lavender Fields, 58 High Street, Colliers Wood, SW19 2BY</td>
<td>Dr Farooq Ahmad</td>
<td>11,450</td>
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<td>4</td>
<td>H85024: Mitcham Medical Centre, 81 Haslemere Avenue, Mitcham, CR4 3PR</td>
<td>Dr Bish Naha</td>
<td>11,173</td>
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<td>5</td>
<td>H85029: Wide Way Surgery, 15 Wide Way, Mitcham CR4 1BP</td>
<td>Dr Mina Patel</td>
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<td>H85090: Figges Marsh, 182 London Road, Mitcham, CR4 3LD</td>
<td>Dr T. Bajwa</td>
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<td>H85027: Wimbledon Village Surgery, 35a High Street, Wimbledon SW19 5BY</td>
<td>Dr Jane Allen</td>
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<td>H85033: Tamworth House Medical Centre, 341 Tamworth Lane, Mitcham CR4 1DL</td>
<td>Dr Geoffrey Hollier</td>
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<td>H85035: Rowans Surgery, 12 Windermere Road, Streatham, SW16 5HF</td>
<td>Dr Karen Worthington</td>
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<td>H85070: Central Medical Centre, 42-46 Central Road, Morden SM4 5RT</td>
<td>Dr C. Vivekananda</td>
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<td>H85072: James O’Riordan Medical Centre, 70 Stonecot Hill, Sutton, SM3 9HE</td>
<td>Dr Jerome Jephcott</td>
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<td>Dr Raghu Lall</td>
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<td>H85110: Wandle Road Surgery, 161 Wandle Road, Morden SM4 6AA</td>
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<td>H85112: Vineyard Hill Road Surgery, 67 Vineyard Hill Road, Wimbledon SW19 7JL</td>
<td>Dr Rob Jones</td>
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<td>H85016: Cannon Hill Lane Medical Practice, 153 Cannon Hill Lane, SW20 9DA</td>
<td>Dr Graham Mason</td>
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<td>Dr Andrew Murray</td>
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<td>H85026: Francis Grove Surgery, 8 Francis Grove, Wimbledon SW19 4DL</td>
<td>Dr Simon Murray</td>
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<td>Dr Paul Alford</td>
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<td>Dr Mark Bish</td>
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<td>H85051: H. Freeman &amp; Partners, 12 Durham Road, Raynes Park, SW20 0TW</td>
<td>Dr Helen Allison</td>
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<td>Dr Vasa Gnanapragasam</td>
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<td>H85101: Grand Drive Surgery, 132 Grand Drive, Raynes Park, SW20 9EA</td>
<td>Dr Sion Gibby</td>
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<td>Y02968: Wilson GP Led Health Centre, Cranmer Road, Mitcham CR4 4TP</td>
<td>Dr Anirban Gupta</td>
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Merton CCG 214,150
Appendix 3

Members Forum Terms of Reference

TO BE DRAFTED AND AGREED WITH THE MEMBERSHIP
Appendix 4
Governing Body
Terms of Reference

NHS Merton Clinical Commissioning Group
Governing Body Terms of Reference – DRAFT v4

1. Introduction
The main function of the Governing Body is to ensure that the Clinical Commissioning Group (CCG) has appropriate arrangements in place to exercise its functions effectively, efficiently and economically and in accordance with generally accepted principles of good governance. The Governing Body shall carry out the duties and responsibilities set out in the CCGs 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 committee and shall have effect as if incorporated into the Clinical Commissioning Group’s Constitution and Standing Orders.

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 of the committee. 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.

The Governing Body is authorised to request funding from the CFO for outside legal advice or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

3. Membership
The Governing Body will comprise of the following voting members:
- CCG Chair (Chair)
- 2 x GPs
- Chief Officer
- Chief Financial Officer
- Lay Member with responsibility for Audit (Deputy Chair, Chair of Audit Committee)
- Lay Member with responsibility for Patient and Public Engagement (Chair of Quality Committee)
- Secondary Care Consultant
- Registered Nurse
- Borough Director of Public Health
Staff and executives may be invited to attend those meetings in which the Committee will consider areas of risk or operation that are their responsibility. They will be non-voting.

The LMC will have an Observer in attendance at the Governing Body meetings in public.

The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate frank and open discussion of particular matters.

4. Secretary
The Governing Body will be supported secretarially by a member of the Business Support team with specific responsibilities towards the Governing Body, whose duties in this respect shall include:
- Agreement of Agenda with the Chair and attendees and collation of papers
- Taking the minutes and keeping a record of matters arising and issues to be carried forward

5. Quorum
The meeting will be quorate when five members are present, with at least two of those present clinical members, one lay member and one voting director (either the Chief Officer or Chief Financial Officer). No business shall be transacted unless the following are present:
- Chair or Deputy Chair; and
- Chief Officer or Chief Financial Officer

6. Frequency and notice of meetings
The Governing Body will meet sufficiently to fulfil its work plan or at least quarterly as a minimum. The Governing Body reserves the right to call a meeting at any time (with appropriate notice) if an urgent matter arises.

A notice period of at least five working days shall be given for any exceptional Governing Body meetings. The Agenda and supporting papers will be circulated three working days prior to the meeting. Meetings will be set in advance annually.

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

At any meeting of the Governing Body or sub-committee, the Chair of the Governing Body or sub-committee, if present, shall preside. If the Chair is absent from the meeting the Deputy Chair shall preside. If the Chair as absent temporarily (i.e. or a specific agenda item) on the grounds of a declared conflict of interest the Deputy Chair, if present, shall preside. If both the Chair and Deputy Chair are absent, are disqualified from participating, or there is neither a Chair or Deputy 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 an Annual General Meeting to be held each year and this will be open to members of the public.

7. Remit and responsibilities of the Governing Body
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 2011 and in any subsequent amendments to the Act or as requested by the NHS Commissioning Board Authority.

The specific responsibilities of the Governing Body are categorised as follows:
- 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 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 Committees

8. **Reporting**
The minutes of all meetings of the Governing Body shall be formally recorded and where appropriate, made available to the public via the Merton CCG website.

The CCG’s annual report shall contain a section describing the work of the Governing Body in discharging its responsibilities.

9. **Review**
The terms of reference for the Committee shall be reviewed by the Governing Body after six months and at least on an annual basis thereafter. This will take into account any new guidance and relevant codes of conduct / good governance practice.

10. **Policy and best practice**
• The Committee will at all times apply best practice in decision making processes as laid out in the Constitution, in accordance with national guidelines and generally accepted standards of good corporate governance.
• The Committee will have full authority to request funding, subject to the advice of the Chief Finance Officer regarding affordability, to commission any reports or surveys it deems necessary to help it fulfil its obligations
• The Committee will work with similar committees from neighbouring CCGs as appropriate where there is added value in so doing. This may be part of the collaborative working arrangements with other CCGs in South London via the Chairs and COs collaborative working arrangements.

11. **Conduct of the Governing Body**
The Governing Body will:
• Adhere at all times to the Merton CCG Conflicts of Interest Policy;
• Be accountable to Parliament, to users of services, to individual citizens, and to staff for the activities of the bodies concerned, for their quality and safety and the extent to which key performance indicators and objectives have been met;
• Comply fully with the principles of the Citizen’s Charter and the Code of Practice on Access to Government Information, in accordance with Government policy on openness; and
• Bear in mind the necessity of keeping comprehensive written records, in line with general good practice in corporate governance.
Appendix 5
Audit and Governance
Committee Terms of Reference

NHS Merton Clinical Commissioning Group

Audit Committee

Terms of Reference

1. Authority

1.1. The audit committee is constituted as the senior standing committee of the CCG’s Governing Body. Its constitution and terms of reference shall be as set out below, subject to amendment at future Governing Body meetings. The audit committee shall not have executive powers in addition to those delegated in these terms of reference.

1.2. The audit committee is authorised by the Governing Body to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any member of staff or member of the CCG and all members of staff and members of the CCG are directed to co-operate with any request made by the audit committee.

1.3. The audit committee is authorised by the Governing Body to obtain outside legal or other independent professional advice. The committee is authorised by the Governing Body to request the attendance of individuals and authorities from outside the CCG with relevant experience and expertise if it considers this necessary or expedient to the carrying out of its functions.

1.4. The audit committee will have primary responsibility for monitoring and reviewing financial and other risks and associated controls, corporate governance and financial assurance.

1.5. These terms of reference and the composition of the audit committee will accord with any published national guidance.

2. Purpose

2.1. The Governing Body is responsible for ensuring effective internal control including:

- exercising its functions effectively, efficiently and economically
- complying with such generally accepted principles of good governance as are relevant to it
- managing the CCG’s activities in accordance with statute, regulations and guidance
• establishing and maintaining a system of internal control to give reasonable assurance that assets are safeguarded, waste or inefficiency avoided and reliable financial information produced, and that value for money is continuously sought.

2.2. The audit committee shall provide the Governing Body with a means of independent and objective review of financial and corporate governance, assurance processes and risk management across the whole of the CCG’s activities (clinical and non-clinical). In addition the audit committee shall:

• assist the CCG in discharging its functions under paragraph 2.1 above
• provide assurance of independence for external and internal audit
• ensure that appropriate standards are set and compliance with them is monitored, in non-financial, non-clinical areas that fall within the remit of the audit committee
• monitor corporate governance (e.g. Compliance with Constitution, Standing Orders, Prime Financial Policies, maintenance of Registers of Interests).

3. **Membership**

3.1. The committee shall be composed of [not less than] [two] lay members of the Governing Body, at least one of whom should have recent and relevant financial experience and not less than [ ] Member Representatives.

3.2. A quorum shall be [two] members, one of whom will be the Audit Committee Chair.

3.3. The committee shall be chaired by a lay person member. A role description for the Chair is attached as Annex A.

4. **Attendance**

4.1. The Accountable Officer, Chief Financial Officer and Head of Internal Audit [include any others] shall generally attend routine meetings of the audit committee.

4.2. A representative of the external auditors may normally also be invited to attend meetings of the audit committee.

4.3. Members of the Governing Body and/or staff and executives shall be invited to attend those meetings in which the audit committee will consider areas of risk or operation that are their responsibility.

4.4. The audit committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

4.5. The CCG chair may be invited to attend meetings of the audit committee as required.

4.6. A representative of the local counter fraud service will be invited to attend meetings of the audit committee.

4.7. Member Representatives will be invited to attend meetings of the audit committee.

4.8. The CFO shall designate a CCG secretary to the audit committee who will provide administrative support and advice. The duties of the CCG secretary in this regard include but are not limited to:
• agreement of the agenda with the chair of the audit committee and attendees together with the collation of connected papers
• taking the minutes and keeping a record of matters arising and issues to be carried forward
• advising the audit committee as appropriate
• reviewing every decision to suspend the standing orders.

5. Frequency of Meetings

5.1. Meetings shall be held at least four times per year with additional meetings convened where necessary.

5.2. The external auditor shall be afforded the opportunity at least once per year to meet with the audit committee without the Accountable Officer; Chief Financial Officer present.

5.3. The CCG Chair and Accountable Officer should be invited to attend, at least annually, to discuss with the Audit Committee the Annual Accounts and the process for assurance that supports the Annual Governance Statement.

5.4. [The audit committee members shall be afforded the opportunity to meet at least once per year with the External and Internal Auditors with no others present.]

6. Duties

6.1. Internal control, risk management and counter fraud

6.1.1. To ensure the provision and maintenance of an effective system of financial risk identification and associated controls, reporting and governance.

6.1.2. To maintain an oversight of the CCG’s general risk management structures, processes and responsibilities, including the production and issue of any risk and control-related disclosure statements.

6.1.3. To review the adequacy of the policies and procedures in respect of all counter-fraud and anti-bribery work.

6.1.4. To review the adequacy of the CCG’s arrangements by which CCG staff may, in confidence, raise concerns about possible improprieties in matters of financial reporting and control and related matters or any other matters of concern.

6.1.5. To review the adequacy of underlying assurance processes that indicate the degree of achievement of corporate objectives and the effectiveness of the management of principal risks.

6.1.6. To ensure the adequacy of policies and procedures for ensuring compliance with relevant regulatory, legal and conduct requirements.

6.2. Internal audit

6.2.1. To review and approve the internal audit strategy and programme, ensuring that it is consistent with the needs of the organisation.

6.2.2. To oversee on an ongoing basis the effective operation of internal audit in respect of:
• adequate resourcing
• its co-ordination with external audit
• meeting mandatory NHS internal audit standards
• providing adequate independence assurances;
• having appropriate standing with the CCG
• meeting the internal audit needs of the CCG.

6.2.3. To consider the major findings of internal audit investigations; the Governing Body’s response and their implications and monitor progress on the implementation of recommendations.

6.2.4. To consider the provision of the internal audit service, the cost of the audit and any questions of resignation and dismissal.

6.2.5. To conduct an annual review of the internal audit function.

6.3. **External audit**

6.3.1. To make a recommendation to the Governing Body in respect of the appointment, re-appointment and removal of an external auditor. To the extent that that recommendation is not adopted by the Governing Body, this shall be included in the annual report, along with the reasons that the recommendation was not adopted.

6.3.2. To discuss with the external auditor, before the audit commences, the nature and scope of the audit, and ensure co-ordination, as appropriate, with other external auditors in the local health economy. This should include discussion regarding the local evaluation of audit risks and assessment of the CCG associated impact on the audit fee.

6.3.3. To assess the external auditor’s work and fees on an annual basis and, based on this assessment, make a recommendation to the Governing Body with respect to the re-appointment or removal of the auditor. This assessment should include the review and monitoring of the external auditor’s independence and objectivity and effectiveness of the audit process in light of relevant professional and regulatory standards.

6.3.4. To oversee the conduct of a market testing exercise for the appointment of an auditor at least once every (five) years and, based on the outcome, make a recommendation to the Governing Body with respect of the appointment of the auditor.

6.3.5. To review external audit reports, including the annual audit letter, together with the Governing Body’s response, and to monitor progress on the implementation of recommendations.

6.3.6. To develop and implement a policy on the engagement of the external auditor to supply non-audit services.

6.3.7. To consider the provision of the external audit service, the cost of the audit and any questions of resignation and dismissal.

6.4. **Annual accounts review**

6.4.1. To review the annual statutory accounts, before they are presented to the Governing Body (who will in turn provide them to the Commissioning Board Authority in accordance with
statutory requirements), to determine their completeness, objectivity, integrity and accuracy. This review will cover but is not limited to:

- the meaning and significance of the figures, notes and significant changes
- areas where judgment has been exercised
- adherence to accounting policies and practices
- adherence to the requirements and any directions given to the CCG by the Commissioning Board Authority
- explanation of estimates or provisions having material effect
- the schedule of losses and special payments
- any unadjusted statements
- any reservations and disagreements between the external auditors and the Governing Body which have not been satisfactorily resolved.

6.4.2. To review the annual report before it is submitted to the Governing Body and presented to Members of the CCG at the Annual General Meeting of the CCG, to determine completeness, objectivity, integrity and accuracy. The Governing Body will provide the annual report to the Commissioning Board Authority in accordance with statutory requirements.

6.4.3. To review all accounting and reporting systems for reporting to the Governing Body, including in respect of budgetary control.

6.5. **Standing orders, Prime Financial Policies and standards of business conduct**

6.5.1. To review on behalf of the Governing Body the operation of, and proposed changes to, the standing orders and prime financial policies, the constitution, codes of conduct and standards of business conduct; including maintenance of registers.

6.5.2. To examine the circumstances of any significant departure from the requirements of any of the foregoing, whether those departures relate to a failing, an overruling or a suspension.

6.5.3. To review the scheme of delegation at least annually.

6.6. **Other**

6.6.1. To review performance indicators relevant to the remit of the audit committee.

6.6.2. To examine any other matter referred to the audit committee by the Governing Body and to initiate investigation as determined by the audit committee.

6.6.3. To annually review the accounting policies of the CCG and make appropriate recommendations to the Governing Body.

6.6.4. To develop and use an effective assurance framework to guide the audit committee’s work. This will include utilising and reviewing the work of the internal audit, external audit and other assurance functions as well as reports and assurances sought from members of the Governing Body and other investigatory outcomes so as fulfil its functions in connection with these terms of reference.
6.6.5. To consider the outcomes of significant reviews carried out by other bodies which include but are not limited to regulators and inspectors within the health (and social care) sector and professional bodies with responsibilities that relate to staff performance and functions.

6.6.6. To review the work of all the other committees of the CCG in connection with the audit committee’s assurance function.

7. **Reporting**

7.1. The minutes of all meetings of the audit committee shall be formally recorded and submitted, together with recommendations where appropriate, to the Governing Body. The submission to the Governing Body shall include details of any matters in respect of which actions or improvements are needed. This will include details of any evidence of potentially ultra vires, otherwise unlawful or improper transactions, acts, omissions or practices or any other important matters. To the extent that such matters arise, the chair of the audit committee shall present details to a meeting of the Governing Body in addition to submission of the minutes.

7.2. The audit committee will report annually to the Governing Body in respect of the fulfilment of its functions in connection with these terms of reference. Such report shall include but not be limited to functions undertaken in connection with the effectiveness of risk management within the CCG; the integration of and adherence to governance arrangements and any pertinent matters in respect of which the audit committee has been engaged.

7.3. The CCG’s annual report shall include a section describing the work of the audit committee in discharging its responsibilities.

8. **Review**

8.1. The terms of reference of the audit committee shall be reviewed by the Governing Body at least annually. This should take into account new guidance and developments in good governance practice.

9. **Required Frequency of Attendance by Members**

9.1. Members of the audit committee must attend at least 75% of all meetings each financial year but should aim to attend all scheduled meetings.
NHS Merton Clinical Commissioning Group

Role Description - Chair of the Audit Committee

The role of the Chair of the Audit Committee goes a good deal beyond chairing meetings and is key to achieving Committee effectiveness. The additional workload should be taken into account in appointment of the Chair.

How a particular Chair manages the Audit Committee will vary depending on the character of the individual and the needs of the specific organisation.

In addition to chairing the Audit Committee meetings, the key activities should include the following.

1. **Agenda setting**
   Before each meeting the Chair and the Committee Secretary should meet to discuss and agree the business for the meeting. The Chair should take ownership of, and have final say in, the decisions about what business will be pursued at any particular meeting.

2. **Communication**
   The Chair should ensure that after each meeting appropriate reports are prepared from the Audit Committee to the Board and the Accounting Officer.
   The Chair should ensure that the Audit Committee provides a suitable Annual Report to the Governing Body.

   The Chair should have bilateral meetings at least annually with the Accounting Officer, the Head of Internal Audit and the External Auditor. In addition, the Chair should meet any people newly appointed to these positions as soon as practicable after their appointment.

   The Chair should also ensure that all Committee members have an appropriate programme of interface with the organisation and its activities to help them understand the organisation, its objectives, business needs and priorities.

