A meeting of the **Fareham & Gosport Clinical Commissioning Group Governing Body** will take place at **2.00 pm on Wednesday 28 May 2014** in the Octagon Room, Ferneham Hall, Osborn Road, Fareham, PO16 7DB

### Agenda

<table>
<thead>
<tr>
<th>No</th>
<th>Time</th>
<th>Item</th>
<th>Clinical Lead</th>
<th>Management Lead</th>
<th>Delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2.00</td>
<td>Chair’s Welcome</td>
<td>Dr David Chilvers CCG Chair</td>
<td>Verbal</td>
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</tr>
<tr>
<td>2</td>
<td>2.02</td>
<td>Apologies</td>
<td>Dr David Chilvers CCG Chair</td>
<td>Verbal</td>
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</tr>
<tr>
<td>3</td>
<td>2.05</td>
<td>Register of Interests and Declarations of Interest</td>
<td>Dr David Chilvers CCG Chair</td>
<td>Paper</td>
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</tr>
<tr>
<td>4</td>
<td>2.07</td>
<td>Minutes of the Previous Meeting</td>
<td>Dr David Chilvers CCG Chair</td>
<td>Paper</td>
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<tr>
<td>5</td>
<td>2.12</td>
<td>Matters Arising from the Minutes</td>
<td>Dr David Chilvers CCG Chair</td>
<td>Verbal</td>
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<tr>
<td>6</td>
<td>2.17</td>
<td>CCG Chair’s Report</td>
<td>Dr David Chilvers CCG Chair</td>
<td>Verbal</td>
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<td>• Positive Partnerships</td>
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<td>• Older People’s Mental Health Service Commissioning Strategy</td>
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<td>• Co-commissioning Primary Care</td>
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<td>• Appointments</td>
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#### Strategy

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<tr>
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<th>2.25</th>
<th>Five Year Strategy:</th>
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<tr>
<td></td>
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<td>- Strategy</td>
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<td></td>
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<td>- Aligned Vision for Portsmouth and South East Hampshire</td>
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<td>- Better Care Fund</td>
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<td></td>
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<td>- Financial Plan</td>
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<td>- Operational Plan</td>
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#### Finance, Planning and Performance

**To Discuss and Ratify**

<table>
<thead>
<tr>
<th>8</th>
<th>2.45</th>
<th>Finance Report</th>
<th>Dr David Chilvers CCG Chair</th>
<th>Andrew Wood Chief Finance Officer</th>
<th>Verbal</th>
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<tbody>
<tr>
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<tr>
<td>9</td>
<td>2.55</td>
<td>Draft Annual Accounts, Annual Report and Governance Statement 2013/14</td>
<td>Dr David Chilvers CCG Chair</td>
<td>Andrew Wood Chief Finance Officer</td>
<td>Paper</td>
</tr>
<tr>
<td>10</td>
<td>3.10</td>
<td>Performance Report</td>
<td>Dr David Chilvers CCG Chair</td>
<td>Andrew Wood Chief Finance Officer</td>
<td>Paper</td>
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**Quality**

<table>
<thead>
<tr>
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<th>Item</th>
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<th>Delivery</th>
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<tbody>
<tr>
<td>11</td>
<td>3.20</td>
<td>Quality Report</td>
<td>Dr Simon Larmer Quality Lead</td>
<td>Julia Barton Chief Quality Officer</td>
<td>Paper</td>
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**Commissioning**

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<tr>
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<th>Time</th>
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<th>Management Lead</th>
<th>Delivery</th>
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<tbody>
<tr>
<td>12</td>
<td>3.30</td>
<td>Commissioning Update</td>
<td>Dr David Chilvers CCG Chair</td>
<td>Alex Berry Chief Commissioning Officer</td>
<td>Paper</td>
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**Governance and Organisational Development**

**To Note**

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<thead>
<tr>
<th>No</th>
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<tr>
<td>13</td>
<td>3.40</td>
<td>Engagement Update</td>
<td>Dr David Chilvers CCG Chair</td>
<td>Sara Tiller Chief Development Officer</td>
<td>Paper</td>
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<tr>
<td>14</td>
<td>3.50</td>
<td>Board Assurance Framework</td>
<td>Dr David Chilvers CCG Chair</td>
<td>Sara Tiller Chief Development Officer</td>
<td>Paper</td>
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<tr>
<td>15</td>
<td>4.00</td>
<td>CCG Constitution - Amendments</td>
<td>Dr David Chilvers CCG Chair</td>
<td>Sara Tiller Chief Development Officer</td>
<td>Paper</td>
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<tr>
<td>16</td>
<td>4.10</td>
<td>Wessex Academic Health Science Network – Membership</td>
<td>Dr David Chilvers CCG Chair</td>
<td>Richard Samuel Chief Officer</td>
<td>Paper</td>
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**Public Health**

**To Note**

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<th>Time</th>
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<th>Clinical Lead</th>
<th>Management Lead</th>
<th>Delivery</th>
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<tbody>
<tr>
<td>17</td>
<td>4.20</td>
<td>Annual Review – Public Health</td>
<td>Dr Christine Jackson Deputy Director for Public Health</td>
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<td>Paper</td>
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**Other Business to Note**

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<th>No</th>
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<th>Clinical Lead</th>
<th>Management Lead</th>
<th>Delivery</th>
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<tbody>
<tr>
<td>18</td>
<td>4.30</td>
<td>Minutes/Notes of Other Meetings • Hampshire Commissioning</td>
<td>Dr David Chilvers CCG Chair</td>
<td></td>
<td>Papers</td>
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<tr>
<td>No</td>
<td>Time</td>
<td>Item</td>
<td>Clinical Lead</td>
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<td>19</td>
<td>4.35</td>
<td>Date of Next Scheduled Meeting</td>
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<td>Wednesday 23 July 2014 2.00 – 5.00 pm</td>
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<td></td>
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<td>Venue – Octagon Room, Ferneham Hall, Osborn Road, Fareham, PO16 7DB</td>
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<tr>
<td>20</td>
<td></td>
<td>Resolution</td>
<td>Dr David Chilvers CCG Chair</td>
<td>Verbal</td>
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<td></td>
<td></td>
<td>To exclude the press and public from the confidential part of the meeting because publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted.</td>
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<tr>
<td>Date of Meeting</td>
<td>28 May 2014</td>
<td>Agenda Item No</td>
<td>3</td>
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</tr>
<tr>
<td>Title</td>
<td>Register of Interests and Declarations of Interests</td>
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</tr>
<tr>
<td>Purpose of Paper</td>
<td>This paper sets out the relevant and material interests of the members of the CCG Governing Body. This paper supports the CCG Governing Body in fulfilling its duties in accordance with the NHS Code of Accountability.</td>
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</table>
| Recommendations/Actions requested | The Governing Body is asked to:  
• receive and note the Register of Interests of Members;  
• receive any oral updates on the interests of Members  
• declare any interests relating to any item on the agenda. |
| Author | Sandra Jenkinson  
Committee Support Officer |
| Sponsoring member | Dr David Chilvers  
CCG Chair |
| Date | 21 May 2014 |
## Governing Body

### Register of Interests

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
<th>Declarations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>VOTING MEMBERS</strong></td>
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</tbody>
</table>
| Dr Keith Barnard            | Lay Member (Patient & Public Involvement)     | Self-employed (freelance) editing and reviewing health news items for Boots Web MD website  
|                             |                                               | Chair, Fareham Centre Practice Patient Participation Group                  |
|                             |                                               | Chair, Fareham Locality Patient Participation Group                         |
| Julia Barton                | Chief Quality Officer (Registered Nurse)      | Governor, Portsmouth Hospitals NHS Trust                                    |
| Dr Ian Bell                 | Clinical Member (Clinical Service & IT)       | Circle Group shareholder                                                   |
| Dr David Chilvers          | Chair                                         | GP Partner - Waterside Medical Centre, Mumby Road, Gosport                  |
|                             |                                               | Undertakes Section 12(2) Mental Health Act assessments for Social Services  |
|                             |                                               | Surgery leases a room one day a week for AQP physiotherapy                  |
|                             |                                               | Runs a monthly half hour surgery at Haslar Immigration Removal Centre       |
|                             |                                               | Governor, South Central Ambulance Service                                   |
| Malcolm Heritage-Owen       | Lay Member (Governance Lead) (Joint Chair – Audit Committee) | No interests to be declared                                                |
| Dr Paul Howden             | Chair – Clinical Cabinet Lead – Planned Care & Prescribing | Partner, The Whiteley Surgery                                           |
|                             |                                               | Member Practice of Fareham & Gosport CCG                                    |
| Dr Simon Larmer            | Clinical Member (Governance Lead)             | nGMS Partner at the Portchester Practice                                     |
|                             |                                               | GP working for SHIP Out Of Hours Service(Care UK) as a self- employed GP    |
|                             |                                               | Two Fareham Area Clinical Enterprise Ltd shares - no directorships         |
| Dr Alan McFarlane          | Clinical Lead (Practice Performance &         | GP Partner (GMS) at Brook Lane Surgery                                     |
|                             |                                               |                                                                             |

Updated: 16 May 2014
<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
<th>Declarations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Ian Reid</td>
<td>Secondary Care Specialist Doctor</td>
<td>No interests to be declared</td>
</tr>
<tr>
<td>Richard Samuel</td>
<td>Chief Officer (Accountable Officer)</td>
<td>Wife works as an accountant for Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust Trustee of an HIV/AIDS charity in Bournemouth Father in law works as a Non-Executive Director for Poole Hospital NHS Foundation Trust Step father elected as Hampshire County Councillor for South Waterside ward, Eastleigh</td>
</tr>
<tr>
<td>Dr Koyih Tan</td>
<td>Clinical Member (Engagement Lead)</td>
<td>GP Partner, Stubbington Medical Practice Wife is a Consultant in Obstetrics and Gynaecology at the Princess Anne Hospital, Southampton, part of the University Hospitals NHS Trust Wife is a shareholder in Portsmouth Health Limited</td>
</tr>
<tr>
<td>Andrew Wood</td>
<td>Chief Finance Officer</td>
<td>No interests to be declared</td>
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</tbody>
</table>

**NON-VOTING MEMBERS**

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
<th>No interests to be declared</th>
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<tbody>
<tr>
<td>Alex Berry</td>
<td>Chief Commissioning Officer</td>
<td>No interests to be declared</td>
</tr>
<tr>
<td>Paul Edwards</td>
<td>Practice Manager Representative (Gosport)</td>
<td>No interests to be declared</td>
</tr>
<tr>
<td>Dr Christine Jackson</td>
<td>Deputy Director of Public Health, Hampshire County Council</td>
<td>No interests to be declared</td>
</tr>
<tr>
<td>Sally Jones</td>
<td>Hampshire County Council Representative</td>
<td>No interests to be declared</td>
</tr>
<tr>
<td>June Thomson</td>
<td>Practice Manager Representative (Fareham)</td>
<td>No interests to be declared</td>
</tr>
<tr>
<td>Sara Tiller</td>
<td>Chief Development Officer</td>
<td>No interests to be declared</td>
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</tbody>
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Updated: 16 May 2014
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<thead>
<tr>
<th>Name</th>
<th>Role</th>
<th>Declarations</th>
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</thead>
<tbody>
<tr>
<td>Cllr Roger Allen</td>
<td>Co-opted member</td>
<td>Daughter is a staff nurse employed at Portsmouth Hospitals NHS Trust</td>
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<tr>
<td></td>
<td>Representative of Gosport Borough Council</td>
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<tr>
<td>Cllr Brian Bayford</td>
<td>Co-opted member</td>
<td>No interests to be declared</td>
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<tr>
<td></td>
<td>Representative of Fareham Borough Council</td>
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To note: Richard Samuel, Andrew Wood, Julia Barton and Sara Tiller work across Fareham and Gosport CCG and South Eastern Hampshire CCG. Alex Berry's role covers Portsmouth CCG, Fareham and Gosport CCG and South Eastern Hampshire CCG.

To note: all GP practices provide locally enhanced services to the CCG.
<table>
<thead>
<tr>
<th>Date of Meeting</th>
<th>28 May 2014</th>
<th>Agenda Item No</th>
<th>4</th>
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</thead>
<tbody>
<tr>
<td>Title</td>
<td>Minutes of the Previous Meeting</td>
<td>Purpose of Paper</td>
<td>The Minutes of the meeting held on 19 March 2014 are presented for consideration by the Governing Body.</td>
</tr>
<tr>
<td>Recommendations/Actions requested</td>
<td>The Governing Body is asked to:</td>
<td>• Approve the Minutes of the meeting held on 12th March 2014, subject to any amendments which will be recorded in the Minutes of this meeting.</td>
<td></td>
</tr>
<tr>
<td>Author</td>
<td>Nikki Roberts Governance and Committee Officer</td>
<td>Sponsoring member</td>
<td>David Chilvers CCG Chair</td>
</tr>
<tr>
<td>Date</td>
<td>19th May 14</td>
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Minutes

Minutes of the meeting of the Fareham & Gosport Clinical Commissioning Group
Governing Body held at 3.00 pm on Wednesday 12th March 2014 in the Octagon Room,
Ferneham Hall, Osborn Road, Fareham, Hampshire PO16 7DB

Present
Dr David Chilvers
Malcolm Heritage-Owen
Dr Alan McFarlane
Dr Paul Howden
Richard Samuel
Andrew Wood
Julia Barton
Dr Christine Jackson
Dennis Wright
June Thomson
Sally Jones

CCG Clinical Chair
Lay Member (Governance Lead)
Clinical Member (Practice Development)
Clinical Member (Planned Care and Prescribing)
Chief Officer
Chief Finance Officer
Registered Nurse and Chief Quality Officer
Deputy Director of Public Health
Healthwatch designate member
Practice Manager
Hampshire County Council

In attendance
Sara Tiller
Alex Berry
Cllr Roger Allen
Michael Drake
Nikki Roberts

Chief Development Officer
Chief Commissioning Officer
Co-opted Gosport Borough Council
Director of Performance and Planning
Governance and Committee Officer

1/6 Chair’s Welcome
Dr David Chilvers welcomed all present to the meeting.

2/6 Apologies
Apologies were received from Dr Keith Barnard, Cllr Brian Bayford, Dr Ian Bell and
Dr Koyih Tan.

3/6 Register of interests and declarations of interest
The CCG Governing Body received the register of interests.

Members were asked if they had any interests to declare relating to agenda items
being considered at this meeting. No specific interests were declared.

The Governing Body received and noted the register of interests.

4/6 Minutes of the Previous Meeting
The minutes of the previous meeting held on Wednesday 15th January 2014 were
discussed. Dr Simon Larmer, Mr Ian Reid and Dr Paul Howden requested their
The Governing Body approved the Minutes of the previous meeting.

5/6 Matters Arising

There were no matters arising from the last meeting.

The Matters Arising were accepted.

6/6 Chair’s Report

The Chair presented the Chair’s Report, reporting on the health campaign run by the Portsmouth Evening News. The campaign aimed to advise people about how best to access the NHS Healthcare services available to them, promoted any healthcare issues within the community and highlighted our key messages. The article also ran an online survey.

The Governing Body agreed to accept the Chair’s Report.

7/6 Five Year Strategy and Two Year Operating Plan

Sara Tiller presented the update on the Five Year Strategy and Two Year Operating Plan. The timeline for submission and the key requirements of the strategy were discussed. It was noted that the strategy was a joint strategy with South Eastern Hampshire, and that events had been running since December 2013 to listen to view and opinions within the localities which have informed the final strategy and operating plan.

Following the first cut submission to NHS England, the feedback that received was positive with very few areas where more information was required. The strategy is now being reviewed and it is anticipated that the final draft will be circulated to Governing Body members after the 21st March 2014. It was requested that Governing Body members noted the progress to date on both the operating plan and the strategy, and approve a Chair’s Action to sign off the final submissions by 4th April.

It was noted that the vision statement should include mention of people being supported to stay healthy, and that Public Health aspects such as, supporting people to stay healthy and tackling health inequalities, could be strengthened within the document. It was reported that engagement with Public Health had already been made with a view to addressing these concerns.

The Governing Body accepted the Five Year Strategy and Operating Plan and agreed to:

- Note the progress to date
- Agree to review and comment on the draft documents between 21st March and 26th March 2014
- Agree for Chair’s Action to sign off final submissions by 4th April.

8/6 Draft Financial Plans 2014/15 – 2018/19

Andrew Wood presented the draft Financial Plans 2014/15-2018/19. It was noted
that the Financial Plans were still in draft format as there were still some unresolved issues. The major issue was that contracts with providers had yet to be signed. The financial allocations were discussed and it was noted that the financial position remains challenging as the CCG was the 15th worst funded out of 211 in the country. The CCG remains efficient through our management costs, with a running cost per head of population of £22. The target is the achievement of a 1% surplus per year, however the CCG only achieved 0.3% in 2013/14 and is planning the same in 2014/15. The CCG is also required to set aside 2.5% non-recurrent expenditure in 2014/15, however the CCG can only afford to set aside 1.5% locally. Therefore this leaves the CCG with little funding for national priorities. There is little to no funding to change care in accordance with the needs of the Better Care Fund. The Chief Finance Officer proposed that the CCG should consider going into deficit over a three year period to enable effective change.

It was noted that during 2013/14 the CCG fell short of its QIPP target, and that the QIPP target would be higher for 2014/15 and higher again for 2015/16. This signalled that the CCG should look to commission differently, including reviewing where money is being spent in the community and considering reinvestment opportunities. It was also noted that the CCG was allowed to declare a planned deficit in special circumstances, and it was deemed that the CCG would be considered as a special case due to its poor funding. Providers were engaging with the CCG regarding future investments however there was no fine detail to report as yet. It was stated that it would be unacceptable to go into planned deficit unless there were robust supportive plans in place. Integrated Care has historically produced mixed outcomes. The CCG is mindful that it only intends to invest transformation money into evidence based professionally backed programmes. Should the CCG declare a planned deficit it would be viewed nationally, with regulators monitoring closely. Any deficit is repayable, however there are no further financial penalties involved with declaring a planned deficit.

The Governing Body agreed to:

- Agree the draft Financial Plans
- Agree the level of investment, reserves and contingency
- Agree the net QIPP challenge of £6.7m (14/15) and £9m (15/16)
- Note that the plan is dependent on contract discussions and any further national guidance
- Note the risks and mitigating actions
- Agree these high level financial programmes which will be used to set budgets in 2014/15.

**9/6 Better Care Fund**

Richard Samuel presented the Better Care Fund paper on behalf of Alex Berry. It was reported that work has been ongoing through the Better Care Fund (BCF) Steering Group and local Health and Wellbeing Board, which governs the BCF Steering Group, to produce a joint plan which reflects the aim of commissioning and providing a 'joined-up' health and care journey through the system for people and communities. The plan addresses the three key challenges of:

- Avoiding unnecessary cost in the system, moving to lower cost solutions, whilst maintaining or improving outcomes;
- Preventing dependency and demand for longer term publically funded services;
• Delaying people’s dependency on long term health and social care interventions.

The Better Care Plan was submitted on the 14th February 2014. It was a single Hampshire plan that aligns with the strategy processes set out by NHS England in The NHS Belongs to the People: A Call to Action, and is an integral part of the the CCG’s operational and strategic plans.

Feedback following submission has been positive, and it was reported that there is a strong governance model. However, there was concern regarding how resources were to be deployed, including how swiftly benefits were to be delivered. Therefore Deloittes are currently considering a procedure of actions in order to realise and identify the benefits. It is already thought that the biggest impact will be felt in the area of continuing healthcare. Discussions are also underway regarding contingency funds and deployment. The Hampshire Commissioning Group is governing the process of the BCF.

Local Authority members stated that money had also been re-allocated to the BCF from the Borough Councils who still had to fulfil their statutory obligations, and this would adversely impact their ability to meet those obligations. It was acknowledged that CCGs were entering a phase of fiscal climate change where budgets will steadily reduce and the cost of running services will continue to rise. Local Authorities had already become attuned to reducing costs and maintaining services as their budgets have been significantly cut. It was considered that CCGs should learn from their experience.

The Governing Body:
• Noted the progress to date to develop the draft plan
• Agreed the draft plan for submission by 14 February 2014

Finance, quality, planning and performance

10/6  Finance Report
Andrew Wood presented the Finance Report for Month 10. It was reported that with three weeks left until the end of the financial year, the CCG is confident of delivering its target surplus of £0.6m with a year to date surplus of £0.4m.

The Governing Body approved the Finance report.

11/6  Performance Report
Michael Drake presented the Performance Report for the month of December. Key achievements included that all three RTT targets were met. There were no patients waiting over 52 weeks for treatment. There were no reported cases of MRSA. There were two reported cases of C.Difficile against a target of four. There were no mixed sex accommodation breaches. Seven out of the nine cancer standards were achieved.

Key areas of underperformance for December was that ED four hour waits did not achieve the target of 95% with 89.4% of patients seen within the timescale. It was reported that there was a delivery problem with the provider and improvements are listed in the performance report. The performance team are about to issue a
The 99% diagnostic target was not achieved, with 97.9% of patients seen within six weeks. It was noted that this target had also struggled to be met in January due to an increase in demand in Portsmouth Hospitals Trust (PHT). An action plan has been requested. Cancer patients receiving subsequent surgery within 31 days achieved 90% against a target of 94%, and cancer patients receiving subsequent radiotherapy within 31 days achieved 92.3% against a target figure of 94%.

Key risks include the RTT targets for specialities not being achieved, ED four hour waits targets not being met, and concerns regarding PHT’s ability to consistently achieve cancer targets. Contract Query notices had been applied on all three areas. It was noted that it would be difficult to fund an improvement in these areas. The contract will always state the target of activity that is to be achieved and the CCG buys that level of activity and each activity has a tariff attached to it. Therefore how the activity is delivered is dependent on the provider, not the contractor, and an increase in money will buy more activity rather than ensuring that activity becomes more efficient.

The Governing Body approved the Performance report.

Quality

12/6 Joint CCG Quality Report

Julia Barton presented the Quality Report, noting the proceedings of the CCG Joint Quality and Safety Committee and exception reports from Portsmouth Hospitals NHS Trust, South Central Ambulance Service NHS Foundation Trust, Solent NHS Trust, Sussex Partnerships child and Adolescent Mental Health Services, Royal Surrey County Hospital NHS Foundation Trust and CCG enquiries, concerns and complaints and serious incidents requiring investigation.

Issues highlighted included:
• Changes were made to the Quality Assurance Committee. The assurance function was strengthened with clear and strong reporting lines;
• Work is underway on the Quality Strategy. The strategy will be shared with the Governing Body in due course;
• The complaints and SIRI process is working well and items are being closed quickly;
• The Quality Surveillance Hub project is developing well and a report will be provided at the next meeting;
• A provider visit was conducted at PHT to review discharge safety;
• Friends and Family test scores have been improving, and low scores may have been attributable to the methodology in reporting;
• A review was conducted at SCAS on the quality aspects of long waits. There have been attempts to meet response times for stroke patients;
• Progress has been made at Southern Health NHS Trust with regard to pressure ulcers;
• C.Difficile trajectories have been reset for next year.

The Governing Body approved the Quality report.

Commissioning
13/6  Commissioning Update

Richard Samuel presented the Commissioning Update on behalf of Alex Berry. It was reported that Solent NHS Trust were in the final stages of implementing the Specialist MSK programme. The new service would be presented to GPs at TARGET. It was noted that there was a robust implementation plan and regular meetings would ensure that there are sufficient staff to deliver the service.

The Governing Body approved the Commissioning Update.

15/5  Engagement Update

Sara Tiller presented a summary of the engagement activity that had taken place over the last two months. Of note:

- Richard Samuel, Dr Keith Barnard attended the first Fareham and Gosport Voluntary Sector Health Forum. Sara Tiller will also be attending the next meeting;
- Dr Keith Barnard, Dr David Chilvers and Richard Samuel had also spoken at meetings with representatives from local groups regarding the development of the CCGs five year strategy;
- Locality Patient Groups had been meeting regularly;
- The Community Engagement Committee had received a presentation about the procurement of a new Non-emergency Patient Transport Service;
- The Gosport Shed initiative was highlighted.

All fora were providing useful and effective engagement and feedback for the CCG.

The Governing Body approved the Engagement Update report.

16/5  Board Assurance Framework

Sara Tiller presented the Board Assurance Framework. The top five highest scoring risks were presented. These were:

- The impact on quality and safety that the inability to improve the ED four hour wait position at PHT;
- The impact on system capacity and organisational pressures as a result of not achieving the required activity changes in the 2013/14 QIPP schemes;
- The organisational sustainability challenge that may be caused by PHT not delivering the planned financial plan in 2013/14;
- The inability of achieve the planned surplus and receive the Quality Premium in 2014/15 as growth and costs will be beyond existing assumptions;
- The challenging C.Dificile national reduction target for the CCG.

The updates and amendments to the progress and assurances of the risks was presented. Six risks were recommended for removal. They were:

- The risk that the challenging financial position of the CCG could limit the ability of the CCG to target support to areas of deprivation. This risk was recommended for removal as the financial position is known and the target score reached;
- The risks that Hampshire-wide Health and Wellbeing Strategy is not sensitive to local deprivation challenges. This risk was recommended for removal as a range of controls are in place and the target score had been reached.
• The risk that the programme to deliver an integrated team with the right skill mix to ensure that any child attending QAH as an emergency is seen by the most appropriate health professional in a timely fashion is not delivered because of organisational resistance or cost constraints. This risk was recommended for removal as it is out of date and a review of the acute paediatric pathway will be started in due course;
• The risk that the impact of transition and re-organisation results in loss of focus on key priorities and a failure to deliver specified outcomes. This risk was recommended for removal as transition is now completed, the authorisations conditions have been cleared and the target score has been reached;
• The risk that the CCG allocation has been announced but there are a number of unresolved baseline issues with a result that spend may not be able to be contained within allocated resources. Risk is recommended for removal as the baseline issues have been resolved;
• The risk that the ‘maximum take’/group three transfers of further services and budgets into the specialised portfolio may remove allocations from the CCG in excess of the saving that will be made on Specialised Commissioning. The risk was recommended for removal as the baseline adjustments had been completed and the target score had been reached.

It was noted that any risks resulting from the Better Care Fund work were currently being collated by Deloittes.

The Governing Body ratified the Board Assurance Framework.

17/5 Public Health Update

Dr Christine Jackson presented the Public Health Update, reporting that engagement regarding the MOU for the forthcoming year is currently underway and all Governing Body members are encouraged to contribute. Public Health have been conducting work locally within Gosport, particularly within Rowner and in support of the leisure facilities. It is anticipated that more work will be done regarding challenging childhood obesity.

The Governing Body noted the Public Health update.

18/5 Minutes/Notes of Other Meetings

Dr David Chilvers presented the minutes and notes of other meetings.

The Governing Body noted the minutes and notes from other meetings.

19/5 Date of Next Meeting

Wednesday 28th May 2014 at 2.00 pm

Octagon Room, Ferneham Hall, Osborne Road, Fareham

Resolution

To exclude the press and public from the confidential part of the meeting because publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted
<table>
<thead>
<tr>
<th>Date of Meeting</th>
<th>28 May 2014</th>
<th>Agenda Item No</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title</td>
<td>Performance Report</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Purpose of Paper</td>
<td>To inform the Governing Body of the latest performance position for the CCG</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recommendations/Actions requested</td>
<td>The Governing Body is asked to:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Note the key achievements of the CCG for the reported period</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Review areas of concern</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Author</td>
<td>Damien Ward</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Performance Manager</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Michael Drake</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Director of Planning and Performance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sponsoring member</td>
<td>Andrew Wood</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Chief Finance Officer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date</td>
<td>19th May 14</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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F&G CCG Executive Summary

- Fareham & Gosport CCG aims to commission good quality care, promote the Rights and Pledges under the NHS Constitution and secure improvement in health outcomes of the local population, and do all of these within our financial plan. The CCG continues to make significant progress towards this aim. The report refers to the latest available data, in the main relating to March.

- The CCG has exceeded the annual trajectory for Clostridium Difficile cases and will not achieve the Healthcare Associated Infections (HCAI) element of the Quality Premium. The majority of cases have been apportioned to the community and the Quality team is working with GP practices and nursing homes to reduce the risk of further cases.

- The CCG remains concerned regarding Referral to Treatment (RTT), A&E 4 hour waits and Cancer performance at Portsmouth Hospitals NHS Trust (PHT). All three RTT targets were achieved at aggregate level in March, however, there continues to be specialty fails at PHT. The sustainability of Cancer performance at PHT remains a risk. The CCG has taken a number of actions including the use of contractual levers. There are also concerns with the recent diagnostic performance at PHT.

- There has been a significant increase in GP referrals from Fareham & Gosport practices into PHT. The CCG is engaging GP practices in referral monitoring, understanding data to create intelligence, and sharing understanding of the resource implications. The current year to date growth rate in GP prescribing costs has exceeded the target.

- Activity at PHT remains above the CCG contract plan in most areas and the final position for the year is £4.5m above the contract plan. Final outturn positions for South Central Ambulance Service (SCAS), Solent NHS Trust and University Hospital Southampton are above plan.

- The CCG has recorded the target surplus of £0.6m. However, Quality, Innovation, Productivity and Prevention (QIPP) delivery is £3.6m under target. The Quality Premium payment for 2014/15 is currently estimated at £657k.

- As part of the management of risks, the following issues were highlighted by the Performance Improvement Action Group (PIAG) to the Portsmouth and South East Hampshire Commissioning Collaborative (PSEHCC) to note in April: QIPP, Unsigned 2014/15 contracts and Cancer and RTT Contract Query Notices.
The dashboard below provides the latest position in relation to quality, performance, contracts and finance.

**Quality**

<table>
<thead>
<tr>
<th>CCG</th>
<th>Target</th>
<th>March</th>
<th>Year to Mar</th>
<th>Ref</th>
</tr>
</thead>
<tbody>
<tr>
<td>MRSA</td>
<td>0</td>
<td>0</td>
<td>G</td>
<td>R</td>
</tr>
<tr>
<td>C.Difficile</td>
<td>3 (Mar) / 39 (YTD)</td>
<td>0</td>
<td>4</td>
<td>R</td>
</tr>
<tr>
<td>Mixed Sex Accommodation breaches</td>
<td>0</td>
<td>0</td>
<td>G</td>
<td>1</td>
</tr>
</tbody>
</table>

**Performance**

<table>
<thead>
<tr>
<th>Planned care</th>
<th>Target</th>
<th>March</th>
<th>Year to Mar</th>
<th>Ref</th>
</tr>
</thead>
<tbody>
<tr>
<td>RTT admitted patients &lt;18 weeks</td>
<td>90%</td>
<td>92.3%</td>
<td>G</td>
<td>90.2%</td>
</tr>
<tr>
<td>RTT non-admitted patients &lt;18 weeks</td>
<td>95%</td>
<td>96.3%</td>
<td>G</td>
<td>96.4%</td>
</tr>
<tr>
<td>RTT incomplete &lt;18 weeks</td>
<td>92%</td>
<td>94.2%</td>
<td>G</td>
<td>94.2%</td>
</tr>
<tr>
<td>Diagnostic test &lt;6 weeks</td>
<td>99%</td>
<td>95.5%</td>
<td>A</td>
<td>95.5%</td>
</tr>
<tr>
<td>Cancer measures achieving target</td>
<td>9</td>
<td>8</td>
<td>8</td>
<td>Pg 9</td>
</tr>
</tbody>
</table>

**Unscheduled care**

| A&E 4 hr waits | 95% | 88.1% | R | 90.5% | A |
| Ambulance handover delays: >30 minutes (PHT) | 104 | A | 1358 | R |
| Ambulance handover delays: > 60 minutes (PHT) | 37 | A | 707 | R |

**Contracts**

<table>
<thead>
<tr>
<th>Year to March*</th>
<th>Target</th>
<th>Actual</th>
<th>Var.</th>
<th>Target</th>
<th>Annual</th>
<th>Forecast</th>
<th>Var.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spend:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Portsmouth Hospitals Trust</td>
<td>91.3</td>
<td>95.8</td>
<td>4.5</td>
<td>R</td>
<td>91.3</td>
<td>95.8</td>
<td>4.5</td>
</tr>
<tr>
<td>Southern Health - Mental Health</td>
<td>15.5</td>
<td>15.3</td>
<td>-0.2</td>
<td>G</td>
<td>15.5</td>
<td>15.3</td>
<td>-0.2</td>
</tr>
<tr>
<td>Southern Health - Community</td>
<td>7.6</td>
<td>7.7</td>
<td>0.1</td>
<td>A</td>
<td>7.6</td>
<td>7.7</td>
<td>0.1</td>
</tr>
<tr>
<td>University Hospital Southampton</td>
<td>7.9</td>
<td>8.0</td>
<td>0.1</td>
<td>A</td>
<td>7.9</td>
<td>8.0</td>
<td>0.1</td>
</tr>
<tr>
<td>Solent Trust</td>
<td>4.5</td>
<td>4.7</td>
<td>0.2</td>
<td>R</td>
<td>4.5</td>
<td>4.7</td>
<td>0.2</td>
</tr>
<tr>
<td>Care UK - St Mary’s Treatment Centre</td>
<td>1.2</td>
<td>1.5</td>
<td>0.3</td>
<td>R</td>
<td>1.2</td>
<td>1.5</td>
<td>0.3</td>
</tr>
<tr>
<td>South Central Ambulance Service</td>
<td>6.0</td>
<td>6.2</td>
<td>0.2</td>
<td>R</td>
<td>6.0</td>
<td>6.2</td>
<td>0.2</td>
</tr>
</tbody>
</table>

**Finance**

<table>
<thead>
<tr>
<th>Year to March</th>
<th>Target</th>
<th>Actual</th>
<th>Var.</th>
<th>Target</th>
<th>Annual</th>
<th>Forecast</th>
<th>Var.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spend</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>203.9</td>
<td>203.3</td>
<td>-0.6</td>
<td>G</td>
<td>203.9</td>
<td>203.3</td>
<td>-0.6</td>
<td>G</td>
</tr>
<tr>
<td>QIPP (gross)</td>
<td>8.0</td>
<td>4.4</td>
<td>-3.6</td>
<td>R</td>
<td>8.0</td>
<td>4.4</td>
<td>-3.6</td>
</tr>
<tr>
<td>Quality premium (estimate)</td>
<td>1.1</td>
<td>0.7</td>
<td>-0.4</td>
<td>R</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Commentary:**

- **The CCG has exceeded the annual C.diff trajectory**
- **Friends and Family Test response rate**
- **Risks (current and future):**
  - Final provider performance may be higher than anticipated for some contracts.

**Contracts (current and future):**

- **Risks (current and future):**
  - Pressure on acute contracts; activity levels above plan will carry financial implications
  - Continuing Healthcare; increases in spend in Fareham & Gosport CCG.

<table>
<thead>
<tr>
<th>Commentary:</th>
</tr>
</thead>
<tbody>
<tr>
<td>The PHT annual forecast has been set to reflect the in-contract part of the settlement reached with the Trust.</td>
</tr>
<tr>
<td>The CCG has met the planned annual surplus of £0.6m.</td>
</tr>
</tbody>
</table>

**Commentary:**

- RTT targets were not achieved for all specialties
- Cancer patients receiving subsequent surgery <31 days' did not achieve target in March.
The key achievements for the month of March are listed below:

- The CCG achieved all three RTT targets: Admitted 92.3% (target 90%), Non-admitted 96.3% (95%) and Incomplete 94.2% (92%).
- There were no patients waiting over 52 weeks for treatment.
- Eight of the nine Cancer standard were achieved.
- There were no reported cases of Methicillin-resistant Staphylococcus Aureus (MRSA).
- There were no reported Mixed Sex Accommodation breaches.
- The CCG has achieved the target surplus of £0.6m.
- The Friends and Family Test net promoter score of 71 at PHT was above the national average of 63.

The key areas where the CCG is underperforming during March are listed below:

- There were four reported cases of Clostridium Difficile (C.diff) against a trajectory of three.
- The 99% diagnostic target was not achieved with 95.5% of patients seen within six weeks.
- A&E 4 hour waits did not achieve the target of 95% with 88.1% of patients seen within the timescale.
- ‘Cancer patients receiving subsequent surgery within 31 days’ narrowly missed the target of 94% with 93.8%.
- Quality, Innovation, Productivity and Prevention (QIPP) delivery under target.
- The current growth in GP prescribing costs of 2.9% in January has exceeded the target of 2.4%.
- The Friends and Family Test response rate of 16.7% at PHT is below the target of 20%.
### Key Risks and Mitigating Actions

<table>
<thead>
<tr>
<th>Key Risks</th>
<th>Mitigating Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Referral to Treatment (RTT)</strong></td>
<td>• The Trust has submitted a Remedial Action Plan providing the proposed timescales for failing specialties to be in a sustainable position.</td>
</tr>
<tr>
<td>• Achieving RTT targets at specialty level remains a challenge, primarily due to the underperformance at PHT.</td>
<td></td>
</tr>
<tr>
<td><strong>A&amp;E 4 hour waits</strong></td>
<td>• The Trust has implemented improvement initiatives to deflect attendances and admissions. An ‘Urgent and Emergency Care Recovery and Improvement Plan’ for 2014/15 has been developed to ensure the sustained delivery of A&amp;E performance.</td>
</tr>
<tr>
<td>• The CCG continues to fail to achieve the A&amp;E target due to the underperformance at PHT.</td>
<td></td>
</tr>
<tr>
<td><strong>Cancer</strong></td>
<td>• The CCG has taken a number of actions including the use of contractual levers. PHT have submitted an updated Remedial Action Plan providing the proposed timescales for failing areas to be in a sustainable position.</td>
</tr>
<tr>
<td>• Concerns remain regarding PHT’s ability to consistently achieve targets.</td>
<td></td>
</tr>
<tr>
<td><strong>Diagnostics</strong></td>
<td>• The Trust continues to provide additional capacity and outsource activity to improve performance. Requests have been made to departments and specialties for referrals to arrive at the imaging department within five days of the referral being made. Similar requests will be made to GP practices.</td>
</tr>
<tr>
<td>• The CCG has not achieved the diagnostic target in four consecutive months due to the underperformance at PHT.</td>
<td></td>
</tr>
<tr>
<td><strong>Ophthalmology</strong></td>
<td>• The Clinical Lead at PHT has established processes to manage the backlog, including a priority scoring system to mitigate patient risks and additional weekend clinics.</td>
</tr>
<tr>
<td>• The CCG has been informed by PHT that the proposed trajectory for reducing the follow up backlog has not been met.</td>
<td></td>
</tr>
<tr>
<td>Indicator</td>
<td>Target</td>
</tr>
<tr>
<td>-----------</td>
<td>--------</td>
</tr>
<tr>
<td><strong>Referral To Treatment waiting times for non-urgent consultant-led treatment</strong></td>
<td></td>
</tr>
<tr>
<td>RTT:% of admitted patients who waited 18 weeks or less</td>
<td>90%</td>
</tr>
<tr>
<td>RTT:% of non-admitted patients who waited 18 weeks or less</td>
<td>95%</td>
</tr>
<tr>
<td>RTT:% of incomplete patients waiting 18 weeks or less</td>
<td>92%</td>
</tr>
<tr>
<td>RTT: Number of admitted patients who waited &gt;52 weeks</td>
<td>0</td>
</tr>
<tr>
<td>RTT: Number of non-admitted patients who waited &gt;52 weeks</td>
<td>0</td>
</tr>
<tr>
<td><strong>Diagnostic test waiting times</strong></td>
<td></td>
</tr>
<tr>
<td>% Patients waiting &lt;6 weeks for a diagnostic test</td>
<td>99%</td>
</tr>
<tr>
<td>A&amp;E waits</td>
<td></td>
</tr>
<tr>
<td>A&amp;E &lt;=4hrs (QTD)</td>
<td>95%</td>
</tr>
<tr>
<td><strong>Cancer waits – 2 week wait</strong></td>
<td></td>
</tr>
<tr>
<td>Cancer patients seen &lt;14 days after urgent GP referral</td>
<td>93%</td>
</tr>
<tr>
<td>Breast Cancer Referrals Seen &lt;2 weeks</td>
<td>93%</td>
</tr>
<tr>
<td><strong>Cancer waits – 31 days</strong></td>
<td></td>
</tr>
<tr>
<td>Cancer diagnosis to treatment &lt;31 days</td>
<td>96%</td>
</tr>
<tr>
<td>Cancer Patients receiving subsequent surgery &lt;31 days</td>
<td>94%</td>
</tr>
<tr>
<td>Cancer Patients receiving subsequent Chemo/Drug &lt;31 days</td>
<td>98%</td>
</tr>
<tr>
<td>Cancer Patients receiving subsequent radiotherapy &lt;31 days</td>
<td>94%</td>
</tr>
<tr>
<td><strong>Cancer waits – 62 days</strong></td>
<td></td>
</tr>
<tr>
<td>Cancer urgent referral to treatment &lt;62 days</td>
<td>85%</td>
</tr>
<tr>
<td>Cancer Patients treated after screening referral &lt;62 days</td>
<td>90%</td>
</tr>
<tr>
<td>Cancer Patients treated after consultant upgrade &lt;62 days (local threshold)</td>
<td>86%</td>
</tr>
<tr>
<td><strong>Category A ambulance calls</strong></td>
<td></td>
</tr>
<tr>
<td>Cat A calls within 8 minutes - Red 1</td>
<td>75%</td>
</tr>
<tr>
<td>Cat A calls within 8 minutes - Red 2</td>
<td>75%</td>
</tr>
<tr>
<td>Cat A calls within 19 minutes</td>
<td>95%</td>
</tr>
<tr>
<td><strong>Mixed Sex Accommodation Breaches</strong></td>
<td></td>
</tr>
<tr>
<td>Mixed Sex Accommodation Breaches</td>
<td>0</td>
</tr>
<tr>
<td><strong>Healthcare Associated Infections</strong></td>
<td></td>
</tr>
<tr>
<td>HCAI: Clostridium Difficile (C. Diff.) Infection rates</td>
<td>39</td>
</tr>
<tr>
<td>HCAI: Incidence of MRSA</td>
<td>0</td>
</tr>
<tr>
<td><strong>Mental health</strong></td>
<td></td>
</tr>
<tr>
<td>Care Programme Approach (CPA): The proportion of people under adult mental illness specialties on CPA who were followed up within 7 days of discharge from psychiatric in-patient care during the period.</td>
<td>95%</td>
</tr>
</tbody>
</table>
Referral to Treatment (RTT)

- The three RTT targets were achieved for the CCG in March, however, there continues to be fails at specialty level: T&O and Gynaecology failed to achieve the admitted target, T&O and Dermatology failed the non-admitted target, and T&O, General Surgery and Urology did not achieve the incomplete target. The three RTT targets were achieved for the CCG at aggregate level in 2013/14.

- The majority of breaches for the failing specialties continue to be a result of the underperformance at PHT. A Remedial Action Plan has been submitted by the Trust proposing the timescales for failing specialties to be in a sustainable position. The table below presents the timescales and measures the (provisional) March RTT performance against the plan.

<table>
<thead>
<tr>
<th></th>
<th>Mar-14</th>
<th>Apr-14</th>
<th>May-14</th>
<th>Jun-14</th>
<th>Jul-14</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Plan</td>
<td>Actual</td>
<td>Plan</td>
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<tr>
<td>ENT</td>
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</tr>
<tr>
<td>Admitted</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
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<td>✔️</td>
<td>✔️</td>
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<tr>
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<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
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<tr>
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<td>✔️</td>
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<td>✔️</td>
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<tr>
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<tr>
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<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>T&amp;O</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<tr>
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<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
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<td>✔️</td>
</tr>
<tr>
<td>Non-admitted</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
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<td>✔️</td>
</tr>
<tr>
<td>Incomplete</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Trust Aggregate</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Admitted</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Non-admitted</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Incomplete</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
</tbody>
</table>

- Performance in March was better than the Trust expected, with the Trust aggregate incomplete position and the General Surgery non-admitted standard achieving targets which had been predicted to fail.

- Additional capacity and the recruitment of a Urology consultant will support the plan to achieve all of the targets from July 2014.

- The CCG RTT performance has also been affected by breaches at University Hospital Southampton Foundation Trust (UHSFT), which has experienced challenges achieving the RTT targets throughout 2013/14; the Trust failed to achieve all three targets in Q4. A Remedial Action Plan has been agreed which is focussed on the delivery of targets in Paediatric Orthopaedics (by November 2014) and Orthopaedics and ENT (by December 2014). There are significant fines attached to the failure of the RTT plans at specialty level.
Diagnostics

- The CCG did not achieve the 99% diagnostics target in March; the target has not been achieved in four consecutive months as shown in the adjacent graph.

- The majority of breaches have occurred at PHT and have been attributed to increased demand, which is also a national picture and is reportedly resulting in a shortage of trained staff.

- The reported increase in demand is being benchmarked by the CCG to better understand the situation:
  - There has been a 6% increase in diagnostic activity in England for two years (2011/12 – 2012/13 and 2012/13 – 2013/14). The increase at PHT during the same period is 16% per annum (which is the largest increase of the six local acute providers). The main drivers for the increase at PHT are CT, MRI and Ultrasound.

- PHT has continued to plan for excess demand through additional lists in the evening and weekends and improving communication with referrers in order to anticipate future demand. Additional capacity has been sought across Hampshire and Western Sussex. The Trust has agreed increased funding to enable more equipment to be available and increase staffing levels.

- The capacity issues in diagnostics will impact on the delivery of RTT targets and the Trust report this is also causing delays on Cancer pathways.

Cancer

- The CCG achieved eight of the nine Cancer standards in March, failing in the ‘Cancer patients receiving subsequent surgery within 31 days’ standard.

- There have been improvements at PHT regarding Cancer performance due to changes in processes and additional capacity. There has been a reduction in the numbers of patients waiting and more targets are being achieved. Provisional data indicates the Trust achieved all nine standards in March, however, concerns remain as there is limited assurance around the sustainability of achieving targets and significant quality issues have been identified.

- The National Cancer Peer review report has raised four serious quality concerns around Cancer services at PHT, relating to staffing levels, administration processes, diagnostics and a serious concern around anal Cancers, which are treated on multiple sites. This has been raised at the Executive Contract Review Meeting (ECRM) and will be monitored by the Quality team.
A&E 4 hour waits

• The CCG has failed to achieve the 95% A&E target in 2013/14 with an annual performance of 90.5%.

• The target was only achieved in one month of 2013/14 and the adjacent graph shows the underperformance was largely driven by breaches at PHT.

• The Trust implemented a number of initiatives throughout the year to deflect attendances and admissions, including the introduction of the Urgent Care Centre in November 2013.

• An ‘Urgent and Emergency Care Recovery and Improvement Plan’ for 2014/15 has been developed to ensure the sustained delivery of A&E performance. The Portsmouth and South East Hampshire Urgent Care operational Board (UCOB) will monitor the implementation, improvement, risks and mitigations to the delivery of the target.

• Performance has not shown improvement in April 2014 with only 85.7% of patients seen within the timescale.

Healthcare Associated Infections (HCAI)

• The CCG has exceeded the annual C.diff trajectory and will not achieve the HCAI element of the Quality Premium (£125,229).

• The adjacent graph shows that the number of reported C.diff cases has been within the monthly trajectory for five months of 2013/14.

• The majority of C.diff cases have been attributed to the community (34) and of the main CCG acute providers, ten cases have been attributed to PHT and one case to UHSFT.

• The Quality Team has developed a recovery plan to improve HCAI performance within the community involving GP practices and nursing homes. It is expected that performance will slowly improve over time as the recovery initiatives are implemented throughout 2014; this may have a negative impact on the short to medium term target delivery.
The CCG’s Quarter 4 estimated performance using NHS England assessment criteria is shown in the Delivery Dashboard below.

<table>
<thead>
<tr>
<th>Section</th>
<th>Titles</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>Q4 Indicators failing</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Quality</strong></td>
<td>Are patients receiving clinically commissioned, high quality services? (Indicators achieved out of 20)</td>
<td>19</td>
<td>18</td>
<td>17</td>
<td>18</td>
<td>• Incidence of MRSA at PHT</td>
</tr>
<tr>
<td></td>
<td>• Incidence of MRSA at PHT</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Southern Health have reported unclosed Serious Incidents Requiring Investigation (SIRIs)</td>
</tr>
<tr>
<td><strong>NHS Constitution</strong></td>
<td>Are patient rights under the NHS Constitution being promoted? (Indicators achieved out of 20)</td>
<td>15</td>
<td>16</td>
<td>16</td>
<td>18</td>
<td>• Diagnostics</td>
</tr>
<tr>
<td></td>
<td>• Diagnostics</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• A&amp;E 4 hour waits (PHT)</td>
</tr>
<tr>
<td><strong>Outcome</strong></td>
<td>Are health outcomes improving for local people? (Indicators achieved out of 8)</td>
<td>6</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>• Incidence of MRSA</td>
</tr>
<tr>
<td></td>
<td>• Incidence of MRSA</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Finance</strong></td>
<td>Are CCGs delivering services within their financial plans? (Indicators achieved out of 10)</td>
<td>8</td>
<td>8</td>
<td>8</td>
<td>9</td>
<td>• Quality, Innovation, Productivity and Prevention (QIPP) delivery</td>
</tr>
</tbody>
</table>
The Quality Premium is intended to reward the CCGs for improvements in the quality of the services that they commission, and for associated improvements in health outcomes and reducing inequalities.

The payment of the 2014/15 premium will be based on the 2013/14 performance on four national measures and three local measures which are detailed in the table below. The CCG estimated Quality Premium for the year is £657,451. This position assumes that all of the financial gateway conditions have been met.

<table>
<thead>
<tr>
<th>Measure</th>
<th>% of Quality Premium</th>
<th>Value for CCG</th>
<th>Mar-14</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>National Measures</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mortality*</td>
<td>12.50%</td>
<td>£125,229</td>
<td>Y</td>
</tr>
<tr>
<td>Avoidable Emergency Admissions*</td>
<td>25%</td>
<td>£250,458</td>
<td>Y</td>
</tr>
<tr>
<td>Patient Experience (Friends and Family Test score)</td>
<td>12.50%</td>
<td>£125,229</td>
<td>Y</td>
</tr>
<tr>
<td>Preventable Infections</td>
<td>12.50%</td>
<td>£125,229</td>
<td>N</td>
</tr>
<tr>
<td><strong>Local Measures</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Onward referral rate from the COAST service to Portsmouth Hospitals Trust (CAU/A&amp;E, including self-referral) to be no more than 20%</td>
<td>12.50%</td>
<td>£125,229</td>
<td>Y</td>
</tr>
<tr>
<td>To increase the number of people being supported to manage their own condition</td>
<td>12.50%</td>
<td>£125,229</td>
<td>Y</td>
</tr>
<tr>
<td>50% of patients attending pulmonary rehab in 2013/14 to have an agreed care plan in place.</td>
<td>12.50%</td>
<td>£125,229</td>
<td>Y</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>100%</td>
<td>£1,001,830</td>
<td></td>
</tr>
</tbody>
</table>

* Assumed position - data not yet available

<table>
<thead>
<tr>
<th>NHS Constitution rights and pledges</th>
<th>% reduction for non-achievement</th>
<th>Measure achieved</th>
<th>Quality Premium adj.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referral to treatment times within 18 weeks (incomplete)</td>
<td>25%</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>A&amp;E waits (PHT level)</td>
<td>25%</td>
<td>N</td>
<td>-£219,150</td>
</tr>
<tr>
<td>Cancer waits (urgent referral to treatment within 62 days)</td>
<td>25%</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>Category A Red 1 ambulance calls (SCAS level)</td>
<td>25%</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td><strong>Total adjustment</strong></td>
<td></td>
<td></td>
<td>-£219,150</td>
</tr>
<tr>
<td><strong>REVISED TOTAL</strong></td>
<td></td>
<td></td>
<td><strong>£657,451</strong></td>
</tr>
</tbody>
</table>
GP Referrals: April – February

• Concerns have been raised regarding the increasing number of GP referrals compared to 2012/13, primarily from Fareham & Gosport and South Eastern Hampshire CCGs.

• The majority of CCG referral activity relates to PHT which has seen a 13.2% increase. T&O referrals represent a significant proportion of the growth, however, part of the increase is due to ‘hand & foot’ referrals being temporarily diverted from PHT in 2012/13.

• The three specialties at PHT which have seen the highest increase from F&G practices are Ophthalmology, ENT and Urology.

• There has been an investment of £500k into an Elective Locally Commissioned Service (LCS), which will incentivise practices to re-engage in referral monitoring, develop and monitor an action plan for how the practice intend to reduce referral variation, have an identified GP referral lead in each practice and engage in an education programme for specific specialties.

• A Direct Expansion Solutions (DXS) tool has been commissioned to alert users of care pathways available where the CCG have set up a pathway or referral protocol. The GP referral lead will be expected to attend DXS training with the practice manager, and feedback to clinicians in the practice for how the tool should be used. All clinicians will be expected to use the DXS tool where pathways, referral forms or guidance are available.
GP Prescribing Costs – period ending January 2014

<table>
<thead>
<tr>
<th>GP practice prescribing budgets 2013/14</th>
<th>£28.68m</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCG calculated forecast outturn on GP practice prescribing 2013/14</td>
<td>£29.11m</td>
</tr>
</tbody>
</table>

- Growth rate is measured by the current 12 month spend of the practice compared to the previous 12 months. To achieve the prescribing Quality, Innovation, Productivity and Planning (QIPP) target, overall growth in prescribing needs to be contained to less than 2.4%. The target is currently not being achieved, with a current growth rate of 2.9%.

- The category M of the drug tariff (reimbursement prices) is used to control the profits of chemists and covers many generic drugs. This was delivering savings each month but has now become a cost pressure.

- The uptake of New Oral Anticoagulants has provided additional cost pressure over the last 12 months and is increasing month on month.

- The table below shows the current 12 month spend by GP practice per 1000 AstroPu (list size weighted for age and sex) and the current growth rate at January 2014.

<table>
<thead>
<tr>
<th>GP Practice</th>
<th>Growth</th>
<th>Spend</th>
<th>GP Practice</th>
<th>Growth</th>
<th>Spend</th>
</tr>
</thead>
<tbody>
<tr>
<td>BROOK LANE SURGERY</td>
<td>18.5%</td>
<td>£33</td>
<td>BURY ROAD SURGERY</td>
<td>1.8%</td>
<td>£45</td>
</tr>
<tr>
<td>BRUNE MEDICAL CENTRE</td>
<td>8.3%</td>
<td>£48</td>
<td>LOCKSWOOD SURGERY</td>
<td>1.7%</td>
<td>£32</td>
</tr>
<tr>
<td>GUDGEHEATH LANE SURGERY</td>
<td>6.7%</td>
<td>£35</td>
<td>STOKE ROAD MEDICAL CENTRE</td>
<td>1.5%</td>
<td>£44</td>
</tr>
<tr>
<td>BROCKHURST MEDICAL CENTRE</td>
<td>6.0%</td>
<td>£43</td>
<td>MANOR WAY SURGERY</td>
<td>0.8%</td>
<td>£39</td>
</tr>
<tr>
<td>JUBILEE SURGERY</td>
<td>4.7%</td>
<td>£35</td>
<td>THE HIGHLANDS PRACTICE</td>
<td>0.6%</td>
<td>£40</td>
</tr>
<tr>
<td>CENTRE PRACTICE</td>
<td>4.1%</td>
<td>£39</td>
<td>WATERSIDE MEDICAL CENTRE</td>
<td>0.6%</td>
<td>£34</td>
</tr>
<tr>
<td>GOSPORT MEDICAL CENTRE</td>
<td>3.6%</td>
<td>£37</td>
<td>FORTON MEDICAL CENTRE</td>
<td>0.2%</td>
<td>£44</td>
</tr>
<tr>
<td>ROWNER HEALTH CENTRE</td>
<td>3.3%</td>
<td>£45</td>
<td>PORTCHESTER PRACTICE</td>
<td>-0.3%</td>
<td>£34</td>
</tr>
<tr>
<td>LEE-ON-THE-SOLENT HEALTH CENTRE</td>
<td>3.2%</td>
<td>£36</td>
<td>STUBBINGTON MEDICAL PRACTICE</td>
<td>-0.3%</td>
<td>£35</td>
</tr>
<tr>
<td>BRIDGEMARY MEDICAL CENTRE</td>
<td>2.1%</td>
<td>£40</td>
<td>THE WHITELEY SURGERY</td>
<td>-6.4%</td>
<td>£33</td>
</tr>
<tr>
<td>WESTLANDS MEDICAL CENTRE</td>
<td>2.0%</td>
<td>£35</td>
<td>CCG average</td>
<td>2.9%</td>
<td>-</td>
</tr>
</tbody>
</table>

- Brook Lane Surgery, Brune Medical Centre and Jubilee Surgery have experienced significant growth through increased patient numbers.

