West Hampshire
Clinical Commissioning Group

NHS WEST HAMPSHIRE

CLINICAL COMMISSIONING GROUP

CONSTITUTION

Revised Version: 1.6

CCG Board Effective Date: 2 August 2012

NHS England Effective Date: 18 January 2013 (revised 26 July 2018)

Constitution Review Log:

Version Number	Review Date	Name of Reviewer	Ratification Process	Notes
1.1	2 August 2012	Board	Approved by the Board, for submission as part of the authorisation process.	
1.2	18 January 2013	NHS Commissioning Board	Authorisation by the NHS Commissioning Board	
1.3	23 August 2013	CCG Board NHS England	Amendments approved by NHS England reflecting: *Changes in the number of member practices in the CCG* *The inclusion of a supplementary statement relating to whistleblowing policies* *Typographical and minor technical amendments (post-authorisation)*	Schedule of changes available on request
1.4	17 January 2014	CCG Board NHS England	Amendment approved relating to the eligibility for the election of GP/ Clinical Board Members (following consultation with members)	Schedule of changes available on request
1.5	5 January 2015	CCG Board NHS England	Amendments approved reflecting: *Changes in the number of member practices in the CCG* *The CCG's application to NHS England to take on joint or delegated commissioning arrangements for primary care* *Eligibility for Clinical Board Membership and Board succession*	Schedule of changes available on request
1.6	23 January 2018	CCG Board NHS England	*Proposed amendments reflecting* *Changes in the number of member practices in the CCG*	Schedule of changes available on request

			Changes in membership of the Board including the Clinical Leadership, to strengthen the locality focus of the CCG's work, and the appointment of the Chairman *Housekeeping of document to take account of the following:* *a) Correct title of organisations, CCG structures or postholders and removal of reference to other pre-authorisation arrangements* *b) Amendments which clarify and reflect CCG operational practice since the last update to the Constitution in 2015 including approved CCG Values, Strategic Objectives and Operating Plans, Primary Care Commissioning, revised Statutory Guidance on Managing Conflicts of Interest, the development of the Sustainability and Transformation Partnership and Local Delivery Systems.*	

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FOREWORD

A Constitution sets out the arrangements made by an organisation to meet its responsibilities. It describes the governing principles, rules and procedures to ensure probity and accountability in the day to day running of the organisation. The following describes the constitutional arrangements within NHS West Hampshire Clinical Commissioning Group.

West Hampshire covers a large population of over 530,000 with 49 member practices in six localities, served by three main acute providers as well as five community hospitals. The CCG borders Dorset County Council (East Dorset District and Christchurch Borough councils), Wiltshire County Council, West Berkshire Council, Southampton City Council, North Hampshire CCG, Southampton City CCG, Fareham & Gosport CCG, South Eastern Hampshire CCG, Dorset CCG and Wiltshire CCG.

We are clear that the delivery of our ambitions will only be achieved by:

- The involvement and engagement of our member Practices, building on the already well established locality structure with locality lead GPs playing their full part in the leadership of the CCG at local level
- The engagement of patients and carers in service development
- The development of our clinical directorate structure to provide strong clinical leadership to all our priority areas, ably supported by a talented workforce both within the CCG itself and in the Commissioning Support Unit
- The development of effective partnerships with commissioners and providers across Southampton, Hampshire, Isle of Wight, Portsmouth and beyond, including the Hampshire and Isle of Wight Sustainability Partnership and its constituent programmes and Local Delivery Systems
- The collaboration between secondary and primary care clinicians, community care and our local authority partners to transform pathways of care which are patient and carer focussed
- Engagement and involvement of the Local Medical Committee in relation to membership issues

Vision

"Quality Services, Better Health"

Our vision is to be consistently recognised for commissioning and enabling the delivery of high quality patient centred healthcare, which is innovative, equitable, efficient, effective and, where possible, prevention based, contributing to the healthiest population in England

1 INTRODUCTION AND COMMENCEMENT

1.1. Name

1.1.1. The name of this clinical commissioning group is NHS West Hampshire Clinical Commissioning Group.

1.2. Statutory Framework

1.2.1. Clinical commissioning groups are established under the Health and Social Care Act 2012 ("the 2012 Act").[1] They are treated as NHS bodies for the purposes of National Health Service Act 2006 ("the 2006 Act").[2] The duties of clinical commissioning groups to commission certain health services are set out in section 3 of the 2006 Act, as amended by section 13 of the 2012 Act, and the regulations made under that provision.[3]

1.2.2. NHS Commissioning Board, hereafter known as NHS England, is responsible for determining applications from prospective groups to be established as clinical commissioning groups[4] and undertakes an annual assessment of each established group.[5] It has powers to intervene in a clinical commissioning group where it is satisfied that a group is failing or has failed to discharge any of its functions or that there is a significant risk that it will fail to do so.[6]

1.2.3. Clinical commissioning groups are clinically led membership organisations made up of general practices. The members of the clinical commissioning group are responsible for determining the governing arrangements for their organisations, which they are required to set out in a constitution.[7]

1.3. Status of this Constitution

1.3.1. This constitution is made between the members of NHS West Hampshire Clinical Commissioning Group and has effect from 18 January 2013, when the NHS England established the group.[8]

1.3.2. The constitution is published on the group's website at www.westhampshireccg.nhs.uk and will be referred to annually at the CCG Annual Meeting to ensure that its standards and contents are upheld.

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1 See section 1I of the 2006 Act, inserted by section 10 of the 2012 Act

2 See section 275 of the 2006 Act, as amended by paragraph 140(2)(c) of Schedule 4 of the 2012 Act

3 Duties of clinical commissioning groups to commission certain health services are set out in section 3 of the 2006 Act, as amended by section 13 of the 2012 Act

4 See section 14C of the 2006 Act, inserted by section 25 of the 2012 Act

5 See section 14Z16 of the 2006 Act, inserted by section 26 of the 2012 Act

6 See sections 14Z21 and 14Z22 of the 2006 Act, inserted by section 26 of the 2012 Act

7 See in particular sections 14L, 14M, 14N and 14O of the 2006 Act, inserted by section 25 of the 2012 Act and Part 1 of Schedule 1A to the 2006 Act, inserted by Schedule 2 to the 2012 Act and any regulations issued

8 See section 14D of the 2006 Act, inserted by section 25 of the 2012 Act

1.3.3. The constitution will be available upon request for inspection at CCG headquarters and upon application, either by:

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

email – whccg.info@nhs.net

1.4. Amendment and Variation of this Constitution

1.4.1. This constitution can only be varied in two circumstances.[9]

a) where the group applies to NHS England and that application is granted;

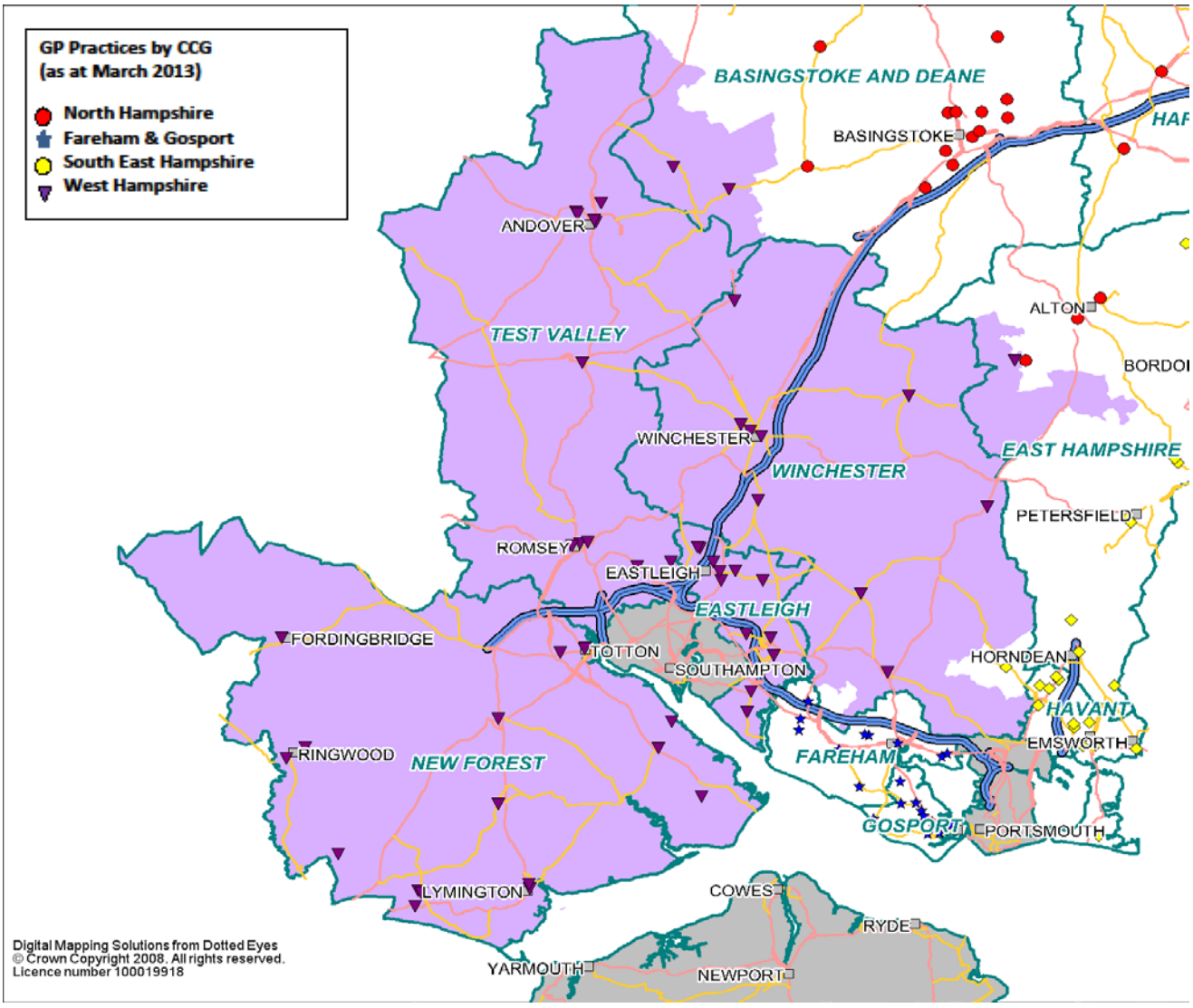
b) where in the circumstances set out in legislation NHS England varies the group's constitution.

