

COMMITTEE TERMS OF REFERENCE

Committee	Status	Notes
Remuneration	Final	Approved by the committee in May 2018
Clinical Executive	Final	Approved by the committee on 31 May 2018
Primary Care Commissioning	Final	To take effect as part of full delegation in April 2019
Finance and Performance	Final	Approved by the committee in August 2018
Audit	Final	CFO and Audit Chair approved 6 September 2018
Patient Safety and Quality	Final	Approved by the committee in December 2018

Non-Executive Governing Body Leadership (March 2019)

Name	Governing Body Appointment	Governing Body Lead Roles
Lou Evans	Lay Member Non-Executive Director (Governance and Audit)	Deputy Lay Chair Conflict of Interest Guardian Cyber Security Non Executive Lead Audit Committee Chair Remuneration Committee Chair
David Heath	Lay Member Non-Executive Director (Patient and Public Involvement)	Primary Care Commissioning Committee Chair Remuneration Committee Member Audit Committee Member Quality and Safety Committee Member
Vacant	Lay Member Non-Executive Director (Finance and Performance)	Finance and Performance Committee Member Remuneration Committee Member
Dr Basil Fozard	Secondary Care Specialist Doctor Non-Executive Director	Remuneration Committee Member Quality and Safety Committee Member
Dr Jayne Chidgey-Clarke	Registered Nurse Non-Executive Director	Quality and Safety Committee Chair Workforce Non Executive Lead Remuneration Committee Member Audit Committee Member

REMUNERATION COMMITTEE

TERMS OF REFERENCE

1 INTRODUCTION

- 1.1 The Remuneration Committee (the Committee) is established in accordance with Somerset's Clinical Commissioning Group's constitution, standing orders and scheme of delegation. These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the Committee, and shall have effect as if incorporated into the Clinical Commissioning Group's constitution and standing orders.
- 1.2 The Terms of Reference for the Committee outlined below are defined by the Governing Body and may be amended by the Governing Body at any time.
- 1.3 All Non-Executive Directors of the Governing Body are members of the Remuneration Committee.

2 MEMBERSHIP

- 2.1 The Committee shall be appointed by the Clinical Commissioning Group from amongst its Governing Body members. Membership shall include:
- Non-Executive Director Lay member (Audit and Governance) - Chair
 - Non-Executive Director Lay member (PPI) – Vice Chair
 - Non-Executive Director Lay member – Chair of the Joint Committee for Commissioning Primary Care
 - Non-Executive Director Clinical Member – Registered Nurse
 - Non-Executive Director Clinical Member - Secondary Care Doctor
- 2.2 The Accountable Officer will be in attendance (except when issues regarding his/her own remuneration are discussed) as required by the Committee.
- 2.3 The Associate Director of Human Resources and Organisational Development will be in attendance (except when issues regarding his/her own remuneration are discussed) to provide guidance to the Committee and to draw the Committee's attention to best practice, national guidance and other relevant documents, as appropriate.
- 2.4 No one other than members of the Committee is entitled to be present at Committee meetings, unless specifically invited by the Committee.

3 SECRETARY

- 3.1 The Committee Chair is responsible for providing secretarial support to the committee and will nominate an appropriate individual to this role. The

secretary will be responsible for supporting the Chair in the management of remuneration business.

4 QUORUM

- 4.1 The quorum for a meeting will be a minimum of two Committee members, one of whom should be the Committee Chair or Vice Chair.

5 FREQUENCY AND NOTICE OF MEETINGS

- 5.1 The Remuneration Committee will meet at least once a year and written notice of the date, venue and agenda will be circulated to all Committee members in advance.
- 5.2 A minimum of five days' notice will be given of any meeting together with an agenda of the business proposed to be transacted
- 5.3 If an item needs to be raised on the day, this will be covered under Any Other Business, subject to there being available time. If separate papers require circulation, these should, wherever possible, be issued with the Agenda. This is intended to enable members to have the opportunity to read information in advance.
- 5.4 At the start of each meeting, Members will be asked to confirm the accuracy of the Declaration of Interests.
- 5.5 The minutes of the meeting will be circulated to all members of the Committee, the Accountable Officer and the Associate Director of Human Resources and Organisational Development.
- 5.6 The Chairman of the Committee will report the outcome to the Governing Body on an exceptional basis.
- 5.7 The Chairman of the Committee may call additional meetings as required.

6 REMIT AND RESPONSIBILITIES OF THE COMMITTEE

- 6.1 The Committee shall make determinations about pay and remuneration for employees of the Clinical Commissioning Group (Accountable Officer, other officer members and senior employees) and people who provide services to the Clinical Commissioning Group, and allowances under any pension scheme it might establish as an alternative to the NHS pension scheme (including salary, any performance-related elements/bonuses, other benefits including pensions and cars, and contractual terms and termination of employment).
- 6.2 Any work being undertaken on behalf of the CCG Executive body (GPs, consultants etc), will need to be ratified by the Remuneration Committee, including approval of proposed remuneration.

- 6.3 The Remuneration Committee is authorised by the Governing Body to obtain legal, remuneration or other professional advice as and when required, at the CCG's expense, and to appoint and secure the attendance of external consultants and advisors if it considers this beneficial.
- 6.4 The Remuneration Committee is authorised to decide on the most appropriate action needed in the achievement of its Terms of Reference.
- 6.5 Other duties for the Committee:
- 6.5.1 To determine the broad policy of the contract of employment and remuneration of the Accountable Officer, Executive Directors and other members of the Governing Body.
- 6.5.2 Through its delegated authority, to set individual remuneration arrangements and performance measures for the Accountable Officer, other Directors and members of the Governing Body where there is no national outline.
- 6.5.3 To determine remuneration for those referred to above and in so doing the Committee shall review and agree:
- overall market positioning of the remuneration package
 - individual base salaries and increases
 - any annual and long-term incentive/bonus arrangements, and the relevant targets for performance related schemes
- 6.6 To consult the Accountable Officer about proposals relating to the remuneration of other Directors.
- 6.7 To approve any changes to the standard contract of employment for Directors, including termination arrangements, taking into account any relevant guidance.
- 6.8 To agree terms for the termination of a contract giving due regard to Treasury¹ guidance
- 6.9 To agree and review the extent to which a full time Director takes on a Non-Executive Director or Chairman role of another organisation of comparable size and complexity to Somerset Clinical Commissioning Group.
- 6.10 To approve management policies including personnel policies incorporating the arrangements for the appointment, removal and remuneration of staff.