3. **Monitoring actions:**
   The Chair should ensure that there is an appropriate process between meetings for action points arising from Committee business to be appropriately pursued. The Chair should also ensure that members who have missed a meeting are appropriately briefed on the business conducted in their absence. Chairs may choose to rely on the Secretariat to take these actions.

4. **Appraisal:**
   The Chair should take the lead in ensuring that Committee members are provided with appropriate appraisal of their performance as a Committee member and that training needs are identified and addressed. The Chair should themselves seek appraisal of their performance from the Accounting Officer (or Chair of the Governing Body, as appropriate).

   The Chair should ensure that there is a periodic review of the overall effectiveness of the Audit Committee and of its Terms of Reference.

5. **Appointments:**
   The Chair should be involved in the appointment of new Committee members, including providing advice on the skills and experience being sought by the Committee when a new member is appointed.

**Audit Committee Support**

A secretariat function is required to support the Chair of the Committee in identifying business to be taken, and the relevant priorities of the business. For this reason, and as the Audit Committee is a committee of the Governing Body, the Audit Committee Secretariat function should be supervised by the Governing Body secretariat. The Chair of the Committee and the secretariat should agree...
procedures for commissioning briefing to accompany business items on the Committee’s agenda and timetables for the issue of meeting notices, agendas, and minutes. The Chair of the Committee should always review and approve minutes of meetings before they are circulated.

The specific responsibilities of the Audit Committee Secretariat should include:

- meeting with the Chair of the Committee to prepare agendas for meetings;
- commissioning papers as necessary to support agenda items;
- circulating meeting documents in good time before each meeting;
- arranging for executives to be available as necessary to discuss specific agenda items with the Committee during meetings;
- keeping a record of meetings and providing draft minutes for the Chair’s approval;
- ensuring action points are being taken forward between meetings;
- support the Chair in the preparation of Audit Committee reports to the Governing Body;
- arranging the Chair’s bilateral meetings with the Accounting Officer, the Head of Internal Audit and the External Auditor;
- keeping the Chair and members in touch with developments and relevant background information about developments in the organisation;
- maintaining a record of when members’ terms of appointment are due for renewal or termination;
- ensuring that appropriate appointment processes are initiated when required;
- ensuring that new members receive appropriate induction training, and that all members are supported in identifying and participating in on-going training;
- managing any budgets allocated to the Audit Committee.

Careful consideration should be given to ensuring that the Secretariat function is not biased. If the function is provided by Internal Audit there may be a risk of bias towards Internal Audit interests. On the other hand there is merit in ensuring the secretariat is independent of pressure from senior management, as could happen if the Board Secretariat also supports the Audit Committee. When the Audit Committee meets privately, the Chair should decide whether the secretariat members should also withdraw. If so, the Chair should ensure that an adequate note of proceedings is kept to support the Committee’s conclusions and advice.
NHS Merton Clinical Commissioning Group

Governing Body Remuneration Committee

Terms of Reference

1. Introduction

The Remuneration Committee (the Committee) is established in accordance with the 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 and shall have effect as if incorporated into the Clinical Commissioning Group’s Constitution and Standing Orders.

2. Remit and responsibilities of the Committee

The Committee shall make recommendations to the Governing Body on determinations about pay and remuneration for employees of the Clinical Commissioning Group and people who provide services to the Clinical Commissioning Group and allowances under any pension scheme it might establish as an alternative to the NHS pension scheme.

Specifically, the Committee will be responsible for:

- Determining the remuneration, allowances, payments for additional responsibilities, other benefits and conditions of service of the senior management team.
- Monitoring and evaluating the performance and achievements of the Accountable Officer and other senior management team members and determining annual salary awards and other payments as appropriate.
- Considering the contractual arrangements and severance payments of the Accountable Officer and of other senior staff, seeking HM Treasury approval as appropriate in accordance with the guidance ‘Managing Public Money’
- Report in writing to the Governing Body the basis of its decisions for ratification.

Remuneration Committees should also remain aware that each individual NHS organisation is corporately responsible for ensuring that its pay arrangements are appropriate in terms of Equal Pay requirements and other relevant legislation.

3. Membership

The Committee shall be appointed by the Clinical Commissioning Group from amongst its Governing Body members and must not have a Member Practice majority. The committee should not include full time employees or individuals who claim a significant proportion of their income
Members:
- Chair of the Committee (Lay Member)
- Deputy Chair of the Committee (Lay Member)
- Chair of the Clinical Commissioning Group
- [Other Lay members as determined by the Governing Body]

Persons in attendance:
- Accountable Officer (as and when required)
- CCG [Director/Head of HR or equivalent] will be responsible for supporting the Chair in the management of Remuneration Committee business and for drawing the Committee’s attention to best practice, national guidance and other relevant documents, as appropriate.
- Chief Finance Officer to advise on any matters that have significant financial implications.

Other parties may only attend at the request of the Committee and only to provide advice and information.

Staff will not be present for the discussion of matters relating to their own remuneration, performance or terms of service.

4. **Secretary**

The secretary will be a [Manager/other Officer in the HR function/Business Manager] who will also take the minutes.

5. **Quorum**

The meeting will be quorate when [two] members are present, with at least [one Lay Member] also present. The majority of those present should be Lay Members.

6. **Frequency and notice of meetings**

The committee will meet sufficiently to fulfil its work plan or at least bi-annually as a minimum. The Governing Body reserves the right to call a meeting at any time (with appropriate notice) if an urgent matter arises.

A notice period of at least 14 days shall be given before the Remuneration Committee meets. The Agenda and supporting papers will be circulated 7 days prior to the meeting.

7. **Relationship with the Governing Body**

Once agreed, reports on activity of the Committee will be reported to the Lay Members of the Governing Body, respecting individual confidentiality.

8. **Decision making**

The Committee will at all times apply best practice in the decision making processes. When considering individual remuneration the committee will:

- Comply with current disclosure requirements for remuneration;
18.9.12

- On occasion seek independent advice about remuneration for individuals; and
- Ensure that decisions are based on clear and transparent criteria.

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

A decision put to a vote at a meeting shall be determined by a majority of the votes of the members present.

9. Conduct of the committee

The Remuneration Committee will:

- Observe the highest standards of propriety involving impartiality, integrity and objectivity in relation to the stewardship of public funds and the management of the bodies concerned;
- Maximise value for money through ensuring that services are delivered in the most efficient and economical way, within available resources, and with independent validation of performance achieved wherever practicable;
- be accountable to Parliament, to users of services, to individual citizens, and to staff for the activities of the bodies concerned, for their stewardship of public funds and the extent to which key performance targets and objectives have been met;
- comply fully with the principles of the Citizen's Charter and the Code of Practice on Access to Government Information, in accordance with Government policy on openness; and
- bear in mind the necessity of keeping comprehensive written records of their dealings, in line with general good practice in corporate governance

10. Review

These Terms of Reference will be reviewed after six months and on an annual basis thereafter. This will take into account any new national guidance and relevant codes of conduct / good governance practice.

Any resulting changes to the terms of reference will be approved by the Governing Body.

[Date agreed]
Appendix 6b: Quality Committee Terms of Reference

NHS Merton Clinical Commissioning Group

Governing Body Clinical Quality Committee

Terms of Reference – FINAL DRAFT

Introduction
The Clinical Quality Committee (the Committee) is established in accordance with the Clinical Commissioning Group’s Constitution, Standing Orders and Schemes of Delegation. 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 effect as if incorporated into the Clinical Commissioning Group’s Constitution and Standing Orders.

Authority
The Committee is directly accountable to the Governing Body and is authorised to undertake 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 within the agreed process.

The Committee is authorised to request funding from the CFO for outside legal advice or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

Membership
The Committee shall be appointed by the Clinical Commissioning Group from amongst its Governing Body and/or staff and executives.

Members:

- Chair of the Governing Body (Chair)
- Lay Member (Patient and Public Engagement) of the Governing Body (Deputy Chair alternating)
- Nurse Member of the Governing Body (Deputy Chair alternating)
- Medical Director
- Director of Commissioning
- Director for Quality
- Clinical Leads for Localities

The following members of staff may be asked to attend the meetings:

- Chief Officer (as and when required)
Chief Finance Officer (as and when required to advise on matters that have significant financial implications)

Senior Representatives of the Commissioning Support Unit (CSU) (or body that undertakes that function) and the Joint Commissioning Unit

Members of the Governing Body and/or staff and executives may be invited to attend those meetings in which the Committee will consider areas of risk or operation that are their responsibility.

The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate frank and open discussion of particular matters.

All members and those attending will be subject to the MCCG declaration of interest policy.

Secretary
The Committee will be supported secretarially by a senior member of the Business Support team, whose duties in this respect shall include:

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

Quorum
The meeting will be quorate when four members are present, with at least two of those present clinical members and either the Chair or Deputy Chair. On all occasions, the majority of those present should be clinical members.

Frequency and notice of meetings
The Committee will meet sufficiently to fulfil its work plan or at least once every two months as a minimum. The Governing Body reserves the right to call a meeting at any time (with appropriate notice) if an urgent matter arises.

Meeting dates will be set in advance for the year. However, in exceptional circumstances a notice period of at least 10 working days shall be given before the Committee meets. The Agenda and supporting papers will be circulated seven days prior to the meeting.

The Chief Officer should be invited to attend at least annually, to review with the Committee the process for assurance that supports the Quality and Safety plan before the Governing Body formally signs off the process of assurance.

Remit and responsibilities of the committee
The duties of the Committee are outlined as follows:

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 regulatory bodies.

Oversee the performance of commissioned services in relation to the quality specification, 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 deterioration in performance.

Review exception reports, action plans and risk assessments produced by the CSU (or body that undertakes the function), Joint Commissioning Unit, Locality Commissioning Groups and subgroups to ensure they include appropriate and robust mitigating actions and controls.
Review information from providers and the CSU of patient experience, including surveys, PALS queries and complaints to identify potential risks and issues.

Have oversight of the process and compliance issues concerning Serious Untoward Incidents (SUIs) and Never Events and informing the Governing Body, when the committee decides escalation is appropriate, of risks and issues in within one working day.

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

Ensure a clear escalation process, including appropriate trigger points, is in place to enable appropriate engagement of external bodies on areas of concern.

Provide assurance that commissioned services, and jointly commissioned services, are being delivered in a high quality and safe manner, ensuring that quality sits at the heart of everything the clinical commissioning group does.

Oversee and be assured that providers of commissioned services and jointly commissioned services manage risk appropriately and have robust mechanisms in place to effectively address clinical governance issues.

Receive and review monitoring reports relating to commissioning quality specifications from CSU and internally from the MCCG Commissioning & Planning Directorate

**Reporting**

The minutes of all meetings of the Committee shall be formally recorded and submitted, together with recommendations where appropriate, to the Governing Body. The submission to the Governing Body shall include details of any matters in respect of where actions or improvements are needed. This will include details of any evidence of potentially Serious Untoward Incidents and Never Events, other serious provider or commissioner failings or any other important matters. To the extent that such matters arise, the Chair of the Committee shall present details to a meeting of the Governing Body in addition to the submission of the minutes. A formal report will be provided to the governing body of SUIs etc. at a non-public meeting.

The Committee will report annually to the Governing Body in respect of the fulfilment of its functions with these terms of reference. Such report shall include, but not be limited to, functions undertaken in relation to the effectiveness of risk management within the CCG; the management of serious quality and safety incidents and any pertinent matters in respect of which the Committee has been engaged. The report will be a quality and risk report which covers all aspects of the committees work.

The CCG’s annual report shall contain a section describing the work of the Committee in discharging its responsibilities.

**Review**

The terms of reference for the Committee shall be reviewed by the Governing Body after six months and at least on an annual basis thereafter. This will take into account any new guidance and relevant codes of conduct / good governance practice.

**Policy and best practice**

- The Committee will at all times apply best practice in decision making processes as laid out in the Constitution, in accordance with national guidelines and generally accepted standards of good corporate governance.

- The Committee will have full authority to request funding from the Chief Finance Officer to commission any reports or surveys it deems necessary to help it fulfill its obligations
The Committee will work with similar committees from neighbouring CCGs and the CSU as appropriate to ensure sharing of best practice and learning, including a list of SUIs.

Conduct of the Committee
The Committee will:

• Observe the highest standards of propriety involving impartiality integrity and objectivity in relation to the quality and safety of commissioned services and the management of the providers concerned;

• Be accountable to users of services, to members of the public, and to staff for the activities of the providers concerned, for their quality and safety and the extent to which key performance indicators and objectives have been met;

• Comply fully with the principles of the Citizen's Charter and the Code of Practice on Access to Government Information, in accordance with Government policy on openness;

• Bear in mind the necessity of keeping comprehensive written records, in line with general good practice in corporate governance; and

• Adhere at all times to the Merton CCG Conflicts of Interest Policy.
Appendix 7
Conflict of Interests Policy

Merton CCG
Conflict of Interests and Dispute Resolution Policy
Draft Version 1
1. STANDARDS OF BUSINESS CONDUCT AND MANAGING CONFLICTS OF INTEREST

1.1 Standards of Business Conduct

Employees, members, committee and sub-committee members of the Merton CCG and members of the Governing Body (and its committees) will at all times comply with this constitution and be aware of their responsibilities as outlined in it. They should act in good faith and in the interests of the Merton CCG and should follow the Seven Principles of Public Life, set out by the Nolan Principles. The Nolan Principles are incorporated in the constitution.

They must comply with the Merton CCG’s policy on business conduct, including the requirements set out in this policy for managing conflicts of interest.

Individuals contracted to work on behalf of the Merton CCG or otherwise providing services or facilities to the Merton CCG will be made aware of their obligation with regard to declaring conflicts or potential conflicts of interest. This requirement will be written into their contract for services.

1.2 Conflicts of Interest

1.2.1 As required by section 14O of the 2006 Act, as inserted by section 25 of the 2012 Act, Merton CCG will make arrangements to manage conflicts and potential conflicts of interest that decisions made by the Merton CCG will be taken and seen to be taken without any possibility of the influence of external or private interest.

A conflict of interest will include:

a) a direct pecuniary interest: where an individual may financially benefit from the consequences of a commissioning decision (for example, as a provider of services);

b) an indirect pecuniary interest: for example, where an individual is a partner, member or shareholder in an organisation that will benefit financially from the consequences of a commissioning decision;

c) a non-pecuniary interest: where an individual holds a non-remunerative or not-for profit interest in an organisation, that will benefit from the consequences of a commissioning decision (for example, where an individual is a trustee of a voluntary provider that is bidding for a contract);

d) a non-pecuniary personal benefit: where an individual may enjoy a qualitative benefit from the consequence of a commissioning decision which cannot be given a monetary value (for example, a reconfiguration of hospital services which might result in the closure of a busy clinic next door to an individual’s house);

e) where an individual is closely related to, or in a relationship, including friendship, with an individual in the above categories.

1.2.2 Where an individual, i.e. an employee, Merton CCG member, member of the Governing Body, or a member of a committee or a sub-committee of the Merton CCG or its Governing Body has an interest, or becomes aware of an interest which could lead to a conflict of interests with the Merton CCG considering an action or decision in relation to that interest, that must be considered as a potential conflict, and is subject to the provisions of this policy and the constitution.

1.2.3 If in doubt, the individual concerned should assume that a potential conflict of interests exists.

1.3 Declaring and Registering Interests

1.3.1 The Merton CCG will maintain one or more registers of the interests of:

a) its Practice Leads;

b) members of its Governing Body;
c) members and attendees, of its committees or sub-committees and the committees or sub-committees of its Governing Body; and

d) its employees.

Individuals will declare any interest that they have, in relation to a decision to be made by Merton CCG, in writing to the Governing Body, as soon as they are aware of it and in any event no later than 28 days after becoming aware.

1.3.2. Where an individual is unable to provide a declaration in writing, for example, if a conflict becomes apparent in the course of a meeting, they will make an oral declaration before witnesses, and provide a written declaration as soon as possible thereafter to the Governing Body.

1.3.3. The Governing Body will ensure that the register(s) of interest is reviewed regularly, and updated as necessary.

The lay member of the Governing Body, with particular responsibility for governance, will make themselves available to provide advice to any individual who believes they have, or may have, a conflict of interest.

1.3.4. The Governing Body will take such steps as it deems appropriate, and request information it deems appropriate from individuals, to ensure that all conflicts of interest and potential conflicts of interest are declared.

1.4 Managing Conflicts of Interest: general

1.4.1. Where an interest has been declared, either in writing or by oral declaration, the declarer will ensure that before participating in any activity connected with the Merton CCG’s commissioning functions, they have received confirmation of the arrangements to manage the conflict of interest or potential conflict of interest from the Governing Body.

1.4.2. The Governing Body will ensure that for every interest declared, either in writing or by oral declaration, arrangements are in place to manage the conflict of interests or potential conflict of interests, to ensure the integrity of the Merton CCG’s decision making processes.

1.4.3. Arrangements for the management of conflicts of interest are to be determined by the Governing Body and will include the requirement to put in writing to the relevant individual arrangements for managing the conflict of interests or potential conflicts of interests, within a week of declaration.

1.4.4. The arrangements will confirm the following:

a) at what point an individual should withdraw from specified activity, on a temporary or permanent basis;

b) monitoring of the specified activity undertaken by the individual, either by a line manager, colleague or other designated individual.

1.4.5. In any meeting where an individual is aware of an interest, previously declared or otherwise, in relation to the scheduled or likely business of the meeting, the individual concerned will bring this to the attention of the chair, together with details of arrangements which have been confirmed by the Governing Body for the management of the conflict of interests or potential conflict of interests. Where no arrangements have been confirmed, the chair may require the individual to withdraw from the meeting or part of it.

1.4.6. Where the chair of any meeting of the Merton CCG, including committees, sub-committees, or the Governing Body, has a personal interest, previously declared or otherwise, in relation to the scheduled or likely business of the meeting, they must make a declaration and the deputy chair will act as chair for the relevant part of the meeting.

1.4.7. Where arrangements have been confirmed with the Governing Body for the management of the conflict of interests or potential conflicts of interests in relation to the chair, the meeting must ensure these are followed.
1.4.8. Where no arrangements have been confirmed, the deputy chair may require the chair to withdraw from the meeting or part of it. Where there is no deputy chair, the members of the meeting will select one.

1.4.9. Any declarations of interests, and arrangements agreed in any meeting of the Merton CCG, committees, sub-committees, or the Governing Body, will be recorded in the minutes.

1.4.10. In any transaction undertaken in support of the Merton CCG’s commissioning functions (including conversations between two or more individuals, e-mails, correspondence and other communications), individuals must ensure, where they are aware of an interest, that they conform to the arrangements confirmed for the management of that interest. Where an individual has not had confirmation of arrangements for managing the interest, they must declare their interest at the earliest possible opportunity in the course of that transaction, and declare that interest as soon as possible thereafter. The individual must also inform either their line manager (in the case of employees), or the Governing Body, of the transaction.