- The GP practices with the highest spend on prescribing tend to be from areas of deprivation. These practices are targeted with actions for extra savings.
Month 11 (February) Activity

Portsmouth Hospitals NHS Trust

• Elective activity has been slightly over the contract plan, with the main increase in Trauma & Orthopaedics.

• Non-elective activity has over-performed, primarily in Orthopaedic Trauma. There has also been pressure in Stroke, Thoracic and Cardiac procedures.

• First Outpatient activity has increased to 12% over the contract plan.

Southern Health NHS Foundation Trust – Community

• The final version of the baseline review was received in December. The Commissioning Support Unit has presented the final variances to the Chief Financial Officers and they are jointly agreeing how and when to conclude the rebasing exercise. The agreement of NHS England remains unknown.

Southern Health NHS Foundation Trust – Mental Health

• The rebasing of this contract is due for completion by 30th June 2014, at which point activity plans shall be amended to reflect agreed CCG allocations. From 1st April 2014 (until the contract is rebased), activity plans will be broadly based on 2013/14 forecast outturn and adjusted where necessary.

University Hospital Southampton Foundation Trust

• Activity remains above the contract plan, with Unbundled Outpatients the main area of pressure.
The total CCG annual planned savings are £8.070m, which were not achieved. The QIPP achieved is £4.442m, a variance of £3.628m against the plan. This achievement represents 55% of the total plan.

The programme table below shows delivery against the planned QIPP submitted to NHS England as part of the financial submission in April 2013.

<table>
<thead>
<tr>
<th>Programme</th>
<th>£'000s</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>13/14 Total</td>
<td>YTD Planned</td>
</tr>
<tr>
<td>Project Plans &amp; Budget Adjustments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enabling Programmes</td>
<td>274</td>
<td>274</td>
</tr>
<tr>
<td>Maternity and Child Health</td>
<td>355</td>
<td>355</td>
</tr>
<tr>
<td>Mental Health</td>
<td>845</td>
<td>845</td>
</tr>
<tr>
<td>Medicines Management</td>
<td>1,797</td>
<td>1,797</td>
</tr>
<tr>
<td>Planned Care and Long Term Conditions</td>
<td>602</td>
<td>602</td>
</tr>
<tr>
<td>Urgent and Integrated Care</td>
<td>1,110</td>
<td>1,110</td>
</tr>
<tr>
<td>Total</td>
<td>4,983</td>
<td>4,983</td>
</tr>
<tr>
<td>Developmental QIPP</td>
<td>3,087</td>
<td>3,087</td>
</tr>
<tr>
<td>Total:</td>
<td>8,070</td>
<td>8,070</td>
</tr>
</tbody>
</table>
Portsmouth Hospitals NHS Trust (PHT)

This dashboard provides an overview of Portsmouth Hospitals Trust (PHT) performance from the quality, performance, contracts and finance perspectives. The data is sourced from PHT’s Integrated Performance Report (with the exception of contracts).

<table>
<thead>
<tr>
<th>Quality</th>
<th>Target</th>
<th>March</th>
<th>Year to March</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCAI - MRSA</td>
<td>0</td>
<td>1</td>
<td>R</td>
</tr>
<tr>
<td>HCAI - C.Difficile</td>
<td>3 (Mar) / 30 (YTD)</td>
<td>1</td>
<td>G</td>
</tr>
<tr>
<td>Venous Thrombo-embolus screening</td>
<td>95%</td>
<td>95.7%</td>
<td>G</td>
</tr>
<tr>
<td>Pressure Ulcer Prevalence (grade 2, 3, 4)</td>
<td>1.06%</td>
<td>0.93%</td>
<td>G</td>
</tr>
<tr>
<td>Hospital Standardised Mortality Ratio (HSMR)</td>
<td>100</td>
<td>90.0</td>
<td>G</td>
</tr>
<tr>
<td>Summary Hospital Level Mortality Indicator (SHMI)</td>
<td>100</td>
<td>104.0</td>
<td>A</td>
</tr>
<tr>
<td>Never events</td>
<td>0</td>
<td>1</td>
<td>R</td>
</tr>
<tr>
<td>Friends and Family Test response rate (QTD)</td>
<td>20%</td>
<td>16.7%</td>
<td>A</td>
</tr>
<tr>
<td>Friends and Family Test net promoter score</td>
<td>&gt;Q1 (63)</td>
<td>71</td>
<td>G</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Performance</th>
<th>Target</th>
<th>March</th>
<th>Year to March</th>
</tr>
</thead>
<tbody>
<tr>
<td>RTT admitted patients &lt;18weeks</td>
<td>90%</td>
<td>90.8%</td>
<td>G</td>
</tr>
<tr>
<td>RTT non-admitted patients &lt;18weeks</td>
<td>95%</td>
<td>96.2%</td>
<td>G</td>
</tr>
<tr>
<td>RTT incomplete &lt;18weeks</td>
<td>92%</td>
<td>94.4%</td>
<td>G</td>
</tr>
<tr>
<td>Diagnostic waits &lt;6 weeks</td>
<td>99%</td>
<td>95.4%</td>
<td>A</td>
</tr>
<tr>
<td>Admission directly to stroke unit</td>
<td>90%</td>
<td>93.7%</td>
<td>G</td>
</tr>
<tr>
<td>Number of cancer measures achieving target</td>
<td>9</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>A&amp;E 4 hr waits</td>
<td>95%</td>
<td>88.9%</td>
<td>R</td>
</tr>
<tr>
<td>A&amp;E unplanned re-attendance rates &lt; 7 days</td>
<td>5%</td>
<td>5.9%</td>
<td>R</td>
</tr>
<tr>
<td>Ambulance handover delays: &gt;30 minutes</td>
<td>104</td>
<td>37</td>
<td>A</td>
</tr>
<tr>
<td>Ambulance handover delays: &gt; 60 minutes</td>
<td>1358</td>
<td>1358</td>
<td>A</td>
</tr>
</tbody>
</table>

**Commentary:**
- The MRSA case in March involved a Portsmouth CCG patient.
- The Trust was within the annual C.diff trajectory of 30.
- The never event in March involved a South Eastern Hampshire CCG patient. The event related to the incorrect extraction of a tooth and the CCG is awaiting the outcome of the Root Cause Analysis. Audits are in place to monitor compliance with the Safer Surgical Checklist and the Trust report that learning has occurred as a result.

**Risks (current and future):**
- Friends and Family Test response rate

<table>
<thead>
<tr>
<th>Contracts</th>
<th>Year to March*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td>Actual</td>
</tr>
<tr>
<td>£m</td>
<td>£m</td>
</tr>
<tr>
<td>Fareham &amp; Gosport</td>
<td>91.3</td>
</tr>
<tr>
<td>South Eastern Hampshire</td>
<td>81.3</td>
</tr>
<tr>
<td>Portsmouth</td>
<td>102.9</td>
</tr>
</tbody>
</table>

*Projected position based on February activity

**Commentary:**
- The Trust has agreed a year-end forecast outturn position with the CCGs.
- The main areas of combined elective pressure for the CCGs:
  - F&G: T&O and Gastroenterology
  - SEH: Breast, T&O, Ophthalmology and Cardiology
  - Portsmouth: T&O, ENT and Upper GI.

<table>
<thead>
<tr>
<th>Finance &amp; Workforce</th>
<th>Year to March</th>
<th>Annual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td>Actual</td>
<td>Var.</td>
</tr>
<tr>
<td>£m</td>
<td>£m</td>
<td>£m</td>
</tr>
<tr>
<td>Surplus / -deficit</td>
<td>0</td>
<td>0.8</td>
</tr>
</tbody>
</table>

**Workforce:**
- Staff turnover: 12.0% | 10.5% | -1.5% | G | 12.0% | 10.5% | -1.5% |
- Sickness: 3.0% | 3.6% | 0.6% | G | 3.0% | 3.6% | 0.6% |

**Commentary:**
- The year-end financial position includes additional income of £2m from the CCGs and £4m from the TDA which was received in March.
- There has been an increase in sickness absence, in particular anxiety and stress related absence, which the Trust report may be a result of pressures regarding high levels of activity.
<table>
<thead>
<tr>
<th>Key Targets Dashboard</th>
<th>2013/14 Targets</th>
<th>Previous Month</th>
<th>Mar-14</th>
<th>Performance Direction</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality of Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meeting CDIFF Objective</td>
<td>&lt; / = 30</td>
<td>1</td>
<td>1</td>
<td></td>
<td>4</td>
<td>10</td>
<td>13</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Meeting MRSA Objective</td>
<td></td>
<td>0</td>
<td>1</td>
<td></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>VTE Risk Assessment</td>
<td>95%</td>
<td>94.3%</td>
<td>96.1%</td>
<td></td>
<td>95.2%</td>
<td>95.7%</td>
<td>95.3%</td>
<td>96.4%</td>
<td>95.4%</td>
</tr>
<tr>
<td>A&amp;E 4 hr arrival to admission/transfer/discharge</td>
<td>95%</td>
<td>87.0%</td>
<td>88.9%</td>
<td></td>
<td>88.9%</td>
<td>90.3%</td>
<td>92.8%</td>
<td>87.5%</td>
<td>89.9%</td>
</tr>
<tr>
<td>Unplanned re-attendances rate &lt;7 days</td>
<td>&lt; 5%</td>
<td>5.6%</td>
<td>5.9%</td>
<td></td>
<td>5.5%</td>
<td>5.8%</td>
<td>5.4%</td>
<td>5.8%</td>
<td>5.6%</td>
</tr>
<tr>
<td>Left without being seen</td>
<td>&lt;= 5%</td>
<td>2.0%</td>
<td>1.9%</td>
<td></td>
<td>1.8%</td>
<td>1.9%</td>
<td>1.1%</td>
<td>1.8%</td>
<td>1.7%</td>
</tr>
<tr>
<td>A&amp;E Patient Impact</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total time in A&amp;E (95th percentile)</td>
<td>&lt; 4hrs</td>
<td>7.10</td>
<td>6.09</td>
<td></td>
<td>6.20</td>
<td>6.04</td>
<td>5.25</td>
<td>7.00</td>
<td>6.30</td>
</tr>
<tr>
<td>Arrival to assessment (95th percentile)</td>
<td>&lt; 15 mins</td>
<td>1.16</td>
<td>1.08</td>
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<td>0.29</td>
<td>0.20</td>
<td>0.16</td>
<td>1.04</td>
<td>0.37</td>
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<tr>
<td>A&amp;E Timeliness</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Median time arrival to treatment</td>
<td>&lt; 60 mins</td>
<td>0.54</td>
<td>0.54</td>
<td></td>
<td>1.00</td>
<td>0.56</td>
<td>0.49</td>
<td>0.51</td>
<td>0.53</td>
</tr>
<tr>
<td>Ambulance delays &gt; 30 minutes</td>
<td>0</td>
<td>85</td>
<td>104</td>
<td></td>
<td>597</td>
<td>257</td>
<td>254</td>
<td>250</td>
<td>1358</td>
</tr>
<tr>
<td>Ambulance delays &gt; 60 minutes</td>
<td>0</td>
<td>33</td>
<td>37</td>
<td></td>
<td>488</td>
<td>93</td>
<td>51</td>
<td>51</td>
<td>707</td>
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<tr>
<td>RTT</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% Admitted</td>
<td>90%</td>
<td>90.0%</td>
<td>90.8%</td>
<td></td>
<td>91.8%</td>
<td>86.3%</td>
<td>84.2%</td>
<td>90.7%</td>
<td>88.2%</td>
</tr>
<tr>
<td>% Non-Admitted</td>
<td>95%</td>
<td>96.1%</td>
<td>96.2%</td>
<td></td>
<td>97.3%</td>
<td>96.6%</td>
<td>95.8%</td>
<td>96.0%</td>
<td>96.4%</td>
</tr>
<tr>
<td>95th percentile for Admitted</td>
<td>23 weeks</td>
<td>28.8</td>
<td>28.8</td>
<td></td>
<td>24.2</td>
<td>31.6</td>
<td>27.0</td>
<td>27.2</td>
<td>27.3</td>
</tr>
<tr>
<td>95th percentile for Non-Admitted</td>
<td>18.3 weeks</td>
<td>18.6</td>
<td>18.5</td>
<td></td>
<td>17.8</td>
<td>18.3</td>
<td>18.7</td>
<td>18.6</td>
<td>18.4</td>
</tr>
<tr>
<td>95th percentile for Incomplete</td>
<td>28 weeks</td>
<td>20.7</td>
<td>19.6</td>
<td></td>
<td>18.2</td>
<td>20.5</td>
<td>19.8</td>
<td>20.3</td>
<td>19.6</td>
</tr>
<tr>
<td>Admitted backlog target</td>
<td>308</td>
<td>804</td>
<td>753</td>
<td></td>
<td>736</td>
<td>844</td>
<td>574</td>
<td>753</td>
<td>753</td>
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<tr>
<td>Incomplete patients waiting &gt; 52 wks</td>
<td>2292</td>
<td>810</td>
<td>723</td>
<td></td>
<td>395</td>
<td>620</td>
<td>878</td>
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<tr>
<td>Diagnostics</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic waits</td>
<td>99% &lt; 6 wks</td>
<td>97.4%</td>
<td>95.4%</td>
<td></td>
<td>99.3%</td>
<td>99.3%</td>
<td>98.8%</td>
<td>96.9%</td>
<td>96.5%</td>
</tr>
<tr>
<td>All 2-week wait referrals</td>
<td>93%</td>
<td>95.3%</td>
<td>96.0%</td>
<td></td>
<td>94.9%</td>
<td>93.8%</td>
<td>92.7%</td>
<td>96.1%</td>
<td>96.4%</td>
</tr>
<tr>
<td>Cancer</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>31-day diagnosis to treatment</td>
<td>96%</td>
<td>97.6%</td>
<td>96.8%</td>
<td></td>
<td>97.2%</td>
<td>98.9%</td>
<td>98.3%</td>
<td>97.5%</td>
<td>98.0%</td>
</tr>
<tr>
<td>31-day subsequent cancers to treatment</td>
<td>94%</td>
<td>92.9%</td>
<td>97.9%</td>
<td></td>
<td>96.5%</td>
<td>96.1%</td>
<td>92.1%</td>
<td>94.3%</td>
<td>94.8%</td>
</tr>
<tr>
<td>31-day subsequent anti-cancer drugs</td>
<td>98%</td>
<td>100%</td>
<td>100%</td>
<td></td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>31-day subsequent radiotherapy</td>
<td>94%</td>
<td>99.0%</td>
<td>100%</td>
<td></td>
<td>97.1%</td>
<td>95.8%</td>
<td>96.9%</td>
<td>97.2%</td>
<td>96.7%</td>
</tr>
<tr>
<td>Stroke Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of high risk TIA seen and treated within 24 hrs of first contact with health professional</td>
<td>60%</td>
<td>68.4%</td>
<td>66.7%</td>
<td></td>
<td>75.8%</td>
<td>86.5%</td>
<td>77.9%</td>
<td>70.6%</td>
<td>77.5%</td>
</tr>
<tr>
<td>Stroke Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgent CT within 60 minutes of arrival</td>
<td>50%</td>
<td>74.3%</td>
<td>65.1%</td>
<td></td>
<td>71.7%</td>
<td>61.2%</td>
<td>70.0%</td>
<td>71.3%</td>
<td>68.8%</td>
</tr>
<tr>
<td>NSF Coronary Heart Disease</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PPCI within 120 mins of call</td>
<td>75%</td>
<td>62.5%</td>
<td>76.0%</td>
<td></td>
<td>77.6%</td>
<td>75.0%</td>
<td>61.2%</td>
<td>69.1%</td>
<td>70.7%</td>
</tr>
<tr>
<td>PPCI within 90 mins of arrival (door to balloon)</td>
<td>80%</td>
<td>89.0%</td>
<td>96.3%</td>
<td></td>
<td>95.0%</td>
<td>91.0%</td>
<td>90.9%</td>
<td>92.0%</td>
<td>92.0%</td>
</tr>
<tr>
<td>PPCI within 60 mins of arrival (door to balloon)</td>
<td>50%</td>
<td>75.7%</td>
<td>81.5%</td>
<td></td>
<td>88.0%</td>
<td>74.2%</td>
<td>76.6%</td>
<td>79.1%</td>
<td>80.1%</td>
</tr>
<tr>
<td>Rapid Access Chest Pain Clinic within 2 wks</td>
<td>98%</td>
<td>100%</td>
<td>100%</td>
<td></td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
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<tr>
<td>Flow</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Re-Admissions within 30 days</td>
<td>7%</td>
<td>6.3%</td>
<td>0%</td>
<td></td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Cancelled Operations - 28 day Guarantee</td>
<td>5%</td>
<td>6.3%</td>
<td>0%</td>
<td></td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Urgent Operations Cancelled for a 2nd time</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
This dashboard provides an overview of University Hospital Southampton Foundation Trust (UHSFT) performance from the quality, performance, contracts and finance perspectives. The data is sourced from the Integrated Performance Report (with the exception of contracts).

### Quality

<table>
<thead>
<tr>
<th>Metric</th>
<th>Target</th>
<th>March</th>
<th>Year to March</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCAI - MRSA</td>
<td>0</td>
<td>1 R</td>
<td>4 R</td>
</tr>
<tr>
<td>HCAI - C.diff.</td>
<td>3 (Mar) / 43 (YTD)</td>
<td>5 R</td>
<td>33 G</td>
</tr>
<tr>
<td>Mixed Sex Accommodation (MSA)</td>
<td>0</td>
<td>0 G</td>
<td>16 R</td>
</tr>
</tbody>
</table>

### Performance

<table>
<thead>
<tr>
<th>Metric</th>
<th>Target</th>
<th>March</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>RTT admitted patients &lt;18weeks</td>
<td>90%</td>
<td>89.1%</td>
<td>G 89.1%</td>
</tr>
<tr>
<td>RTT non-admitted patients &lt;18weeks</td>
<td>95%</td>
<td>93%</td>
<td>A 90%</td>
</tr>
<tr>
<td>RTT incomplete &lt;18weeks</td>
<td>92%</td>
<td>92%</td>
<td>A 91%</td>
</tr>
<tr>
<td>Diagnostics &lt;6weeks</td>
<td>99%</td>
<td>99%</td>
<td>G 99%</td>
</tr>
<tr>
<td>Cancer measures achieved (Feb)</td>
<td>9</td>
<td>8</td>
<td>8</td>
</tr>
</tbody>
</table>

### Commentary:

- The MRSA case in March involved a West Hants CCG patient. A review of processes will be completed and learning shared with the staff involved. There have been no MRSA cases in 2013/14 relating to F&G.
- A joint MSA action plan was agreed at the April Clinical Quality Review Meeting; there have been no MSA breaches in 2013/14 involving F&G CCG patients.

### Risks:

- HCAI and MSA

### Contracts

<table>
<thead>
<tr>
<th>Metric</th>
<th>Year to March*</th>
</tr>
</thead>
<tbody>
<tr>
<td>UHSFT</td>
<td></td>
</tr>
<tr>
<td>Fareham &amp; Gosport</td>
<td>7.9 8.0 0.1 A 7.9 8.0 0.1 A</td>
</tr>
<tr>
<td>South Eastern Hampshire</td>
<td>1.8 2.3 0.5 R 1.8 2.3 0.5 R</td>
</tr>
<tr>
<td>Portsmouth</td>
<td>1.9 2.0 0.1 A 1.9 2.0 0.1 A</td>
</tr>
</tbody>
</table>

*Projected position based on February activity

### Commentary:

- Activity remains above the F&G contract plan, with Unbundled Outpatients the main area of pressure.

### Finance & Workforce

<table>
<thead>
<tr>
<th>Metric</th>
<th>Year to Feb</th>
<th>Annual Forecast</th>
<th>Var.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Finance: Surplus / -deficit</td>
<td>0.5</td>
<td>0 -0.5</td>
<td>R</td>
</tr>
<tr>
<td>Workforce (UHSFT)</td>
<td>3.5%</td>
<td>3.3%</td>
<td>-0.2%</td>
</tr>
</tbody>
</table>

### Commentary:

- The Trust continues to be short of the expected Cost Improvement Programme delivery.
This dashboard provides an overview of Southern Health’s (SHFT) performance from the quality, performance, contracts and finance perspectives.

### Quality

<table>
<thead>
<tr>
<th>Measure</th>
<th>Target</th>
<th>March</th>
<th>Year to March</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCAI - MRSA</td>
<td>0</td>
<td>G</td>
<td>0</td>
</tr>
<tr>
<td>HCAI - C.diff.</td>
<td>6</td>
<td>G</td>
<td>2</td>
</tr>
<tr>
<td>Never events</td>
<td>0</td>
<td>G</td>
<td>0</td>
</tr>
<tr>
<td>MSA breaches</td>
<td>0</td>
<td>G</td>
<td>0</td>
</tr>
</tbody>
</table>

#### Commentary:
- Patients rating service as 'excellent': 75% in March, 72.3% in Year to March.
- Patients rating service as 'very poor': 0.5% in March, 1.2% in Year to March.

### Performance

<table>
<thead>
<tr>
<th>Measure</th>
<th>Target</th>
<th>March</th>
<th>Year to March</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delayed Transfer of Care (DTOC)</td>
<td>7.5%</td>
<td>4.2%</td>
<td>4.5%</td>
</tr>
<tr>
<td>RTT admitted patients &lt;18weeks</td>
<td>90%</td>
<td>97.7%</td>
<td>97.8%</td>
</tr>
<tr>
<td>RTT non-admitted patients &lt;18weeks</td>
<td>95%</td>
<td>99.0%</td>
<td>99.5%</td>
</tr>
<tr>
<td>Minor Injuries Unit attendances &lt;4 hours</td>
<td>90%</td>
<td>98.9%</td>
<td>99.9%</td>
</tr>
<tr>
<td>Receiving treatment within 3 weeks</td>
<td>90%</td>
<td>91.3%</td>
<td>90.2%</td>
</tr>
<tr>
<td>End of life - dying in preferred location</td>
<td>80%</td>
<td>91.4%</td>
<td>90.5%</td>
</tr>
</tbody>
</table>

#### Commentary:
- Areas of concern continue to include the high use of Out of Area beds within Adult mental health and the cost of agency spend, largely occurring in services with high vacancy rates.

### Contracts

#### Commentary:
- The pre qualification CQUINs have been rated as green on the condition that SHFT roll some elements of the schemes through to 2014/15.

### Finance & Workforce

#### Commentary:
- No major risks identified.

#### Workforce (Feb):
- Staff sickness: 4.0% in March, 4.6% in Year to March.
The dashboard below provides an overview of South Central Ambulance Service (SCAS), NHS 111 and Out of Hours performance.

<table>
<thead>
<tr>
<th>Provider</th>
<th>Area</th>
<th>Metric</th>
<th>Target</th>
<th>Mar-14</th>
<th>13/14 YTD</th>
<th>Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td>SCAS</td>
<td>Response Times</td>
<td>Red 1 Incidents &lt;8 minutes</td>
<td>75%</td>
<td>83.3%</td>
<td>78.7%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Red 1 Incidents &lt;19 minutes</td>
<td>95%</td>
<td>97.7%</td>
<td>97.3%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Red 2 Incidents &lt;8 minutes</td>
<td>75%</td>
<td>74.5%</td>
<td>75.8%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Red 2 Incidents &lt;19 minutes</td>
<td>95%</td>
<td>94.6%</td>
<td>95.3%</td>
<td></td>
</tr>
<tr>
<td>NHS 111</td>
<td>Calls Overview</td>
<td>Calls answered &lt;60 seconds</td>
<td>95%</td>
<td>88.2%</td>
<td>93.0%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Abandoned Calls</td>
<td>Abandoned calls &lt;5%</td>
<td>&lt;5%</td>
<td>2.2%</td>
<td>1.5%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Urgent calls &lt;15 minutes</td>
<td>95%</td>
<td>94.9%</td>
<td>93.0%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Routine calls &lt;1 hour</td>
<td>95%</td>
<td>86.1%</td>
<td>87.3%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Routine calls &lt;2 hours</td>
<td>95%</td>
<td>96.9%</td>
<td>96.1%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Routine calls &lt;3 hours</td>
<td>95%</td>
<td>98.2%</td>
<td>98.3%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Primary Care Centre (Emergency) &lt;60 minutes</td>
<td>95%</td>
<td>100%</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Primary Care Centre (Urgent) &lt;120 minutes</td>
<td>95%</td>
<td>92.8%</td>
<td>93.6%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Primary Care Centre (Routine) &lt;360 minutes</td>
<td>95%</td>
<td>97.7%</td>
<td>97.1%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Home Visit (Emergency) &lt;60 minutes</td>
<td>95%</td>
<td>100%</td>
<td>95.8%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Home Visit (Urgent) &lt;120 minutes</td>
<td>95%</td>
<td>90.7%</td>
<td>93.7%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Homes Visit (Routine) &lt;360 minutes</td>
<td>95%</td>
<td>90.2%</td>
<td>93.6%</td>
<td></td>
</tr>
</tbody>
</table>

- The CCG Quality Premium is assessed on the ‘Red 1 incidents within eight minutes’ measure at trust level for SCAS and has been achieved.

- The Trust has failed in the ‘Red 2 incidents within 8 minutes’ and ‘Red 2 incidents within 19 minutes’ standards in March due to challenges with significant flooding, which affected demand and the Trust’s ability to respond.

- The CCG has raised concerns regarding staff sickness at NHS 111, as this continues to be reported as the primary reason for breaches. SCAS are managing the staff concerned through the sickness and capability policy as well as reviewing call volumes against staff going forward. The Trust has reported significant developments in recruitment to provide additional cover.

- Out of Hours have found challenges regarding call response times due to GP sickness. Significant fluctuations in demand have also been causing difficulties. Care UK is reviewing how best to address resilience with the level of demand fluctuation in fortnightly meetings with CCG input.

- The inability to restore the Out of Hours Home Visits compliance in March was partly due to the influence of persistent bad weather which disrupted the road network, particularly in exposed coastal and rural areas.
## GOVERNING BODY

<table>
<thead>
<tr>
<th>Date of Meeting</th>
<th>28 May 2014</th>
<th>Agenda Item No</th>
<th>11</th>
</tr>
</thead>
</table>
| **Title**       | **Joint Quality report**  
(Quarter 4 and Month 12 of 2013/14)** |
| **Purpose of Paper** | To update the Governing Body on all key aspects of provider and internal CCG quality assurance. |
| **Recommendations/Actions requested** | The Governing Body is asked to:  
• Review and accept the joint quality report  
• Confirm any areas of outstanding assurance required |
| **Author**      | Julia Barton, Chief Quality officer |
| **Sponsoring member** | Dr Simon Larmer  
Quality Lead |
| **Date**        | 12th May 14 |
Governing Body
Joint Quality Report
May 2014
Julia Barton
Chief Quality Officer/Chief Nurse
<table>
<thead>
<tr>
<th>Page(s)</th>
<th>Item</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>The Patient’s Voice: Phlebotomy</td>
</tr>
<tr>
<td>4</td>
<td>CCG Joint Quality Operational Group proceedings</td>
</tr>
<tr>
<td>5-8</td>
<td>Portsmouth Hospitals NHS Trust Quality Exceptions</td>
</tr>
<tr>
<td>9</td>
<td>South Central Ambulance Service NHS Foundation Trust (SCAS) 999 Quality Exceptions</td>
</tr>
<tr>
<td>10-11</td>
<td>Southern Health NHS Foundation Trust (SHFT) Quality Exceptions</td>
</tr>
<tr>
<td>12</td>
<td>Sussex Partnership NHS Foundation Trust Child and Adolescent Mental Health services (CAMHs) Quality exceptions</td>
</tr>
<tr>
<td>13</td>
<td>Provider Exception Reports: Care UK, SCAS 111, University Hospitals Southampton Foundation Trust (UHSFT) &amp; Royal Surrey County Hospital Foundation Trust (RSCHFT)</td>
</tr>
<tr>
<td>14</td>
<td>Joint Quality Team Internal Risk Register</td>
</tr>
<tr>
<td>15</td>
<td>Healthcare Acquired Infection (HCAI)</td>
</tr>
<tr>
<td>16</td>
<td>CCG Enquiries, Concerns and Complaints</td>
</tr>
<tr>
<td>17</td>
<td>Serious Incidents Requiring Investigation (SIRI)</td>
</tr>
<tr>
<td>18</td>
<td>Healthcare Associated Infections (HCAI)</td>
</tr>
<tr>
<td>19</td>
<td>CCG Clinical Visits Programme</td>
</tr>
<tr>
<td>20</td>
<td>2014/15 Quality Priorities</td>
</tr>
</tbody>
</table>
The Patient’s Voice

The CCGs have received a number of patient concerns and complaints about phlebotomy services:

Patient 1: ‘The doctor advised me to book a blood test with the clinic – she mentioned there were a couple of options, the Petersfield one or Cosham one. Petersfield is more convenient but having called them the earliest appointment they could do was in 3 weeks time. Whoever I spoke to was also very rude and abrupt and also knew “absolutely nothing” about the Cosham place, other than to sigh loudly after finding me the phone number. Not the ideal response when calling to make an appointment.’

Patient 2: ‘I had called to arrange a Health Check but the receptionist advised me that I would require a fasting blood test prior to the health check. The leaflet that they sent suggested that this would be done as part of the 20 minute check! I was appalled that there was apparently no option but for me to travel 6 miles to have a simple blood test taken. I am very aware that the surgery has a phlebotomy facility which is only made available for those who don’t drive.’

Patient 3: ‘If I understand it correctly your practice is funded to look after my health requirements and at the moment this includes a blood test every couple of weeks. Can you please therefore tell me who has withdrawn the funding for the blood tests at the XX practice as I see no reason why I should make a journey which would be well in excess of 2 hours, to either Havant or Cosham as Petersfield Hospital has a waiting list in excess of two weeks, when your XX practice is only a 5 minute walk from my house.’

‘Patient 4: Apart from the stress caused by finding out that I have to take warfarin for the rest of my life, obtaining blood tests at relatively short notice from the Fareham Community Hospital is a real problem that I could do without. The warfarin/anti-coagulant clinic in QA tell me when I need to get the next blood test and, depending on my blood results, is usually within a week. To get a blood test at the Fareham Community Hospital in that time period is impossible, the earliest appointment available is usually 10 days to a fortnight. Being told by them that they do not do blood tests on a Tuesday and there is a walk-in centre at Cosham is not helpful.’

Learning points and actions:
Following a review of the phlebotomy service in 2013, it has been identified that there are currently a number of providers of phlebotomy services including GP practices, Southern Health NHS Foundation Trust Community Services, and Portsmouth Hospitals NHS trust operating across the joint CCGs area. The CCGs have increased the investment in funding for phlebotomy and as a result more GP practices have the opportunity to offer these services from 1st April 2014. The CCGs are committed to undertaking further review of phlebotomy services in 2014 to establish the most appropriate way to provide a reliable and local blood test service in the future.
The Joint Quality Assurance Committee now meets quarterly and is due to meet again on 21st May 2014. The Joint Quality Operational Group met in both March and April 2014 and accepted the following reports:

- Update on progress with development of quality strategy
- Update on the progress with developing a quality surveillance hub
- Quality contract and CQUIN updates
- Provider and CCG risk registers
- Provider cost improvement plans report
- Safeguarding adult and children reports
- Serious incident report
- Complaints report
- NHS staff survey report
- Focus item on clostridium difficile
- Healthcare acquired infection 2014/15 plans

The committee is continuing to adjust its focus to ensure the right balance between lay and secondary care assurance function and the operational delivery of the quality agenda.

There are no issues identified from the Joint Quality Committee to escalate to the Governing Body. Committee minutes and papers are available for Governing Body members to review on request.
### Portsmouth Hospitals NHS Trust Quality Exceptions

<table>
<thead>
<tr>
<th>Commissioner risk scoring</th>
<th>Controls in place</th>
<th>Actions planned</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>15</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Discharge Summaries</strong></td>
<td>not consistently issued within 24 hours and are not completed to standard. Electronic Discharge Summary (EDS) usage not in line with plan. Estimated electronic usage is 60% and paper is 40%</td>
<td>Trial of an amended IT system (EPRO). 2014/15 NHS Contract Utilisation monitored daily by the Trust Scanner for day surgery in place Monthly progress reports at CQRM Escalation to ECRM</td>
</tr>
<tr>
<td><strong>PHT Risk Rating = 9 – moderate risk)</strong></td>
<td>No internal audits being undertaken regarding the quality of discharge summaries.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>16</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Staffing: Capacity &amp; Demand:</strong> Impact on the quality of care delivery and staff wellbeing in light of increased challenges of capacity and demand and the bed reduction plan PHT Risk Rating = 16 – high risk)</td>
<td>Monthly CQRM – reporting and analysing a variety of quality data National ard based staffing reporting commenced Workforce review undertaken indicated there will be 55 vacancies in junior doctor rotas from August 2014 112 Registered Nurse vacancies ED Consultant cover best in the country and 2 further ED Consultants to start in July 2014. Mitigating actions in place to ensure safe ward staffing. Internal CQC compliance assessment for Medicine indicated non compliance (with minor impact) for staffing. Medicine are holding 20 RN vacancies - covered through temporary staff The internal CQC assessment for surgery &amp; cancer declared non compliance, with a moderate impact on patients for “complaints”. E rostering deployed for all staff groups CQC Intelligent Monitoring Report published on 13th March 2014 placed the Trust in Band 6 – lowest risk. CQC inspection on 13th March 2014 as part of themed inspection programme into dementia indicated full compliance (report awaited)</td>
<td>Recruitment process for medical and nursing staff including plans for overseas Histopathology recruitment process Monthly monitoring of quality intelligence and review of workforce issues CSC plans to address internal CQC declarations of non-compliance 2014/15 Local CQUIN schemes for medical and nursing workforce</td>
</tr>
<tr>
<td></td>
<td>National recruitment issue</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The Board Assurance Framework for PHT highlighted current and future workforce demand is outstripping supply:</td>
<td></td>
</tr>
</tbody>
</table>

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**South East London and South Essex NHS Foundation Trust/Healthcare Commissioning Groups**
# Portsmouth Hospitals NHS Trust Quality Exceptions (2)

<table>
<thead>
<tr>
<th>Commissioner risk score/issue</th>
<th>Controls in place</th>
<th>Actions taken/planned</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>16</strong> Safe Discharge from hospital incidents: 34 concerns raised in quarter 4 by HCP, 8 discharge safeguarding alerts 19 complaints for admission, discharge &amp; transfer issues <strong>PHT risk register issues:</strong> Care of patients outside of speciality in times of high demand (Rating 16 – High Risk) Implementation of Trust bed reduction plan (Rating 16 – High Risk) Electronic Discharge Summaries (Rating 9 - Moderate risk)</td>
<td>➢ CQRM reviews on quality intelligence ➢ NHS Inpatient survey indicates that the overall “discharge” section is rated by CQC as being worse than expected ➢ Meeting between PHT and Local Authority agreed the process for raising incidents and concerns. ➢ PHT report that there are no cases of moderate or major harm</td>
<td>➢ Workshop on admission, discharge and transfer scheduled for June 2014 ➢ Development of discharge standards across the health system ➢ Improvement programme to be established from June workshop ➢ Monitor progress as part of intelligence monitoring and delivery of CQUIN. ➢ Whole system admission, discharge and transfer CQUIN for 14/15 ➢ Analysis of themes arising from Healthcare professional feedback indicating improvement required in discharge planning and discharge medication</td>
</tr>
<tr>
<td><strong>12</strong> Ophthalmology: proposed trajectory for reducing backlog of patients has not been met. (Initial report indicated a backlog of 3,081 patients awaiting for follow up appointments – with a trajectory to reduce to &lt;700 by March 2014. The current backlog position as at 5th March 2014 is 1,773. Initial risk rating of 20</td>
<td>➢ Commissioner visit to ophthalmology ➢ Clinical prioritisation process in place ➢ Consultant review of current lists/triage ➢ Reduction in backlog reported ➢ Increased capacity – however there has been an increase in referrals. ➢ Outpatient letters in ophthalmology reported as issued within 4 days ➢ Assurance from PHT that the ophthalmology triage process is in place</td>
<td>➢ Management of demand through community based screening programme ➢ Update on progress at June 14 CQRM</td>
</tr>
<tr>
<td><strong>12</strong> Never Events: 3 Never Events in 2013/14 • 1 Drug Error – Incorrect labelling of methotrexate No harm caused • 1 wrong site surgical incision – (gum incision) • 1 wrong tooth extraction – reported March 2014</td>
<td>➢ Audits to monitor compliance with World Health Organisation checklist have demonstrated 100% compliance</td>
<td>➢ Drug error Never Event root cause analysis is with Local Area Team for final closure. ➢ Wrong Site Surgical Incision – awaiting RCA ➢ Wrong tooth extraction – awaiting RCA – audits introduced.</td>
</tr>
<tr>
<td>Commissioner risk score/Issue</td>
<td>Controls in place</td>
<td>Actions taken/planned</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>----------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>12 Histology: increased backlog</td>
<td>• Interviews for consultants being conducted week commencing 12th May 2014.</td>
<td>• Update on recruitment due at June 2014 CQRM</td>
</tr>
<tr>
<td></td>
<td>• Interim processes in place to support demand</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Urgent cases do not form part of the backlog</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Triage process in place</td>
<td></td>
</tr>
<tr>
<td>16 Emergency Department: PHT not</td>
<td>• Emergency Care Intensive Support team programme – scheduled visit 9.5.2014.</td>
<td>• Monitor FFT responses and other ED quality metrics</td>
</tr>
<tr>
<td>meeting the 4 hour target and</td>
<td>• FFT score above national average and improved response rates.</td>
<td>• Monitor progress with breach compliance</td>
</tr>
<tr>
<td>have reported patient queues.</td>
<td></td>
<td>• ED update provided at the April CQRM:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Increased pressure reported on staff working in ED and deterioration in staff morale</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• ED performance remains challenging</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Improvement initiatives in place to deflect attendance and admissions (internal and across the health system)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Extra administrative staff in majors</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Urgent care centre seeing 25 – 40 patients daily</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• All patients tracked on Oceano system</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Utilisation of bank staff as demand requires.</td>
</tr>
<tr>
<td>N/A Healthcare Associated Infections (HCAIs)</td>
<td>• HCAI plan for 2014/15</td>
<td>• CQRM monitoring</td>
</tr>
<tr>
<td>MRSA: The year to date position</td>
<td></td>
<td></td>
</tr>
<tr>
<td>is 4 cases against a target of</td>
<td>• Whole system working</td>
<td></td>
</tr>
<tr>
<td>zero:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 2 deemed unavoidable, 1 avoidable, 1 (pending).</td>
<td>• CDIFF: The year end position is 30 against a trajectory of 30</td>
<td></td>
</tr>
<tr>
<td>N/A Unauthorised Deprivation of</td>
<td>• Full investigation undertaken and actions identified</td>
<td>• Increased Mental Capacity act and DoLS training</td>
</tr>
<tr>
<td>Liberty</td>
<td></td>
<td>• Sharing of learning trust-wide</td>
</tr>
<tr>
<td>1 unauthorised deprivation of</td>
<td></td>
<td>• Guidance for staff who “special” patients and daily</td>
</tr>
<tr>
<td>liberty safeguard breach under</td>
<td></td>
<td>assessment of risk when making staffing decisions</td>
</tr>
<tr>
<td>investigation following a bed</td>
<td></td>
<td>• Review of handover procedures to formally include capacity issues.</td>
</tr>
<tr>
<td>rails incident</td>
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</tbody>
</table>
### Portsmouth Hospitals NHS Trust Quality Exceptions (4)

<table>
<thead>
<tr>
<th>Commissioner risk scoring/Issue</th>
<th>Controls in place</th>
<th>Actions taken/planned</th>
</tr>
</thead>
</table>
| **12 Pressure Ulcers**: For 2013/14 there were 33 avoidable grade 3 and 4 pressure ulcers against a target of 25. In addition the median prevalence target of 1.06 set via the Patient Safety thermometer has not been met and is 1.55. | ➢ Monthly CQRM reviews  
➢ Internal practice changes listed in previous report | ➢ 2014/15 CQUIN to support the reduction of pressure ulcers  
➢ Focus on increasing compliance with skin bundle and grade 2 reporting.  
➢ Trust continued joint working via the system-wide Stamp Out Sores project |

| **12 Cancer Services**: Cancer peer review visit undertaken on 4th and 27th February 2014 raised serious concerns around:  
➢ Colorectal cancer management & Wessex site configuration  
➢ Staffing levels & flagging systems  
➢ Serious concerns regarding multidisciplinary decision making for patients with metastatic spinal cord compression  
➢ Access to MRI scans out of hours  
➢ Administrative supports  
➢ Historically PHT had reported breaches in the 2 week waits and the national cancer patient experience survey outcomes was unsatisfactory Previous risk rating = 12. | ➢ Cancer Improvement Plan  
➢ Quality review update deferred until full peer review report available  
➢ Escalated to executive contract group  
➢ Urology consultant due to start in summer 2014  
➢ Limited flexibility regarding clinical staffing for neurological cancer: PHT reviewing recruitment initiatives  
➢ Response letter to peer review findings shared with commissioners  
➢ Commissioner visit to Haematology and Oncology Day Unit 04/14 | ➢ Monitor delivery of cancer breaches and plan to improve patient experience  
➢ Follow up on breach information being sent to commissioners  
➢ Monitor FFT responses  
➢ Monitor progress with recruitment of Urologist & Neurologist  
➢ Cancer peer review outcome review (when published) |

| **12 Falls**: The year end position is 35 moderate and severe harm falls reported against a target of 34. This represents a 7.9% reduction.  
Falls rate per 1,000 bed days is 6 against a national average of 5.6 | ➢ Provider root cause analysis of falls and key themes reported.  
➢ Recruitment into medical wards and supported leadership and interim cover  
➢ Interim lead identified for Falls to cover post  
➢ Monthly CQRM reviews | ➢ Continued implementation of FallSafe care bundle with a target roll out by October 2014.  
➢ DH dementia care environmental improvement project.  
➢ Falls training  
➢ MOPRS installing a number of falls prevention initiatives |

| **9 Friends & Family Test**: Response rate for quarter 4 below target of 20% at 16.7% therefore not achieving the CQUIN requirements | ➢ Monthly national and local reporting by ward and specialty  
➢ Monthly monitoring via CQRM |  |

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Score (national)</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>ED</td>
<td>76 (73)</td>
<td>31%</td>
</tr>
<tr>
<td>Inpatients</td>
<td>64 (54)</td>
<td>10%</td>
</tr>
<tr>
<td>Maternity</td>
<td>80(72)</td>
<td>22%</td>
</tr>
<tr>
<td>Commissioner risk score/Issues</td>
<td>Controls in place</td>
<td>Actions taken/planned</td>
</tr>
<tr>
<td>-----------------------------------------------------------------------------------------------</td>
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<td>----------------------------------------------------------------------------------------</td>
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</tbody>
</table>
| **15** Long Waits: organisational data - waits over 30 mins. for red 8 responses = 141, for red 19 responses = 204. Over 1 hour for amber responses: 599 Long waits is a key theme in complaints. 6 SIRIs reported relating to delays. **Healthcare professional (HCP) delays:** occurring in all categories of call outs e.g. 3 hour response time, 100 people waited between 3 and 6.5 hours (data contested) | ➢ Monthly contract monitoring  
➢ Bi monthly audits to determine if harm caused  
➢ Welfare checks by call desk  
➢ New HCP Policy (estimated April 2014) with phased implementation to September 2014  
➢ Implementation on a roll out programme of NHS Pathways 17th March 2014 to June 14.  
➢ Recruitment process in call centre (EOC)  
➢ Vehicles off road - (risk rated 16 by Provider) plans to increase vehicle capacity and retain older vehicles and fleet structure review. | ➢ Further discussions required around HCP data and agreement of plans for improvement.  
➢ Implementation of HCP policy  
➢ SIRI analysis re long waits to identify themes  
➢ CQRM agenda re review of interventions for quality & safety  
➢ Review of workforce modelling – capacity & demand & vehicle availability  
➢ Review process for informing primary care re HCP policy and monitor roll out programme |
| **16** Stroke Response Times: SCAS are not meeting targets and are placed 11th out of 11 Trusts | ➢ Audit and analysis undertaken indicated that 22% of stroke patients are not covered by the 21 minute drive time target  
➢ 39% of stroke incidents not graded as red 8 category  
➢ 45% of stroke incidents not coded as stroke  
➢ Non-red coded show longer average call connect time to arrival at hospital and longer time spent at scene  
➢ Trajectories set for improvement | ➢ Internal plan includes early identification by EOC supported by pathways migration  
➢ Minimise on scene times  
➢ Training, information sharing, performance by locality, campaigns, electronic patient records  
➢ Review of HCP calls and impact on stroke performance  
➢ External: improve access and alerts to HASU (stroke unit)  
➢ Seek agreement to send patients to nearest HASU  
➢ Information sharing on activity/performance  
➢ Improve clinical feedback loops including primary care on HCP impact |
| **12** Safeguarding: previous concerns raised re: safeguarding capacity. Recent concerns about involvement and timeliness of responses to Serious Case Reviews from SCCCG and Safeguarding Children’s Board. | ➢ Investigation of specific incidents undertaken and response sent to Southampton City CCG  
➢ Face to face training recommenced  
➢ Peer review undertaken and action plan in place. | ➢ CQO visit to SCAS to discuss safeguarding concerns (April 2014) – action plan agreed.  
➢ Follow up on closure of all actions as outlined in peer review  
➢ Follow up training outcomes & referrals |
| **9** Special notes: of poor quality, out of date and there is no system to ensure timely and systematic review. | ➢ IT Work programmes are progressing on Hampshire Care Records and summary Care Records – no timescale around delivery  
➢ Special Notes' group has not met and IT structures are currently not fully compatible. | ➢ Raised issue of “special notes” group at CRM  
➢ SCAS re auditing  
➢ IT lead to take forward IT work programmes  
➢ Clinical lead to take forward requirements in primary care to enable effective special notes to be utilised |
### Commissioner risk score/Issue

| 12 | **Pressure Ulcers – grades 3 and 4.**
A total of 76 grade 3 and 4 pressure ulcers have been reported for 2013/14 (Fareham & Gosport and South Eastern Hampshire CCGs). Includes those where SHFT is not sole care provider. A 2013/14 target was set to reduce pressure ulcer prevalence to 4.35% from a baseline of 8.70%. The full prevalence reduction was not achieved. A prevalence reduction of 5.54% has been achieved which is 73% of the target. |
| - | **Controls in place**
  - Monthly monitoring via CQRM
  - Root cause analysis review of all avoidable pressure ulcers.
  - Whole system work-streams in place
  - Good reporting culture |
| - | **Actions Taken/ planned**
  - New contractual targets for 2014/2015, including CQUIN to reduce rate of pressure ulcers and whole system working |

| 16 | **SHFT – Mental Health**
Lack of Section 136 Places to provide timely and effective care for patients with mental health needs |
| - | **Controls in place**
  - Multi-agency Hampshire and IOW Criminal Justice Liaison Group leading Section 136 review across the health system
  - Two pilot projects in conjunction with Hampshire constabulary commenced Jan 14.
  - Pilot involved mental health worker in patrol car in Southampton 3 x evenings per week and 1 mental health worker in Netley control room .(results reported as encouraging)
  - NHS Pathways work being led by Portsmouth City CCG
  - Review of provision of Section 136 places. |
| - | **Actions Taken/ planned**
  - Mental health quality review to the Quality Assurance Committee May 2014.
  - Follow up on strategic plans to ensure provision of section 136 places of safety.
  - Update on progress to be presented at the May 14 CQRM
  - Update on outcomes of the pilot of mental health workers to be presented at the May 2014 CQRM |

| TBC | **Enforcement Action issued by Monitor**
On 23rd April 2014, enforcement action was issued to SHFT by Monitor. The enforcement action requires SHFT to act faster to improve quality of care in Oxfordshire, strengthen governance and improve the way it manages it services to assure problems identified by the Care Quality Commission are not repeated elsewhere. |
| - | **Controls in place**
  - NHS England Regional Risk Summit Jan 14 and follow up meeting Mar 14.
  - SHFT internal Deloitte governance review undertaken and recommendations provided around improving the governance processes at divisional level and data provided to the Board. |
| - | **Actions Taken/ planned**
  - Action plan to address enforcement issues and the CQC concerns is being prepared by SHFT. This will be presented to the May CQRM.
  - Tracking through SHFT mental health and learning disability CQRM hosted by West Hants CCG with F&G/SEH CCG representation. |
<table>
<thead>
<tr>
<th>Commissioner risk score/Issue</th>
<th>Controls in place</th>
<th>Actions taken/ planned</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>N/A</strong> Care Quality Committee Inspections &amp; standards deemed non compliant:</td>
<td>• Recruitment at Antelope House in progress being monitored via SCCCG.</td>
<td>➢ Monthly CQRM</td>
</tr>
<tr>
<td>CQC raised concerns in care delivery and failure to meet standards in 3 mental health</td>
<td>• Daily reporting to senior management</td>
<td></td>
</tr>
<tr>
<td>settings (not in SEH or F&amp;G CCG localities):</td>
<td>• Closure of some beds</td>
<td></td>
</tr>
<tr>
<td>• Antelope House</td>
<td>• Nurse consultant appointment for 9 months to work with staff and address</td>
<td></td>
</tr>
<tr>
<td>• Melbury Lodge</td>
<td>CQC issues</td>
<td></td>
</tr>
<tr>
<td>• Parklands</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Between 40 – 50% of staff at Antelope House are non permanent staff (agency)</td>
<td></td>
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<tr>
<td><strong>N/A</strong> CQC Inspections for Learning Disability in patient settings in Oxford.</td>
<td>• NHS England risk summit (Jan and Mar 14) and key work streams identified</td>
<td>➢ Quality team to review recommendations from 2nd risk summit meeting</td>
</tr>
<tr>
<td>CQC issued 6 enforcement actions following a visit in September 2013 for non Hampshire</td>
<td>• Monitored via West CCG CQRM (F &amp; G and South Eastern CCG quality representation</td>
<td>➢ Follow up on recommendations and consider any implications for local services</td>
</tr>
<tr>
<td>LD in patient services at Slade House and John Sharich House</td>
<td>at the meetings).</td>
<td>➢ Quality review paper for Quality Assurance Committee in May 2014</td>
</tr>
<tr>
<td></td>
<td>• Raised at joint CCGs Performance &amp; Information Action Group</td>
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<td></td>
<td>• Independent review by Deloitte</td>
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<td></td>
<td>• Commissioner engagement in internal SIRI panels</td>
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</tr>
<tr>
<td><strong>N/A</strong> Unexpected Deaths/suicides</td>
<td>• Quality team attendance at Mental Health SIRI panels (hosted by West CCG)</td>
<td>➢ Continue to support the SIRI panels hosted by West Hants. CCG with representation</td>
</tr>
<tr>
<td>Increase in number of SIRIs raised within the “unexpected death category” as a result of</td>
<td>• SEH Mental Health GP lead now a member of SIRI panel</td>
<td>from the quality team</td>
</tr>
<tr>
<td>suicide or suspected suicide reported in February 2014. (n=9)</td>
<td>• Previous analysis indicated SHFT not a national outlier for suicide rates</td>
<td>➢ Continued analysis and challenge regarding key themes</td>
</tr>
<tr>
<td>For the year 2013/14, 42 patient suicides reported (41 out patients in receipt of care and</td>
<td>• Analysis of themes (record keeping, risk assessment and lack of crisis plans,</td>
<td>➢ Follow up implementation of actions identified from root cause analysis.</td>
</tr>
<tr>
<td>1 inpatient in receipt of care)</td>
<td>care planning, communication)</td>
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<tr>
<td><strong>N/A</strong> SIRI Management</td>
<td>• West Hants. CCG host MH/LD Panels - quality team attend meetings</td>
<td>➢ Continue to support the SIRI panels hosted by West CCG with representation from the</td>
</tr>
<tr>
<td>Breaches for set timescales for SIRI investigations. For the 103 SIRIs reported by</td>
<td>• Locality Mental Health GP lead attending SIRI panels.</td>
<td>quality team</td>
</tr>
<tr>
<td>SHFT for the locality CCGS, 51 remain open. 29 relate to community services (25 within</td>
<td></td>
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<tr>
<td>target) 22 relate to Mental Health and LD (11 within target)</td>
<td></td>
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</tbody>
</table>
### Sussex Partnership NHS Foundation Trust CAMHS Service Quality Exceptions

<table>
<thead>
<tr>
<th>Commissioner risk scoring</th>
<th>Controls in place</th>
<th>Actions planned</th>
</tr>
</thead>
</table>
| **16** Appropriate capacity and utilisation of Section 136 places of safety | ‣ Joint work with police to ensure information sharing regarding access to services out of hours and consideration of alternative options  
‡ Risk management plans shared with police  
‡ Pilot of street triage scheme | ‣ Further work required to determine level of risk, and exact numbers of children affected locally  
‡ Children's commissioning team to link with SHFT for adult 136 work programmes – no potential outcomes until December 2014. |
| **16** Whistle blowing incident: by Consultant Psychiatrists raising concerns around level of staffing and resource to meet a safe and effective CAMHS service. Consultants reported urgent reviews not being undertaken & waiting times exceeding best practice  
Feedback from primary care indicates that there are excessive waits at locality level causing patient safety concerns | ‣ North East Hants & Farnham CCG leading with Hampshire County Council.  
‡ Reviews undertaken with Sussex Partnership  
‡ Actions plans in place to addressing staffing issues (however performance data indicates waiting times are still not being met) | ‣ Quality team attendance at monthly CAMHS quality contract meetings.  
‡ Escalation of incidents raised from primary care and request for investigation of specific cases.  
‡ Locality review required |
| **16** Autism: The provision of care for patients with autism is inconsistent across Hampshire and leads to lengthy waiting times for assessment and support | ‣ Monitoring via complaints and PALs service and escalation to Hampshire wide commissioning team | ‣ Anticipated increase in staff to undertake assessment by end of Q1 of 2014/2015. |
### Out of Hours (Care UK)

<table>
<thead>
<tr>
<th>Commissioner risk scoring</th>
<th>Controls in place</th>
<th>Actions planned</th>
</tr>
</thead>
</table>
| 12 | **Face to face consultations and home visits** is below 95% target at 93.7% for urgent and 91.8 for routine (02/14 data) but position is improving. | • Clinical governance & contract review meetings (hosted by PCCCG)  
• Planned workforce / demand management predictions with 111 service | ➢ Quality team to follow up progress at clinical governance review meeting  
➢ Follow up on patient reported outcomes  
➢ Monitor performance on monthly basis. |

### ISTC – CARE UK

<table>
<thead>
<tr>
<th>ISTC – CARE UK</th>
<th>ISTC – CARE UK</th>
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</thead>
</table>
| 9 | Projected number of patients who have not had routine 3-year follow up post endoscopy procedure. | • PCCG managing process of potential re-call and working with primary care to ensure patients are reviewed  
• Current investigation underway | ➢ Quality team in this locality to determine level of affected patients and risk status |

### SCAS 111 Service

<table>
<thead>
<tr>
<th>SCAS 111 Service</th>
<th>SCAS 111 Service</th>
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<tbody>
<tr>
<td>12</td>
<td>Inconsistent performance for call response times</td>
</tr>
</tbody>
</table>

### University Hospitals Southampton NHS Foundation Trust

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<thead>
<tr>
<th>University Hospitals Southampton NHS Foundation Trust</th>
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</table>
| 12 | **Health Education Wessex Deanery**: raised concerns in Trauma & Orthopaedics: lack of clinical supervision, workload, adequate experience, local teaching & study leave  
**ED**: UHS are failing to consistently meet the 4 hour target in ED. "Monitor placed on special measures". Risk 9 | • Wessex Quality Surveillance Group monitoring - previously de-escalated however, not all actions delivered at follow up visit, therefore risk escalated.  
• SCCCG clinical visit to review patient pathway.  
• Regular meetings with unscheduled care team  
• Remedial action plans in place  
• Monthly CQRM | ➢ Monitored and managed by Southampton City CCG and Wessex Quality Surveillance Group.  
➢ Quality team to request progress report |

### Royal Surrey County Hospital

<table>
<thead>
<tr>
<th>Royal Surrey County Hospital</th>
<th>Royal Surrey County Hospital</th>
</tr>
</thead>
</table>
| 12 | Number of areas identified as sub optimal by Guildford & Waverley CCG CQC Inspection on 16/17th October 2013. | • CQC report determine services are safe  
• Deep dive report presented to quality assurance committee in February 2014 – assurance received that monitoring processes are in place  
• Main areas of concern are staffing in Medicine and Ophthalmology and administration  
• ED and cancer waiting times are a concern | ➢ Deep dive report shared with G& WCCG  
➢ Extra assurance requested– response outstanding  
➢ Monitor feedback from primary care  
➢ Review staff survey and national in-patient survey (report to Quality Operational Group in April 2014. |
<table>
<thead>
<tr>
<th>Risk No.</th>
<th>Risk</th>
<th>Date of Risk</th>
<th>Latest Risk Update</th>
<th>Original Risk</th>
<th>Current Risk</th>
<th>Target Risk</th>
<th>April 14</th>
<th>May</th>
<th>June</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>Gaps in Designated Doctor for Safeguarding Children in Hampshire</td>
<td>01/04/13</td>
<td>March 14 - Options for a new model have been circulated April 14 – Post has been advertised Interim Designated Doctor in post</td>
<td>16</td>
<td>16</td>
<td>6</td>
<td>16</td>
<td></td>
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<tr>
<td>5</td>
<td>Challenging HCAI, Cdiff numbers for F&amp;G and SEH CCGs National reduction targets</td>
<td>01/04/14</td>
<td>March 14 - Both CCGs exceeded the nationally designated local reduction target for MRSA and C.Difficile. April 14. National reduction target for 14/15 is higher than 2013/14 as both CCGs benchmark well. Approval given for increased resource for specialist HCAI role. Robust action plan on track for delivery. Joint working across Hants CCGs commenced.</td>
<td>16</td>
<td>16</td>
<td>9</td>
<td>16</td>
<td></td>
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<tr>
<td>6</td>
<td>Challenges with the complaints process of handover from April 2013</td>
<td>01/04/13</td>
<td>March 2014 - Q&amp;SC Successful transition to CCG. complaints manager and administrator in post. Revise d complaints policy ratified by both CCGs and in progress, Risk reduction to 6 (acceptable risk and archive with a review in 3 months)</td>
<td>16</td>
<td>6</td>
<td>6</td>
<td>6</td>
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<tr>
<td>8</td>
<td>Quality assess future commissioning plans/QIPP plans unless a review process is in place</td>
<td>01/04/13</td>
<td>Feb-March 14 - risk reduced to 6. April 14. LS to request further documents from planning (LM)</td>
<td>4</td>
<td>6</td>
<td>6</td>
<td>6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Impact of the Francis Report</td>
<td>01/02/13</td>
<td>March 14 - Reviewed suggest unchanged and review monthly as impact 4 (major) April 14. No change</td>
<td>4</td>
<td>8</td>
<td>6</td>
<td>8</td>
<td></td>
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</tr>
<tr>
<td>10</td>
<td>Duty to assure the provision of high quality safe and effective services from providers</td>
<td>01/02/13</td>
<td>March 14 - Quality Strategy reviewed. Quality Surveillance Hub progressing. Triangulation of quality information in progress suggest risk reduced from 10 (2x5) to 8 (2x4) April 14. No change</td>
<td>10</td>
<td>8</td>
<td>6</td>
<td>8</td>
<td></td>
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</tr>
<tr>
<td>12</td>
<td>Inability to access some PID</td>
<td>01/04/13</td>
<td>March 14 - Continued guidance from IG Team April 14. No change</td>
<td>12</td>
<td>12</td>
<td>6</td>
<td>12</td>
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</tbody>
</table>
### CCG Health Care Associated Infection (HCAI)

<table>
<thead>
<tr>
<th><strong>F&amp;G CCG</strong></th>
<th><strong>SEHCCG</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>47 cases of Clostridium difficile infection have been reported for 2013/14. This is 8 over the CCG’s allocated annual reduction target of 39. Analysis of cases shows 2 received antibiotics which did not follow prescribing guidelines. 39% of patients were prescribed proton pump inhibitors. 8 of the 14 cases attributed to the community in the period analysed were most likely hospital acquired based on the fact that they had attended the hospital within the previous 4 weeks. Root Cause Analysis confirms cases have the usual complex co-morbidities.</td>
<td>49 cases of Clostridium difficile infection have been reported for 2013/14. This is 17 over the CCG allocated annual reduction target of 32. Antibiotic prescribing was the most prevalent risk factor in 90% of cases followed by proton pump inhibitor prescribing (55%) and hospital admissions in preceding four weeks (52%). High risk antibiotics were prescribed by GPs in five out of nine instances when antibiotics were prescribed. Root Cause Analysis confirms cases have the usual complex co-morbidities.</td>
</tr>
<tr>
<td>1 case of hospital acquired MRSA bacteraemia has been reported in January 2014 at PHT. Early analysis shows the case was avoidable and learning has been identified through the Post Infection Review (PIR) and will be actioned by the Trust.</td>
<td>1 case of MRSA bacteraemia has been attributed to SEHCCG in Q1. The Post Infection Review (PIR) deemed the case unavoidable, with no healthcare attributable learning identified. <strong>NB:</strong> 1 MRSA bacteraemia was reported in April 2014 and has undergone investigation. Likely outcome is community avoidable.</td>
</tr>
</tbody>
</table>

#### Actions
- Root Cause Analysis of all cases of C. Difficile taking a pathway approach across primary care, community and acute.
- Link with Medicines management team for support with PPI and anti-microbial prescribing/audit.
- Continue engagement and proactive support for GP surgeries and practice nurses in IPC (all now trained through target).
- Attendance at a newly established IPC prevention group. Providing strategic assistance for Portsmouth CCG from April 2014.
- Ongoing development of relationships with PHT microbiology lab - regular meetings set up with Caroline Mitchell. Support from Dr Helen Chesterfield and Dr Robert Porter established.
CCG Enquiries, Concerns and Complaints

The Quality Team responds to enquiries, comments and concerns from our local population. This service includes responding to complaints in accordance with the NHS Complaints Regulations (2009) and MP enquiries on behalf of the organisation.