¹ 'Managing Public Money' www.hm-treasury.gov.uk/psr_mpm_index.htm

6.11 The Workforce Group, chaired by the Non-Executive Director, Registered Nurse, has been established and reports to the Remuneration Committee on matters arising.

6.12 To undertake any other duties as directed by the Governing Body.

7 POLICY AND BEST PRACTICE

7.1 The Committee will apply best practice in the decision making processes relating to its responsibilities, including individual remuneration, performance and terms of service. In so doing the Committee will:

- comply with current disclosure requirements for remuneration
- on occasion seek independent advice about remuneration for Individuals
- ensure that decisions are based on clear and transparent criteria

8 CONDUCT OF THE COMMITTEE

8.1 The Committee will conduct its business in accordance with any national guidance and relevant codes of conduct or good governance practice, including but not exclusively reserved to Nolan's seven principles of public life.

8.2 The Committee will review its performance, membership and terms of reference annually.

9 MONITORING AND REPORTING MECHANISM

9.1 The minutes of each meeting of the Remuneration Committee will be formally recorded and maintained on file by the Chairman for scrutiny by the Governing Body if required.

9.2 The Chair of the Committee will provide a verbal report to the Governing Body on an exceptional basis.

Updated May 2018

CLINICAL EXECUTIVE COMMITTEE

TERMS OF REFERENCE

13 June 2018

1 CONSTITUTION

1.1 The Somerset Clinical Executive Committee is established as a Committee of the Somerset Clinical Commissioning Group (CCG).

2 PURPOSE

2.1 The purpose of the CEC is to support the CCG's Governing Body to deliver its statutory duties as a commissioner and in doing so ensure that high quality safe NHS care is available to meet the healthcare needs of the people of Somerset within available resources.

2.2 These Terms of Reference set out the membership, remit, responsibilities and reporting arrangements of the committee and shall have effect as if incorporated into the Clinical Commissioning Group's constitution and standing orders.

3 MAIN FUNCTIONS

3.1 The Clinical Executive Committee is the primary executive decision making body of the CCG, authorised to make decisions within the powers delegated to it by the CCG Governing Body and is accountable to the CCG Governing Body. Its main functions are:

- responsible for developing the CCG strategy, clinical and other policies, and operational plans for consideration and approval by the Governing Body
- within the strategic and operational planning framework agreed by the Governing Body, the Clinical Executive Committee is the primary decision making body responsible for delivery of these plans. It is held to account for progress against these plans
- to oversee and performance manage clinical commissioning teams and to receive updates on key areas of responsibility
- to oversee and performance manage all operational, financial, clinical and risk management issues
- to oversee and performance manage the quality of commissioned services, quality being defined as clinically effective, personal and safe care
- to ensure that the patient's view has been effectively considered in commissioning decisions made by the group

- to receive reports on statutory corporate responsibilities including Information Governance, Emergency Preparedness, Health and Safety and workforce and inform the Governing Body on recommendations or areas of concern

3.1 The Clinical Executive Committee will operate within the powers delegated to it by the Governing Body as expressed within CCG Standing Orders, Standing Financial Instructions and the Scheme of Delegation.

4 FORMATION OF SUBGROUPS

4.1 The Clinical Executive Committee is able to establish working groups of a fixed term nature in order to take forward significant pieces of work and achieve strategic objectives. These groups will have a clear remit, objectives and benefits realisation.

5 MEMBERSHIP

5.1 The membership of the Clinical Executive Committee is as follows:

- Chief Officer
- GP Clinical Commissioning leads
- Chief Financial Officer and Director of Performance
- Chief Operating Officer
- Director of Quality and Safety
- Director of Strategic Clinical Services Transformation

5.2 The following will be in attendance, with speaking rights, but no voting rights:

- LMC representative
- Senior Management support (short term basis)
- Public Health Consultant

5.3 The Clinical Executive Committee is currently in a period of transition from a previous governance model based on provider localities to this clinical commissioning model. Future representation of locality issues and practice management representation will be through separate Primary Care and Integrated locality development groups within the strategic change programme. It is anticipated that this transfer will be effective from August 2018.

5.4 The Chair of the Clinical Executive Committee will be the Chief Officer. In their absence the role of the Chair will be covered by one of the GP Clinical Commissioning leads who will act as the Vice Chair for that meeting.

5.5 An officer identified as Secretary to the Committee will also be in attendance but have no voting rights.

6 DEPUTISATION

- 6.1 Where a regular member of Clinical Executive Committee is unable to attend, they may nominate a deputy to attend in their place provided this is agreed in advance with the Chair.
- 6.2 GPs and Senior Managers asked to formally deputise for a voting member of the Clinical Executive Committee shall have the same speaking and voting rights as that member.

7 OTHER ATTENDEES

- 7.1 The Clinical Executive will extend invitations to other staff/personnel with relevant skills, experience or expertise as necessary to deal with the business on the agenda. Such personnel will be in attendance and will have no voting rights.

8 APPROACH AND STYLE

- 8.1 Clinical Executive Committee members will behave in ways which facilitate an inclusive, open and transparent style of discussion and decision-making and one in which members and invited guests feel able to contribute fully.
- 8.2 As public servants, members will conduct the business of the Clinical Executive Committee in accordance with the Nolan Principles.
- 8.3 Members are expected to develop an environment where learning from any discussions can take place.

9 ACCOUNTABILITY AND REPORTING

- 9.1 The Clinical Executive Committee is accountable to the Governing Body and will seek its formal approval for these Terms of Reference and any proposed changes to them.
- 9.2 The Clinical Executive Committee will provide the Governing Body with:
- a copy of minutes detailing key decisions or recommendations to part B of the Governing Body
 - a verbal report monthly by the Chair/Chief Officer
 - other regular or ad-hoc reports as requested

10 QUORUM

- 10.1 The Committee is quorate when at least six members are present, including at least four GP members and two executive directors.

10.2 If the meeting is not quorate, a meeting may proceed but recommendations arising from the meeting would require ratification by the Clinical Executive Committee before being taken forward.