1.5  Managing Conflicts of Interest: Governing Body

1.5.1. Individual members of the Governing Body will comply with the Merton CCG’s policy for managing conflicts of interest or potential conflicts of interest. This policy will be agreed by the Governing Body as a whole in a public meeting where quoracy conditions have been met.

1.5.2. Where a Governing Body member is aware of an interest which has not been declared, either in the register or orally to the Governing Body, they will declare this at the start of the meeting. The Governing Body will then determine how this should be managed and inform the member of their decision. The member will then comply with these arrangements, which must be recorded in the minutes of the meeting.

1.5.3. Where more than 50% of the members of the Governing Body are required to withdraw from a meeting or part of it, owing to the arrangements agreed by the Governing Body for the management of conflicts of interests or potential conflicts of interests, the remaining chair will determine whether or not the discussion can proceed.

1.5.4. In making this decision the chair will consider whether the meeting is quorate, in accordance with the number and balance of membership set out in the Merton CCG’s standing orders/constitution. Where the meeting is not quorate, owing to the absence of certain members, the discussion will be deferred until such time as a quorum can be convened.

1.5.5. Where a quorum cannot be convened from the membership of the Governing Body, owing to the arrangements for managing conflicts of interest or potential conflicts of interests, the chair may invite on a temporary basis one or more of the following to make up the quorum so that the Merton CCG can progress the item of business:

a) a member of the Merton CCG;
b) an individual appointed by a member to act on its behalf in the dealings between it and the Merton CCG;
c) a member of a relevant Health and Wellbeing Board;
d) a member of a Governing Body of another clinical commissioning group.

1.5.6. These arrangements must be recorded in the minutes.

1.6  Managing Conflicts of Interest: contractors

1.6.1. Anyone seeking information in relation to a procurement, or participating in a procurement, or otherwise engaging with the Merton CCG in relation to the potential provision of services or facilities to the Merton CCG, will be required to make a declaration of interest.
1.6.2. Anyone contracted to provide services or facilities directly to the Merton CCG will be subject to the same provisions of this constitution in relation to managing conflicts of interests. This requirement will be set out in the contract for their services.

1.7. Transparency in Procuring Services

1.7.1. The Merton CCG recognises the importance in making decisions about the services it procures in a way that does not call into question the motives behind the procurement decision that has been made. The Merton CCG will procure services in a manner that is open, transparent, non-discriminatory and fair to all potential providers.

1.7.2. The Merton CCG will publish a Procurement Strategy approved by its Governing Body which will ensure that:

a) all relevant clinicians (not just members of the Merton CCG) and potential providers, together with local members of the public, are engaged in the decision-making processes used to procure services;

b) service redesign and procurement processes are conducted in an open, transparent, non-discriminatory and fair way
2. DISPUTE RESOLUTION

2.1 Where disputes arise we would hope that in most cases these could be resolved informally, without recourse to a formal process. If however the dispute cannot be resolved informally, this document sets out the process by which the perceived breach will be handled.

2.2 The design of the procedure is based on the principle that disputes should be resolved at the most local level possible.

2.2.1 The first port of call is the Merton CCG

2.2.2 If the dispute is not successfully resolved at this level, the complaint should then be heard by a The NHS Health and Wellbeing Board.

2.2.3 If the provider is unhappy with the NHS HWB response it should be escalated to the National Commissioning Board.

2.2.4 Subject to being invited by a member practice involved in a dispute, the practice may invite the local LMC to be informally involved.

The CCG is committed to engaging with its members around strategic proposals and developments. However, where a member finds it has a dispute or grievance with the wider CCG as a whole, or its Governing Body or committees to whom it has delegated powers with regard to:

(a) Matters of eligibility or disqualification; or
(b) The interpretation and application of their respective powers and obligations under this Constitution; or
(c) A decision which the CCG has made on behalf of its members; or
(d) Any other relevant matter that the CCG considers fair and equitable to be the subject of a complaint or guidance,

it may follow the dispute procedure outlined in 2.2.5

2.2.5 If the member wishes to raise and issue with the CCG as a whole:

(a) In the first instance, the member may raise such an issue through the elected locality representative on the Governing Body, in writing within 60 days of the issue arising for resolution;
(b) The locality representative on the Governing Body will respond to the member in writing within 30 working days, unless the locality representative is on leave or otherwise away, in which case the Chair can direct any other elected Board member to receive and resolve the issue;
(c) If the locality representative is unable to resolve the issue, the member may formally write to the Chair, or, if the Chair is unavailable, to the statutory vice Chair (lay member), clearly outlining the issues(s) and contact details. The Chair, in conjunction with the Chief Officer where appropriate, will contact the member within 30 working days through the member representative to resolve the dispute;
(d) Where the dispute is unable to be resolved as above in (c), parties may decide, at their own cost, to refer to mediation, the independent third party mediator being appointed by the Centre for Effective Dispute Resolution.

2.3 Objectives of the procedure

2.3.1 The objectives of the procedure are as follows:

• To provide the Merton CCG with an appropriate mechanism for dealing with reasonable disputes
• To resolve disputes transparently, fairly and consistently.
• To assure providers that the process is fair and transparent.
• To mitigate risks and protect the reputation of the Merton CCG
To prevent where possible legal challenge/ expensive external referral processes.

When handling disputes, Merton CCG will:

- Commit to transparency
- Communicate the process and decision making criteria widely and in advance
- Engage all relevant stakeholders
- Enforce declarations of interest
- Publish findings within and across the Merton CCG to enable consistency
- Be objective and base the analysis and the decision on objective information and criteria
- Maintain an audit trail

The Procedure

The Merton CCG dispute resolution procedure is made up of the following stages:

**Stage 1: Making the Complaint**

Any complaint must be submitted to the Chair of the Merton CCG in writing. The complaint will be acknowledged within five working days.

**Stage 2: Triage**

Following the receipt of the complaint, the Merton CCG may get in contact with the complainant at this stage and request clarification or further information. If the complaint is not deemed to warrant proceeding further the complainant is notified that the complaint will not progress.

If the complaint should be fast tracked to another organisation, the claimant is informed of the course of action.

Where the complaint is in scope and not subject to fast tracking, it will proceed to the next stage. In most cases we would envisage that the triage process will be carried out within five working days.

**Stage 3: Chair review**

Following the triage, the Merton CCG Chair will review the complaint to determine whether a swift resolution can be achieved without the need to involve the Governing Body. The Chair may call a meeting of the parties concerned to discuss the matter informally and without prejudice.

**Stage 4: The Governing Body**

If the complaint cannot be resolved by the Chair, the Governing Body will then formally review the complaint and may refer on to the Audit Committee to advise.

**Stage 5: The decision**

Once the Governing Body has made the decision, it will write to the complainant notifying them of the decision, explaining the rationale and necessary the course of action. It will also notify the NHS CCB of the dispute and the outcome.

If the complainant does not believe that the case has been satisfactorily resolved it can appeal. The Governing Body may convene a separate forum to advise on the appeal. In most cases, this stage of the process is expected to take no longer than 20 days.

While the timescales set out for each stage above are illustrative, the process as a whole will take no longer than three months.

**2.5 Right of Appeal**

The expectation is that most complaints will be successfully resolved. However, if the complainant is unsatisfied by the results of this procedure, they can refer the complaint to the NHS CCB process. Appeals to the NHS CCB must be made within 3 months of the complainant being informed of the Merton CCG’s decision.
Appendix 8
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 Merton 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 (see Appendix [x] of the Constitution).

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 Authority, 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 make provision for the appointment of committees and sub-committees of its governing body. Where such committees and sub-committees of the CCG, or committees and sub-committees of its governing body, are appointed they are included in Chapter 6 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, the CCG shall determine the membership and terms of reference of committees and sub-committees and shall, if it requires, receive and consider reports of such committees at the next appropriate meeting of the CCG.

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 an appendix.

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 including those the governing body. 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:
18.9.12

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 Merton 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 9
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 found at Appendix [x].

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/MertonClinicalCommissioningGroup.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 Authority 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 Authority 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 Authority;

   b) ensure money drawn from the NHS Commissioning Board Authority 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 Authority.

6. **ALLOTMENTS**

6.1. The CCG’s Chief Finance Officer will:

   a) periodically review the basis and assumptions used by the NHS Commissioning Board Authority 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**

**POLICY** – 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.

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 Authority 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 Authority 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 Authority.

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

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

   e) publishes the external auditor’s management letter on the CCG’s website at http://www.southwestlondon.nhs.uk/About/clinicalcommissioninggroups/Pages/MertonClinicalCommissioningGroup.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 Authority;

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 Authority 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 Authority 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 Authority, 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.
* Admin Support will be provided to all staff as necessary. Dedicated support will be provided to senior staff including the Chief Officer, Chair, Director of Commissioning and Planning and Head of Clinical Commissioning.
Draft MCCG Org Structure – Excluding CSS / Shared Resources

**Key**
- Team Names
- MCCG Resource
- MCCG Clinical Resource

**MCCG Delivery Team**
- Chief Officer (1 WTE/VSM)
- Executive Assistant (1 WTE/Band 6)
- Business Support 2 WTE PA’s (Band 5) and 1 WTE Band 4

**MCCG Board**
- Chair (0.6 WTE/VSM)
- CFO (1 WTE/VSM)
- Secondary Care Consultant (0.1 WTE/Band 9)
- Lay Person - Audit Committee (0.1 WTE/Band 9)
- GP 1 (0.2 WTE/Band 9)
- GP 2 (0.2 WTE/Band 9)
- Registered Nurse (0.1 WTE/Band 9)
- Local Mental Health Commissioning Manager (0.5 WTE/Band 8a)

**MCCG Resource Team Names**
- MCCG Clinical Resource
- MCCG Board

*Admin Support will be provided to all staff as necessary. Dedicated support will be provided to senior staff including the Chief Officer, Chair, Director of Commissioning and Planning and Head of Clinical Commissioning.*
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And

Framework for a Service Level Agreement

To describe the relationship between

South London Commissioning Support Unit

and

Merton Clinical Commissioning Group
Memorandum of Understanding

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Memorandum of Understanding

1 Introduction

1.1 Context

The South London Commissioning Support Service (CSU) and the emerging Merton Clinical Commissioning Group (CCG) have been working together to develop arrangements for commissioning support during 2012/2013, and post authorisation, whilst recognising that during 2012/13 NHS Sutton & Merton Primary Care Trust remains the accountable body.

In order to support CCGs as they prepare for authorisation, and to support the development of the CSU in such a way as to meet its own authorisation requirements, it is expected that this Memorandum of Understanding (MoU) describes in sufficient detail the proposed offer of the CSU to meet both organisations’ needs at this stage. It also recognises a shared commitment to co-develop the detail required to conclude a robust Service Level Agreement (SLA) by October 2012. This MoU and subsequent SLA will govern the relationship between the two organisations, as they work in shadow form until March 2013, and from April 2013 onwards.

It is important to recognise that this is new territory for both the CCG and the CSU. This MoU describes the intended principles and content expected to be reflected in the SLA. Both parties will be as specific as they can be during the development of the SLA.

In order for the CCG and the CSU to demonstrate that sustainable plans for commissioning support are in place to support authorisation, the parties agree to a four year partnership (transition year plus three years, with the possibility of further extension) that will be further described and developed during 2012/13 and reassessed on an annual basis, subject to the termination arrangements described in this document.

1.2 Mutual intentions underlying this Agreement

- The CSU recognises and appreciates the importance of having the CCG as one of its key customers, who are seen as critical to the future success of the CSU. In the same way, the CCG recognises the importance to it of the successful development of the CSU. The CSU and the CCG view this relationship as a collaboration that will help build two successful new organisations.
- The support provided through the services listed in this Agreement is seen as an important part of the authorisation process for the CCG. The CSU commits to supporting the CCG throughout this authorisation process.
- To enable the CSU to deliver services effectively the CCG commits to engaging constructively with the CSU to help improve services as both organisations develop.
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1.3 Objectives of development of the relationship of between the CSU and the CCG

- The shared objective of both parties is to secure high quality commissioning support services, supporting the CCG in commissioning the best possible health care services for the residents of Merton within the available budget.
- The cooperation defined in this MoU will help achieve this objective, by allowing the CCG to get best value for its commissioning budget through economies of scale the CSU can offer, and by helping the CCG access additional expertise, technical skills and infrastructure. This will allow the CCG to focus on core strategic commissioning decisions and exercising clinical leadership.
- The CSU regards the CCG as one of the foundation customers for its business. The benefits and implications of this are outlined in Schedule 4 ‘South London CCG and South London Commissioning Support Unit Organisational Development narrative to support authorisation V3.1 (21/8/12)’
- The CSU commits to working with the CCG to ensure a long-term financially sustainable offer. The CSU will be transparent about what it costs to provide services to the CCGs, but must retain a margin on top of costs so as to invest in improving services and developing new products.

1.4 Learning process as part of initial cooperation

- Both parties recognise that 2012/13 will be a period of learning for both the CCG and the CSU. They agree to work closely together to ensure the learning process will be as constructive as possible.
- The CSU commits to collaborating with the CCG to refine commissioning support services year on year to meet the CCG’s commissioning support needs, as both organisations and the environment in which they operate evolve.

1.5 Process going forward

- Both parties recognise that during 2012/13 the new commissioning system is developing. Both parties therefore agree to cooperate closely and agree to be guided by the principles and spirit of this MoU.
- During 2012/13, the CSU will support the CCG in their commissioning and their related processes to achieve authorisation. The parties will meet regularly to evaluate progress during this time of development.
- The CSU and CCG will work together between April 2012 and October 2012 to refine and detail specific elements to be included in the SLA, including defining Key Performance Indicators and any additional services to be incorporated.
- The CSU and CCG will meet formally in or before October 2012 to conclude the Service Level Agreement, including:
  - KPIs
  - Delivery model for the services
  - Performance management arrangements
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- Any additional services to be included in the offer and the charge for these

- It is anticipated that by October 2012, the key leadership team and other staff in the CSU will be in post and the delivery of services to CCGs will have started. However, whilst every effort will be made to ensure the new CSU organisation is operational by October 2012, it is unlikely that all staff and infrastructure will be in place until subsequent months. Similarly it is unlikely that all CCG staff will be in post. The period to March 2013 will be one of intense development. During this period, both parties will aim to operate as far as possible to the standard set in the SLA, although the formal SLA will not be effective until April 2013.

- The next formal review point (after October 2012) will be in February / March 2013, in which both parties will finalise the thresholds to be set on the KPIs and the handling of performance issues. After this, the SLA will be reviewed on an annual basis.

- The timescales outlined in this MoU are based on the current understanding of future developments within the national system. Both parties recognise that any changes to this may impact the time lines and therefore require an update to this MoU.

- It is possible that the NHS Commissioning Board will define mandatory national services in specific areas, which may require reassessment of specific CSU services.

- This agreement, and the subsequent SLA, may be superseded in the future by a national model contract but it is anticipated that the core content will remain the same.

2 Outline of Terms and Conditions agreed

2.1 Introduction

The CSU is the commissioning support function created through a partnership of the clusters of South East London and South West London, set up to support clinical commissioning groups (and other customers).

The CSU will work closely with the CCG in the transition period until April 2013. This collaboration will be underpinned by this MoU and subsequent SLA that makes explicit what the relationship and deliverables will be in practice.

This MoU outlines

- key relationships and contacts
- the services to be provided, set out in section 3
- the operating model, set out in section 4
- the agreed pricing, set out in section 5
- the performance management approach, set out in section 6 and the overall governance approach, set out in section 7, including escalation procedures if either party is not happy with the execution of the MoU.

The operating model and the performance management sections of this MoU may be revised as needed in October 2012 as part of the SLA.
2.2 **Duration**

This agreement shall be valid until it is superseded by a formal SLA. It is anticipated that the SLA will be effective from April 2013 and valid until March 2016. It will be reviewed regularly and formally on an annual basis.

2.3 **Variations**

Additional areas of commissioning support can be added over the period of this MoU and the subsequent SLA. These will be mutually agreed and will be formally appended to any agreement as a variation. CCGs will be able to give notice on areas of commissioning support in accordance with the terms of the notice of the SLA.

2.4 **Terms and termination**

This agreement and the subsequent SLA will remain valid unless superseded by a revised agreement mutually endorsed by both parties.

The MoU and subsequent SLA will outline the parameters of all services covered as they are mutually understood by both parties as set out in section 3 and Schedule 2.

The CCG and the CSU recognise the importance to both of the stability and sustainability of commissioning support services. The CCG needs to balance this with retaining appropriate flexibility. The CSU and the CCG have therefore agreed that this MoU, and the subsequent SLA, may be terminated in whole or in part by either of the parties prior to the formal expiry date, subject to giving notice in writing, as follows:

a) for the core services and for ICT for Primary Care services – twelve months’ notice

b) for enhanced services – six months’ notice.

In addition, a process for partial or complete termination as a consequence of performance issues is outlined separately in section 5, performance management.

The SLA will be automatically renewed on an annual basis after the initial contract period of three years, unless either party requests a contract renegotiation at least 12 months prior to the contract expiry date.

2.5 **Lead Contacts in relation to the MoU**

The key contacts in relation to this MoU are:

For the CSU: Nick Relph, Interim Managing Director

For the CCG:
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2.6 Previous agreement

This MoU supersedes the Memorandum of Understanding between the parties dated 29th March 2012.

3 Services to be provided

3.1 Commissioning priorities for Merton CCG

The CSU will support the CCG in delivering its commissioning plans and priorities, through the delivery of the services outlined in this section. The CCGs vision, values and commissioning intentions are included in Schedule 1.

3.2 Provision of Core Services

This paragraph lists the portfolio of services the CSU will provide to the CCG as part of the Core Service offering (the “Core Services”). More detailed service descriptions are set out in Schedule 2.

- Acute contract management (including quality)
- Individual Funding Requests (IFR) management
- Provider Performance Management
- Advice & Support on Clinical Procurement
- Performance and activity reporting and analysis
- Financial Governance & Control, Counter Fraud
- Financial Management and Planning
- Estates and health and safety
- Human Resources and organisational development
- Purchasing (non-clinical)
- ICT Support
- Communications and Engagement

3.3 Customised agreement

The parties recognise that some customisation of these services may be required to meet the specific needs of the CCG and that further work may be required to define this.

3.4 Enhanced Services

In addition to the Core Services, the CSU will offer the CCG additional services (the “Enhanced Services”). The CSU and CCG are still in the process of developing the detail for these additional services and expect to
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reach firm agreement by October 2012.

For continuing care, recognising that CCGs have concerns about the affordability of the service offer as currently described, the CSU will organise a workshop with CCGs buying this service during early September, to discuss the delivery model and associated price for this service. If the CSU is not able to agree a service offer at a price that CCGs feel they can afford by 30 September 2012, CCGs reserve the right to not take this service offering. For Merton CCG the same applies to the enhanced governance offer and resolution on the same basis is required.