Concerns and Enquiries

- The 22 inherited complaints at authorisation are now all closed
- Fareham and Gosport CCG received 39 complaints within the year.
- South Eastern Hampshire CCG received 36 complaints within the year
- All complaints received have been acknowledged within 3 working days
- No complaints have been referred to the Parliamentary and Health Service Ombudsman in 2013/14
- A CCG complainant satisfaction survey has been completed in quarter 4
- The CCGs’ complaints policy has been revised and is now fully operational
- The top 3 themes from complaints in quarter 4 were: OOO/111 service, CAMHS and phlebotomy service

Compliments

The following quotation was taken from the compliment about a call to the 111/Out of Hours service in respect of a request for assistance with a palliative cancer patient

“I can never adequately express my thanks to the NHS 111 service and to the telephone operator and the physician”.

Concerns raised from 01.04.2013 – 31.03.2014

<table>
<thead>
<tr>
<th>Concerns</th>
<th>Open</th>
<th>Closed</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>SEHCCG</td>
<td>3%</td>
<td>97%</td>
<td>28</td>
</tr>
<tr>
<td>FGCCG</td>
<td>3%</td>
<td>97%</td>
<td>32</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>2</td>
<td>60</td>
<td>62</td>
</tr>
</tbody>
</table>

- Fareham & Gosport CCG received 33 concerns in 2013/14
- South Eastern Hampshire CCG received 29 concerns

Complaints raised from 1.4.2013 – 31.03.2014

<table>
<thead>
<tr>
<th>Complaints</th>
<th>Open</th>
<th>Closed</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>SEHCCG</td>
<td>30%</td>
<td>70%</td>
<td>36</td>
</tr>
<tr>
<td>FGCCG</td>
<td>26%</td>
<td>74%</td>
<td>39</td>
</tr>
</tbody>
</table>

- The 22 inherited complaints at authorisation are now all closed
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- The CCGs’ complaints policy has been revised and is now fully operational
- The top 3 themes from complaints in quarter 4 were: OOO/111 service, CAMHS and phlebotomy service
Serious Incidents Requiring Investigation (SIRI)

78 SIRI were reported during Quarter 4
72 of the 78 SIRI reported were categorised as Grade 1 (grading information can be accessed through the below hyper link)
The top 3 Grade 1 incidents reported were:
- Pressure Ulcers
- Child Deaths – there is no correlation between the cases
- Unexpected Deaths
6 incidents were Grade 2 - 3 PHT Never Events (2 Wrong Site Surgery & 1 Drugs Incident) - 2 Child deaths & 1 Safeguarding Vulnerable Child.

Key Themes of investigations:
- It is too soon to identify any themes from child deaths as the investigations are underway but they are unlikely to be connected.
- 3 cases of delayed diagnosis due to lack of follow up in outpatients – this theme is a priority for the quality team
- CAMHS remain an issue both for complaints and SIRIs with Section 136 being a major theme, this is a national problem and so is being investigated nationally and locally. Members of the quality team attend CQRM for commissioned CAMHS services as part of the assurance process
- Slips/trips and falls have seen a significant increase in one acute trust, a deeper analysis will be undertaken in quarter 1 of 14/15
- A continuing issue is the potential for the missed diagnosis of physical illness by psychiatric teams and mental illness by physicians – the quality team are monitoring this.
- There are also emerging themes around dual diagnosis in mental health, referral management and vulnerable patients who have recently left secondary care

This year has been challenging for the management of SIRIs due to changes in the organisation but this has improved significantly with partnership working and streamlining of processes.
### Safeguarding Adults and Children

#### Safeguarding Children:
- Safeguarding children and adult governance for the CCGs is executed via the Hampshire Vulnerable Person’s Committee.
- The CCG has refreshed it’s children’s safeguarding section 11 audit and action plan.
- The Hampshire Safeguarding Children’s board is in the process of establishing a Health Sub group.
- Arrangements for the health assessments for children in care are under review.
- The CCG’s safeguarding children's consultant nurse is supporting a number of local child death and serious case reviews.
- The recent Hampshire Ofsted report into children’s services resulted in full compliance and good partnership working across health was noted.
- Progress is being made to recruit a substantive safeguarding children’s designated doctor. Interim post holder in place to mitigate risk.
- The 5 Hampshire CCGs commissioned an expert review of children’s safeguarding in Hampshire and are developing an action plan related to this reviews' recommendations.

#### Safeguarding Vulnerable Adults:
- The number and spread of safeguarding alerts and investigations is being monitored through close partnership working with the Hampshire Vulnerable Adults team and Hampshire County Council. This includes joint working around mapping and monitoring care homes and domiciliary care providers.
- There are 2 domestic homicide reviews underway in South Eastern Hampshire CCG area, overseen by East Hampshire Community Safety Partnership. The CCG’s are supporting primary care practices through the completion of chronologies and are authoring the internal management reviews (IMRs) as well as providing representation on both panels.
- An alleged Deprivation of Liberty safeguards breach related to bed rails is being investigated at Portsmouth Hospitals NHS trust.
- Emerging themes from safeguarding investigations include:
  - Documentation
  - Mental Capacity Act
  - Governance, Leadership and staffing
  - Training
  - End of Life planning
  - Culture
  - Infection Control
  - Activities
  - Health and Safety.
<table>
<thead>
<tr>
<th>Organisation/Clinical Specialty Visited</th>
<th>Summary of the Review</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHT: Integrated Discharge Bureau</td>
<td>Observation of the multidisciplinary daily review of patients who have been deemed medically fit for discharge.</td>
</tr>
<tr>
<td>PHT: Cancer Day Services</td>
<td>Haematology and oncology day unit reviewed. Positive visit overall and areas of innovative practice identified. Areas for development identified around capacity &amp; staffing and waiting room environmental impact on patient experience.</td>
</tr>
<tr>
<td>PHT: Trauma and Orthopaedic unit</td>
<td>Wards visited D1, D3, D5 and outpatients. Best practice was noted as follows: A twice monthly mock CQC inspection is carried out. Learning from incidents is being shared within the unit. Induction on pre-op pathway for elective patients includes a compulsory 2 hour session to provide information, prepare the patient and their carer and to measure them up for post-op appliances. Pressure Ulcer rates are good. Increased therapy input into the wards has improved the post-operative experience for the patients. Areas identified for development included trust wide focus on electronic discharge summary forms and the friends and family test.</td>
</tr>
<tr>
<td>PHT Medical Unit &amp; Wards</td>
<td>D2 Ward (Medicine + 10 Flexible beds), E6/7 (30 beds) &amp; Respiratory high Care (10 beds) visited. 8 specific areas of good practice noticed. Suggestions for development included review of physiotherapy services and integration of locum medical &amp; nursing staff into team.</td>
</tr>
<tr>
<td>PHT: Medicine for Older People and Rehabilitation/Stroke Services</td>
<td>G4, F1, F2 (Stroke Unit) &amp; F3 wards visited. Multiple areas of good practice noted with no recommendations for development other than need to push for continued MDT engagement at board rounds to keep focus on discharge.</td>
</tr>
<tr>
<td>SHFT: Bordon Integrated Care Team</td>
<td>Reviewers met the team, heard about some of their challenges which included an imminent change over in leadership and</td>
</tr>
<tr>
<td>SHFT: Gosport 1 community nursing team</td>
<td>Very positive meeting. Lots of examples of good MDT working and positive nursing leadership. Areas for development were identified around engagement with adult MH services.</td>
</tr>
<tr>
<td>SCAS: Otterbourne 111 call centre</td>
<td>Evidence of comprehensive assessment and onward referral in accordance with agreed pathways. Callers were polite and courteous.</td>
</tr>
<tr>
<td>Woodcot Lodge nursing home (Fareham and Gosport CCG(multiple visits))</td>
<td>Provision of support to the ongoing safeguarding investigation at this nursing home.</td>
</tr>
</tbody>
</table>
Quality Team Priorities for 2014/15:

- Completion of the revisions to the CCGs’ quality strategy and specific quality objectives
- Review of quality reporting requirements
- Mapping of all contracts and processes for quality assurance
- Delivery of the quality surveillance hub, early warning systems and quality triangulation reporting
- Achievement of quality improvements through whole system work projects such as Safe Discharge and Stamp out Sores
- Continuing partnership working with other commissioners to ensure quality assurance across geographical boundaries of the CCGs
- Understanding the quality requirements of future NHS England co-commissioning arrangements for primary care
- Practice nurse strategy
- Contractual Relations
- Standardisation of investigation processes.
<table>
<thead>
<tr>
<th>Date of Meeting</th>
<th>28 May 2014</th>
<th>Agenda Item No</th>
<th>12</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Title</strong></td>
<td>Commissioning Update</td>
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<tr>
<td><strong>Purpose of Paper</strong></td>
<td>To inform the Governing Body of the work of the Commissioning Team.</td>
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<tr>
<td><strong>Recommendations/Actions requested</strong></td>
<td>The Governing Body is asked to:</td>
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</tr>
<tr>
<td></td>
<td>• Note the update</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| **Author**           | Lyn Darby  
Deputy Chief Commissioning Officer |
| **Sponsoring member**| Dr David Chilvers  
CCG Chair |
| **Date**             | 22 May 14 |
Commissioning Briefing Paper

1. Introduction

1.1 This paper is to brief the Governing Body on key areas of commissioning that are being undertaken for Fareham and Gosport Clinical Commissioning Group (CCG).

2. 18 Week Referral to Treatment

2.1 The latest validated position for Portsmouth Hospitals NHS Trust (PHT) in March shows the Trust failing the incomplete targets in General Surgery, Urology and Trauma and Orthopaedics (T&O) as well as a fail for T&O in admitted and in non-admitted. The Trust has been undertaking its own internal plan to reach a sustainable backlog position. Due to an increase in capacity the backlog has decreased since March in the following specialties of Ophthalmology, Ear Nose and Throat (ENT), and T&O.

2.2 Commissioners issued a Contract Query Notice (CQN) to PHT due to their failure to deliver the Referral to Treatment (RTT) targets and in order to gain assurance. As part of the contractual process commissioners met with PHT on 7th January to discuss the options open to the both parties to resolve the performance issues. The Trust has sent two iterations of a Remedial Action Plan (RAP) which have not been agreed by commissioners due to a lack of detail regarding the actions taking place, when these actions will happen and who will be responsible.

2.3 Despite meeting with the Trust to discuss what was required in the RAP, commissioners have not received a plan that gives the level of assurance required. As a result commissioners sent an additional letter to PHT clarifying what is expected in the RAP which is due for return by 28th May and agreement by 4th June.

3. Elective Improvement Work stream (Action on Electives)

3.1 As a result of both the RTT performance and the increasing pressure on electives the elective improvement work stream has been established across the three local CCGs. The primary purpose of the group is to oversee and monitor actions related to the management of elective activity under a single team approach. This will incorporate actions to manage referrals as well as the resulting diagnostic and elective out patient (OP) activity, day case (DC) and inpatient (IP) activity.

3.3 The group will form the key means through which the CCGs can monitor actions and progress related to the management of the elective activity linked to the 18 weeks RTT.

3.4 The group will work to deliver a sustainable RTT position. Once this has been completed the group will transition the monitoring and performance arrangements on RTT and elective through the performance and planning existing reporting structures.

4. Specialist Musculoskeletal (MSK) and Pain Service Update

4.1 Both elements of the Specialist MSK and Persistent Pain service have now commenced with NHS Solent.

a) Specialist MSK
   • The service provides specialist assessment, education for both patients and clinicians and specialist treatments with direct access to diagnostics
In Fareham & Gosport CCG the service is based in Fareham Community Hospital and Gosport War Memorial Hospital

In South Eastern Hampshire CCG the service is based in Petersfield Hospital, Oak Park Community Clinic, Havant and Chase Community Hospital, Bordon

b) Persistent Pain service

The service is designed for patients with a confirmed diagnosis of persistent pain with the aim of teaching and promoting self-management skills. This will be achieved via group work with patients to improve the management of their condition and promote the philosophy of self-care. There is a strong emphasis on education for both patients and frontline clinicians.

In Fareham & Gosport CCG the service will be operating from Crofton Community Centre, Stubbington

In South Eastern Hampshire CCG the service will be operating from Waterlooville Community Centre and Chase Community Hospital, Bordon

5. Cancer Performance

5.1 The latest validated position for PHT in March shows the Trust achieving all of the National Cancer Standards. Commissioners have not seen evidence to date that this is a sustainable position.

5.2 Commissioners issued a CQN to PHT due to their failure to deliver the cancer targets and in order to gain assurance. As part of the contractual process commissioners met with PHT on 7th January to discuss the options open to both parties to resolve the performance issues.

5.3 PHT has in place a detailed cancer improvement plan that was agreed to be submitted to commissioners as a RAP. Despite this agreement PHT have failed to submit this plan and instead have submitted two separate iterations of a RAP which have not been agreed by commissioners due to a lack of detail regarding the actions taking place, when these actions will happen and who will be responsible.

5.4 Despite meeting with the Trust to discuss what was required in the RAP, commissioners have not received a plan that gives the level of assurance required and PHT are unwilling to submit the cancer improvement plan as their RAP. As a result commissioners sent an additional letter to PHT clarifying what is expected in a RAP which is due for return by 28th May and agreement by 4th June.

6. Integrated Care (Out of Hospital)

6.1 The final version of the Better Care Fund for Hampshire was submitted on the 4th April 2014. The plan will focus on older people, older people with mental health needs and carers in 2014-16. The key metrics underpinning the plan are permanent admissions of older people to residential and nursing homes, proportion of older people still at home 91 days after discharge, delayed transfers of care from hospital, avoidable emergency admissions and the proportion of people aged 65 and over receiving reablement. The plan will now be peer reviewed at regional level prior to recommendation for approval by the national team.

6.2 The Integrated Care Programme Board continues to meet to oversee and guide delivery of the development of the nine Integrated Care Teams (ICTs) in South Eastern Hampshire and Fareham and Gosport.

6.3 Optum Consultants are supporting commissioners with work on the integrated care service specification which will cover the crisis, complex, discharge, hub and prevention/early intervention
elements of the model. Southern Health Foundation Trust (SHFT) is continuing with the mobilisation of the enhanced supported discharge service which is run by the Hampshire rehabilitation and reablement team. The first meeting of the ICT Coordinator Forum has been held which will provide training and peer support.

7. **Urgent Care Improvement Group**

7.1 On-going problems remain which are associated with delivering the four hour target within PHT. Performance has been poor for a considerable period with the service standard not being met for the last five quarters. Despite plans and resources being put in place both within the PHT and across the system, this has not had a material impact on the target.

7.2 System leaders agreed to establish a ‘turnaround’ programme for the Emergency Department (ED). The purpose is to accelerate the development and delivery of safe sustainable service improvements that result in the delivery of the ED target. This is necessary to ensure a sustainable solution, whilst continuously improving services for patients and the care they receive.

7.3 The turnaround programme will enable further temporary support and extra focused attention to ensure we meet our organisational goals. Executed well, the turnaround programme will enable the Portsmouth and South East Hampshire system to be stronger, more effective, with a better capability to effect change at pace.

7.4 The group has been meeting on a weekly basis and has agreed a work Programme. Fiona Wise has been appointed as the turnaround director.

8. **Recommendations**

8.1 The Fareham and Gosport Clinical Commissioning Governing Body are requested to note the Commissioning Update.
## GOVERNING BODY

<table>
<thead>
<tr>
<th>Date of Meeting</th>
<th>28th May 14</th>
<th>Agenda Item No</th>
<th>13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title</td>
<td>Engagement Update</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Purpose of Paper</td>
<td>To provide members of the Governing Body with information on engagement with public and patients that has taken place in the CCG in the last two months.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Recommendations/Actions requested | The Governing Body is asked to:  
  - Note the Engagement Update |
| Author          | Elizabeth Kerwood  
  Head of Communications and Engagement |
| Sponsoring member | Dr Keith Barnard  
  Lay Member (Patient Participation and Involvement) |
| Date            | 13 May, 2014 |
FAREHAM & GOSPORT CCG – ENGAGEMENT REPORT
May 2014

1. Purpose

1.1 The purpose of this paper is to provide members of the Governing Body with information on engagement with public and patients that has taken place in the CCG in the last two months.

2. April 2014

2.1 Keith Barnard attended the second Fareham and Gosport Voluntary Sector Health Forum. This is a joint venture between Community Action Fareham and Gosport Voluntary Action. The meeting discussed the CCG draft commissioning plan; care navigators; a potential Directory of Health Groups; patient transport; and positive partnerships. Feedback from the group was positive with members saying they felt they were being listened to by the CCG.

2.2 The CCG attended the Gosport Locality Patient Group which discussed feedback from the Practice Patient Groups; the Voluntary Sector Health Forum and Community Engagement Committee (CEC); ensuring receipt of GP cancer referrals to Queen Alexandra Hospital in Portsmouth are confirmed to avoid delays if they are not processed appropriately; delays in discharge; the possible underuse of the Minor Injuries Unit at Gosport War Memorial Hospital; vascular services; and the confusion around the use and security of computerised medical records. This is a major concern that has been raised at both Locality Patient Groups and the CEC. There is much confusion about the types of electronic records held, who can use them, and their security. This has been compounded by the promotion and then postponement of the Government’s NHS Care Data scheme. It was felt that a great deal of effort needs to be put into ensuring our local population are confident about any such schemes, which have undoubted benefits but may flounder because of fears for confidentiality or lack of understanding.

2.3 The CCG attended the GAIN Community Networking lunch which was an opportunity to raise the profile of the organisation with key local stakeholders.

3. May 2014

3.1 Keith Barnard chaired the Community Engagement Committee. The Committee was given a presentation by the CCG’s Primary Care Team which explained the roles of the CCG, NHS England, Public Health England and local authority in commissioning Primary Care services.

A second presentation was given by Portsmouth Hospitals NHS Trust which updated the Committee on its ‘What matters most’ initiative which aims to ensure the Trust listens to and engages with patients, their families and carers, and uses this feedback to make improvements on both a Trust-wide and individual service basis.
The Committee was informed that the Trust is making strenuous efforts to expand the response to the Friends and Family test. Currently of a potential 8,000 respondents canvassed each month, only 1500 complete replies. The aim is to increase this to all departments, which would involve asking 19,000 patients per month to complete responses.

The Committee received an update from the Locality Patient Groups, the voluntary sector and Commissioning.

Keith Barnard has been asked by patient groups to bring several specific concerns to the attention of the Governing Body. These include:

- Recorded messages sent as reminders for out-patient appointments. These digitally produced voices have been described as “dalek-like” and can be frightening or confusing for older patients, especially when they may have multiple appointments
- DNA’s in GP surgeries continue to be a concern and patient groups are aware that these can waste as many as 100 appointments a month in some practices. They ask if there is anything the CCG can do to raise awareness of this issue, and practices are investigating such things as text reminders
- Palliative and end of life care: Since the closure of Ward G5 in QAH in 2010 patients complain that the alternative “mobile nursing team” arrangements put in place have not been adequate. There is only one palliative care specialist doctor, are there are not enough specialist nurses or psychologists/counsellors to cover the wards as was promised when Ward G5 was closed. Furthermore it was pointed out by a bereaved patient that there is no bereavement service available over the weekends and the office is closed. The result is that on Mondays, following the inevitable deaths in the hospital over weekends, the phones are overwhelmed by people seeking advice and support with inevitable delays. Even on other weekdays there is often just an answering machine with an offer to return the call. Patients and carers do not find this acceptable.

4. The Governing Body is asked to note this report.
## GOVERNING BODY

<table>
<thead>
<tr>
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<th>28 May 2014</th>
<th>Agenda Item No</th>
<th>14</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Title</strong></td>
<td>Board Assurance Framework</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Purpose of Paper</strong></td>
<td>To present the Board Assurance Framework to the Governing Body for approval.</td>
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</tbody>
</table>
| **Recommendations/Actions requested** | The Governing Body is asked to:  
  - Approve the attached recommendations for amendment to the Board Assurance Framework  
  - Note the top risk scores |
| **Author**      | Nikki Roberts  
Governance and Committee Officer |
| **Sponsoring member** | Sara Tiller  
Chief Development Officer |
| **Date**        | 20th May 2014 |
# Board Assurance Framework Update

**May 2014**

## Top Risk Scores

<table>
<thead>
<tr>
<th>Risk Ref</th>
<th>Description of Risk and Impact</th>
<th>Current Risk Score</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strategic Objective: Supporting the access of all communities to high quality care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>COR 1-4</td>
<td>There is a risk that Portsmouth Hospitals NHS Trust is unable to improve its 4 hour ED wait position this creates quality and safety risks.</td>
<td>(4x4)16</td>
</tr>
<tr>
<td><strong>Strategic Objective: Care that is planned is delivered in the best way at the best time in the best place</strong></td>
<td></td>
<td></td>
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<tr>
<td>COR 3-3</td>
<td><strong>New Risk</strong> - There is a risk that there will be elective activity overspend on diagnostics elective activity driven by an increase in referrals or the Trust's financial position</td>
<td>(4x4)16</td>
</tr>
<tr>
<td><strong>Strategic Objective 6: Managing change in the health and social care system while ensuring continuity and improving quality</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>COR 6-2</td>
<td>There is a risk that 2014/15 QIPP schemes do not deliver the required activity changes resulting in inability to reduce system capacity and cause organisational financial pressures. Significant level of unidentified QIPP.</td>
<td>(4x5)20</td>
</tr>
<tr>
<td>COR 6-8a</td>
<td>There is a risk that Portsmouth Hospital Trust will be unable to deliver the planned financial plan in 14/15 which will create a sustainability challenge for the organisation.</td>
<td>(4x4)16</td>
</tr>
<tr>
<td>COR 6-17</td>
<td><strong>New Risk</strong> - The CCG has little non-recurrent headroom funding to make the investments needed to change the health system to make it financially sustainable.</td>
<td>(4x4)16</td>
</tr>
<tr>
<td>COR 6-18</td>
<td><strong>New Risk</strong> - There is a risk to Continuing Healthcare: Proposed re-basing to 2014-15 outturn exposes CCGs to a significant cost pressure</td>
<td>(4x4)16</td>
</tr>
<tr>
<td>COR 6-19</td>
<td><strong>New Risk</strong> - There is a risk that the partnership between HCC and CCGs to deliver integrated models of care fails to deliver within agreed timeframe and realise savings required by 2015/16 to support the maintenance of social care services and health savings.</td>
<td>(4x4)16</td>
</tr>
<tr>
<td><strong>Strategic Objective: Improving quality of care and outcomes for patients</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>COR 7-5</td>
<td><strong>New Risk</strong> - There is a risk to the quality of contracts provided by Southern Health Foundation Trust as it has been issued an enforcement action which requires SHFT to act faster to improve quality of care in Oxfordshire, strengthen governance and improve the way it manages its services to ensure problems identified by the CQC are not repeated elsewhere.</td>
<td>(4x4)16</td>
</tr>
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</table>
# Board Assurance Framework Update

**May 2014**

<table>
<thead>
<tr>
<th>Risk Ref</th>
<th>Description of Risk and Impact</th>
<th>Amendments</th>
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</thead>
<tbody>
<tr>
<td><strong>Strategic Objective: Supporting the access to all communities to high quality care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>COR 1-3</td>
<td>There is a risk that the newly commissioned 111 service and out of hours service does not realise the benefits and outcomes set out within the specification.</td>
<td><strong>Amendment to Progress and Assurances:</strong> Assurance on planned recruitment</td>
</tr>
<tr>
<td>COR 1-4</td>
<td>There is a risk that Portsmouth Hospitals NHS Trust is unable to improve its 4 hour ED wait position and this creates quality and safety risks.</td>
<td><strong>Amendment to Key Controls in Place:</strong> Unplanned care improvement manager, Fiona Wise, in place <strong>Amendment to Progress and Assurances:</strong> Continuation of Urgent Care Centre</td>
</tr>
<tr>
<td><strong>Strategic Objective: Care that is planned is delivered in the best way at the best time in the best place</strong></td>
<td></td>
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</tr>
<tr>
<td>COR 3-1</td>
<td>There is a risk that Portsmouth Hospitals NHS Trust is unable to sustain national performance requirements for Referral to Treatment time.</td>
<td><strong>Amendment to Key Controls in Place</strong> Interim Managing Director for cancer, surgery, head and neck and MSK to attend planned care meetings. <strong>Amendment to Gaps in Control and Actions Required:</strong> Lack of performance overview data, process being reviewed in month <strong>Amendment to Progress and Assurances:</strong> CQN contract process in place</td>
</tr>
<tr>
<td>Risk Ref</td>
<td>Description of Risk and Impact</td>
<td>Amendments</td>
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</tr>
<tr>
<td><strong>Strategic Objective: Improving maternity services and services for children</strong></td>
<td></td>
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</tbody>
</table>
| COR 4-3 | Gaps in Designated Doctor Safeguarding Children in Hampshire may lead to inadequate strategic medical oversight, damage to reputation | Increase to Risk Score:  
From (3x3) 9 to (3x4) 12  
Amendment to Progresses and Assurances:  
Post has been advertised and recruitment process commenced. Interim Designated Doctor is in post. |
| **Strategic Objective: Managing change in the health and social care system while ensuring continuity and improving quality** | | |
| COR 6-16 | There is a risk that poor performance/lack of delivery in functions supplied by NHS South CSU results in an inability of the CCG to monitor performance of provider Trusts and therefore commission effectively. | Amendment to Key Controls in Place:  
External review of contracting team in place. |
| **Strategic Objective: Improving Quality of Care and Outcomes for Patients** | | |
| COR 7-3 | Challenging C. difficile national reduction target for the CCG. | Amendment to progresses and assurances:  
National reduction target for 14/15 is higher than 2013/14 as both CCGs benchmark well. Approval given for increased resource for specialist HCAI role. Robust action plan on track for delivery. Joint working across Hants CCGs commenced. |

**New Risks**

<table>
<thead>
<tr>
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<tbody>
<tr>
<td><strong>Strategic Objective: Care that is planned is delivered in the best way at the best time in the best place</strong></td>
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</tbody>
</table>
| COR 3-3 | There is a risk that there will be elective activity overspend on diagnostics elective activity driven by an increase in referrals or the Trust's financial | Risk Score: (4x4) 16  
Key Controls in Place: Actions on elective group, day five meetings, PIAG, |
<table>
<thead>
<tr>
<th>Case Reference</th>
<th>Description</th>
<th>Risk Score</th>
<th>Controls/Actions</th>
<th>Action Owner</th>
</tr>
</thead>
<tbody>
<tr>
<td>COR 6-17</td>
<td>The CCG has little non-recurrent headroom funding to make the investments needed to change the health system to make it financially sustainable.</td>
<td>(4x4) 16</td>
<td>Quality premium funding will be used for system change.</td>
<td>Chief Finance Officer</td>
</tr>
<tr>
<td>COR 6-18</td>
<td>There is a risk to Continuing Healthcare: Proposed re-basing to 2014-15 outturn exposes CCGs to a significant cost pressure</td>
<td>(4x4) 16</td>
<td>Forensic review of CHC database, Phased pace of change movement</td>
<td>Chief Finance Officer</td>
</tr>
<tr>
<td>COR 6-19</td>
<td>There is a risk that the partnership between HCC and CCGs fails to deliver integrated models of care within agreed timeframe and realise savings required by 2015/16 to support the maintenance of social care services and health savings.</td>
<td>(4x4) 16</td>
<td>Risk share arrangements to be put in place between CCGs/HCC</td>
<td>Chief Finance Officer</td>
</tr>
</tbody>
</table>
Strategic Objective: Improving quality of care and outcomes for patients

COR 7-5

There is a risk to the quality of contracts provided by Southern Health Foundation Trust as it has been issued an enforcement action which requires SHFT to act faster to improve quality of care in Oxfordshire, strengthen governance and improve the way it manages its services to ensure problems identified by the CQC are not repeated elsewhere.

Risk Score: (4x4) 16

Key Controls in Place:
- NHS England Regional Risk Summit Jan 14 and follow up meeting Mar 14
- SHFT internal Deloitte governance review undertaken and recommendations provided around improving the governance processes at divisional level and data provided to the Board.

Progresses and Assurances:
- Action plan to address enforcement issues and the CQC concerns is being prepared by SHFT. This will be presented to the May CQRM.
- Tracking through SHFT mental health and learning disability CQRM hosted by West Hants CCG 3with F&G/SEH CCG representation.

Action Owner:
Chief Quality Officer

Risks Recommended for Removal

<table>
<thead>
<tr>
<th>Risk Ref</th>
<th>Description of Risk and Impact</th>
<th>Amendments</th>
</tr>
</thead>
</table>
| COR 7-4  | PHT FFT scoring Friends & Family Test net promoter inpatient score is lowest in England for October 2013. Response rates for ED below average. Patients report a less positive experience in inpatient settings than the national average. | Key Controls in place:  
Friends and Family Test scores for ED, in-patients and maternity are above the national average. PHT did not meeting CQUIN target for achieving 20% response rates in Quarter 4. They achieved 16.67%. 
Target risk score has been reached. Risk score is now (3x2) 6. |
<table>
<thead>
<tr>
<th>Risk Ref</th>
<th>Date Raised</th>
<th>Description of the Risk and Impact</th>
<th>Original Risk Score (I x L)</th>
<th>Current Risk Score (I x L)</th>
<th>Key Controls in Place</th>
<th>Gaps in Control and Actions Required</th>
<th>Deadline for Action</th>
<th>Action Owner</th>
<th>Progress and assurances</th>
<th>Level of assurance</th>
<th>Risk Owner (Accountable Person)</th>
<th>Target Risk Score (I x L)</th>
<th>Date of Last Review</th>
</tr>
</thead>
<tbody>
<tr>
<td>F&amp;G (J)</td>
<td>COR 1-3 Nov-12</td>
<td>There is a risk that the newly commissioned 111 service and out of hours service does not realise the benefits and outcomes set out within the specification</td>
<td>(4x3) 12</td>
<td>(4x2) 8</td>
<td>- PCCG currently coordinator of 111 contract - group established to review effectiveness of services and report back to CCG Clinical Cabinet/Governing Board. - 111 has been achieving its target from June. - OoH is under performance measures but has not been beginning to achieve its targets from September</td>
<td>111 live and advertising campaign underway</td>
<td>monthly</td>
<td>Senior Commissioning Officer (Debbie Purdy)</td>
<td>111 programme board to address service improvement - investigating direct booking from 111 to ooh - both contracts on tariff deflator - activity modelling completed to look at demand vs services</td>
<td>significant</td>
<td>Chief Commissioning Officer</td>
<td>3 May-14</td>
<td></td>
</tr>
<tr>
<td>F&amp;G (J)</td>
<td>COR 1-4 Jan-13</td>
<td>There is a risk that Portsmouth Hospitals NHS trust is unable to improve its 4 hour ED wait position and this creates quality and safety risks.</td>
<td>(4x4) 16</td>
<td>(4x4) 16</td>
<td>- ECIST action plan in place - monitored through unscheduled delivery board - key actions being progressed eg front door in ED - ED Summit scheduled - CCG now holds weekly reviews with the Chief Executive of the Trust - Unplanned care improvement manager, Fiona Wise, in place</td>
<td>Delays in implementing more effective working practices in ED; impact of out of hours and 111 arrangements on ED attendances</td>
<td>31/04/2014</td>
<td>Chief Commissioning Officer</td>
<td>- Action Plan being developed: &quot;Gold Command&quot; in place - Action Plan being progressed through the unscheduled care delivery board - Service Specification for unscheduled care produced. - Daily monitoring of ED activity and performance - Continuation of Urgent Care Centre</td>
<td>Chief Commissioning Officer</td>
<td>4 May-14</td>
<td></td>
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</tbody>
</table>

**Strategic Objective: Supporting the access of all communities to high quality care**

**Strategic Objective: Improving experience and outcomes for the frail elderly and people requiring long term care including dementia**
## Appendix A Board Assurance Framework

**Strategic Objective:** Care that is planned is delivered in the best way at the best time in the best place

### F&G (J) COR3-1

<table>
<thead>
<tr>
<th>Risk Ref</th>
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<th>Original Risk Score (I x L)</th>
<th>Current Risk Score (I x L)</th>
<th>Key Controls in Place</th>
<th>Gaps in Control and Actions Required</th>
<th>Deadline for Action</th>
<th>Action Owner</th>
<th>Progress and assurances</th>
<th>Level of assurance</th>
<th>Risk Owner (Accountable Person)</th>
<th>Target Risk Score (I x L)</th>
<th>Date of Last Review</th>
</tr>
</thead>
</table>
| F&G (J) COR3-1 | Jul-12 | There is a risk that Portsmouth Hospitals NHS Trust is unable to sustain national performance requirements for Referral to Treatment time | (3x3) 9 | (3x4) 12 | - fortnightly performance reviews with PHT  
- monthly Governing Body meetings to review performance  
- monthly SHAALAT performance assurance  
- financial risk pool established to ensure RTT delivery  
- Interim Managing director for cancer, surgery, head and neck and MSK to attend planned care meetings | - Limited data received on RTT | Deputy Chief Commissioning Officer | | | | | Chief Commissioning Officer | 2 | May-14 |

### F&G (J) COR3-2

<table>
<thead>
<tr>
<th>Risk Ref</th>
<th>Date Raised</th>
<th>Description of the Risk and Impact</th>
<th>Original Risk Score (I x L)</th>
<th>Current Risk Score (I x L)</th>
<th>Key Controls in Place</th>
<th>Gaps in Control and Actions Required</th>
<th>Deadline for Action</th>
<th>Action Owner</th>
<th>Progress and assurances</th>
<th>Level of assurance</th>
<th>Risk Owner (Accountable Person)</th>
<th>Target Risk Score (I x L)</th>
<th>Date of Last Review</th>
</tr>
</thead>
<tbody>
<tr>
<td>F&amp;G (J) COR3-2</td>
<td>Jul-12</td>
<td>There is a risk that provider partners will not remain committed to the planned care QIPP programme and will seek to pursue expansion strategies in an emerging market</td>
<td>(4x3) 12</td>
<td>(4x3) 12</td>
<td>Continued engagement and communication, underpinning contracting framework to support the delivery of QIPP. Relevant delivery boards hold systems to account. Sign off role for PHT and Solent IBP and LTfM</td>
<td>Robust contract based system for monitoring and challenging elective activity</td>
<td>monthly</td>
<td>Deputy Chief Commissioning Officer</td>
<td>Clinical Leaders meeting to discuss planned care and QIPP on 12th March 14. Post has been advertised and recruitment process commenced. Interim Designated Doctor is in post.</td>
<td></td>
<td>Chief Commissioning Officer</td>
<td>4</td>
<td>May-14</td>
</tr>
</tbody>
</table>

### F&G(U) COR 3-3

<table>
<thead>
<tr>
<th>Risk Ref</th>
<th>Date Raised</th>
<th>Description of the Risk and Impact</th>
<th>Original Risk Score (I x L)</th>
<th>Current Risk Score (I x L)</th>
<th>Key Controls in Place</th>
<th>Gaps in Control and Actions Required</th>
<th>Deadline for Action</th>
<th>Action Owner</th>
<th>Progress and assurances</th>
<th>Level of assurance</th>
<th>Risk Owner (Accountable Person)</th>
<th>Target Risk Score (I x L)</th>
<th>Date of Last Review</th>
</tr>
</thead>
<tbody>
<tr>
<td>F&amp;G(U) COR 3-3</td>
<td>May-14</td>
<td>There is a risk that there will be elective activity overspend on diagnostics elective activity driven by an increase in referrals or the Trust's financial position.</td>
<td>(4x4) 16</td>
<td>(4x4) 16</td>
<td>Actions on elective group, day five meetings, PIAG, QIPP Plans</td>
<td>None</td>
<td>01-Jun</td>
<td>Deputy Chief Commissioning Officer</td>
<td>Working group established to pull in multiple workstrams and achieve a level of affordability in planned care. Actions are being progressed through this group with updates to executive level.</td>
<td></td>
<td>Chief Commissioning Officer</td>
<td>8</td>
<td>May-14</td>
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</tbody>
</table>

**Strategic Objective:** Improving maternity services and services for children.

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8
<table>
<thead>
<tr>
<th>Risk Ref</th>
<th>Date Raised</th>
<th>Description of the Risk and Impact</th>
<th>Original Risk Score (I x L)</th>
<th>Current Risk Score (I x L)</th>
<th>Key Controls in Place</th>
<th>Gaps in Control and Actions Required</th>
<th>Deadline for Action</th>
<th>Action Owner</th>
<th>Progress and assurances</th>
<th>Level of assurance gained from arrangements (substantial, limited etc)</th>
<th>Level of assurance (Accountable Person)</th>
<th>Target Risk Score (I x L)</th>
<th>Date of Last Review</th>
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</thead>
<tbody>
<tr>
<td>F&amp;G (J) COR4-3 Q04</td>
<td>Jul-12</td>
<td>Gaps in substantive Designated Doctor Safeguarding Children in Hampshire may lead to inadequate strategic medical oversight, damage to reputation</td>
<td>(5x3) 15</td>
<td>(3x4) 12</td>
<td>safeguarding children policy agreed by Governing Body - Quality Framework and quality monitoring arrangements approved by Governing Body - GP Quality Leads appointed - authorisation review of arrangements - agreement between PHT and commissioners on future delivery model - SG nurse in post</td>
<td>National recognition that the model requires revision by PCP and National Leads</td>
<td>ongoing</td>
<td>Chief Quality Officer</td>
<td>significant</td>
<td>Chief Quality Officer</td>
<td>6</td>
<td>May-14</td>
<td></td>
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</table>
## Appendix A Board Assurance Framework

### Risk Ref | Date Raised | Description of the Risk and Impact | Original Risk Score (I x L) | Current Risk Score (I x L) | Key Controls in Place | Gaps in Control and Actions Required | Deadline for Action | Action Owner | Progress and assurances | Level of assurance | Risk Owner (Accountable Person) | Target Risk Score (I x L) | Date of Last Review |
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<tbody>
<tr>
<td>F&amp;G (J) COR5-1</td>
<td>Jul-12</td>
<td>There is a risk that the transition from Hampshire PCT to five Hampshire CCGs will result in the fragmentation of existing joint-commissioning strategies for adult and older peoples mental health</td>
<td>(4x3) 12</td>
<td>(3x2) 6</td>
<td>- established Hampshire 5 CCG Commissioning Group to ensure collaborative commissioning arrangements continue - HCC Adult Services representative on CCG Governing Body - collaboration agreement reached with Hampshire 5 Commissioning Group</td>
<td>- The CCG needs a detailed understanding of the implementation and impact of the Better Care Fund</td>
<td>Sep-14</td>
<td>Chief Commissioning Officer</td>
<td>BCF 1st cut submitted 14/2/14</td>
<td>limited</td>
<td>Chief Officer</td>
<td>6</td>
<td>May-14</td>
<td></td>
</tr>
</tbody>
</table>

**Strategic Objective:** Enabling people with mental health conditions and learning disabilities to secure care closer to home at the right time.

| F&G (J) COR6-2a | Mar-13 | There is a risk that 2013/14 QIPP schemes do not deliver the required activity changes resulting in inability to reduce system capacity and cause organisational financial pressures. Significant level of unidentified QIPP. | (4x4) 16 | (4x5) 20 | + Greater system collaboration on the design and delivery of QIPP schemes + CQUIN and contracts used as a driver to ensure greater integration between providers of care (e.g. QIPP) + Continued performance management and assurance through system sustainability + Increased ownership of the challenge in Primary Care through CCG leadership + Robust monitoring during 13/14 and beyond to ensure QIPP on target. + Use of 2% non recurring fund to support system reconfiguration. + Contingency will provide further risk mitigation if necessary. | - continued existence of unidentified QIPP | Mar-14 | Chief Finance Officer | QIPP plans. Reported financial position. Contract performance. | substantial | Chief Finance Officer | 6 | May-14 |

**Strategic Objective:** Managing change in the health and social care system while ensuring continuity and improving quality

| F&G (J) COR6-7 | Jul-12 | There is a risk that QIPP schemes / commissioning intentions result in an under-utilisation of PHT’s fixed cost estate such that efficiencies are not realised by the system | (4x3) 12 | (3x3) 9 | - Estates rationalisation plan continues to manage capacity transfer to Queen Alexandra Hospital and is under review  - Gap in capacity utilisation is to be covered by Portsmouth Hospitals Trust (PHT) through:  - Seeking to increase market share for NHS activity outside of Portsmouth & F&G CCGs;  - Marketing excess capacity to non-NHS market (private patients, retail, pharmaceutical industry, etc) | - Need to reinvigorate estates strand of sustainability work. | Mar-14 | Chief Finance Officer | - financial position - estate savings | limited | Chief Finance Officer | 6 | May-14 |

<p>| F&amp;G (J) COR6-8 | Jul-12 | PHT is not yet an FT and may require system support to secure such status | (4x3) 12 | (4x3) 12 | - Respective tri-partite agreements in place. - Regular communication on progress and monitoring of QIPP and contract performance | - PHT financial review and performance position prevents progression of FT status at this time. | Jan-15 | Chief Finance Officer | - PHT FT application | limited | Chief Finance Officer | 4 | May-14 |</p>
<table>
<thead>
<tr>
<th>Risk Ref</th>
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<th>Gaps in Control and Actions Required</th>
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<th>Level of assurance</th>
<th>Risk Owner (Accountable Person)</th>
<th>Target Risk Score (IxL)</th>
<th>Date of Last Review</th>
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</table>
| F&G (J) COR 6-8a | Jun-13 | There is a risk that Portsmouth Hospital Trust will be unable to deliver the planned financial plan in 13/14 which will create a sustainability challenge for the organisation. | (4x4) 16 | (4x4) 16 | - key issues meeting held with Trust Executive on a monthly basis  
- Board to board meeting between 3 CCGs and PHT now in place  
- monthly contract meetings continuing  
- joint work programme underway between 2 CCGs, CFOs and PHT’s FD to map the impact of further commissioning intentions  
- discussion and actions agreed with the Trust Development Authority and Area Team  
- recovery plan established and an assurance process agreed  
- Meetings held with Trust Development Authority and agreement reached on collaboration between the agencies. | - ill defined understanding of relationship between commissioners and trust development agency.  
- a framework will need to be developed. | Mar-14 | Chief Finance Officer | Discussions with PHT have agreed a common view of the Year End position. | Substantial | Chief Officer | 4 | May-14 |
| F&G (J) COR6-14 | Jul-12 | There is a risk that growth and costs are beyond existing assumptions with the result that cost pressures meant the CCG is unable to achieve planned surplus and receive the Quality Premium in 14/15. | (5x3) 15 | (5x3) 15 | - Close scrutiny of contract monitoring and regular contract reviews will highlight areas of concern and address any issues that emerge  
- Contingency available to manage the position | Lack of control over elective referrals | Mar-14 | Chief Finance Officer | Discussions with PHT and PCCG about how to limit our respective financial risk. | substantial | Chief Finance Officer | 4 | May-14 |
| F&G (J) COR 6-15 | Jun-13 | Impact of Health and Social Care Information Centre (HSCIC) Guidance poses a significant risk to financial controls on contracts, and increased financial cost to CCGs from CSUs. | (4x4) 16 | (2x4) 12 | - Letter sent to Director Wessex LAT highlighting issue, Jun 13.  
- Guidance has been received from NHS England  
- CSU is undertaking investigative actions | - Gap in guidance continues to limit the use of PID for non-direct care purposes which may result in an inability to validate invoice payments | | Chief Finance Officer | - Further guidance has been provided, allowing for PCD to be used for invoice validation. | limited | Chief Finance Officer | 4 | May-14 |
<table>
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<th>Risk Ref</th>
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<th>Risk Owner (Accountable Person)</th>
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<tbody>
<tr>
<td>F&amp;G (J) COR 6-16</td>
<td>Sep-13</td>
<td>There is a risk that poor performance/lack of delivery in functions supplied by NHS South CSU results in an inability of the CCG to monitor performance of provider Trusts and therefore commission effectively.</td>
<td>(4x4) 16</td>
<td>(4x3) 12</td>
<td>- CSU user group meeting monthly to identify issues. - Weekly meeting with CSU customer relationship lead to monitor performance and raise issues of concern - Issue log in place &amp; monitored monthly. - CSU senior manager attends CCG management meetings. - Rectification plans in place for contracting a HR and monitored through CSU User Group. - CSU senior manager attends CCG management meetings.</td>
<td>Service specifications are ill defined and therefore performance is difficult to monitor.</td>
<td>Sep-14</td>
<td>Chief Finance Officer</td>
<td>- Regular reports taken to Clinical Cabinet. Hants-wide review of service specifications under way. CSU/CCG Staff workshop undertaken to improve joint working.</td>
<td>substantial</td>
<td>Chief Finance Officer</td>
<td>4</td>
<td>May-14</td>
</tr>
<tr>
<td>F&amp;G(J) COR 6-17</td>
<td>May-14</td>
<td>The CCG has little non-recurrent headroom funding to make the investments needed to change the health system to make it financially sustainable</td>
<td>(4x4) 16</td>
<td>(4x4) 16</td>
<td>Quality premium finding will be used for system change</td>
<td>QIPP non-delivery will restrict availability of funding</td>
<td>Chief Finance Officer</td>
<td>Chief Finance Officer</td>
<td>Chief Finance Officer</td>
<td>Chief Finance Officer</td>
<td>May-14</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F&amp;G(J) COR 6-18</td>
<td>May-14</td>
<td>There is a risk to Continuing Healthcare: Proposed re-basing to 2014-15 outturn exposes CCGs to a significant cost pressure</td>
<td>(4x4) 16</td>
<td>(4x4) 16</td>
<td>- Forensic review of CHC database - Phased pace of change movement</td>
<td></td>
<td>Chief Finance Officer</td>
<td>Chief Finance Officer</td>
<td>Chief Finance Officer</td>
<td>May-14</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F&amp;G(J) COR 6-19</td>
<td>May-14</td>
<td>There is a risk that the partnership between HCC and CCGs fails to deliver integrated models of care within agreed timeframe and realise savings required by 2015/16 to support the maintenance of social care services and health savings.</td>
<td>(4x4) 16</td>
<td>(4x4) 16</td>
<td>- Risk share arrangements to be put in place between CCGs/HCC</td>
<td></td>
<td>Chief Finance Officer</td>
<td>Chief Finance Officer</td>
<td>Chief Finance Officer</td>
<td>May-14</td>
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### Appendix A Board Assurance Framework

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<tbody>
<tr>
<td>F&amp;G (J)</td>
<td>COR7-1</td>
<td>Significant differences in how the Community Care Teams around the locality are working with primary care could lead to a failure to develop teams according to the integrated care model resulting in the outcomes of the commissioning strategy not being realised.</td>
<td>(5x3) 15</td>
<td>(4x3) 12</td>
<td>- programme management arrangements established (in partnership with HCC and Southern Health NHS FT reporting to the Clinical Cabinet) - Locality Clinical leads have been appointed supported by an overall GP Clinical lead</td>
<td>Details of any expected controls that are not in place or controls that are not operating effectively</td>
<td></td>
<td>Chief Commissioning Officer</td>
<td>Review of specifications and outcomes. Contract management meetings addressing progress. Regular dialogue to Southern Health NHS Trust. Additional project management support introduced.</td>
<td>substantial</td>
<td>Clinical Chair</td>
<td>4</td>
<td>May-14</td>
</tr>
<tr>
<td>F&amp;G (J)</td>
<td>COR7-3 Q05</td>
<td>Challenging C. difficile national reduction target for the CCG</td>
<td>(4x4) 16</td>
<td>(4x4) 16</td>
<td>- Intermediate cover via DCQO - HCAI cover via secondment</td>
<td>- Secondee commences 2/9/13 - Interim HCAI expert cover stops 15/8/13 - DCQO is covering 2 weeks in August - PID sharing disagreement escalated to Public Health and DoH to seek clarity as a matter of urgency - Limited access to PID required for full Root Cause Analysis (national problem)</td>
<td>Sep-13</td>
<td>Deputy Chief Quality Officer</td>
<td>Assurance around impact of change in methodology. Further update from PHT indicates this has improved scores for January. Improvement in scores brings PHT in line with other acute trusts in Wessex.</td>
<td>good</td>
<td>Chief Quality Officer</td>
<td>6</td>
<td>May-14</td>
</tr>
<tr>
<td>F&amp;G(U)</td>
<td>COR7-4 May-14</td>
<td>PHT FFT scoring Friends &amp; Family Test net promoter inpatient score is lowest in England for October 2013. Response rates for ED below average. Patients report a less positive experience in inpatient settings than the national average.</td>
<td>(4x5) 20</td>
<td>(3x2) 6</td>
<td>Joint CCG &amp; Wessex Area Team visit. CCG FFT analysis undertaken. FFT report received from PHT. Escalation to ECRM. Early indications shows improvements.</td>
<td></td>
<td></td>
<td>Head of Quality</td>
<td>Assurance around impact of change in methodology. Further update from PHT indicates this has improved scores for January. Improvement in scores brings PHT in line with other acute trusts in Wessex.</td>
<td>good</td>
<td>Chief Quality Officer</td>
<td>6</td>
<td>May-14</td>
</tr>
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</table>

**Strategic Objective:** Improving quality of care and outcomes for patients
### Description of the Risk and Impact

There is a risk to the quality of contracts provided by Southern Health Foundation Trust as it has been issued an enforcement action which requires SHFT to act faster to improve quality of care in Oxfordshire, strengthen governance and improve the way it manages its services to ensure problems identified by the CQC are not repeated elsewhere.