11 VOTING

11.1 Where an issue is considered by the Chair to require a vote, voting will be conducted by a show of hands (by voting members)

11.2 In the case a hung vote, the Chair will have a casting vote

12 FREQUENCY OF MEETINGS

12.1 Meetings of the Committee will be held on a monthly basis.

13 MEETING MANAGEMENT

13.1 An Agenda will be issued five days prior to the meeting.

13.2 In usual circumstances requests by Clinical Executive Committee members for items to be included on the Agenda should be sent to the meeting Secretary at least 10 days before the meeting. All requests will be discussed and agreed in advance with the Chair.

13.3 If an item needs to be raised on the day, this will be covered under Any Other Business, subject to there being available time.

13.4 If separate papers require circulation, these should, wherever possible, be issued with the Agenda. This is intended to enable members to have the opportunity to read information in advance.

13.5 Minutes will be kept and the Secretary will record the discussions. The approved Minutes will be issued by the Chair, no later than 10 days after the meeting, and will list the topics discussed, actions agreed and any individual responsible for undertaking the action.

14 MANAGING CONFLICTS OF INTEREST

14.1 Clinical Executive Committee members will remain alert to the potential for a conflict of interest to arise and for the risk of a perception of conflict to arise in the view of external agencies.

14.2 Clinical Executive members will remain vigilant in mitigating the risks of conflicts of interest and measures to achieve this will include:

- The Chair has ultimate responsibility for deciding whether there is a conflict of interest and for taking the appropriate course of action in order to manage the conflict of interest.
- In the event that the Chair of a meeting has a conflict of interest, a Vice Chair is responsible for deciding the appropriate course of action in order

to manage the conflict of interest. If the Vice Chair is also conflicted then the remaining non-conflicted voting members of the meeting should agree between themselves how to manage the conflict(s).

- The Chair should ask at the beginning of each meeting if anyone has any conflicts of interest to declare in relation to the business to be transacted at the meeting. Each member of the group should declare any interests which are relevant to the business of the meeting whether or not those interests have previously been declared. Any new interests which are declared at a meeting must be included on the CCG's electronic database of interests and hospitality to ensure the registers remain up to date.
- An up-to-date schedule of Declarations of Interest for the Committee will be maintained by the Clinical Executive Committee Secretary from the CCG electronic database.

14.3 Where a conflict of interest is identified this will be recorded in the minutes on each occasion and the appropriate action taken could include one or more of the following:

- Where the Chair has a conflict of interest, deciding that a Vice Chair (or another non-conflicted member of the meeting if the Vice Chair is also conflicted) should Chair all or part of the meeting
- Requiring the individual who has a conflict of interest (including the Chair or a Vice Chair if necessary) not to attend the meeting
- Ensuring that the individual concerned does not receive the supporting papers or minutes of the meeting which relate to the matter(s) which give rise to the conflict
- Requiring the individual to leave the discussion when the relevant matter(s) are being discussed and when any decisions are being taken in relation to those matter(s)
- Allowing the individual to participate in some or all of the discussion when the relevant matter(s) are being discussed but requiring them to leave the meeting when any decisions are being taken in relation to those matter(s). This may be appropriate where, for example, the conflicted individual has important relevant knowledge and experience of the matter(s) under discussion, which it would be of benefit for the meeting to hear, but this will depend on the nature and extent of the interest which has been declared
- be the appropriate course of action where it is decided that the interest which has been declared is either immaterial or not relevant to the matter(s) under discussion.

15 REVIEW

15.1 These Terms of Reference for the Clinical Executive Committee are transitional and will be updated in line with the overall strategic change programme for the CCG. Thereafter, they will be reviewed annually.

PRIMARY CARE COMMISSIONING COMMITTEE

TERMS OF REFERENCE

Introduction

1. Simon Stevens, the Chief Executive of NHS England, announced on 1 May 2014 that NHS England was inviting CCGs to expand their role in primary care commissioning and to submit expressions of interest setting out the CCG's preference for how it would like to exercise expanded primary medical care commissioning functions. One option available was that NHS England would delegate the exercise of certain specified primary care commissioning functions to a CCG.
2. In accordance with its statutory powers under section 13Z of the National Health Service Act 2006 (as amended), NHS England has delegated the exercise of the functions specified in Schedule 2 to these Terms of Reference to Somerset CCG. The delegation is set out in Schedule 1.
3. The CCG has established the Somerset CCG Primary Care Commissioning Committee ("Committee"). The Committee will function as a corporate decision-making body for the management of the delegated functions and the exercise of the delegated powers.
4. It is a committee comprising representatives of the following organisations:
 - Somerset CCG
 - Somerset County Council
 - Healthwatch Somerset (observer)
 - NHS England (observer)
 - Somerset Local Medical Committee (observer)

Statutory Framework

5. NHS England has delegated to the CCG authority to exercise the primary care commissioning functions set out in Schedule 2 in accordance with section 13Z of the NHS Act.
6. Arrangements made under section 13Z may be on such terms and conditions (including terms as to payment) as may be agreed between the Board (NHS England) and the CCG.

7. Arrangements made under section 13Z do not affect the liability of NHS England for the exercise of any of its functions. However, the CCG acknowledges that in exercising its functions (including those delegated to it), it must comply with the statutory duties set out in Chapter A2 of the NHS Act and including:
 - a) Management of conflicts of interest (section 14O);
 - b) Duty to promote the NHS Constitution (section 14P);
 - c) Duty to exercise its functions effectively, efficiently and economically (section 14Q);
 - d) Duty as to improvement in quality of services (section 14R);
 - e) Duty in relation to quality of primary medical services (section 14S);
 - f) Duties as to reducing inequalities (section 14T);
 - g) Duty to promote the involvement of each patient (section 14U);
 - h) Duty as to patient choice (section 14V);
 - i) Duty as to promoting integration (section 14Z1);
 - j) Public involvement and consultation (section 14Z2).
8. The CCG will also need to specifically, in respect of the delegated functions from NHS England, exercise those in accordance with the relevant provisions of section 13 of the NHS Act.
9. The Committee is established as a committee of the Governing Body of Somerset CCG in accordance with Schedule 1A of the “NHS Act”.
10. The members acknowledge that the Committee is subject to any directions made by NHS England or by the Secretary of State.