We recognise that the funding for commissioning Primary Care ICT services has not yet been confirmed by the NHS CB. Given this uncertainty, our commitment to you is that if the eventual allocation of funds does not cover our prices, we will work with you to reduce costs to the funded level within a twelve month period (or if possible before the end of the 2012/13 year). In the meantime, the CSU will be transferring in the staff and contracts necessary to maintain and improve the current services and we do need your support for this part of our business.

4 Operating model

4.1 A mixed delivery model

This section describes the planned operating model for the delivery of CSU services. Whilst this represents the current position, the parties acknowledge that this may vary from time to time to ensure that services are delivered effectively and efficiently.

The CSU will deliver its services to the CCG through a mix of local dedicated staff, multi-disciplinary teams working across a number of CCGs, based locally, and some centralised resources. This allows for the service provision both to reflect local needs and to benefit from the economies of scale and skill that the CSU is set up to deliver.

4.2 Dedicated local staff

Details of staff dedicated to the CCG and their physical location will be identified as part of the October 2012 SLA. Where CSU staff are based with CCGs and accommodation costs for those staff are already included in our service prices, we will refund a fair allowance for these costs to a maximum of the figure included in our business plan.

4.3 Staff teams working across a number of CCGs

Some CSU staff will be based in multi-disciplinary teams supporting a group of CCGs. The multi-disciplinary team is likely to consist of staff working on:

- Acute contract Management (including quality)
- Individual Funding Requests
- Provider Performance Management
- Performance and activity reporting and analysis
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- Financial management, in relation to the above

4.4 Central support

There are some functions which are best delivered centrally, once only to deliver maximum effectiveness and Value for Money. These are likely to include:

- IT infrastructure
- HR services
- Invoicing and payroll
- Procurement
- Accounting and financial management

4.5 Roles of Account Directors and Account Managers

Each CCG will have:

- One named Board Level Director of SL CSU to be the accountable person for delivery of the totality of their commissioning support offer, known as the **Account Director**
- A relationship managers who will be based locally to ensure for accessibility, known as the **Account Manager**
- **Named contacts** – for each service who will respond to day to day issues

Nominated Account Directors and Account Managers will attend CCG meetings to oversee the delivery and performance of the SLCSU services.

The CCG will identify a named officer (the “Nominated Officer”) to lead on matters relating to the contract with the CSU, including monthly performance meetings.

5 Pricing

5.1 Total price for the core offer

Subject to agreement of the SLA, the CSU will provide the CCG with the Core Services and the Enhanced Services described in Section 3 for the price set out in Schedule 3. At this stage, this is an indicative sum, at 2012/13 prices, and may be subject to change as service development and SLA negotiations proceed. The CSU has committed to a core package price set in April 2012.

This pricing will be revised on an annual basis, based on inflation, mutually agreed changes to the service delivery, changes to national policies and regulations and other factors influencing the costs to the CSU.
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Payment will be monthly in advance, subject to any NHS CBA guidance on the financial regime for commissioning support units.

6 Performance management

6.1 Introduction

Performance management by the CCGs of the CSU will comprise a range of measures, which are outlined below and which will be detailed in the October 2012 SLA.

6.2 CSU performance assessment survey

As an overarching method of collecting qualitative feedback, the CSU will send out a regular performance assessment survey to the CCG, to be filled out by key people in the CCG, including the Chair and Accountable Officer. It will be co-designed to ensure it is effective, but does not become an unhelpful burden on CCG time. This survey will be a key input to quarterly performance reviews.

This survey will be used to evaluate the qualitative aspects of the CSU services rather than quantitative benchmarks.

The CSU will consolidate the responses, and communicate them back to the CCG as an integral component of the performance report. Any areas that are 'red' or 'amber' will be addressed in the quarterly performance review.

The survey will be co-developed with CCGs and used to inform the priority areas for improvement.

6.3 Key performance indicators by service line

In addition to the CSU performance assessment survey, the CSU will measure its performance on a set of key performance indicators by service line and communicate this back to the CCG on a regular basis. These will be introduced on a trial basis in the period from October 2012 to March 2013. The draft KPIs are set out in Schedule 2.

By April 2013, the CCG and CSU will agree on the target performance levels for these KPIs and the consequences of meeting, exceeding or not meeting these levels.

6.4 Monitoring & review process

The monitoring process for this MoU and subsequent SLA is as follows:

- Monthly (or at different frequency as mutually agreed) – The CCG Nominated Officer and the Account Manager will meet to discuss the overall development of support from the CSU. They will specifically address any performance issues raised with the Account Manager and
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any the KPIs that are below the agreed threshold. The CCG and the CSU will agree on an approach to address any performance issues.

- **Quarterly** – The CCG Nominated Officer, the CCG Accountable Officer (if different), the Account Manager and the Account Director will meet to discuss the overall performance and development of support from the CSU, discuss the results of the performance assessment survey and to address any performance issues previously raised in the monthly reviews.

- **Annually** - The CCG Nominated Officer, the CCG Accountable Officer (if different), the Account Manager and the Account Director will meet to discuss the following topics:
  
  - Evaluation of last year’s cooperation and key areas for attention next year.
  - Any adjustments to the details in the SLA for next year, in terms of services included in the SLA, pricing, the operating model and/or adjustments to the performance management system.

### 6.5 Management, escalation & remediation process

There is a responsibility on both parties to support delivery in line with the specification. If this is not the case, this should be raised with the relevant service delivery lead. All reasonable endeavours at a local level will be completed before escalation to the next stage. The proposed escalation procedure for matters not dealt with in this way, or resolved as part of the monitoring process described in paragraph 6.4, is as outlined below:

- **Stage 1 – escalation to Account Manager**: An issue of material concern should be stated clearly, confirmed by email or letter, to the CCG’s Account Manager. The Account Manager will convene a resolution meeting if needed, investigate the concern and formally respond to the CCG within [3] working days.

- **Stage 2 – escalation to CSU Account Director**: If the matter has not been satisfactorily resolved, or is not being satisfactorily addressed, the Account Manager and CCG will jointly agree that it should be escalated to the Account Director of the CSU for resolution, who will review the concern from the CCG, the investigation and attempts at resolution to date, meet with the CCG if necessary and formally respond to the CCG within a further [5] working days.

- **Stage 3 – agreement of an improvement plan for performance issues**: If performance issues cannot be resolved there will be an agreement of a specific and agreed improvement plan within a further [10] working days and joint monitoring that will be in place until the performance has improved.

- **Stage 4 – dedicated delivery improvement team**: Where the performance has failed to improve following the improvement plan and joint monitoring a commitment of a dedicated delivery improvement team
Memorandum of Understanding

funded by the CSU may be put in place to resolve the issue within [90] working days following implementation of the improvement plan.

- **Stage 5 – market test** – The CCG may ultimately decide to tender either the specific service or the full service offering, in line with national policy if a resolution cannot be reached.

7 Governance

7.1 Overall communication between both parties

The named Account Manager for the CCG will be single point of contact for the integral portfolio of services, and will work with the CCG to ensure the CSU support meets the CCG’s needs. For daily operations, the CCG will communicate directly with the CSU service leads responsible for delivery of the service. These service leads will be identified as the CSU appoints staff to key posts during the period to October.

The CCG will identify named leads to work with the CSU on a transactional basis, for example, around troubleshooting operational IT issues.

In case of any issues that cannot be resolved as part of daily operations, the escalation process outlined in section 6.5 will apply.

7.2 CSU business strategy and development

The CSU and the South London CCGs will establish a Strategic Advisory Group to advise the CSU management team on strategic direction and on priorities for investment, innovation and service development, as set out in the recommendations of the July/August 2012 working group (Schedule 4).

7.3 Roles and Responsibilities

In addition to the specific responsibilities for the individual services as defined in Section 3 and Schedule 2, the CSU and CCG commit to meeting their responsibilities as part of this partnership, as set out below:

**Commissioning Support Service**

The CSU commits to working with the CCG in a way that is appropriate to the CCG and meets its needs.

The specific responsibilities of the CSU in the delivery of services have been outlined by service in Schedule 2.

In addition to these responsibilities with respect to the service delivery, the CSU sees the following as its overarching responsibilities:
Memorandum of Understanding

- Support delivery of CCG priorities, Commissioning Plan and financial management.
- Work with the CCG to ensure the support agreed as part of this MoU is part of an overall delivery model that will enable the CCG to achieve its objectives.
- Work closely with CCG leads in the delivery of all CSU services, and in particular those related to contract negotiation and provider performance management, so that the CCG maintains the provider relationship and clinical leadership.
- Engage with the CCG on an ongoing basis on any issues or concerns that may arise as we support the CCG, and agree how these will be addressed.
- Look beyond the CSU’ direct responsibilities defined in this MoU and subsequent SLA and be a strategic partner to the CCG, using the CSU’ understanding of the overall health system to provide the CCG with advice when asked to, and proactively raise matters for attention.
- Provide the CCG with advice and support where possible in the CCG’s interactions with other stakeholders in the national health system, such as the National Commissioning Board and local authorities – the CSU sees supporting the CCG in the process to authorisation as a crucial first step in this.
- Work to agreed deadlines, and ensure we agree on clear deadlines where these are not already in place as part of standard service delivery.
- Incorporate feedback received from the CCGs in the regular performance reviews, and address performance issues as a key CSU priority.

The Clinical Commissioning Group

For the Commissioning Support Service to be able to deliver the services covered within the MoU effectively, both parties will have to work closely together. The specific responsibilities the CCG has in the delivery of the specific services are outlined in Schedule 1. In addition to that, the CCG agrees it has the following overarching responsibilities to support effective co-operation with the CSU:

- Provide the CSU with clarity on its priorities – on an annual basis, and as they change throughout the year, so finite resources can be allocated optimally.
- Provide the CSU with access to all data sources relevant (subject to Information Governance protocols) for the support functions they are providing through data sharing agreements.
- Provide the CSU with sufficient access to lead contacts who will work with the CSU on effective service delivery.
- Engage the CSU as early as possible in any relevant stakeholder engagements that will require some form of CSU support (such as financial reports).
- Coordinate with the CSU on communication towards the providers and other relevant stakeholders, to appear as ‘one united team’.
- Directly inform the CSU of any matters that may impact the services provided by the CSU, for instances incidents that will translate into high media attention.
Memorandum of Understanding

- Provide the CSU with regular and constructive feedback on the service delivery as agreed in the performance management section, and in case of performance issues, work with the CSU on resolving this issue as part of a trust based partnership.
Memorandum of Understanding

8 Signatures

Signed on behalf of South London Commissioning Support Services

Name: Nick Relph
Role: Managing Director
Signature: ________________________________
Date: ________________________________

Signed on behalf of Merton Clinical Commissioning Group

Name:
Role:
Signature: ________________________________
Date: ________________________________
South West London Clinical Commissioning Groups

Memorandum of Understanding
August 2012
Memorandum of Understanding

Purpose of document

This memorandum of understanding (MOU) and lays out the framework for relationships, roles and responsibilities between South West London Clinical Commissioning Groups (SWL CCGs) including Croydon CCG, Kingston CCG, Merton CCG, Richmond CCG, Sutton CCG and Wandsworth CCG. The SWL CCGs have identified a number of areas where they wish to collaborate to support effective clinical commissioning to improve quality, outcomes and value for money for their residents.

Context

Clinical leaders have agreed to a model for commissioning support that;

- Ensures commissioning resources are predominantly locally based, for example each CCG will retain local lead commissioners for both acute and non-acute commissioning as well as support to develop local CCG strategy, QIPP and service re-design work

- A common set of commissioning support functions purchased from South London Commissioning Support Unit (SL CSU)

- Identified a small set of areas where CCGs wish to collaborate, i.e. bring together, co-ordinate and align existing resources to support clinical commissioning.

The diagram below summarises the model for commissioning support. This MOU should be read alongside the South West London Framework for Collaboration, which describes in greater detail how the model for commissioning support will work in practice.
The document is structured to include the following:

1. General commitments.
2. Acute commissioning.
3. Mental health.
4. Out of hospital.
5. Continuing health care.
General Commitments

Clinical commissioning will be owned, provided and led by each individual CCG.

To support the collaborative activities identified in the framework for collaboration, each CCG will;

- Play an equal and active part in the proposed SWL CCG strategy group, accountable officers’ group, operational networks, and other collaborative fora that emerge.
- Take responsibility for chairing and organising the above named fora for six months on a rolling basis
- Commit to sharing information including annual needs analysis and CSP, strategy, QIPP and operating plans to facilitate the identification of common goals and alignment of strategic priorities
Acute Commissioning

The model for commissioning support assumes that, as with all areas of commissioning, acute commissioning will be owned, provided and led by the CCG. The SWL CCGs have agreed “host commissioner” responsibilities for all Trusts which are geographically located within the CCG, liaising closely with the other CCGs to ensure that all CCGs achieve maximum leverage across all Trusts. The South London CSU will provide contracting, performance management and transactional support to the annual commissioning cycle.

The table below sets out the current host commissioning responsibilities and associate CCGs across both South West London Trusts and other Out of Sector Trusts which are important to SWL CCGs. An associate CCG is defined as any other CCG with an interest in a particular provider.

<table>
<thead>
<tr>
<th>Provider</th>
<th>Host CCGs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>In-sector Trusts</strong></td>
<td></td>
</tr>
<tr>
<td>Kingston Hospital NHS Trust</td>
<td>Kingston CCG</td>
</tr>
<tr>
<td>SWL &amp; St George’s Mental Health Trust</td>
<td>Kingston CCG</td>
</tr>
<tr>
<td>St George’s Healthcare NHS Trust</td>
<td>Wandsworth CCG</td>
</tr>
<tr>
<td>St George’s Healthcare NHS Trust (Queen Mary Roehampton)</td>
<td>Wandsworth CCG</td>
</tr>
<tr>
<td>Croydon University Hospital (Croydon Health Services NHS Trust)</td>
<td>Croydon CCG</td>
</tr>
<tr>
<td>Epsom and St Helier University Hospitals NHS Trust</td>
<td>Sutton CCG</td>
</tr>
<tr>
<td>Epsom and St Helier University Hospitals NHS Trust (SWLEOC)</td>
<td>Sutton CCG</td>
</tr>
<tr>
<td>Royal Marsden</td>
<td>Possibly hosted jointly between Sutton and Merton - currently under discussion</td>
</tr>
<tr>
<td><strong>Out of Sector Trusts</strong></td>
<td></td>
</tr>
<tr>
<td>Imperial College Healthcare NHS Trust</td>
<td>Hammersmith and Fulham CCG</td>
</tr>
<tr>
<td>West Middlesex University Hospital NHS Trust</td>
<td>Hounslow CCG</td>
</tr>
<tr>
<td>Chelsea &amp; Westminster Hospital</td>
<td>Kensington &amp; Chelsea CCG</td>
</tr>
<tr>
<td>Royal Brompton Hospital</td>
<td>Kensington &amp; Chelsea CCG</td>
</tr>
<tr>
<td>Kings College Hospital</td>
<td>Southwark CCG</td>
</tr>
<tr>
<td>Guys &amp; St Thomas’s FT</td>
<td>Southwark CCG</td>
</tr>
<tr>
<td>Moorefield’s</td>
<td>Islington CCG</td>
</tr>
</tbody>
</table>

Host CCGs will:

- Collate and aggregate individual CCG commissioning intentions and develop Trust wide commissioning intentions, set direction and agree negotiating lines.

- Lead on contract negotiations for host Trust, agree final terms and conditions after due consultation with associate CCGs.

- Manage the performance against contract, undertake clinical audits and report back to associate CCGs on a regular basis on agreed KPIs.

- Consult with associate CCGs to agree pro-active management action to rectify performance or variances to plan.
• Co-ordinate clinical dialogue on investment and disinvestment in services. Sign-off decisions and monitor and review outcomes, reporting back to associate CCGs.

• Collate and aggregate QIPP and CQUIN schemes for all SWL CCGs. Align priorities and agree collective negotiating priorities. Present schemes to provider.

• Lead negotiations with Trust on in-year financial settlement, taking into account individual associate CCG concerns.

• Chair the monthly Clinical Quality Review Group (CQRG).

• Oversee Serious Incident (SI) reviews and ensure sign-off with National Commissioning Board (NCB)

**Associate CCGs will:**

• Be responsible for co-ordinating the monitoring and management of the CCG’s total acute portfolio.

• Provide local clinical expertise, for example in the completion of clinical audits, review of care pathways and medicines management.

• Work collaboratively with other CCGs to align priorities and agree collective negotiation strategies with provider Trusts to support the achievement of better outcomes, improved quality and value for money.

• Share CCG commissioning intentions and service re-design priorities to identify areas of common interest and difference.

• Support contract negotiation meetings and provide information to host commissioner and other SWL CCGs on a timely basis.

• Support the Trust performance management process.

• Where individual CCGs have specific performance issues pertaining to their own CCG, it is expected that that CCG will hold one-to-one dialogue with the Trust. Associate CCGs will follow protocol to inform both the host and other CCGs.

• Share individual CCGs views on investment and disinvestment with host commissioner and SWL CCGs on a timely basis.

• Share QIPP and CQUIN schemes with host commissioner and other SWL CCGs on a timely basis.

• Provide clinical expertise to support Serious Untoward Incidents.

• Play an active part in Trust clinical for a including Clinical Reference Group, Clinical Quality and Review Groups and Clinical Integrated Governance Committee.
Mental Health Commissioning

The model for collaborative working assumes that, as with all areas of commissioning, mental health commissioning will be owned, provided and led by the Clinical Commissioning Groups. SWL CCGs have nominated Kingston CCG to act as host commissioner for health services commissioned from South West London St George’s Mental Health Trust (SWLSTG MH) on behalf of associate CCGs including Merton, Richmond, Sutton and Wandsworth CCGs. Separate arrangements will be put in place to support Croydon CCG and South London and the Maudsley NHS Foundation Trust (SLAM).

The contract management and transactional support to deliver mental health clinical commissioning will be provided by the SL CSS. A summary of key roles and responsibilities is set out below.

Host Commissioner – Kingston CCG will:

- Provide managerial and clinical leadership to the negotiation of the South West London and St George’s Mental Health Trust (SWLSTG) contract, ensuring the views of Kingston, Merton, Richmond, Sutton and Wandsworth are fairly represented.
- To work with the NHS Commissioning Board on the FT application process for SWLSTG ensuring that the views of Kingston, Merton, Richmond, Sutton and Wandsworth are fairly represented.
- Collate and aggregate commissioning plans and intentions to support and facilitate the development of a joint mental health strategy for SLWSTG agreed between Kingston, Merton, Richmond, Sutton and Wandsworth.
- Provide clinical leadership on agreed mental health work streams and strategy (SWLSTG).
- Provide clinical governance leadership to the SWLSTG’s contact.
- Contribute to the development of, Kingston, Merton, Wandsworth and Sutton CCG commissioning plans and intentions for mental health commissioning. Support and administrate SWLSTG’S Clinical Quality Review Group.
- Lead contract and performance meetings with SWLSTG.
- Lead on relationship management with the South London Commissioning Support Unit (SL CSU), including performance managing SL CSU contract management support, providing regular reports to associate CCGs.