### Key Controls in Place

- NHS England Regional Risk Summit Jan 14 and follow up meeting Mar 14
- SHFT internal Deloitte governance review undertaken and recommendations provided around improving the governance processes at divisional level and data provided to the Board.

### Gaps in Control and Actions Required

- Action plan to address enforcement issues and the CQC concerns is being prepared by SHFT. This will be presented to the May CQRM.
- Tracking through SHFT mental health and learning disability CQRM hosted by West Hants CCG with F&G/SEH CCG representation.

### Risk Owner (Accountable Person)

Chief Quality Officer
<table>
<thead>
<tr>
<th>Date of Meeting</th>
<th>28 May 2014</th>
<th>Agenda Item No</th>
<th>15</th>
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<tbody>
<tr>
<td><strong>Title</strong></td>
<td><strong>CCG Constitution - Amendments</strong></td>
<td></td>
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<tr>
<td><strong>Purpose of Paper</strong></td>
<td>To inform members of the amendments for inclusion to the 1 June 2014 submission to NHS England for amendments to the CCG constitution. The Clinical Assembly has approved the proposed amendments.</td>
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<tr>
<td><strong>Recommendations/Actions requested</strong></td>
<td>The Governing Body is asked to:</td>
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<tr>
<td></td>
<td>• Note the proposed amendments to the CCG Constitution</td>
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<tr>
<td><strong>Author</strong></td>
<td>Nikki Roberts</td>
<td></td>
<td></td>
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<td></td>
<td>Governance and Committee Officer</td>
<td></td>
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<tr>
<td><strong>Sponsoring member</strong></td>
<td>Sara Tiller</td>
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<td></td>
<td>Chief Development Officer</td>
<td></td>
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<tr>
<td><strong>Date</strong></td>
<td>19th May 14</td>
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FAREHAM AND GOSPORT CLINICAL COMMISSIONING GROUP
GOVERNING BODY – 28TH MAY 2014
PROPOSED CONSTITUTIONAL AMENDMENTS

Introduction

1. Any amendments that a CCG wishes to make to its Constitution are to be forwarded to NHS England for approval by the 1st June and 1st November each year. This paper proposes that Governing Body members consider and approve the following Constitutional amendments detailed below.

Detail of Amendments

2. During the first year of the CCG a number of issues arose which could have been resolved through greater direction from the Constitution. There were also issues which would help clarify to the membership how they can hold their elected clinical members to account. It was also considered that the eligibility criteria should be widened to allow non-partners of member practices to stand for election. It is hoped that this will encourage consideration from the widest possible body of clinical expertise within the geographic area of the CCG, to stand for election.

3. Therefore, the following amendments to the constitution are proposed:

- A small number of general typo amendments and changes to names such as the Community Advisory Committee has been renamed the Community Engagement Committee;

- Terms of Reference have been revised for the Remuneration Committee, the Community Engagement Committee, the Quality Assurance Committee and inserted for the Corporate Governance Committee;

- It has been established that the Lay Member for Audit post, rather than the Lay Member for Patient and Public Involvement post is the more appropriate post to hold the position of Deputy Chair, and this has been formally reflected in the Constitution;

- A minimum attendance requirement has been inserted which requires all Governing Body members to attend three quarters of any CCG formal or portfolio related meetings throughout the year;

- Two new grounds for removal have been inserted for Clinical Members. These are;
  - That their representation is no longer supported by a Member Practice
  - That they are unable to consistently fulfil their requirements of their Job Description

- Amendments have been made to the eligibility criteria required in order to stand for election to the Governing Body. The criteria now includes any clinical member who is:
o A GP who is a member, whether they be partners, non-partners or locums, of a member practice of the CCG. At least three of the Clinical Board Members elected by the constituents should be Partners of member practices
o Nominations for Clinical Cabinet Members must be accompanied by written confirmation of support from a CCG member practice.

4. A copy of the tracked change document is attached at the Appendix.

Recommendation

3. The Clinical Assembly has approved the proposed amendments for inclusion at the 1st June submission to NHS England for amendments to the CCG constitution. Therefore the Governing Body is requested to note the proposed amendments.

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<td>3</td>
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<td>Mission, Values and Aims</td>
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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 Fareham and Gosport Clinical Commissioning Group.

Fareham and Gosport covers a large population of over 200,366 with 21 practices and one main acute provider as well as three other service providers. The CCG borders South Eastern Hampshire CCG, West Hampshire CCG and Portsmouth CCG.
INTRODUCTION AND COMMENCEMENT

1.1. Name

1.1.1. The name of this clinical commissioning group is NHS Fareham and Gosport 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 statutory bodies which have the function of commissioning services for the purposes of the health service in England and are treated as NHS bodies for the purposes of the 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 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 Fareham and Gosport Clinical Commissioning Group and has effect from 1st day of April 2013, when the NHS England established the group \(^8\).

1.3.2. The constitution is published on the group’s website at www.farehamandgosportccg.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 11 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:
   a) Post:
      Fareham and Gosport CCG, Commissioning House, Building 003, Fort Southwick, James Callaghan Drive, Fareham, Hampshire, PO17 6AR
   b) Email:
      F&G.inquiries@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 the NHS England and that application is granted;
   b) where in the circumstances set out in legislation the 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 Fareham and Gosport Clinical Commissioning Group is 40.7 square miles and is also covered by Hampshire County Council. The area, however, is broadly co-terminus with Fareham Borough Council and Gosport Borough Council.

Fareham and Gosport CCG Area
3. MEMBERSHIP

3.1. Membership of the Clinical Commissioning Group

3.1.1. The following practices comprise the members of Fareham and Gosport Clinical Commissioning Group.

<table>
<thead>
<tr>
<th>Practice Name</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bridgemary Medical Centre</td>
<td>2 Gregson Avenue, Gosport, PO13 0HR</td>
</tr>
<tr>
<td>Brockhurst Medical Centre</td>
<td>139-141 Brockhurst Road, Gosport PO12 3AX</td>
</tr>
<tr>
<td>Brook Lane Surgery</td>
<td>233a Brook Lane, Sarisbury Green, SO31 7DQ</td>
</tr>
<tr>
<td>Brune Medical Centre</td>
<td>10 Rowner Road, Gosport, PO13 0EW</td>
</tr>
<tr>
<td>Bury Road Surgery</td>
<td>Gosport War Memorial Hospital, Bury Road</td>
</tr>
<tr>
<td></td>
<td>GosportPO12 3PW</td>
</tr>
<tr>
<td>The Fareham Centre Practice</td>
<td>Osborn Road, Fareham, PO16 7ER</td>
</tr>
<tr>
<td>Gudgeheath Lane Surgery</td>
<td>187 Gudge heath Lane, Fareham, PO14 7ER</td>
</tr>
<tr>
<td>Forton Medical Centre</td>
<td>White Place, Gosport, PO12 3JP</td>
</tr>
<tr>
<td>Gosport Medical Centre</td>
<td>Gosport War Memorial Hospital, Bury Road,</td>
</tr>
<tr>
<td></td>
<td>Gosport, PO12 3AQ</td>
</tr>
<tr>
<td>Highlands Medical Centre</td>
<td>103 Highlands Road, Fareham, PO15 6JF</td>
</tr>
<tr>
<td>Jubilee Surgery</td>
<td>High Street, Titchfield, PO14 4EH</td>
</tr>
<tr>
<td>Lee on Solent Health Centre</td>
<td>Manor Way, Lee on Solent, PO13 9JG</td>
</tr>
<tr>
<td>Lockswood Road Surgery</td>
<td>Centre Way, Locks Heath, SO31 6DX</td>
</tr>
<tr>
<td>Manor Way Surgery</td>
<td>Manor Way, Lee on Solent, PO13 9JG</td>
</tr>
<tr>
<td>The Portchester Practice</td>
<td>West Street, Portchester, PO16 9TU</td>
</tr>
<tr>
<td>Rowner Health Centre</td>
<td>143 Rowner Road, Gosport, PO13 9SP</td>
</tr>
<tr>
<td>Stubbington Medical Practice</td>
<td>Park Lane, Stubbington, Fareham, PO14 2JP</td>
</tr>
<tr>
<td>Stoke Road Surgery</td>
<td>66-68 Stoke Road, Gosport, PO12 1PA</td>
</tr>
<tr>
<td>Waterside Medical Centre</td>
<td>Mumby Road, Gosport, PO12 1BA</td>
</tr>
<tr>
<td>Westlands Medical Centre</td>
<td>20b Westlands Grove Portchester, PO16 9AE</td>
</tr>
<tr>
<td>Whiteley Surgery</td>
<td>Yew tree Drive, Whiteley, Fareham, PO16 9AE</td>
</tr>
</tbody>
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3.1.2. Appendix B of this constitution contains the list of member practices together with the signatures of the practice representatives confirming their agreement to this constitution.

3.2 Eligibility

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 Fareham and Gosport shall be eligible for membership of the CCG.
3.3 **Key relationships**

3.3.1 The CCG recognises the LMC as the statutory representative of GPs and the role of the LMC in the local provision of primary medical services. Fareham & Gosport CCG and the LMC recognise the benefits of cooperation and dialogue in the effective provision of services for patients. Fareham & Gosport CCG will seek to engage with the LMC whenever appropriate.

3.3.2 The CCG recognises the role of other representative medical groups that exist in the area and will engage with these whenever it is appropriate.

3.3.3 The CCG acknowledges the existence of ‘One Compact for Hampshire’ and will engage constructively with voluntary and third sector partners.
4. MISSION, VALUES AND AIMS

4.1. Mission

4.1.1. The mission of NHS Fareham and Gosport Clinical Commissioning Group is to positively improve the health and well-being of people in Fareham and Gosport within available resources and reducing health inequalities by ensuring that clinicians, patients, the public and partners are at the heart of commissioning.

4.1.2. The group will promote good governance and proper stewardship of public resources in pursuance of its goals and in meeting its statutory duties.

4.2. Values

4.2.1. Good corporate governance arrangements are critical to achieving the group's objectives.

4.2.2. The values that lie at the heart of the group's work are:

   a) Integrity, trust, respect, honesty
   b) Objectivity and transparency
   c) Inclusivity (listening to patients, public, providers and clinicians).
   d) Positivity
   e) Communication and sharing

4.3. Aims/Vision

4.3.1. The vision of the Clinical Commissioning Group is to commission excellent, integrated patient centred care for the population of Fareham and Gosport.

4.4. Principles of Good Governance

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

   a) 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;

   b) \textit{The Good Governance Standard for Public Services}\textsuperscript{11};

   c) the standards of behaviour published by the \textit{Committee on Standards in Public Life (1995)} known as the “Nolan Principles”\textsuperscript{12}.

\textsuperscript{10} Inserted by section 25 of the 2012 Act
\textsuperscript{11} \textit{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
\textsuperscript{12} See Appendix F
d) the seven key principles of the *NHS Constitution*\(^\text{13}\);

e) the Equality Act 2010\(^\text{14}\);


### 4.5. Accountability

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

a) publishing its constitution;

b) appointing independent lay members and non GP clinicians to its governing body;

c) holding meetings of its governing body in public (except where the group considers that it would not be in the public interest in relation to all or part of a meeting);

d) publishing annually a commissioning plan;

e) complying with local authority health overview and scrutiny requirements;

f) meeting annually in public to publish and present its annual report (which must be published);

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

h) having a published and clear complaints process;

i) complying with the Freedom of Information Act 2000;

j) providing information to NHS England as required.

4.5.2. In addition to these statutory requirements, the group will demonstrate its accountability by:

a) Reserving powers in the Clinical Assembly of which all member practices can hold the group to account

b) Forming a [Community Engagement Committee Stakeholder-Advisory Board](http://www.legislation.gov.uk/ukpga/2010/15/contents) which will engage with patients and members of the public who are resident within the geographical area

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\(^{13}\) See Appendix G

c) Publishing a Communications & Engagement strategy on the group’s website which sets out its policy and plans to engage with stakeholders

4.5.3. The governing body 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:

a) commissioning certain health services (where NHS England is not under a duty to do so) that meet the reasonable needs of:
   
i) all people registered with member GP practices, and
   
ii) people who are usually resident within the area and are not registered with a member of any clinical commissioning group;

b) commissioning emergency care for anyone present in the group's area;

c) paying its employees’ remuneration, fees and allowances in accordance with the determinations made by its governing body and determining any other terms and conditions of service of the group’s employees;

d) determining the remuneration and travelling or other allowances of members of its governing body.

5.1.2. In discharging its functions the group will:

a) act\(^{15}\) consistently with the discharge by the Secretary of State and the 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:

   i) delegating tasks to the group’s governing body, 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.

   ii) 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.

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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
iii) requiring progress of delivery of the duty to be monitored through the group’s reporting mechanisms as governed by the standing orders (Appendix C)

b) **meet the public sector equality duty** by:

i) Delegating responsibility to the Accountable Officer for ensuring that Fareham and Gosport 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 monitored by the Audit Committee as a standing agenda item

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 report at the AGM describing progress against agreed Equality Objectives

c) work in partnership with its local authorities to develop **joint strategic needs assessments** and **joint health and wellbeing strategies** by:

i) ensuring Governing Body level engagement

ii) ensuring the Clinical Chair of the CCG is the representative on the Hampshire Health & Wellbeing Board

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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
5.2. 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\(^{21}\) by:
   
a) Establishing a Community Engagement Committee
b) Publishing an annual Communications & Engagement strategy
c) Publishing an annual statement of engagement

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:
   
a) Ensuring robust and appropriate governance arrangements are in place
b) Delegating responsibility to the Governing Body and its subcommittee, the clinical cabinet
c) Publishing a Communications & Engagement strategy
d) Creating a Community Advisory Committee

5.2.3. Act effectively, efficiently and economically\(^{23}\) by:
   
a) Delegating powers to make the Governing Body responsible for this
b) The establishment of The Clinical Cabinet, reporting to the Governing Body. The Terms of Reference are appended (appendix K).
c) The role of The Clinical Cabinet is to:
   
   • Coordinate performance management across the CCG. This includes:
     o identifying areas of poor performance;
     o identifying and initiating actions required to address performance issues;
     o 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

d) Publishing an annual commissioning plan which will be approved by the Clinical Assembly.
e) Delegating responsibility for providing assurance that the CCG is commissioning effectively, efficiently and economically to the audit committee
f) Publishing a policy on how we plan
g) Providing formal reports on financial performance at Governing Body meetings.

5.2.4. Act with a view to securing continuous improvement to the quality of services\(^ {24}\) by:

\(^{21}\) See section 14Z2 of the 2006 Act, inserted by section 26 of the 2012 Act
\(^{22}\) 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
a) The Clinical Cabinet will be responsible for securing continuous improvement to the quality of services. The Terms of Reference are appended (appendix K).

b) Publishing a quality framework

c) Publishing an annual statement around quality of the services commissioned
d) Having quality as an agenda item at every Governing Body meeting
e) Establishing a joint Quality & Safety sub-committee of the Clinical Cabinet which will work jointly with South Eastern Hampshire CCG and Portsmouth CCG.

5.2.5. Assist and support the NHS England in relation to the Board’s duty to improve the quality of primary medical services by:

a) The establishment of a Clinical Cabinet, which is a sub-committee of the Governing Body. The Terms of Reference are appended (appendix K)

b) The development of arrangements that support and reward practice improvement in primary care. The clinical cabinet will monitor the performance of these arrangements.

5.2.6. Have regard to the need to reduce inequalities by:

a) Using the NHS Equality Delivery System to support its work to tackle health inequalities experienced by equality groups (protected characteristics)
b) Publishing an Equality & Diversity strategy
c) Co-opting the Director of Public Health on to our Governing Body as an observer
d) Publishing a Commissioning Strategy and Annual Commissioning Plan which include a credible approach to reducing inequality
e) Reporting on progress against plan to reduce inequality

5.2.7. Promote the involvement of patients, their carers and representatives in decisions about their healthcare 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

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25 See section 14S of the 2006 Act, inserted by section 26 of the 2012 Act
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
c) Delegating responsibility to the Community Engagement Committee chaired by the lay member for patient and public engagement who will review and provide assurance to the board on the ways the CCG seeks to involve patients, their carers and the public.

d) Our methods for promoting the involvement of patients and their carers and representatives will be published in our Communications & Engagement strategy.

e) Publishing an annual statement of engagement which reports on the effectiveness of our strategy.

5.2.8. Act with a view to enabling patients to make choices28 by:

a) Placing responsibility with the Accountable Officer for this

b) Having one of the lay members of the Governing Body being responsible for Patient & Public Involvement and chairing the Community Engagement Committee.

c) The Community Engagement Committee will report at least annually to the governing body on the fulfilment of this requirement.

5.2.9. Obtain appropriate advice29 from persons who, taken together, have a broad range of professional expertise in healthcare and public health by:

a) In addition to statutory membership, the following people will be co-opted to the governing body as non-voting members:
   i) The Director of Public Health
   ii) A representative of the Local Medical Committee
   iii) Adult & Children’s social care representatives
   iv) Healthwatch representative
   v) Practice Manager representative

5.2.10. Promote innovation30 by:

a) Delegating responsibility for innovation to the Clinical Cabinet.

b) Making the Clinical Chair the lead for innovation

5.2.11. Promote research and the use of research31 by:

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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
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
a) Delegating responsibility for research to the Clinical Cabinet
b) Making the Clinical Chair the lead for Research, particular in relation to oversight of research governance in secondary care and the approval process of excess treatment costs in secondary care.
c) Fareham and Gosport CCG currently has access to a shared Research Management and Governance service and a Comprehensive Local Research Network.

d) An initial briefing paper has been prepared for the CCG and a generic job description developed for a CCG lead for Research and Evidence

5.2.12. Have regard to the need to **promote education and training**\(^\text{32}\) 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\(^\text{33}\) by:

a) Making the Governing Body responsible for this
b) Publishing a commissioning strategy which will outline how we will assist those partners who are responsible for commissioning education and training programmes.

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\(^\text{34}\). To facilitate this the following has been agreed:

a) A Collaboration agreement exists between the CCG and South Eastern Hampshire CCG.

b) Compact agreements exist between South Eastern Hampshire CCG; Fareham & Gosport CCG and Portsmouth CCG.

c) The five CCGs across Hampshire work together to take a Hampshire-wide view of specific pathway development e.g. mental health in particular those related to Hampshire County Council.

d) The eight CCGs across Hampshire (including Portsmouth, Southampton and the Isle of Wight) working together as the Board of Clinical Commissioners and working together to clarify Make, Share, Buy arrangements and will work together as individual CCGs to promote integration of health services as appropriate.

e) The Portsmouth & South East Hampshire System Sustainability Board

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

\(^{32}\) 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
5.3.1. **Ensure its expenditure does not exceed the aggregate of its allotments for the financial year**\(^{35}\) by

a) 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.

b) The Chief Finance Officer shall monitor financial performance against plan and periodically report to the Governing Body.

c) The Audit Committee will assure the CCG’s Governing Body on these matters.

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

a) Prior to the start of the financial year the Chief Finance Officer will on behalf of the Accountable Officer prepare and submit budgets to the Governing Body for approval.

b) The Chief Finance Officer shall monitor financial performance against plan and periodically report to the Governing Body.

c) 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.

d) The Accountable Officer may delegate the management of budgets to others with the CCG in line will an agreed scheme of delegation.

e) The Audit Committee will assure the CCG’s Governing Body on these matters.

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

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

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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

\(^{37}\) See section 223J of the 2006 Act, inserted by section 27 of the 2012 Act
a) The Chief Finance Officer will be responsible for establishing systems to monitor the expenditure against any resources specified for specific use by NHS England.

b) The Chief Finance Officer will be responsible for regular review of the financial performance against plan and periodic reporting of that performance to the Governing Body.

c) The Audit Committee will assure the CCG’s Governing Body on these matters.

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

a) The Chief Finance Officer on behalf of the Accountable Officer is responsible for producing a detailed review of any payments made in respect of quality.

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

c) The Audit Committee will assure the CCG’s Governing Body on these matters.

5.4. Other Relevant Regulations, Directions and Documents

5.4.1. The group will

a) comply with all relevant regulations;

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

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

d) 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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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:

   a) any of its members;
   b) its governing body;
   c) employees;
   d) 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:

   a) the group’s scheme of reservation and delegation; and
   b) for committees, their terms of reference.

6.2. Scheme of Reservation and Delegation

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

   a) those decisions that are reserved for the membership as a whole;
   b) those decisions that are the responsibilities of its governing body (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 governing body (and its committees, joint committees and sub committees), and individuals must:

   a) comply with the group’s principles of good governance,
   b) operate in accordance with the group’s scheme of reservation and delegation.

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39 See Appendix D
40 See section 4.4 on Principles of Good Governance above
c) comply with the group’s standing orders,

d) comply with the group’s arrangements for discharging its statutory duties,

e) 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.

6.3.3. Where delegated responsibilities are being discharged collaboratively, the joint (collaborative) arrangements must:

a) identify the roles and responsibilities of those clinical commissioning groups which are working together;

b) identify any pooled budgets and how these will be managed and reported in annual accounts;

c) specify under which clinical commissioning group’s scheme of reservation and delegation and supporting policies the collaborative working arrangements will operate;

d) specify how the risks associated with the collaborative working arrangement will be managed between the respective parties;

e) identify how disputes will be resolved and the steps required to terminate the working arrangements;

f) specify how decisions are communicated to the collaborative partners.

6.4. Committees of the group

6.4.1. The Governing Body will have the following committees:

a) The Clinical Cabinet which will have two sub-committees:
   a. The Practice Managers Commissioning Advisory Group
   b. The Performance and Assurance Committee
   c. Portsmouth and South East Hampshire Commissioning Collaborative Prescribing Forum

41 See appendix D
42 See appendix C
43 See chapter 5 above
b) Community Engagement Committee  
c) Audit Committee  
d) Remuneration Committee  
e) Joint Quality Assurance Committee  
f) Corporate Governance Committee  

d)  

6.4.2. 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 group or the committee they are accountable to.  

6.5. Joint Arrangements  

6.5.1. The group has entered into joint arrangements with the following clinical commissioning groups:  
a) South Eastern Hampshire Clinical Commissioning Group  
b) South Eastern Hampshire Clinical Commissioning Group and Portsmouth Clinical Commissioning Group  
c) The five Hampshire Clinical Commissioning Groups.  
d) CCG Commissioning Group (8 CCGs across Southampton, Hampshire, Isle of Wight & Portsmouth)  

6.5.2 The group has joint committee(s) with the following local authority:  
a) Hampshire County Council  

6.6. The Governing Body  

6.6.1. Functions - the governing body 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 regulations44 or in this constitution. The governing body may also have functions of the clinical commissioning group delegated to it by the group. Where the group has conferred additional functions on the governing body connected with its main functions, or has delegated any of the group’s functions to its governing body, these are set out from paragraph 6.6.1(d) below. The governing body has responsibility for:  

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

NHS Fareham and Gosport Clinical Commissioning Group’s Constitution - 22 -  
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a) 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);

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

c) approving any functions of the group that are specified in regulations;\(^{46}\)

d) approving the:

i) vision and strategy following endorsement by the Clinical Assembly

ii) commissioning plans following endorsement by the Clinical Assembly

iii) monitoring performance against plans

iv) providing assurance against strategic risk

6.6.2. **Composition of the Governing Body** - the governing body shall have a maximum of 12 (twelve) designated members and shall comprise of:

Voting Members:

a) Six GP representatives of member practices (one of whom shall be the Governing Body Chair)

b) Two lay members:

i) one to lead on governance, remuneration and conflict of interest matters,

ii) one to lead on patient and public participation matters (who shall be the Deputy Chair of the Governing Body);

c) One Registered Nurse;

d) One Secondary Care Specialist Doctor;

e) Accountable Officer;

f) Chief Finance Officer;

Non-Voting Members:

g) Director of Public Health (Hampshire)

h) Healthwatch Representative

i) Hampshire County Council Officer/Member

j) LMC representative

k) Practice Manager Representatives

l) Chief Development Officer

m) Chief Commissioning Officer

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\(^{45}\) See section 4.4 on Principles of Good Governance above

\(^{46}\) See section 14L(5) of the 2006 Act, inserted by section 25 of the 2012 Act
Committees of the Governing Body - the governing body has appointed the following committees and sub-committees:

a) Audit Committee – the audit committee, which is accountable to the group’s governing body, provides the governing body 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 governing body has approved and keeps under review the terms of reference for the audit committee, which includes information on the membership of the audit committee.

In addition the governing body has conferred or delegated the following functions, connected with the governing body’s main function, to its audit committee:

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

ii) 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

iii) Assurance that rigorous processes are in place to support public disclosure statements

b) Remuneration Committee – the remuneration committee, which is accountable to the group’s governing body makes recommendations to the governing body 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 any pension scheme that the group may establish as an alternative to the NHS pension scheme. The governing body has approved and keeps under review the terms of reference for the remuneration committee, which includes information on the membership of the remuneration committee.

In addition, the governing body has conferred or delegated the following functions, connected with the governing body’s main function, to its remuneration committee:

i) Arrangements for termination of employment and other contractual terms.

c) Community Engagement Committee – The Community Engagement Committee will be chaired by a member of the governing body. The committee will include representatives of the voluntary sector; Healthwatch; local council representatives; practice participation group members, local provider representatives, local patient groups and public health. The purpose of the committee is to support the Clinical Commissioning Group in achieving

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
its strategic objectives by interpreting and influencing both the external and internal environments and by creating positive relationships with stakeholders through the appropriate management of their expectations and agreed objectives.

d) **Clinical Cabinet** – the Clinical Cabinet, which is accountable to the group’s Governing Body, approves strategy and policy, makes recommendations to the Governing Body 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 Governing Body 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.

e) **Joint Quality Assurance Committee** - is shared between Fareham & Gosport CCG, South Eastern Hampshire CCG and Portsmouth CCG (through the compact agreement) and is accountable to the Governing Body. The Joint Quality & Safety Committee provides the Clinical Cabinet with updates and information relating to patient safety and complaints for which the Chair of the Clinical Cabinet remains responsible. The Chief Quality Officer is a member of the committee.

d) **Corporate Governance Committee** - is shared between Fareham & Gosport CCG and South Eastern Hampshire CCG and is accountable to the Governing Body for the development, implementation and monitoring of corporate governance by maintaining an oversight and ensuring the effectiveness of a range of systems and processes designed to deliver the corporate responsibilities and objectives of both organisations.

6.6.4. **Sub-committees of the Clinical Cabinet**

a) **Practice Managers’ Commissioning Advisory Group** - which is accountable to the group’s Governing Body, provides a link between the Clinical Cabinet and the Practice Managers of the member practices. The Governing Body has approved and keeps under review the terms of reference for the Clinical Cabinet which includes information on the membership of the Practice Managers’ Commissioning Advisory Group 50.

b) **Performance and Assurance Committee - Joint Quality & Safety Committee** – is shared between Fareham & Gosport CCG, South Eastern Hampshire CCG and Portsmouth CCG (through the compact agreement) and is accountable to the Governing Body. The Joint Quality & Safety Committee provides the Clinical Cabinet with updates and information relating to patient safety and

49 See appendix K for the terms of reference of the Clinical Cabinet
50 See appendix M for the terms of reference of the Practice Manager’s Commissioning Advisory Group Committee
complaints for which the Chair of the Clinical Cabinet remains responsible. The Chief Quality Officer is a member of the committee.

Portsmouth and South East Hampshire Commissioning Collaborative -

Prescribing Forum - which provides oversight and governance in primary care services that use medicines in the CCG. It ensures that constituent practices are accountable for their usage of medicines, through monthly reviews and practice visits where appropriate.

7. ROLES AND RESPONSIBILITIES

7.1. Practice Representatives

7.1.1. Practice representatives represent their practice’s views and act on behalf of the practice in matters relating to the group. The role of each practice representative is to:

a) Nominate commissioning and prescribing leads to a) represent the practice at CCG meetings and b) represent the needs of the practice’s patient population within the CCG
b) Actively engaging with the CCG to help improve services within the area
c) Sharing appropriate referral, prescribing and emergency admissions data
d) Follow the clinical pathways and referral protocols agreed by the CCG (except in individual cases where there are justified clinical reason for not doing this)
e) Managing the practice’s prescribing budget
f) Participating in and delivering, as far as possible, the clinical and cost effective strategies agreed by the CCG
g) Means of obtaining the views and experiences of patients and carers
h) Working constructively within the Clinical Assembly and the Clinical Discussion Forums
i) Practice Representatives must attend the CCG’s formal meetings to ensure that the business of the CCG is conducted properly and both committees are kept informed on the post holder’s portfolio area(s). Representatives are expected to attend three quarters of all meetings each year (e.g. minimum of three formal Governing Body meetings; minimum of nine Clinical Cabinet meetings);
j) Attend other meetings, to include Clinical Assembly and TARGET, to represent the CCG;
k) Attend committees/meetings specific to the portfolio(s).

7.2. All Members of the Group’s Governing Body

7.2.1. Guidance on the roles of members of the group’s governing body is set out in a separate document51. In summary, each member of the governing body will share responsibility as part of a team to ensure that the group exercises its functions effectively, efficiently and economically, with good governance and in

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51 Draft clinical commissioning group Governing Body Members – Roles Attributes and Skills, NHS Commissioning Board Authority, March 2012
accordance with the constitution. Each member brings their unique perspective, informed by their expertise and experience.

7.3. **The Chair of the Governing Body**

7.3.1. The chair of the governing body is responsible for:

a) leading the governing body, ensuring it remains continuously able to discharge its duties and responsibilities as set out in this constitution;

b) building and developing the group’s governing body and its individual members;

c) ensuring that the group has proper constitutional and governance arrangements in place;

d) ensuring that, through the appropriate support, information and evidence, the governing body is able to discharge its duties;

e) supporting the Accountable 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 governing body 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 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 authorities.

7.4. **The Deputy Chair of the Governing Body**

7.4.1. Where the Chair is a GP or an individual from a member practice, the Deputy Chair shall be a lay member who shall also take the Chair’s role for discussions and decisions involving conflict of interest or is otherwise unable to act.
7.5. **Role of the Accountable Officer**

7.5.1. The Accountable Officer of the group is a member of the governing body.

7.5.2. This role of Accountable Officer (AO) has been summarised in a national document as: 52

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 chair of the governing body, the Accountable Officer will ensure that proper constitutional, governance and development arrangements are put in place to assure the members (through the governing body) 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.

d) The Accountable Officer will be a manager and will be an employee of the CCG. The role of Accountable Officer will be shared with South Eastern Hampshire CCG.

7.6. **Role of the Chief Finance Officer**

7.6.1. The Chief Finance Officer is a member of the governing body and is responsible for providing financial advice to the clinical commissioning group and for supervising financial control and accounting systems

7.6.2. The role of the Chief Finance Officer will be shared with South Eastern Hampshire CCG.

7.6.3. This role of Chief Finance Officer has been summarised in a national document as: 53

a) being the governing body’s professional expert on finance and ensuring, through robust systems and processes, the regularity and propriety of expenditure is fully discharged;

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52 See the latest version of the NHS Commissioning Board Authority’s Clinical commissioning group governing body members: Role outlines, attributes and skills

53 See the latest version of the NHS Commissioning Board Authority’s Clinical commissioning group governing body members: Role outlines, attributes and skills
b) making appropriate arrangements to support and monitor 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 governing body 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.

7.7. Joint Appointments with other Organisations

7.7.1. The group has the following joint appointment with another organisation:

a) Accountable Officer and Chief Finance Officer roles are shared with Fareham and Gosport Commissioning Group

7.7.2. These joint appointments are supported by a memorandum of understanding between the organisations who are party to these joint appointments. Other non-statutory appointments may exist between Fareham & Gosport and South Eastern Hampshire CCGs so long as they are subject to a hosting agreement.
7.8. **Standards of Business Conduct**

7.8.1. Employees, members, committee and sub-committee members of the group and members of the governing body (and its committees) will at all times comply with this constitution and be aware of their responsibilities as outlined in it. They should act in good faith and in the interests of the 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.

7.8.2. They must comply with the group’s policy on business conduct, including the requirements set out in the policy for managing conflicts of interest. This policy will be available on the group’s website at http://www.farehamandgosportccg.nhs.uk.info

7.8.3. 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.

7.9. **Conflicts of Interest**

7.9.1. 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.

7.9.2. Where an individual, i.e. an employee, group member, member of the governing body, or a member of a committee or a sub-committee of the group or its governing body 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.

7.9.3. A conflict of interest will include:

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

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

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

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

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

7.10. Declaring and Registering Interests

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

a) the members of the group;

b) the members of its governing body;

c) the members of its committees or sub-committees and the committees or sub-committees of its governing body; and

d) its employees.

7.10.2. The registers will be published on the group’s website at http://www.farehamandgosportccg.nhs.uk

7.10.3. 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 governing body, as soon as they are aware of it and in any event no later than 28 days after becoming aware.

7.10.4. 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.
7.10.5. The Governance and Committee Officer will ensure that the register of interest is reviewed regularly, and updated as necessary.

7.11. Managing Conflicts of Interest: general

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

7.11.2. The Governance & Committee Officer 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.

7.11.3. Arrangements for the management of conflicts of interest are to be determined by the Governance & Committee Officer 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.

7.11.4. 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 Governance & Committee Officer.

7.11.5. 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 chair 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.
7.11.6. The chair 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 chair 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.

7.11.7. Where the chair of any meeting of the group, including committees, sub-committees, or the governing body and the governing body'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 chair will act as chair 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 chair, the meeting must ensure these are followed. Where no arrangements have been confirmed, the deputy chair may require the chair to withdraw from the meeting or part of it. Where there is no deputy chair, the members of the meeting will select one.

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

7.11.9. 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 chair (or deputy) will determine whether or not the discussion can proceed.

7.11.10. In making this decision the chair will consider whether the meeting is quorate, in accordance with the number and balance of membership set out in the 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 chair of the meeting shall consult with the Governance and Committee Officer.

7.11.11. This may include:

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

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

   i) a member of the clinical commissioning group who is an individual;
ii) an individual appointed by a member to act on its behalf in the dealings between it and the clinical commissioning group;

iii) a member of a relevant Health and Wellbeing Board;

iv) a member of a governing body of another clinical commissioning group.

These arrangements must be recorded in the minutes.

7.11.12. 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 Governance and Committee Officer.

7.11.13. The Governance & Committee Officer 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.

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

7.12.1. Anyone seeking information in relation to procurement, or participating in 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.

7.12.2. 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.

7.13. Transparency in Procuring Services

7.13.1. 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.

7.13.2. The group will publish a Procurement Strategy approved by its governing body which will ensure that:
a) all relevant clinicians (not just members of the group) and potential providers, together with local members of the public, are engaged in the decision-making processes used to procure services;

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

7.13.3. Copies of this Procurement Strategy will be available on the group’s website at www.farehamandgosportccg.nhs.uk
8. THE GROUP AS EMPLOYER

8.1. 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.

8.2. 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.

8.3. 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.

8.4. 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.

8.5. 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.

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

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

8.8. 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.

8.9. The group will adopt 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.

8.10. Copies of this Code of Conduct, together with the other policies and procedures outlined in this chapter, will be available on the group’s website at http://www.farehamandgosportccg.nhs.uk
9. TRANSPARENCY, WAYS OF WORKING AND STANDING ORDERS

9.1. General

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

9.1.2. Key communications issued by the group, including the notices of procurements, public consultations, governing body meeting dates, times, venues, and certain papers will be published on the group’s website at http://www.farehamandgosportccg.nhs.uk

9.1.3. 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.

9.2. Standing Orders

9.2.1. 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:

a) 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 governing body;

b) 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 governing body, the governing body’s committees and sub-committees, the group’s committees and sub-committees, individual members and employees;

c) Prime financial policies (Appendix E) – which sets out the arrangements for managing the group’s financial affairs.
## APPENDIX A
**DEFINITIONS OF KEY DESCRIPTIONS USED IN THIS CONSTITUTION**

<table>
<thead>
<tr>
<th>Description</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2006 Act</strong></td>
<td>National Health Service Act 2006</td>
</tr>
<tr>
<td><strong>2012 Act</strong></td>
<td>Health and Social Care Act 2012 (this Act amends the 2006 Act)</td>
</tr>
</tbody>
</table>
| **Accountable Officer**          | an individual, as defined under paragraph 12 of Schedule 1A of the 2006 Act (as inserted by Schedule 2 of the 2012 Act), appointed by NHS England, with responsibility for ensuring the group:  
   - complies with its obligations under:  
     - sections 14Q and 14R of the 2006 Act (as inserted by section 26 of the 2012 Act),  
     - sections 223H to 223J of the 2006 Act (as inserted by section 27 of the 2012 Act),  
     - paragraphs 17 to 19 of Schedule 1A of the NHS Act 2006 (as inserted by Schedule 2 of the 2012 Act), and  
     - any other provision of the 2006 Act (as amended by the 2012 Act) specified in a document published by the Board for that purpose;  
   - exercises its functions in a way which provides good value for money. |
| **Area**                         | the geographical area that the group has responsibility for, as defined in Chapter 2 of this constitution                                  |
| **Chair of the governing body**  | the individual appointed by the group to act as chair of the governing body                                                                |
| **finance officer**              | the qualified accountant employed by the group with responsibility for financial strategy, financial management and financial governance |
| **Clinical commissioning group** | a body corporate established by NHS England in accordance with Chapter A2 of Part 2 of the 2006 Act (as inserted by section 10 of the 2012 Act) |
| **Committee**                   | a committee or sub-committee created and appointed by:  
   - the membership of the group  
   - a committee / sub-committee created by a committee created / appointed by the membership of the group  
   - a committee / sub-committee created / appointed by the governing body |
| **Financial year**              | this usually runs from 1 April to 31 March, but under paragraph 17 of Schedule 1A of the 2006 Act (inserted by Schedule 2 of the 2012 Act), it can for the purposes of audit and accounts run from when a clinical commissioning group is established until the following 31 March |
| **Group**                       | NHS Fareham and Gosport Clinical Commissioning Group, whose constitution this is                                                            |
| **Governing body**              | the body appointed under section 14L of the NHS Act 2006 (as inserted by section 25 of the 2012 Act), with the main function of ensuring that a clinical commissioning group has made appropriate arrangements for ensuring that it complies with:  
   - its obligations under section 14Q under the NHS Act 2006 (as inserted by section 26 of the 2012 Act), and  
   - such generally accepted principles of good governance as are relevant to it. |
| **Governing body member**       | any member appointed to the governing body of the group                                                                                     |
| **Lay member** | a lay member of the governing body, appointed by the group. A lay member is an individual who is not a member of the group or a healthcare professional (i.e. an individual who is a member of a profession regulated by a body mentioned in section 25(3) of the National Health Service Reform and Health Care Professions Act 2002) or as otherwise defined in regulations |
| **Member** | a provider of primary medical services to a registered patient list, who is a member of this group (see tables in Chapter 3 and Appendix B) |
| **Practice representatives** | an individual appointed by a practice (who is a member of the group) to act on its behalf in the dealings between it and the group, under regulations made under section 89 or 94 of the 2006 Act (as amended by section 28 of the 2012 Act) or directions under section 98A of the 2006 Act (as inserted by section 49 of the 2012 Act) |
| **Registers of interests** | registers a group is required to maintain and make publicly available under section 14O of the 2006 Act (as inserted by section 25 of the 2012 Act), of the interests of: the members of the group; the members of its governing body; the members of its committees or sub-committees and committees or sub-committees of its governing body; and its employees. |
### APPENDIX B - LIST OF MEMBER PRACTICES

<table>
<thead>
<tr>
<th>Practice Name</th>
<th>Address</th>
<th>Practice representative’s signature &amp; date signed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bridgemary Medical Centre</td>
<td>2 Gregson Avenue, Gosport, PO13 0HR</td>
<td></td>
</tr>
<tr>
<td>Brockhurst Medical Centre</td>
<td>139-141 Brockhurst Road, Gosport PO12 3AX</td>
<td></td>
</tr>
<tr>
<td>Brook Lane Surgery</td>
<td>233a Brook Lane, Sarisbury Green, SO31 7DQ</td>
<td></td>
</tr>
<tr>
<td>Brune Medical Centre</td>
<td>10 Rowner Road, Gosport, PO13 0EW</td>
<td></td>
</tr>
<tr>
<td>Bury Road Surgery</td>
<td>Gosport War Memorial Hospital, Bury Road Gosport PO12 3PW</td>
<td></td>
</tr>
<tr>
<td>The Fareham Centre Practice</td>
<td>Osborn Road, Fareham, PO16 7ER</td>
<td></td>
</tr>
<tr>
<td>Gudge Heath Lane Surgery</td>
<td>187 Gudge Heath Lane, Fareham, PO14 7ER</td>
<td></td>
</tr>
<tr>
<td>Forton Medical Centre</td>
<td>White Place, Gosport, PO12 3JP</td>
<td></td>
</tr>
<tr>
<td>Gosport Medical Centre</td>
<td>Gosport War Memorial Hospital, Bury Road Gosport PO12 3AQ</td>
<td></td>
</tr>
<tr>
<td>Highlands Medical Centre</td>
<td>103 Highlands Road, Fareham, PO15 6JF</td>
<td></td>
</tr>
<tr>
<td>Jubilee Surgery</td>
<td>High Street, Titchfield, PO14 4EH</td>
<td></td>
</tr>
<tr>
<td>Lee on Solent Health Centre</td>
<td>Manor Way, Lee on Solent, PO13 9JG</td>
<td></td>
</tr>
<tr>
<td>Lockswood Road Surgery</td>
<td>Centre Way, Locks Heath, SO31 6DX</td>
<td></td>
</tr>
<tr>
<td>Manor Way Surgery</td>
<td>Manor Way, Lee on Solent, PO13 9JG</td>
<td></td>
</tr>
<tr>
<td>The Portchester Practice</td>
<td>West Street, Portchester, PO16 9TU</td>
<td></td>
</tr>
<tr>
<td>Rowner Health Centre</td>
<td>143 Rowner Road, Gosport, PO13 9SP</td>
<td></td>
</tr>
<tr>
<td>Stubbington Medical Practice</td>
<td>Park Lane, Stubbington, Fareham, PO14 ZJP</td>
<td></td>
</tr>
<tr>
<td>Stoke Road Surgery</td>
<td>66-68 Stoke Road, Gosport, PO12 1PA</td>
<td></td>
</tr>
<tr>
<td>Waterside Medical Centre</td>
<td>Mumby Road, Gosport, PO12 1BA</td>
<td></td>
</tr>
<tr>
<td>Westlands Medical Centre</td>
<td>20b Westlands Grove Portchester, PO16 9AE</td>
<td></td>
</tr>
<tr>
<td>Whiteley Surgery</td>
<td>Yew tree Drive, Whiteley, Fareham, PO16 9AE</td>
<td></td>
</tr>
</tbody>
</table>
1. **STATUTORY FRAMEWORK AND STATUS**

1.1. **Introduction**

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

1.1.2. The standing orders, together with the group’s scheme of reservation and delegation\(^{54}\) and the group’s prime financial policies\(^{55}\), provide a procedural framework within which the group discharges its business. They set out:

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

b) the appointment of member practice representatives;

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

d) the process to delegate powers,

e) the declaration of interests and standards of conduct.

These arrangements must comply, and be consistent where applicable, with requirements set out in the 2006 Act (as amended by the 2012 Act) and related regulations and take account as appropriate\(^{56}\) of any relevant guidance.

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

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

1.2.1. The 2006 Act (as amended by the 2012 Act) provides the group with powers to delegate the group’s functions and those of the governing body to certain bodies (such as committees) and certain persons. The group has decided that certain

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\(^{54}\) See Appendix D

\(^{55}\) See Appendix E
decisions may only be exercised by the group in formal session. These
decisions and also those delegated are contained in the group’s scheme of
reservation and delegation.

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

2.1. Composition of membership

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

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

2.2. Key Roles

2.2.1. Paragraph 6.6.2 of the group’s constitution sets out the composition of the
group’s governing body whilst Chapter 7 of the group’s constitution identifies
certain key roles and responsibilities within the group and its governing body.
These standing orders set out how the group appoints individuals to these key
roles.

2.2.2. The Chair, as listed in paragraph 6.6.2 of the group’s constitution, is subject to
the following appointment process:

a) **Nominations** – individuals put themselves forwards for election by the
Clinical Cabinet

b) **Eligibility** – the Chair shall be a GP who is a member of the CCG and has
been elected to the Clinical Cabinet in elections conducted by the Local
Medical Committee (LMC);

c) **Appointment process** – the Chair shall be selected by the Clinical Cabinet
and confirmed by the Governing Body;

d) **Term of office** – the Chair shall remain in post for a period of no more than
three years;

e) **Eligibility for reappointment** – the reappointment of the Chair follows the
same appointment process;

f) **Grounds for removal from office** – the Chair could be removed from office by
NHS England or if they are or subsequently become:

- Retired from their practice or primary care service provider;
- Suspended by either the General Medical Council or NHS England;
- Subject to serious misconduct proceedings;
- A member of a practice which ceases to be eligible for membership of the CCG;
- Without a contract for the provision of primary medical services within the Area of the Clinical Commissioning Group.

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

2.2.3 The **Deputy Chair** as listed in paragraph 6.6.2 of the group’s constitution, is subject to the following appointment process:

a) **Nominations** – individuals put themselves forwards for the position

b) **Eligibility** – must be a lay member representative and may not be the Chair of the Audit Committee;

c) **Appointment process** – the Deputy Chair will be selected by the Governing Body from the lay members on the Governing Body;

d) **Term of office** – shall remain in post for a period of no more than three years;

e) **Eligibility for reappointment** – the reappointment process is the same as the appointment process. No one shall serve on the governing body as the Deputy Chair for a period of more than two consecutive terms of office (i.e. six years) without a break of at least one year;

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

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

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

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

g) Notice period – three months prior written notice to the Governing Body.

2.2.4 The Accountable Officer as listed in paragraph 6.6.2 of the group’s constitution, is subject to the following appointment process:

a) Nominations – The Accountable Officer shall not be subject to election but shall be appointed subject to a formal application and interview process;

b) Eligibility – The Accountable Officer shall be an individual with experience acting at Very Senior Manager level in the NHS;

c) Appointment process – selection and appointment by the Governing Body following successful outcome of national assessment centre and approval by NHS England;

d) Term of office – no limit;

e) Eligibility for reappointment – not applicable;

f) Grounds for removal from office – the Accountable Officer can be removed from office by the Chair of the CCG under circumstances described in the HR policies

g) Notice period – six months prior written notice to the governing body.

2.2.5 The Clinical Cabinet Members (Representatives of Member Practices) as listed in section 6.6.2 of the group’s constitution, are subject to the following appointment process:

a) Nominations – individuals nominate themselves;

b) Eligibility – must be a GP who is a member, whether they be partners, non-partners or locums, of a member practice of the CCG. At least three of the Clinical Board Members elected by the constituents should be Partners of member practices;

c) Appointment process – elections shall be by simple majority and be conducted by the Local Medical Committee where every member of a member practice shall be able to vote for up to the number of positions that are available. Nominations for Clinical Cabinet Members must be
accompanied by written confirmation of support from a CCG member practice;

d) **Term of office** – shall remain in post for a period of no more than three years;

e) **Eligibility for reappointment** – the re-election process is the same as the election process. No individual shall serve on the Clinical Cabinet for a period of more than two consecutive terms (i.e. six years) without a break of at least three years;

f) **Grounds for removal from office** – A Member of the Clinical Cabinet could be removed from office by NHS England or if they are, or subsequently become:

i) Retired from their practice or primary care service provider;
ii) Suspended by either the General Medical Council or NHS England;
iii) Subject to serious misconduct proceedings;
iv) A member of a practice which ceases to be eligible for membership of the CCG;

v) Without a contract for the provision of primary medical services within the Area of the Clinical Commissioning Group.

vi) No longer supported by a CCG member practice.

vii) Unable to consistently fulfil the requirements of the job description.

g) **Notice period** – three months prior written notice to the governing body.

2.2.6 The **Practice Manager** representatives as listed in section 6.6.2 of the constitution is subject to the following appointment process:

a) **Nominations** – any individual may nominate themselves;

b) **Eligibility** – must be a practice manager or recognised equivalent of a member practice;

c) **Appointment process** – via elections administered by the CCG;

d) **Term of Office** – shall remain in post for a period of no more than three years;

e) **Eligibility for reappointment** – re-election as per the election process. No individual may be a member of the Governing Body for more than two consecutive terms of office (i.e. six years) without a break of at least three years;

f) **Grounds for removal from office** –

i) left member practice;
ii) practice ceases to be eligible for membership;
iii) member practice ceases to hold a contract for the provision of primary medical services within the area of the group;

iv) suspended by the practice;
v) subject to serious misconduct proceedings.

g) Notice period – three months prior written notice to the governing body.

2.2.7 The Lay Members are subject to the following appointment process:

a) Nominations – selection process from members of the local community;

b) Eligibility – One lay member will have recent financial and audit experience and another member will have expertise and knowledge of the local community and shall normally be resident within the area covered by the CCG. One of the lay members will have the additional role of Deputy Chair of the Governing Body;

c) Appointment process – formal application, interview and appointment by the Chair;

d) Term of office - the lay members shall serve on the governing body of the CCG for a period of no more than three years;

e) Eligibility for reappointment – No one shall serve on the governing body as a Lay Member of a period of more than two consecutive terms of office (i.e. six years) without a break of at least three years;

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

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

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

g) Notice period – three months prior written notice to the governing body.

2.2.8 The Registered Nurse, as listed in section 6.6.2 of the group’s constitution, is subject to the following appointment process:

a) Nominations – formal application and interview process;

b) Eligibility – a registered nurse who has developed a high level of professional expertise and knowledge. The individual should have no conflicts of interest i.e. they should not be employed by any organisation from which the CCG secures any significant volume of provision. The individual should bring significant additional perspectives beyond primary care and should not be a general practice employee;

c) Appointment process – formal application and interview by the Chair;

d) Term of office – no limit;

e) Eligibility for reappointment – not applicable;

f) Grounds for removal from office – the Registered Nurse can be removed from office by the Chair of the CCG under circumstances described in the HR policies

g) Notice period – as stipulated in their contract of employment.

h) NHS England

2.2.9 The Secondary Care Specialist Doctor as listed in section 6.6.2 of the group’s constitution, is subject to the following appointment process:

a) Nominations – formal application and interview process;

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

c) Appointment process – formal application and interview by the Chair;

d) Term of office - shall serve on the governing body of the CCG for a period of no more than three years;
e) **Eligibility for reappointment** – no individual may serve on the governing body for a period of more than two consecutive terms of office (i.e. six years) without a break of at least three years;

f) **Grounds for removal from office** -
   i) fully retired from practice;
   ii) suspended by the GMC;
   iii) subject to serious misconduct proceedings;
   iv) the individual becomes employed in an organisation from which the CCG commissions.

g) **Notice period** – three months prior written notice to the governing body.

2.2.10 The **Chief Finance Officer** as listed in section 6.6.2 of the group’s constitution, is subject to the following appointment process:

a) **Nominations** – formal application;

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

c) **Appointment process** – formal application and interview by the Chair and Accountable Officer following successful outcome of national assessment centre;

d) **Grounds for removal from office** – the Chief Finance Officer can be removed from office by the Accountable Officer of the CCG under circumstances described in the HR policies;

e) **Notice period** – as stipulated in their contract of employment.

2.2.11 The **Representative of Hampshire County Council** as listed in section 7.4 of the group’s constitution, will be a Nominated Director.

2.2.12 The **Director of Public Health** as listed in section 7.4 of the group’s constitution, will be appointed Director of Public Health employed by Hampshire County Council.

2.2.13 The roles and responsibilities of each of these key roles are set out throughout section 7 of the group’s constitution.

3. **MEETINGS OF THE CLINICAL COMMISSIONING GROUP**

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

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

3.1.3. The meetings of the Governing Body shall be held at least four/six times per annum and shall be open to the public.

3.1.4. The date, time and venue of all meetings of the Governing Body will be made public with at least five working days’ notice on the CCG website.

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

3.1.6. The AGM of the Governing Body shall be held in premises which are accessible to the public within the geographical area of the CCG.

3.1.7. All members of the Governing Body whether elected or appointed or co-opted members shall be permitted to carry a vote on any decision of the Board. No observer shall carry a vote.

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

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

3.2. **Agenda, supporting papers and business to be transacted**

3.2.1. Items of business to be transacted for inclusion on the agenda of a meeting need to be notified to the Chair of the meeting at least eleven working days (i.e. excluding weekends and bank holidays) before the meeting takes place. Supporting papers for such items need to be submitted at least eleven working days before the meeting takes place.

3.2.2. The Agenda and supporting papers for the meeting will be circulated to all members of a meeting at least five/eight working days before the date the meeting takes place.

3.2.3. The names of the Chair and Members present at the meeting shall be recorded.

3.2.4. Agendas and certain papers for the group’s governing body – including details about meeting dates, times and venues - will be published on the group’s website at www.farehamandgosportccg.nhs.uk and will be available on request either in person, by letter of e-mail to the CCG’s Headquarters at:
3.3. Petitions

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

3.4. Chair of a meeting

3.4.1. At any meeting of the group or its governing body or of a committee or sub-committee, the chair of the group, governing body, committee or sub-committee, if any and if present, shall preside. If the chair is absent from the meeting, the deputy chair, if any and if present, shall preside.

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

3.5. Chair's ruling

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

3.6. Quorum

3.6.1. The Governing Body shall be quorate when there are five voting members present, at least three of which must be clinicians.

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

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

3.6.4. Elected GP members may submit proxy votes in advance of meetings by providing these in writing to the clinical chair. Any proxy votes are to be included in the quorum.

3.6.5. Where any of the positions are occupied on a shared basis by more than one individual that position shall only exercise one vote.
3.6.6. Others may be invited to attend for specific items with the prior agreement of the chair or Accountable officer but shall not count towards the quorum or be able to vote.

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

3.7. Decision Making

3.7.1. Section 9 of the group’s constitution, together with the scheme of reservation and delegation, sets out the governing structure for the exercise of the group’s statutory functions. The Chair will work to establish consensus as the basis for decisions of the governing body. If, exceptionally, the governing body cannot reach a decision, the chair will put the matter to a vote usually by a show of hands. The process for which is set out below:

   a) Eligibility – only designated members of the governing body (as in 6.6.2 of the constitution) may vote. Deputies for members may not vote unless a formal acting-up arrangement is in place;

   b) Majority necessary to confirm a decision – majority of one;

   c) Casting vote – in the event of a tied vote the Chair shall have a second vote;

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

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

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

3.8. Emergency powers and urgent decisions

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

3.8.2. The Chair may call an emergency meeting.
3.8.3. Urgent decisions (those matters that need to be concluded within five working days) may be taken by the Chair (or in their absence, the Deputy Chair), the Accountable Officer (or in their absence, a nominated deputy) and one other member of the governing body. Any decisions of this nature will immediately be conveyed to the Governing Body members via e-mail and a record made of the decision, rationale and the communications.

3.9. Suspension of Standing Orders

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

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

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

3.10. Record of Attendance

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

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

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

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

3.11. Minutes

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

3.11.2. No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate.
3.11.3. Minutes shall be circulated in accordance with members’ wishes. Where providing a record of a public meeting the minutes shall be made available to the public as required by Code of Practice on Openness in the NHS.