Role of the Committee

11. The Committee has been established in accordance with the above statutory provisions to enable the members to make collective decisions on the review, planning and procurement of primary care services in Somerset, under delegated authority from NHS England.

12. In performing its role the Committee will exercise its management of the functions in accordance with the agreement entered into between NHS England and Somerset CCG, which will sit alongside the delegation agreement and terms of reference.
13. The functions of the Committee are undertaken in the context of a desire to promote increased co-commissioning to increase quality, efficiency, productivity and value for money and to remove administrative barriers.
14. The role of the Committee shall be to carry out the functions relating to the commissioning of primary medical services under section 83 of the NHS Act. This includes the following:
 - GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action such as issuing branch/remedial notices, and removing a contract);
 - Newly designed enhanced services (“Local Enhanced Services” and “Directed Enhanced Services”);
 - Design of local incentive schemes as an alternative to the Quality Outcomes Framework (QOF);
 - Decision making on whether to establish new GP practices in an area;
 - Approving practice mergers; and
 - Making decisions on ‘discretionary’ payment (e.g. returner/retainer schemes).
15. The committee will also carry out the following activities:
 - Plan, commission and deliver primary medical services for the population of Somerset
 - Make primary care commissioning decisions; contribute to the development of the primary care strategy, ensuring recommendations are in line with the CCG Governing Body’s Health and Care Strategy,
 - Oversee the implementation and delivery of the primary care strategy and work plan
 - To secure the provision of comprehensive and high quality primary medical service in Somerset
 - To co-ordinate a common approach to the commissioning of primary care services generally

- To make decisions on investment on the infrastructure of primary medical services, to ensure adequate and high quality provision as well as value for money for the public.
- Undertake reviews of primary medical services in Somerset
- To manage the commissioning budget for primary medical services in Somerset
- Provide oversight across a number of functions, including but not limited to: Primary Care Workforce; Primary Care Premises; Primary Care Information Management and Technology (IM&T); Primary Care Networks

Geographical Coverage

16. The Committee will comprise of Somerset CCG who will undertake the function of commissioning primary medical services for Somerset.

Membership

17. The Committee shall consist of:

Somerset CCG

- Non-Executive Director (Chair) (V)
- Non- Executive Director (Vice Chair) (V)
- Director of Finance, Performance and Contracting (V)
- Chief Operating Officer (V)
- Deputy Director of Contracts (V)
- Associate Director of Primary Care (V)
- Director of Quality and Nursing or Associate Director of Safety and Quality Improvement (V)
- GP Clinical Lead Primary Care
- GP Representative from a neighbouring CCG (V)
- Patient Representative (PPG Chairs) (V)

Somerset County Council

- Representative for Public Health (V)

In Attendance

- NHS England Head of Primary Care or nominated representative
- Somerset Local Medical Committee representative
- Somerset Healthwatch representative

18. The Chair and Vice Chair of the Committee shall be CCG Non-Executive Directors.
19. The non-voting attendees of the Committee will include a standing invitation to representatives from NHS England, the Local Medical Committee, Healthwatch and the Health and Wellbeing Board. The nominated representatives are invited to stay for the private session of the meeting, but the Chair reserves the right to exclude attendance for individual items when considered appropriate.

Meetings and Voting

20. The Committee shall adopt the Standing Orders of Somerset CCG insofar as they relate to the:
 - a) Notice of meetings;
 - b) Handling of meetings;
 - c) Agendas;
 - d) Circulation of papers; and
 - e) Management of conflicts of interest as set out in the Somerset CCG Constitution and the associated policies and procedures
21. All members or attendees at the Committee are required to declare potential or actual conflicts of interest before items are discussed. There will be a standing agenda item at the beginning of each meeting for this purpose. Even if an interest has been recorded in the register of interests, it must still be declared in meetings where matters relating to that interest are discussed. Declarations of interest will be recorded in minutes of meetings.
22. Each member of the Committee shall have one vote. The Committee shall reach decisions by a simple majority of members present, but with the Chair having a second and deciding vote, if necessary. However, the aim of the Committee will be to achieve consensus decision-making wherever possible.
23. The Chair of the Primary Care Commissioning Committee will request the setup of panels on an ad-hoc basis to consider items which are time bound or require an urgent decision before the next scheduled committee meeting, this includes but not limited to:

- List closure applications
- Branch Surgery Closure applications
- Breach Notices
- Contract Handbacks
- Practice Merger

24. Membership of the panel will include:

- Chair or Vice Chair of the Primary Care Commissioning Committee
- Director of Finance, Performance and Contracting or the Chief Operating Officer (or nominated representative)
- Director of Quality (or nominated representative)
- Clinical Lead
- Deputy Director of Contracting (or nominated representative)
- Associate Director of Primary Care (or nominated representative)
- Patient Representative

A minimum of 5 representatives are required in order for the meeting to be quorate. This includes the Chair/Vice Chair, a manager from contracting, a manager from commissioning and the clinical lead.

The following organisations will be invited as an observer:

- Somerset Local Medical Committee
- Healthwatch
- NHS England

25. The outcome and the reasons for the panel meeting will be formally reported to the next meeting of the Committee and recorded in the minutes.

Quorum

26. The Primary Care Commissioning Committee is quorate when at least five members are present, including the Chair or Vice Chair of the Primary Care Committee. There is also a minimum requirement that either the Director of Finance, Performance and Contracting, Chief Operating Officer, or the Director of Quality is present.

Frequency of meetings

27. The Committee will meet at least four times a year and may meet more frequently as required to conduct its business.

28. Meetings of the Committee shall:
- a) be held in public, subject to the application of 27(b);
 - b) the Committee may resolve to exclude the public from a meeting that is open to the public (whether during the whole or part of the proceedings) whenever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time.
29. Members of the Committee have a collective responsibility for the operation of the Committee. They will participate in discussion, review evidence and provide objective expert input to the best of their knowledge and ability, and endeavour to reach a collective view.
30. The Committee may delegate tasks to such individuals, sub-committees or individual members as it shall see fit, provided that any such delegations are consistent with the parties' relevant governance arrangements, are recorded in a scheme of delegation, are governed by terms of reference as appropriate and reflect appropriate arrangements for the management of conflicts of interest.
31. The Committee may call additional experts to attend meetings on an ad hoc basis to inform discussions.
32. Members of the Committee shall respect confidentiality requirements as set out in the CCG's Standing Orders, unless separate confidentiality requirements are set out for the Committee in which event these shall be observed.