Kingston Merton, Richmond, Sutton and Wandsworth CCGs will:

- Provide mental health clinical leadership at local level to support, facilitate and advise local health and social care integrated mental health commissioning.
- Lead local planning, service design and integration of local CCG and SW London CCG wide mental health strategy.
- Consider and review implications of local performance data.
- Lead local borough performance reviews.
- Provide local perspective into contract requirements.
- Support the SL CSU performance management process.
Resources

The resources required to deliver this MOU are as follows:

- The host CCG will take on the financial stewardship of this resource.
- The resource will be divided equally between the host CCG and the four associate CCGs.
- Recharge by Kingston CCG to all four associate CCGs will be on the basis of per head of total population as follows:

<table>
<thead>
<tr>
<th>CCG</th>
<th>Population</th>
<th>Total Contribution (£)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kingston CCG</td>
<td>196,000</td>
<td>22,523</td>
</tr>
<tr>
<td>Merton CCG</td>
<td>206,000</td>
<td>23,672</td>
</tr>
<tr>
<td>Richmond CCG</td>
<td>192,400</td>
<td>22,109</td>
</tr>
<tr>
<td>Sutton CCG</td>
<td>186,400</td>
<td>21,419</td>
</tr>
<tr>
<td>Wandsworth CCG</td>
<td>324,400</td>
<td>37,277</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,457,600</strong></td>
<td><strong>£127,000</strong></td>
</tr>
</tbody>
</table>

- Individual CCGs will need to ensure adequate resources are allocated to Mental Health Commissioning Management and Clinical Leadership to deliver local CCG functions.

Terms of this agreement

The length of this agreement and the specific arrangements for terminating the relationship will be agreed by the CCGs. It is expected that the terms of the agreement will be aligned to those for other commissioning support for example, services provided by the SL CSU.
Continuing healthcare

The SW CCGs are proposing a hub and spoke model that covers Croydon, Merton, Richmond, Sutton and Wandsworth CCGs. Kingston CCG are pursuing separate arrangements in partnership with their local authority.

The hub, a centralised commissioning and support service for continuing health care will be provided by SL CSS, with each of the five CCGs retaining locally based clinical leadership and clinical assessor roles.

Each CCG will:

- Have statutory responsibility for the provision, quality and cost effectiveness of continuing healthcare services,
- Be responsible for ensuring appropriate safeguarding, clinical governance and quality assurance arrangements are in place,
- Have local lead nurses and nurse assessors based within the CCG responsible for managing relationships with GPs and providers, undertaking reviews for all patients, safeguarding investigations and ensuring patients are placed appropriately.

Wandsworth and Richmond and Sutton and Merton CCGs each will:

- Share Lead Nurse posts and their role will be to provide clinical leadership to support safeguarding, commissioning development, oversee serious incident reporting and complaints.

Out of Hospital Network

In recognition of the common goals and aspiration of moving care out of hospital and closer to home it is proposed that a network of the local commissioners and lead clinicians with responsibility for out of hospital care is established in order to facilitate local collaboration. A summary of the roles and responsibilities is summarised below.

Each CCG will:

- Play an active and equal part in the network, nominating both GP and managerial support.
- Each CCG commits to ensuring consistent membership of the group and regular attendance at quarterly meetings.
- Commit to share information and best practice e.g. on service re-design pathways.
- Agree to take responsibility for chairing and organising the group on a rolling six monthly basis.

Merton CCG will

- Lead on establishing the Out of Hospital Network and act as chair for the initial period from September 2012.
- Commit to leading a process to review the impact of the group after six months i.e. April 2013 and reporting progress to the accountable officers’ group.

Strategy Contingency Fund

SWL CCGs have agreed to create a joint strategy contingency fund, totalling £300,000 to address strategic issues that are common to all six CCGs.
Each CCG will:

- Commit to contributing the amount listed below, based on capitation and from CCG running costs.

<table>
<thead>
<tr>
<th>CCG</th>
<th>Population</th>
<th>Total Contribution (£)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Croydon CCG</td>
<td>352,400</td>
<td>72,530</td>
</tr>
<tr>
<td>Kingston CCG</td>
<td>196,000</td>
<td>40,340</td>
</tr>
<tr>
<td>Merton CCG</td>
<td>206,000</td>
<td>42,398</td>
</tr>
<tr>
<td>Richmond CCG</td>
<td>192,400</td>
<td>39,599</td>
</tr>
<tr>
<td>Sutton CCG</td>
<td>186,400</td>
<td>38,364</td>
</tr>
<tr>
<td>Wandsworth CCG</td>
<td>324,400</td>
<td>66,767</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,457,600</strong></td>
<td><strong>300,000</strong></td>
</tr>
</tbody>
</table>

- Agree to adhere to the criteria and decision-making process for deploying the fund as set out in the framework for collaboration

Wandsworth CCG will;

- Act as the accountable body for the strategy contingency fund, with overall responsibility for managing the fund in line with audit rules.

- Provide reports on planned and actual spend and to the SWL CCG Strategy Group and accountable officers’ group as required.
Signatures

Croydon CCG
Signed ..............................................................................................................................................

Kingston CCG
Signed ..............................................................................................................................................

Merton CCG
Signed ..............................................................................................................................................

Richmond CCG
Signed ..............................................................................................................................................

Sutton CCG
Signed ..............................................................................................................................................

Wandsworth CCG
Signed ..............................................................................................................................................
South West London Clinical Commissioning Groups

Framework for collaboration
June 2012
This document describes a framework for Clinical Commissioning Groups (CCGs) in South West London to collaborate to support effective clinical commissioning. It includes the following specific sections:

Section 1: Introduction and context 1
Section 2: Agreed principles of collaboration 5
Section 3: Mechanisms for collaboration 7
Section 4: Collaborating in acute commissioning 9
Section 5: Collaborating in non-acute commissioning 13
Section 5.1: Model for mental health commissioning support 13
Section 5.2: Continuing Healthcare 16
Section 5.3: Out of Hospital Care 18
Section 6: Strategy, business planning an organisational performance 20
Section 7.0: Risk Sharing 23

Appendix 1: Mechanisms for collaboration 1
Section 1: Introduction and context

South West London comprise the following 6 CCGs,

- Croydon CCG
- Kingston CCG
- Merton CCG
- Richmond CCG
- Sutton CCG
- Wandsworth CCG

Over recent months clinical leaders, managing directors and senior managers have been working together, through a series of collaborative workshops, to design clinical commissioning support arrangements for CCGs in south west London. In defining clinical commissioning support arrangements CCGs have considered what they want to build (within local CCGs) buy (purchase from a Commissioning Support Organisation or elsewhere) and share (share roles or functions between CCGs) across the spectrum of commissioning support functions.
Design principles

In appraising the options, all CCGs have held a common goal to ensure that where possible, commissioning support is ‘local’ to CCGs and where needed SWL CCGs will collaborate to improve outcomes, quality and value for money in the services that they commission. The CCGs agreed the following design principles to inform the development of the model for commissioning support.

- Where possible commissioning support should remain local to each CCG
- Proposed arrangements are affordable within the current operating framework costs
- Supports the authorisation process and enables CCGs to become established
- Provides continuity and stability throughout transition
- Arrangements are resilient and sustainable
- The model is flexible, enabling CCGs to
  - tailor commissioning support to meet local requirements
  - meet requirements for 2012/2013 and is able to adapt to new world in 2013/2014
  - meet the increasing requirements placed upon CCGs for primary care improvement
  - supports and enables joint working with local authorities

South West London CCGs model for commissioning support arrangements

Clinical leaders have agreed to a model for commissioning support that;

- Ensures commissioning resources are predominantly locally based, for example each CCG will retain local lead commissioners for both acute and non-acute commissioning as well as support to develop local CCG strategy, QIPP and service re-design work
- A common set of commissioning support functions purchased from South London Commissioning Support Services (SL CSS)
- Identified a small set of areas where CCGs wish to collaborate, i.e. bring together, co-ordinate and align existing resources to support clinical commissioning.

The diagram below provides a high-level description of the areas where CCGs wish to collaborate and how this relates to local and SL CSS activities. The model outlines initial priority areas for the CCG collaboration, other areas where CCGs may wish to collaborate may be added as new clinical commissioning arrangements bed in.
South West London Clinical Commissioning Groups

SWL CCGs also recognise that it will be necessary to come together to manage the inter-face with other bodies in the wider health system, including managing the relationship with the National Commissioning Board and responding to and co-ordinating the performance management of the South London Commissioning Support Service.

The remainder of this document seeks to describe in more detail what collaboration will mean in practice for SWL CCGs, beginning with the over-arching principles for collaboration. Subsequent sections describe how the model will work in practice, the mechanisms for collaboration and how CCGs will hold each other to account for each of the following areas:

- Acute commissioning
- Mental Health
- Out of Hospital
- Strategy
- Continuing Healthcare
- Risk Sharing
Status of this document

This document, drafted in June 2012, represents the culmination of months of collaborative working between SWL CCGs to define and agree their commissioning support arrangements and how they wish to collaborate in future. It summarises the current position and agreement amongst the CCGs, however, it is recognised that this agreement may evolve as the new commissioning system beds in. For example, some areas of the agreement, acute commissioning, mental health commissioning and continuing healthcare will be influenced by the detailed service specifications that are soon to emerge from the South London CSS. In this context therefore, this document is considered an interim agreement. SWL CCGs have committed to reviewing and refreshing it ahead by April 2013, in line with the timetable for CCG authorisation.
Section 2: Agreed principles of collaboration

In defining this framework for collaboration, SWL CCGs have identified a number of principles to frame and guide the detailed design of how collaboration will work in practice. These include:

- Recognising the sovereignty of the six CCGs and that CCGs are membership organisations.
- Focus on building relationships and trust so CCGs have confidence in each other’s ability to deliver on their behalf and don’t always feel they have to be in the room to have a voice.
- Have a clear transparent framework by which we hold each other to account.
- Create space for CCGs early in the annual commissioning cycle to come together to build understanding of each other’s clinical commissioning and service re-design priorities and where possible align and agree collective strategies to support the achievement of better outcomes, improved quality and value for money.
- Co-ordinate dialogue with providers to maximise impact by ensuring that CCGs speak with a single voice.
- Ensure regular opportunities for dialogue between clinical and executive leaders and local provider Trusts.
- Seek to co-ordinate and combine efforts to manage relationships and influence both the National Commissioning Board and the South London Commissioning Support Service (SL CSS).
- Deploy clinical capacity where it is most needed, in a timely way and ensure that critical meetings are held at times when clinicians can attend.
- Learn from existing experience and make time to reflect on and build ‘what good looks like’ as CCGs progress through transition, authorisation and beyond.

Leadership, values and behaviours

To bring the principles to life and enact the intentions set out in this framework document, CCG Chairs and Accountable Officers will need to provide leadership and model collaborative values and behaviours to enable the system to work together.

Values

- Put the patient and public at the centre of our work
- Focus on improving outcomes and quality for the patients we serve
- Lead and take responsibility, not blame others
- Create a supportive environment in which we work together not undermine each other
- Be loyal to one another
- As leaders, model the collaborative behaviours we wish to inspire in others
Behaviours

- Treat patients and colleagues with respect, dignity and empathy
- Recognise that patient care is improved by effective teamwork
- Recognise our individual responsibility to contribute to overall success
- Involve others as early as possible
- To be open and honest and transparent about opportunities and concerns and voice opinions in the room
- Be prepared to delegate responsibility and give authority to others to act on our behalf and trust them to deliver
- Commit our personal time and effort to ensure collaboration is a success.
Section 3: Mechanisms for collaboration

In order to support the collaborative activities set out in this document, SWL CCGs have identified the need to come together, to share and align strategic priorities and commissioning intentions on issues that are of common interest to all six organisations.

To support this, a governance structure will need to be put in place that allows clinicians and managers across the six CCGs to come together to set strategic direction, review progress, agree a direction of travel and hold each other to account.

CCG’s propose to create two forums to support collaboration – summarised below. The purpose of the proposed groups is to facilitate collaborative leadership by creating space for dialogue and interaction across the six CCGs and make connections between strategic, managerial and operational levels within the new commissioning system.

Discussions that take place at a collaborative level will support decision making at Board level within each individual CCG. Accountability and responsibility for decision making sits with the Boards of each CCG, in line with good governance, whilst the collaborative provides a forum for the six CCGs to work through issues relevant to the group.

It is envisaged these forums will be formally constituted from April 2013 onwards. However, the intention is to set up shadow running arrangements from September 2012 to support the forthcoming annual commissioning cycle and the overall development of CCGs. It is recognised that for the transition period from September 2012 to April 2013, the proposed arrangements will need to run in tandem with existing NHS SW London cluster arrangements.
Appendix 1 sets out a timetable for establishing key groups and a forward plan of key meetings.

<table>
<thead>
<tr>
<th>Group</th>
<th>Membership</th>
<th>Role</th>
<th>Frequency</th>
</tr>
</thead>
</table>
| SWL CCGs strategy group      | Clinical Chairs and Accountable officers        | • To provide strategic direction and drive forward collaborative working  
• Focus on improving outcomes, quality and VFM  
• Align SWL CCG wide priorities, commissioning intentions and service re-design priorities  
• Agree collective SWL wide negotiating strategies with e.g. provider Trusts  
• Monitor, challenge and review progress of joint working; and identify future opportunities for collaboration  
• To act as an escalation point for issues arising from collaborative activities  
• To collaborate on performance management of the CSS – holding the CSS to account  
• To hold each other to account | Bi-monthly |
| SW CCGs accountable officers group | Accountable officers | • To support clinical leaders to develop strategic direction & align priorities  
• Provide oversight on performance and quality  
• Ensure leadership accountabilities are in place to deliver and hold each other to account  
• Act as the first point of escalation for issues arising from relating to collaborative activities | Monthly |

It is recognised that these formal meetings will be supplemented by informal and ad hoc interactions, and that there may be a need to convene special meetings of the groups at different points in the annual commissioning cycle to transact more urgent business.

Additional forums may need to be developed as the new clinical commissioning arrangements bed in, for example, on specific strategic or commissioning issues.

**Operational groups**

There are a number of areas in which the CCG will be required to collaborate on a day to day basis to an operational level. The nature, scope and role of each of these areas is described within the relevant sections of this Framework for Collaboration, for example for acute commissioning.

**Decision-making and process for holding each other to account**

CCGs aim is to always achieve collective decision-making in a collaborative manner through consensus. The six CCGs will have a collective responsibility to resolve and minimise any local challenges or disproportionate impact of CCG wide decisions on any one CCG. If either the proposed strategy group or executive leaders group need to take a formal vote on any issue the majority of members in attendance will apply. Detailed terms of reference for each group will need to be developed and agreed by CCGs setting out the full roles and responsibilities and the decision-making process.
Section 4: Collaborating in acute commissioning

Model for acute commissioning support

The model for commissioning support assumes that, as with all areas of commissioning, acute commissioning will be owned, provided and led by the Clinical Commissioning Groups although this will be fully supported by contracting, performance management and transactional support provided by the SL CSS.

A summary of key roles and responsibilities is set out below.

Local CCG led

- Each CCG will have a senior manager who will be responsible for co-ordinating the monitoring and management of the CCG’s total acute portfolio and providing robust and expert professional advice and guidance to the CCG on the commissioning of acute services. The ‘Head of Acute Contracting’ will be employed by the SL CSS but will be predominantly based in the local CCG and will draw support from the acute multi-disciplinary team in SL CSS to ensure the provision of timely, comprehensive and systematic support to manage the annual cycle of commissioning activity.
- Each CCG will provide clinical leadership, chairing contract management & quality meetings and leading the annual acute negotiating process. Local clinicians will provide expertise, for example in the completion of clinical audits, review of care pathways and medicines management.

Services delivered by South London Commissioning Support Unit (SL CSU)

SWL CCGs have agreed to purchase acute contract management support from the SL CSU as part of their core package of commissioning support.

- SWL CCGs will have a dedicated multi-disciplinary acute contracting team, comprising dedicated leads for acute contracting, finance and information, plus a shared resource between CCGs for performance, medicines management, public health intelligence and acute contract administration. This team will be directly employed by the SL CSU, and will support the overall delivery of the commissioning cycle by:
  - Supporting annual and on-going contract negotiations.
  - Co-ordinating contract management including challenging over performance, performance targets, quality standards, KPIs and acute QIPP and Demand Management schemes.
  - Delivery of robust claims management.
  - Supporting and challenging the host/lead commissioners role to ensure the interests of their own CCG.
  - Advising on impact of service redesign, Cquin or QIPP proposals on acute contracts.
  - Translating service design, Cquin & QIPP plans into acute contracts.

CCG collaborative activity

- The SWL CCGs have agreed to act as “host commissioner” for all London CCGs, for one or more Trusts which are geographically located within the CCG, liaising closely with the other CCGs’ acute contract
management teams to ensure that all CCGs achieve maximum leverage across all Trusts in South West London.

- In order to deliver the major benefits of inter-CCG collaboration to maximise scale and leverage with the large acute Trusts CCGs recognise that they will need to work together to:
  - Share CCG commissioning intentions and service re-design priorities to identify areas of common interest and difference.
  - Align priorities and agree collective negotiation strategies with provider Trusts to support the achievement of better outcomes, improved quality and value for money.
  - Co-ordinate dialogue with provider Trusts to maximise impact by ensuring that they speak with a single voice.
  - Improve efficiency by avoiding multiple conversations with providers where possible.

**Host commissioner arrangements**

From 1st April 2013, the Host Commissioner will be charged with taking forward the delivery & performance management of a hospital contract, on behalf of a host CCG and its associate CCGs.

This will require the Host Commissioner to coordinate and empower a number of different relationships including with clinicians, the accountable officer and commissioning support staff of the Host CCG, and also those of its key associate CCGs.

The draft Memorandum of Understanding sets out the current host commissioning responsibilities and associate CCGs across both South West London Trusts and other Out of Sector Trusts which are important to SWL CCGs.

**Roles and responsibilities of host commissioners, associate commissioners and CSU**

The table below summarises the broad roles and responsibilities for the host commissioner, associate CCGs and SL CSU. An associate CCG is defined as any other CCG with an interest in a particular provider.

Host CCGs and associate CCGs will need to sign a consortium agreement in advance of annual negotiations which define their responsibilities to each other. This agreement will set out arrangements for quoracy and decision making between CCGs as well as a process for dispute resolution.