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

3.11.5. The minutes will be published on the group’s website at www.farehamandgosportccg.nhs.uk and will be available on request either in person, letter or e-mail to the CCGs Headquarters at:

Post - Room 23, Building 003, Commissioning House, Fort Southwick, James Callaghan Drive, Fareham, Hampshire, PO17 6AR

E-Mail - Nikki.roberts2@hampshire.nhs.uk

3.11.6. Members will receive minutes via e-mail and will also have access via the CCGs website.

3.12. Admission of public and the press

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

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

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

3.12.2 General Disturbances

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

‘That in the interests of public order the meeting adjourn for (the period to be specified) to enable the governing body to complete its business without the presence of the public’. Section 1 (8) Public Bodies (Admission to Meetings) Act 1960.
3.12.3 Business Proposed to be transacted when the press and public have been excluded from a meeting

3.12.3.1 Matters to be dealt with by the governing body following exclusion of representatives of the press, and members of the public, as provided in (3.6.1) and (3.6.2) above shall be confidential to the members of the governing body.

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

3.12.4.1 Nothing in these Standing Orders shall be construed as permitting the introduction by the public, or press representatives, of recording, transmitting, video or similar apparatus into meetings of the governing body or committee thereof. Such permission shall be granted only upon resolution of the governing body.

4. APPOINTMENT OF COMMITTEES AND SUB-COMMITTEES

4.1. Appointment of committees and sub-committees

4.1.1. The group may appoint committees and sub-committees of the group, subject to any regulations made by the Secretary of State, and make provision for the appointment of committees and sub-committees of its governing body.

4.1.2. Committees established by the group are outlined below:

4.1.3. Audit Committee

In line with requirements of the NHS Audit Committee Handbook, NHS Codes of Conduct and Accountability, and more recently the Higgs report, an Audit Committee will be established and constituted to provide the group with an independent and objective review of its financial systems, financial information and compliance with laws, guidance, and regulations governing the NHS. The Terms of Reference will be approved by the Governing Body and reviewed on a periodic basis.

4.1.4. Remuneration Committee

In line with requirements of the NHS Audit Committee Handbook, NHS Codes of Conduct and Accountability, and more recently the Higgs report, a Remuneration Committee will be established and constituted.

The Remuneration Committee, which is accountable to the group’s governing body, makes recommendations to the governing body on determinations about the:

- remuneration, fees and other allowances for CCG employees;
- remuneration, fees and other allowances for people who provide services to
the group; and
- allowances under any pension scheme that the group may establish as an alternative to the NHS pension scheme.

4.1.5. **Community Engagement Committee**

4.1.6. The purpose of the Community Engagement Committee is to support the Clinical Commissioning Group in achieving its strategic objectives by interpreting and influencing both the external and internal environments and by creating positive relationships with stakeholders through the appropriate management of their expectations and agreed

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

4.2. **Delegation of Powers by Committees to Sub-committees**

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

4.3. **Approval of Appointments to Committees and Sub-Committees**

4.3.1. The group shall approve the appointments to each of the committees and sub-committees which it has formally constituted including those of the governing body.

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

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

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

6.1. **Custody of seal**

6.1.1. The seal shall be kept in a secure place by the Accountable Officer.

6.2. **Sealing of Documents**

NHS Fareham and Gosport Clinical Commissioning Group’s Constitution - 55 -
Version: 1.1 NHS England Effective Date: - 1/4/13
6.2.1 Where it is necessary that a document shall be sealed, the seal shall be affixed (by one member of the Governing Body as denoted in section 6.4.1) in the presence of one other who can be a member of the Governing Body, but not also from the originating department and shall be attested by them.

6.3. Register of Sealing

The Governance and Committee Officer shall keep a register and shall enter a record of the sealing of every document.

6.4. Clinical Commissioning Group’s seal

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

a) the Accountable Officer;

b) the chair of the governing body;

c) the Chief Finance Officer;

d) the chief operating officer.

6.5. Use of Seal – General Guide

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

(i) All contracts for the purchase/lease of land and/or building;
(ii) All contracts for capital works exceeding £100,000;
(iii) Any other lease agreement where the total payable under the lease exceeds £100,000;
(iv) Any contract or agreement with organisations other than NHS or other government bodies including local authorities where the annual costs exceed or are expected to exceed £100,000.

6.6. Execution of a document by signature

6.6.1. Where any document will be a necessary step in legal proceedings on behalf of the group, it shall, unless enactment or otherwise requires or authorises, be signed by the Accountable Officer, or any Executive Director/Officer.

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

a) the Accountable Officer;

b) the chair of the governing body;
c) the Chief Finance Officer;

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

7.1. Policy statements: general principles

7.1.1. The governing body will from time to time agree and approve policy statements/procedures which will apply to all or specific groups of staff employed by NHS Fareham and Gosport Clinical Commissioning Group. The decisions to approve such policies and procedures will be recorded in an appropriate group minute and will be deemed where appropriate to be an integral part of the group’s standing orders.
APPENDIX D – SCHEME OF RESERVATION & DELEGATION

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

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

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

1.3. The following table shows those matters which are reserved and delegated for the discharge of the groups’ functions.
<table>
<thead>
<tr>
<th>Policy Area</th>
<th>No</th>
<th>Decision</th>
<th>Reserved to the Membership</th>
<th>Reserved or delegated to Governing Body</th>
<th>Clinical Cabinet</th>
<th>Remuneration Committee</th>
<th>Audit Committee</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. REGULATION AND CONTROL</td>
<td>1.1</td>
<td>Determine the arrangements by which the members of the group approve those decisions that are reserved for the membership.</td>
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<td>1.2</td>
<td></td>
<td>Consideration and approval of applications to NHS England on any matter concerning changes to the group’s constitution, including terms of reference for the group’s governing body, its committees, membership of committees, the overarching scheme of reservation and delegated powers, arrangements for taking urgent decisions, standing orders and prime financial policies.</td>
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<td>1.3</td>
<td></td>
<td>Prepare the group’s overarching scheme of reservation and delegation, which sets out those decisions of the group reserved to the membership and those delegated to the:</td>
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<td></td>
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<td>- Group’s governing body</td>
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<td></td>
<td>- Committees and sub-committees of the group, or</td>
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<td>- Its members or employees</td>
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<td></td>
<td>And sets out those decisions of the governing body reserved to the governing body and those delegated to the:</td>
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<td>- Governing body's committees and sub-committees;</td>
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<td>- Members of the governing body;</td>
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<td>- An individual who is a member of the group but not the governing body or a specified person for inclusion in the group’s constitution</td>
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<td>Policy Area</td>
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<td>Reserved to the Membership</td>
<td>Reserved or delegated to Governing Body</td>
<td>Clinical Cabinet</td>
<td>Remuneration Committee</td>
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<td>1.4</td>
<td>Approval of the group’s overarching scheme of reservation and delegation.</td>
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<td></td>
<td>1.5</td>
<td>Prepare the group’s operational scheme of delegation, which sets out those key operational decisions delegated to individual employees of the clinical commissioning group, not for inclusion in the group’s constitution.</td>
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<td></td>
<td>1.6</td>
<td>Approval of the group’s operational scheme of delegation that underpins the group’s ‘overarching scheme of reservation and delegation’ as set out in its constitution.</td>
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<td>1.7</td>
<td>Prepare detailed financial policies that underpin the clinical commissioning group’s prime financial policies.</td>
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<td>1.8</td>
<td>Approve detailed financial policies.</td>
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<td>1.9</td>
<td>Approve arrangements for making exceptional funding requests.</td>
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<td></td>
<td>1.10</td>
<td>Set out (within the Group’s Standing Orders) who can execute a document by signature / use of the seal.</td>
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<tr>
<td><strong>2. PRACTICE MEMBER REPRESENTATIVES AND MEMBERS OF THE GOVERNING BODY</strong></td>
<td>2.1</td>
<td>Approve the arrangements for:</td>
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<td></td>
<td>o Identifying practice members to represent practices in matters concerning the work of the group; and</td>
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<td>o Appointing clinical leaders to represent the group’s membership on the group’s governing body.</td>
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<td>Policy Area</td>
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<td>2.2</td>
<td>Approve the appointment of governing body members, the process for recruiting and removing non-elected members to the governing body (subject to any regulatory requirements) and succession planning.</td>
<td>✓</td>
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<td>2.3</td>
<td>Approve arrangements for identifying the group’s proposed Accountable Officer.</td>
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<td>✓</td>
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<tr>
<td>3. STRATEGY AND PLANNING</td>
<td>3.1</td>
<td>Agree the vision, values and overall strategic direction of the group.</td>
<td>✓</td>
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<td></td>
<td>3.2</td>
<td>Approval of the group’s operating structure.</td>
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<td>✓</td>
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<td></td>
<td>3.3</td>
<td>Approval of the group’s commissioning plan.</td>
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<td>✓</td>
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<td></td>
<td>3.4</td>
<td>Approval of the group’s corporate budgets that meet the financial duties as set out in section 5.3 of the main body of the constitution.</td>
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<td></td>
<td>3.5</td>
<td>Approval of variations to the approved budget where variation would have a significant impact on the overall approved levels of income and expenditure or the group’s ability to achieve its agreed strategic aims.</td>
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<td>✓</td>
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<td></td>
<td>3.6</td>
<td>Approve common commissioning strategies and approaches and provider proposals, outline business cases within agreed limits, clinical priority statements and locality constitutions.</td>
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<td>✓</td>
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<td>3.7</td>
<td>Agree priorities for the CCG, developments and solutions to needs and delivery, including the group’s QIPP requirements.</td>
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<td>✓</td>
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<tr>
<td>Policy Area</td>
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<td>Audit Committee</td>
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<td>3.8</td>
<td></td>
<td>Advise on or approve matters relating to primary care contracting, specifically in relation to commissioning Locally Enhanced Services, Out of Hour services and Walk-in Centres.</td>
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<tr>
<td>4. ANNUAL REPORTS AND ACCOUNTS</td>
<td>4.1</td>
<td>Approval of the group’s annual report and annual accounts.</td>
<td>✅</td>
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<td></td>
<td>4.2</td>
<td>Review the group’s annual accounts prior to submission to Governing Body.</td>
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<td>✓</td>
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<td></td>
<td>4.3</td>
<td>Approval of the arrangements for discharging the group’s statutory financial duties.</td>
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<td>✓</td>
</tr>
<tr>
<td>5. HUMAN RESOURCES</td>
<td>5.1</td>
<td>Approve the terms and conditions, remuneration and travelling or other allowances for governing body members, including pensions and gratuities.</td>
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<td>✓</td>
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<td></td>
<td>5.2</td>
<td>Approve terms and conditions of employment for all employees of the group including, pensions, remuneration, fees and travelling or other allowances payable to employees and to other persons providing services to the group.</td>
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<td>5.3</td>
<td>Approve any other terms and conditions of employment for all employees of the group.</td>
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<td>5.4</td>
<td>Determine the terms and conditions of employment for all employees of the group.</td>
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<td>✓</td>
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<td></td>
<td>5.5</td>
<td>Determine pensions, remuneration, fees and allowances payable to employees and to other persons providing services to the group.</td>
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<td>✓</td>
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<tr>
<td>Policy Area</td>
<td>No</td>
<td>Decision</td>
<td>Reserved to the Membership</td>
<td>Reserved or delegated to Governing Body</td>
<td>Clinical Cabinet</td>
<td>Remuneration Committee</td>
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<td>5.6</td>
<td>Recommend pensions, remuneration, fees and allowances payable to employees and to other persons providing services to the group.</td>
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<td>5.7</td>
<td>Approve disciplinary arrangements for employees, including the Accountable Officer (where he/she is an employee or member of the clinical commissioning group) and for other persons working on behalf of the group.</td>
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<td>✓</td>
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<td>5.8</td>
<td>Review disciplinary arrangements where the Accountable Officer is an employee or member of the clinical commissioning group.</td>
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<td>✓</td>
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<td></td>
<td>5.9</td>
<td>Approval of the arrangements for discharging the group’s statutory duties as an employer.</td>
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<td>✓</td>
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<td>5.10</td>
<td>Approve Human Resources policies for employees and for other persons working on behalf of the group.</td>
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<td>✓</td>
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<td>5.11</td>
<td>Determine arrangements for termination of employment and other contractual terms.</td>
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<td>✓</td>
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<tr>
<td>6. QUALITY AND SAFETY</td>
<td>6.1</td>
<td>Approve arrangements, including supporting policies, to minimise clinical risk, maximise patient safety and to secure continuous improvement in quality and patient outcomes.</td>
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<td>✓</td>
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<td></td>
<td>6.2</td>
<td>Approve arrangements for supporting NHS England in discharging its responsibilities in relation to securing continuous improvement in the quality of general medical services.</td>
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<td>6.3</td>
<td>Approve arrangements to drive improvements in healthcare assurances within the providers from whom the CCG commissions care so that providers demonstrate year on year improvements, identifying and managing risk and underperformance.</td>
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<td>6.4</td>
<td>Provide assurance to the governing body and member practices that appropriate systems and processes are in place to realise continuous improvement in the quality of commissioned services and to ensure wider system learning from any emergent issues relating to poor quality service provision.</td>
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<td>6.5</td>
<td>Receive and scrutinise independent investigation reports relating to patient safety issues and agree publication plans.</td>
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<td>6.6</td>
<td>Ensure there are effective early warning systems which draw on a range of quality indicators and other sources of information to identify gaps in assurance about providers.</td>
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<td>6.7</td>
<td>Respond to specific clinical governance and healthcare assurance issues identified by the Clinical Cabinet, Governing Body and external regulatory bodies.</td>
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<td>7. OPERATIONAL AND RISK MANAGEMENT</td>
<td>7.1</td>
<td>Prepare and recommend an operational scheme of delegation that sets out who has responsibility for operational decisions within the group.</td>
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<td>7.2</td>
<td>Approve the group’s counter fraud and security management arrangements.</td>
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<p>|                                   |    | 7.3 Approval of the group’s risk management arrangements.                  |                             |                                        |                 |                        |                 |
|                                   |    | 7.4 Approve arrangements for risk sharing and or risk pooling with other organisations (for example arrangements for pooled funds with other clinical commissioning groups or pooled budget arrangements under section 75 of the NHS Act 2006). |                             | ![Check]                                              |                 |                        |                 |
|                                   |    | 7.5 Approval of a comprehensive system of internal control, including budgetary control, that underpins the effective, efficient and economic operation of the group. |                             |                                        |                 | ![Check]               |                 |
|                                   |    | 7.6 Approve proposals for action on litigation against or on behalf of the clinical commissioning group. |                             | ![Check]                                              |                 |                        |                 |
|                                   |    | 7.7 Approve the group’s arrangements for business continuity and emergency planning. |                             | ![Check]                                              |                 |                        |                 |
|                                   |    | 7.8 Approve the group’s arrangements for managing dispute resolution.       |                             | ![Check]                                              |                 |                        |                 |
| 8. INFORMATION GOVERNANCE         |    | 8.1 Approve the group’s arrangements for handling complaints.             |                             | ![Check]                                              |                 |                        |                 |
|                                   |    | 8.2 Approval of the arrangements for ensuring appropriate and safekeeping and confidentiality of records and for the storage, management and transfer of information and data. |                             | ![Check]                                              |                 |                        |                 |
| 9. TENDERING AND CONTRACTING      |    | 9.1 Approval of the group’s contracts for any commissioning support.      |                             | ![Check]                                              |                 |                        |                 |</p>
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<th>Remuneration Committee</th>
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<tr>
<td>9.2 Approval of the group’s contracts for corporate support (for example finance provision).</td>
<td>10.1</td>
<td>Approve decisions that individual members or employees of the group participating in joint arrangements on behalf of the group can make. Such delegated decisions must be disclosed in this scheme of reservation and delegation.</td>
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<td>10. PARTNERSHIP WORKING</td>
<td>10.2</td>
<td>Approve decisions delegated to joint committees established under section 75 of the 2006 Act.</td>
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<td>11. COMMISSIONING AND CONTRACTING FOR CLINICAL SERVICES</td>
<td>11.1</td>
<td>Approval of the arrangements for discharging the group’s statutory duties associated with its commissioning functions, including but not limited to promoting the involvement of each patient, patient choice, reducing inequalities, improvement in the quality of services, obtaining appropriate advice and public engagement and consultation.</td>
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<td>11.2 Approve arrangements for co-ordinating the commissioning of services with other groups and or with the local authority(ies), where appropriate</td>
<td>12.1</td>
<td>Approving arrangements for handling Freedom of Information requests.</td>
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<tr>
<td>12. COMMUNICATIONS</td>
<td>12.2</td>
<td>Determining arrangements for handling Freedom of Information requests</td>
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APPENDIX E – PRIME FINANCIAL POLICIES

1. INTRODUCTION

1.1. General

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

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

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

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

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

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

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

1.2. Overriding Prime Financial Policies

1.2.1. If for any reason these prime financial policies are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next formal meeting of the governing body’s audit committee for referring action or ratification. All of the group’s members and employees have a duty to disclose any non-compliance with these prime financial policies to the Chief Finance Officer as soon as possible.
1.3. Responsibilities and delegation

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

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

1.4. Contractors and their employees

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

1.5. Amendment of Prime Financial Policies

1.5.1. To ensure that these prime financial policies remain up-to-date and relevant, the Chief Finance Officer will review them at least annually. Following consultation with the Accountable Officer and scrutiny by the governing body’s audit committee, the Chief Finance Officer will recommend amendments, as fitting, to the governing body for approval. As these prime financial policies are an integral part of the group’s constitution, any amendment will not come into force until the group applies to NHS England and that application is granted.

2. INTERNAL CONTROL

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

2.1. The governing body is required to establish an audit committee with terms of reference agreed by the governing body (see paragraph 6.6.3(a) of the group’s constitution for further information).

2.2. The Accountable Officer has overall responsibility for the group’s systems of internal control.

2.3. The Chief Finance Officer will ensure that:

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

   b) a system is in place for proper checking and reporting of all breaches of financial policies; and
c) a proper procedure is in place for regular checking of the adequacy and effectiveness of the control environment.

3. **AUDIT**

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

3.1. The person appointed by the group to be responsible for internal audit and the appointed external auditor will have direct and unrestricted access to audit committee members and the chair of the governing body, Accountable Officer and Chief Finance Officer for any significant issues arising from audit work that management cannot resolve, and for all cases of fraud or serious irregularity.

3.2. The person appointed by the group to be responsible for internal audit and the external auditor will have access to the audit committee and the Accountable Officer to review audit issues as appropriate. All audit committee members, the chair of the governing body and the Accountable Officer will have direct and unrestricted access to the head of internal audit and external auditors.

3.3. The Chief Finance Officer will ensure that:

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

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

4. **FRAUD AND CORRUPTION**

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

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

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

5.1. The group is required by statutory provisions\(^{58}\) to ensure that its expenditure does not exceed the aggregate of allotments from NHS England and any other sums it has received and is legally allowed to spend.

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

5.3. The Chief Finance Officer will:

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

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

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

6. ALLOTMENTS\(^{59}\)

6.1. The group’s Chief Finance Officer will:

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

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

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

7. COMMISSIONING STRATEGY, BUDGETS, BUDGETARY CONTROL AND MONITORING

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\(^{58}\) See section 223H of the 2006 Act, inserted by section 27 of the 2012 Act

\(^{59}\) See section 223(G) of the 2006 Act, inserted by section 27 of the 2012 Act.
POLICY – the group will produce and publish an annual commissioning plan\textsuperscript{60} that explains how it proposes to discharge its financial duties. The group will support this with comprehensive medium term financial plans and annual budgets.

7.1. The Accountable Officer will compile and submit to the governing body a commissioning strategy which takes into account financial targets and forecast limits of available resources.

7.2. Prior to the start of the financial year the Chief Finance Officer will, on behalf of the Accountable Officer, prepare and submit budgets for approval by the governing body.

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

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

7.5. The governing body will approve consultation arrangements for the group’s commissioning plan\textsuperscript{61}.

8. ANNUAL ACCOUNTS AND REPORTS

POLICY – the group will produce and submit to NHS England accounts and reports in accordance with all statutory obligations\textsuperscript{62}, relevant accounting standards and accounting best practice in the form and content and at the time required by NHS England.

8.1. The Chief Finance Officer will ensure the group:

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

b) prepares the accounts according to the timetable:

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

\textsuperscript{60} See section 14Z11 of the 2006 Act, inserted by section 26 of the 2012 Act.
\textsuperscript{61} See section 14Z13 of the 2006 Act, inserted by section 26 of the 2012 Act.
\textsuperscript{62} See paragraph 17 of Schedule 1A of the 2006 Act, as inserted by Schedule 2 of the 2012 Act.
d) considers the external auditor’s management letter and fully address all issues within agreed timescales; and

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

9. INFORMATION TECHNOLOGY

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

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

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

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

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

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

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

10.1. The Chief Finance Officer will ensure:

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

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

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

11. BANK ACCOUNTS

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

11.1. The Chief Finance Officer will:

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

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

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

11.2. The audit committee shall approve the banking arrangements.

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63 See section 223H(3) of the NHS Act 2006, inserted by section 27 of the 2012 Act
12. INCOME, FEES AND CHARGES AND SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS.

POLICY – the group will
- operate a sound system for prompt recording, invoicing and collection of all monies due
- seek to maximise its potential to raise additional income only to the extent that it does not interfere with the performance of the group or its functions\(^{64}\)
- ensure its power to make grants and loans is used to discharge its functions effectively\(^{65}\)

12.1. The Chief Finance Officer is responsible for:

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

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

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

d) developing effective arrangements for making grants or loans.

13. TENDERING AND CONTRACTING PROCEDURE

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

13.1. The group shall ensure that the firms / individuals invited to tender (and where appropriate, quote) are among those on approved lists or where necessary a

\(^{64}\) See section 14Z5 of the 2006 Act, inserted by section 26 of the 2012 Act.
\(^{65}\) See section 14Z6 of the 2006 Act, inserted by section 26 of the 2012 Act.
framework agreement. Where in the opinion of the Chief Finance Officer it is desirable to seek tenders from firms not on the approved lists, the reason shall be recorded in writing to the Accountable Officer.

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

a) the group’s standing orders;

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

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

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

14. COMMISSIONING

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

14.1. The group will coordinate its work with NHS England, other clinical commissioning groups, local providers of services, local authority (ies), including through Health & Wellbeing Boards, patients and their carers and the voluntary sector and others as appropriate to develop robust commissioning plans.

14.2. The Accountable Officer will establish arrangements to ensure that regular reports are provided to the governing body detailing actual and forecast expenditure and activity for each contract.

14.3. The Chief Finance Officer will maintain a system of financial monitoring to ensure the effective accounting of expenditure under contracts. This should provide a suitable audit trail for all payments made under the contracts whilst maintaining patient confidentiality.
15. **RISK MANAGEMENT AND INSURANCE**

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

15.1 The Group will manage risk by:

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

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

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

16. **PAYROLL**

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

16.1 The Chief Finance Officer will ensure that the payroll service selected:

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

b) has adequate internal controls and audit review processes;

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

16.2 In addition the chief finance office shall set out comprehensive procedures for the effective processing of payroll
17. NON-PAY EXPENDITURE

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

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

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

17.3. The Chief Finance Officer will:

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

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

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

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

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

18.1. The Accountable Officer will

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

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

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

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

18.2. The Chief Finance Officer will prepare detailed procedures for the disposals of assets.

19. RETENTION OF RECORDS

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

19.1. The Accountable Officer shall:

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

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

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

20. TRUST FUNDS AND TRUSTEES

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

20.1. The Chief Finance Officer shall ensure that each trust fund which the group is responsible for managing is managed appropriately with regard to its purpose and to its requirements.
APPENDIX F - NOLAN PRINCIPLES

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

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

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

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

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

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

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

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

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

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66 Available at http://www.public-standards.gov.uk/
APPENDIX G – NHS CONSTITUTION

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

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

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

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

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

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

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

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

Source: *The NHS Constitution: The NHS belongs to us all* (March 2012)67

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APPENDIX H – TERMS OF REFERENCE FOR THE AUDIT COMMITTEE

1.0 CONSTITUTION

1.1 The Audit Committee (the Committee) is a Committee of the Clinical Commissioning Group (CCG) Governing Body and has those executive powers specifically delegated to it by the CCG Governing body within the Scheme of Reservation and Delegation and in these Terms of Reference, which will be reviewed annually by the CCG Governing Body.

1.2 In line with requirements of the NHS Audit Committee Handbook, NHS Codes of Conduct and Accountability, and more recently the Higgs report, an Audit Committee will be established and constituted to provide the group with an independent and objective review of its financial systems, financial information and compliance with laws, guidance, and regulations governing the NHS.

2.0 PURPOSE

2.1 The Audit Committee, which is accountable to the group’s governing body, will support the governing body discharge its functions related to overseeing efficiency, effectiveness, economy and governance.

2.2 The committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the group’s activities that support the achievement of the group’s objectives.

2.3 This will include providing the governing body 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.

2.2 The Committee will:

- support the CCG Governing Body in its governance and oversight role;
- provide assurance and scrutiny on objectives and risks;
- monitor the effectiveness of systems;
- oversee the Assurance Framework;
- oversee external audit, internal audit, local counter fraud services and other external assurance functions;
- review the CCG’s Annual Accounts prior to approval by the CCG Governing Body;
- review the register of gifts and hospitality;
- review the register of interests;
- review policies for ensuring compliance with regulatory, legal and code of conduct reporting requirements;
- review of risk and control related disclosure statements

3.0 RESPONSIBILITIES

3.1 The Committee has a number of principle responsibilities as follows:

3.2 INTEGRATED GOVERNANCE, RISK MANAGEMENT AND INTERNAL CONTROL

3.2.1 The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the CCG’s activities that support the achievement of the CCG’s objectives.
3.2.3 In particular, the Committee will review the adequacy and effectiveness of:

- Financial planning, reporting and controls;
- Integrated governance systems and processes;
- All risk and control related disclosure statements (in particular the annual governance statement), together with any accompanying Head of Internal Audit statement and declarations of compliance with External Audit opinion any other appropriate independent assurances, prior to endorsement or approval by the CCG Governing Body;
- The underlying assurance processes that indicate the degree of achievement of CCG corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements;
- The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certification; and
- The policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the NHS Counter Fraud and Security Management Service.

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

3.3 EXTERNAL AUDIT

3.3.1 The Committee shall review the work and findings of the external auditors and consider the implications and management’s responses to their work. This will be achieved by:

- Consideration of the performance of the external auditors, as far as the rules governing the appointment permit;
- Discussion and agreement with the external auditors, before the audit commences, on the nature and scope of the audit as set out in the annual plan, and ensure co-ordination, as appropriate, with other external auditors in the local health economy;
- Discussion with the external auditors of their local evaluation of audit risks and assessment of the CCG and associated impact on the audit fee;
- Review of all external audit reports, including agreement of the annual audit letter before submission to the CCG Governing Body and any work undertaken outside the annual audit plan, together with the appropriateness of management responses.
- Discussing any problems and/or reservations arising from the external auditors work and any other matters the external auditor may wish to discuss (in the absence of CCG officers, as necessary).

3.4 INTERNAL AUDIT

3.4.1 The Committee shall ensure that there is an effective internal audit function that meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Accountable Officer and CCG Governing Body. This will be achieved by:

- Consideration of the provision of the internal audit service, the cost of the audit and any questions of resignation and dismissal.
• Review and approval of the internal audit strategic plan and annual audit plan, ensuring it is consistent with the audit needs of the organisation, as identified in the assurance framework.
• Considering the major findings of internal audit work (and management’s response) and ensuring co-ordination between the internal and external auditors to optimise audit resources.
• Ensuring that the internal audit function is adequately resourced and has appropriate standing within the clinical commissioning group.
• Undertaking an annual review of the effectiveness of internal audit.

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

3.5 OTHER ASSURANCE FUNCTIONS

3.5.1 The audit committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications for the governance of the CCG.

3.5.2 These will include, but will not be limited to, any reviews by Department of Health arm’s length bodies or regulators/inspectors (for example, the Care Quality Commission and NHS Litigation Authority) and professional bodies with responsibility for the performance of staff or functions (for example, Royal Colleges and accreditation bodies).

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

3.6 COUNTER FRAUD

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

3.7 FINANCIAL REPORTING

3.7.1 The Audit Committee shall monitor the integrity of the financial statements of the CCG and any formal announcements relating to the CCG’s financial performance.

3.7.2 The Committee shall ensure that the systems for financial reporting to the CCG, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the CCG Governing Body.

3.7.3 The Committee shall review the Annual Accounts, and where possible, the Annual Report before submission to the Governing Body, focusing particularly on:

• The wording in the annual governance statement and other disclosures relevant to the terms of reference of the Committee;
• Changes in, and compliance with, accounting policies, practices and estimation techniques;
• Unadjusted mis-statements in the financial statements;
• Significant judgements in preparing of the financial statements;
• Significant adjustments resulting from the audit;
• Letter of representation; and
• Qualitative aspects of financial reporting.
4.0 SCOPE OF AUTHORITY AND DECISION-MAKING

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

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

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

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

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

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

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

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

- receive the External Audit Plan with the external auditor before the Audit commences and agree the extent of reliance to be placed upon the Annual Internal Audit Report
  - review the external audit Annual Audit Letter and management response
  - agree, on an annual basis, the programme of internal audit review for the coming year and endorse any subsequent variation in this programme
  - review the Annual Governance Statement which should reflect the findings of relevant self assessments or inspections for example, Care Quality Commission reports, internal audit reports and the Assurance Framework
  - review the work plan and periodic reports of the local counter fraud service and consider actions necessary by the CCG to combat fraud and corruption
  - consider any other issues relating to internal control, such as variations to Standing Orders and Prime Financial Policies, schedules of losses & compensations, and receive details pertaining to the use of CCG’s official Seal
  - a review of every decision to suspend Standing Orders, as required by Standing Orders

5.0 MEMBERSHIP, QUORUM AND ATTENDANCE

5.1 The Committee will have four voting members and will comprise the two lay members from...
the governing body and two lay members from South Eastern Hampshire CCG’s governing body.

5.2 The Committee will be chaired by Fareham & Gosport CCG’s lay member for governance.

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

5.4 The Committee has the power to invite others to attend (including other CCG employees) when it believes this would provide it with relevant and necessary expertise and experience that otherwise would not be available to it, particularly when the Committee is discussing areas of risk or operation that are the responsibility of that individual.

5.5 Representatives from NHS Protect may be invited to attend meetings and will normally attend at least one meeting each year.

5.6 Regardless of attendance, external audit, internal audit, local counter fraud and security management (NHS Protect) providers will have full and unrestricted rights of access to the audit committee.

5.7 The Accountable Officer would normally be invited to attend and discuss, at least annually with the Committee, the process for assurance that supports the statement on internal control. The Accountable Officer would also normally attend when the Committee considers the draft internal audit plan and the annual accounts.

5.8 The Chair of the Governing Body will not be a member of the Committee, but may be invited to attend one meeting each year in order to form a view on, and understanding of, the Committee’s operations.

5.9 The meetings will be quorate when there are two voting members present, one of whom must be a Fareham & Gosport lay member.

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

6.0 FREQUENCY

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

6.2 The External Auditor, Internal Audit or Local Counter Fraud Service may request a meeting should they consider that one is necessary.

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

7.0 MANAGEMENT

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

7.2 In the case of an equality of votes, the Chair shall have a second vote which will be the casting vote.
7.3 The Chair will provide reports on the work of the Committee to Part I or Part II of the CCG Governing Body meeting according to the nature of the business to be reported.

7.4 The Committee shall receive secretarial services from the Governance and Committee Team.

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

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

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

7.8 The Committee should conduct its business in accordance with any national guidance and relevant codes of conduct/good governance practice e.g. the Nolan report.

7.9 The Committee should review its own performance in line with the Audit Committee Handbook, membership and terms of reference on an annual basis. Any resulting changes to the terms of reference or membership should be approved by the Governing Body.

8.0 REPORTING

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

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

8.3 The Committee will ensure that it monitors the adequacy and effectiveness of its work in support of the Annual Governance Statement, specifically commenting on the fitness for purpose of the Assurance Framework, the completeness and embeddedness of risk management in the organisation and the integration of governance arrangements.
APPENDIX I – TERMS OF REFERENCE FOR THE REMUNERATION COMMITTEE

1.0 CONSTITUTION

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

2.0 PURPOSE

2.1 In line with requirements of the NHS Audit Committee Handbook, NHS Codes of Conduct and Accountability, and more recently the Higgs report, a Remuneration Committee will be established and constituted. The Remuneration Committee, which is accountable to the group’s governing body, makes recommendations to the governing body on determinations about the:

- remuneration, fees and other allowances for CCG employees;
- remuneration, fees and other allowances for people who provide services to the group; and
- allowances under any pension scheme that the group may establish as an alternative to the NHS pension scheme.

3.0 RESPONSIBILITIES

3.1 The responsibilities of the Committee are to:

- Review and approve pay arrangements for employees of the CCG;
- Review and approve remuneration for Governing Body members;
- Consider national guidance and requirements in relation to pay and remuneration;
- Review and approve policies related to workforce matters;
- Consider reports on workforce numbers, costs and key performance indicators;
- Review and consider staff survey (or equivalent), process and reports, recognising that people are the group’s most valuable asset;
- Scrutinise matters related to remuneration, obtaining advice/approval from other agencies as appropriate (i.e. HM Treasury for termination payments).
- assist the CCG Chair evaluate the performance of the Accountable Officer and, through the Accountable Officer, the Chief Finance Officer, and advise on and oversee appropriate contractual arrangements for such staff.

4.0 SCOPE OF AUTHORITY AND DECISION-MAKING
4.1 The Committee is required to work in accordance with these Terms of Reference and the CCG’s Standing Orders, Prime Financial Policies and Scheme of Reservation and Delegation.

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

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

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

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

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

6.0 MEMBERSHIP, QUORUM AND ATTENDANCE

6.1 Only members of the Governing Body may be members of the Remuneration Committee. The member practices should not be in the majority.

6.2 The Committee will comprise two lay members and two elected member practice representatives from the governing body.

6.3 The Committee will be chaired by the lay member for governance.

6.4 The Accountable Officer and Chief Finance Officer will attend Committee meetings, but will not be present for matters involving their personal remuneration.

6.5 The meetings will be quorate when there are two voting members present, at least one being a lay member.

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

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

6.0 FREQUENCY
6.1 Meetings shall be held a minimum of twice a year. Additional meetings may be called by the Chair if deemed necessary.

7.0 MANAGEMENT

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

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

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

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

7.5 Minutes of the CCG Governing Body’s meetings should record such decisions. Where reports to the CCG Governing Body contain confidential information about individuals, these should be considered in Part II of the CCG Governing Body meeting.

7.6 The Committee shall receive secretarial support from the Governance and Committee team.

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

8.0 REPORTING

8.1 The Committee will report to the CCG Governing Body. The minutes of the Committee shall be formally recorded and submitted to the Governing Body.

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

8.3 The Committee Chair shall draw to the attention of the CCG Governing Body any issues which require full disclosure to the CCG Governing Body.
9.0 TERMS OF SERVICE COMMITTEE

9.1 The Remuneration Committees for Fareham & Gosport Clinical and South Eastern Hampshire Commissioning Groups will meet together to discuss the joint appointments between the two Clinical Commissioning Groups. There will be separate terms of reference for this committee but for any decision to be binding it must, at a minimum, meet the requirements set out in these terms of reference.
APPENDIX J – TERMS OF REFERENCE FOR THE JOINT QUALITY & SAFETY COMMITTEE

1. Purpose of the Committee

The Joint Quality and Safety Committee (the committee) is established in accordance with South Eastern and Fareham and Gosport Clinical Commissioning Group constitutions, standing orders, scheme of delegation and compact agreement. These terms of reference set out the membership, remit responsibilities and reporting arrangements of the committee and shall have effect as if incorporated into the CCGs’ constitution and standing orders. The committee will promote and assure quality so that the CCG population has effective and safe care with a positive experience of services. The committee is responsible for the development and implementation of the CCGs’ quality frameworks, which set out the strategies for quality improvement and quality assurance of services provided to its population.

2. Responsibilities of the Committee

The committee will:

- Ensure that the CCGs’ ‘Commissioning for Quality’ strategic framework is developed and implemented so as to support the South Eastern Hampshire CCG and Fareham and Gosport CCG commissioning strategies. In doing so, the committee will seek assurance that commissioning incorporates and upholds the tenets of quality; (patient safety, experience and clinical effectiveness), and that the quality priorities within the NHS Mandate, NHS Outcomes Framework, Operating Framework and recommendations for the National Quality Board are met.

- Provide assurance to the CCGs’ governing bodies that quality assurance and clinical governance mechanisms are integral to monitoring commissioned services to ensure better outcomes for patients.

- Ensure that the quality agenda including patient experience, safety and outcomes, leads to improvements in productivity and prevention through innovation and provide assurance that patient safety is not compromised by commissioners’ decisions.

- Oversee processes to be assured of the effective and safe management of the investigation of serious incidents, never events and subsequent compliance with investigation recommendations, including organisational learning, to reduce risk of recurrence within commissioned services.

- Oversee the development and monitoring of quality indicators and metrics within commissioned services and seek assurance of implementation through quality schedules.
• Liaise with the Wessex Local Area Team (NHS England) to ensure appropriate and timely sharing of quality information, enabling assurance of the quality of services in primary care and for specialised services, for the CCGs’ population.

• Oversee the development of Commissioning for Quality and Innovation (CQUIN) schemes and other incentive schemes to promote quality improvement including patient experience in commissioned services.

• Receive minutes and papers from the pan Hampshire Vulnerable Person’s Committee, whose role is to scrutinise assurance reports that identify themes and statutory regulations in areas of non-compliance in relation to safeguarding children and safeguarding vulnerable adults. The Quality & Safety Committee will ensure action is taken on recommended areas for change through the commissioning process.

• Receive and scrutinise reports relating to Healthcare Associated Infections (HCAI) to provide the Committee with assurance that all commissioned services are compliant with statutory regulations.

• Receive and scrutinise reports relating to patient experience, including Patient Advice and Liaison Service (PALS) and complaints, and surveys that identify themes and trends and recommend areas for change through the commissioning process, linking with the CCG’s stakeholder engagement committees and other relevant patient experience groups.

• Review and provide commissioner response to provider annual Quality Accounts.

• Advise the governing bodies on actions required following national enquiries, national and local reviews undertaken by external agencies (e.g. Care Quality Commission) in relation to commissioned services and oversee the performance management of recommendations implementation.

• Ensure clear escalation and monitoring processes, including early warning systems are in place to identify areas of concern in commissioned services, to enable appropriate engagement of external bodies (e.g. NHS Commissioning Board, Care Quality Commission).

• Scrutinise and seek assurance on the performance of commissioned services with regard to regulatory requirements in relation to quality and safety, e.g. Care Quality Commission, Monitor, National Institute for Health and Excellence (NICE) recommendations/guidelines.

• Promote research and development within commissioned services and seek assurance of robust research governance that is in accordance with the Research Governance Framework (DH revised 2011).
• Maintain an oversight of transitional arrangements as determined by the National Quality Board to ensure robust handover processes between organisations and in doing so safeguarding quality of care.

3. Membership

Following agreement from the CCG, membership will comprise:

- Chair and co-chair: CCG Lay Member Governance Lead x2
- CCG Chief Quality Officer
- Deputy Chief Quality Officer
- CCG Governing Body GP Executive members – quality leads x 2
- CCG Governing Body Secondary Care Doctors x 2
- CCG Governing Body Lay members for patient engagement and experience x2
- Head of Quality and Patient Experience
- HealthWatch Representative
- Safeguarding Lead for Children
- Safeguarding Lead for Adults
- Hampshire County Council Adult Services Team representative

Co-opted members may include:

- CCG Quality Team members
- Patient Experience and Engagement Leads
- Clinical representatives from commissioned services

4. Quorum and attendance

For this meeting to be quorate the following CCG members should be in attendance:

a) The chair or co-chair
b) 1 executive clinical lead from each CCG or their appointed deputy
c) The chief quality officer or deputy chief quality officer
d) 1 lay member or lay secondary care doctor from each CCG

Additional members may be co-opted to contribute to specialised areas of discussion. Fully briefed deputies with relevant decision making authority shall be permitted, where necessary, with agreement of the chair. All committee members should attend at least 7 of the 9 meetings annually.

5. Frequency of meetings

The committee will meet a minimum of 9 times annually, (with exceptions for April, August, and December). The agenda for the meeting will be drawn up by the chief quality officer in collaboration with the chair. Call for papers will be 3 weeks prior to the meeting. The agenda and papers will be distributed 1 working week in advance of the meeting, unless there are exceptional circumstances for individual papers. Papers will be submitted to members either via secure nhs.net e-mail preferably in
PDF format or economy post in accordance with NHS Information Governance requirements. Paper copies will be available at the meeting on request via the committee secretarial support.

6. Restricted Section sessions

If the Committee needs to discuss matters of a confidential nature, the chair may convene a private ‘restricted’ session of the meeting. This may include for example, the review of specific complaints and serious untoward incidents. HealthWatch and other members will be asked to leave the committee prior to the restricted section on the agenda. The committee minutes for the restricted part of the agenda will not be placed in the public domain.

7. Conflicts of interest

Members will be expected to declare any conflicts of interests to the chair and co-chair prior to the meetings and the chair will determine how those discussions will be conducted.

8. Accountability and reporting

The committee is a sub-committee of the governing body and is accountable to it. The Committee shall report to the Governing Body bimonthly and to clinical cabinet on the alternate months.

9. Secretarial support

Secretarial support will be provided by the joint CCGs’ Governance & Committee team.

10. Review

The Terms of Reference will be reviewed annually or before if the CCG’s governance structures are amended.

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| Review due          | August 2014   |
### Annex A - Annual Plan *(Draft Example and subject to change)*

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<td>Risk Register</td>
<td>Monthly standing item</td>
<td>CQO/DCQO</td>
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<td>Monthly update on work programme</td>
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NHS Fareham & Gosport Clinical Commissioning Group’s Constitution 96
Version 1.1 NHS England Effective Date: - 1/4/13
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Joint CCG: Compact System wide Governing Body Other CCG Health Watch WLAT
APPENDIX K – TERMS OF REFERENCE FOR THE CLINICAL CABINET

1. INTRODUCTION

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

2. PURPOSE

2.1. The Clinical Cabinet [Cabinet] is accountable to the CCG’s Governing Body. The Cabinet acts on behalf of the Governing Body to discharge its functions related to:

- developing and commissioning services;
- performance management of contracts, particularly QIPP;
- patient safety and quality improvement
- risk identification and management;
- financial control.

2.2. The Clinical Cabinet will at all times be responsible for maintaining an integrated view of quality, performance and finance.

3. RESPONSIBILITIES

3.1. The responsibilities delegated to the Clinical Cabinet are to:

- develop commissioning strategies and approaches, provider proposals, outline business cases within agreed limits, clinical priority statements and locality constitutions and where required make recommendation to the Governing Body;
- develop commissioning priorities and QIPP proposal for the CCG, in collaboration with Member practices, for approval by the Governing Body;
- approve and execute arrangements, including supporting policies, to minimize clinical risk, maximize patient safety and to secure continuous improvement in the quality and patient outcomes;
- approve and execute arrangements for supporting the NHS England in discharging its responsibilities in relation to securing continuous improvement in the quality of general medical services;
- approve and execute arrangements to drive improvements in healthcare assurances within the providers from whom the CCG commissions care so that providers demonstrate year on year improvements identifying and managing risk and underperformance;
- provide assurances to the governing body and member practices that appropriate systems and processes are in place to realise continuous improvement in the quality of
commissioned services and to ensure wider system learning from any emergency issues relating to poor quality service provision;

- receive and scrutinise independent investigation reports relating to patient safety issues and agree publication plans;

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

- respond to specific clinical governance and healthcare assurances issues identified by the Governing body, and its committees, and external regulatory bodies;

- manage the CCG performance ensuring all statutory and operating plan requirements are fulfilled and taking any appropriate and necessary action to address performance challenges;

- act as the CCG Finance Committee, receiving monthly reports of CCG financial performance and taking any appropriate and necessary action to address financial challenges;

- develop and review the CCG’s risk register and provide assurance to the CCG Governing Body;

- approve proposals for action on litigation against or on behalf of the clinical commissioning group;

- approve the group’s arrangements for business continuity and emergency planning;

- managing dispute resolution and handling complaints;

- determine and execute arrangements for handling Freedom of Information requests.

4. SCOPE OF AUTHORITY AND DECISION-MAKING

4.1. The Clinical Cabinet is required to work in accordance with these Terms of Reference and the CCG’s Scheme of Reservation and Delegation.

4.2. The Clinical Cabinet will ensure that it reports to the CCG Governing Body on any matters which properly fall within the CCG Governing Body’s ‘Schedule of Matters Reserved to the Board’.

4.3. The Clinical Cabinet is authorized by the Governing Body to investigate any activity with its terms of reference.

4.4. Matters for consideration by the Clinical Cabinet may be nominated by any member of the Clinical Cabinet or the Chair of the CCG Governing Body.

4.5. The Committee is authorised by the CCG Governing Body to obtain independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

5. MEMBERSHIP, QUORUM AND ATTENDANCE
Membership

5.1. Membership will comprise:

- CCG Clinical chair
- Five elected GP representatives
- CCG Chief Officer
- CCG Chief Finance Officer
- CCG Chief Quality Officer
- Chair of Practice Managers’ Commissioning Advisory Group

5.2. Co-opted, non-voting members will include:

- Chief Commissioning Officer;
- Chief Development Officer;
- Public Health representative
- Primary Care Relationship Officer
- Primary Care Performance Officer

5.3. In addition, the Chair may allow for other staff members with responsibility for commissioning; performance; contracting; and communications and engagement to attend.

Quorum

5.4. The quorum is four voting members, with at least two of those being elected GP representatives. Fully briefed deputies with relevant decision making authority shall be permitted, where necessary, with agreement of the chair.

Attendance

5.5. Members are expected to attend at least two thirds of meetings.

Frequency

5.6. The Clinical Cabinet will meet monthly, usually on the first Wednesday of the month.

5.7. Additional meetings may be called by the Chair of the Clinical Cabinet if required.

6. MANAGEMENT

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

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

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

6.4. The Committee will report in writing to the CCG Governing Body the basis for its
recommendations. The CCG Governing Body will use that report as the basis for their decisions but will remain accountable for taking decisions.

6.5. Minutes of the CCG Governing Body's meetings should record such decisions. Where reports to the CCG Governing Body contain confidential information about individuals, these should be considered in Part II of the CCG Governing Body meeting.

6.6. The Committee shall receive secretarial support from the Governance and Committee team.

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

7. REPORTING

7.1. The Clinical Cabinet Chair will provide reports on the work of the Clinical Cabinet to Part I or Part II of the CCG Governing Body meeting according to the nature of the business to be reported.

7.2. The Clinical Cabinet Chair shall draw to the attention of the CCG Governing Body any issues which require full disclosure to the CCG Governing Body.


APPENDIX L – TERMS OF REFERENCE FOR THE COMMUNITY ENGAGEMENT COMMITTEE

Purpose of the Community Engagement Committee

The purpose of the Community Engagement Committee (CEC) is to support the Fareham & Gosport Clinical Commissioning Group (F&G CCG) in achieving its strategic objectives by interpreting and influencing both the external and internal environments and by creating positive relationships with stakeholders through the appropriate management of their expectations and agreed objectives. It will be chaired by a member of the F&G CCG Governing Body.

Objectives of the Community Engagement Committee

- To provide a forum for engagement with a cross-section of stakeholders in relation to the strategic objectives of the F&G CCG.
- Recognise and acknowledge stakeholders’ needs, concerns, wants, authority, common relationships, interfaces and align this information within the stakeholder map.
- Ensure that all stakeholders have access to relevant information on the objectives and progress of the process.
- Identify the views of stakeholders and ensure they are reported to the CEC in a co-ordinated way.
- Identify any key issues which may not have been addressed by the CCG in order that these can be fed back to the Governing Body of the CCG.
- Contribute to the Communication and Engagement Strategy of the CCG.
- Advise on engagement activities for the Strategy (including patients, staff, the public and other organisations).
- Provide feedback on communications and engagement activity to date in order to influence the future approach.

The Board is advisory to the F&G CCG Governing Body and is not in itself a decision making group.

Location and timing of meetings

The inaugural meeting will be held on Thursday 7th June, with subsequent meetings to be held quarterly on the second Tuesday of the month: September, December and March held from 1.00pm – 3.00pm. The inaugural meeting will be held at Cams Golf Club, Fareham.

Reporting Mechanisms

The Chair of the CEC will also be a member of the Governing Body and will ensure there is a 2-way communication mechanism between each Board. It will be the responsibility of each CEC member to communicate between its own organisation and the CEC and the F&CCCG Board to ensure there are no gaps in the process.

Membership

Guiding Principles on determining membership of the CEC
• The panel should provide a representative canvas of stakeholder opinion – it will not be possible to involve every group or organisation associated with the F&G CCG
• Numbers need to be kept manageable at a maximum of 25 attendees per meeting to ensure that the panel is able to operate effectively and does not create unnecessary administrative burden
• Ideally membership should be fixed (that is, not on a rotational basis), with named substitutes for each member

Key stakeholders

Those to be offered seats on the Community Engagement Committee

• Gosport Voluntary Action
• Fareham Community Action
• Mind/italk
• BME Health & Wellbeing Network, GBC
• Gosport Councillor
• Fareham Councillor
• Parliamentary Agent for Gosport
• Parliamentary Agent for Fareham
• Head of Economic Prosperity, Tourism & Culture, GBC
• LINks
• Carers Association
• Chairs of Fareham & Gosport Locality Patient Groups
• 2 Patient Participation Group representatives, 1 for Gosport, 1 for Fareham
• Learning Disabilities/Physical Disabilities
• Board level representation from Portsmouth Hospitals Trust
• Adult Services
• South Central Ambulance Service
• Out of Hours Service
• Public Health
• Southern Health NHS Foundation Trust
• Practice Nurse Representative

Those key stakeholders who will be kept informed:

• Job Centre Plus
• CEO Relate Portsmouth & District
• YOU trust
• Community Independence Team
• Groundwork Solent
• Gosport Discovery Centre
• Parentline Plus
• Royal Marine Welfare Advice Service
• Adult Mental Health Area Manager
• Chair of Partners Through Pain Gosport, & Friends Through Pain, Fareham
• Chair of Solent Diabetes Association
• SureStart Rowner
• Stubblee Hill Children’s Centre
• Shaw Trust
• Service User Network
- Bridgemary School and Local Children’s Partnership
- Fareham College
- St Vincent College Gosport
- District Drugs Co-ordinator
- Local schools via Head Teachers’ Clusters
- Citizens Advice Bureau
- Naval Personnel & Family Services
- Specialist OPMH Link Worker
- Chair, Naval Families Federation
- Little Waves Children’s Centre
- Development Manager, Gosport Voluntary Centre
- HCC Libraries
- Naval MH Services
- Contracts Managers, Queen Alexandra Hospital
- Communications & Engagement Team, NHS Hampshire
- HOCS

This list is not exhaustive and can be added to as and when the need arises

**Meeting management, advice and administrative support**

- Hugh Janes, Head of Strategy & Service Development
- Brenda Woon, Communications & Engagement Manager, NHS Hampshire
- Louise Hale-Tait, Project Support Administrator

Membership has been drawn from key stakeholders to ensure total and transparency within the internal mechanisms of the F&G CCG. Membership and Terms of Reference will be reviewed annually.

Date Created: June 2012
To be reviewed by: June 2013
APPENDIX M – TERMS OF REFERENCE FOR THE PRACTICE MANAGERS’ ADVISORY COMMITTEE

1. Functions:

1.1 To support the Practice Manager Representatives on the Fareham & Gosport Clinical Executive.

1.2 To review commissioning proposals from a practice perspective.

1.3 To aid the development of commissioning proposals to provide a forum for gaining a consensus view from all Stakeholders regarding key developments which meet the overall health service national/ local targets and reform.

1.4 To ensure practices understand and are in a position to support the implementation of new pathways/services approved by the Clinical Executive.

1.5 To support the development of any proposed Clinical Commissioning LES for 2012/13.

1.6 To support the on-going development of the QP indicators within QOF for 2012/13.

1.7 To support and develop any project the group undertakes.

2. Membership:

2.1 The Group shall be chaired by the F&G CCG Executive lead Practice Manager. There will be a Vice-Chair to act up if the Chair is not available.

2.2 Membership of the Group shall also consist of a F&G CCG Head of Business and Performance, F&G CCG Head of Strategy and Service Development, 6 Practice Managers and a CCG Administrator.

2.3 Membership of the Group, including the appointment of a Chair shall be reviewed on an annual basis in April of each year.

2.4 Additional persons may be co-opted for specified projects to be agreed by the group.

3. Operation of the Group:

3.1 The Group will meet monthly for no longer than 2 hours per meeting.

3.2 The agenda for each meeting shall be prepared by the Chair and Administrator. Members of the Group will be invited to submit items at any time but no later than 1 week before the next meeting. The agenda and all related papers will be distributed electronically to members to allow them the opportunity to read prior to the meeting.

3.3 Minutes of the meeting shall be taken by the CCG Administrator and distributed within two weeks of the meeting being held. When the agenda is disseminated the minutes of the previous meeting will also be attached for reference.
3.4. Between meetings of the Practice Managers Advisory Group, if there are any issues which require a decision, discussion or dissemination to the Group, the representatives on behalf of the Chair will communicate with members by email.

4. Administration of the meeting:

4.1 Items for ‘Any Other Business’ are to be forwarded to the Administrator at least 48 hours prior to the meeting taking place. If this condition cannot be met then urgent issues are to be raised with the Chair immediately prior to the meeting, all members of the group are to endeavour to arrive on time.

5. Information

5.1.1 The PMCAG members will agree to share information to the Group for the purposes of planning, developing and monitoring the effectiveness of any associated project or task.

6. Review

The Terms of Reference for the Practice Managers Advisory Group shall be reviewed on an annual basis.
APPENDIX N – TERMS OF REFERENCE FOR THE CLINICAL ASSEMBLY

1. Functions:

1.1 To promote the Primary Care service delivery within the locality to best serve and improve quality of care to the local population.

1.2 Contribute to and sign off the CCG Commissioning Strategy

1.3 Review any proposals regarding the amendment of the CCG Constitution

1.4 Participate in the review of the CCG performance including comparative performance of member practice

1.5 To provide a forum for discussion, to ensure that all Stakeholders in General Practice are actively engaged in key issues and developments of Clinical Commissioning Group (CCG) and to ensure the CCG is working to achieve local aims and objectives.

1.6 To provide a forum for gaining a consensus view from Fareham and Gosport Practices regarding key developments which meet the overall health service national/local targets and reform.

1.7 To provide the Fareham and Gosport Clinical Assembly with the opportunity to highlight developments, service issues relating to primary, secondary or social care services. Where necessary, highlight these issues for the CCG to take further action.

1.8 To ensure that all the Fareham and Gosport CCG member practices are kept informed of:
   - local issues and key work areas of the CCG (e.g. GMS/PMS, Prescribing, Governance, commissioning and health improvement, CCG Development, Practice/performance planned activity against actual)
   - national legislation and its implications at a local level

1.9 To share good practice, in particular regarding the provision of primary care services, prescribing and achieving the national primary care and CCG local and national targets

1.10 To monitor and review effectiveness of CCG developments in the area.

2. Membership:

2.1. The Group shall consist of a nominated GP and Practice Manager from each Practice. There must be one member attending from each Practice who has voting rights. If the nominated Clinician is not present for a meeting, the Practice should send an alternate Clinician who will be entitled to vote on their behalf. Voting will be undertaken using the agreed voting process

2.2. Members (GP & Practice Manager) shall miss no more than 1 out of the 3 meetings per annum unless there are extenuating circumstances. A percentage of Component 1 of the CCG LES may be deducted for non-compliance at the discretion of the Clinical Cabinet.

2.3. The CCG will provide representation from their Commissioning teams who will endeavour to support the Clinical Assembly in achieving its aims and objectives in the delivery of local services.