[9] See sections 14E and 14F of the 2006 Act, inserted by section 25 of the 2012 Act and any regulations issued

2. AREA COVERED

2.1. The geographical area covered by NHS West Hampshire Clinical Commissioning Group is West Hampshire and is also covered in part by Hampshire County Council. The area, however, is broadly co-terminous with the four local authorities of New Forest District Council, Eastleigh Borough Council, Test Valley Borough Council and Winchester City Council. There are also substantial links to Dorset County Council and Wiltshire County Council. A more detailed description of the geographical area can be found at Annex 1.

West Hampshire CCG Area



3. MEMBERSHIP

3.1. Membership of the Clinical Commissioning Group

3.1.1 Appendix B of this constitution contains the list of member practices and the localities in which they are based.

3.2. Eligibility for membership of the Clinical Commissioning Group

3.2.1 Any General Practice situated within the geographical area covered by the CCG which holds a contract for the provision of primary medical services and whose practice population is in the majority resident in West Hampshire shall be eligible for membership of the CCG.

3.3. Clinical Board Members

3.3.1 There will be a maximum of seven Clinical Board Members elected by the member practices:

- Six Clinical Board Members, comprising one elected member from within each of the six CCG Localities (Locality Clinical Directors)
- A Chairman, elected by the whole CCG membership, independent from the Board Member roles elected by the Localities

3.3.2 The roles of the Clinical Board Members are set out in more detail in the CCG's Standing Orders (Appendix C), including a summary of the appointment process.

3.4. Eligibility for Clinical Board Members

3.4.1 All general practitioners practising in West Hampshire CCG member practices, whether they be partners, non-partners or locums.

3.4.2 All general practitioners must meet prevailing revalidation standards.

3.4.3 Nominations for Locality Clinical Directors must be accompanied by written confirmation of support from a West Hampshire CCG member practice located within the respective locality.

3.4.4 Nominations for the role of Chairman must be accompanied by written confirmation of support from a West Hampshire CCG member practice. Nominees will then undertake the required internal and mandatory assessment and election process.

4. MISSION STATEMENT, VISION, VALUES AND STRATEGIC OBJECTIVES

4.1. Mission Statement

The Mission Statement of the WHCCG is comprised of 2 elements, the vision or purpose of the CCG and the values or guiding principles by which it works.

Our Vision (purpose) is:

> ***"Quality Services, Better Health"***
>
> *To be consistently recognised for commissioning and enabling the delivery of high quality patient centred healthcare, which is innovative, equitable, efficient, effective and, where possible, prevention based, contributing to the healthiest population in England*

4.2. Our Values (guiding principles)

4.2.1 In everything we do we aim to be **compassionate, honest, ambitious, fair and inclusive.**

4.3. Strategic Objectives and Priorities

4.3.1 In December 2015, the NHS shared planning guidance 2016/17 - 2020/21 outlined a new approach to help ensure that health and care services are built around the needs of local populations. To do this, every health and care system in England produced a multi-year Sustainability and Transformation Plan (STP), showing how local services will evolve and become sustainable over the next five years – ultimately delivering the Five Year Forward View vision of better health, better patient care and improved NHS efficiency.

4.3.2 West Hampshire CCG is a member of the Hampshire and Isle of Wight Health and Care System. To deliver our shared priorities we are working with our partners across Hampshire and Isle of Wight in ten delivery programmes: six core programmes focused on transforming the way health and care is delivered, and four enabling programmes to create the infrastructure, environment and capabilities to deliver successfully.

4.3.3 Our care strategy helps us deliver the STP priorities and has helped shape the priorities within our annual Operating Plan. This care strategy enables us to change focus and to move from a reactive to a proactive care model, to be less dependent on hospital services and to improve community and GP services to enable people to help themselves maintain their health. People will have greater levels of support to manage their own condition, with their goals recorded and care increasingly being available in the community until the end of life. Everyone within our community will have the opportunity to maintain a healthy lifestyle.

4.3.4 Full details of the CCG's approved Strategy and current Operating Plan, as well as the Hampshire and Isle of Wight Sustainability and Transformation Plan, can be found on our

website at www.westhampshireccg.nhs.uk. This includes the CCG strategic priorities, an overview of the current work programmes and the planned outcomes summarised in a 'plan on a page'.

4.3.5 Our overarching strategic objectives, which drive the work of the CCG Board and its Committees, are to:

4.3.5.1 Ensure safe and sustainable high quality services – to provide the best possible care for patients

4.3.5.2 Ensure system financial sustainability – to ensure compliance with business rules

4.3.5.3 Work in partnership to commission health and social care collaboratively – to commission services at the appropriate tier to achieve the best possible outcomes for patients

4.3.5.4 Establish local delivery systems to deliver patient centred care closer to home which is integrated, prevention based, equitable and high quality

4.3.5.5 Develop the CCG workforce – to meet the future commissioning needs of the population

4.4 Principles of Good Governance

4.4.1 In accordance with section 14L (2) (b) of the 2006 Act,[10] the group will at all times observe "such generally accepted principles of good governance" in the way it conducts its business. These include:

4.4.1.1 the highest standards of propriety involving impartiality, integrity and objectivity in relation to the stewardship of public funds, the management of the organisation and the conduct of its business;

4.4.1.2 *The Good Governance Standard for Public Services*;[11]

4.4.1.3 the standards of behaviour published by the *Committee on Standards in Public Life (1995)* known as the 'Nolan Principles'[12]

4.4.1.4 the seven key principles of the *NHS Constitution*;[13]

4.4.1.5 the Equality Act 2010.[14]

4.4.1.6 standards for Members of NHS Boards and Governing Bodies in England

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10 Inserted by section 25 of the 2012 Act

11 *The Good Governance Standard for Public Services*, The Independent Commission on Good Governance in Public Services, Office of Public Management (OPM) and The Chartered Institute of Public Finance & Accountability (CIPFA), 2004

12 See Appendix F

13 See Appendix G

14 See http://www.legislation.gov.uk/ukpga/2010/15/contents

4.5 Accountability

4.5.1 The group will demonstrate its accountability to its members by:

4.5.1.1 consulting on and publishing its constitution;

4.5.1.2 making provision for members to meet in locality groups on a regular basis and as a group at least annually;

4.5.1.2.1 Each individual practice is represented by an individual from the practice and this group, will meet at least annually. Two thirds of this group, (currently 33 members – January 2018), can among other things take a vote of no confidence in the elected members and expect a process of election to take place. There will also be the opportunity to call additional meetings if required.

4.5.1.3 providing information to the Members;

4.5.1.4 taking account of feedback from the Members in its decisions;

4.5.1.5 supporting a locality structure where Locality Clinical Directors are both voting members of the Clinical Cabinet and the CCG Board;

4.5.2 the group will demonstrate its accountability to its members, local people, stakeholders and NHS England in a number of ways, including by:

4.5.2.1 appointing independent lay members and a nurse and a secondary care doctor to its Board;

4.5.2.2 holding meetings of its Board in public at least twice yearly and publish annually a commissioning plan;

4.5.2.3 complying with local authority health overview and scrutiny requirements;

4.5.2.4 producing annual accounts in respect of each financial year which must be externally audited;

4.5.2.5 having a published and clear complaints process and complying with the Freedom of Information Act 2000;

4.5.2.6 developing additional mechanisms during and after Authorisation

4.5.3 The Board of the group will throughout each year have an ongoing role in reviewing the group's governance arrangements to ensure that the group continues to reflect the principles of good governance.

5. FUNCTIONS AND GENERAL DUTIES

5.1. Functions

5.1.1 The functions that the group is responsible for exercising are largely set out in the 2006 Act, as amended by the 2012 Act. An outline of these appears in the Department of Health's *Functions of clinical commissioning groups: a working document*. They relate to:

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

5.1.1.1.1 All people registered with member GP practices, and

5.1.1.1.2 people who are usually resident within the area and are not registered with a member of any clinical commissioning group;

5.1.1.2 Commissioning emergency care for anyone present in the group's area;

5.1.1.3 Paying its employees' remuneration, fees and allowances in accordance with the determinations made by its Board and determining any other terms and conditions of service of the group's employees;

5.1.1.4 Determining the remuneration and travelling or other allowances of members of its Board.

5.1.2 In discharging its functions the group will:

5.1.2.1 Act[15] consistently with the discharge by the Secretary of State and NHS England of their duty to ***promote a comprehensive health service***[16] *and* with the objectives and requirements placed on the NHS England through *the mandate*[17] published by the Secretary of State before the start of each financial year by:

5.1.2.1.1 Delegating tasks to the group's Board, and sub-committees or individual members as it shall see fit provided that any such delegations are recorded in the Scheme of Delegation (Appendix D) and are governed by terms of reference.