<table>
<thead>
<tr>
<th>Host</th>
<th>Associate CCGs</th>
<th>CSS</th>
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</thead>
<tbody>
<tr>
<td><strong>Set individual and trustwide commissioning intentions while being mindful of the intentions of Associate CCGs</strong></td>
<td>Share individual commissioning intentions and play an equal and active part in dialogue between CCGs</td>
<td>Co-ordinate dialogue between host CCG and associate CCGs to align priorities, set direction and agree negotiating lines. Provide robust and professional advice on the commissioning of acute services</td>
</tr>
<tr>
<td>Lead on contract negotiations, agreeing final terms and conditions after due consultation with associate CCG.</td>
<td>Support contract negotiation meetings and provide information on a timely basis.</td>
<td>Support CCGs to translate commissioning intentions and priorities into signed acute contracts, while ensuring Host CCG is appropriately facilitated to lead negotiations and agree terms &amp; conditions acceptable to all parties.</td>
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</tbody>
</table>
Manage the performance against contract reporting back to associate CCGs on a regular basis. Consult with associate CCGs to agree pro-active management action to rectify performance or variances to plan.

Support performance management process. Where individual CCGs have specific performance issues pertaining to their own CCG, it is expected that that CCG will hold one-to-one dialogue with the Trust. Associate CCGs will follow protocol to inform both the host and other CCGs.

Ensuring host CCG is appropriately facilitated to manage performance and ensure management action both Trust wide and on behalf of all CCGs.

Monthly monitoring reports against contractual targets and validates price and activity (claims management), underpinned by analysis and interpretation of issues and trends.

**Mechanisms for collaboration**

The **SWL CCGs strategy group** will be the main forum for clinical chairs and accountable officers to come together to share and align commissioning intentions and service re-design priorities and where possible agree a SWL wide strategy for negotiating across the portfolio of providers serving residents and patients in SW London. The **accountable officers’ group** will support the strategy group in developing the strategic direction and will act as the first point of escalation for collaborative activity.

At an operational level it is expected that each host CCG will establish mechanisms to co-ordinate dialogue between associate CCGs and the provider Trust, with support and input from SL CSS. One size will not fit all, and arrangements will need to be tailored to deal with individual Trust circumstances and the available time of local clinicians. The model established for St George’s Healthcare NHS Trust (described below) is viewed as an exemplar way of working.

These groups will have regard to the strategic direction set out by the SWL CCG strategy group and escalate issues of concern to the accountable officers’ group as a first point of escalation.
### Clinical Reference Group (CRG)

- **Role:** Discuss commissioning intentions, agree negotiation objectives. Manage in year performance and financial settlement. Secure agreement to final contact terms and conditions.
- **CCG Membership:** Clinical lead for host commissioner and CSU lead manager plus clinical and managerial leads from associate CCGs

### Clinical Quality Review Group (CQRG)

- **Role:** Monthly monitoring of National Standards of Care, Review of Serious Incidents, Review of Audit Outcomes, Monitoring of Cquins, Reviewing Service Areas
- **CCG Membership:** Clinical lead for host commissioner and CSU lead manager, Public Health Advisor

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Each Trust will also have an internal Clinical Integrated Governance Committee that will involve the clinical lead and AO from the host commissioner. This group will be responsible for reporting on all quality matters across the Trust. The SWL CCG strategy group will require regular reports on quality issues from across all Trusts and expects that this will be a standing item on its agenda.
Section 5: Collaborating in non-acute commissioning

Section 5.1: Model for mental health commissioning support

This model for collaborative working assumes that, as with all areas of commissioning, mental health commissioning will be owned, provided and led by the Clinical Commissioning Groups. SWL CCGs have nominated Kingston CCG to act as host commissioner for health services commissioned from South West London St George’s Mental Health Trust (SWLSTG MH) on behalf of associate CCGs including Merton, Richmond Sutton and Wandsworth CCGs. Separate arrangements will be put in place to support Croydon CCG and South London and the Maudsley NHS Trust (SLAM).

The contract management and transactional support to deliver mental health clinical commissioning clinical leadership provided by the SL CSS. A summary of key roles and responsibilities is set out below.

Host commissioner – Kingston CCG will:

- Provide managerial and clinical leadership to the negotiation of the South West London and St George’s Mental Health Trust (SWLSTG) contract, ensuring the views of Kingston, Merton, Richmond, Sutton and Wandsworth are fairly represented.
- To work with the NHS Commissioning Board on the FT application process for SWLSTG ensuring that the views of Kingston, Merton, Richmond, Sutton and Wandsworth are fairly represented.
- Collate and aggregate commissioning plans and intentions to support and facilitate the development of a joint mental health strategy for SLWSTG agreed between Kingston, Merton, Richmond, Sutton and Wandsworth.
- Provide clinical leadership on agreed mental health work streams and strategy (SWLSTG).
- Provide clinical governance leadership to the SWLSTG’s contact.
- Support and administrate SWLSTG’S Clinical Quality Review Group.
- Lead contract and performance meetings with SWLSTG.
- Lead on relationship management with the SL CSU, including performance managing SL CSU contact management support, providing regular reports to associate CCGs.
- Provide regular reports into the five CGGs on performance of the SWLSTG contract, highlighting any actions the CCGs need to take as the statutory bodies accountable for mental health commissioning.

Role of associate CCGs - Kingston Merton, Richmond, Sutton and Wandsworth CCGs will:

- Provide mental health clinical leadership at local level to support, facilitate and advise local health and social care integrated mental health commissioning.
- Lead local planning, service design and integration of local CCG and SW London CCG wide mental health strategy.
- Consider and review implications of local performance data.
- Lead local borough performance reviews.
• Provide local perspective into contract requirements.

• To be involved in the SWLSStG’s Foundation Trust application.

Services delivered by SL CSU

To support contract negotiations and management of the contracts on behalf of the Kingston, Merton, Richmond, Sutton and Wandsworth CCGs advising on appropriate contractual levers and risk sharing mechanisms, including;

• Provide data analysis function and review performance trends across all services within all mental health contracts.

• To support Richmond, Kingston, Merton, Wandsworth and Sutton CCG wide performance monitoring meetings and provide appropriate information to facilitate local CCG performance monitoring as required.

• To provide expert advice on areas such as procurement, MH Individual Funding Request (IFRs), public consultations and service redesign as required.

Mechanisms for collaboration

In line with the model to support acute commissioning, the following groups will be established to support annual commissioning cycle for SWLSStG’s. As host commissioner, Kingston CCG will have responsibility for co-ordinating and chairing each of the forums.

The mental health Clinical Reference Group, will have regard to the SWL Strategy Group’s SWL wide commissioning strategy and intentions in setting its direction and will provide quarterly updates on progress with the development of mental health clinical leadership, contract management, service quality and improvement issues.

<table>
<thead>
<tr>
<th>Group</th>
<th>Role</th>
<th>CCG Membership</th>
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<tbody>
<tr>
<td>Clinical Reference Group (CRG)</td>
<td>Discuss commissioning intentions, agree negotiation objectives. Manage in year performance and financial settlement. Secure agreement to final contract terms and conditions.</td>
<td>Clinical lead for host commissioner and SL CSU lead manager plus clinical and managerial leads from associate CCGs</td>
</tr>
<tr>
<td>Clinical Quality Review Group (CQRG)</td>
<td>Monthly monitoring of National Standards of Care</td>
<td>Clinical lead for host commissioner and CSS lead manager</td>
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<tr>
<td></td>
<td>Review of Serious Incidents</td>
<td>Public Health Advisor</td>
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<td>Review of Audit Outcomes</td>
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<tr>
<td></td>
<td>Monitoring of CQuins</td>
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<tr>
<td></td>
<td>Reviewing Service Areas</td>
<td></td>
</tr>
<tr>
<td>Clinical Integrated Governance Committee (CIGC)</td>
<td>Reporting on quality matters across all Trusts in SWL</td>
<td>Clinical lead and AO for all host commissioners of SWL trusts &amp; CCGs</td>
</tr>
</tbody>
</table>

SWLSStG’s will also have an internal Clinical Integrated Governance Committee that will involve the clinical lead and AO from the host commissioner. Kingston CCG will be responsible for reporting on all quality matters to associate CCGs and the SWL CCG strategy Group as appropriate.
Process for holding each other to account

The accompanying memorandum of understanding describes in detail the roles and responsibilities for the host commissioner and associate CCGs. The terms of the agreement will be finalised in coming months. The MOU will be the primary tool for host and associate CCGs to hold each other to account. The accountable officers group will act as the first point of escalation for any issues emerging, with the SWL Strategy Group as the final point of escalation.
Section 5.2: Continuing Healthcare

(Draft subject to clarification on the service specification from SL CSU)

Introduction

Continuing healthcare proposals cover packages of care for patients outside of hospital who have ongoing healthcare needs. The services are provided to individuals who are aged over 18 with physical or mental health needs that have arisen as a result of an accident, disability or illness. Care can be provided in any setting, usually a person's own home or a care home with nursing. The proposed model also covers the commissioning of specialist neuro, neuro rehab, learning disabilities young physically disabled and mental health.

Model for collaboration

This model for collaborative working assumes that, as with all areas of commissioning, continuing healthcare commissioning will be owned, provided and led by the Clinical Commissioning Groups.

The SW CCGs are proposing a hub and spoke model that covers Croydon, Merton, Richmond, Sutton and Wandsworth CCGs. Kingston CCG are pursuing separate arrangements in partnership with their local authority.

The hub, a centralised commissioning and support service for continuing health care will be provided by SL CSU, with each of the five CCGs retaining locally based clinical leadership and clinical assessor roles. A summary of key roles and responsibilities is set out below.

Local CCG led

Each CCG will have statutory responsibility for the provision, quality and cost effectiveness of continuing healthcare services. Each individual CCG will be responsible for ensuring appropriate safeguarding, clinical governance and quality assurance arrangements are in place.

Local nurse assessors will be based in each CCG and their role will be to:

- Manage local relationships with GPs, Community Health Services, care homes, acute trusts and local authorities.
- Undertake quality and timely reviews for all patients.
- Undertake safeguarding investigations and responses.
- Spot placements with pre-negotiated providers.

CCG collaborative activity

Richmond and Wandsworth and Sutton and Merton are proposing to share lead nurse posts. Their role is to:

- Provide safeguarding leadership for both nurses and providers.
- Work with Local Authorities to monitor safeguarding action plans.
- Provide clinical expertise to inform commissioning and market development.
- Lead staff recruitment and retention and performance management.
- Handle incident reporting (Serious Untoward Incident) and complaints and solicitors letters.
Services delivered by SL CSU

A team based within SL CSU will provide strategic commissioning, governance and administrative support to clinical leads and locally based lead nurses and nurse assessors. The SL CSU will be accountable for providing the following services:

- Contribute to wider governance and quality assurance process.
- Provide clinical supervision of continuing healthcare services.
- Support complex safeguarding and complex case management.
- Strategic workforce development and strategic project leadership.
- Development of local market of quality providers.
- Creation of preferred provider list across participating SW London CCGs.
- Annual negotiation of provider contracts and cross-cluster block contracts.
- Undertake regular audit of cost/care package and provider quality.
- Provide timely data and analysis reports to support CCG to undertake performance monitoring.
- Manage the available beds’ list.
- Effective resolution of commissioning complaints/enquiries.
- Provide a single point of access for patients and referrals.
- Administrative support to nurse assessors to schedule reviews.
- Provide administrative support to communicate with patients and their advocates.
Section 5.3: Out of Hospital Care

Model for out of hospital care support

Local CCG resource

Each CCG will have lead local commissioners who will work with the local authority and be responsible for commissioning services, contract management and pathway redesign. As such, in all circumstances, commissioning responsibility for out of hospital care remains with each CCG.

Services delivered by SL CSU

There are no arrangements with the CSU to deliver any out of hospital care services.

CCG collaborative activity

In recognition of the common goals and aspiration of moving care out of hospital and closer to home it is proposed that a network of the local commissioners and lead clinicians with responsibility for out of hospital care is established in order to facilitate local collaboration. The aim of the network is to:

- Consider local needs and commissioning intentions and align service redesign priorities to meet shared ambitions and goals.
- Share best practice, innovation and intelligence on a regular basis in both a formal and informal environment.
- Develop ideas for out of hospital care once across the SWL CCGs in order work efficiently and reduce costs where possible.
- Focus on driving implementation of good practice and ideas that are known to work.
- Challenge and improve one another acting as critical friends.
- Respond to local innovation and the delivery of London/NHS CBA Programmes in a co-ordinated way.
- Support clinical leads to co-ordinate discussions and make effective decisions.

All the services that are responsible for delivering out of hospital care are included in the remit of the group and the specific services that are in and out of scope are detailed in the table below:

| In scope                                                                    | Out of scope                                           |
|                                                                           |                                                       |
| Community Services:                                                       | Mental Health - secondary                              |
|  - Child, adult, older people                                             | Acute – secondary and tertiary                         |
|  - Prevention and care/treatment                                           | Public Health-led commissioned services (e.g. Drugs & Alcohol; Sexual Health) |
|  - Care pathways                                                          | Local Authority-led commissioned services (e.g. Learning Disabilities) |
| Primary Care development and improvement                                  |                                                       |
| Shifts of care settings (Acute Community/Primary)                         |                                                       |
| Integrated Health and Social Care (unless led by the local authority)      |                                                       |
| Mental Health – primary and tertiary                                      |                                                       |
It is recognised that there is a risk of possible duplication with the existing Long Term Conditions (LTCs) workstream within the Better Services, Better Value programme and with other programmes aimed at sharing best practice such as the Academic Health Sciences Network. CCGs have agreed to review progress after 6 months to ensure that the network is adding value.

**Mechanisms for collaboration**

The group itself will act as a standalone group in the long-term and will be driven by its membership and will support collaboration at an operational level.

The membership of the group will comprises of 2 representatives from each CCG; a lead clinician and relevant commissioner, who will be nominated on an annual basis. All members of the group will have a responsibility to help the group achieve its aims outlined above and must commit to attending meetings and participating throughout the year to reflect the demands of the group.

To facilitate communication between the operational, executive and clinical groups at least one member of the executive commissioning group and one member of the clinical strategy group should be involved in the network.

Merton CCG has agreed to lead and facilitate the establishment of the network on behalf of the group from September 2012 to April 2013. During this period they will have responsibility for:

- Supporting the establishment of the network.
- Arranging and chairing quarterly meetings.
- Facilitating ongoing discussions.

From April 2013 the group will rotate its chair between the clinical leads every six months.

The activity of the group will be funded out of existing CCG resources and no additional resource will be made available.

Discussions, learning, outputs and feedback from the group will be shared with and considered by the executive strategy group at least every six months or when required for decision making purposes. The executive strategy group can refer any decisions or outputs to the clinical commissioning group as appropriate.

The executive strategy group will consider the role, purpose and validity of the group every 6 months in its first year and then on an annual basis from September 2013.

**Process for holding each other to account**

The members of the executive strategy group will encourage participation from their respective CCGs and the accountable officers will be required to address low levels of cooperation and participation.
Section 6: Strategy contingency fund

Model for strategy, business planning and organisational performance

Local CCG resource

Each CCG will maintain local resources for strategy, business planning and organisational performance, to lead the development of statutory planning requirements such as CSP, Operating Plans, QIPP plans and JSNA (in partnership with Local Authority). This funding will therefore not be used to support the development of any strategic business that is the responsibility of an individual CCG.

CCG collaborative activity

All CCGs party to this agreement will contribute to a strategic contingency fund that will be used to:

- Address any strategic issues that are common to all six CCGs and where benefit can be derived from addressing these at scale.

The fund is designed to be flexible in order to contribute to a range of activities that can be considered to be strategic. Examples of the type of project that could be commissioned using this fund include:

- Service reviews including performance benchmarking and improvement reviews, such as that recently commissioned by NHS SW London on mental health services.

- Funding of strategic communications that are above the core CSS offer and are required by all CCGs. Such communications may be required for issues such as a system wide transformation.

- Considering provider issues that span multiple CCGs, including the trajectory to FT status of a number of local providers.

- Redesigning clinical pathways where there is a benefit if they are delivered at scale across CCGs.
The fund will total £300k and contributions will be based on capitation and funded from CCG running costs. In the event of an under-spend the remaining budget will be rolled over into the next financial year. The amount that each CCG will contribute each year is:

<table>
<thead>
<tr>
<th>CCG</th>
<th>Population</th>
<th>Total Contribution (£)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Croydon CCG</td>
<td>352,400</td>
<td>72,530</td>
</tr>
<tr>
<td>Kingston CCG</td>
<td>196,000</td>
<td>40,340</td>
</tr>
<tr>
<td>Merton CCG</td>
<td>206,000</td>
<td>42,398</td>
</tr>
<tr>
<td>Richmond CCG</td>
<td>192,400</td>
<td>39,599</td>
</tr>
<tr>
<td>Sutton CCG</td>
<td>186,400</td>
<td>38,364</td>
</tr>
<tr>
<td>Wandsworth CCG</td>
<td>324,400</td>
<td>66,767</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,457,600</strong></td>
<td><strong>300,000</strong></td>
</tr>
</tbody>
</table>

When making a decision any activity using this fund should meet the following criteria:

- The issue to be addressed must impact all six CCGs.
- The issue will benefit all CCGs in this agreement equally (i.e. no-one CCG will gain a disproportionate benefit from activity commissioned using this fund).
- Funding can relate to clinical work streams but cannot be used to commission any service delivery.
- Funding cannot be used to fund gaps in other areas for example to cover shortfalls or overspends in service areas.

**Services delivered by SL CSU**

There are no arrangements with the CSU to deliver strategy, business or organisational performance support.

**Mechanisms for collaboration**

Wandsworth CCG have agreed to act to hold the fund on behalf of the group with the relevant Chief Finance Officer responsible for monitoring the expenditure. Funding decisions will be taken by the accountable officers group after consultation with clinical leads, in line with the agreed decision-making process outlined in section 3.

The executive strategy group will be accountable for setting performance measures and monitoring the performance of any projects commissioned using this fund and will report planned and actual spend to the SW CCGs strategy group on a regular basis. Day to day management will be delegated to a responsible officer, most likely the Accountable Officer from the host CCG.

Any project commissioned using the fund will be subject to a funding agreement. The executive strategy group will delegate signing rights to the Chief Finance Officer of the host CCG.
Process for holding each other to account

The accountable officers’ group will be ultimately responsible for the fund whilst the Chief Finance Officer of the host CCG will be accountable for the day-to-day transactions. The SRO (Wandsworth Accountable Officer) will be responsible for communicating any issues to the accountable officers group.
Section 7.0: Risk Sharing

Financial Risk Sharing across SWL CCGs.

Through the CCG Transition and CCG Collaboration workshops, the awareness and need for financial risk sharing has been considered and explored.

The SWL CCGs remain committed to understanding financial risk and its drivers, and exploring opportunities to share risk in-year as part of a broader risk management/mitigation strategy within each CCG.

It is recognised that in the new system, the natural hedges between primary care, specialist commissioning and the CCG commissioning portfolio are no longer available, and for Sutton CCG and Merton CCG the historical sharing of financial risk across the two boroughs is also removed.

Although the 2012/13 Operating Framework indicates continuation of the financial risk management principles of (i) 2% non-recurring top slice, (ii) 0.5% contingency and (iii) 1% surplus, the adequacy of these principle across a smaller portfolio needs to be reviewed, as does a collective position if guidance to CCGs is not prescriptive.