Primary Care Operational Group

33. The Primary Care Operational Group (PCOG) will act as a sub-group to this committee with Terms of Reference agreed by the Primary Care Commissioning Committee.
34. Functions undertaken by the PCOG include;

- Identifying and agreeing a work programme for recommendation to the Primary Care Commissioning Committee to aid planning, commissioning and delivery of primary medical services for the population of Somerset.
- Developing papers for the Primary Care Commissioning Committee, including options appraisals. Where appropriate, recommendations will be detailed in the papers for the Primary Care Commissioning Committee to consider.
- The group will take forward any necessary recommendations agreed by the Primary Care Commissioning Committee.
- Implementing and management of the agreed actions of the Primary Care Commissioning Committee.
- Identifying any areas of risk or difference of opinion and resolving them wherever possible.
- Ensuring that members of the Primary Care Commissioning Committee are fully briefed on issues before meetings.
- Oversight of the Assurance Framework and ensuring actions implemented as appropriate.
- Oversight of quality issues arising from primary care to ensure delivery of high quality primary care.
- Establish any Task and Finish Groups as required to progress work streams.
- The group will make decisions within the bounds of its remit. Decisions made during the meetings will be reported on through the Primary Care Update report at the Primary Care Commissioning Committee.
- Identify and discuss any areas of potential financial pressure.
- Receive, interpret and discuss primary care data, highlighting any areas of concern.

Reporting Arrangements

35. The Committee will present its minutes to South (South West) DCO Team of NHS England and the next appropriate Governing Body of Somerset CCG after each

Committee meeting for information, including the minutes of any sub-committees to which responsibilities are delegated under paragraph 29 above.

36. There may be groups that will form part of the overall full delegation governance structure and will support the Commissioning Committee deliver its responsibilities. Terms of reference for each group will be in place and the groups will operate in accordance with existing CCG policies e.g. Conflicts of Interest.
37. The Committee will receive reports relevant to its responsibilities from any other group or working group as appropriate.
38. The CCG will also comply with any reporting requirements set out in its constitution.
39. These Terms of Reference will be reviewed on an annual basis, reflecting experience of the Committee in fulfilling its functions and the wider experience of NHS England and CCGs in primary medical services co-commissioning.

Accountability of the Committee

40. The Committee is authorised to determine matters within its remit where those matters involve expenditure up to the limit delegated to the Accountable Officer under the Scheme of Delegation, relating to expenditure within the NHS. Where the expenditure involved exceeds these sums the Committee is authorised to make representations to the Governing Body in respect of those matters. For the avoidance of doubt, in the event of any conflict between the terms of the Delegation and Terms of Reference and the Standing Orders of Standing Financial Instructions of any of the members, the Delegation will prevail.

Procurement of Agreed Services

41. The detailed arrangements regarding procurement will be set out in the delegation agreement.

Decisions

42. The Committee will make decisions within the bounds of its remit.
43. The decisions of the Committee shall be binding on NHS England and NHS Somerset CCG.

44. The Committee will produce an executive summary report which will be presented to South (South West) DCO Team of NHS England and the Governing Body of Somerset of the CCG after each meeting for information.

SOMERSET CLINICAL COMMISSIONING GROUP

FINANCE AND PERFORMANCE COMMITTEE

TERMS OF REFERENCE

1 INTRODUCTION

1.1 The Finance and Performance Committee (the Committee) is established in accordance with Somerset Clinical Commissioning Group's constitution.

1.3 These Terms of Reference set out the purpose, governance, structure, membership, remit, responsibilities and reporting arrangements of the Committee.

1.4 The purpose of this Committee is to provide assurance to the Clinical Commissioning Group Governing Body on the Clinical Commissioning Group's finance and performance. The Committee will look at the overall Somerset system position in terms of finance and performance. As an assurance Committee of the Governing Body, it will hold to account the CCG Executive team for delivery of the financial and performance plan, and recommend further areas for turnaround and performance improvement. This will be done through:

- reviewing the financial and service performance of the Clinical Commissioning Group against statutory financial targets, financial control targets and the annual commissioning plan
- reviewing the Clinical Commissioning Group's financial, performance and improving value schemes (QIPP) agenda and provide assurance to the Board in the delivery against annual plans
- reviewing performance improvement plans, identifying areas for further improvement or commissioner actions and monitors trajectories towards improvement
- monitoring the overall process of financial planning across the system and reviewing through the 5 year financial plan
- where finance and performance issues are raised then these will be highlighted to the Clinical Executive Committee, A&E Delivery Board and Elective Care Delivery Board to agree actions and mitigations (via the Clinical Commissioning Group's Chief Officer) to rectify the issue
- ensure that the Committee agenda and papers take into account the risks on the Board Assurance Framework (BAF) and risk registers. The Committee will wish to be assured that matters of risk are being effectively managed.

2 GOVERNANCE STRUCTURE

- 2.1 The Committee will be a committee of the Governing Body and as such, action notes of the meeting will be regularly presented to the Governing Body.
- 2.2. The Committee will produce a highlight report for the Governing Body after each of its meetings.

3 MEMBERSHIP

- 3.1 The membership of the Committee will consist of the following, pending the outcome of the governance review:

Members (Voting)	
Nick Robinson	Chief Officer
Alison Henly	Chief Finance Officer (Chair)
Sandra Corry	Director of Quality, Patient Safety and Engagement
David Freeman	Chief Operating Officer
In Attendance (Non-Voting)	
Dr Ed Ford	CCG Clinical Chair
Lou Evans	Audit Committee Chair and Non-Executive Director (Vice Chair)
Members of Joint Committee Teams	
Michelle Skillings	Senior Performance Manager
Tanya Whittle	Deputy Director: Primary Care, Community Services and Acute Commissioning
Debbie Hillier	Deputy Chief Finance Officer
Michael Bainbridge	Head of Primary Care
Simon Edwards	Head of Community Contracts

- 3.2 Other senior managers shall be invited to attend where appropriate to present specific agenda items.
- 3.3 Meetings will be chaired by the Clinical Chair of the Clinical Commissioning Group. In the absence of the Chair, the Non-Executive Director will chair. (I would suggest another GP or NED. The GB has delegated F&P assurance to this committee to undertake the work. The Chair requires reporting to him about what is being done via this delegation. (he can attend but suggest he does not chair. This should be someone with a financial background if at all possible.)