5.1.2.1.2 Setting out in the Scheme of Delegation (Appendix D) the, 'Schedule of Matters Reserved to the Clinical Commissioning Group and Scheme of Delegation certain powers and decisions that may only be exercised by the Board in formal session and shall have effect as if incorporated into the Standing Orders.

5.1.2.1.3 Requiring progress of delivery of the duty to be monitored through the group's reporting mechanisms as governed by the standing orders (Appendix C)

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15 See section 3(1F) of the 2006 Act, inserted by section 13 of the 2012 Act

16 See section 1 of the 2006 Act, as amended by section 1 of the 2012 Act

17 See section 13A of the 2006 Act, inserted by section 23 of the 2012 Act

5.1.2.2 ***meet the public sector equality duty***[18] by:

i) Delegating responsibility to the Chief Officer for ensuring that West Hampshire CCG complies with the general and specific duties of the public sector equality duty (Section 149 of the Equality Act 2010)

ii) Having an Equality and Diversity Policy which sets out how we will deliver this duty, including:

- Gathering information on how our work affects different people
- Publishing, at least annually, sufficient information to demonstrate compliance with the public sector equality duty
- Consulting employees, patients/service users and trade unions about how our commissioning and employment practices could be improved
- Assessing the equality impact of current and proposed policies, functions and commissioning decisions
- Identifying priorities and setting Equality Objectives
- Taking action to achieve those objectives
- Publishing and reviewing Equality Objectives at least every four years

iii) Requiring that legal compliance and equalities performance is reviewed by the Board on an annual basis. The CCG may consider establishing an Equality and Diversity Sub-Committee of the Board, although this work is likely to be reviewed by an existing Committee.

iv) Adopting the NHS Equality Delivery System as the framework to assist the CCG in delivering the public sector equality duty.

v) The CCG will publish an annual Equality and Diversity review, as part of the CCG's Annual Report at the AGM describing progress against agreed Equality Objectives

5.1.2.3 work in partnership with its local authority[ies] to develop ***joint strategic needs assessments***[19] (JSNAs) and ***joint health and wellbeing strategies***[20] by:

5.1.2.3.1 Ensuring Board level engagement

5.1.2.3.2 Ensuring the Chairman of the CCG is the representative on the Hampshire Health & Wellbeing Board along with the nominated CCG Public Health representative

5.1.2.3.3 Ensuring the JSNA for West Hampshire CCG takes account of the previous Hampshire-wide JSNA.

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18 See section 149 of the Equality Act 2010, as amended by paragraphs 184 and 186 of Schedule 5 of the 2012 Act

19 See section 116 of the Local Government and Public Involvement in Health Act 2007, as amended by section 192 of the 2012 Act

20 See section 116A of the Local Government and Public Involvement in Health Act 2007, as inserted by section 191 of the 2012 Act

5.1.2.3.4 Ensuring locality leads are linked to the appropriate district Health & Wellbeing Boards.

5.2 General Duties - in discharging its functions the group will:

5.2.1 Make arrangements to ***secure public involvement*** in the planning, development and consideration of proposals for changes and decisions affecting the operation of commissioning arrangements[21].

5.2.1.1 The aims and objectives of West Hampshire CCG in respect of public involvement include:

a) Building continuous and meaningful engagement with the public, patients and carers to influence the shaping of services and improve the health of people in West Hampshire, including:

- ensuring the public voice influences and is directly involved in the decisions made by the CCG
- working closely with seldom heard groups to ensure they have a voice
- using patient experience data and information to inform our work

b) Engaging all GP members, including practice managers, in the development and ongoing work of the CCG to ensure they are involved in the core business and related work streams

c) Support the development of key relationships between West Hampshire stakeholders and CCG leads to ensure partnership working and involvement

d) Develop core materials and mechanisms for ongoing two-way communications and engagement to allow continual feedback in commissioning decisions

e) Develop a communications and engagement network and reference group for West Hampshire to ensure use of existing networks and skills and to allow ongoing involvement in commissioning decisions

5.2.1.2 The Statement of Principles of West Hampshire CCG in respect of public involvement are:

a) We will work in partnership and involve local people, partners and staff at all stages in planning, shaping, designing and delivering services, and in setting priorities for West Hampshire. We will make the involvement of people central to everything we do and we aim to make it as easy as we can for people to be involved and to actively include them in ways that are meaningful and give real opportunities to influence.

b) We will also tell people how their involvement has influenced decisions. Prioritising local health needs may mean that on occasions we are not able to do what people want, if that happens we will explain why and be held to account for our decisions.

[21] See section 14Z2 of the 2006 Act, inserted by section 26 of the 2012 Act

c) We aim to involve and engage local people through ongoing engagement and through project engagement, including through the following mechanisms:

- **Membership of Healthwatch** – a member of the CCG will be part of and attend Healthwatch meetings to provide regular updates and bring information and questions back to the CCG to provide two-way communications. A member of Healthwatch is invited to sit on the Board.
- **Communications and engagement network** – a map and contacts database for the groups across West Hampshire that link to patients and the public to ensure a mechanism to for two-way communication into and out from the CCG to existing groups
- **Communications and engagement group** – a group of representatives from across the network for greater involvement and to share information from the CCG and bring feedback to the CCG
- **Patient participation groups (PPGs)/Reference Groups** – drawing in representatives from PPG groups to join the communications and engagement group and using the network contacts to reach out to all practice populations
- **Membership** – development of an existing local membership database for patients and public within West Hampshire, who want to be involved in a range of projects of their choice

5.2.1.3 As well as ongoing engagement through the above mechanisms, we will ensure each project is reviewed and if required a communications and engagement plan produced, with individual stakeholder mapping. This will ensure a wide range of stakeholders can be involved and input into project development and outcomes, through two-way communications. A range of methods will be used as appropriate to each stakeholder.

5.2.1.4 All communications and engagement will also take into account of the diversity of the population we serve, and the potential barriers to communication and involvement some people face. We will also gather evidence of our communications and engagement work in order to demonstrate compliance with equalities law.

5.2.1.5 All engagement activity will be published on the CCG's website ('Get Involved') and through other media including newsletters, Facebook and Twitter.

5.2.1.6 All formal papers to the CCG Board and its Committees are required to highlight the groups where evidence supporting the paper has been considered as well as the public involvement activity taken or planned. In addition an annual 'Duty to Involve' report is prepared to ensure all remain informed and updated on current communications and engagement activity and to monitor and report compliance against this statement of principles.

5.2.1.7 Regular communication and engagement occurs with the local health overview and scrutiny committee to ensure they remain informed of potential changes and the engagement to support this. This involves regular testing with the committee of our activities and fuller reports and presentations when required.

5.2.2 ***Promote awareness of, and act with a view to securing that health services are provided in a way that promotes awareness of, and have regard to the NHS Constitution***[22] by:

5.2.2.1 Ensuring robust and appropriate governance arrangements: see appendix P Governance Structure.

5.2.2.2 The development of clear terms of reference for the sub-committee Board Committees.

5.2.3 Act ***effectively, efficiently and economically***[23] by:

5.2.3.1 The establishment of a Finance and Performance Committee, reporting to the Board. The Terms of Reference are appended (appendix M).

5.2.3.2 Part of the remit of the Committee is to:

- Coordinate performance management across the CCG. This includes:
  - identifying areas of poor performance and best practice;
  - identifying and initiating actions required to address performance issues;
  - assuring the delivery of remedial action plans covering QIPP and non-financial performance targets.
- Provide a source of escalation for those issues that are not being resolved at operational level
- Assess CCG performance in accordance with the accountability agreement
- Agree the appropriate responses to CCG Assurance requirements

5.2.4 Act with a view to ***securing continuous improvement to the quality of services***[24] by:

5.2.4.1 The establishment of a Clinical Governance Committee, which is a sub- committee of the Board. The Terms of Reference are appended (appendix J).

5.2.4.2 Clinical leads are identified to work with the CCG's Quality Team and the Commissioning Support Unit personnel in relation to the Clinical Quality Review meetings with individual providers.

5.2.5 Assist and support NHS England in relation to the Board's duty to ***improve the quality of primary medical services***[25] by:

5.2.5.1 The establishment of a Clinical Cabinet and a Primary Care Commissioning Committee, which are sub-committees of the Board. The Terms of Reference are appended (appendices K and L)

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22 See section 14P of the 2006 Act, inserted by section 26 of the 2012 Act and section 2 of the Health Act 2009 (as amended by 2012 Act)

23 See section 14Q of the 2006 Act, inserted by section 26 of the 2012 Act

24 See section 14R of the 2006 Act, inserted by section 26 of the 2012 Act

25 See section 14S of the 2006 Act, inserted by section 26 of the 2012 Act

5.2.5.2 The development of Local Enhanced Services (LES) e.g. Clinical Commissioning LES which supports and rewards practice development in primary care. The CCG will monitor compliance with the LES via the locality structure.