2.4. Additional persons may be co-opted for specified periods of time.

2.5. The Group shall nominate a Clinical Chair, who shall be a member of the Clinical Assembly.
2.6. There shall be a Vice-Chair (clinical) to act up if the Chair is not available.

2.7. Membership of the Group, including the appointment of a Chair shall be reviewed on an annual basis in April of each year.

3. **Operation of the Group:**

3.1. The Group will meet three times per annum for no longer than 2 hours per meeting.

3.2. The agenda for each meeting shall be prepared by the Head of Business and Development, collaborating with the clinical chair and the Chief Officer (Designate) or Commissioning representative in collaboration with the Chair. Members of the Group will be invited to submit items at any time but no later than 1 week before the next meeting. The agenda and all related papers will be distributed electronically to members to allow them the opportunity to read prior to the meeting.

3.3. The Group shall have a quorum of two-thirds of all representatives. Voting will normally be by a show of hands. In matters where a vote is equal, the Chair or person acting as Chair of the meeting shall have the casting vote. The voting process will be used.

3.4. Minutes of the meeting shall be taken by the CCG Administrator and distributed within two weeks of the meeting being held. When the agenda is disseminated the minutes of the previous meeting will also be attached for reference.

3.5. Between meetings of the Fareham and Gosport Clinical Assembly, if there are any issues, which require decision, discussion or dissemination to the Group, the Commissioning representatives on behalf of the Chair will communicate with members by email/web-based discussion group.

4. **Administration of the meeting:**

4.1. Items for ‘Any Other Business’ are to be forwarded to the Head of Business and Development or Commissioning representative at least 48 hours prior to the meeting taking place. If this condition cannot be met then urgent issues are to be raised with the Chair immediately prior to the meeting, all members of the group are to endeavour to arrive on time.

5. **Finances:**

   Attendance at these meeting is part of the CC LES 2012/13

6. **Information:**

6.1. The Clinical Assembly will agree to share practice identifiable information within the CCG for the purposes of planning and developing CCG and monitoring of practice information.

7. **Conflict of Interest:**

7.1. CCG Clinical Assembly members will be invited to declare any potential conflicts of interest which they are aware of on taking up the post. A Register of Interests will be maintained by the Head of Business and Development and members will be invited to confirm or update their personal entries prior to the start of the meetings. The register will be reviewed annually.
7.2 Where a CCG Clinical Assembly member has a conflict of interest he/she will be expected to excuse themselves from proceedings whilst matters are discussed and decisions reached, unless the group invite the member with COI to remain in the meeting.

7.3 Guidance on making a Declaration of Interests is at Annex A. A Declaration Form is at Annex B.

8. Review:

8.1 The Terms of Reference for the Fareham and Gosport Clinical Assembly Group shall be reviewed on an annual basis.
APPENDIX O – TERMS OF REFERENCE FOR THE PRESCRIBING FORUM

1. TITLE

The name of the forum shall be: - “The Fareham & Gosport Clinical Commissioning Group Prescribing Forum”.

2. PURPOSE

To provide a consultative forum that can effectively provide news, education, medical warnings and other up-to-date information with particular reference to NICE, MHRA and local NHS establishments authorised to provide guidance and information. It will also provide a forum to discuss any other local issues pertaining to medicines management. The forum is an opportunity for practices to appraise current activities and voice opinions on all such activities to assist with local decision making. The forum does not have any statutory decision making role.

3. MEMBERSHIP

a) All members have equal status
b) Practices will nominate a representative, who will be the practice prescribing lead, or someone delegated to represent the practice on their behalf
c) A quorum of members must be present for the forum to proceed. At least six practice members and two medicines management representatives must be present for the forum to proceed
d) Other members will include a chairperson, an organiser and an administrator
e) Internal or external persons may be invited to the forum at the request of the chairperson or organiser to provide advice and assistance where necessary
f) Forum members will cease to be members if they resign from their employment, breach confidentiality or resign from the forum

4. VACANT POSITIONS

Vacant positions will be filled on a casual basis until the term of office has expired.

5. CHAIRPERSON

The chairperson shall be the clinical commissioning group prescribing lead. Their responsibilities include:-
a) Inviting specialists to attend meetings
b) Guiding the meeting according to the agenda and time available
c) Ensuring all discussion items end with a decision, action or definite outcome
d) Review and approve draft agenda before distribution
e) Review and approve any documents to be distributed after the forum

6. ORGANISER

The organiser shall be responsible for:-
a) Inviting specialists to attend meetings in order to provide educational or informational sessions
b) Arranging the agenda for the forum
c) Setting the date, time and venue
d) Preparing and presenting any news items regarding current activities and safety warnings
e) Distribute relevant documents to forum members after the forum
7. **ADMINISTRATOR**

The administrator is responsible for:-
- Arranging catering for the forum
- Arranging and confirming venue and date for the forum
- Arranging certificates for participants
- Collecting attendance records, feedback forms and homework from practice representatives
- Administration of application for tutor approval of educational sessions
- Take minutes as required
- Send out details of date, time and venue of meeting plus details of speakers and any preparatory work required by members prior to the forum

8. **FUNCTIONS**

- Educational: to share information and advice on clinical issues and to support training
- Informative: to share current issues, especially regarding patient safety
- Consultative: to comment on and influence CCG policies, strategies, plans, and other decisions that impact upon the CCG and the patient and future development
- Promotional: to adopt and promote best practice
- Financial: to comment on and consider activities that will enable improved management of prescribing costs

9. **ORGANISATION**

- The forum will meet six times a year, usually on the third Thursday of the months of May, July, September, November, January and March of each financial year
- The forum will be based at Lysses House Hotel, Fareham, but meetings may be held elsewhere
- The meeting will be serviced by the forum organiser who will delegate and advise the chairperson and administrator as necessary
- The range of topics to be discussed will be based on suggestions from members and officers of the forum. The chairperson and organiser will be responsible for the agenda
- Meeting dates will be set at the beginning of the year and advertised in advance via email
- The agenda will be circulated at least one week in advance of the forum and any relevant documents arising from the forum will be circulated within two weeks of the forum having taken place
- The meeting will be chaired by the chairperson or a suitable representative in their absence, typically the organiser.
- The administration of the forum is the responsibility of Fareham & Gosport Medicines Management Team. The administrator will distribute the agenda and homework, keep an up-to-date contact list of members, organise meeting rooms, organise refreshments and publicise the meetings

10. **AMENDMENTS**

The terms of reference shall be reviewed annually from the date of approval. They may be altered to meet the current needs of all forum members, by agreement of the majority organisers and forum members.

The above terms of reference have been agreed to:

Organiser

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NHS Fareham & Gosport Clinical Commissioning Group’s Constitution
Version 1.1 NHS England Effective Date: - 1/4/13
Chairperson

CCG Board Member

Representative forum member
APPLICATION TO AMEND THE CONSTITUTION FOR NHS FAREHAM & GOSPORT AND SOUTHEASTERN HAMPSHIRE CLINICAL COMMISSIONING GROUPS

Following the publication of NHS England’s ‘Procedures for clinical commissioning group constitution change, merger and dissolution’, please find enclosed an application from NHS Fareham & Gosport and South Eastern Hampshire Clinical Commissioning Groups to amend their constitution.

The application is set out in accordance with the guidance as follows:

The reasons why a variation is being sought

There are four components to the proposed variations:

i. Typographical/Minor amendments – Some committees have updated their terms of reference and title. Amendments have been made where reference to these committees has been made in the main constitution.

ii. Refining the assurance framework - The assurance framework has been amended to reflect practice. The Prescribing Forum is not an assurance committee, and as such has been withdrawn from the assurance framework. However, the Performance and Assurance Committee is delegated responsibility and provides assurance to the Clinical Cabinet for Performance data across Portsmouth, Fareham & Gosport and South Eastern Hampshire CCG, (the Compact), and this has been reflected. In addition, Portsmouth and South East Hampshire Commissioning Collaborative considers commissioning across the Compact and is delegated responsibility and provides assurance to the Clinical Cabinet and this is also reflected.

iii. Governing Body membership amendments – Healthwatch have asked to withdraw their member from the Governing Body and this is reflected. The Deputy Chair role has been re-allocated to the Lay Member for Audit and the constitution amended to reflect NHS guidance.¹ Eligibility criteria for clinical members has been amended to reflect both the

¹ NHS Commissioning Board, ‘Clinical commissioning group governing body members: Role outlines, attributes and skills’ dated October 2012.
changing circumstances of some existing members and so that the widest possible clinical expertise can be considered for election. Minimum attendance requirements and additional grounds for removal of clinical members have been added to strengthen the CCG Membership’s ability to hold the elected members to account.


The proposed varied constitution with the amended clauses clearly signposted

A copy of the varied constitution is attached which identifies the tracked changes. A schedule of amendments is also forwarded at Annex A.

Assurance that member practices have agreed to the proposed changes

All changes outlined in this application were supported by the CCG’s Clinical Assemblies.

Assurance that stakeholders have been consulted if required

The proposed changes in this application are supported by the CCG’s Governing Body and Clinical Assembly. Given the nature of the proposed changes, a wider consultation with stakeholders was not considered to be necessary.

A self-certification by the Chair or Accountable Officer, on behalf of the CCGs, that the revised constitution continues to meet the requirements of the Act

By this letter, we certify that the revised constitution continues to meet the requirements of the Health and Social Care Act 2012.

Assurance that the CCGs have considered the need for legal advice on the implications of the proposed changes, including whether advice has been sought

The CCG has considered the need for legal advice on the implications of the proposed changes. Given the nature of the proposed changes, as laid out in this application, legal advice was not considered to be necessary.

A completed impact assessment of the changes, which should cover as a minimum the factors required to be considered by NHS England

The CCG has completed an impact assessment of the proposed changes and concluded the following:

- The constitutions meet the requirements of the Health and Social Care Act 2012
- All of the members of both CCGs continue to be a provider of primary medical services
- There are no changes to the area of either of the CCGs
- There is no change in the Accountable Officer arrangements
- The CCGs have made appropriate arrangements to ensure it is able to discharge its functions
- The Governing Body is correctly constituted.
- There are no changes to either of the registered and resident population of the CCG
- There are no changes to either of the CCG’s financial allocations as a result of the proposed amendments
- There is no impact on NHS England’s function
The CCGs have undertaken appropriate consultation with members and stakeholders, and received support via the corporate governance framework and membership.

There is no impact on the upper-tier county council, Hampshire County Council, whose area covers the whole of both of the CCGs areas.

The changes do not affect the operation of any other CCG, person or body.

Should have any queries or require further clarification, please do not hesitate to contact us.

Yours sincerely

Richard Samuel  Dr David Chilvers  Dr Barbara Rushton
Chief Officer  Clinical Chair  Clinical Chair

Fareham & Gosport and South Eastern Hampshire Clinical Commissioning Groups

Annexes:

A. Schedule of Amendments – Fareham & Gosport CCG.
B. Schedule of Amendments – South Eastern Hampshire CCG.

Enclosure:

1. Tracked Change Constitution – Fareham & Gosport CCG.
2. Tracked Change Constitution – South Eastern Hampshire CCG.
### GOVERNING BODY

<table>
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<tr>
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<tbody>
<tr>
<td>28 May 2014</td>
<td>16</td>
<td>Wessex Academic Health Science Network - Membership</td>
</tr>
</tbody>
</table>

**Purpose of Paper**

To request the Governing Body to consider affiliation and membership of the Wessex Academic Health Science Network (WAHSN).

**Recommendations/Actions requested**

The Governing Body is asked to consider whether SEH CCG should:

- Become a voting member of Wessex AHSN, and
- A guarantor of Wessex AHSN, and/or
- Appoint a member of the CCG executive team as nominee director for agreement with other NHS providers, to act as director on the Wessex AHSN board.

**Author**

Nikki Roberts  
Governance and Committee Officer

**Sponsoring member**

Sara Tiller  
Chief Development Officer

**Date**

19th May 2014
1. Introduction

1.1 The purpose of this briefing is to ask the Governing Body to decide whether Fareham and Gosport Clinical Commissioning Group (CCG) will be affiliated with Wessex AHSN, a Company Limited by Guarantee (CLG).

1.2 Academic Health Science Networks (AHSNs) are a core element of ‘Innovation Health and Wealth’ (2011), the NHS contribution to the Government’s ‘Plan for Growth’. AHSNs are intended to improve the identification, adoption and spread of innovation and best practice across the NHS. Established as membership organisations with a geographical footprint, AHSNs encompass NHS commissioning bodies and providers, universities, industry, and other organisations. The core purpose of the networks is to enable the NHS and academia to work collaboratively with industry to spread innovation, enhance patient care and generate wealth. The intention is that all NHS organisations should look to be affiliated to their local AHSN.

2. Becoming a member of the Wessex Academic Health Network

2.1 Fareham and Gosport CCG needs to decide whether it will become a voting member and guarantor of Wessex AHSN as well as nominating an executive officer to act on the Wessex AHSN Board.

2.2 If Fareham and Gosport CCG becomes a voting member of the Wessex AHSN, it will commit to payment of an annual membership fee for at least two years. This is because there is a two year lock in period which limits the CCG’s ability to terminate its membership. The level of membership fee for year one has been agreed at £10,000. The level of membership fees has not been set for subsequent years; therefore a level of financial risk has been identified in relation to payment of year two membership fee. The risk is reduced for subsequent years because the CCG has the ability to terminate its membership if it does not approve a membership fee increase.

2.3 The Wessex AHSN Board will be made up of 4 directors nominated by NHS providers, 3 directors nominated by CCGs and 2 directors nominated by Universities. The Board may determine to vary these numbers in the future. Board papers, including minutes will be circulated to all of the voting members, however, voting members will not be allowed to attend Board meetings as observers unless they are invited by the chief executive to attend.

2.4 Should affiliation to Wessex AHSN be approved, the Governing Body is asked to consider the following:

a) The CCG becomes a voting member
   • Whether to approve Fareham and Gosport CCG becoming a voting member.
To ratify the completion and signing of the Deed of Adherence for the Voting Members Agreement (VMA).

Whether to approve payment of Year 1 membership fee of £10,000. Subsequent years level of membership fees are to be set by the Wessex AHSN Board and approved by voting members on a 2/3 majority basis.

Whether to approve the appointment of an authorised representative who should be an executive officer of Fareham and Gosport CCG to act on its behalf as a voting member. Please note, if the authorised representative is unable to attend a voting members’ meeting, Fareham and Gosport CCG may provide for a deputy to attend instead of the authorised representative.

Whether to approve the appointment of an executive officer of SEH CCG and delegate powers to act as the authorised representative of Fareham and Gosport CCG as a voting member of Wessex AHSN.

No limitations on the delegation of powers are proposed provided that the authorised representative should act in accordance with the Fareham and Gosport CCG’s constitution and refer any concerns to the Governing Body for guidance.

Report back to the Governing Body on a six-monthly basis on the activities of Wessex AHSN.

b) In addition, the nominated executive officer would become a guarantor

Whether to approve a nominated executive officer of Fareham and Gosport CCG becoming a guarantor and payment of £1 in the event that Wessex AHSN is wound up whilst the nominated executive director is a Guarantor or within 1 year of it ceasing to be a guarantor.

To ratify the completion and signature of the Application for Admission as a Guarantor.

Whether to approve the appointment of the nominated executive officer to act as authorised representative of Fareham and Gosport CCG as a guarantor of Wessex AHSN.

No limitations on the delegation of powers are proposed provided that the authorised representative should act in accordance with the CCG’s constitution and refer any concerns to the governing body for guidance.

c) Optional - nominate a director to the board of Wessex AHSN

Approve the appointment of an executive director of Fareham and Gosport CCG to act as a director on the board of Wessex AHSN, if nominated by a majority of the CCGs who are members of Wessex AHSN. It is intended that there will be three places on Wessex AHSN’s Board for directors nominated by CCGs.

Approve the appointment of a member of the CCG executive team to act as director on the board of Wessex AHSN if subsequently approved by a majority of the CCGs who are members of Wessex AHSN. Such a director on the Board of Wessex AHSN is to represent CCGs and not specifically Fareham and Gosport CCG and to act in the interests of the company (Wessex AHSN).
2.5 The WAHSN Articles of Association and the Voting Members Agreement can be viewed by contacting the Governance And Committee Officer. The Governance and Committee Officer can also answer more in-depth governance questions regarding membership.

4. Recommendation

4.1 Following review of this briefing paper and all appendices, the Governing Body is asked to consider whether Fareham and Gosport CCG wishes to:

- Become a voting member of Wessex AHSN, and
- A guarantor of Wessex AHSN, and/or
- Appoint a member of the CCG executive team as nominee director for agreement with other NHS providers, to act as director on the Wessex AHSN board.
## GOVERNING BODY

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<tr>
<td>Title</td>
<td>Hampshire Public Health Working with CCGs 2013 - 2014</td>
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<tr>
<td>Purpose of Paper</td>
<td>To present the Hampshire Public Health Working with CCGs 2013/14 Annual Review.</td>
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</table>
| Recommendations/Actions requested | The Governing Body is asked to:  
  - Note the Review |
| Author          | Dr Ruth Milton  
                     Director of Public Health |
| Sponsoring member | Dr Christine Jackson  
                       Deputy Director of Public Health |
| Date            | 19\textsuperscript{th} May 14 |
This is the second annual report from the Director of Public Health (DPH) summarising the work that the Hampshire Public Health team and Fareham and Gosport CCG have undertaken to ensure delivery of a comprehensive healthcare public health service. It describes how the service has been delivered during 2013-2014, the lessons learnt and makes recommendations for 2014-2015.

1. Background

1.1 National Context
Delivering good population health outcomes and reducing health inequalities are priorities for Clinical Commissioning Groups. Achieving these goals depends on health protection, health improvement, and the quality and accessibility of healthcare services. Healthcare public health advice is critical in giving NHS commissioning a population focus. As part of their responsibilities for improving and protecting the public’s health, local authorities have a statutory duty to provide population health and healthcare public health advice to clinical commissioning groups (CCGs), through Statutory Instrument (2013) 351 of the Health and Social Care Act (2012). Provision of this population healthcare service is also known as the core offer.

1.2 Local Context
For the five CCGs in Hampshire healthcare public health advice is delivered by the Hampshire public health team working a matrix model of business delivery, from Hampshire County Council.

The service is delivered through a Memorandum of Understanding agreed between the Director of Public Health and each CCG.

2. Activity during 2013-2014 – the post transition year

2.1 Memorandum of Understanding (MOU)
An MOU was developed and agreed between the DPH and the CCG and first came into operation for 2012/13. The MOU operated in shadow form during this transition year and was reviewed and updated for 2013/14. The MOU established the framework for the working relationship between the CCG and the public health team and sets out the full range
of public health specialist advice that can be provided to the CCG as part of the core offer. The purpose of the MOU is to describe the way in which Hampshire County Council’s Public Health Specialists and Fareham and Gosport will work together to improve and protect the health of the CCG population, to reduce health inequalities and to ensure delivery of healthcare public health advice to support the CCG’s commissioning responsibilities.

2.2 Work Programme
Following a deliberately high level work plan for the transition year focusing on the development of the Joint Strategic Needs Assessment (JSNA) and public health advice to the development of CCG commissioning and QIPP plans a considerably more detailed framework for the work plan was used for 2013/14.

While this was initially helpful in identifying and agreeing specific areas of work against the range of technical public health advice that can support CCGs achieving their objectives, the framework has proved too complex and can be confusing. The need for flexibility in the workplan has become very apparent with significant new areas of work requiring public health advice – for example the development of the Better Care Fund – arising during the year.

For 2014-15 it is proposed that a workplan is developed to respond to the needs of the CCG commissioning strategy and operating plan priorities.

2.3 Building strategic relationships with CCGs to lead the delivery of population healthcare advice
There continues to be good engagement between the CCGs and the Hampshire public health team. The Deputy Director of Public Health is a member of the CCG Board and, with senior members of the team, provides public health advice and expertise in all areas of commissioning supported by the range of analysis and skills across the whole team.

Thus a public health consultant provides senior leadership in support of the DPH and acts as the link between the CCG and the wider public health team. This means that the CCG can access the full range of PH expertise and technical advice. The link public health consultant is an established member of the Clinical Cabinet.

The Hampshire public health team carried a number of consultant vacancies – for most of 2013-14 leading to a significant reduction (just under a third of the team) in public health consultant capacity. Action was taken to mitigate the effect of this on the delivery of CCG
work but inevitably this led to some impact on the timeliness of delivery and limitations to the scope of work.

2.4 Development of the Health and Wellbeing Board
The Director of Public Health continues to provide leadership to the development of the Hampshire Health and Wellbeing Board and the Joint Hampshire Health and Wellbeing Strategy.

2.5 Health Protection
We worked with partners to ensure health protection functions were continued over the transition and have now set up mechanisms to provide assurance that the health of the population is being protected through the Public Health sub-group of the Health and Wellbeing Board. Where information has been available we have been monitoring the uptake of immunisations and contributing to the planning and evaluation of programmes commissioned by NHS England.

During the course of the year we have participated in regional and local exercises to test the multiagency response. One of the outcomes has been the development of public health support for CCG activity.

2.6 Delivering public health advice to support NHS Commissioning
2.6.1. Health Needs Assessment
The PH team developed a JSNA for Fareham and Gosport CCG, identifying priorities for the CCG population. The JSNA is being completed by the Health and Wellbeing Board with the updating of the Hampshire Pharmaceutical needs Assessment within the required timeframe. A JSNA provides a strategic overview and benefits from detailed needs assessments for specific issues. Consequently, the CCG has access to 38 further needs assessment chapters developed by the team that address particular population groups/health conditions and make recommendations for commissioning evidence based interventions. A continuous programme of further detailed needs assessments provides topic specific and timely support to commissioning.

We have supported the CCG to use the JSNA and its detailed needs assessments to inform their commissioning strategies and commissioning intentions.
2.6.2 Strategic planning
We have provided PH specialist advice and content to the CCG’s 5 year strategic commissioning plan. Continued engagement of the senior members of the PH team in strategy development will further support the CCG realising the benefits of public health advice.

The team has undertaken a detailed analysis of the PYLL indicator as defined in the quality premium to assist the CCG with their planning. Other workstreams have included supporting the development of locally commissioned services for primary care and input into commissioning specifications.

2.6.3 Better Care Fund
The public health team has developed the metrics for the Better Care Fund submission and an evaluation framework for local monitoring. The public health team have provided a review of the evidence to the CCGs to inform the development of integrated teams and actively participated in supporting the submission and discussions by the health and wellbeing board.

2.6.4 Planned Care
The public health team provides specialist advice to the commissioning of planned care.

We provided a comprehensive individual funding request evidence review service working jointly with the public health teams in Portsmouth and Southampton.

The PH team provided leadership and technical input to the development of the business case and facilitated agreement for the commissioning of cascade testing for Familial Hypercholesterolaemia across Hampshire, Portsmouth, Southampton and the Isle of Wight. The Familial Hypercholesterolaemia service is the first population based service in England and was soft launched in 2013/14. Following the recruitment of three Familial Hypercholesterolaemia specialist nurses there will be a full launch for GPs in the first half of 2015/16.

Public health led an audit of the preventative management of people diagnosed with atrial fibrillation. This showed lower than expected levels of anticoagulation, particularly in the frail elderly. The audit findings have been used by medicines management teams to improve atrial fibrillation prescribing patterns in their CCGs.
2.6.5 Unscheduled Care
Public health consultants provide advice and support to the CCG unscheduled care work programmes which are identified. The Public Health team have provided a series of evidence briefings to highlight effective interventions that can address the increase in inappropriate unscheduled attendances and admissions and ongoing work to develop local intelligence about unscheduled care to inform future planning.

2.6.6 Children and maternity services
The public health team provides senior leadership across the age range and this has included the breadth of the maternity and children’s agenda in 2013 -14 focusing on public health advice in support of the maternity specifications, the review of the Child and Adolescent Mental Health Service and leadership to the development of a wider strategy to promote emotional wellbeing and mental health in children and young people.

3. Future developments
The working relationship between CCGs and the public health team and the model of delivery of public health advice to CCGs is of necessity evolving with the changing landscape and should be kept under review during 2014/15 so that it remains fit for purpose to support:

• development and delivery of the CCG two and five year strategies
• closer working between health and social care services
• the move towards integrated commissioning
• delivery of key public health and NHS outcomes.

Areas for future development are:

• continuing to embed public health advice across the breadth of the work of the CCG by ensuring that it is accessed at the optimal stage in processes for CCG strategic planning, service redesign and quality improvement. We have demonstrated that when public health advice is provided at the early stages of planning this brings the greatest benefit to the CCG.

• joint working by both the public health team and the CCG to ensure that everyone working in the CCG understands the full range of PH specialist advice that is available to them as part of the mandated responsibility of the local authority and how they can appropriately access this resource and that public health appreciates the business requirements of the CCG.
• agreeing a work plan between the CCG and Hampshire public health for 2014/15 that is explicitly linked to the CCGs strategic plan.

4. Recommendations for 2014-15

1. To maintain and further improve communications between the CCG and the Hampshire public health department:
   • the public health link consultant for the CCG will include in their annual job plan that they have a regular physical presence in the CCG head offices, in order to facilitate two way communication that meets business need.

2. To maximise the value of specialist public health advice to the CCG:
   • public health advice should be sought and provided at the early stage of developing commissioning plans and be integral to the development of such plans
   • the annual work plan will be linked to the CCGs strategic plan with built in flexibility to meet in year developments
   • the CCG and the public health team should ensure that the CCG workforce understand how to work most effectively with the public health team.

3. The model of delivery of public health advice to CCGs should be kept under review to ensure that it is remains fit for purpose and able to best meet the needs of the CCG while remaining a cost effective use of the specialist and scarce consultant resource.

4. The CCG should work with Hampshire public health to maximise opportunities to commission for prevention and reduce health inequalities where there is a strong evidence base regarding avoidable ill health and related health and social care costs.
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<td>Recommendations/ Actions requested</td>
<td>The Governing Body is asked to:</td>
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<td>- Hampshire Commissioning Group – 19 February 2014</td>
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<td>- Hampshire Commissioning Group – 19 March 2014</td>
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<td>- Fareham and Gosport CCG Clinical Cabinet – 26 February 2014</td>
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<td>- Joint CCG Clinical Cabinet 26 February 2014</td>
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<td>- Fareham and Gosport CCG Clinical Cabinet – 23 April 2014</td>
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<td>- Joint CCG Clinical Cabinet – 23 April 2014</td>
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<td>- Joint CCG Audit Committee – 21 January 2014</td>
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<td>- Corporate Governance Committee – 24 January 2014</td>
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<td>- Corporate Governance Committee – 21 March 2014</td>
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<td>- Corporate Governance Committee – 11 April 2014</td>
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<tr>
<td>Author</td>
<td>Sandra Jenkinson</td>
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<td></td>
<td>Governance and Committee Support Officer</td>
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<td></td>
<td>Josie Abbascia</td>
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<td>Sponsoring member</td>
<td>Sara Tiller</td>
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<td></td>
<td>Chief Development Officer</td>
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<td>Date</td>
<td>20th May 2014</td>
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HAMPshire Commissioning Group

Minutes
Minutes of the meeting of the Hampshire Commissioning Group held at 9.00 am on Wednesday 19 February 2014 in the Denning Room, Elizabeth II Court, Hampshire County Council, The Castle, Winchester, SO23 8UJ

Summary of Actions

<table>
<thead>
<tr>
<th>Minute Ref</th>
<th>Action</th>
<th>Who</th>
<th>By</th>
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<tbody>
<tr>
<td>6</td>
<td>Draft an introductory statement to the Positive Partnerships document for signature by BA &amp; HF</td>
<td>KA</td>
<td>End of the month</td>
</tr>
<tr>
<td>10</td>
<td>Discuss management of Personal Health Budgets</td>
<td>KA/AB</td>
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Present:
Richard Samuel (chair) Chief Officer Fareham & Gosport / South Eastern Hampshire CCGs
Lisa Briggs Chief Operating Officer North Hampshire CCG
David Chilvers Chair Fareham & Gosport CCG
Heather Hauschild Chief Officer West Hampshire CCG
Barbara Rushton Chair South Eastern Hampshire CCG
Andy Whitfield Chair North East Hampshire & Farnham CCG

In attendance:
Karen Ashton Strategic Commissioning Director Hampshire County Council
Alex Berry Chief Commissioning Officer Fareham & Gosport / South Eastern Hampshire CCGs
Lisa Briggs Chief Operating Officer North Hampshire CCG
Clare Bryan Deputy Chief Finance Officer North Hampshire CCG
Hugh Freeman Chair North Hampshire CCG
Mike Fulford Chief Finance Officer West Hampshire CCG
Rachel Harrison Chair Hampshire Voice of Disabled People
Inger Hebden Director of Commissioning, Long Term Conditions and Community West Hampshire CCG

Christine Jackson Deputy Director of Public Health Hampshire County Council
Sandra Jenkinson Committee Support Officer Fareham & Gosport / South Eastern Hampshire CCGs
Angela Murphy Interim Associate Director for Children and Maternity North East Hampshire & Farnham CCG
Roshan Patel Chief Finance Officer North East Hampshire & Farnham CCG
Diane Wilson Associate Director, Vulnerable Adults Team West Hampshire CCG
Geoff Woollan (for item 6) Care Commissioning Officer, Adult Services Hampshire County Council
1 Welcome and Apologies

The chair welcomed everyone to the meeting. Apologies were received from Ros Hartley, Pam Hobbs (represented by Clare Bryan, Maggie McIsaac, Ruth Milton (represented by Christine Jackson), Sarah Schofield and Andrew Wood.

2 Declarations of Interest

There were no declarations of interest relating to any items on the agenda.

3 Minutes of the previous meeting

The minutes of the meeting held on 22 January 2014 were approved as a correct record, with the following amendment:

Item 6, page 3, second paragraph: the second sentence should read “Both CCGs planned to make 5.5% QIPP savings.”

4 Matters Arising

<table>
<thead>
<tr>
<th>Date</th>
<th>Minute Ref</th>
<th>Action</th>
<th>Who</th>
<th>Progress</th>
</tr>
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<tbody>
<tr>
<td>22.01.14</td>
<td>5</td>
<td>Co-ordinate sharing of QIPP plans with CFOs and Deloitte</td>
<td>All</td>
<td>Ongoing</td>
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<tr>
<td>22.01.14</td>
<td>5</td>
<td>Arrange dialogue re SHFT</td>
<td>IH</td>
<td>Planned</td>
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<tr>
<td>22.01.14</td>
<td>7</td>
<td>Draft response to letter from Chief Executive of HCC and agree with other Chief Officers</td>
<td>HH</td>
<td>Completed</td>
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Inger Hebden informed the meeting that a lot of communication had taken place around Southern Health NHS Foundation Trust, and it was planned to hold talks at the end of February.

Richard Samuel reminded members of the discussions around partnership working with Hampshire County Council (HCC) and the Better Care Fund (BCF). HCC had funded Deloitte to work on a project to identify and quantify opportunities around joint commissioning between HCC and the five Hampshire CCGs. Governance proposals were under development, and a Programme Infrastructure was being identified. NHS
South Commissioning Support Unit (CSU) was working with HCC to identify the back office functions required.

The Chairs and Chief Officers of the five Hampshire CCGs had been invited to a meeting with the Chief Executive and senior officers of HCC earlier that morning. Richard Samuel gave a brief report of that meeting, and a short discussion took place where it was agreed that the meeting was positive, although challenging. It was noted that HCC accepted that the Health and Wellbeing Board would need some improvement to the way that it operated. Heather Hauschild added that some clarity was needed over the relationship of the CCGs with Deloitte, and suggested that one person per CCG should be nominated to link with Deloitte. Richard Samuel said that a hub would be formed, with a Steering Group for consistency. This would be confirmed following a telephone conversation with HCC.

5 Finance Matters

Mike Fulford gave a brief verbal update on finance matters. Work on planning guidance was ongoing. All provider organisations were attempting to request significant increases in contract values, which would prove a risk to planning. The CSU contracting team was discussing contracts with providers. There had been changes to the national direction of Continuing Care provision. Commissioning leads planned to meet soon with acute providers regarding implications arising out of the Better Care Fund. A discussion would be held at the next meeting to decide who would lead on acute contracts.

The Hampshire Commissioning Group noted the verbal update on finance matters.

6 Positive Partnerships

Geoff Woollan and Rachel Harrison were in attendance to present a shared strategy for support and care for people with physical, neurological and/or sensory impairments that provides equal opportunity, choice and independence. The strategy had been developed following a meeting held in November 2013, where 45 people were present (including service users and representatives from commissioning and provider organisations). The strategy had been endorsed by the Executive Members of Hampshire County Council. The draft strategy was now in a period of consultation, finishing at the end of May 2014. Rachel Harrison added that many people were unsure of how to access services. The strategy was about an individual’s whole life, and their quality of life. Some service users may also have different perceptions of which organisations provide services.

Geoff Woollan agreed to attend a meeting of the Hampshire Commissioning Group to discuss actions, following the completion of the consultation. He would also be available to attend appropriate meetings to discuss the strategy during the consultation period.
Members were supportive of the strategy, which had great potential. The aims of the strategy would fit well with the planned integration of services arising out of the Better Care Fund. It was agreed that it was important to move from fragmented services, and aim to meet holistic needs. There had been discussions about NHS 111 and HantsDirect working together to provide help and advice. This was one example of how multi-agencies could work together. This would also be a suitable topic for the Health and Wellbeing Board to discuss.

It was agreed that each CCG should respond to the consultation individually.

It was noted that the strategy was slanted towards HCC, and therefore it was suggested that it be rebranded to include NHS organisations. Karen Ashton would draft a joint introductory statement by the end of the month, to be signed by both Hugh Freeman and Barbara Rushton.

**Action:** KA

**The Hampshire Commissioning Group commented on the draft strategy, and agreed to submit an introductory statement.**

### Structure for Hampshire Vulnerable Adults Service Team

The paper had been deferred from the previous meeting held on 22 January 2014 due to lack of time.

Inger Hebden reminded the meeting that Diane Wilson would be retiring from her post as Associate Director of the Vulnerable Adults team. This would give an opportunity to review the structure of the whole team. It was therefore proposed that an interim appointment for a period of six months be made to cover the post of Associate Director; the process for this had already begun.

Members discussed the proposal to make an interim appointment. One concern expressed was the difficulty of an interim appointment leading such a large team. The team would need strong leadership.

It was agreed that the current model did need some revision, as the small teams had an unsustainable workload. The introduction of the Better Care Fund would have an effect on the way that the team worked. The CCGs were currently on a convergent course with HCC regarding integrated commissioning, with an undecided timeframe. It was anticipated that the report being prepared by Deloitte would give an insight into opportunities for joint working leading to the window of integration during 2016/18.

Members acknowledged the need to engage in succession planning for key posts in order to maintain business continuity.

Following a discussion, it was agreed that a further report be brought to a future meeting with principles and options for a revised structure.

**The Hampshire Commissioning Group:**
• Noted the progress on the recruitment to the Head of Mental Health Commissioning
• Approved the proposed next steps
• Noted feedback on the criteria to be used to evaluate options
• Discussed any requirement for further involvement from nominated CCG leads, eg in the evaluation process
• Delegated authority to recruit to the replacement role for the Associate Director for Vulnerable Adults

8 Better Care Fund – final submission

Richard Samuel presented a paper to brief the meeting on the draft Better Care Fund plan submitted to NHS England on 14 February 2014. Thanks were expressed to all involved in the preparation of the submission, which was a good start towards integration. The next six weeks would see significant developments to the plan.

The Hampshire Commissioning Group:
• Noted the progress to date to develop the draft plan
• Noted the draft plan submitted to NHS England on 14 February 2014

9 Continuing Healthcare: Proposals

Diane Wilson presented a brief summary of the actions taken on the agreed phase 1 and 2 to manage and support the Continuing Healthcare agenda. The paper had been deferred from the meeting held on 22 January 2014 due to lack of time. A full update report on Continuing Healthcare/Free Nursing Care would be provided to the meeting scheduled for Wednesday 19 March 2014.

The report covered the process as well as staffing and structural changes. The three-month project had been outsourced to a company called UK Independent Medical Services.

The team had received and responded to over 4000 referrals, with 1600 new packages, as well as additional work arising out of the retrospective application process.

The QIPP plan was attached to the report, but was as yet incomplete. The Chief Finance Officers would sign off the QIPP, following a debate around the proposed savings related to the piece of work being carried out by Deloitte.

The Hampshire Commissioning Group noted the work undertaken.

10 Personal Health Budgets: Proposal

Diane Wilson presented a proposal to support a joint approach between HCC and the five Hampshire CCGs to implement arrangement for access to personal health
budgets (PHBs). The subject had previously been discussed at meetings of the Hampshire Commissioning Group in 2013.

Karen Ashton informed the meeting that the local authority carried out work in support of the planning process, which equated to about five and a half working days per case. The proposal for PHBs would need to feed into longer term strategies for out of hospital care.

Members discussed the proposal and the way forward for the CCGs and HCC. A pilot project for 50 people had been in place in Hampshire. There was an ongoing review of the scheme, which would need to be agreed between the local authority and the CCGs. One of the differences cited was the difference in pay scales across local government and the NHS.

Members were reminded that the introduction of PHBs was a statutory duty. Richard Samuel added that around £40k was being made into the new arrangements, which was expected to be sufficient to meet the statutory requirements.

Karen Ashton reported that there had been 18 requests for PHBs so far. It was agreed that she discuss the way forward with Alex Berry. This was a topic that should be discussed by the Commissioning Leads Group.

**Action: KA/AB**

**The Hampshire Commissioning Group:**
- Noted the work undertaken
- Requested that the proposal be considered by the Commissioning Leads Group to review and refine
- The proposal be brought to a future meeting of the Hampshire Commissioning Group for ratification.

11 Hampshire Safeguarding Adult Board – Budget

Inger Hebden presented a report which summarised the budget required to service the Hampshire Safeguarding Adults Board (HSAB) in 2013/14 and the projected costs for 2014/15.

Heather Hauschild referred to a letter that had been received recently regarding financial contributions to the HSAB. There was a lack of clarity over the inclusion of a training cost in the calculations.

**The Hampshire Commissioning Group agreed to the cost share as detailed in the report.**

12 Adult Services – Update

Diane Wilson informed the meeting that a full report would be brought to the next meeting.
The Hampshire Commissioning Group noted the verbal update on Adult Services.

13 Children’s Risk Log

Angela Murphy presented an update on current risks related to Children’s Services delivery, excluding safeguarding factors. Two risks had increased:

- NER18: Children’s Continuing Care, relating to safeguarding concerns
- NER34 – Children’s Therapies Retendering. There were issues around estates, and the use of premises regarding this service. Discussions were taking place around funding of the premises for the service.

There was one new risk:
- A new risk related to Hampshire County Council savings proposals for the year 2015/16. This may have an effect on the contract contribution towards Child and Adolescent Mental Health Services, and could see cuts in funding for short break services.

Richard Samuel suggested that the risks be included in the work being undertaken by Deloitte for HCC, to examine the potential cost impacts.

Members noted that an OFSTED inspection of HCC Children’s Services had just begun.

It was suggested that a representative from HCC Children’s Services be invited to attend future meetings. However, this may be addressed by future changes to the membership.

The Hampshire Commissioning Group noted the Children’s Risk Log.

14 Meetings Schedule 2014/15

The Hampshire Commissioning Group noted the meeting schedule for 2014/15.

15 Hampshire Health and Wellbeing Board

Heather Hauschild had led a seminar on mental health for the Health and Wellbeing Board (HWB).

Members had a brief discussion on the management of the HWB meetings, and agreed that it was important to build relationships with members. It would be crucial to agree governance arrangements, which was part of the work being carried out by Deloitte.

The Hampshire Commissioning Group noted the update on the Hampshire Health and Wellbeing Board.
16 Hampshire Health Overview and Scrutiny Committee

Hampshire Hospitals NHS Foundation Trust had been discussed at the last meeting. The redevelopment of the Chase Community Hospital would be on the agenda of the next meeting (scheduled for 17 March 2014) along with Specialist Commissioning.

The Hampshire Commissioning Group noted the update on the Hampshire Health Overview and Scrutiny Committee.

17 Future Agenda Items

- Formal Review on Safeguarding
- Adoption Medical Advisors (Naomi Black)
- S136 Alternative Place of Safety – AM
- Chronic Fatigue Syndrome – interim arrangements
- Positive Partnerships – Update (Geoff Woollan)

18 Any Other Business

David Chilvers informed the meeting that work was ongoing in SHIP8 regarding the role of the Priority Committee.

Barbara Rushton added that a Primary Care Workshop had been held by the Wessex Commissioning Assembly. The place of Primary Care in integrated care teams was under discussion.

Discussions were also taking place around the role of the SHIP8 meeting.

19 Next Meeting

The next meeting would be held at 9.00 am on Wednesday 19 March 2014 in the Nightingale Room, Wells Place Centre, Wells Place, Eastleigh, Hants, SO50 5LJ.
HAMPSHIRE COMMISSIONING GROUP

Minutes
Minutes of the Hampshire Commissioning Group held at 9.00 am on Wednesday 19 March 2014 in Room 135, Elizabeth II Court South, Hampshire County Council, Winchester, SO23 8UJ

Summary of Actions

<table>
<thead>
<tr>
<th>Minute Ref</th>
<th>Action</th>
<th>Who</th>
<th>By</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>Discuss approach to CAMHS regarding the Health and Wellbeing Board</td>
<td>HF/MM/BR</td>
<td></td>
</tr>
</tbody>
</table>

Present:
Richard Samuel (Chair) Fareham & Gosport / South Eastern Hampshire CCGs
Lisa Briggs Chief Operating Officer North Hampshire CCG
David Chilvers Chair Fareham & Gosport CCG
Hugh Freeman Chair North Hampshire CCG
Heather Hauschild Chief Officer West Hampshire CCG
Maggie MacIsaac Chief Officer North East Hampshire & Farnham CCG
Barbara Rushton Chair South Eastern Hampshire CCG
Sarah Schofield Chair West Hampshire CCG
Andy Whitfield Chair North East Hampshire & Farnham CCG

In attendance:
Karen Ashton Strategic Commissioning Director Hampshire County Council
Alex Berry Chief Commissioning Officer Fareham & Gosport / South Eastern Hampshire CCGs
Philippa Darnton (for item 6) Senior Commissioning Manager - Respiratory and Cardiovascular West Hampshire CCG
Mike Fulford Chief Finance Officer West Hampshire CCG
Inger Hebden Director of Commissioning, Long Term Conditions and Community West Hampshire CCG
Beverley Meeson (for item 6) Associate Director – Long Term Conditions West Hampshire CCG
Ruth Milton Director of Public Health Hampshire County Council
Angela Murphy Associate Director for Children and Maternity North East Hampshire & Farnham CCG
Diane Wilson Associate Director Hampshire Continuing Healthcare
Jo York Associate Director Fareham & Gosport / South Eastern Hampshire CCGs

Apologies:
Ros Hartley Director of Strategy & North East Hampshire & Farnham CCGs
Welcome and Apologies

The Chair welcomed everyone to the meeting, which followed a meeting between the Chairs and Chief Officers of the CCGs and the Chief Executive and senior officers of Hampshire County Council.

Apologies were received from Ros Hartley and Pam Hobbs.

Declarations of Interest

There were no declarations of interest relating to any items on the agenda.

Minutes of the Previous Meeting

The minutes of the meeting held on Wednesday 19 February 2014 were approved as a correct record.

Matters Arising

<table>
<thead>
<tr>
<th>Date</th>
<th>Minute Ref</th>
<th>Action</th>
<th>Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>19.02.14</td>
<td>6</td>
<td>Draft an introductory statement to the Positive Partnerships document for signature by BR and HF</td>
<td>Completed</td>
</tr>
<tr>
<td>19.02.14</td>
<td>10</td>
<td>Discuss management of Personal Health Budgets</td>
<td>Completed</td>
</tr>
</tbody>
</table>

It was reported that informal discussions had been held on the management of Personal Health Budgets between Inger Hebden, Alex Berry and Karen Ashton.

Members were reminded of an update on Children’s Services at the meeting held on 15 May 2013 (agenda item 11). It had been agreed that the CHC team could be increased with 1.5 nurse assessor posts and 0.5 admin. Following several failed recruitments it had now been decided to use the same resource to appoint 1 wte Band 4 (already in post) and a band 7 Co-ordinator to support the statutory function of the Children and Families Bill (ie to cover SEN, Transition and Personalised Budgets, this could be delivered within the same resource envelope).

This was agreed by all the Chief Officers.

Finance Matters

Mike Fulford outlined the key issues relating to finance matters across the five Hampshire CCGs.
Contract negotiations were under way; however there were issues around three of the four main providers, which would have an impact on financial planning. Work was ongoing around the baselines and risk sharing of Continuing Healthcare and Free Nursing Care.

There were concerns over issues around legacy debt with NHS England. It was suggested that formal legal advice be sought through NHS Clinical Commissioners.

The Hampshire Commissioning Group noted the verbal update on finance matters.

5.1 Strategic Estates

Mike Fulford informed the meeting that NHS Property Services was being restructured, and there would be a reduction of approximately 100 staff. It was expected that there would be a substantial reduction in support staff across the south of England, which could cause significant problems. One solution would be to buy in a dedicated resource across Hampshire. Members recognised the risks to all CCGs and were broadly in support of the proposed solution. Mike Fulford would bring a formal proposal to a future meeting. The matter would also be raised at the meeting of SHIP 8.

The Hampshire Commissioning Group noted the verbal report on NHS Property Services, and agreed to consider a formal proposal to buy in dedicated resource across Hampshire.

6 Complex Rehabilitation Development: Project Evaluation and Business Case

Beverley Meeson and Philippa Darnton were in attendance to present an evaluation of the outcomes of a Hampshire wide commissioner led project to review and redesign pathways for patients with complex rehabilitation needs. A proposal for the coordinated commissioning for complex rehabilitation would build on the successes of the project evaluation.

The service was a low volume but high cost service for patients with brain injury. Improvements had been made during the review and redesign of the pathway, with £500k of savings made during the year. This had been done by a reduced length of acute stay and specialist placements.

The complex rehabilitation development steering group considered three options, and the preferred option was described on page 20 of the report. It was anticipated that further savings of 10-15% would be achieved, with a £74k investment across Hampshire.

The NHS England Local Area Team (Wessex) and NHS England (South) had engaged with the project, and had agreed on specialist commissioning responsibility.
Members discussed the challenges of the interface with specialist services. It was noted that the number of patients had increased over the previous two years from 20 to 30.

Karen Ashton reminded members of the link to the Positive Partnerships consultation, which was described at the previous meeting.

The Hampshire Commissioning Group agreed to:

- Approve the recommendations of the report, to have dedicated resource to commission/review services for patients with complex rehabilitation needs across the five Hampshire CCGs:
  - 1 WTE band 7 Complex Rehabilitation Nurse Assessor with CHC knowledge and experience
  - 0.5 WTE band 8a Complex Rehabilitation Strategic ABI expert and Strategic Lead
  - Up to four Consultant sessions to provide clinical recommendations and oversight into caseload if there are particularly challenging complex cases which require an independent clinical opinion.
  - The above costs £74,532 per annum.

- Approve the recommendations of the business case to invest £74,532 to deliver a minimum of £250,000 per year to contribute to the overall CHC QIPP of £2.598m (3%) which should be delivered by improved demand management.

7 Re-tendering the Child and Adolescent Mental Health Service

Angela Murphy presented a report to seek agreement to re-tender the Child and Adolescent Mental Health Service (CAMHS) for an implementation date of 1 April 2015, to consider and agree the recommended approach detailed within the report and to consider and comment upon the potential financial pressures for the service. Re-tender was a legal requirement, and the process would need to begin in the near future to meet the implementation date. Detailed work was being undertaken regarding the specification, the budget and funding of the service. The budget was an issue following the withdrawal of funding by Hampshire County Council.

Ruth Milton informed the meeting that Children’s Services had seen a reduction in funding. However, Public Health did fund services such as school nursing.

Members discussed the CAMHS service and agreed that early intervention would inhibit the growth in future need, and the impact on a number of services. The new CAMHS specification would be focused on outcome, and would have clear pathways across tiers 1-4.

Barbara Rushton considered that the issue should be the subject of discussion at the Hampshire Health and Wellbeing Board. It was agreed that Hugh Freeman, Maggie MacIsaac and Barbara Rushton discuss an approach with members and officers of Hampshire County Council and feed back to a future meeting.
Members recognised the need to proceed with the tender, although the funding issues would need resolution. Alex Berry would look at the S75 to check for a reasonable handover clause. It was agreed that the steering group be extended to include a representative of each CCG as part of the quorum, and include membership from public health and the NHS England Local Area Team (Wessex). The proposal should be taken to the Clinical Cabinets of the five Hampshire CCGs.

The Hampshire Commissioning Group agreed to:
- The re-tender of the Child and Adolescent Mental Health Service, with a five year contract plus two one year extensions
- The proposed approach for the decision making and management of the project
- Consider the financial envelope for the service and the likelihood for any additional investment and confirm the timescales for this decision, given the likely funding gap for the service in 2015/2016 onwards
- And
- Requested that the steering group be amended
- Requested that the proposal should be taken to the five CCG Clinical Cabinets

Proposal for the use of NHS Funding for Social Care, 2014/2015

Karen Ashton presented a paper which outlined the proposed approach to allocating funds associated with the 2014/15 'NHS Support for Social Care' (s256) funding from NHS England to Hampshire County Council. The formal agreement would need to be signed by 31 March 2014 to confirm the arrangements for investment in services. Effective use of the funding would underpin components of the Better Care Fund plan.

Richard Samuel thought that the proposal was helpful, and would be used as part of the CCGs’ planning cycle. Mike Fulford queried figures in paragraph 3.4.2 of the report, in particular the £35m mentioned in the final sentence on page 7. Karen Ashton agreed to amend the wording, as this was a figure internal to Hampshire County Council. Paragraph 3.4.3 referred to significant financial risks, but this was unclear. Deloitte was currently working on aspects of the transformation, including costs.

Mike Fulford agreed to discuss the legal implications of the agreement with the Director of Finance of NHS England Local Area Team (Wessex); West Hampshire CCG would broker the agreement.

The Hampshire Commissioning Group:
- Considered the use of ‘NHS Funding for Social Care’ as set out in the paper
- Noted that a Section 256 agreement was required to transact the funding transfer
• Agreed that West Hampshire CCG would broker the agreement, following consultation with the NHS England Local Area Team (Wessex)

9 Joint Commissioning – Discussion Paper

Inger Hebden presented a paper which outlined the opportunities for joint commissioning in Hampshire and suggested the principles and outcomes to take forward. The need to define joint commissioning would assist in the preparation of the structure for the Vulnerable Adults Team.

Members were supportive of the need to align the principles, scale and models of joint commissioning across the five Hampshire CCGs, as each CCG was at a different stage. There was also a need for alignment with the work on transformation being carried out by Deloitte and funded by Hampshire County Council.

Members agreed that a forum was needed to align all aspects of commissioning. It was agreed that a facilitated workshop be held as soon as possible.

The Hampshire Commissioning Group:
• Agreed to establish a small group to review the principles, scale and models of joint commissioning
• Agreed to the arrangement of a facilitated workshop

10 Vulnerable Adults Team

Diane Wilson presented an update on the 2013/14 work plan and risk register for the team and the draft work plan for 2014/15. A meeting was planned to discuss the 2014/2015 work plan.

The Hampshire Commissioning Group agreed to:
• Note the work plan for the year 2013/14
• Note the risk register for the year 2013/14
• Note the draft work plan for the year 2014/15

11 Safeguarding Adults Team

Diane Wilson presented an update on the role, activity and work streams of the safeguarding adults team.

The Hampshire Commissioning Group agreed to accept the paper for information.

12 Continuing Healthcare Update

Diane Wilson presented an update on Continuing Healthcare.

The Hampshire Commissioning Group agreed to note the contents of the report.
13 **Children’s Risk Log**

Angela Murphy presented an update on current risks related to Children’s Services delivery (excluding safeguarding factors). The CAMHS retender had been included as a new risk.

14 **Hampshire Health and Wellbeing Board**

The Hampshire Commissioning Group noted that the next meeting of the Hampshire Health and Wellbeing Board was scheduled for 1 May 2014.

15 **Hampshire Health Overview and Scrutiny Committee (HOSC)**

Richard Samuel informed the meeting that he would be attending the next meeting of HOSC on 25 March 2014 to support the item on vascular services.

16 **Future Agenda Items**

- Formal Review on Safeguarding
- Children’s Contracts S256 – AM
- Adoption Medical Advisors (Naomi Black)
- S136 Alternative Place of Safety – AM
- Strategic Estates – MF

17 **Any Other Business**

Angela Murphy informed the meeting that a four week Ofsted inspection had just ended. Briefings had been held and a positive outcome was anticipated.

18 **Next Meeting**

The next meeting would be held at 9.00 am on Wednesday 16 April 2014, venue to be confirmed.
Minutes

Minutes of the meeting of the Fareham & Gosport Clinical February Group
Clinical Cabinet held at 12.30 pm on Wednesday 26 February 2014 in the
Spindle meeting room, 1000 Lakeside, North Harbour, Western Road,
Portsmouth, PO6 3EN

Summary of Actions

Present
Dr David Chilvers CCG Chair
Dr Ian Bell Clinical Member – Clinical Service & IT
Sian Davies Public Health Consultant
Paul Edwards Practice Manager Representative (Gosport)
Dr Simon Larmer Clinical Member – Governance Lead
Ian Reid Secondary Care Doctor Representative

In attendance
David Bailey Deputy Chief Finance Officer
Alex Berry Chief Commissioning Officer
Sandra Jenkinson Committee Support Officer
Dr Sally Robins Children and Maternity Lead

Apologies
Dr Paul Howden Lead – Planned Care & Prescribing
Dr Alan McFarlane Clinical Lead – Practice Performance & Development
June Thomson Practice Manager (Fareham)
Andrew Wood Chief Finance Officer

1 Apologies for Absence

Apologies for absence were received from Dr Paul Howden, Dr Alan
McFarlane, June Thomson and Andrew Wood (represented by David Bailey).

It was noted that Richard Samuel and Sara Tiller were present at the meeting
of the South Eastern Hampshire CCG Clinical Cabinet, being held concurrently.

2 Register and Declarations of Interest

Members were asked if they had any interests to declare relating to agenda
items being considered at the meeting. No interests were declared.

The Clinical Cabinet:
• Received and noted the Register of Interests
3 Minutes previous meeting

The minutes of the meeting held on 29 January 2014 were approved as an accurate record.

4 Summary of Actions and Matters Arising

<table>
<thead>
<tr>
<th>Date</th>
<th>Minute Ref</th>
<th>Action</th>
<th>Who</th>
<th>Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>29.01.14</td>
<td>5.1</td>
<td>Progress payment for community wellbeing day</td>
<td>DB</td>
<td>Under way</td>
</tr>
<tr>
<td>29.01.14</td>
<td>5.1</td>
<td>Deal with procurement aspects of self-management programme</td>
<td>DB</td>
<td>Under way</td>
</tr>
<tr>
<td>29.01.14</td>
<td>5.2</td>
<td>Identify funding for Exercise Referral Scheme</td>
<td>DB/KT</td>
<td></td>
</tr>
<tr>
<td>29.01.14</td>
<td>5.2</td>
<td>Respond to the letter from Cllr Brian Bayford</td>
<td>DC</td>
<td>Completed</td>
</tr>
</tbody>
</table>

Item 5.2: Fareham Leisure Centre – Exercise Referral Scheme Funding

Members discussed the funding for the scheme. It was believed within Public Health that this scheme was not good value for money. However Public Health would support any CCG schemes that fit in with good practice.

Work was ongoing with Gosport Borough Council, where local initiatives were discussed including healthy schools schemes. The introduction of walking and cycling groups was also being considered.

Members discussed the opportunities for promoting Public Health campaigns within practices. One suggestion was of piloting the use of volunteers in the reception areas of GP surgeries.