3.4 If a member of the Committee is unable to attend, then a nominated deputy should be recommended but shall not have voting rights

4 QUORACY

4.1 The quorum shall be 2 voting members to include at least the Chair of the Committee and one executive.

5 SECRETARY

5.1 The Committee shall be supported administratively by the PA to the Chief Finance Officer and Director of Performance.

6 FREQUENCY OF MEETINGS

6.1 Meetings will be held monthly.

6.2 Agenda items and papers must be forwarded to the Secretary by 10 days before the meeting, to enable all information to be circulated to the meeting membership 7 days in advance of the meeting date.

6.3 The Committee will have an annual schedule of business to ensure that agenda are planned well in advance of meetings.

6.4 Dates and times of meetings will be planned at least 12 months in advance providing the Committee with notice of meetings.

7 REMIT

7.1 The Group shall:

- oversee and recommend to the Governing Body the 5 year financial recovery plan and annual financial plan that reflects the prioritised commissioning plan for the Clinical Commissioning Group, including any performance implications
- receive reports that provide assurance on activity and financial performance in relation to the following areas:
 - performance against agreed contract levels
 - performance against local and national targets including detailed information on specific performance areas where recovery action plans are in place
 - 'in year' financial position by receiving a detailed report of the financial position, variances and progress towards meeting the targets within the Clinical Commissioning Group financial plan, statutory financial targets and financial control targets

- detailed reports on each QIPP programme, to monitor in year delivery against programme initiation document (PID)
- challenge the delivery plans to achieve targets or improve performance and understand and proactively identify and agree remedial actions
- review opportunities to improve performance of identified schemes or ad-hoc finance and performance related issues that may arise
- have oversight of the development of the annual finance plan and the prioritisation process for both investment and savings that supports the Clinical Commissioning Group in formulating the annual financial and performance plans for the next year
- obtain assurance of the development of QIPP schemes and services, approving the business cases and mobilisation plans
- obtain assurance that the CCG's QIPP schemes will meet targets
- receive and consider evaluation reports for commissioned services in order to inform commissioning and decommissioning decisions
- ensure that the financial and performance risks on the Board Assurance Framework are being managed and are mitigated against in accordance with the CCGs agreed risk appetite
- identify any new financial or performance risks not recorded and ensure these are entered onto the risk register(s) as appropriate
- review work plans for the Committee to ensure preparatory work to meet national planning timelines are appropriately scheduled
- oversee strategic financial planning for newly commissioned services
- **Procurement:** Question: The CCG may require a separate process for Procurement as many officers in attendance may/will be conflicted?). If it's a general oversight of all procurements taking place, this may be ok.
 - oversight of process including invitation to tender, evaluation and preferred bidder appointment and contract award for new contracts (where material or where there is a significant reputational risk)
 - oversight of procurement plan/strategy and reporting
 - approval of Clinical Commissioning Group's contract for commissioning and corporate support

- review and scrutiny of business cases prior to approval
- **Policies and Procedures:**
 - approval of procedures, policies and strategies relevant to the Committee's Terms of Reference
 - agree the operational scheme of delegation setting out key operational decisions of Chief Finance Officer and schemes of delegation
 - approve/ratify detailed financial policies
- **Risk Management:**
 - receive assurance from officers of the CCG and provide assurance to the Board that the risks to the finances and operational performance of the Clinical Commissioning Group are appropriately managed
 - highlight to Governing Body any high risks and issues for review, escalation and inclusion on Corporate Risk Register and Governing Body Assurance Framework
 - act as an assurance committee of the Clinical Commissioning Group's business and finance risks via the Assurance Framework and Risk Registers
 - review, update and seek assurance that finance, planning and performance risks escalated to the Governing Body are being managed effectively by the CCG

8 REPORTING ARRANGEMENTS

- 8.1 The Action Notes of the Finance and Performance Committee shall be formally presented to the Clinical Commissioning Group Governing Body. A headline narrative update paper will be produced after each meeting and presented to the next Governing Body meeting.

9 PROCESS FOR MONITORING THE EFFECTIVENESS OF THE COMMITTEE

- 9.1 Annually, the Committee will review its performance against the requirements of the Terms of Reference and assess its effectiveness.
- 9.2 The Committee Terms of reference will be reviewed following the outcome of the governance review.

AUDIT COMMITTEE

TERMS OF REFERENCE

1 INTRODUCTION

- 1.1 The Audit Committee (the committee) is established in accordance with Somerset's Clinical Commissioning Group's constitution. 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 constitution.

2 GOVERNANCE STRUCTURE

- 2.1 The Committee will be a committee of the Governing Body and as such, minutes of the meeting will be regularly presented to the Governing Body.

3 MEMBERSHIP

- 3.1 The Committee shall be appointed by the Clinical Commissioning Group as set out in the Clinical Commissioning Group's Constitution and may include individuals who are not on the Governing Body.
- 3.2 The Committee shall be comprised of at least three members nominated from the Independent Lay members and Clinical Members of the CCG. The Committee is a Non-Executive Committee and the Chair of the Governing Body and the Chief Finance Officer will not be members of the Audit Committee although they may be called to attend meetings. At least one member will have significant, recent and relevant financial experience.
- 3.3 The Voting Membership of the Committee shall include the following members of the Governing Body:

- Chair: Non-Executive Director – Audit and Governance, appointed by Governing Body
- Vice Chair: Non-Executive Director – appointed by Governing Body (tbc)
- Non-Executive Director – Registered Nurse

In addition, a GP Clinical Adviser to the Audit Committee will attend the meetings.

The Chair of the Committee will be appointed for a term of three years. A Vice Chair will be appointed from within the Committee membership and this is shown in the membership above.