5.2.6 Have regard to the need to ***reduce inequalities***[26] by:

a) Using the NHS Equality Delivery System to support its work to tackle health inequalities experienced by equality groups (protected characteristics)

5.2.7 ***Promote the involvement of patients, their carers and representatives in decisions about their healthcare***[27] by:

a) Ensuring that information to promote and support the involvement of patients and carers in decisions about their healthcare is available in a range of formats so that it is accessible to all
b) Ensuring that diverse local communities, including those who are more difficult to reach, have a voice and are central to the CCG Communications and Engagement Strategy

5.2.8 Act with a view to ***enabling patients to make choices***[28] by:

5.2.8.1 Identification of a member of the Board to lead the Patient & Public Involvement Strategy

5.2.8.2 A programme of engagement meetings and periodic reports to the Board and its Committees, arising from the engagement undertaken in relation to specific work programmes.

5.2.8.3 Considering commissioning options which facilitate Choice.

5.2.9 ***Obtain appropriate advice***[29] from persons who, taken together, have a broad range of professional expertise in healthcare and public health by:

5.2.9.1 The establishment of a Board with a wide range of skills and experience, including a secondary care clinician, local authority representation and lay advisors.

5.2.9.2 The establishment of a Clinical Cabinet which includes Clinical Director leads for Planned Care, Unscheduled Care, Mental Health, Children & Families, Primary Care, Community Services, Medicines Management, Long Term Conditions, Education and Information Technology and the six Locality Clinical Directors This group also has Public Health representation.

5.2.9.3 The Clinical Cabinet is a committee of the Board and provides a direct link between the membership and the Board.

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26 See section 14T of the 2006 Act, inserted by section 26 of the 2012 Act
27 See section 14U of the 2006 Act, inserted by section 26 of the 2012 Act
28 See section 14V of the 2006 Act, inserted by section 26 of the 2012 Act
29 See section 14W of the 2006 Act, inserted by section 26 of the 2012 Act

5.2.10 ***Promote innovation***[30] by:

5.2.10.1 The establishment of a Clinical Cabinet which includes Clinical Director leads for Planned Care, Unscheduled Care, Mental Health, Children & Families, Primary Care, Community Services, Medicines Management and Long Term Conditions and the six Clinical Locality Leads. This group also has Public Health representation.

5.2.10.2 The identification of a Board lead for innovation who will be supported by the Localities.

5.2.11 ***Promote research and the use of research***[31]:

5.2.11.1 West Hampshire CCG currently has access to a shared Research Management and Governance service and a Comprehensive Local Research Network.

5.2.11.2 The CCG has identified a Research Governance lead, in particular in relation to oversight of research governance in secondary care and the approval process of excess treatment costs in secondary care.

5.2.12 Have regard to the need to ***promote education and training***[32] 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 for Health in the discharge of his related duty[33] by:

5.2.12.1 Producing a training and development policy.

5.2.12.2 Implementing the CCG development plan.

5.2.12.3 Sourcing external support with CCG strategy development, Board development and Intelligent Commissioner development.

5.2.13 Act with a view to ***promoting integration*** of *both* health services with other health services *and* health services with health-related and social care services where the group considers that this would improve the quality of services or reduce inequalities[34]. To facilitate this the following has been agreed:

5.2.13.1 The establishment of Local Delivery Systems with neighbouring health and social care commissioners and providers; as well as other core programmes of the Hampshire and Isle of Wight Sustainability and Transformation Partnership

30 See section 14X of the 2006 Act, inserted by section 26 of the 2012 Act
31 See section 14Y of the 2006 Act, inserted by section 26 of the 2012 Act
32 See section 14Z of the 2006 Act, inserted by section 26 of the 2012 Act
33 See section 1F(1) of the 2006 Act, inserted by section 7 of the 2012 Act
34 See section 14Z1 of the 2006 Act, inserted by section 26 of the 2012 Act

5.2.13.2 Hampshire County Council is invited to provide a representative who is a non-voting member of the Board.

5.2.13.3 The Chairman of the CCG Board is a member of the Hampshire Health & Wellbeing Board.

5.2.13.4 The five CCGs across Hampshire have established formal collaborative arrangements and work together to take a Hampshire-wide view of specific pathway development e.g. Childrens Services and adult joint commissioning in particular those related to Hampshire County Council.

5.2.13.5 The eight CCGs across Hampshire (including Portsmouth, Southampton and the Isle of Wight) have established formal collaborative arrangements where it is necessary to establish a whole system view to commissioning services, for example related to clinical networks, ambulance services and others.

5.3 General Financial Duties – the group will perform its functions so as to:

5.3.1 ***Ensure its expenditure does not exceed the aggregate of its allotments for the financial year***[35] by

5.3.1.1 The Chief Finance Officer will be responsible for ensuring that adequate systems of monitoring financial performance are in place to enable the CCG to fulfil its statutory responsibility not to exceed the aggregate of its allotments for the financial year.

5.3.1.2 The Chief Finance Officer shall monitor financial performance against plan and periodically report to the Board.

5.3.2 ***Ensure its use of resources*** *(both its capital resource use and revenue resource use)* ***does not exceed the amount specified by NHS England for the financial year***[36] by

5.3.2.1 Prior to the start of the financial year the Chief Finance Officer will on behalf of the Chief Officer prepare and submit budgets to the Board for approval.

5.3.2.2 The Chief Finance Officer shall monitor financial performance against plan a report at each Board meeting taking actions to address identified issues.

5.3.2.3 The Chief Finance Officer will devise and maintain systems of budgetary control including monthly financial reporting and review and investigation of any variances from plan.

5.3.2.4 The Chief Officer may delegate the management of budgets to others within the CCG in line will an agreed scheme of delegation.

The full detailed requirements will be contained in the CCGs standing financial instructions.

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35 See section 223H(1) of the 2006 Act, inserted by section 27 of the 2012 Act

36 See sections 223I(2) and 223I(3) of the 2006 Act, inserted by section 27 of the 2012 Act

5.3.3 ***Take account of any directions issued by NHS England, in respect of specified types of resource use in a financial year, to ensure the group does not exceed an amount specified by NHS England*** [37] by

5.3.3.1 The Chief Finance Officer will be responsible for establishing systems to monitor the expenditure against any resources specified for specific use by NHS England.

5.3.3.2 The Chief Finance officer will be responsible for regular review of the financial performance against plan and periodic reporting of that performance to the Board.

5.3.4 ***Publish an explanation of how the group spent any payment in respect of quality*** made to it by NHS England[38] by

5.3.4.1 The Chief Finance Officer on behalf of the Chief Officer will be responsible for producing a detailed review of any payments made in respect of quality.

5.3.4.2 The review will be as a minimum undertaken on an annual basis and publish as part of the CCG's annual report.

5.4 Other Relevant Regulations, Directions and Documents

5.4.1 The group will

5.4.1.1 comply with all relevant regulations;

5.4.1.2 comply with directions issued by the Secretary of State for Health or NHS England;

5.4.1.3 take account, as appropriate, of documents issued by NHS England and

5.4.1.4 ensure adequate Standing Financial Instructions, Standing Orders and a Scheme of Delegation is in place to support the governance of the CCG operations.

5.4.2 The group will develop and implement the necessary systems and processes to comply with these regulations and directions, documenting them as necessary in this constitution, its scheme of reservation and delegation and other relevant group policies and procedures.

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37 See section 223J of the 2006 Act, inserted by section 27 of the 2012 Act

38 See section 223K(7) of the 2006 Act, inserted by section 27 of the 2012 Act

6. DECISION MAKING: THE GOVERNING STRUCTURE

6.1. Authority to act

6.1.1 The clinical commissioning group is accountable for exercising the statutory functions of the group. It may grant authority to act on its behalf to:

6.1.1.1 any of its members;

6.1.1.2 its Board;

6.1.1.3 employees;

6.1.1.4 a committee or sub-committee of the group.

6.1.2 The extent of the authority to act of the respective bodies and individuals depends on the powers delegated to them by the group as expressed through:

6.1.2.1 the group's scheme of reservation and delegation; and

6.1.2.2 for committees, their terms of reference.

6.2. Scheme of Reservation and Delegation[39]

6.2.1 The group's scheme of reservation and delegation sets out:

6.2.1.1 those decisions that are reserved for the membership as a whole;

6.2.1.2 those decisions that are the responsibilities of its Board (and its committees), the group's committees and sub-committees, individual members and employees.

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

6.3. General

6.3.1 In discharging functions of the group that have been delegated to its Board (and its committees, joint committees and sub committees), and individuals must:

6.3.1.1 comply with the group's principles of good governance,[40]

6.3.1.2 operate in accordance with the group's scheme of reservation and delegation,[41]

6.3.1.3 comply with the group's standing orders,[42]

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39 See Appendix D

40 See section 4.5 on Principles of Good Governance above

41 See appendix D

6.3.1.4 comply with the group's arrangements for discharging its statutory duties,[43]

6.3.1.5 where appropriate, ensure that member practices have had the opportunity to contribute to the group's decision making process.

6.3.2 When discharging their delegated functions, its committees, joint committees and sub committees must also operate in accordance with their approved terms of reference.

6.4. Joint commissioning arrangements with other Clinical Commissioning Groups

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

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

6.4.2.1 delegating any of the CCG's commissioning functions to another CCG;

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

6.4.2.3 exercising jointly the commissioning functions of the CCG and another CCG.