The Clinical Cabinet noted the summary of actions and matters arising.

5 Feedback from Member Practices

Dr Alan McFarlane was not present to give feedback. It was noted that a five-year strategy was in place to overcome the shortage of GPs.

6 Any Other Business

Alex Berry reminded the meeting that funding was in place for beds at the Cams Ridge Nursing Home in Fareham. The initiative was not as cost effective as had been expected. A paper would be brought to a future meeting of the Clinical Cabinet to explore options.
Ian Bell reported that he was working with the Communications Team on the Summary Care Record project. An article would be submitted to the local newspaper.

The Clinical Cabinet noted items raised under Any Other Business

7 Date of Next Scheduled Meeting

Wednesday 26 March 2014
4.00 – 5.00 pm
Arundel Room, Portsmouth Marriott, Southampton Road, Portsmouth, PO6 4SH
Minutes

Minutes of the joint meeting of the Joint Fareham & Gosport CCG and South Eastern Hampshire CCG Clinical Cabinet held at 1.00 pm on Wednesday 26 February 2014 in the Spindle meeting room, 1000 Lakeside, North Harbour, Western Road, Portsmouth, PO6 3EN

Present:

Dr Barbara Rushton Chair South Eastern Hampshire CCG
Dr Jenny Allinson Unscheduled Care and Mental Health Lead South Eastern Hampshire CCG
Julia Barton Chief Quality Officer South Eastern Hampshire CCG
Dr Alastair Bateman Prescribing Lead South Eastern Hampshire CCG
Dr Ian Bell Clinical Member (Clinical Service & IT) Fareham & Gosport CCG
Dr David Chilvers CCG Chair Fareham & Gosport CCG
Paul Edwards Practice Manager Representative (Gosport) Fareham & Gosport CCG
Jo Hockley Chair, Practice Managers Commissioning Advisory Group South Eastern Hampshire CCG
Dr Andrew Holden Practice Performance Lead South Eastern Hampshire CCG
Dr Alan McFarlane Clinical Lead (Practice Performance and Development) Fareham & Gosport CCG
Dr Sally Robins Co-opted member – Children and Maternity Lead Fareham & Gosport CCG
Ian Reid Secondary Care Specialist Doctor Fareham & Gosport CCG
Richard Samuel Chief Officer Fareham & Gosport CCG
June Thomson Practice Manager Representative (Fareham) Fareham & Gosport CCG
Sara Tiller Chief Development Officer

In Attendance:

David Bailey Deputy Chief Finance Officer Hampshire County Council
Alex Berry Chief Commissioning Officer Fareham & Gosport, Portsmouth & South Eastern Hampshire CCGs
Sian Davies Public Health Consultant Optum
Michael Drake Director of Planning & Performance Fareham & Gosport, Portsmouth & South Eastern Hampshire CCGs
Sandra Jenkinson Committee Support Officer Hampshire County Council
Keeley Ormsby (for item 6) Primary Care Team Optum
Rochelle Morris (for item 7) Public Health Consultant Optum
Teresa Salami-Adeti (for item 7) Public Health Consultant Hampshire County Council
Julia Wilkinson (for item 7)
1 Apologies for Absence

Apologies for absence were received from Dr Roddy Bowerman, Dr Andrew Douglas, Dr Paul Howden, Dr Simon Larmer, Adel Resouly and Andrew Wood (represented by David Bailey).

Dr Barbara Rushton welcomed Teresa Salami-Adeti to her first meeting, and asked members to introduce themselves.

2 Declarations of Interest

Members were asked if they had any interests to declare relating to agenda items being considered at the meeting. Clinical members would have an interest in agenda item 8.1 Pharmacy Locally Commissioned Services.

3 Minutes of Previous Meeting

The minutes of the meeting held on 29 January 2014 were agreed as an accurate record.

4 Matters Arising and Summary of Actions

<table>
<thead>
<tr>
<th>Date</th>
<th>Minute Ref</th>
<th>Action</th>
<th>Who</th>
<th>Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>29.01.14</td>
<td>4</td>
<td>Take End of Life Baseline Review to a meeting of the Clinical Leaders Group</td>
<td>LD</td>
<td>Ongoing</td>
</tr>
<tr>
<td>29.01.14</td>
<td>6.1</td>
<td>Distribute notes of a discussion with the LAT on performance at PHT</td>
<td>JB</td>
<td>Follow up</td>
</tr>
<tr>
<td>29.01.14</td>
<td>6.1</td>
<td>Share Action Plan relating to SHFT on request</td>
<td>JB</td>
<td>Completed</td>
</tr>
<tr>
<td>29.01.14</td>
<td>7.1</td>
<td>Distribute a paper which defines GMS+</td>
<td>AH</td>
<td>Ongoing</td>
</tr>
<tr>
<td>29.01.14</td>
<td>7.1</td>
<td>Complete the Care Home LCS and take to a future meeting of the Clinical Cabinet</td>
<td>AH/KO</td>
<td>Ongoing</td>
</tr>
</tbody>
</table>

Item 4 Matters Arising

Members discussed the role of the End of Life Steering Group, and the roles of nursing homes and residential care homes. It was agreed that the Advance Care Plan and the Co-ordinating Future Care Register should be referenced in the specification.
Item 7.1 Locally Commissioned Services – Recommendations
No national Direct Enhanced Service had yet been published, therefore feedback could not yet be given.

5 Accountable Officer’s Report

Richard Samuel presented a report to update members of the Clinical Cabinet on:

- Current operational priorities of the CCGs
- The latest performance headlines
- An exception report of quality issues
- The current financial position
- The key risks to organisational objectives and progress against managing these risks.

Key points from the report are detailed below. The full reports were made available to members electronically.

Operational Update

The CCGs would be participating in a performance review of the Portsmouth Hospitals NHS Trust (PHT) Emergency Department on 26 February 2014. The CCGs would also be involved in a ‘hot-house’ event on Friday 28 February to align system partners around the strategic direction of the system.

The CCGs’ draft operating plans, financial plans and strategic narrative were submitted to NHS England on 14 February. Positive feedback had been received from the NHS England Local Area Team (Wessex) on the submission. The final submission would be due in June 2014.

The Better Care Fund plan for Hampshire was submitted to NHS England by the local authority on 14 February 2014. High level meetings with the Chief Executive and senior officers of Hampshire County Council (HCC) were currently ongoing. Deloitte had been engaged by HCC to work on the integration programme and would examine QIPP and financial plans; a statement of opportunities for joint commissioning would then be prepared. Deloitte would be attending a seminar session of the Governing Body.

Negotiations were ongoing regarding contracts with provider organisations, in particular PHT.

Performance

Both CCGs continued to make significant progress towards aims to commission good quality care, promote Rights and Pledges under the NHS Constitution and secure improvement in health outcomes of the local population. In December Fareham and Gosport CCG achieved against 19 out of 23 indicators and South Eastern Hampshire CCG achieved 16 out of 23 indicators.

The position with referral to treatment times was deteriorating, however this was close to a resolution. The emergency department was a major challenge for both CCGs.
Quality
The report contained a summary of top risks by provider, extracted from the reports presented to the Quality Assurance Committee in February 2014. One issue of note was the exceeded trajectories for the incidence of C.Difficile.

Portsmouth Hospitals NHS Trust: Safe Discharge; Friends and Family Test for In-Patient Areas; Healthcare Acquired Infection; Discharge Summaries; breach of the 4-hour emergency department target; assurance of the quality of care delivery and stall wellbeing in the light of increased challenges of capacity and demand and the bed reduction plan. A total of 30 patient incidents around safe discharge had been collated, and reports had been requested. A deep dive review had been undertaken around the Friends and Family test, and it had been noted that there were problems in data collection. Improvements had been made to the process for the Friends and Family test.

South Central Ambulance NHS Foundation Trust: Patients experienced long waits for all categories of calls; not meeting the response times for stroke patients.

Southern Health NHS Foundation Trust: Quality concerns have arisen in connection with access to mental health services and Section 136 patients.

Child and Adolescent Mental Health Services: Concerns had been raised by Consultant Psychiatrists around the level of staffing and resource to meet a safe and effective service.

Royal Surrey NHS Trust: A variety of quality data had indicated concerns regarding capacity, staffing and quality of services.

Finance
The financial position for both CCGs was tight, however it was expected that the required surpluses would be achieved. Fareham and Gosport CCG was on plan to meet a target surplus of £0.6m with a YTD surplus of £0.5m. South Eastern Hampshire CCG was currently on plan to meet its target surplus of £0.6m with a YTD surplus of £0.5m.

The Joint Clinical Cabinet:
- Noted the Accountable Officer’s report
- Noted that full reports had been distributed electronically

6 Referral Management Approaches
Keeley Ormsby and Andrew Holden gave a presentation on GP referral management approaches, which was an important part of the commissioning process.

Referrals had increased year on year in both CCGs, but the data did not show conversion rates from referral to outpatient appointments.

Work was ongoing to raise awareness of the issue, including discussion at a number of meetings and fora. The use of software had been examined: a DXS tool had been presented to members earlier, and the Harvey Walsh software package was currently being implemented. The next step was for education within member practices. As part of this, it would be vital to engage
Practice Managers, including via the Practice Managers Commissioning Advisory Group. Links would also be made with health campaigns.

GP Decision Support would be in place, and advice and guidance would be developed with the commissioning team and planned care leads.

Practice Financial Incentives would be developed, and would be part of the Locally Commissioned Service. Any savings made from referral management may be available to reinvest in practices. It would be more appropriate to link incentives to levels of activity. Members then had a short discussion on the role of the Local Medical Committee.

During a discussion on the presentation, it was noted that referrals had increased, but without a corresponding increase in the budget. It was agreed that there was a need to manage referrals, ensuring that patients should be able to access an appointment as appropriate. It was suggested that the Clinical Leaders Group should look at pathways.

One issue noted was that secondary care consultants did not normally inform GPs that individual referrals had been inappropriate. If GPs had a response on unsuitable referrals they would learn from the feedback. There may also be a difference of opinion between GPs and consultants, with some consultants set in their ways of working.

Discussions on referral management had taken place at Clinical Assembly and Target meetings. The Commissioning Team had also been working with clinical leaders.

Members of the Joint CCG Clinical Cabinet agreed to amend the Action Plan for GP Referral Management, and agreed that the Commissioning Team be engaged in the development of pathways.

The Joint CCG Clinical Cabinet:
- Noted the update on progress on approaches to Referral Management
- Noted the suggestion that the Clinical Leaders Group should look at referral pathways
- Agreed that the Action Plan for GP Referral Management be amended following the discussion
- Agreed that the Commissioning Team be engaged in the development of pathways

7 Integrated Community Teams

Rochelle Morris and Julia Wilkinson had been engaged to carry out a piece of work on Integrated Care Teams on behalf of the CCGs. The work was being carried out with the support of the Commissioning Team.

Six Integrated Care Teams (ICTs) were either operational or under way across both CCG areas. The Governance structures for the teams were in place, and membership would be reviewed to include stakeholders. A Design Group was in place chaired by Jen Allinson.

Two models had been developed as part of the project: an Out of Hospital Model and an Operational Model. Members noted the models and commented
on both. General practice was integral to the success of the ICTs, in identifying individual patients suitable for integrated care. The ICTs would be located within practices, and not across practices.

One question raised related to the resources needed to implement the ICTs. It was explained that current resources would need to be re-aligned with some new key roles and a change in culture and behaviour of practitioners. The resource model had been discussed with Southern Health NHS Foundation Trust (SHFT). However, the level of resources within SHFT may be an issue.

Further questions were around the skills base and operation of the teams. It was explained that the teams would have a complex structure with a Care Coordinator (band 4) and professional practitioners engaged in clinical work. It was noted that the ICTs would be jointly resourced by the local authority, and would link to the Better Care Fund integration programme. It was expected that any duplication of work between health and social care would be avoided.

Andrew Holden commented that the ICT was beginning to take effect in Petersfield. GPs would co-ordinate care, and would need to have regular updates on the work of the team.

Members were supportive of the implementation of the Integrated Care Teams. There would need to be a structured programme of implementation led by a robust programme office, and this should be CCG led. The Commissioning Team was currently working to put a structure in place, and regular updates would be provided to members of the Joint Clinical Cabinet.

The Joint Clinical Cabinet:
- Noted the updated on the development of the Integrated Care Teams project
- Expressed support for the implementation of the Integrated Care Teams
- Requested that a structured programme of implementation be put in place led by a robust programme office which would be CCG led
- Requested regular updates on the implementation of the Integrated Care Team

8 Items for Ratification

8.1 Pharmacy Locally Commissioned Service (LCS)

The Joint Clinical Cabinet was asked to ratify the following services by means of LCS contracts.

1. Commissioning of a service to provide dressings to community and practice nursing staff via community pharmacies using a web-based ordering system.

The proposal was to replace the existing dressing scheme where district nurses and pharmacies kept a supply of stock dressings. It was agreed to rationalise the non-prescription supply options, and an online ordering system would be implemented which would keep to the formulary. Each practice would have an indicative budget. The new service would be
managed, monitored and reviewed under an LCS by the Medicines Management team.

2. Commissioning of a service to enable strategic provision of stocks of palliative care medicines in community pharmacies.

A scheme had been in place to ensure that a number of community pharmacies maintain an agreed stock of medicines commonly prescribed in palliative care. NHS England currently hosted this service under a LES which would expire at the end of the financial year. The service had been poorly monitored in the past. The list of medication required had been checked with the Rowans Hospice. The re-established service would be managed, monitored and reviewed under an LCVS by the Medicines Management team.

Members noted that there were a number of errors in the report.

The Joint Clinical Cabinet agreed to ratify the commissioning of both services by means of Locally Commissioned Service contracts. Ratification was dependent on the correction of errors within the report.

9 Date of Next Scheduled Meeting

Wednesday 26 March 2014
1.00 – 4.00 pm
Havant Room, Portsmouth Marriott, Southampton Road, Portsmouth, PO6 4SH
Minutes

Minutes of the meeting of the Fareham & Gosport CCG Clinical Cabinet held at 4.00 pm on 26 March 2014 in the Arundel Room, Portsmouth Marriott, Southampton Road, Portsmouth, PO6 4SH

Summary of Actions

<table>
<thead>
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<th>Minute Ref</th>
<th>Action</th>
<th>Who</th>
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<tr>
<td>7.1</td>
<td>Write to FACE to express thanks for work on Cams Ridge</td>
<td>DC</td>
<td>Next meeting</td>
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Present
Dr Paul Howden            Lead – Planned Care & Prescribing (Chair)
Dr David Chilvers         CCG Chair
Paul Edwards               Practice Manager Representative (Gosport)
Dr Simon Larmer            Clinical Member – Governance Lead
Dr Alan McFarlane          Clinical Lead – Practice Performance & Development
Ian Reid                   Secondary Care Doctor Representative
Richard Samuel            Chief Officer
June Thomson               Practice Manager Representative (Fareham)
Andrew Wood                Chief Finance Officer

In attendance
Sian Davies                Public Health Consultant
Lyn Darby                  Deputy Chief Commissioning Officer
Dr Sally Robins            Co-opted Member – Children and Maternity Lead
Sara Tiller                Chief Development Officer

Apologies
Dr Ian Bell                Clinical Member – Clinical Service & IT

1 Apologies for Absence

Apologies for absence were received from Dr Ian Bell.

It was noted that Alex Berry was present at the meeting of the South Eastern Hampshire CCG Clinical Cabinet, being held concurrently.

2 Register and Declarations of Interest

Members were asked if they had any interests to declare relating to agenda items being considered at the meeting. No interests were declared.

Paul Edwards informed the meeting that his interests had changed, and he would inform the Governance team by email.
The Clinical Cabinet:
• Received and noted the Register of Interests

3 Minutes previous meeting

The minutes of the meeting held on 26 February 2014 were approved as an accurate record.

4 Summary of Actions and Matters Arising

There were no matters arising.

5 Gosport Physical Activity Care Pathway / Exercise Referral Scheme Pilot

Dr David Chilvers presented a summary of how the new evidence based and quality assured Gosport Exercise Referral system pilot would be delivered.

Members discussed the scheme, and expressed support.

The Clinical Cabinet agreed to:
• Support and commit to the delivery of a specific, clinical condition focused Exercise Referral scheme pilot at Gosport Leisure Centre as part of an overarching physical activity care pathway approach
• Commit a named GP to contribute to governance arrangements ensuring safe and effective delivery of the scheme (commitment x 2 per year plus ad hoc advice)
• Provide a small amount of matched funding (£2000) to pilot patient management/data collection system (Refer-All) [contributions from Gosport Borough Council and DC Leisure]

6 Feedback from Member Practices

Dr Alan McFarlane reported on an issue with histopathology waiting times due to the departure of a locum from the service. This issue had been raised with the Commissioning Team, and being progressed.

Dr McFarlane reported on the receipt of three queries about changes to the ICE form; particularly the fact that non-fasting cholesterol tests were not included. It was agreed that further discussion was required with GPs within South Eastern Hampshire.

Paul Edwards reported that the process for sign-up to the public health local enhanced scheme was different to the process used by the CCG, and this had caused some difficulties in practices. Practices had also found it difficult to use the new CQRS.
The Clinical Cabinet noted the feedback from Member Practices

7 Any Other Business

7.1 Lyn Darby tabled a paper which gave an evaluation of the Cams Ridge nursing home pilot scheme. The paper concluded that while the quality of the service was reported as good, 28% of patients had been readmitted to hospital. The Clinical Cabinet therefore agreed with the recommendations of the paper and noted its thanks to FACE for work on the pilot. David Chilvers agreed to write to FACE to express thanks for its contribution.

Action: DC

7.2 Richard Samuel raised the issue of strategic estate and the need to develop a strategic framework which might involve subsiding providers to rent or lease space in NHS Property Services estate.

8 Date of Next Scheduled Meeting

Wednesday 23 April 2014
4.00 – 5.00 pm
Rowan Meeting Room, 1000 Lakeside, North Harbour, Western Road, Portsmouth, PO6 3EN
Minutes

Minutes of the joint meeting of the Joint Fareham & Gosport CCG and South Eastern Hampshire CCG Clinical Cabinet held at 1.00 pm on Wednesday 26 March 2014 in the Havant Suite, Portsmouth Marriott, Southampton Road, Portsmouth, PO6 4SH

Summary of Actions

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<td>10.1</td>
<td>Investigate possible duplication of payment for high cost drugs</td>
<td>AB</td>
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Present:
- Dr Paul Howden: Chair – Clinical Cabinet Lead – Planned Care & Prescribing
- Dr Jenny Allinson: Unscheduled Care and Mental Health Lead
- Julia Barton: Chief Quality Officer
- Dr Alastair Bateman: Prescribing Lead
- Dr Roddy Bowerman: Quality and Governance Lead
- Dr David Chilvers: CCG Chair
- Dr Andrew Douglas: Planned Care Lead
- Paul Edwards: Practice Manager Representative (Gosport)
- Jo Hockley: Chair, Practice Managers Commissioning Advisory Group
- Dr Simon Larmer: Clinical Member (Governance Lead)
- Dr Alan McFarlane: Clinical Lead (Practice Performance and Development)
- Ian Reid: Secondary Care Specialist Doctor
- Dr Barbara Rushton: Chair
- Richard Samuel: Chief Officer
- June Thomson: Practice Manager Representative (Fareham)
- Andrew Wood: Chief Finance Officer

In Attendance:
- David Bailey: Deputy Chief Finance Officer
- Alex Berry: Chief Commissioning Officer
- Lyn Darby (for item 7): Deputy Chief Commissioning Officer
1 Apologies for Absence

Apologies for absence were received from Dr Ian Bell, Dr Andrew Holden and Adel Resouly.

2 Declarations of Interest

Members were asked if they had any interests to declare relating to agenda items being considered at the meeting. It was noted that all GPs would have an interest in agenda item 7: Elective Activity and Referrals.

3 Minutes of Previous Meeting

The minutes of the meeting held on 29 January 2014 were agreed as an accurate record, with the following amendment:

Page 4, second paragraph: amend the work ‘stall’ in the fourth line to read ‘staff’.

4 Matters Arising and Summary of Actions

There were no matters arising.

5 Accountable Officers Report

Richard Samuel presented a report to update the Clinical Cabinet on:

• Current operational priorities of the CCGs
• The latest performance headlines
- An exception report of quality issues
- The current financial position
- The key risks to organisational objectives and progress against managing these risks.

Key points from the report are detailed below. The full reports were made available to members electronically.

**Operational Update**
Both CCGs had participated in a system-wide summit regarding problems in delivery of the four-hour wait within the Emergency Department at Portsmouth Hospitals NHS Trust (PHT). The meeting was chaired by NHS England and the Trust Development Authority (TDA). Following the meeting, NHS England and the TDA set out requirements for making improvements to the system in a letter to all partners in the local health system. The local system had responded to the letter.

The CCGs were involved in a ‘hot house’ event on Friday 28 February to align system partners around the strategic direction of the system. Accountable officers would meet to discuss implementation. Members were recommended to read the report, which underpinned the paradigm shift of how healthcare was provided.

The first cut submission of the Strategy Document had been positively received by NHS England Local Area Team (Wessex) (LAT). The final Operating and Financial Plans as well as the next draft of the Strategy were due for submission by 4 April 2014.

It was noted that Debbie Fleming had left the post of Area Director of the LAT; Felicity Cox would take on the role of Interim Area Director from 1 April 2014.

**Contracting**
Andrew Wood informed the meeting that the deadline for signing of contracts was 28 February 2014. The main issue over contracts was with PHT; discussions had been held and concessions made. However there was a risk of the CCGs going into deficit. There had been over-performance of £11m on the PHT contract during the current financial year.

Members discussed the contract negotiations, and noted that the results of arbitration were expected in the near future.

**Performance**
The main challenges to both CCGs were the achievement of four hour waits in the Emergency Department of PHT, which was below target; and the referral to treatment target speciality levels. Both CCGs had exceeded the annual trajectory of Clostridium Difficile cases and would not achieve the Healthcare Associated element of the Quality Premium.

**Quality**
The latest Quality report had been presented to meetings of both CCG Governing Bodies. A root cause analysis had been undertaken on the Clostridium Difficile cases. The PHT Friends and Family test had shown considerable improvement; one reason for this may have been a change in
counting methodology. The Care Quality Commission had visited a number of facilities managed by Southern Health NHS Foundation Trust.

Finance
Andrew Wood reported that both CCGs were on plan to meet the target surpluses. Discussions were currently under way with Solent NHS Trust on premises costs.

The Joint Clinical Cabinet noted the Accountable Officers report.

6 Benchmarking Summaries

Michael Drake, Ben Gallagher and Lucy Mitchell were in attendance to give an overview on benchmarking. The presentation showed a high level summary of the key findings from a number of local and national benchmarking tools, which included input from Public Health and Business Intelligence from the NHS South Commissioning Support Unit.

As an example, the presentation focused on respiratory services, which featured in the Commissioning for Value Insight Pack for the CCGs. The Business Intelligence team had extrapolated the data for the year 2011/12 into 2013/14.

Members of the Clinical Cabinet noted the presentation, and engaged in a discussion around benchmarking. It was accepted that the examples shown in the presentation were high-level data, which could be drilled down to give more specific information.

It was agreed that the benchmarking data should be reflected in both CCG strategies, and would need to align with priorities and goals of the CCGs. The information should be fed into the Commissioning Team and the Primary Care team. It would also be useful to triangulate the data with the Quality and Outcomes Framework.

The Joint Clinical Cabinet noted and commented on the presentation on Benchmarking Summaries.

7 Elective Activity and Referrals

Lyn Darby and Keeley Ormsby were in attendance to give a verbal update on work on elective activity and referrals.

Year on year, the elective share of PHT contracts had increased; and specialities were being examined in terms of cost. Although there had been an increase in referrals, there was not a corresponding increase in elective activity. One example was in the urology services, with a 7% increase in referrals and a 2% increase in elective work. It was thought that the increase in referrals related to a national campaign. Some referrals resulted in the receipt of advice and guidance. Feedback at speciality level was expected to be given on 1 April 2014.

It was noted that Portsmouth CCG had not experienced a similar increase in referrals.
A document had been published by the British Medical Association on changes to GP contracts for 2014-15 (copies circulated); in particular the new agreed unplanned admissions enhanced service.

There had been no formal guidance on the Care Home Local Commissioned Service (LCS), and discussions had been held with the Local Medical Committee.

The Adjusted Clinical Groups tool was not appropriate to monitor elective activities and referrals, and the licence would expire on 31 March 2015. The Harvey Walsh tool was more appropriate. A business case for the DXS clinical decision support system had been prepared; the licence fee would have no cost but statutory costs would need to be paid.

Members then had a discussion around options for an Unplanned Admissions Direct Enhanced Service against a Care Home LCS, as detailed in a tabled paper. Four options for discussion were listed in the paper. The first option, ‘do nothing’ was not considered to be a real option. Members agreed that there would be advantages in reducing the number of elective admissions, including investment into integrated care. If consultants were able to work in the community, that would support general practice.

Members agreed that a working group prepare a proposal to bring to a future meeting.

An elective LCS would be built around units of planning, and would need to be signed off by lay members.

The Joint Clinical Cabinet:
- noted the update on elective activities and referrals
- agreed to form a working group to look at an Unplanned DES and Care Home LCS

8 TARGET and Training

Jo Parkinson was in attendance to present an item on Target and training. A framework had been developed for education, training and development within both CCGs and aimed at GPs, nurses and practice staff.

Members discussed the events and it was agreed that the programme was broadly successfully. A number of points arose in the discussion. Events for practice staff held in the locality were successful. It was noted that the NHS England Local Area Team (Wessex) did not support closing practices to facilitate attendance at Target events, and discussions were currently being held. It was proposed that the practice of using the Out of Hours service alongside a skeleton administrative staff should continue. A small number of people did not attend Target events, and it would be useful to have feedback on the reasons. Julia Barton would work with practice nurses on suitable training events, and would report back to a future meeting of the Joint Clinical Cabinet.

The Joint Clinical Cabinet noted the presentation on Target and Training.
Elections for Governing Body Members

Sara Tiller presented a paper which set out a proposal to move to a rolling cycle of elections of clinical members of both CCGs.

The current Constitutions of both CCGs state that elected clinical members should serve for a period of no longer than three years. However, it was uncertain whether the term of elections would run from the date of the first elections (June 2011) or from the statutory authorisation date of the CCGs (1 April 2013). It was considered that the current wording of the constitution gave a significant governance risk to both organisations. It was therefore proposed that the constitutions be amended to operate a rolling programme of elections to mitigate the risks, beginning in 2014. Guidance was currently being sought from NHS England on the proposal.

Members discussed the proposal, and a number of points arose. One suggestion was that portfolios be shared across both CCGs. There was no certainty that other clinical members would be willing to stand for election. There was uncertainty over the requirements of contracts with GPs, and it was suggested that members may need to formally step down. However, there was a need to encourage succession planning within member practices. It was noted that the constitutions of both CCGs would be changed to allow nominations of GPs not part of member practices.

Alan McFarlane took the opportunity of informing the meeting that he had written a letter of intention to step down from his membership of the Governing Body of Fareham & Gosport CCG. He thanked members for their support during his term of office, and would be prepared to carry out a handover. Members thanked Alan McFarlane for his contribution to the work of both CCGs.

The Joint Clinical Cabinet:
• approved the proposal to run elections during 2014
• approved the proposal to move to a rolling cycle of re-election
• approved the programme of posts for re-election
• agreed to amend the constitutions of both CCGs to enable clinical representation from GPs who were not part of member practices

Items to Note

10 Medicines Management

Paul Howden presented a report which detailed expenditure on high cost drugs used in services commissioned by the CCGs during the current financial year at Portsmouth Hospitals NHS Trust.

The report cited drugs used in rheumatology, dermatology, gastroenterology and ophthalmology. The aim was to standardise use and choice across Fareham & Gosport, Portsmouth and South Eastern Hampshire CCGs.

Alastair Bateman commented that there was some similarity between the high cost drugs and the list of high cost drugs which came under the umbrella of NHS England. He was concerned that the CCGs were paying for high cost
drugs unnecessarily, and agreed to check with Director of Professional and Clinical Development for Portsmouth CCG.

Action: AB

The Joint Clinical Cabinet noted the report on high cost drugs.

11 Any Other Business

Sian Davies requested a letter of support from the CCGs for the Hampshire County Council bid from the Local Sustainable Transport Fund.

12 Date of Next Scheduled Meeting

Wednesday 23 April 2014
1.00 – 4.00 pm
Spindle Meeting Room, 1000 Lakeside, North Harbour, Western Road, Portsmouth, PO6 3EN
Minutes

Minutes of the joint meeting of the Joint Fareham & Gosport CCG and South Eastern Hampshire CCG Clinical Cabinet held at 1.00 pm on Wednesday 23 April 2014 in the Spindle meeting room, 1000 Lakeside, North Harbour, Portsmouth, PO6 3EN

Present:

Dr Barbara Rushton (Chair) CCG Chair & Strategic Development Lead South Eastern Hampshire CCG
Dr Jenny Allinson Unscheduled Care & Mental Health Lead South Eastern Hampshire CCG
Julia Barton Chief Quality Officer South Eastern Hampshire CCG
Dr Ian Bell Clinical Member (Clinical Service & IT) Fareham & Gosport CCG
Dr Roddy Bowerman Quality & Governance Lead South Eastern Hampshire CCG
Dr Andrew Douglas Planned Care Lead South Eastern Hampshire CCG
Paul Edwards Practice Manager Representative (Gosport) Fareham & Gosport CCG
Jo Hockley Chair, Practice Managers Commissioning Advisory Group South Eastern Hampshire CCG
Dr Andrew Holden Practice Performance Lead South Eastern Hampshire CCG
Dr Paul Howden Chair – Clinical Cabinet Lead – Planned Care & Prescribing Fareham & Gosport CCG
Dr Simon Larmer Clinical Member (Governance Lead) Fareham & Gosport CCG
Dr Alan McFarlane Clinical Lead (Practice Performance & Development) Fareham & Gosport CCG
Adel Resouly Secondary Care Doctor Representative South Eastern Hampshire CCG
Richard Samuel Chief Officer Fareham & Gosport CCG
June Thomson Practice Manager Representative (Fareham) Fareham & Gosport CCG
Andrew Wood Chief Finance Officer

In Attendance:

Alex Berry Chief Commissioning Officer
Susan Clarke Community & Primary Care Nurse Project
Sian Davies Public Health Consultant Hampshire County Council
Michael Drake Director of Planning & Performance
Sandra Jenkinson Committee Support Officer
Keeley Ormsby (for items 6, 7, 8 & 9) Primary Care Team
Dr Sally Robins Co-opted member – Children and Maternity Lead Fareham & Gosport CCT
Teresa Salami-Adeti Public Health Consultant Hampshire County Council
Sara Tiller Chief Development Officer

Apologies:

Dr Alastair Bateman Prescribing Lead South Eastern Hampshire CCG
1  **Apologies for Absence**

Apologies for absence were received from Dr David Chilvers and Ian Reid.

2  **Declarations of Interest**

Members were asked if they had any interests to declare relating to agenda items being considered at the meeting. There were no declarations of interest relating to any items on the agenda.

3  **Minutes of Previous Meeting**

The minutes of the meeting held on 26 March 2014 were agreed as an accurate record.

4  **Matters Arising and Summary of Actions**

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It was reported that Dr Alastair Bateman had discuss the matter with the Director of Clinical and Professional Development (Portsmouth CCG), and it was agreed that there were no concerns over this issue.

5  **Accountable Officers Report**

Richard Samuel presented a report to update the Clinical Cabinet on:
- Current operational priorities of the CCGs
- The latest performance headlines
- An exception report of quality issues
- The current financial position
- The key risks to organisational objectives and progress against managing these risks.

Key points from the report are detailed below. The full reports were made available to members electronically.

**Operational Update**

The CCGs continued to participate in the system-wide plans for improvement to waiting times in the Emergency Department at Portsmouth Hospitals NHS Trust (PHT). A director (Fiona Wise) had been appointed with the remit of improvement in the Emergency Department, with other members of staff having responsibility for named areas. It was noted that performance in the Emergency Department had been challenging over the Easter bank holiday weekend.

Both CCGs had submitted the final versions of the Operating Plan, Financial Plan and Better Care Fund plans to NHS England on 4 April 2014. Feedback
was awaited on the latest version of the Strategy; the final submission would be
made on 20 June 2014. The first submission of the Annual Report and
Accounts had been made to NHS England on the morning of 23 April 2014.

Felicity Cox had taken up the post of Director at NHS England Local Area
Team (Wessex). It was noted that she would also retain accountability for NHS
England Local Area Team (Kent and Medway).

A new priorities process was being implemented across Southampton,
Hampshire, the Isle of Wight and Portsmouth. This was being administered by
Solutions for Public Health; a dedicated lay chair of the committee would be
appointed.

The portfolios of lay members and chairs were being considered, and a paper
would be brought to a future meeting. The appointment of additional lay
members would be considered at a meeting of the Remuneration Committee.

Performance
Both CCGs had achieved all three Referral to Treatment targets. All nine
cancer standards were achieved in South Eastern Hampshire CCG, with eight
of the nine cancer standards being achieved in Fareham & Gosport. There had
been an improvement in the scores of the Friends and Family test at PHT, with
a changed methodology of data collection.

Both CCGs remained concerned regarding Referral to Treatment, Emergency
Department four hour waits and cancer performance at PHT.

Quality
The level of Healthcare Associated Infections was high, with a majority of
cases apportioned to the community. The approach to HCAI in 2014/15 was
being considered at the Quality Operational Group.

Finance
Both CCGs had met target surpluses at the end of the financial year; this result
was subject to an audit. The cash drawdown and remaining cash balance
requirements for each CCG had also been achieved.

The Quality Premium for 2014/15 was better than had been expected.

PHT had reported a breakeven position, with a £6m underlying deficit.

The commissioning team had undertaken a review of elective activity at PHT,
and growth was forecast for the year 2014/15 in the top six specialties. The
forecast growth was based on historic figures by a computer generated model
provided by the business intelligence and planning and performance teams.
Members discussed the projected growth and felt that there should be a
realistic target to aim at. A managed approach was being followed by the three
Portsmouth and south east Hampshire CCGs, led by a team from the
Commissioning team. Terms of Reference, a programme structure and action
plan were in place. The primary care team was engaging with GP practices.

Barbara Rushton wished to express thanks to all of the CCG officers and
teams for their efforts during the 2013/14 financial year. This had been a
challenging first year and the teams had been working effectively.
The Joint Clinical Cabinet noted the Accountable Officers report.

5.1 Quality Issues – Southern Health NHS Foundation Trust

Julia Barton presented an overview of quality issues within Learning Disability and Mental Health services provided by Southern Health NHS Foundation Trust (SHFT). The presentation showed maps of service location accompanied by areas of concern associated with units.

Learning Disability
The main issue for the CCGs was a police investigation into allegations of theft at the Willow Ward, Moorgreen Hospital. There were also serious concerns in Oxfordshire, Buckinghamshire and Wiltshire.

Adult Mental Health
There were no areas of concern for the CCGs.

Older People’s Mental Health
Issues had been identified at Melbury Lodge, where improvements were required in treating people with respect and involving them in their care. There were other issues in Gosport War Memorial Hospital (GWM) and Parklands.

A number of issues around safeguarding adults had been identified in learning disability and mental health services. Nine inpatient units had areas of Care Quality Commission (CQC) non-compliance, with common themes. The CQC was taking enforcement action in three cases.

Daedalus ward at GWM had been under Level 4 safeguarding process; this had been resolved quickly with an action plan in place.

A regional risk summit had been held in January 2014, and actions were reported to be progressing well. A follow up risk summit had been held in March 2014. An investigation was under way to look at quality governance issues. There were no specific concerns over local quality issues; concerns would be discussed at Care Quality Review meetings, and contracts contained reporting requirements.

A number of detailed clinical review visits had been undertaken. A detailed action plan was in place in Denmead and Waterlooville community team, where staffing issues had been identified.

Members discussed the issues raised in the presentation. It was noted that an experienced clinical quality lead had been appointed and was working to make improvements across SHFT.

Members commented on the poor handling of the death of an in-patient at a learning disability facility in Oxfordshire, which had been subject to external review.

Barbara Rushton reminded the meeting that Children’s Services had received a good Ofsted report. Julia Barton added that the rapid response team was giving good service.

The Joint CCG Clinical Cabinet noted the presentation and update on quality issues at Southern Health NHS Foundation Trust.
6 Elective Local Commissioned Service (LCS) and Update on the Improvement Programme

Keeley Ormsby gave a verbal update on referrals. A communication had been released to member practices on the LCS, and the LCS had been published.

As previously agreed £500k had been moved from the care home LCS and put in the Elective LCS. This had been invested across both CCGs.

Practice Managers had undertaken training on the Harvey Walsh system, and referral data was available to the primary care team.

Education events would be held around the top six specialities. Attendance would be mandatory to practices that were outliers and voluntary to other practices.

The purchase of the DXS system was under way, and this could be installed in practices remotely. The LCS could be progressed without the installation of the DXS system.

Members had a brief discussion on pathways. Pathways could not be enforced but would be evolutionary. Practices would receive an upfront payment for taking part in the LCS and achieving pathways. The Local Medical Committee was in agreement.

One suggestion was that a talent register of GPs be formed to list the specialist interests of GPs. This would assist in discussions around pathways.

In the elective LCS a practice would put an action plan in place aimed at reducing referrals, and referrals could be subject to peer review.

South Eastern Hampshire would have a workshop on referrals, and on the compliant or non-compliant patient. This would also take place in Fareham & Gosport.

Members discussed the issue of consultant request for re-referrals, and consultant to consultant referrals.

It was suggested that regular locum GPs should continue to be invited to Target.

Another suggestion was that a CQUIN be put in place around referrals as part of an educative system. Consultants could be asked to give advice and feedback, which would assist with GP education.

The Joint Clinical Cabinet noted the verbal update on the Elective Local Commissioned Service and Update on the Improvement Programme.

7 Improving General Practice – a Call to Action

Keeley Ormsby presented a paper which summarised the Phase 1 report issued by NHS England in March 2014.

NHS England had launched ‘Improving General Practice – a call to action’ in August 2013 to support action to transform services in local communities and
to stimulate debate on how to support the development of general practice to improve outcomes and tackle inequalities.

The summary report focused on general practice, and in particular on four areas. The report was under consultation until June 2014, with a projected publication of a strategic framework for commissioning primary care in the autumn of 2014.

The Friends and Family test would be rolled out to GP practices by the end of 2014. It was noted that no applications for funding from the Prime Minister’s Challenge Fund had been successful in the Wessex area.

It was noted that some areas had a workforce issue, where difficulties were found in recruitment of GPs.

NHS Improving Quality had held a multi-agency workshop on a facilitated change programme. A commitment had been made to Hampshire Health Record and support had been given to the implementation of Direct Enhanced Services.

Dr Barbara Rushton queried the funding of £5 per head which CCGs would need to provide to support practices in transforming the care of patients aged 75 or over and in reducing avoidable admissions. Andrew Wood responded that work was ongoing to identify the funding. Richard Samuel did not believe that the CCGs would be held to account on this funding. The priority for the CCGs was an investment into Integrated Care Teams. It was noted that A Call to Action Evidence packs had been produced by NHS England for CCGs, and both CCGs had received positive results.

The NHS England Local Area Team (Wessex) (LAT) was not well resourced in primary care commissioning. It was noted that the new Director of the LAT had a positive approach to primary care. A workshop was planned for 7 May arranged by the Wessex Commissioning Assembly.

Members engaged in discussion about the best way to move forward. The two strands to be entwined were performance and workforce. All member practices would need to be engaged in the process of change. There were opportunities in the Independent Sector Treatment Centre, re-procurement of the Out of Hours service and the Urgent Care Centre. The GP Alliance, practice managers and other partners should form a working group on a Call to Action. This may be fulfilled by the Programme Board between the GP Alliance and SHFT.

The Joint CCG Clinical Cabinet agreed to support changes in general practice:
- To meet the changing needs and expectations of our populations
- To improve outcomes and tackle inequalities
- To maximise limited resources across the system
- To secure a sustainable service for the next decade

8 Primary Care Information Portal

Dr Ian Bell presented a paper on the options to be considered for the development of the Primary care Information Portal (PIP CCG Extranet).
The PIP for Fareham & Gosport CCG had begun in April 2012, and South Eastern Hampshire CCG had begun in the spring of 2013. The sites had proved to be disappointing with problems in functionality, and neither site was seen to be user-friendly. Advice had been sought from NHS South Commissioning Support Unit (CSU), and it was suggested that the system could be rebuilt to make improvements.

The report detailed three options. The first was to do nothing; the second to request the CSU to rebuild the system; and the third to decommission the existing PIP and commission a new system provided by Sitekit. Sitekit provided the websites of both CCGs, and the PIP could be linked by a portal to the websites. This was the preferred option. It was estimated that the PIP could be built in up to ten weeks with a cost of £9700, with £2010 per annum for support and maintenance.

Members were supportive of the third option, and did not believe that the second option would solve the issues. The first option of ‘do nothing’ was not supported as the current PIP was not fit for purpose.

The Joint Clinical Cabinet agreed:
• that the Primary Care Information Portal was not fit for purpose
• to redesign the Primary Care Information Portal using Sitekit.

9 Primary Care Practice Visits – Principles

Keeley Ormsby presented a paper which set out principles regarding practice visits. Visits would be undertaken for engagement with the practices and to monitor contracts and activity.

Julia Barton requested that quality aspects be linked to the visits. It was noted that these visits would be in addition to visits by the Care Quality Commission and GP revalidation visits.

The Joint Clinical Cabinet:
• agreed the principles of practice visits
• requested that all GPs commit to the process

10 Any Other Business

10.1 Wessex Commissioning Assembly on 7 May 2014 would focus on primary care.

10.2 A paper on non-contraceptive IUS services would be promoted to all member practices.

10.3 Richard Samuel informed the meeting that he was now a formal member of the Academic Health Science Network.

11 Date of Next Scheduled Meeting

Wednesday 14 May 2014
1.00 – 4.00 pm
Slipper Room, Brookfield Hotel, Havant Road, Emsworth, PO10 7LF
Minutes of the Joint Audit Committee meeting held on Tuesday 21 January 2014 in the Board Room, Commissioning House, Building 003, Fort Southwick, James Callaghan Drive, Fareham, Hampshire, PO17 6AR

Present:
Susanne Hasselmann Joint Chair South Eastern Hampshire CCG
Malcolm Heritage-Owen Chair Fareham & Gosport CCG
Keith Barnard Lay Member Fareham & Gosport CCG
Tracey Faraday-Drake Lay Member South Eastern Hampshire CCG

In attendance:
David Bailey Deputy Chief Finance Officer Ernst & Young LLP
Kate Handy Audit Director Deloitte & Touche
Andy Jefford General Manager Fareham & Gosport CCG
Nikki Roberts (for item 9.4) Governance and Committee Officer Deloitte & Touche
Pat Stothard Engagement Manager Hampshire & Isle of Wight Counter Fraud Service
Rachel Struthers Local Counter Fraud Specialist Hampshire & Isle of Wight Counter Fraud Service
Andrew Wood Chief Finance Officer Ernst Young LLP
Ian Young Manager, Government and Public Sector Ernst Young LLP
Sandra Jenkinson Committee Support Officer

1 Apologies for Absence
There were no apologies for absence. Malcolm Heritage-Owen welcomed everyone to the meeting.

2 Declarations of Interest
There were no declarations of interest relating to any specific agenda items for this meeting.

3 Minutes of the Previous Meeting
The minutes of the meeting held on 10 September 2013 were agreed as a correct record.
4 Matters Arising

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<tr>
<th>Date</th>
<th>Minute Ref</th>
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<th>Who</th>
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<tbody>
<tr>
<td>10.09.13</td>
<td>4</td>
<td>Supply further information on the current relationship between the CCGs and CSU to Susanne Hasselmann</td>
<td>AW</td>
<td>Completed</td>
</tr>
<tr>
<td>10.09.13</td>
<td>4</td>
<td>Circulate a paper on the CSU hat had been considered at a meeting of the Joint Clinical Cabinet</td>
<td>AW</td>
<td>Completed</td>
</tr>
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5 Audit Committee Workplan

Andrew Wood presented a list of items to be considered by the Joint CCG Audit Committee in the year 2014/15. A meeting had been scheduled on 2 June 2014 to sign off the annual accounts of the CCGs.

The Joint CCG Audit Committee agreed the Audit Committee workplan for the year 2014/15.

6 Update on NHS South Commissioning Support Unit (CSU)

Andrew Wood gave a verbal update on the current position with the CSU.

A rectification plan had been put in place to make improvements with the Human Resources, Business Intelligence and Contracting services. Improvements in delivery of service had been made and key performance indicators were being delivered. A paper would be submitted to both Governing Body meetings on the current position.

A senior member of CSU staff was now in attendance at CCG Management Team meetings, giving improved engagement. One issue of note was the shortage of accommodation within Commissioning House, which caused difficulties when asking CSU staff to attend on a regular basis. The CCGs were working with the CSU to change internal culture and to put the relationship on a firm footing.

The CSU was currently undergoing an accreditation process, and was working with the South West Commissioning Support Unit. The NHS Business Services Unit was carrying out accreditation of CSUs.

Members recognised that the CSU had only one source of funding, which was from CCGs. In future CSUs would have to compete for contracts on the open market with companies such as Capita.

The Joint CCG Audit Committee noted the verbal update on the current position with NHS South Commissioning Support Unit.

7 Audit Updates

7.1 Report from Internal Auditors

Pat Stothard presented the following reports to update the Audit Committee on progress against the 2013/14 Internal Audit Plan:

- Internal Audit Progress Report
Current, there were three finalised audit reports, three reports in draft, three reports in progress and five reports to commence. The audit on Commissioning Strategy was in draft, while awaiting further information. The CSU Contract and Performance Management Information audit was in draft form, with agreement on the recommendations. This audit had been carried out in conjunction with West Hampshire CCG. Work was ongoing on the outstanding audits, which would be completed by the end of the financial year. The audit for Hosted Services – Continuing Healthcare was being carried out jointly with West Hampshire CCG, and it was expected that the first draft would be ready by 3 February 2014. Some delays had occurred due to access to Personal Confidential Data. A draft report on Financial Feeder Systems had been issued on 21 January 2014. It had been agreed that the audit on Patient & Public Engagement be deferred. The audit on Quality and Early Warning Systems had begun in December 2013; however there were a number of review points to clear. The Risk Management and Assurance Framework was due to begin on 3 February 2014 and the terms of reference had been issued. The Safeguarding audit had begun on 13 January 2014, and was a joint audit across Hampshire CCGs.

A substantial recommendation had been given following the audit on Financial Sustainability 2013/14. A substantial recommendation had also been given following the audit on Financial Reporting & Budgetary Control. No significant issues had been identified in either area.

A substantial recommendation had been given following the audit on Financial Reporting & Budgetary Control. Four recommendations had been made including the Service Level Agreement for CCG Shared Services should be finalised, and the need to review budget holder access to business intelligence.

Andrew Wood informed the meeting that the recommendations from the audits would form part of the CCGs’ Statement of Financial Control. The recommendations from each audit would give learning points to the organisations.

The Governance Toolkit was a review of self-assessment being audited by NHS South Commissioning Support Unit, which was being overseen corporately. Both Andrew Wood and Julia Barton (Chief Quality Officer) were involved in the process.

The Sustainability Programme Board had now changed to the Accountable Officers Board, with new streamlined Terms of Reference. It was planned to align the strategic plans of the two CCGs with Portsmouth CCG, and triangulate with Portsmouth Hospitals NHS Trust.

The Joint Audit Committee noted the following reports:
• Internal Audit Progress Report
• Final Internal Audit Report – Financial Reporting & Budgetary Control 2013/14
• Final Internal Audit Report – Financial Sustainability 2013/14

7.2 Report from External Auditors

Kate Handy presented a report which summarised the work undertaken to date and plans for the remainder of the 2013/14 year.
The work had been undertaken in liaison with Deloitte & Touche Public Sector Internal Audit Ltd (internal auditors). Reliance would be placed on the work of the internal auditors to:

- Document the financial systems of the CCGs as new organisations; and
- Test the operation of key system controls where it was believed that provided the most efficient approach to discharging the responsibilities of external auditors.

A controls approach would not be taken in the first year, as the CCGs were not expected to pass in year one.

A detailed work plan had been prepared and shared with Andrew Wood, the plan also related to Portsmouth CCG. This would be presented to the Joint Audit Committee in April 2014.

The external auditors would not apply two specified reporting criteria when auditors of CCGs give their statutory conclusion on arrangements to secure Value For Money. This recognised that CCGs were new organisations which were developing arrangements following authorisation.

The Value for Money duty would be met by:

- reviewing the Annual Governance Statement;
- reviewing the results of the work of the Commission and other relevant regulatory bodies or inspectorates (including NHS England reviews), to consider whether there is any impact on the auditor’s responsibilities at the audited body; and
- undertaking other local risk-based work as required, or any work mandated by the Commission.

Ian Young presented the Accounting update. It had been anticipated that a portion of legacy balances from the Primary Care Trusts and Strategic Health Authorities would transfer to CCGs at the beginning of the 2013/14 financial year. However the process had not been straightforward and no balances had been inherited. Further information was awaited from the Department of Health. There may be issues around retrospective claims for Continuing Healthcare.

The Annual Reporting Manual had not been finalised, and guidance would follow.

Following a request, David Bailey agreed to add the cash position of the CCGs to reports to both Governing Bodies.

The Joint CCG Audit Committee noted the contents of the report.

8 Local Counter Fraud Service

8.1 Counter Fraud Update Report

Rachel Struthers presented a report on action undertaken in each of the four strategic areas for countering fraud and corruption in the NHS during the period 1 September 2013 to 31 December 2013.

The areas of responsibility of the Local Counter Fraud Service (LCFS) were being clarified. The LCFS was responsible for counter fraud within the CCGs, but not the NHS England Local Area Team.
Fraud Awareness training was continuing, and work would be carried out with CCG staff. Information on training would be included in the NHS South Commissioning Support Unit training prospectus, and advice would be given to contractors.

The report included details of a number of investigations and sanctions carried out by the LCFS. A number of cases related to prescription fraud. Investigation was being carried out into a claim that a copyright had been breached by the use of a photograph on the Fareham & Gosport CCG website. Andrew Wood explained the issue to members.

Susanne Hasselmann queried if there was a schedule of GP practices which showed whether or not training had been carried out. Rachel Struthers said that information could be provided, but that the training was not mandatory. A presentation would be made to the Practice Managers Forum to generate interest in the subject.

The Joint CCG Audit Committee accepted the Counter Fraud Update.

9 Governance

9.1 Information Governance Update

Andrew Wood informed the meeting that the finance team had not had the ability to validate invoices and had approved a number of invoices for payment under a certain level. The situation had changed, and the finance team now had the ability to check invoices before payment.

The Joint CCG Clinical Cabinet noted the verbal update on information governance.

9.2 Payment by Results data Assurance Framework

Andrew Wood presented a final report detailing the findings from the Payment by Results Data Assurance Framework clinical coding audit undertaken in 2013/14 at Portsmouth Hospitals NHS Trust (PHT). The findings and action plans had been agreed with the providers as part of the audit process, and the full report shared with them for comment.

Members discussed issues around coding. It was believed that there was a proportion of mis-coding, illustrated by over-performance in fractured neck of femur. This was on the agenda of a contract review meeting, and an action plan was in preparation. It was agreed that processes within PHT needed improvement. Members would be informed of how the situation was being managed before the next meeting. Andrew Wood reported that this would be a part of the QIPP for the next financial year.

The Joint CCG Audit Committee noted the report.

9.3 Record of Chair’s Action

Andrew Wood presented the following Records of Chair’s Action, for information:

- Community Heart Failure and Respiratory Pathways – Clinical Cabinet, 23 October 2013

The Joint CCG Audit Committee noted the Records of Chair’s Action.
9.4 **Risk Management Processes**

Nikki Roberts was in attendance to discuss risk management processes, which had been the subject of discussion with Andrew Wood, Sara Tiller (Chief Development Officer) and Julia Barton (Chief Quality Officer).

The risk management process would need to have an executive overview, which would be the Corporate Governance Committee (CGC). This would be a forum for the CCG executive to review risks, which would need solid action plans. Both the Clinical Cabinets and Governing Bodies would then be informed how risks were being dealt with. Training on risk management would be available if needed.

A framework for internal risk management had been submitted as part of the authorisation process, and this would be reviewed. A risk management strategy and policy and processes were also under review.

Each team within the CCGs ran individual risk registers.

Nikki Roberts then explained the reason for the setting up of the Corporate Governance Committee. A paper on the CGC had been submitted to meetings of both Governing Bodies.

Following a discussion, Nikki Roberts would revisit the Terms of Reference of the CGC to take account of input from members. Lay members would be asked for involvement if lay advice was needed.

**The Joint CCG Audit Committee noted the verbal update on risk management process and the Corporate Governance Committee.**

10 **Any Other Business**

10.1 Andy Jefford informed the meeting that the audit division of Deloitte & Touche had transferred to Mazars at the end of January 2014.

10.2 David Bailey reported that a specification for the procurement of internal audit services across Hampshire and the Isle of Wight was in preparation. A Project Board had been set up, and was working to a timetable.

10.3 Tracey Faraday-Drake informed the meeting that she had been approached by a member of the 38 degrees organisation who had raised a challenge on the openness and transparency of the CCGs.

10.4 Malcolm Heritage-Owen informed the meeting that a number of charitable organisations had queried how they could make bids for CCG services.

11 **Date of Next Scheduled Meeting**

Wednesday 23 April 2014
10.00 am – 12 noon
Board Room, Commissioning House
Minutes

Present:
Richard Samuel (RS) Chief Officer (Chair)
Sara Tiller (ST) Chief Development Officer
Andrew Wood (AW) Chief Finance Officer
Alex Berry (AB) Chief Commissioning Officer
Julia Barton (JB) Chief Quality Officer

Administrator:
Josie Abbascia Governance & Committee Administrator

Guest:
Michael Drake Director of Planning & Performance

For information: A glossary of acronyms has been included in the minutes.