The Finance Transition Workstream has identified some potential service specific areas for financial risk sharing, for which historical data is being collected to inform decisions on risk sharing in these areas (e.g. critical care, high cost low volume treatments, independent inquiries). A stock-take of current borough based risk sharing agreements is being undertaken.

It is also recognised that SWL CCGs will need to consider the risk sharing implications for the current Better Services, Better Value programme. This issue will be discussed with the Programme Board and decisions taken in line with the timetable set out below.

The following timetable is agreed to take forward the development of potential risk sharing opportunities for CCGs in SWL. It is critical that any proposals to be considered by CCGs have the benefit of the insight and leadership of the newly appointed Chief Financial Officers (CFOs).
## Appendix 1: Mechanisms for collaboration

### Authorisation milestones

<table>
<thead>
<tr>
<th>Month</th>
<th>July</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
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<td>Wave 1</td>
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<td>Wave 2</td>
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<td>Wave 4</td>
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</table>

- Commissioning responsibility commences
- Shadow running from 1 Oct

### Key milestones in annual commissioning cycle

- Align CCG priorities e.g. pathway re-design
- Review actual activity against contracted activity
- Needs analysis
- CCGs agree CSP / QIPP / Operating Plans
- Review previous year CCG plans
- CCGs agree CSP / QIPP / Operating Plans
- Needs analysis
- Contract negotiations
- Review & identify learning for FY 2012/14
- Align CCG priorities e.g. pathway re-design

### SW London Strategy Group

- Share & align priorities
- Agree strategic priorities for 6 month notice letter to Trusts
- Share and align priorities
- Agree priorities for contract negotiations
- Resolve issues contract negotiation process
- Review & identify learning for FY 2012/14

### Executive leaders

- Regular dialogue between AOs

### Operational

- Establish OOH Network
- Quarterly meeting
- Quarterly meeting

- Quarterly meeting
NHS Merton Clinical Commissioning Group

Audit Committee

Terms of Reference

1. Authority

1.1. The audit committee is constituted as the senior standing committee of the CCG’s Governing Body. Its constitution and terms of reference shall be as set out below, subject to amendment at future Governing Body meetings. The audit committee shall not have executive powers in addition to those delegated in these terms of reference.

1.2. The audit committee is authorised by the Governing Body to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any member of staff or member of the CCG and all members of staff and members of the CCG are directed to co-operate with any request made by the audit committee.

1.3. The audit committee is authorised by the Governing Body to obtain outside legal or other independent professional advice. The committee is authorised by the Governing Body to request the attendance of individuals and authorities from outside the CCG with relevant experience and expertise if it considers this necessary or expedient to the carrying out of its functions.

1.4. The audit committee will have primary responsibility for monitoring and reviewing financial and other risks and associated controls, corporate governance and financial assurance.

1.5. These terms of reference and the composition of the audit committee will accord with any published national guidance.

2. Purpose

2.1. The Governing Body is responsible for ensuring effective internal control including:

- exercising its functions effectively, efficiently and economically
- complying with such generally accepted principles of good governance as are relevant to it
- managing the CCG’s activities in accordance with statute, regulations and guidance
• establishing and maintaining a system of internal control to give reasonable assurance that assets are safeguarded, waste or inefficiency avoided and reliable financial information produced, and that value for money is continuously sought.

2.2. The audit committee shall provide the Governing Body with a means of independent and objective review of financial and corporate governance, assurance processes and risk management across the whole of the CCG’s activities (clinical and non-clinical). In addition the audit committee shall:

• assist the CCG in discharging its functions under paragraph 2.1 above
• provide assurance of independence for external and internal audit
• ensure that appropriate standards are set and compliance with them is monitored, in non-financial, non-clinical areas that fall within the remit of the audit committee
• monitor corporate governance (e.g. Compliance with Constitution, Standing Orders, Prime Financial Policies, maintenance of Registers of Interests).

3. Membership

3.1. The committee shall be composed of [not less than] [two] lay members of the Governing Body, at least one of whom should have recent and relevant financial experience and not less than [four] Member Representatives.

3.2. A quorum shall be [two] members, one of whom will be the Audit Committee Chair.

3.3. The committee shall be chaired by a lay person member. A role description for the Chair is attached as Annex A.

4. Attendance

4.1. The Accountable Officer, Chief Financial Officer and Head of Internal Audit [include any others] shall generally attend routine meetings of the audit committee.

4.2. A representative of the external auditors may normally also be invited to attend meetings of the audit committee.

4.3. Members of the Governing Body and/or staff and executives shall be invited to attend those meetings in which the audit committee will consider areas of risk or operation that are their responsibility.

4.4. The audit committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.
4.5. The CCG chair may be invited to attend meetings of the audit committee as required.

4.6. A representative of the local counter fraud service will be invited to attend meetings of the audit committee.

4.7. Member Representatives will be invited to attend meetings of the audit committee.

4.8. The CFO shall designate a CCG secretary to the audit committee who will provide administrative support and advice. The duties of the CCG secretary in this regard include but are not limited to:

- agreement of the agenda with the chair of the audit committee and attendees together with the collation of connected papers
- taking the minutes and keeping a record of matters arising and issues to be carried forward
- advising the audit committee as appropriate
- reviewing every decision to suspend the standing orders.

5. **Frequency of Meetings**

5.1. Meetings shall be held at least four times per year with additional meetings convened where necessary.

5.2. The external auditor shall be afforded the opportunity at least once per year to meet with the audit committee without the Accountable Officer; Chief Financial Officer present.

5.3. The CCG Chair and Accountable Officer should be invited to attend, at least annually, to discuss with the Audit Committee the Annual Accounts and the process for assurance that supports the Annual Governance Statement.

5.4. [The audit committee members shall be afforded the opportunity to meet at least once per year with the External and Internal Auditors with no others present.]

6. **Duties**

6.1. **Internal control, risk management and counter fraud**

6.1.1. To ensure the provision and maintenance of an effective system of financial risk identification and associated controls, reporting and governance.

6.1.2. To maintain an oversight of the CCG’s general risk management structures, processes and responsibilities, including the production and issue of any risk and control-related disclosure statements.

6.1.3. To review the adequacy of the policies and procedures in respect of all counter-fraud and anti-bribery work.
6.1.4. To review the adequacy of the CCG's arrangements by which CCG staff may, in confidence, raise concerns about possible improprieties in matters of financial reporting and control and related matters or any other matters of concern.

6.1.5. To review the adequacy of underlying assurance processes that indicate the degree of achievement of corporate objectives and the effectiveness of the management of principal risks.

6.1.6. To ensure the adequacy of policies and procedures for ensuring compliance with relevant regulatory, legal and conduct requirements.

6.2. **Internal audit**

6.2.1. To review and approve the internal audit strategy and programme, ensuring that it is consistent with the needs of the organisation.

6.2.2. To oversee on an ongoing basis the effective operation of internal audit in respect of:

- adequate resourcing
- its co-ordination with external audit
- meeting mandatory NHS internal audit standards
- providing adequate independence assurances;
- having appropriate standing with the CCG
- meeting the internal audit needs of the CCG.

6.2.3. To consider the major findings of internal audit investigations; the Governing Body's response and their implications and monitor progress on the implementation of recommendations.

6.2.4. To consider the provision of the internal audit service, the cost of the audit and any questions of resignation and dismissal.

6.2.5. To conduct an annual review of the internal audit function.

6.3. **External audit**

6.3.1. To make a recommendation to the Governing Body in respect of the appointment, re-appointment and removal of an external auditor. To the extent that that recommendation is not adopted by the Governing Body, this shall be included in the annual report, along with the reasons that the recommendation was not adopted.

6.3.2. To discuss with the external auditor, before the audit commences, the nature and scope of the audit, and ensure co-ordination, as appropriate, with other external auditors in the local health economy. This should include discussion
regarding the local evaluation of audit risks and assessment of the CCG associated impact on the audit fee.

6.3.3. To assess the external auditor’s work and fees on an annual basis and, based on this assessment, make a recommendation to the Governing Body with respect to the re-appointment or removal of the auditor. This assessment should include the review and monitoring of the external auditor’s independence and objectivity and effectiveness of the audit process in light of relevant professional and regulatory standards.

6.3.4. To oversee the conduct of a market testing exercise for the appointment of an auditor at least once every (five) years and, based on the outcome, make a recommendation to the Governing Body with respect of the appointment of the auditor.

6.3.5. To review external audit reports, including the annual audit letter, together with the Governing Body’s response, and to monitor progress on the implementation of recommendations.

6.3.6. To develop and implement a policy on the engagement of the external auditor to supply non-audit services.

6.3.7. To consider the provision of the external audit service, the cost of the audit and any questions of resignation and dismissal.

6.4. **Annual accounts review**

6.4.1. To review the annual statutory accounts, before they are presented to the Governing Body (who will in turn provide them to the Commissioning Board Authority in accordance with statutory requirements), to determine their completeness, objectivity, integrity and accuracy. This review will cover but is not limited to:

- the meaning and significance of the figures, notes and significant changes
- areas where judgment has been exercised
- adherence to accounting policies and practices
- adherence to the requirements and any directions given to the CCG by the Commissioning Board Authority
- explanation of estimates or provisions having material effect
- the schedule of losses and special payments
- any unadjusted statements
- any reservations and disagreements between the external auditors and the Governing Body which have not been satisfactorily resolved.
6.4.2. To review the annual report before it is submitted to the Governing Body and presented to Members of the CCG at the Annual General Meeting of the CCG, to determine completeness, objectivity, integrity and accuracy. The Governing Body will provide the annual report to the Commissioning Board Authority in accordance with statutory requirements.

6.4.3. To review all accounting and reporting systems for reporting to the Governing Body, including in respect of budgetary control.

6.5. **Standing orders, Prime Financial Policies and standards of business conduct**

6.5.1. To review on behalf of the Governing Body the operation of, and proposed changes to, the standing orders and prime financial policies, the constitution, codes of conduct and standards of business conduct; including maintenance of registers.

6.5.2. To examine the circumstances of any significant departure from the requirements of any of the foregoing, whether those departures relate to a failing, an overruling or a suspension.

6.5.3. To review the scheme of delegation at least annually.

6.6. **Other**

6.6.1. To review performance indicators relevant to the remit of the audit committee.

6.6.2. To examine any other matter referred to the audit committee by the Governing Body and to initiate investigation as determined by the audit committee.

6.6.3. To annually review the accounting policies of the CCG and make appropriate recommendations to the Governing Body.

6.6.4. To develop and use an effective assurance framework to guide the audit committee’s work. This will include utilising and reviewing the work of the internal audit, external audit and other assurance functions as well as reports and assurances sought from members of the Governing Body and other investigatory outcomes so as fulfil its functions in connection with these terms of reference.

6.6.5. To consider the outcomes of significant reviews carried out by other bodies which include but are not limited to regulators and inspectors within the health (and social care) sector and professional bodies with responsibilities that relate to staff performance and functions.

6.6.6. To review the work of all the other committees of the CCG in connection with the audit committee’s assurance function.

7. **Reporting**
7.1. The minutes of all meetings of the audit committee shall be formally recorded and submitted, together with recommendations where appropriate, to the Governing Body. The submission to the Governing Body shall include details of any matters in respect of which actions or improvements are needed. This will include details of any evidence of potentially ultra vires, otherwise unlawful or improper transactions, acts, omissions or practices or any other important matters. To the extent that such matters arise, the chair of the audit committee shall present details to a meeting of the Governing Body in addition to submission of the minutes.

7.2. The audit committee will report annually to the Governing Body in respect of the fulfilment of its functions in connection with these terms of reference. Such report shall include but not be limited to functions undertaken in connection with the effectiveness of risk management within the CCG; the integration of and adherence to governance arrangements and any pertinent matters in respect of which the audit committee has been engaged.

7.3. The CCG’s annual report shall include a section describing the work of the audit committee in discharging its responsibilities.

8. Review

8.1. The terms of reference of the audit committee shall be reviewed by the Governing Body at least annually. This should take into account new guidance and developments in good governance practice.

9. Required Frequency of Attendance by Members

9.1. Members of the audit committee must attend at least 75% of all meetings each financial year but should aim to attend all scheduled meetings.
NHS Merton Clinical Commissioning Group

Role Description - Chair of the Audit Committee

The role of the Chair of the Audit Committee goes a good deal beyond chairing meetings and is key to achieving Committee effectiveness. The additional workload should be taken into account in appointment of the Chair.

How a particular Chair manages the Audit Committee will vary depending on the character of the individual and the needs of the specific organisation. In addition to chairing the Audit Committee meetings, the key activities should include the following.

1. **Agenda setting**
   Before each meeting the Chair and the Committee Secretary should meet to discuss and agree the business for the meeting. The Chair should take ownership of, and have final say in, the decisions about what business will be pursued at any particular meeting.

2. **Communication**
   - The Chair should ensure that after each meeting appropriate reports are prepared from the Audit Committee to the Board and the Accounting Officer.
   - The Chair should ensure that the Audit Committee provides a suitable Annual Report to the Governing Body.

   The Chair should have bilateral meetings at least annually with the Accounting Officer, the Head of Internal Audit and the External Auditor. In addition, the Chair should meet any people newly appointed to these positions as soon as practicable after their appointment.

   The Chair should also ensure that all Committee members have an appropriate programme of interface with the organisation and its activities to help them understand the organisation, its objectives, business needs and priorities.

3. **Monitoring actions:**
   The Chair should ensure that there is an appropriate process between meetings for action points arising from Committee business to be appropriately pursued. The Chair should also ensure that members who have missed a meeting are appropriately briefed on the business conducted in their absence. Chairs may choose to rely on the Secretariat to take these actions.

4. **Appraisal:**
   The Chair should take the lead in ensuring that Committee members are provided with appropriate appraisal of their performance as a Committee member and that training needs are identified and addressed. The Chair should themselves seek appraisal of their performance from the Accounting Officer (or Chair of the Governing Body, as appropriate).

   The Chair should ensure that there is a periodic review of the overall effectiveness of the Audit Committee and of its Terms of Reference.
5. Appointments:
The Chair should be involved in the appointment of new Committee members, including providing advice on the skills and experience being sought by the Committee when a new member is appointed.

Audit Committee Support
A secretariat function is required to support the Chair of the Committee in identifying business to be taken, and the relevant priorities of the business. For this reason, and as the Audit Committee is a committee of the Governing Body, the Audit Committee Secretariat function should be supervised by the Governing Body secretariat. The Chair of the Committee and the secretariat should agree procedures for commissioning briefing to accompany business items on the Committee’s agenda and timetables for the issue of meeting notices, agendas, and minutes. The Chair of the Committee should always review and approve minutes of meetings before they are circulated.

The specific responsibilities of the Audit Committee Secretariat should include:
- meeting with the Chair of the Committee to prepare agendas for meetings;
- commissioning papers as necessary to support agenda items;
- circulating meeting documents in good time before each meeting;
- arranging for executives to be available as necessary to discuss specific agenda items with the Committee during meetings;
- keeping a record of meetings and providing draft minutes for the Chair’s approval;
- ensuring action points are being taken forward between meetings;
- support the Chair in the preparation of Audit Committee reports to the Governing Body;
- arranging the Chair’s bilateral meetings with the Accounting Officer, the Head of Internal Audit and the External Auditor;
- keeping the Chair and members in touch with developments and relevant background information about developments in the organisation;
- maintaining a record of when members’ terms of appointment are due for renewal or termination;
- ensuring that appropriate appointment processes are initiated when required;
- ensuring that new members receive appropriate induction training, and that all members are supported in identifying and participating in on-going training;
- managing any budgets allocated to the Audit Committee.

Careful consideration should be given to ensuring that the Secretariat function is not biased. If the function is provided by Internal Audit there may be a risk of bias towards Internal Audit interests. On the other hand there is merit in ensuring the secretariat is independent of pressure from senior management, as could happen if the Board Secretariat also supports the Audit Committee.

When the Audit Committee meets privately, the Chair should decide whether the secretariat members should also withdraw. If so, the Chair should ensure that an adequate note of proceedings is kept to support the Committee’s conclusions and advice.
NHS Merton Clinical Commissioning Group
Governing Body Clinical Quality Committee
Terms of Reference

1. Introduction

The Clinical Quality Committee (the Committee) is established in accordance with the Clinical Commissioning Group’s Constitution, Standing Orders and Schemes of Delegation. 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 effect as if incorporated into the Clinical Commissioning Group’s Constitution and Standing Orders.

2. Authority

The Committee is directly accountable to the Governing Body and is authorised 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 request funding from the CFO for outside legal advice or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

3. Membership

The Committee shall be appointed by the Clinical Commissioning Group from amongst its Governing Body and/or staff and executives.

Members:

- Lay Member (Patient and Public Engagement) of the Governing Body (Chair)
- Nurse Member of the Governing Body (Deputy Chair alternating)
- Medical Director (Deputy Chair alternating)
- Director of Commissioning
- Director for Quality
- Clinical Leads for Localities

The following members of staff may be asked to attend the meetings:

- Chief Officer (as and when required)
• Chief Finance Officer (as and when required to advise on matters that have significant financial implications)
• Senior Representatives of the Commissioning Support Services (or body that undertakes that function) and the Joint Commissioning Unit

Members of the Governing Body and/or staff and executives may be invited to attend those meetings in which the Committee will consider areas of risk or operation that are their responsibility.

The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate frank and open discussion of particular matters.

4. Secretary

The Committee will be supported secretari ally by a senior member of the Business Support team, whose duties in this respect shall include:

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

5. Quorum

The meeting will be quorate when four members are present, with at least two of those present clinical members. On all occasions, the majority of those present should be clinical members.

6. Frequency and notice of meetings

The Committee will meet sufficiently to fulfil its work plan or at least quarterly as a minimum. The Governing Body reserves the right to call a meeting at any time (with appropriate notice) if an urgent matter arises.

A notice period of at least 14 days shall be given before the Committee meets. The Agenda and supporting papers will be circulated seven days prior to the meeting.

The CCG Chair and Accountable Officer should be invited to attend at least annually, to discuss with the Committee the process for assurance that supports the Quality and Safety plan.

7. Remit and responsibilities of the committee

The duties of the Committee are categorised as follows:

7.1.1. 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 regulatory bodies.
7.1.2. 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 deterioration in performance.

7.1.3. 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.

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

7.1.5. Have oversight of the process and compliance issues concerning Serious Untoward Incidents (SUIs); being informed of all Never Events and informing the governing body of any escalation or sensitive issues in good time.

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

7.1.7. Ensure a clear escalation process, including appropriate trigger points, is in place to enable appropriate engagement of external bodies on areas of concern.

7.1.8. Provide assurance that commissioned services, and jointly commissioned services, are being delivered in a high quality and safe manner, ensuring that quality sits at the heart of everything the clinical commissioning group does.