6.4.3 For the purposes of the arrangements described at paragraph 6.4.2, the CCG may:

6.4.3.1 make payments to another CCG;

6.4.3.2 receive payments from another CCG;

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

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

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

6.4.5 For the purposes of the arrangements described at paragraph 6.4.2 above, the CCG may establish and maintain a pooled fund made up of contributions by any of the CCGs working together pursuant to paragraph 6.4.2.3 above. Any such pooled fund may be used to make payments towards expenditure incurred in the discharge of any of the commissioning functions in respect of which the arrangements are made.

6.4.6 Where the CCG makes arrangements with another CCG as described at paragraph 6.4.2 above, the CCG shall develop and agree with that CCG an agreement setting out the arrangements for joint working, including details of:

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42 See appendix C

43 See chapter 5 above

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

6.4.7 The liability of the CCG to carry out its functions will not be affected where the CCG enters into arrangements pursuant to paragraph 6.4.2 above.

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

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

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

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

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

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

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

6.5.3 The arrangements referred to in paragraph 6.5.2 above may include other CCGs.

6.5.4 Where joint commissioning arrangements pursuant to 6.5.2 above are entered into, the parties may establish a joint committee to exercise the commissioning functions in question.

6.5.5 Arrangements made pursuant to 6.5.2 above may be on such terms and conditions (including terms as to payment) as may be agreed between NHS England and the CCG.

6.5.6 Where the CCG makes arrangements with NHS England (and another CCG if relevant) as described at paragraph 6.5.2 above, the CCG shall develop and agree with NHS England a framework setting out the arrangements for joint working, including details of:

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

6.5.7 The liability of the CCG to carry out its functions will not be affected where the CCG enters into arrangements pursuant to paragraph 6.5.2 above.

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

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

6.5.10 The Board of the CCG shall require, in all joint commissioning arrangements that the lead commissioning director of the CCG make a written report at least every four months to the Board and hold at least annual engagement events to review aims, objectives, strategy and progress and publish an annual report on progress made against objectives.

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

6.6. Joint commissioning arrangements with NHS England for the exercise of NHS England function

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

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

- Exercise such functions as specified by NHS England under delegated arrangements;
- Jointly exercise such functions as specified with NHS England.

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

6.6.4 Arrangements made between NHS England and the CCG may be on such terms and conditions (including terms as to payment) as may be agreed between the parties.

6.6.5 For the purposes of the arrangements described at paragraph 6.6.2 above, NHS England and the CCG may establish and maintain a pooled fund made up of contributions by the parties working together. Any such pooled fund may be used to make payments towards

expenditure incurred in the discharge of any of the commissioning functions in respect of which the arrangements are made.

6.6.6 Where the CCG enters into arrangements with NHS England as described at paragraph 6.6.2 above, the parties will develop and agree a framework setting out the arrangements for joint working, including details of:

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

6.6.7 The liability of NHS England to carry out its functions will not be affected where it and the CCG enter into arrangements pursuant to paragraph 6.6.2 above.

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

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

6.6.10 The Board of the CCG shall require, in all joint commissioning arrangements that the lead commissioning director of the CCG make a written report at least every four months to the Board and hold at least annual engagement events to review aims, objectives, strategy and progress and publish an annual report on progress made against objectives.

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

6.7. Committees of the Board

6.7.1 The following committees have been established by the group:

a) Clinical Cabinet

b) Clinical Governance Committee

c) Finance and Performance Committee

d) Audit Committee

e) Remuneration Committee

f) Primary Care Commissioning Committee

6.7.2 Committees will only be able to establish their own sub-committees, to assist them in discharging their respective responsibilities, if this responsibility has been delegated to them by the Board or the committee they are accountable to.

6.8. Collaborative Arrangements and Relationships

6.8.1 The group has entered into collaborative arrangements with neighbouring health and social care commissioners and providers to work as Local Delivery Systems and with other core programmes of the Hampshire and Isle of Wight Sustainability and Transformation Partnership :

6.8.2 This also includes collaborative arrangements within the five CCGs within the Hampshire Local Authority area and the eight CCGs including Portsmouth, Southampton and the Isle of Wight

6.8.3 The group also has formal arrangements with the local Health & Wellbeing Board. Representation on this Board is by the Chairman of the CCG who ensures shared duties are discharged by the CCG.

6.8.4 The CCG also has strong links with Hampshire County Council Health and Adult Social Care Select Committee, Safeguarding Children Board, Safeguarding Adult Board, Children's Trust, the District Health & Wellbeing Boards, joint commissioning groups and public health.

6.8.5 The CCG will have strong links with the Local Medical Committee in relation to:

6.8.5.1 Management of the election process for the CCG Chairman;

6.8.5.2 Provision of advice and support with regard to membership issues.

6.9. The Board

6.9.1 **Functions** - the Board has the following functions conferred on it by sections 14L(2) and (3) of the 2006 Act, inserted by section 25 the 2012 Act, together with any other functions connected with its main functions as may be specified in regulations.[44]. The Board has responsibility for:

6.9.1.1 ensuring that the group has appropriate arrangements in place to exercise its functions *effectively, efficiently and economically* and in accordance with the groups *principles of good governance*[45] (its main function);

6.9.1.2 determining the remuneration, fees and other allowances payable to employees or other persons providing services to the group and the allowances payable under the NHS pension scheme;

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44 See section 14L(3)(c) of the 2006 Act, as inserted by section 25 of the 2012 Act

45 See section 4.5 on Principles of Good Governance above

6.9.1.3 approving any functions of the group that are specified in regulations;[46]

6.9.2 ***Composition of the Board*** - the Board shall have a minimum of fifeen designated members. Seven GP clinical members of the Board (including the Locality Clinical Directors, i.e. the elected member from within each of the six CCG Localities, and the Chairman) will be voting members along with four Lay members, the Chief Officer, the Chief Finance Officer, the Director of Quality and Nursing, and the Secondary Care Consultant.

a) The four lay members have responsibility as follows:

   i) one to lead on audit, remuneration and conflict of interest matters (as Conflicts of Interest Guardian), This individual will also act as Deputy Chairman.

   ii) one to lead on quality, patient and public participation matters;

   iii) one to lead on strategy and finance; and

   iv) one to lead on primary care and digital technologies.

   The portfolios of lay members will remain under review, and it is expected that each individual is a Chairman of a Committee of the CCG Board.

b) Other individuals of a description specified in this constitution who will be members will be:

   i) a Public Health representative

   ii) an Officer of the Local Authority

   iii) a representative of Healthwatch

   iv) others co-opted by the Board as appropriate (for example, Director(s) of Commissioning, Director of Strategy and Service Development, Director of Performance and Delivery).

   These individuals have full participation rights but do not have a vote.

c) The tenure associated with elected members is five years, which is renewable.

d) The Deputy Chairman will be a lay member. A ViceClinical Chairman will be appointed on an ad-hoc basis from amongst the Clinical Board Members to deputise for the Chairman when he/she is absent. This will be agreed between the Locality Clinical Directors and the Chief Officer once the period of absence is known

6.9.3 In the event of the Chairman being absent when a vote is required and an equal vote being cast, the Vice Clinical Chairman will have an additional vote to ensure a clinical majority.

6.9.4 In the event of one of the clinical members (not the Chairman) being absent when a vote is required and an equal vote being cast, the Chairman will have an additional vote to ensure a clinical majority.

[46] See section 14L(5) of the 2006 Act, inserted by section 25 of the 2012 Act

6.9.5 ***Committees of the Board*** - the Board has appointed the following committees and sub-committees:

6.9.5.1 **Audit Committee** – the audit committee, which is accountable to the group's Board, provides the Board with an independent and objective view of the group's financial systems, financial information and compliance with laws, regulations and directions governing the group in so far as they relate to finance. The Board has approved and keeps under review the terms of reference for the audit committee, which includes information on the membership of the audit committee[47].

In addition the Board has conferred or delegated the following functions, connected with the Board's main function[48], to its audit committee:

6.9.5.1.1 Assurance that any risks to clinical services from financial pressures have adequate controls in place and reliable assurances are received

6.9.5.1.2 Assurance that the strategic risks identified in the assurance framework relate to the group's objectives and that the controls and assurances to manage those risks are reliable

6.9.5.1.3 Assurance that rigorous processes are in place to support public disclosure statements, including oversight of arrangement to manage conflicts of interests.

6.9.5.2 **Remuneration Committee** – the remuneration committee, which is accountable to the group's Board makes recommendations to the Board on determinations about the remuneration, fees and other allowances for employees and for people who provide services to the group and on determinations about allowances under the NHS pension scheme. The Board has approved and keeps under review the terms of reference for the remuneration committee, which includes information on the membership of the remuneration committee[48].

In addition, the Board has conferred or delegated the following functions, connected with the Board's main function[48], to its remuneration committee:

6.9.5.2.1 Arrangements for termination of employment and other contractual terms.

6.9.5.3 **Clinical Cabinet** – the clinical cabinet which is accountable to the group's Board, approves strategy and policy, makes recommendations to the Board across all the business of the CCG, develops a common approach to commissioning strategies, facilitates engagement with the wider clinical body, provides timely clinical commissioning consideration of key work programmes, maximizes clinical engagement in commissioning and QIPP and Reform plans and provides a forum for decisions relating to clinical networks. The Board has approved and keeps under review the terms of reference for the Clinical Cabinet, which includes information on the membership of the Clinical Cabinet [49].