- 3.4 The Chief Finance Officer, a Chief Internal Auditor, an External Auditor and a Local Counter Fraud Specialist shall normally attend meetings but are not members of the Committee.
- 3.5 The Governing Body Chair may attend the meetings as requested by the Chair or Vice Chair of the Audit Committee, but is not a member of the committee.
- 3.6 Regardless of attendance, external audit, internal audit, local counter fraud and security management providers will have full and unrestricted rights of access to the audit committee.
- 3.7 At least once a year the Committee should meet privately with the External and Internal Auditors, and Local Counter Fraud Specialist to review the Committees performance.
- (In addition, it is good practice for the Committee members to hold a pre-meeting with the Auditors prior to every Committee Meeting)
- 3.8 Representatives from NHS Protect may be invited to attend meetings and will normally attend at least one meeting each year.
- 3.9 The Chair of the Governing Body, Accountable Officer and other Senior Officers may be invited to attend, but particularly when the Committee is discussing areas of risk or operation that are the responsibility of that officer. For clarity, the Audit Committee may summons any member of staff employed by the Clinical Commissioning Group to appear before it.
- 3.10 The Accountable Officer should be invited to attend, at least annually, to discuss with the Audit Committee the process for assurance that supports the Statement on Internal Control. He or she will also normally attend when the committee considers the draft internal audit plan and the annual accounts.
- 3.11 Members of the Audit Committee will be appointed by the Chair of the Governing Body, including the post of Audit Committee Chair and Vice Chair. The Audit Committee Chair will be appointed for a term to be determined by the Governing Body. The Audit Committee Chair must be a lay person who has qualifications, expertise or experience such as to enable the person to express informed views about financial management and audit matters.
- 3.12 Members of the Audit Committee tenure will follow the tenure in the role of member of the Governing Body.
- 3.13 No one other than members of the Committee is entitled to be present at Committee meetings.

4 QUORACY

- 4.1 A quorum shall be two members (This will be reviewed following appointment of additional non-executive member).

5 SECRETARY

- 5.1 The Committee Chair is responsible for providing secretarial support to the committee and will nominate an appropriate individual to this role.
- 5.2 The secretary will be responsible for supporting the chair in the management of audit and associated business and for drawing the committee's attention to best practice, national guidance and other relevant documents, as appropriate.

6 FREQUENCY AND NOTICE OF MEETINGS

- 6.1 Meetings shall be held not less than three times a year.
- 6.2 The External Auditor or Chief Internal Auditor may request a meeting if they consider that one is necessary.
- 6.3 The Committee will agree a schedule of business, (similar to the Audit handbook).

7 REMIT AND RESPONSIBILITIES OF THE COMMITTEE

- 7.1 The Committee shall critically review the clinical commissioning group's financial, performance, and quality reporting and internal control principles and ensure an appropriate relationship with both internal and external auditors is maintained.
- 7.2 The Committee is a non-executive committee of the Governing Body and has no executive powers, other than those specifically delegated in these Terms of Reference.
- 7.3 The Committee is authorised by the Governing Body to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.
- 7.4 The Committee may require the attendance at its meetings of any officer of the CCG and the production of any document.
- 7.5 The Committee is authorised by the Governing Body to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

8 DUTIES

- 8.1 The duties of the Committee can be categorised as listed below.

External Audit

- 8.2 The Committee shall review the work and findings of the External Auditor and consider the implications and management's responses to their work. This will be achieved by:
- 8.2.1 Consideration of the appointment and performance of the External Auditor, and the audit fee, as far as the national regulations and rules permit.
 - 8.2.2 Discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan, and ensure coordination, as appropriate, with other External Auditors in the local health economy.
 - 8.2.3 Discussion with the External Auditors of their local evaluation of audit risks and assessment of the CCG and associated impact on the audit fee.
 - 8.2.4 Review of all External Audit reports, including agreement of the annual audit letter before submission to the Board and any work carried outside the annual audit plan, together with the appropriateness of management responses.
- 8.3 The Audit Committee will ensure external audit function is provided to the CCG through the appropriate NHS procurement framework, the cost of the audit and any questions of resignation and dismissal,

Internal Audit

- 8.4 The Committee shall ensure that there is an effective internal audit function that meets mandatory public sector Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Governing Body. This will be achieved by:
- 8.4.1 ensuring the provision of the Internal Audit service through appropriate procurement processes, the cost of the audit and any questions of resignation and dismissal,
 - 8.4.2 review and approval of the Internal Audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework,
 - 8.4.3 ensuring co-ordination between the Internal and External Auditors to optimise audit resources, and to determine the extent and reliance to be placed on the work of Internal Audit,
 - 8.4.4 ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the Clinical Commission Group and Governing Body,
 - 8.4.5 consideration of the major findings of internal audit work, and management's response,
 - 8.4.6 annual review of the effectiveness of internal audit.

Counter Fraud

- 8.5 Historically, NHS bodies were subject to the counter fraud provisions contained within the Secretary of State Directions. However, new legislation introduced under the Health and Social Care Act 2012 meant that for providers of NHS services, counter fraud arrangements are now contained within the standard commissioning contract, under Service Condition 24, and the Audit Committee will ensure appropriate Counter Fraud arrangements through the NHS procurement framework, the cost of the audit and any questions of resignation and dismissal,
- 8.6 As well as overseeing the anti-fraud, bribery and corruption arrangements in place with their providers, commissioners must also ensure there are appropriate arrangements within their own organisations, as set out in the NHS Protect Standards for Commissioners on fraud, bribery and corruption. NHS England's Audit Committee has approved and adopted NHS Protect standards to ensure a unified approach to tackling economic crime against the NHS.
- 8.7 The Committee will:
- ensure non-executive Directors and board level senior management demonstrate clear and demonstrable support and provide strategic direction for anti-fraud, bribery and corruption work
 - ensure that those carrying out anti-fraud, bribery and corruption work have all the necessary support to enable them to carry out their role efficiently, effectively and promptly
 - review and approve the counter fraud work plan and ensure that the anti-fraud, bribery and corruption provision is proportionate to the level of risk identified
 - review progress reports provided by the appointed Local Counter Fraud Specialist. An annual report will be provided to the Audit Committee detailing all proactive and reactive work undertaken during the reporting period
 - consider the findings of any reports provided by the Local Counter Fraud Specialist and ensure and agree recommendations are implemented within agreed timescales

Governance, Risk Management and Internal Control

- 8.8 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 (both clinical and non-clinical), that supports the achievement of the CCG's objectives.