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<tr>
<th>Item</th>
<th>Minute:</th>
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<tr>
<td>1.1.14</td>
<td>Welcome &amp; Apologies</td>
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<td>The chair welcomed members and Michael Drake to the meeting.</td>
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<td>No apologies were received.</td>
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<td>2.1.14</td>
<td>Register of Interests</td>
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<td>The register of interests (CGC1.1.14) was considered and it was noted</td>
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<td>they were those as presented to the governing bodies. The chair</td>
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<td>requested members to declare any interests for the agenda and any</td>
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<td>updates to the register. Members had no further updates and agenda</td>
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<td>interests to declare.</td>
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<td>3.1.14</td>
<td>Performance: Q3 assurance self-certification</td>
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<td>The CCGs’ self-certification dashboard (CGC2.1.14) was tabled by</td>
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<td>Michael Drake. The self-certification process indicates the most up to</td>
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<td>date information for both the CCGs and enabling NHS England to have</td>
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<td>insight into the aspects of provider performance which could indicate</td>
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<td>safety concerns for patients. The quarter 3 certificates cover the</td>
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<td>period from October 2013 to December 2013 inclusive. The committee</td>
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<td>noted areas of compliance and the chair asked members to raise any</td>
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<td>queries around the areas of concern.</td>
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<td>Julia Barton requested clarity on whether the performance monitoring</td>
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<td>of SHFT related to MH services as this was not indicated in the specific</td>
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<td>question. Julia noted action plans were in place on the two SHFT</td>
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<td>concerns, however, in order to mitigate any potential risks clarity</td>
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<td>was sought on: (a) whether the CQC enforcement notice related to the</td>
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<td>Trust or community establishment managed by SHFT within the respective</td>
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<td>CCGs’ patch; and (b) the identity of the ‘unclosed SIRI’.</td>
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<td>Action: Michael Drake to liaise with Julia Barton.</td>
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<td>Alex Berry noted that the CCGs were not shown as on track to deliver</td>
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<td>the personal health budget plans by 2015 for patients needing long</td>
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<td>term care and requested a status briefing be produced by the continuing</td>
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<td>care lead to ascertain.</td>
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<td>4.1.14</td>
<td><strong>CGC terms of reference (ToRs)</strong>&lt;br&gt;The chair requested members to consider the draft ToRs (CQC3a.1.14) and recommend any changes prior to endorsement. Sara Tiller gave a brief overview of the purpose of the committee’s business which was to undertake the effective management of corporate governance on behalf of existing committees thereby enabling clinical committees to perform their function of clinical business. <strong>Noted.</strong>&lt;br&gt;Andrew Wood reported that the draft ToRs had been presented to the Audit Committee for consideration where it was agreed that the committee would act as an ‘ensuring’ entity as opposed to an ‘assuring’ entity. No lay member membership is required. <strong>Noted.</strong>&lt;br&gt;Delegation of the performance management element was discussed. Andrew Wood recommended this be re-considered pending the review of the respective governing bodies’ schemes of delegation and constitutions by June 2014. <strong>Agreed.</strong>&lt;br&gt;The Committee discussed further minor changes and the inclusion of other relevant clauses specifically in terms of (i) covering the review of constitutional changes at the appropriate intervals in line with CCG development, prior to approval of the governing bodies and (ii) the acknowledgement of the IG Group as a sub-group of the Committee, with ad-hoc relevant business discussed at internal Management team meetings.&lt;br&gt;Subject to those changes the ToRs were <strong>agreed.</strong>&lt;br&gt;<strong>Action:</strong> Nikki Roberts, Governance &amp; Committee Officer to finalise the ToRs and circulate to members. Final ToRs to be presented to the Governing Bodies.</td>
<td><strong>NR</strong></td>
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<td><strong>Information Governance Group ToRs (IG Group)</strong>&lt;br&gt;The chair requested members to note the IG Group ToRs (CGC3b.1.14) and asked for confirmation of the areas represented by each member of the IG Group. Andrew Wood confirmed the following:&lt;br&gt;Andrew Wood: Chair and SIRO&lt;br&gt;Julia Barton: Deputy chair and Caldicott Guardian&lt;br&gt;Sara Tiller: IG lead and Information Asset Owner&lt;br&gt;Janice Boucher: CSU IG lead for the CCGs&lt;br&gt;Nikki Roberts: Governance lead and Data Custodian&lt;br&gt;Lyn Darby: Commissioning lead&lt;br&gt;Lou Court: Business services lead and Data Custodian&lt;br&gt;The Committee <strong>endorsed</strong> the IG Group ToRs in recognition of its function as a sub-group of the Committee working on matters appertaining to the CCGs’ information governance programme.</td>
<td><strong>MD/AB</strong></td>
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| 5.1.14 | Lay members  
The chair requested Sara Tiller to give an update on the current position with regards to the lay members’ current work remit. Sara advised consultations have taken place with all lay members in line with developing the CCGs’ organisational structure going forward. It would benefit the CCGs if an additional lay member be appointed working across both CCGs and whose role would be to drive forward the integration and partnership working agenda.  

**It was agreed** that each CCG should have a SID (Senior Independent Director), and that an additional lay member should be appointed.  
The chair recommended that Sara prepares a written proposal to include the financial aspect, the proposal to be presented to the respective chairs of both CCGs for consideration. The outcome to be reported at the next committee meeting. **Agreed.**  
**Action:** Sara Tiller. | **ST** |
| 6.1.14 | Equality & Diversity – Equality Delivery System 2 (EDS2)  
The chair requested Sara Tiller to give a brief outline of the EDS2 return (CGC4.1.14).  
Sara explained the CCGs have a statutory duty under the public sector equality duty to publish information about equality. The CCGs are adopting the EDS2 mechanism to meet this requirement. Deadline for initial publication on the CCGs’ websites is the 31st January 2014. The process is measured on providing evidence on 18 outcomes. The strategy officer is the equality lead who has collated evidence from various internal and external sources to this effect. The overall self-assessment indicated the CCGs were ‘developing’ organisations. Arrangements are in place that as from 1st April 2014 the equality function will be delivered by Portsmouth CCGs as part of the 3 CCGs integrated working structure, with F&G & SE Hants CCGs leading on emergency planning. **Noted.**  
The next phase is to test the evidence with the community based on personal experience. The CCGs’ respective community engagement committees have indicated their support and will assess the CCGs’ appraisal of their position. The outcome and any gaps will be monitored through the development of an action plan. **Noted.**  
The chair recommended the committee consider the areas where evidence was not available, the following 2 areas were further considered:  
**Better Health Outcomes:** “1.5: screening vaccination and other health promotion services reach and benefit all local communities”: Andrew Wood and Alex Berry requested further clarity on the CCGs’ accountability for services commissioned by Public Health England and their responsibilities on reporting to the CCGs how they are meeting the needs of both populations.  
The chair recommended the rating to remain red subject to further investigations with Hampshire Public Health and the obtaining of any evidence around primary care vaccination screening for the CCGs’ area populations. **Agreed.**  
**Action:** Sara Tiller.  
**Workforce:** “3.6: Staff report positive experiences of their membership of the workforce”: Sara Tiller explained the self-assessment criteria involved collation of evidence around the outcomes of the national staff survey which NHS England stated was not a compulsory requirement for CCGs. It was therefore decided not to take the survey. (Post meeting note: A letter from NHS England of 10th | **ST** |
September 2013 stated: “It is not compulsory for CCGs, CSUs or Social Enterprises to undertake the NHS national staff survey”.

Members discussed and agreed that a number of staff events are in place to ensure staff have a positive experience within the working environment, that the rating should be changed. **Agreed. Action:** Sara Tiller to investigate further and report at the next meeting.

“4.3: “Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination”: Sara advised this relates to training which is underdeveloped and will be considered going forward.

The committee **endorsed** the first publication of the EDS2 subject to further consideration of 1.5 and 3.6 above.

### 7.1.14 IG Update Report
The chair requested members to note the paper (CGC5.1.14). Andrew Wood gave a brief outline:

Andrew reported the IG Group has been actively involved in collating evidence to ensure the CCGs are meeting the IG Toolkit Levels 1 & 2 compliance by 31st March 2014. Plans to work on level 3 will begin after 1st April 2014. An audit has been arranged for both CCGs in February which should indicate any gaps around the evidence collection process. **Noted.**

**It was noted** that the IG policies and specified procedures were on the committee's agenda for endorsement at today’s meeting.

Andrew expressed concerns on the low number of staff complying with the basic IG training and acknowledgement of the IG Handbook. Sara Tiller stated monitoring with the CSU IG lead is ongoing and pressure will be maintained to ensure staff comply prior to deadline.

**The following actions were agreed:**
- Sara Tiller to arrange for a notice to be placed in the staff newsletter, Commissioning Times.
- Administrator to distribute the IG staff handbooks to those who have not yet completed acknowledgement slips. **Action:** Distribute an up to date non-compliance list to chief officers.
- Chief officers to take responsibility for their teams to include the separate training required to be completed by data custodians and information asset owners giving them appropriate notice to ensure compliance.

Alex Berry requested any reference to ‘planned and unplanned care’ be extracted from any evidence in line for submission and replaced with ‘Commissioning’. **Action:** Sara Tiller to highlight to the CSU IG manager.

### 8.1.14 IG policies F&G & SEH CCGs
The chair requested Andrew Wood to report on the process of developing the seven IG policies (CGC6a-6g.1.14). Administrator stated the F&GCCG policies were not presented as they were in an identical format to the SEHCCGs’; the Governance Office had stated these could be processed as joint policies. **Noted.**

Andrew explained the CSU IG lead had put together a coherent and robust set of draft policies with ownership and input from chief officers, the drafts of which were presented at the IG Group for final approval. The final policies and relevant IG procedures will be accessible to staff via a dedicated folder in the CCGs’ IT system and a programme for staff awareness will be developed and rolled-out. It will also form part of the new staff induction programme, as indicated in the Policy of Policies already ratified at November’s Governing Body meetings. **Noted.**
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<td>Julia Barton recommended a short summary of the policy outlining the basics is attached as an appendix to each policy and an acknowledgement 'read receipt' be included. A policies briefing template was also recommended which could be used for other organisational policies. <strong>Agreed.</strong></td>
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<td>Andrew Wood asked what process will be in place for the adherence of the policies. Julia Barton advised the NHSLA requirements state that each policy has a statement on how organisations monitor compliance. Sara Tiller confirmed the Policy of Policies includes the requirement to audit each policy. It is the function of this committee to oversee that process. <strong>Noted.</strong></td>
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<td></td>
<td>The Committee <strong>ratified</strong> the policies.</td>
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<tr>
<td>9.1.14</td>
<td><strong>Information Governance – papers to endorse</strong></td>
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<td>The chair requested members to consider the following papers for endorsement:</td>
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<td></td>
<td>IG policies framework (CGC6h.1.14)</td>
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<td>Julia Barton explained the paper is an overarching framework which simply defines the IG policies to assist staff to understand their principles. The chair recommended sign-off.</td>
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<td>The Committee <strong>ratified</strong> the framework.</td>
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<td>Privacy Impact Assessment (PIA) – (CGC7a.1.14)</td>
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<td>The chair requested members to note the function of the form as described in the guidance sheet presented and recommended sign-off on the strength that the CSU IG lead qualified its use within the IG frameworks. <strong>Agreed.</strong></td>
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<td>The Committee <strong>ratified</strong> the use of the PIA.</td>
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<td>Health &amp; Social Care Information Sharing Framework (CGC7b.1.14)</td>
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<td>The chair recommended members consider the contents of the framework on the strength that it had been approved and agreed by Hampshire CCG partners, specified providers and as recommended by the IG CSU lead.</td>
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<td></td>
<td>The Committee <strong>endorsed</strong> the framework.</td>
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<td></td>
<td>Training Needs Analysis (TNA) – (CGC7c.1.14)</td>
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<td>Sara Tiller stated the TNA is a map indicating ‘mandatory’ or ‘recommended’ training requirements based on a set of training modules within the IG framework. The SIRO is responsible for ensuring staff are monitored and trained appropriately to meet IG mandatory training. Sara requested the Committee to review or agree the present model, as recommended by the CSU IG lead.</td>
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<td></td>
<td>The Committee <strong>ratified</strong> the present model of the TNA.</td>
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<tr>
<td>10.1.14</td>
<td><strong>Board Assurance Framework</strong></td>
<td>JA</td>
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<td>The Committee noted the papers presented for both organisations (CGC8a &amp; 8b.1.14) which were recently presented to the respective governing bodies. Sara Tiller suggested an in-depth review of the 5-10 risks be undertaken as some of the risks had been mitigated, therefore not reflecting the current progress of both organisations. Sara recommended the review to take place by the executive team at the 14th February management team meeting. <strong>Agreed.</strong></td>
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<td><strong>Action:</strong> Administrator to ensure Karen Pearson, PA to the Chief Officer is made aware.</td>
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<tr>
<td>11.1.14</td>
<td><strong>Schedule of Policies</strong></td>
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<td>The chair recommended that members note the schedule (CGC9.1.14). Sara Tiller advised the schedule is a work-in-progress and policies will be in place by</td>
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<td>Item</td>
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<td>Action:</td>
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<td>31(^{st}) March 2014. <strong>It was agreed</strong> monitoring will continue to meet the deadline.</td>
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</table>

### 12.1.14 Estates (office) update

The chair requested Andrew Wood to update the Committee on the present position regarding staff accommodation.

Andrew Wood reported that as the organisations progress, the necessity to accommodate new and existing CSU staff will increase. To this effect consideration has been given to a suite of offices within the Fort Southwick complex. Update as follows:

- premises require roofing and heating duct works – in progress but no timescale given to complete;
- high rents to consider – the need to triangulate the rent with current premises and consider renegotiation with the leaseholders; and
- potential to lease the building from April 2014 for 12 months – lease would expire in March 2015

The Committee considered the above points and discussed strategic location options to coincide with the potential CCGs’ development towards integrated commissioning with HCC and the current compact arrangements with Portsmouth CCG.

Richard Samuel stated that initial plans on the direction of travel have been discussed with the Director of Adult Services at HCC who has indicated they will be appointing a deputy director to lead the adult services team for both CCGs. Alex Berry and Julia Barton reported that both the commissioning and quality teams were moving towards integration and contact with HCC had been established to that effect. **Noted.**

The chair recommended that Andrew Wood commence active dialogue with HCC and consider the development of a sub-group going forward. **Agreed.**  
**Action:** Richard Samuel to initially inform the Director of Adult Services of this arrangement; Andrew Wood to take forward.

Sara Tiller stated that there is a pressing need for extra office space as due to organisational growth across the CCGs more staff have been deployed and vacancies filled. Sara proposed that as a temporary solution, the boardroom be utilised as additional desk space and appropriate meetings be relocated to external venues, until such time as options have been fully considered in the longer term solution. **Agreed** subject to costs.  
**Action:** Sara Tiller to liaise with the Chief Finance Officer on financial viability and make arrangements with the Business Services Officer on logistics.

### 13.1.14 CSU Autonomy

The chair requested members to note the Lead Provider Framework draft Scope (CGC10.1.14) recently published for consultation by NHS England and requested members to consider the CCGs direction of travel on whether to debate the CSU ‘make, share, buy’ strategy or adopt the integrated commissioning model in collaboration with HCC going forward. Members considered the following:

Andrew Wood reported discussions with the NHS South CSU director have not been conclusive in terms of the development of a sound business services model which aligns with the CCGs’ commissioning requirements although, the CSU have proposed to offer major service redesigns. SLAs and service specifications are currently being reviewed together with the pricing model. **Noted.**

Sara Tiller reported that aspects of the service level agreement, in terms of the quality and delivery of services, have been reviewed on a monthly basis and work has been undertaken with CSU colleagues on improving their current service delivery strategy. Sara stated that the CCGs have a much better understanding of the direction of travel than the previous year prior to authorisation. **Noted**
<table>
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<th>Item</th>
<th>Minute:</th>
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<tr>
<td>14.1.14</td>
<td>Richard Samuel reported that at the recent Hampshire SHIP 8 meeting the CSU director of finance presented a health paper outlining CSU’s business plan for private providers. <strong>Action:</strong> Richard Samuel to circulate to members for information. The Committee agreed that preparations for the “make, share, buy” model should commence. <strong>Action:</strong> Richard Samuel to prepare a paper outlining the CCGs’ model and Andrew Wood to take forward.</td>
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</table>

| 15.1.14 | **Minutes to note**<br>The chair requested members to note the minutes of the IG Group (CGC11.1.14) for 5th December 2013. **Noted.** |

| 15.1.14 | **Any other business**<br>The chair asked members if they wished to raise any other business. Sara Tiller reported that CSU have drafted a policy around managing service transfers between the CSU, CCGs and other service users on the protection of staff in terms of having an appropriate HR process in place which also covers redundancies. The chair suggested the policy be circulated to the Committee for information. **Action:** Sara Tiller Julia Barton reported the annual PHT Cost Improvement Programme (CIP) 2013/2014, has been reviewed for quality assurance. Julia advised whilst some of the schemes have been compliant, there are issues around the Unify return particularly on: length of stay; bed reduction plan; medical workforce; and nursing – monitoring will be ongoing. **Noted.** **Action:** Julia Barton to submit the CIP returns for Richard Samuel to consider. Alex Berry reported that the responses on the contract query notices issued to PHT for cancer and RTT are insufficient. A report will be submitted to the Governing Bodies for further action. The ED contract query notice has been issued to PHT and awaiting a response. **Noted.** Sara Tiller informed members that the Portsmouth News will be running a daily series of articles on PHT and primary care called ‘urgent care week’ commencing on Monday 27th January. The News will be asking readers to answer a series of questions about their experience on urgent care. **Noted.** The chair thanked members and the administrator for their input to a successful first meeting of the Committee. |

| 7 | **Next meeting**<br>The next meeting will take place on the 7th March 2014 at 12.30 in the Finance Office, Commissioning House, Fort Southwick, Fareham. |

**Glossary of acronyms:**

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
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<tbody>
<tr>
<td>BCF</td>
<td>Better Care Fund</td>
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<td>CEC</td>
<td>Community Engagement Committee</td>
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<td>CGC</td>
<td>Corporate Governance Committee</td>
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<td>CIP</td>
<td>Cost Improvement Plan</td>
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<td>CQC</td>
<td>Care Quality Commission</td>
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<td>CSU</td>
<td>Commissioning Support Unit, South</td>
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<td>ED</td>
<td>Emergency Department</td>
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<td>F&amp;G CCG</td>
<td>Fareham &amp; Gosport Clinical Commissioning Group</td>
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<tr>
<td>FFT</td>
<td>Friends &amp; Family Test</td>
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<tr>
<td>GP</td>
<td>General Practitioner</td>
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<tr>
<td>Abbreviation</td>
<td>Description</td>
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<tr>
<td>HCC</td>
<td>Hampshire County Council</td>
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<tr>
<td>HSAB</td>
<td>Hampshire Safeguarding Adults Board</td>
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<tr>
<td>LAT</td>
<td>Local Area Team</td>
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<tr>
<td>MH</td>
<td>Mental Health</td>
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<tr>
<td>NHS</td>
<td>National Health Service</td>
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<tr>
<td>NHSLT</td>
<td>National Health Service Litigation Authority</td>
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<tr>
<td>PHT</td>
<td>Portsmouth Hospitals Trust</td>
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<tr>
<td>PPI</td>
<td>Patient &amp; Public Involvement</td>
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<tr>
<td>SEH CCG</td>
<td>South Eastern Hampshire Clinical Commissioning Group</td>
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<tr>
<td>SHFT</td>
<td>Southern Health Foundation Trust</td>
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<tr>
<td>SIRI</td>
<td>Serious Incidents Requiring Investigation</td>
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<tr>
<td>ToRs</td>
<td>Terms of Reference</td>
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Joint Corporate Governance Committee
Fareham & Gosport and South Eastern Hants Clinical Commissioning Groups

Meeting held on 21st March 2014, Finance Office, Commissioning House, James Callaghan Drive, Fort Southwick, Fareham PO17 6AR

Minutes

Present:
Richard Samuel (RS) Chief Officer (Chair)
Sara Tiller (ST) Chief Development Officer
Andrew Wood (AW) Chief Finance Officer
Julia Barton (JB) Chief Quality Officer

Guests: Michael Drake, Director of Planning & Performance
Dr Barbara Rushton, Chair SEHCCG

Apologies: Alex Berry, Chief Commissioning Officer

Administrator: Josie Abbascia, Governance & Committee Administrator

For information: A glossary of acronyms has been included in the minutes.

<table>
<thead>
<tr>
<th>Item</th>
<th>Minute:</th>
<th>Action:</th>
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<tbody>
<tr>
<td>1.3.14</td>
<td>Welcome &amp; Apologies</td>
<td>The chair welcomed members, Dr Barbara Rushton and Michael Drake to the meeting. Apologies were noted.</td>
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<tr>
<td>2.3.14</td>
<td>Register of Interests</td>
<td>The register of interests was produced (CGC1.3.14). The chair requested members to declare any interests for the agenda and any updates to the register. Members had no updates to the register or agenda interests to declare.</td>
</tr>
<tr>
<td>3.3.14</td>
<td>Unconfirmed minutes 24th January 2014</td>
<td>The unconfirmed minutes (CGC2.3.14) were produced and confirmed as accurate. There were no matters arising from the minutes.</td>
</tr>
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Action log:
The Committee agreed the closure of those actions rated green. The chair requested members to consider the following remaining actions:

3. Lay members–SID: Open: Dr Barbara Rushton received an overview of the proposal from Sara Tiller and Richard Samuel.

Further actions arising from the discussion:
(a) Richard Samuel to discuss options with the Governance lay member and advise Sara Tiller of outcome for inclusion in the proposal. RS
(b) Sara Tiller to discuss governance options with the Medical Director, Wessex LAT. ST
(c) Sara Tiller to present a final proposal to the Chairs of both governing bodies prior to submission at the next meeting of the Remuneration Committee. ST
(d) Administrator to ensure this item is included on the agenda of the next Remuneration Committee meeting. JA

9b. CIP return: Open: Richard Samuel expressed concerns on the delayed submission of the CIP return by PHT. Julia Barton stated an updated version was being withheld by the Trust and will escalate to the medical director for its return.

Action: Julia Barton to update on outcome at next meeting. JB
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<td>4.3.14</td>
<td>Note approval of ToR</td>
<td>The amended draft ToR (CGC4.3.14) was produced. <strong>It was noted</strong> that at the last meeting it was agreed that the ToR would be agreed outside the meeting. Andrew Wood and Julia Barton had previously approved the amendments. The chair requested all members to formally approve the draft ToR. The Committee <strong>endorsed</strong> the ToR as final.</td>
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| 5.3.14 | Corporate timetable for GBs and CCs | Sara Tiller presented the draft governance timetable (CGC5.3.14) for 2014/2015 showing the meeting dates for both the CCGs’ governing bodies and clinical cabinets and requested members to note the deadline dates for submission of papers the final of which will be presented at the next meeting for endorsing. **Noted.** The chair recommended the following actions:  
  - Sara Tiller to produce a final version at the next meeting.  
  - Chief Officers to ensure deadlines are met for submission of reports from each directorate in accordance with the deadline dates. |
| 6.3.14 | Board Assurance Framework – top risks | The chair requested members to note the top risks (CGC6a-6b.3.14) which were recently presented and discussed at the March governing body meetings.  
At the advice of Dr Barbara Rushton, the chair recommended that a 15 minute slot be added to subsequent governing body agendas in order to facilitate a more in-depth review of the BAF. **Agreed.**  
**Action:** Dr Barbara Rushton to discuss this option with the Governance & Committee Officer at the agenda setting meetings.  
Julia Barton recommended a review of the internal risk management system be undertaken, in terms of the collection, amalgamation, presentation and final scrutiny of all directorate risks. Sara Tiller advised both the Director of Planning & Performance and Governance & Committee Officer are presently liaising on devising an alternative process in the capturing of risks. **Noted.**  
The chair recommended that each directorate retains a record of their own risks and that a peer review of each directorate’s top risks, on a rotational basis, is presented for scrutiny at this committee. **Agreed.**  
**Note for Administrator:** to note for subsequent agendas. |
| 7.3.14 | Strategy paper | The chair requested Sara Tiller to provide an update on the current status of the paper (CGC7.3.14). Sara Tiller stated the Strategy is presently in its first draft format and requested a more detailed review be undertaken prior to next submission on 4th April, the deadline of which was **noted.** The chair recommended members review the draft directly after the meeting. **Agreed.**  
**Action:** Sara Tiller to update at the next meeting. |
| 8.3.14 | Operational Plan | Michael Drake tabled the plan (CGC8.3.14) and requested the Committee to consider the draft plan prior to submission to NHS England on 4th April. The chair noted the deadline and recommended a review of the paper be undertaken directly after the meeting. **Agreed.**  
**Action:** Michael Drake to update at the next meeting. |
| 9.3.14 | Performance & Planning Tool | Michael Drake presented a briefing paper (CGC8b.3.14) and requested that the Committee consider the use of the tool across both organisations. The chair requested Michael to give a brief summary of the proposal. Michael explained the tool will enhance the ability to deliver an effective and |
### Item 1.3.14
**Minute:**

Efficient planning and performance service to the CCGs enabling management of data more efficiently and in a proactive way. The tool is an ‘add-on’ module to the existing programme and does not require additional funding in terms of procurement but a licensing fee is required. Sara Tiller stated the tool is currently being considered with the Governance & Committee Officer for its practical use on its ability to provide alerts in the mitigation of risks.

**Action:**

- It was agreed that a demonstration of the tool be arranged with participation of relevant key staff.
- **Action:** Michael Drake.

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### Item 10.3.14
**Financial Risk Sharing Agreement**

The chair requested Andrew Wood to outline the purpose of the paper (CGC08c.3.14). Andrew explained the agreement is based on the commissioning shared funding arrangements with Portsmouth CCGs for the acute contract 2013/2014 spend for ITU, drugs and devices. Members considered the contents of the agreement and supported the collaborative funding arrangement with Portsmouth CCGs.

The Committee **ratified** the agreement.

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### Item 11.3.14
**IG update report**

The chair requested Sara Tiller to give a brief outline of the IG report (CGC9.3.14). Sara Tiller stated the report highlights evidence outstanding for the IG toolkit requirements which is being addressed. Sara gave further assurances that HITS, the IG CSU team and the CCGs’ Governance team are successfully co-ordinating efforts to realise compliance by 31st March 2014. Staff IG training is also being monitored. SIRO to ratify the final compliance report prior to deadline.

The Committee **acknowledged** the exemplary work and commitment carried out on the CCGs’ behalf from the CSU IG team during the past 12 months and the co-operation of CCG staff towards completion of the IG Toolkit Levels 1 and 2.

The Committee **received and noted** the report.

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### Item 12.3.14
**NHS Commissioning Board – NHS Standard Contracts**

The administrator tabled the NHS contracts for formal committee endorsement. The chair requested assurance that the provider contract schedules had been adopted by both organisations throughout 2013/2014. Andrew Wood confirmed this was the case and assurances have been received from the CSU contracts lead that the list of contracts provided have been reviewed for compliance with the IG clauses, ensuring action plans are in place for any contracts that are found to be lacking. Andrew stated an email confirming adoption has been sent to the CSU IG Manager as evidence of compliance for the toolkit. **Noted.**

The Committee **endorsed** the formal adoption of the contract schedules in light of the assurances received by Andrew Wood and the CSU contracts lead.

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### Item 13.3.14
**IG policies framework – structure chart**

The chair noted the framework had been ratified previously in January and requested Sara Tiller to explain the reason for the resubmission of the Structure Chart. Sara stated the chart was presented with a minor change and requested the Committee to note that the previous reference to Chase Community Hospital was inappropriately entered and had been deleted.

The Committee **approved** the amendment.

**PIA procedure – Cloud screening**

Sara Tiller requested that the Committee consider the approval of the Cloud screening questionnaire attached to the PIA (CGC14b.3.14), which had been...
endorsed at the last meeting, for use within the CCGs. The chair requested further clarity on its use.

Sara Tiller advised the CCGs are required to have PIA assessment carried out against all projects undertaken across the organisation to determine risk on the downloading of patient identifiable or sensitive and confidential data. The Planning & Development team have piloted the process which is now embedded within their projects and plans.

Andrew Wood explained the ‘Cloud’ software stores data on multiple virtual servers (accessed via the internet) that are generally hosted by third parties. The Cloud questionnaire requires ‘Cloud’ users to comply with IG governance standards. Sara Tiller gave an example of the ‘Board Packs’ system which is a Cloud based data website, currently used throughout the organisation, which would require this type of screening. A retrospective audit will be carried out.

Julia Barton requested that the IG Policy Framework be reviewed to ensure the Cloud screening process has been included.

The chair concluded and the Committee agreed the following actions:
(a) that the use of the Cloud be adopted as part of the PIA;
(b) that the PIA in its present format be rolled out across the organisation;
(c) that a retrospective audit be undertaken on the screening process for ‘Board Packs’; and
(d) that the PIA be included as an appendix to the Confidentiality Policy and noted on the IG Policy Framework.

### Policies

The chair requested members to consider the ratification or review of the organisational policies (CGC15a-15l.3.14) as presented. Andrew Wood stated a majority of the policies, IG and corporate facing, had been scrutinised at the recent IG Group meeting and approved by its members.

Andrew Wood and Sara Tiller explained policies 4-11 (following the numbering in on the agenda) were ICT policies which have been formally adopted by HITS and which were recommended for adoption by the CCGs as HITS customers. Formal confirmation of adoption is shown in the attached email of 6th March 2014 from the CSU Director to the CSU IG lead. Noted.

Discussions took place. As part of the CCGs’ policies development plan, members were satisfied that the adopted policies were CCG facing and met the criteria set by the NHS Commissioning Board’s standards and rules on information governance for the development of all policies and that they were simplistic in their content to help staff and the public in their understanding of each policy.

The Committee was satisfied the above criteria had been met and agreed to ratify the following policies:

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<tr>
<th>Policy No:</th>
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<tr>
<td>ICT/001/V1.0</td>
<td>Access Control</td>
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<tr>
<td>ICT/002/V1.0</td>
<td>Password</td>
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<tr>
<td>ICT/003/V1.0</td>
<td>Sending Information to Third Parties</td>
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<tr>
<td>ICT/004/V1.0</td>
<td>Network Security</td>
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<td>ICT/005/V1.0</td>
<td>Clear Screen</td>
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<tr>
<td>ICT/006/V1.0</td>
<td>Clear Desk</td>
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<tr>
<td>ICT/007/V1.0</td>
<td>Antivirus</td>
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<tr>
<td>ICT/008/V1.0</td>
<td>Acceptable Use (Email &amp; Internet)</td>
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<td>Q&amp;S/007/V1.0</td>
<td>Complaints</td>
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<tr>
<td>IG/009/V1.0</td>
<td>Copyright</td>
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<tr>
<td>IG/010/V1.0</td>
<td>Intellectual Property</td>
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<td>Item</td>
<td>Minute:</td>
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<td><strong>15.3.14</strong></td>
<td><strong>1. Estate (office) update</strong>&lt;br&gt;The chair requested Andrew Wood to provide an update on office accommodation. Andrew Wood stated no further progress to report and still at negotiation stage. Permission has been granted for the CCGs to utilise offices in the Commcen building at Fort Southwark as an alternative meetings venue for the facilitation of local meetings. <strong>Noted.</strong></td>
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<td><strong>2. GP Estate</strong>&lt;br&gt;The chair requested members to consider the relocation of local surgeries in accordance with the criteria being set by NHS England and NHS Property Services to centralise surgeries into multi-practice centres and the likely health implications this would have on deprived populations. Reference was made to the loss of Emsworth and the relocation of Staunton Park to Leigh Park. Members discussed this in detail.&lt;br&gt;&lt;br&gt;<strong>It was agreed</strong> this would be taken up with the GP Alliance for further discussion prior to discussion at the respective Clinical Cabinets.&lt;br&gt;&lt;br&gt;<strong>Action:</strong> Sara Tiller</td>
<td>ST</td>
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<td><strong>3. Estate costs</strong>&lt;br&gt;Andrew Wood reported recently receiving a request from Solent NHS Trust for payment of £400,000 to meet the shortfall in estate costs for services at Oak Park and Fareham Community Hospital. NHS Property Services assumed this was an inherited cost from Hampshire PCT for which the CCGs had liability which is not the case. Members were asked to consider the point of principle in that Hampshire PCT breached the excess costs. This issue only applies to Solent NHS Trust.&lt;br&gt;&lt;br&gt;Richard Samuel stated that with the allocation of new estate consideration should be given to any premium payments attached to community support organisations as CCG funds were not allocated for this purpose.&lt;br&gt;&lt;br&gt;<strong>It was noted</strong> that the CCGs would only be liable for costs attached to the services they commission.</td>
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<td><strong>16.3.14</strong></td>
<td><strong>HR report</strong>&lt;br&gt;The chair requested members to consider the report (CGC16.3.14) and requested Andrew Wood for any comments or concerns.&lt;br&gt;&lt;br&gt;Andrew advised information on staff sickness and recruitment levels was lacking and the accuracy of data was questionable. The overall reporting method was too generalised which did not reflect the current staffing position for the CCGs. <strong>Noted.</strong>&lt;br&gt;&lt;br&gt;The chair recommended the report is received and to ensure the next and subsequent reports reflect the needs of the CCGs. <strong>Agreed.</strong>&lt;br&gt;&lt;br&gt;<strong>Action:</strong> Andrew Wood to address with CSU HR personnel.</td>
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<td><strong>17.3.14</strong></td>
<td><strong>Commissioning Support Unit</strong>&lt;br&gt;The chair requested members to consider the level of quality services to date</td>
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<td>provided by the CSU in terms of achieving the CCGs’ requirements for their patient populations and the consequences of non-delivery in terms of business continuity. The service areas of concern are: (a) human resources; (b) business intelligence; and (c) contracting.</td>
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<td>Members discussed the option of undertaking a review of these services in accordance with the ‘make, share, buy’ arrangements available to the CCGs. Areas of concern included:</td>
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<td>• the inability for each directorate to meet targets and deadlines within the scope of their business due to the none or late delivery of vital accurate data;</td>
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<td>• unresolved internal staffing issues and the non-provision of essential staff contracts;</td>
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<td>• delays in the provision of provider reports and essential provider contract monitoring; and</td>
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<td>• lack of transactional knowledge in systems and processes.</td>
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<td>It was agreed that in accordance with the recommendations made by NHS England for the ‘Make, Share, Buy’ toolkit, options be considered to ensure appropriate workforce requirements are in place, taking into account compliance with the NHS Agenda for Change criteria; to include shared preferences with Portsmouth CCG in line with the Compact arrangements.</td>
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<td></td>
<td>Action: Sara Tiller and Andrew Wood to take this forward.</td>
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<tr>
<td>18.3.14</td>
<td>Joint Commissioning Hub</td>
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<td>Richard Samuel reported that the Adult Social Services Director for HCC had developed a draft Memorandum of Understanding in the form of a single team model between HCC, the CCGs and proposed representation from Public Health. The model is still under discussion and an update will be brought to the next Committee meeting. Noted.</td>
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<td>Action: Richard Samuel to provide a briefing paper at the next meeting.</td>
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<tr>
<td>19.3.14</td>
<td>Minutes to note</td>
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<td></td>
<td>The Committee received and noted the IG Group minutes (CGC17a-b.3.14) of 31st December 2013 and 28th January 2014.</td>
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<tr>
<td>20.3.14</td>
<td>Any Other Business</td>
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<td></td>
<td>1. Organisational Development (OD) Plan</td>
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<td>Sara Tiller presented the OD plan (CQC18.3.14) to the Committee stating this will form part of the Quarter 3 assurance submission to NHS England and requested members to note the paper outlines the CCGs' working programme around the six domains for organisational development. Noted.</td>
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<td>The chair recommended the plan be discussed at the next Assurance pre-meet. Agreed.</td>
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<td>Action: Sara Tiller to provide a brief.</td>
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<td>Primary Care – GP practice contracts</td>
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<td>The chair requested members to consider the issues encountered around the DES contract overlap with the care home LCS elective care element and modifications to the latter in terms of duplication and excess funds. Sara Tiller gave an overview of the current concern and cited the specific contractual requirement to inform the committee. The elective element will be discussed at the next SE Hants Clinical Cabinet meeting. Further discussions took place.</td>
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<td>The chair concluded and recommended that an email discussion take place between members and the CCG chairs and to consider the following options:</td>
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<tr>
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<td>1. Whether to adopt the care home model to go DES plus;</td>
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<td>2. Whether the DES plus and care home model is divided;</td>
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<td>3. Whether to combine into one elective model as an LCS;</td>
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<td>4. Whether we commit the resource under any LCS and utilise the funds to create a referral facilitation service where practices can benefit from</td>
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<td>Item</td>
<td>Minute:</td>
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<td>financially. The Committee <strong>agreed</strong> this course of action prior to presenting to Clinical Cabinet. <strong>Action:</strong> Sara Tiller to brief members and the CCG chairs on the above four options.</td>
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<td></td>
<td>2. <strong>TARGET.</strong> Sara Tiller reported that NHS England South have written to all the CCGs specifying that they are not prepared to allow practices to close for one afternoon every 2 months to facilitate GP attendance at TARGET. Alternative options are being considered. <strong>Noted.</strong></td>
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<td><strong>Next meeting</strong> The next meeting will take place on the 16th May 2014 at 12.30 in the Finance Office, Commissioning House, Fort Southwick, Fareham.</td>
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**Glossary of acronyms:**

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
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<tbody>
<tr>
<td>CCs</td>
<td>Clinical Cabinets</td>
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<td>CGC</td>
<td>Corporate Governance Committee</td>
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<tr>
<td>CIP</td>
<td>Cost Improvement Plan</td>
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<td>CSU</td>
<td>Commissioning Support Unit, South</td>
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<td>DES</td>
<td>Directed Enhanced Services</td>
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<td>F&amp;G CCG</td>
<td>Fareham &amp; Gosport Clinical Commissioning Group</td>
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<tr>
<td>GB</td>
<td>Governing Bodies</td>
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<tr>
<td>GP</td>
<td>General Practitioner</td>
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<tr>
<td>HITS</td>
<td>Hampshire IT Solutions</td>
</tr>
<tr>
<td>HCC</td>
<td>Hampshire County Council</td>
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<tr>
<td>IG</td>
<td>Information Governance</td>
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<tr>
<td>LAT</td>
<td>Local Area Team</td>
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<td>LCS</td>
<td>Locally Commissioned Services</td>
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<tr>
<td>LES</td>
<td>Local Enhanced Services</td>
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<td>OD</td>
<td>Operational Development</td>
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<tr>
<td>PIA</td>
<td>Privacy Impact Assessment</td>
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<tr>
<td>PPI</td>
<td>Patient &amp; Public Involvement</td>
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<td>SEH CCG</td>
<td>South Eastern Hampshire Clinical Commissioning Group</td>
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<td>SID</td>
<td>Senior Independent Director</td>
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<td>SIRO</td>
<td>Senior Information</td>
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<tr>
<td>ToRs</td>
<td>Terms of Reference</td>
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Joint Corporate Governance Committee
Fareham & Gosport and South Eastern Hants Clinical Commissioning Groups

Meeting held on 28th April 2014, Finance Office, Commissioning House, James Callaghan Drive, Fort Southwick, Fareham PO17 6AR

Confirmed Minutes

Present:
Richard Samuel (RS) Chief Officer (Chair) – part of meeting
Andrew Wood (AW) Chief Finance Officer (deputy chair) – part of meeting
Sara Tiller (ST) Chief Development Officer
Andrew Wood (AW) Chief Finance Officer
Julia Barton (JB) Chief Quality Officer

Guest: Keeley Ormsby, Primary Care lead, CCGs
In attendance: Dr Barbara Rushton – Chair SEH CCG Governing Body
Apologies: Richard Samuel (part of meeting)
Sara Tiller

Administrator: Josie Abbascia, Governance & Committee Administrator

For information: A glossary of acronyms has been included in the minutes.

<table>
<thead>
<tr>
<th>Item</th>
<th>Minute:</th>
<th>Action:</th>
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<tbody>
<tr>
<td>1.4.14</td>
<td>Welcome &amp; Apologies</td>
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<td>The chair welcomed members and Keeley Ormsby, the CCGs’ Primary Care lead. Apologies were noted.</td>
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<td>The chair notified members of his early departure from the meeting at 1.30 pm and recommended that due to time constraints the order of the agenda is as below with Andrew Wood, deputising thereafter:</td>
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<td></td>
<td>1. 2.4.14:Register of Interests</td>
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<td>2. 9.4.14:Locally Commissioned Services (LCS) – Pace of Change</td>
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<td>3. 10.4.14:Better Care Fund submission</td>
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<td>4. 13.4.14:Estates</td>
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<td>5. 14.4.14:HR</td>
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<td>6. 15.4.14:CSU</td>
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<td></td>
<td>For the purposes of the minutes, these will be recorded in the same sequence as the formal agenda.</td>
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<td></td>
<td>Noted and agreed.</td>
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<td>2.4.14</td>
<td>Register of Interests</td>
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<td>The register of interests was produced (CGC1.4.14). The chair requested members to declare any interests for the agenda and any updates to the register. Members had no updates to the register or agenda interests to declare.</td>
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<td>It was noted that Dr Barbara Rushton, in attendance, declared a conflict of interest on any discussions around the LCS (item no: 9.4.14) as a GP for the Liphook and Liss practice. The chair proposed for Dr Rushton not to participate in any of the discussions. Agreed and noted.</td>
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</table>
### Item 3.4.14

**Minute:**
(a) Unconfirmed minutes 21 March 2014
The unconfirmed minutes (CGC2.4.14) were produced. Julia Barton requested a small change be made to the wording at 3.3.14 – 9b – action log from ‘withheld’ to ‘awaited’. **Noted.** Subject to this change the minutes were confirmed as accurate.

(b) Matters arising from the minutes: there were no matters arising from the minutes.

(b) **Action log (CGC3.4.14):**
The Committee agreed the closure of those actions rated green. The deputy chair requested members to consider the open items. The outcome has been recorded in the attached log. **Action no. 3.4.14-9b:** Alex Berry requested sight of any approved CIPs. **Action:** Julia Barton to submit to Alex Berry.

### Item 4.4.14

**BAF Review**
The deputy chair requested members to note both the F&G & SEH CCGs’ Risk Registers (CGC4a-4b.4.14) and requested Nikki Roberts to brief members on the Top Five Risks (CGC4c.4.14) in terms of changes to risk scoring. Nikki explained both the F&G and SEH CCGs’ risk registers are identical with the exception of Chase Community Hospital for SEHCCGs which has been included. **Noted**

#### Top Five Risks
1-4: Whole system direct call to address bed capacity and initiate patient discharge and patient flow: this risk has progressed in terms of changing the control. Liaise with Commissioning lead re scoring.
6-8a: Delivery of the PHT financial plan 2013/2014 – sustainability issue: risk score remains.
6-14: CCGs’ potentially unable to receive the quality premium for 2014/2015 due to cost pressures: risk score remains.
6-18: Chase Project: GPs yet to agree occupation of the premises – risk score remains.

**Action:** Nikki Roberts to make the recommended changes. **Noted.**

The Committee agreed the recommended changes and remaining risks.

**BAF update to April**
The deputy chair requested members to note the BAF updated schedule (CGC4d.4.14). **Noted.**

### Item 5.4.14

**Commissioning peer review of directorate risk register**
The deputy chair requested members for any comments/concerns on scoring and appropriate recording of the key issues in the commissioning risk register (CRR) (CGC5.4.14). Members discussed the following risks:

1-3: NHS 111 & OOH: scoring for the 111 service is low and has been mitigated. Delete from BAF and CRR. OOH risk to be entered as a separate risk both on the BAF and the CRR.

**2-1:** Primary Care providers - integrated care: risk scoring to be reviewed.

**3-1:** RTT: risk and score remains at 12. **Action:** Julia Barton to check this has been included in the quality provider risk register in terms of impacting on the quality of care.

Hospital discharge: timeliness of discharge is still an issue – risk score to be raised appropriately.

**Stroke TIA:** stroke service model tender lifted – risk score to be raised appropriately.

Ophthalmology: risk score to be raised appropriately. Julia Barton confirmed PHT have not met their target to decrease their backlog.

MSK and pain service: risk has been mitigated, contingency plan in place.

**Action:** Julia Barton to submit to Alex Berry.
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<th>Item</th>
<th>Minute:</th>
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<td><strong>Care Homes:</strong> risk and score changed and reflected in the April CRR; risk remains with a lower score.</td>
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<td><strong>Cancer:</strong> risk mitigated; this will be reflected in the April update to the register.</td>
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<td>5-1</td>
<td><strong>Fragmentation of joint commissioning strategies for MH:</strong> score decreased; issues are more visible as a result of awareness across the patch. Julia Barton raised concerns around the CAMHs work stream on delayed referrals. Alex advised any issues regarding CAMHs should be communicated to the Vulnerable Persons teams and Children and Maternity lead for inclusion on their respective risk registers. The MH liaison risk is also included in the Vulnerable Persons teams’ risk register. <strong>Julia to note.</strong></td>
<td>JB</td>
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<td>Dr Rushton also recommended any CAMHs issues should also be brought to the Hampshire Commissioning Group with a view to action. <strong>Julia to note.</strong></td>
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<td><strong>Community care:</strong> Risk score to be reviewed.</td>
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<td>Alex Berry advised there are a number of new Tier 2 contracts that will need to be included in the NHS contracts review and managed by the CSU contracting team. <strong>Action:</strong> Andrew Wood stated this is in hand and will follow-up accordingly.</td>
<td>AW</td>
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<td>Julia Barton suggested it would be beneficial to all staff if all local risk registers were linked and a process be established to allow viewing access only to each directorate’s risk register. This would enable information to be shared more robustly and assist in the mitigation of risks allowing up-to-date information to be accessed on a regular basis. <strong>Agreed. Action:</strong> Nikki Roberts.</td>
<td>NR</td>
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</table>
| 6.4.14 | **Strategy update**  
The deputy chair requested Nikki Roberts to provide an update. Nikki reported a revised version of the strategy paper was submitted to all GP members and relevant personnel. All amendments provided have been incorporated. Dr Rushton and the Committee commended Sara Tiller and her team for producing a comprehensive paper. |         |
| 7.4.14 | **Operational Plan – update**  
Andrew Wood gave an update on the CCGs’ financial activity returns for 2013/2014 which have now been submitted to NHS England’s Wessex LAT. The provider submissions are in hand with the Planning & Performance team and are awaiting sign-off prior to submission. The Finance, Planning & Performance report which will be submitted at the next Governing Body meeting will include a full update on the fiscal year submissions. **Noted.** Further discussions took place. |         |
|      | Dr Rushton expressed concerns on the lack of information available to GP locums within practices with regards to elective LCS referrals. Dr Rushton requested that the Harvey Walsh reports produced by the primary care lead, are distributed to practices to ensure any GP locums employed by them are referring appropriately. **Agreed. Action:** Alex Berry to discuss with Sara Tiller going forward. | AB      |
| 8.4.14 | **GB and CC timelines:**  
The deputy chair requested Nikki Roberts to give an update on the reporting timelines and potential agenda items going forward for both the Governing Bodies and the Clinical Cabinets.  
Nikki reported a bi-monthly forward planner has been developed to reflect the reporting timelines for both meetings and provide transparency to agenda planning going forward. The April and May agenda items have been placed in relevant locations within the building on the information boards. Feedback from staff has been positive enabling them to have first-hand knowledge of agenda planning and contributing in the provision of the reports.  
Julia Barton requested clarity on the likely contents of the AO’s report for the governing bodies; agenda planning for the quality surveillance hub and practice |         |

**Corporate Governance Committee Minutes 28.4.14**
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<th>Item</th>
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<td></td>
<td>nursing for clinical cabinets.</td>
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<td>Andrew Wood requested that agenda planning could be extended for 12 months rather than bi-monthly. Nikki advised this is possible with updates being placed on the information boards. The communications and engagement lead is presently liaising with the commissioning team, in terms of forward planning, on the likely timelines around clinical engagement topics for the clinical cabinet agenda. These will be included going forward.</td>
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<td>Alex Berry requested longer notice be given to the teams on presentations for both meetings to aid in preparation. Alex also recommended that the planning and performance team contribute more in terms of providing detailed reporting on key themes i.e. ED improvement works and the elective programme on delivery, to be developed for the governing body commissioning update.</td>
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<td>Dr Rushton suggested that GP members highlight aspects of their portfolios on short paper format for presentation at clinical cabinet.</td>
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<td>The Committee agreed that Nikki Roberts liaise with Sara Tiller and colleagues to take the above actions forward.</td>
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<td>9.4.14</td>
<td>Locally Commissioned Services – Pace of Change</td>
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<td>The chair requested Keeley Ormsby to give an outline of the paper produced (CGC7a.4.14) and for members to consider its contents prior to endorsement. Discussions took place. The chair recommended the paper be endorsed subject to the following changes and actions:</td>
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<td>(a) under the Nursing Home LES that the Brook Lane GP practice will be removed from the classification of being in receipt of a Nursing Home LES and moved into the classification of being received into a medical services payment. This is because of a previous agreement reached between HCC and the NHS that the practice would be paid resource for the delivery of medical services into Hawthorn Court Nursing Home. Agreed.</td>
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<td>(b) that Alex Berry mobilises a member of the commissioning team to take responsibility for working with the Brook Lane GP practice around specifying the medical service supplied and working through performance indicators and the value of the contract on an ongoing basis. Agreed.</td>
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<td><strong>Action:</strong> Alex Berry</td>
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<td>The chair recommended and the Committee agreed that Keeley Ormsby carry out the following actions:</td>
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<td>• report to Sara Tiller on the outcome of discussions;</td>
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<td>• update the paper to reflect the changes discussed and circulate to members indicating changes made;</td>
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<td>• report decisions made to the lead CCG GP for the Brook Lane practice in terms of their nursing home contract;</td>
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<td>• meet with the senior commissioning officer to arrange the transfer of the contract from the primary care team to the commissioning team; and</td>
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<td>• arrange with finance for the funding to be moved from the primary care team to commissioning.</td>
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<td><strong>The Committee ratified</strong> the LCS paper subject to changes discussed at item (a) above.</td>
<td>KO</td>
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<td>10.4.14</td>
<td>Better Care Fund (BCF) submission</td>
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<td>The chair requested Alex Wood to present the paper (CGC8.4.14) for endorsement by the Committee.</td>
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<td>Alex Wood stated the final paper was presented to the respective CCG governing bodies in March 2014 and ratified. It is now being presented to the Committee</td>
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<td>Item</td>
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<td>from a governance perspective for formal sign-off and to note the KPIs, metrics and work that will be taken forward.</td>
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<td>Richard Samuel reported discussions have already taken place with potential BCF colleagues on the proposed funding arrangements and next steps. Alex Berry explained the paper describes a phased cash release approach to full realisation within 5 years.</td>
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<td>Richard explained that in view of the timescales, advice has been sought from financial consultants who have identified three areas where funding could be utilised: (a) cost of individual through improved co-ordinated care – supporting people in their homes health and well-being; (b) scaled procurement – purchasing services as a consortium; and (c) identifying funding over-spend from back office commissioning costs. Funding from other sources to include in the ‘pot’ will be investigated.</td>
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<td>Richard recommended that both Alex Berry and Andrew Wood liaise with primary care, community/acute providers and social care colleagues going forward. It was also recommended that any future IRM (Invited Review Mechanism) trust penalty monies be considered and utilised for patients needing out of hospital care.</td>
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<td><strong>Actions:</strong> Alex Berry and Andrew Wood to mobilise their respective teams to investigate and identify sources of funding in preparation of a briefing for the next meeting. <strong>Noted.</strong></td>
<td><strong>AB/AW</strong></td>
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<td>Nikki Roberts to request the CCGs’ primary care lead to investigate any funding available from the primary care and the practice managers’ challenge fund.</td>
<td><strong>NR</strong></td>
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<td>The Committee agreed the above course of action.</td>
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<td><strong>11.4.14 IG update report</strong></td>
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<td>The IG update was produced (CGC9a-9e.4.14). Andrew Wood, in his capacity as chair of the IG Group, stated that the report is presented to the Committee to note and approve. The official completion of both IG levels 1 and 2 was signed-off by Andrew Wood for both CCGs (in his capacity as SIRO), on the 26th March 2014. The CCGs will be working towards the criteria for level 3 during 2014/2015.</td>
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<td>The Committee noted and approved the report.</td>
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<td><strong>12.4.14 IG SIRI Guidance</strong></td>
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<td>The SIRI Guidance paper (CGC10.4.14) was produced for ratification by the Committee. Members considered the guidance and commended Julia Barton in that it portrayed a workable and simplistic process when reporting AIR IG breaches (Adverse Incident Report). Julia explained the paper will be available in a dedicated folder on G drive for staff to access. <strong>Noted.</strong></td>
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<td>The Committee approved the guidance.</td>
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<td><strong>13.4.14 Estates – general</strong></td>
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<td>The chair requested members to consider the strategic accommodation options for the CCGs available both in the long and short term in line with the new health and social care commissioning model, the compact arrangements with Portsmouth CCG, the Hampshire LIFT (Local Improvement Finance Trust) properties, such as the management of Fareham Community Hospital, Leigh Park and Oak Park; the maintenance of primary care premises; the potential for strategic accommodation for the locality implementation teams and the requirements of community providers, such as SHFT. Discussions took place.</td>
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<td><strong>Members agreed</strong> the following actions:</td>
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**Item** | **Minute:** | **Action:**
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• To forge ahead with the integrated care model proposed for Leigh Park and liaise with NHS England, HCC, NHS Property Services going forward; consideration should be given, in any strategic planning session, to NHS Property Services’ staff restructuring programme in terms of timings and resource.
• To consider the impact of high costs for the LIFT buildings and maintenance requirements;
• To create a workable locality plan around any strategic property requirements, encompassing all elements of the health, community and social care model and liaising with appropriate commissioning partners in the planning process to include the compact arrangements with Portsmouth CCG and accommodating the locality implementation teams.
• To take into account the budget requirements of all parties concerned.
• To consider Lakeside, Havant Plaza, Park Way, Fareham and Segensworth as potential premises and take into account the rental budget requirements, staff liaison of all parties concerned and mobilise the HR teams accordingly.
• To arrange a session with all Chief Officers to present the outcome of investigations.

**Actions:** Andrew Wood and Alex Berry.

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<th>Date</th>
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<th>Description</th>
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<tr>
<td>14.4.14</td>
<td>HR Report</td>
<td>The deputy chair requested members to note the report (CGC11.4.14) and requested members for any comments or concerns. Andrew Wood stated that the HR report was still a work in progress and discussions with the HR lead are ongoing. Sickness levels and staff recruitment were discussed and considered satisfactory. Julia Barton expressed concern that staff mandatory training as well as executive level mandatory training i.e. safeguarding adults and children, was not included in the report and recommended a record of training be produced quarterly in line with the HR report to include GPs and lay members. <strong>Agreed. Action:</strong> Julia Barton to liaise with Sara Tiller. <strong>The Committee</strong> acknowledged the work being carried out to improve the HR report going forward.</td>
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</table>
| 15.4.14 | CSU - update | Andrew Wood reported the following: 
• The proposed re-costing prices for next year have been submitted, with a 5% decrease from last year. 
• There is a cursory reduction on financial services which is not sufficient and on the strength of shared functions with Portsmouth CCGs notice has been given as a result. 
• There are still issues with regards to the contracting function and a specification has been submitted to the CSU with our requirements. Alex explained both work-streams were still RAG rated red in the Commissioning Risk Register which indicated overall performance metrics were at risk of non-delivery. Discussions ongoing. 
• Service specifications are in draft form awaiting sign-off in readiness for the next contract run in October. Alex stated that the commissioning SLA needs to be reviewed as it does not specify the needs of the CCGs from a commissioning perspective. **Action:** Alex Berry to produce a redraft of the |
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<th>Item</th>
<th>Minute:</th>
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|      | SLA and submit to Andrew Wood to take forward.  
• GP IT finance issues need further review; HR service arrangements are also being reviewed.  
The Committee acknowledged the update. | |
| 16.4.14 | Joint Commissioning  
The deputy chair stated this was discussed at 10.4.14 above. **Agreed.** | |
| 17.4.14 | Any other business  
Julia Barton explained in January this year, a website copyright infringement by the CSU occurred involving the use of patient photographs for our CCG brochures. An out of court settlement is still at negotiation stage and the claimant has been advised to seek the advice of a solicitor. CSU legal services lead will keep us informed of developments. **Noted.** | |

**Next meeting**

The next meeting will take place on the 16th May 2014 at 12.30 in the Finance Office, Commissioning House, Fort Southwick, Fareham.

**Glossary of acronyms:**

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
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<tbody>
<tr>
<td>AIR</td>
<td>Adverse Incident Report</td>
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<td>BAF</td>
<td>Board Assurance Framework</td>
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<td>BCF</td>
<td>Better Care Fund</td>
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<td>CCs</td>
<td>Clinical Cabinets</td>
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<td>CGC</td>
<td>Corporate Governance Committee</td>
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<td>CIP</td>
<td>Cost Improvement Plan</td>
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<td>CSU</td>
<td>Commissioning Support Unit, South</td>
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<td>DES</td>
<td>Directed Enhanced Services</td>
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<td>F&amp;G CCG</td>
<td>Fareham &amp; Gosport Clinical Commissioning Group</td>
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<td>GB</td>
<td>Governing Bodies</td>
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<td>Hampshire County Council</td>
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<td>Information Governance</td>
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<td>IRM</td>
<td>Invited Review Mechanism</td>
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<td>Local Area Team</td>
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<td>Locally Commissioned Services</td>
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<td>Operational Development</td>
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<td>Out of Hours</td>
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