6.9.5.4 **Clinical Governance Committee** – the Clinical Governance Committee which is accountable to the group's Board, provides an assurance and scrutiny function to the Board in relation to the quality of services it commissions relating specifically to patient

47 See appendix H for the terms of reference of the Audit Committee

48 See appendix I for the terms of reference of the Remuneration Committee

49 See appendix K for the terms of reference of the Clinical Cabinet

safety, patient experience and clinical effectiveness and ensures appropriate action is taken where such assurances are lacking. The Board has approved and keeps under review the terms of reference for the Clinical Governance Committee, which includes information on the membership of the Clinical Governance Committee [50].

In addition, the Board has delegated the following additional functions to its Clinical Governance Committee:

6.9.5.4.1 To drive improvements in healthcare in services it commissions

6.9.5.4.2 To provide the Board with assurances that appropriate systems and processes are in place to realise continuous improvement in the quality of commissioned services and ensure wider system learning from any emergent issues relating to poor quality service provision.

6.9.5.5 **Finance and Performance Committee** – the finance and performance committee which is accountable to the Board is primarily responsible for providing the Board on the robustness of financial and performance reporting including identifying areas of poor performance and identifying actions required to address performance issues and escalate areas of concern. It approves and manages arrangements for financial risk sharing, risk pooling and risk management. The Finance and Assurance Committee will take formal business decisions delegated to it by the Board. The Board has approved and keeps under review the terms of reference for the Finance and Performance Committee, which includes information on the membership of the Finance and Performance Committee[51].

6.9.5.6 **Primary Care Commissioning Committee –** the primary care commissioning which is accountable to the Board is primarily responsible for the review, planning and procurement of primary care services in West Hampshire under delegated authority from. The Board has approved and keeps under review the terms of reference for the Primary Care Commissioning Committee, which includes information on the membership of the Primary Care Commissioning Committee[52]. The role of the Committee is to carry out the functions relating to the commissioning of primary care medical care services under section 83 of the NHS Act. This includes the following:

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

50 See appendix J for the terms of reference of the Clinical Governance Committee

51 See appendix M for the terms of reference of the Finance and Assurance Committee

52 See appendix L for the terms of reference of the Primary Care Commissioning Committee

This Committee is chaired by a lay member, who is also the Chairman of the Audit Committee, and has a majority of lay and executive members of the board

6.9.6 ***Sub-committees of the Clinical Cabinet***

a) The **Locality Committees** which are accountable to the Clinical Cabinet (who approves and keeps under review the locality constitutions[53]), are responsible for the following functions delegated to it:

i) Provide feedback and advice on the commissioning of high quality services for their locality.

ii) To implement CCG policy within the locality

iii) To engage practices in commissioning activities

iv) To promote

- clinical and wider stakeholder engagement in commissioning
- good practice in clinical commissioning
- equity of access in commissioning services

v) To maintain a holistic overview of all local activities

[53] See appendix N for the Locality Constitutions

7. ROLES AND RESPONSIBILITIES

7.1. Practice Representatives

7.1.1 Practice representation takes place on two levels.

7.1.1.1 The Board has seven elected members who represent the membership on the Board; six appointed by the localities (Locality Clinical Directors) and one directly elected as Chairman. These individuals are also members of the Clinical Cabinet.

7.1.1.2 CCG membership model:

- Each practice has a clinical, managerial and medicines management lead who sits on the locality committee.
- Each of the localities has a lead clinician (Locality Clinical Director) who has a seat on the Clinical Cabinet which is directly accountable to the Board.
- The Clinical Cabinet also comprises Clinical Directors across a range of portfolios and clinical areas, each with a vote.
- The Locality Clinical Directors also represent the Clinical Cabinet at the Board

7.1.1.3 Each member practice within the CCG has a representative on the Members Group which will meet at least annually to consider the organisation's annual accounts and influence future plans. Each member of this Group derived from the practices has a vote.

See Membership Model, appendix Q.

7.2. All Members of the Group's Board

7.2.1 Guidance on the roles of members of the group's Board is set out in a separate document[54]. In summary, each member of the Board should share responsibility as part of a team to ensure that the group exercises its functions effectively, efficiently and economically, with good governance and in accordance with the terms of this constitution. Each brings their unique perspective, informed by their expertise and experience.

7.3. The Chairman

7.3.1 The Chairman is responsible for:

a) leading the Board, ensuring it remains continuously able to discharge its duties and responsibilities as set out in this constitution;
b) building and developing the group's Board and its individual members;
c) ensuring that the group has proper constitutional and governance arrangements in place;

[54] *Clinical commissioning group governing body members: Role outlines, attributes and skills, NHS Commissioning Board, October 2012*

d) ensuring that, through the appropriate support, information and evidence, the Board is able to discharge its duties;
e) supporting the Chief Officer in discharging the responsibilities of the organisation;
f) contributing to building a shared vision of the aims, values and culture of the organisation;
g) leading and influencing to achieve clinical and organisational change to enable the group to deliver its commissioning responsibilities;
h) overseeing governance and particularly ensuring that the Board and the wider group behaves with the utmost transparency and responsiveness at all times;
i) ensuring that public and patients' views are heard and their expectations understood and, where appropriate as far as possible, met;
j) ensuring that the organisation is able to account to its local patients, stakeholders and the NHS England;
k) ensuring that the group builds and maintains effective relationships, particularly with the individuals involved in overview and scrutiny from the relevant local authority(ies).

7.3.2 Where the Chairman is also the senior clinical voice of the group they will take the lead in interactions with stakeholders, including the NHS England.

7.4. The Deputy Chairman

7.4.1 The Deputy Chairman is the lay member who has lead responsibility for the Audit and Remuneration Committees, and is the CCG's Conflicts of Interest Guardian.

7.4.2 The Deputy Chairman deputises for the Chairman or vice clinical Chairman where he or she has a conflict of interest or is otherwise unable to act.

7.5. Deputising arrangements for the Chairman

7.5.1 A Vice Clinical Chairman will be appointed on an ad-hoc basis from amongst the Clinical Board Members to deputise for the Chairman when he/she is absent. This will be agreed between the Locality Clinical Directors and the Chief Officer once the period of absence is known.

7.5.2 In the event of the Chairman being absent when a vote is required and an equal vote being cast, the Vice Clinical Chairman will have an additional vote to ensure a clinical majority.

7.6. Role of the Chief Officer

7.6.1 The Chief Officer of the group is a member of the Board.

7.6.2 This role of chief officer has been summarised in a national document[55] as:

[55] See the latest version of the NHS Commissioning Board Authority's *Clinical commissioning group governing body members: Role outlines, attributes and skills*

a) being responsible for ensuring that the clinical commissioning group fulfils its duties to exercise its functions effectively, efficiently and economically thus ensuring improvement in the quality of services and the health of the local population whilst maintaining value for money;
b) at all times ensuring that the regularity and propriety of expenditure is discharged, and that arrangements are put in place to ensure that good practice (as identified through such agencies as the Audit Commission and the National Audit Office) is embodied and that safeguarding of funds is ensured through effective financial and management systems.
c) working closely with the Chairman, the Chief officer will ensure that proper constitutional, governance and development arrangements are put in place to assure the members (through the Board) of the organisation's ongoing capability and capacity to meet its duties and responsibilities. This will include arrangements for the ongoing developments of its members and staff.

7.7. Role of the Chief Finance Officer

7.7.1 The chief finance officer is a member of the Board and is responsible for providing financial advice to the clinical commissioning group and for supervising financial control and accounting systems

7.7.2 This role of chief finance officer has been summarised in a national document[56] as:

a) being the Board's professional expert on finance and ensuring, through robust systems and processes, the regularity and propriety of expenditure is fully discharged;
b) making appropriate arrangements to support, monitor on the group's finances;
c) overseeing robust audit and governance arrangements leading to propriety in the use of the group's resources;
d) being able to advise the Board on the effective, efficient and economic use of the group's allocation to remain within that allocation and deliver required financial targets and duties; and
e) producing the financial statements for audit and publication in accordance with the statutory requirements to demonstrate effective stewardship of public money and accountability to NHS England.

[56] See the latest version of the NHS Commissioning Board Authority's *Clinical commissioning group governing body members: Role outlines, attributes and skills*

8. STANDARDS OF BUSINESS CONDUCT AND MANAGING CONFLICTS OF INTEREST

8.1. Standards of Business Conduct

8.1.1 Employees, members, committee and sub-committee members of the group and members of the Board (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 group and should follow the *Seven Principles of Public Life*, set out by the Committee on Standards in Public Life (the Nolan Principles) The Nolan Principles are incorporated into this constitution at Appendix F.

8.1.2 They must comply with the group's policy on standards of business conduct and managing conflicts of interest. This policy is available on the group's website at www.westhampshireccg.nhs.uk and sets out in further detail the procedures and supporting documentation by which potential and real conflicts can be managed. This section of the Constitution summarises key aspects.

8.1.3 Individuals contracted to work on behalf of the group or otherwise providing services or facilities to the group 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.