7.1.9. Oversee and be assured that providers of commissioned services and jointly commissioned services manage risk appropriately and have robust mechanisms in place to effectively address clinical governance issues.

8. Reporting

The minutes of all meetings of the Committee shall be formally recorded and submitted, together with recommendations where appropriate, to the Governing Body. The submission to the Governing Body shall include details of any matters in respect of where actions or improvements are needed. This will include details of any evidence of potentially Serious Untoward Incidents and Never Events, other serious provider or commissioner failings or any other important matters. To the extent that such matters arise, the Chair of the Committee shall present details to a meeting of the Governing Body in addition to the submission of the minutes.

The Committee will report annually to the Governing Body in respect of the fulfilment of its functions with these terms of reference. Such report shall include, but not be limited to, functions undertaken in relation to the effectiveness of risk management.
within the CCG; the managements of serious quality and safety incidents and any pertinent matters in respect of which the Committee has been engaged.

The CCG’s annual report shall contain a section describing the work of the Committee in discharging its responsibilities.

9. Review

The terms of reference for the Committee shall be reviewed by the Governing Body after six months and at least on an annual basis thereafter. This will take into account any new guidance and relevant codes of conduct / good governance practice.

10. Policy and best practice

10.1 The Committee will at all times apply best practice in decision making processes as laid out in the Constitution, in accordance with national guidelines and generally accepted standards of good corporate governance.

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

10.3 The Committee will work with similar committees from neighbouring CCGs as appropriate.

11. Conduct of the Committee

The Committee will:

- Observe the highest standards of propriety involving impartiality integrity and objectivity in relation to the quality and safety of commissioned services and the management of the bodies concerned;
- Be accountable to Parliament, to users of services, to individual citizens, and to staff for the activities of the bodies concerned, for their quality and safety and the extent to which key performance indicators and objectives have been met;
- Comply fully with the principles of the Citizen’s Charter and the Code of Practice on Access to Government Information, in accordance with Government policy on openness; and
- Bear in mind the necessity of keeping comprehensive written records, in line with general good practice in corporate governance.

Date agreed
27 September 2012
NHS Merton Clinical Commissioning Group

Governing Body Remuneration Committee

Terms of Reference

1. Introduction
The Remuneration Committee (the Committee) is established in accordance with the 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 and shall have effect as if incorporated into the Clinical Commissioning Group's Constitution and Standing Orders.

2. Remit and responsibilities of the Committee
The Committee shall make recommendations to the Governing Body on determinations about pay and remuneration for employees of the Clinical Commissioning Group and people who provide services to the Clinical Commissioning Group and allowances under any pension scheme it might establish as an alternative to the NHS pension scheme.

Specifically, the Committee will be responsible for:

- Determining the remuneration, allowances, payments for additional responsibilities, other benefits and conditions of service of the senior management team.
- Monitoring and evaluating the performance and achievements of the Accountable Officer and other senior management team members and determining annual salary awards and other payments as appropriate.
- Considering the contractual arrangements and severance payments of the Accountable Officer and of other senior staff, seeking HM Treasury approval as appropriate in accordance with the guidance ‘Managing Public Money’
- Report in writing to the Governing Body the basis of its decisions for ratification.

Remuneration Committees should also remain aware that each individual NHS organisation is corporately responsible for ensuring that its pay arrangements are appropriate in terms of Equal Pay requirements and other relevant legislation.

3. Membership
The Committee shall be appointed by the Clinical Commissioning Group from amongst its Governing Body members and must not have a Member Practice majority. The committee should not include full time employees or individuals who claim a significant proportion of their income from the group. Only members of the Remuneration Committee have the right to attend Remuneration Committee meetings:
Members:
- Chair of the Committee (Lay Member)
- Deputy Chair of the Committee (Lay Member)
- Chair of the Clinical Commissioning Group
- [Other Lay members as determined by the Governing Body]

Persons in attendance:
- Accountable Officer (as and when required)
- CCG [Director/Head of HR or equivalent] will be responsible for supporting the Chair in the management of Remuneration Committee business and for drawing the Committee’s attention to best practice, national guidance and other relevant documents, as appropriate.
- Chief Finance Officer to advise on any matters that have significant financial implications.

Other parties may only attend at the request of the Committee and only to provide advice and information.

Staff will not be present for the discussion of matters relating to their own remuneration, performance or terms of service.

4. Secretary
The secretary will be a [Manager/other Officer in the HR function/Business Manager] who will also take the minutes.

5. Quorum
The meeting will be quorate when [two] members are present, with at least [one Lay Member] also present. The majority of those present should be Lay Members.

6. Frequency and notice of meetings
The committee will meet sufficiently to fulfil its work plan or at least bi-annually as a minimum. The Governing Body reserves the right to call a meeting at any time (with appropriate notice) if an urgent matter arises.

A notice period of at least 14 days shall be given before the Remuneration Committee meets. The Agenda and supporting papers will be circulated 7 days prior to the meeting.

7. Relationship with the Governing Body
Once agreed, reports on activity of the Committee will be reported to the Lay Members of the Governing Body, respecting individual confidentiality.

8. Decision making
The Committee will at all times apply best practice in the decision making processes. When considering individual remuneration the committee will:
- Comply with current disclosure requirements for remuneration;
- On occasion seek independent advice about remuneration for individuals; and
- Ensure that decisions are based on clear and transparent criteria.
The Committee will have full authority to commission any reports or surveys it deems necessary to help it fulfil its obligations.

A decision put to a vote at a meeting shall be determined by a majority of the votes of the members present.

9. Conduct of the committee
The Remuneration Committee will:

- Observe the highest standards of propriety involving impartiality, integrity and objectivity in relation to the stewardship of public funds and the management of the bodies concerned;
- Maximise value for money through ensuring that services are delivered in the most efficient and economical way, within available resources, and with independent validation of performance achieved wherever practicable;
- be accountable to Parliament, to users of services, to individual citizens, and to staff for the activities of the bodies concerned, for their stewardship of public funds and the extent to which key performance targets and objectives have been met;
- comply fully with the principles of the Citizen’s Charter and the Code of Practice on Access to Government Information, in accordance with Government policy on openness; and
- bear in mind the necessity of keeping comprehensive written records of their dealings, in line with general good practice in corporate governance

10. Review
These Terms of Reference will be reviewed after six months and on an annual basis thereafter. This will take into account any new national guidance and relevant codes of conduct / good governance practice.

Any resulting changes to the terms of reference will be approved by the Governing Body.

[Date agreed]
MERTON CLINICAL COMMISSIONING GROUP

Executive Management Team - Terms of Reference

1. **Aim and Purpose**
   These Terms of Reference set out the membership, remit, responsibilities and reporting arrangements of the Executive Management Team (EMT).

2. **Authority**
   The MT is authorised by the Governing Body to pursue any activity within these Terms of Reference and within the Scheme of Reservation and Delegation, including (without limiting the generality of the foregoing) to:
   
   a) Seek any information it requires from CCG employees, in line with its responsibility under these terms of references and the Scheme of Reservation and Delegation.

   b) Require all CCG employees to co-operate with any reasonable request made by the EMT, in line with its responsibility under these terms of references and the Scheme of Reservation and Delegation.

   c) Review and investigate any matter within its remit and grants freedom of access to the CCG records, documentation and employees.

   d) To set up any joint working arrangements with other bodies.

   e) To establish sub-group to deliver its objectives.

   The Executive Management Team is required to comply with:

   - the CCG’s Standing Orders and Standing Financial Instructions
   - the CCG’s Conflict of Interest Policy
   - the section of the CCG’s Scheme of Delegation which refers to these committees

3. **Duties**
   The Executive Management Team (EMT) is the operational group, whose purpose is to fulfil the responsibilities of the CCG and to enable the development and delivery of corporate direction.

   The EMT will:

   - Appraise and lead the debate on strategic issues facing the CCG and provide expert advice to the Governing Body.
   - Appraise how these issues should be managed and led within the organisation.
   - Consider corporate issues relating to national policy and local priorities, and agree leadership responsibility and arrangements for delivery as appropriate.
   - Oversee overall operational management of the CCG.
   - Ensure that EMT actions are defined and timescale for delivery and reporting is agreed.
   - Ensure business of the CCG is conducted in accordance with Standing Orders (SOs) and Standing Financial Instructions (SFIs).
   - Establish and review the assurance framework for the CCG to ensure that risks are assessed and managed.
   - Appraise priorities and risks across directorates and organisations and identify options for resolution/mitigation including the Commissioning Support Unit.
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- Appraise and monitor performance of the CCG corporately in accordance with Key Performance Indicators and the NHS Outcomes Framework.
- Identify key actions and timescales arising from performance appraisal.
- Identify and implement remedial plans as appropriate to address variances in performance, health outcomes and inequalities.
- Prepare and review plans in respect of the application and delivery of available financial resources, develop budgets for approval by the Governing Body and scrutinises expenditure.

4. Items for inclusion on Agendas
   - Operational issues – day to day running of the CCG.
   - Appraisal and debate of strategic issues facing the CCG.
   - Consideration of how issues should be managed and led within the organisation and provision of advice to the Governing Body.
   - Pre-approval and preparation of papers relating to CCG strategy including application of financial resources, draft business cases, CSP etc.
   - Papers that require decision/shaping in order to progress.
   - Papers that shape operational process – development of CCG policies and procures.
   - Proposals to set up working groups or joint working arrangements in order to deliver objectives.

5. Membership and Quoracy
   The membership of the EMT will comprise:
   - Chief Officer
   - Chief Financial Officer
   - Director of Commissioning and Planning
   - Director of Quality
   - Medical Director (as required)
   - 3 x Locality Clinical Leads
   - 4 x Clinical Reference Group Clinical Leads (on a rotational basis)
   - Director of Public Health (in attendance)
   - Executive Assistant

   The meeting will be chaired by the Chief Officer. The Locality Leads and Clinical Reference Group Leads will attend the monthly QIPP review plus one other meeting per month. The meeting will be quorate if attended by 4 members, including 2 GPs and 1 Director.

6. Attendance
   The Locality Leads and Clinical Reference Group Leads will be expected to attend the QIPP meeting plus one other EMT per month. All other 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. If the representative from any area is unable to attend then apologies are expected prior to the meetings.

   Additional members may be required to attend on an ad hoc basis subject to relevant items being on the agenda. This will be agreed with the Chair.

7. Frequency
   The EMT will meet weekly with one meeting dedicated to QIPP to oversee the operational delivery and performance of all aspects of commissioning responsibilities within Merton.

   Meetings will be held on Wednesday mornings 9.30 – 11.00 am. (TBA)
8. **Reporting**
   The Chief Officer will report to the Governing Body on the CCG’s progress and agenda. Any documentation requiring formal sign off is to be presented to the Governing Body on behalf of the EMT by the nominated representative.

9. **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.

10. **Administration**
    The Agenda for meetings and supporting papers will be distributed at least two working days in advance of the meetings to allow time for members’ due consideration of issues.

    Minutes will be kept of the proceedings and submitted for approval at of each EMT meeting.

    The Minutes, Agenda and associated papers will be circulated to Members via e-mail.

11. **Review**
    The Terms of Reference will be reviewed annually.
Draft NHS Merton CCG Practice Leads Forum

Terms of Reference

Purpose
The Practice Leads Forum (PLF) will play an important role in enabling practice leads to shape its priorities. As a network of practices, the PLF will create opportunities for shared learning, collective problem solving and professional development and best practice exchange.

Scope
- The role of the PLF is to provide a regular forum for Practice Leads to explore how the MCCG ensures commissioning decisions reflect the needs of the patients.
- To promote the highest standards of excellence in the provision of high quality care that is safe, effective and focused on the patient experience.
- To support the MCCG to improve the health outcomes for the population and deliver excellent and innovative healthcare by working together through the MCCG Business Plan.

Objectives
- To discuss and input to MCCG strategy, operating and implementation plans
- To advise on priorities and issues as requested by the MCCG Board or Executive
- To act as a forum to discuss and review MCCG issues relating to patient care, as appropriate
- To represent the views of their Member Practice
- To share practice progress and knowledge about primary care and local issues
- To review performance data and information reports
- To engage with other Member Practice leads and practice teams
- To promote best practice and better working practices across all practices

Decision-making
The PLF is not a formal decision making body, so Governing Body governance functions are not delegated. The Practice Lead represents a formal relationship and statutory link between the MCCG and its Member Practices. The PLF is a network that will advise and influence the Governing Body along with other stakeholders. The forum will suggest ideas and offer an evaluation on issues arising from and relating to the Merton CCG Business Plan, commissioning strategies and operating plans.

Membership
As part of MCCG constitution:
- Each Member Practice will nominate a GP to represent the Member Practice on the PLF, the Practice Lead
- A Member Practice may replace its Practice Lead from time to time by notice in writing to the Governing Body
- MCCG will consider the Practice Lead has the authority to act on the behalf of a Member until it receives notification of the replacement in writing
- Each Member will authorise its Practice Lead to act on its behalf as follows:
  - Attend and receive notice of any meetings of the PLF
- Vote at meetings of PLF on behalf of the Member in accordance with MCCG Constitution.
- Sign any written resolution on behalf of the Member.
- Receive any notices from the MCCG on behalf of the Member and any notice delivered by the MCCG to the Practice Lead shall be deemed to have been made or served on the Member.

Appoint a proxy; and

- Approve or provide any consent required by the MCCG in respect of the powers and duties of the Member described in MCCG Constitution.

**Responsibilities**

Each practice has chosen their own representative to support the development and implementation of clinical commissioning. The Practice Lead must be someone within the Practice who has the mandate of the Practice to represent the clinicians within their Practice in dealings with MCCG. They will need to be an effective communicator within their practice team and have the ability to meet actions and report back information in a timely manner.

The role of the Practice Lead is seen as central to the success of the new organisation. Some Practice Leads will lead their localities. Components of the Practice Lead role include working within their practices and across localities to:

- lead the review of practice patient needs
- implement agreed care pathways
- review reports on activity & resources, ensuring these are shared with those who make decisions regarding the use of resources in their practices (become an expert for your practice)
- act as a channel of communication between the practice & the MCCG Executive
- take part in change management and other development opportunities
- take part in bringing about service change within MCCG
- attend meetings within the locality as agreed – bi monthly
- attend meetings of MCCG, as agreed
- attend Practice Leads Forum – bi monthly

The role will be reviewed during the year. Developmental support such as training and coaching will be provided to Practice Leads to recognise the significant level of change management that is required and the pivotal role that Practice Leads will play in embedding new ways of working to make MCCG different and better in future.

**Frequency of meetings**

The Practice leads have agreed to meet monthly, alternating between all 26 leads (the Practice Leads Forum) and smaller groups/the localities. This will enable practices to influence and give feedback to the Board and ensure clear and efficient lines of communication.
Reporting

The PMF can elect to report back via the Locality Clinical Lead on a monthly basis, or when necessary.

Review

The terms of reference for the group to be reviewed annually
NHS Merton CCG Practice Managers Forum

Terms of Reference

Aim

- The role of the MCCG Practice Managers Forum (PMF) is to provide a regular forum for Practice Managers to meet and share knowledge about general practice and primary care.
- To support the MCCG to deliver excellent and innovative healthcare by working together through the MCCG Business Plan.

Scope

- The PMF will support the networking of practices, ensure consistent approaches are taken across the CCG and encourage shared learning and contribute to strategy formation.
- The Governing Body might ask the PMF to contribute practically towards implementation of initiatives because of their role within the practices.

Objectives

- To share practice progress and share knowledge about primary care
- To review data and information reports
- To advise on issues as requested by the MCCG Board or Executive
- To discuss and input to MCCG implementation plans
- To act as a vehicle for MCCG issues relating to patient care as appropriate

How

Regularly to attend monthly meetings.

Decision-making

The group is a sub-group of the MCCG Executive, not a decision-making group. The group will suggest ideas and offer an evaluation on issues arising from and relating to the Merton CCG Business Plan.

Membership

Louise Aitken  Lee Beesley  Jayita Biswas
Christine Board  Laura Bond  Linda Bradley
Sandra Clapham  Rita De Oliviera  Vanessa Dias
Jane Fisk  Gill Frost  Garg Kuldeep
Stephen Hartley  Pat Hennessy  Michelle Izzo
Alison Kirk  Savita Lall  Sheila Leach
Diana Ljubic  Maryanne Michael  Chris Newman
Vincent Poncia  Mohinder Riyat  Beverley Snell
Susan Stansfield  Ruth Steines  Rohini Vivekananda
Barbara Young
In attendance

Daniel Archer, Eleanor Brown, Lynne Jackson, Sima Hairian

Frequency of meetings

The Group will meet monthly. In addition, the group may meet on an exception basis in response to a specific issue/concern.

Reporting

The PM Representative will report back to the MCCG Management Team on a monthly basis, or when necessary.

Review

The terms of reference for the group to be reviewed 6 monthly
NHS Merton CCG Practice Nurses Forum

Terms of Reference

Aim

To provide a regular forum for Practice Nurses (PN) to meet and share knowledge about general practice, nursing and primary care.

Scope

- The Practice Nurse Forum (PNF) will support the networking of local practice nurses and enable MCCG to achieve better quality care for patients.
- It will provide scope for the networking of practices in relation to clinical initiatives, as well as, create opportunities for shared learning and professional development.
- The PNF will also contribute to strategy formation as well as implementation of key initiatives.

Objectives

- To harness PN expertise to influence change and contribute to service and practice developments.
- To share and disseminate good practice, as required.
- To give feedback on issues as requested by the MCCG Board or Executive.
- To promote learning and personal and professional development.
- To review the effectiveness of initiatives and their impact on patient care, draw together patient experiences and ways to improve outcomes including leading work with groups of practices, as required.

Decision-making

The group is a sub-group of the MCCG Executive and is not a decision-making group. The group will suggest ideas and offer feedback on issues arising from and relating to practice issues.

Membership

Membership is extended to any practice nurse, nurse practitioner, health care assistant or nurse consultant employed by the member practices.

Frequency of meetings

The Group will meet monthly. The group can also meet on an exceptional basis in response to a specific issue/concern.
**Reporting**

The PN Representative will report back to the MCCG Management Team on a monthly basis, or when necessary.

**Review**

The terms of reference for the group to be reviewed annually

**Ground Rules**

1. Time for supervision will be protected- making an effort to attend and be on time,

2. All group members will actively participate so as to facilitate in-depth reflections on issues affecting practice, with the aim to develop personally and professionally

3. Prepare for the session- e.g. examples feedback on actions and bringing new issues

4. Group members agree to take responsibility for making effective use of the time and be committed to professional development

5. Be willing to learn and open to receiving support and challenge

6. Demonstrate respect and equity for all members views

7. Confidentiality will be maintained except where disclosures during the supervision reveal unsafe unethical or illegal practice, and compromise the supervisee's code of conduct

8. Record keeping- a log of attendees will be kept with a summary of themes discussed.

9. Supervisee to maintain personal reflective account or records