8.2. Conflicts of Interest

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

8.2.2 In 2014, NHS England offered CCGs the opportunity to take on an increased responsibility for the commissioning of primary care. This will enable West Hampshire CCG to commission care for their patients and population in more coherent and joined-up ways — but it also exposes the group to a greater risk of conflicts of interest, both real and perceived

8.2.3 In preparation for taking on these new responsibilities and in response to strengthened statutory guidance published by NHS England in 2016 and 2017 for the management of conflicts of interest, West Hampshire CCG has updated and refreshed the Standards of Business Conduct & Managing Conflicts of Interest Policy, and continues to review it on a regular basis.

8.2.4 Where an individual, i.e. an employee, group member, member of the Board, or a member of a committee or a sub-committee of the group or its Board has an interest, or becomes aware of an interest which could lead to a conflict of interests in the event of the group 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 constitution.

8.2.5 A conflict of interest can be captured in four different categories: :

Financial Interests This is where an individual may get direct financial benefits from the consequences of a commissioning decision. This could, for example, include being:	• A director, including a non-executive director, or senior employee in a private company or public limited company or other organisation which is doing, or which is likely, or possibly seeking to do, business with health or social care organisations • A shareholder (or similar owner interests), a partner or owner of a private or not-for-profit company, business, partnership or consultancy which is doing, or which is likely, or possibly seeking to do, business with health or social care organisations • A management consultant for a provider • A provider of clinical private practice • In secondary employment outside of the CCG • In receipt of secondary income from a provider • In receipt of a grant from a provider • In receipt of any payments (for example honoraria, one off payments, day allowances or travel or subsistence) from a provider • In receipt of research funding, including grants that may be received by the individual or any organisation in which they have an interest or role • Having a pension that is funded by a provider (where the value of this might be affected by the success or failure of the provider).
Non-Financial Professional Interests This is where an individual may obtain a non-financial professional benefit from the consequences of a commissioning decision, such as increasing their professional reputation or status or promoting their professional career. This may, for example, include situations where the individual is:	• An advocate for a particular group of patients • A GP with special interests e.g. in dermatology, acupuncture etc • A member of a particular specialist professional body (although routine GP membership of the Royal College of General Practitioners (RCGP), British Medical Association (BMA0 or a medical defence organisation would not usually by itself amount to an interest which needed to be declared) • An advisor for Care Quality Commission (CQC) or National Institute for Health and Care Excellence (NICE) • Engaged in a research role • The development and holding of patents and other intellectual property rights which allow staff to protect something that they create, prevent unauthorised use of products or the copying of protected ideas • GPs and practice managers who are members of the Board or committee of the CCG should declare details of their roles and responsibilities held within their GP practices.

Non-Financial Personal Interests This is where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit. This could include, for example, where the individual is:	• A voluntary sector champion for a provider • A volunteer for a provider • A member of a voluntary sector board or has any other position of authority in or connection with a voluntary sector organisation • Suffering from a particular condition requiring individually funded treatment • A member of a lobby or pressure groups with an interest in health and care.
Indirect Interests This is where an individual has a close association with an individual who has a financial interest, a non-financial professional interest or a non-financial personal interest in a commissioning decision (as those categories are described above). For example, this should include:	• Spouse / partner • Close relative e.g. parent, grandparent, child, grandchild or sibling • Close friend • Business partner.

8.2.6 It is not possible to define all instances in which an interest may be a real or perceived conflict. However, if an individual is unsure as to whether an interest should be declared then advice should be sought from the board secretary, who will co-ordinate advice from the chief finance officer, the Chairman and consult the lay member for audit (who holds the position of conflicts of interest guardian), as required. If any doubt remains the individual concerned should assume that a potential conflict of interest exists.

8.27 The Chairman of the Audit Committee has a lead role in ensuring that the CCG Board and the wider CCG behaves with the utmost probity at all times. The Chairman of Audit Committee oversees key elements of governance including the appropriate management of conflicts of interest as the Conflicts of Interest Guardian. The conflicts of interest guardian should in collaboration with the Board Secretary:

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

8.3. Declaring and Registering Interests

8.3.1 The group will maintain one or more registers of the interests of:

8.3.1.1 the members of the Board;

8.3.1.2 the members of its Board's committees or sub-committees;

8.3.1.3 its employees;

8.3.1.4 GP partners, company directors and employees of member practices directly involved with the business or decision-making of the CCG.

8.3.2 The register(s) will be published on the group's website at www.westhampshireccg.nhs.uk.

8.3.3 Individuals will declare any interest that they have, in relation to a decision to be made in the exercise of the commissioning functions of the group, in writing to the Board, as soon as they are aware of it and in any event no later than 28 days after becoming aware.

8.3.4 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.

8.3.5 The Board Secretary will ensure that the register of interests is reviewed regularly, and updated as necessary. Provisions are also in place around the management of gifts, hospitality and sponsorships and a register also published on the group's website.

8.4. Managing Conflicts of Interest: general

8.4.1 Individual members of the group, the Board, committees or sub-committees, the committees or sub-committees of its Board and employees will comply with the arrangements determined by the group for managing conflicts or potential conflicts of interest.

8.4.2 All committees 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 group's decision making processes.

8.4.3 Arrangements for the management of conflicts of interest are to be determined by the Board 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. The arrangements will confirm the following:

a) when an individual should withdraw from a 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.

8.4.4 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 group's exercise of its commissioning functions, they have received confirmation of the arrangements to manage the conflict of interest or potential conflict of interest from the Chief Finance Officer / Board Secretary.

8.4.5 Where an individual member, employee or person providing services to the group is aware of an interest which:

a) has not been declared, either in the register or orally, they will declare this at the start of the meeting;
b) has previously been declared, in relation to the scheduled or likely business of the meeting, the individual concerned will bring this to the attention of the Chairman of the meeting, together with details of arrangements which have been confirmed for the management of the conflict of interests or potential conflict of interests.

8.4.6 The Chairman of the meeting will then determine how this should be managed and inform the member of their decision. Where no arrangements have been confirmed, the Chairman of the meeting may require the individual to withdraw from the meeting or part of it. The individual will then comply with these arrangements, which must be recorded in the minutes of the meeting.

8.4.7 Where the Chairman of any meeting of the group, including committees, sub-committees, or the Board and the Board's committees and sub-committees, 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 Chairman will act as Chairman for the relevant part of the meeting. Where arrangements have been confirmed for the management of the conflict of interests or potential conflicts of interests in relation to the Chairman, the meeting must ensure these are followed. Where no arrangements have been confirmed, the Deputy Chairman may require the Chairman to withdraw from the meeting or part of it. Where there is no Deputy Chairman, the members of the meeting will select one.

8.4.8 Any declarations of interests, and arrangements agreed in any meeting of the clinical commissioning group, committees or sub-committees, or the Board, the Board's committees or sub-committees, will be recorded in the minutes.

8.4.9 Where more than 50% of the members of a meeting are required to withdraw from a meeting or part of it, owing to the arrangements agreed for the management of conflicts of interests or potential conflicts of interests, the Chairman (or Deputy Chairman) will determine whether or not the discussion can proceed.

8.4.10 In making this decision the Chairman will consider whether the meeting is quorate, in accordance with the number and balance of membership set out in the group's standing orders. 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. Where a quorum cannot be convened from the membership of the meeting, owing to the arrangements for managing conflicts of interest or potential conflicts of interests, the Chairman of the meeting shall consult with the Chief Finance Officer / Board Secretary.

8.4.11 This may include:

8.4.11.1 requiring another of the group's committees or sub-committees, the group's Board or the Board's committees or sub-committees (as appropriate) which can be quorate to progress the item of business, or if this is not possible,

8.4.11.2 inviting on a temporary basis one or more of the following to make up the quorum (where these are permitted members of the Board or committee / sub-committee in question) so that the group can progress the item of business:

8.4.11.2.1 a member of the clinical commissioning group who is an individual;

8.4.11.2.2 an individual appointed by a member to act on its behalf in the dealings between it and the clinical commissioning group;

8.4.11.2.3 a member of a relevant Health and Wellbeing Board;

8.4.11.2.4 a member of a Board of another clinical commissioning group.

These arrangements must be recorded in the minutes.

8.4.12 In any transaction undertaken in support of the clinical commissioning group's exercise of its 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 Chief Finance Officer / Board Secretary of the transaction.

8.4.13 The Chief Finance Officer / Board Secretary will take such steps as deemed appropriate, and request information deemed appropriate from individuals, to ensure that all conflicts of interest and potential conflicts of interest are declared

8.5. Managing Conflicts of Interest: contractors and people who provide services to the group

8.5.1 Anyone seeking information in relation to a procurement, or participating in a procurement, or otherwise engaging with the clinical commissioning group in relation to the potential provision of services or facilities to the group, will be required to make a declaration of any relevant conflict / potential conflict of interest.

8.5.2 Anyone contracted to provide services or facilities directly to the clinical commissioning group 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.

8.6. Transparency in Procuring Services

8.6.1 The group 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 group will procure services in a manner that is open, transparent, non-discriminatory and fair to all potential providers.

8.6.2 The Procurement, Patient Choice and Competition Regulations in place set out that commissioners:

- manage the conflicts and potential conflicts of interests when awarding a contract by prohibiting the award of a contract where the integrity of the award has been or appears to have been affected by a conflict; and
- keep appropriate records of how they have managed any conflicts in individual cases.

8.6.3 A key area where conflicts arise is where the group commissions (or continues to commission by contract extension) healthcare services, including GP services, in which a member of the CCG has a financial or other interest. This is particularly relevant in the context of co-commissioning of primary care and in areas where GPs or GP federations are current or possible providers. The CCG's procurement framework highlights a range of factors for consideration and provides evidence of deliberations on conflicts which are publicly available and supports the CCG in fulfilling its duty in relation to public involvement. It will also provide appropriate assurance:

- That the CCG is seeking and encouraging scrutiny of its decision-making process.
- To Health and Wellbeing Boards, Healthwatch Hampshire and to local communities that the proposed service meets local needs and priorities. It will enable them to raise questions if they have concerns about the approach being taken.
- To the CCG Audit Committee and external auditors that a robust process has been followed in deciding to commission the services, in selecting the procurement route, and in addressing potential conflicts.
- To NHS England in their role as assurers of co-commissioning of primary care services.

8.6.4 In respect of the co-commissioning of primary care, the procurement decision will be made by the Primary Care Commissioning Committee, which is a committee of the Board. The terms of reference and details of membership is set out in Appendix L of the CCG Constitution. This Committee is chaired by a lay member, , and has a majority of lay and executive members of the board.

8.6.5 The CCG will engage relevant providers, especially clinicians, in confirming that the design of service specification will meet patient need, and will seek to specify the outcomes that it wishes to see delivered through a service. This engagement will follow the main principles of procurement law, namely equal treatment, non-discrimination and transparency, ensuring that the same information is given to all. The CCG will engage with providers on service design in line with Monitor guidance.

8.6.6 Other steps may include:

- Advertising the fact that a service design/re-design exercise is taking place widely and invite comments from any potential providers and other interested parties (ensuring a record is kept of all interactions)
- As the service design develops, engaging with a wide range of providers on an ongoing basis to seek comments on the proposed design, e.g. via the CCG's website or via workshops with interested parties.
- Using engagement to help shape the requirement to meet patient need but take care not to gear the requirement in favour of any particular provider(s).
- If appropriate, engaging the advice of an independent clinical adviser on the design of the service.
- Being transparent about procedures.
- Ensuring at all stages that potential providers are aware of how the service will be commissioned.
- Maintaining commercial confidentiality of information received from providers

8.6.7 The CCG will also ensure that it will manage conflicts of interest on an ongoing basis, for instance, by monitoring a contract that has been awarded to a provider in which an individual commissioner has a vested interest.

8.6.8 The CCG will maintain a register of procurement decisions taken including:

- the details of the decision.
- who was involved in the decision (such as the Board, Primary Care Commissioning Committee or other Committee members with decision-making responsibility).
- a summary of any conflicts of interest in relation to the decision and how this was managed by the CCG).

8.6.9 In the interests of transparency, as with the register of interests, the register of procurement of decisions will be available from the CCG's website and made available upon request for inspection at the CCG headquarters. It will also form part of the CCG's annual accounts and will thus be signed off by external auditors

8.6.10 In line with commitments on transparency of GP earnings, there will be a new contractual requirement for GP practices to publish on their practice website by 31 March 2016, the mean net earnings of GPs in their practice (to include contractor and salaried GPs) relating to 2014/15 financial year. Alongside the mean figure, practices must publish the number of full and part time GPs associated with the published figure. The figure will include earnings from NHS England, CCGs and local authorities for the provision of GP services that relate to the contract and which would have previously been commissioned by PCTs

8.7. Raising concerns, failure to disclose and management of breaches

8.7.1 There will be situations when interests will not be identified, declared or managed appropriately and effectively. This may happen innocently, accidentally, or because of the deliberate actions of staff or organisations. For the purposes of this policy, these situations are referred to as 'breaches'.

8.7.2 The CCG's Standards of Business Conduct and Conflicts of Interest policy has been prepared to help individuals approach their decision making properly where there is a conflict of interest. Individuals are expected to use this policy to fulfil their duty to act only in the best interests of the CCG and to be able to provide a convincing justification for their decisions in the event of challenge. The CCG takes seriously the failure to disclose such information as required by this policy.

8.7.3 It is the duty of every CCG employee, Board member, committee or sub-committee member and GP practice member to speak up about genuine concerns in relation to the administration of the CCG's policy on conflicts of interest management, and to report these concerns. Individuals should not ignore suspicions or investigate themselves, but rather speak to the designated CCG point of contact for these matters.

8.7.4 Concerns should be raised in the first instance with either the board secretary or chief finance officer. If individuals prefer to speak to someone else in strict confidence, they can also contact the conflict of interest guardian. All notifications will be dealt with the strictest confidence in accordance with the CCG's other policies (including the Whistleblowing & Concerns Policy). The Local Anti-Fraud and Corruption Policy will be consulted and an appropriate referral made to the local counter fraud specialist where applicable. The Local Counter Fraud Service may also be consulted directly.

8.7.5 If conflicts of interest are not effectively managed, the CCG could face civil challenges to decisions they make. For instance, if breaches occur during a procurement exercise, the CCG risks a legal challenge from providers that could potentially overturn the award of a contract, lead to damages claims against the CCG, and necessitate a repeat of the procurement process. Breaches also damage public trust and confidence in the NHS generally.

8.7.6 In extreme cases, staff and other individuals could face personal civil liability, a claim for misfeasance in public office or fitness to practice proceedings by their professional regulator. Failure to manage conflicts of interest could also lead to criminal proceedings including for offences such as fraud, bribery and corruption. The Fraud Act 2006 created a criminal offence of fraud and defines three ways of committing it:

- Fraud by false representation
- Fraud by failing to disclose information
- Fraud by abuse of position.

8.7.7 Individuals who fail to disclose any relevant interests or who otherwise breach the CCG's rules and policies relating to the management of conflicts of interest will be subject to investigation and, where appropriate, to disciplinary action. CCG staff, Board and committee members in particular should be aware that the outcomes of such action may, if appropriate, result in the termination of their employment or position with the CCG.

8.7.8 All breaches will be anonymised, recorded and published on the CCG's website along with any outcomes/actions, once investigations have been completed. NHS England will be notified of breaches as soon as possible, including as part of the quarterly returns for the Improvement and Assessment Framework.

9. THE GROUP AS EMPLOYER

9.1 The group recognises that its most valuable asset is its people. It will seek to enhance their skills and experience and is committed to their development in all ways relevant to the work of the group.

9.2 The group will seek to set an example of best practice as an employer and is committed to offering all staff equality of opportunity. It will ensure that its employment practices are designed to promote diversity and to treat all individuals equally.

9.3 The group will ensure that it employs suitably qualified and experienced staff who will discharge their responsibilities in accordance with the high standards expected of staff employed by the group. All staff will be made aware of this constitution, the commissioning strategy and the relevant internal management and control systems which relate to their field of work.

9.4 The group will maintain and publish policies and procedures (as appropriate) on the recruitment and remuneration of staff to ensure it can recruit, retain and develop staff of an appropriate calibre. The group will also maintain and publish policies on all aspects of human resources management, including grievance and disciplinary matters

9.5 The group will ensure that its rules for recruitment and management of staff provide for the appointment and advancement on merit on the basis of equal opportunity for all applicants and staff.

9.6 The group will ensure that employees' behaviour reflects the values, aims and principles set out above.

9.7 The group will ensure that it complies with all aspects of employment law.

9.8 The group will ensure that its employees have access to such expert advice and training opportunities as they may require in order to exercise their responsibilities effectively.

9.9 The group has adopted a Code of Conduct for staff and will maintain and promote effective 'whistleblowing' procedures to ensure that concerned staff have means through which their concerns can be voiced.

9.10 The group recognises and confirms that nothing in or referred to in this constitution (including in relation to the issue of any press release or other public statement or disclosure) will prevent or inhibit the making of any protected disclosure (as defined in the Employment Rights Act 1996, as amended by the Public Interest Disclosure Act 1998) by any member of the group, any member of its governing body, any member of any of its committees or sub-committees or the committees or sub-committees of its governing body, or any employee of the group or of any of its members, nor will it affect the rights of any worker (as defined in that Act) under that Act.

9.11 Copies of the Code of Conduct for staff, together with the other policies and procedures outlined in this chapter, will be available on the group's website at www.westhampshireccg.nhs.uk.

10. TRANSPARENCY, WAYS OF WORKING AND STANDING ORDERS

10.1. General

10.1.1 The group will publish annually a commissioning plan and an annual report, presenting the group's annual report to a public meeting.

10.1.2 Key communications issued by the group, including the notices of procurements, public consultations, Board meeting dates, times, venues, and certain papers will be published on the group's website at www.westhampshireccg.nhs.uk.

10.1.3 The group may use other means of communication, including circulating information by post, or making information available in venues or services accessible to the public.

10.2 Standing Orders

10.2.1 This constitution is also informed by a number of documents which provide further details on how the group will operate. They are the group's:

10.2.1.1 **Standing orders (Appendix C)** – which sets out the arrangements for meetings and the appointment processes to elect the group's representatives and appoint to the group's committees, including the Board;

10.2.1.2 **Scheme of reservation and delegation (Appendix D)** – which sets out those decisions that are reserved for the membership as a whole and those decisions that are the responsibilities of the group's Board, the Board's committees and sub-committees, the group's committees and sub-committees, individual members and employees;

10.2.1.3 **Prime financial policies (Appendix E)** – which sets out the arrangements for managing the group's financial affairs.