- 8.9 In particular, the Committee will review the adequacy of:
- 8.9.1 All risk and control related disclosure statements (in particular the Statement on Internal Control and declarations of compliance, together with any accompanying Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Governing Body.
- 8.9.2 The underlying assurance processes that indicates the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements.
- 8.9.3 The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and the requirements that pertain to the Bribery Act 2010.
- 8.10 In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from officers and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.
- 8.11 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.

Other Assurance Functions

- 8.12 The Audit Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications to the governance of the organisation.
- 8.13 These will include, but will not be limited to, any reviews by Department of Health Arms Length Bodies or Regulators/Inspectors (eg. Care Quality Commission, NHS Litigation Authority, etc.), or professional bodies with responsibility for the performance of staff or functions (eg. Royal Colleges, accreditation bodies, etc.)
- 8.14 In addition, the Committee will review the work of other committees within the organisation, whose work can provide relevant assurance to the Audit Committee's own scope of work. This will particularly include the Governance Committee and any Quality and or Risk Management committees that are established.
- 8.15 In reviewing the work of the Governance Committee, and issues around clinical risk management, the Audit Committee will wish to satisfy themselves on the assurance that can be gained from the clinical audit function.

- 8.16 In reviewing the work of the Audit Committee and other committees seek assurance that there is implementation and operation of the anti-fraud, bribery and corruption initiatives.

Management

- 8.17 The Committee shall request and review reports and positive assurances from officers and managers on the overall arrangements for governance, risk management and internal control. They may also request specific reports from individual functions within the organisation (e.g. clinical audit) as they may be appropriate to the overall arrangements.

Financial Reporting

- 8.18 The Audit Committee shall review the month 9 financial accounts and agreement of balances exercise, Annual Report and Financial Statements before submission to the Board, focusing particularly on:

- The Statement on Internal Control and other disclosures relevant to the Terms of Reference of the Committee.
- Changes in, and compliance with, accounting policies and practices'
- Unadjusted mis-statements in the financial statements.
- Major judgmental areas.
- Significant adjustments resulting from the audit.

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

Other Duties

- 8.20 Where the Committee considers that there is evidence of ultra vires or improper actions, it shall report them to the Governing Body through its Chair.

- 8.21 The Committee will also:

- 8.21.1 undertake the role of the audit panel, to appoint external and internal auditor services and counter fraud through the NHS procurement framework
- 8.21.2 review and advise on proposed changes, or suspension of, to the Standing Orders and Standing Financial Instructions
- 8.21.3 monitor compliance with Standing Orders and Standing Financial Instructions

- 8.21.4 comment on circumstances when Standing Orders have been waived
- 8.21.5 recommend any changes in accounting policies for approval by the Governing Body
- 8.21.6 monitor the implementation of CCG policies on standards of business conduct
- 8.21.7 review schedules of losses and compensations and make recommendations to the Governing Body

9 REPORTING RELATIONSHIP WITH THE GOVERNING BODY

- 9.1 The minutes of Audit Committee meetings shall be formally recorded and submitted to the Governing Body. The Chair of the Committee shall draw to the attention of the Governing Body any issues that require disclosure to the full Governing Body, or require executive action
- 9.2 The Committee will report to the Governing Body annually on its work in support of the Statement on Internal Control, specifically commenting on the fitness for purpose of the Assurance Framework, the completeness and embedment of risk management in the organisation, the integration of governance arrangements.

10 CONDUCT OF THE COMMITTEE

- 10.1 The Committee will conduct its business in accordance with any national guidance and relevant codes of conduct or good governance practice, including but not exclusively reserved to Nolan's seven principles of public life.
- 10.2 The Committee will review its performance, membership and terms of reference annually. Any amendments will be approved by the Governing Body.

Reviewed: May 2018

Sources of information

www.hm-treasury.gov.uk/d/auditcommitteehandbook140307.pdf

These Terms of reference will be reviewed every 12 months.

TERMS OF REFERENCE FOR

THE PATIENT SAFETY AND QUALITY ASSURANCE COMMITTEE

1 PURPOSE, SCOPE AND FUNCTION

1.1 The purpose of the Committee is to:

- promote a culture within Somerset Clinical Commissioning Group that focuses on Patient Safety and Quality Improvement
- provide assurance on all NHS Provider services governance arrangements and patient safety performance, through receiving exception reports on quality and safety issues, patient experience and safeguarding concerns and alerts for health services. The Committee will report areas of concerns and quality improvement to the Somerset Clinical Commissioning Group Governing Body
- monitor serious incidents, incidents and action plans linked to key areas of responsibility where Somerset Clinical Commissioning Group:
 - are Lead Commissioners
 - have statutory responsibility
 - or where responsibility falls directly to Somerset Clinical Commissioning Group for improving the quality of services
- to ensure that key themes and lessons learned from serious incidents, safeguarding, domestic homicide reviews and significant event audits are identified and shared across all NHS providers for continuous quality improvement of service provision and to prevent re-occurrence
- to monitor mortality data and review findings, including Learning Disability Mortality Reviews (LeDeR) and the implementation of improvement actions
- monitor progress in promoting harm free care across all NHS providers to include a focus on organisational actions to reduce pressure ulcer incidence, falls, health care acquired infection and medication incidents
- receive assurance from the Clinical Executive Committee that service strategy and redesign have prioritised quality and safety alongside service delivery efficiency
- review service and pathway redesign proposals and make recommendations about patient safety concerns and outcome of quality impact assessments to the Clinical Executive Committee
- receive focussed subject matter reports from the Clinical Executive Committee as required, with evidence that quality and patient safety issues and safeguarding alerts in respect of health services are fully considered, risks identified and reduced or mitigated
- have oversight of the CCGs providers integrated quality dashboard and request attendance of providers, as required
- provide a forum for representatives from the Finance and Performance,

Strategic Clinical Services Transformation, Commissioning and Governance, and Quality, Safety and Engagement directorates to work collaboratively with members of the Committee to provide assurance around patient safety/quality improvement aspects of the Health and Care Strategy

- receive reports on the CCGs duty to promote quality improvement in primary care. Assurance for quality and safety in primary care is currently discharged through the Joint Committee for Primary Care
- receive reports on patient experience of NHS services from patient surveys, real time feedback, Friends and Family test and complaints and PALS enquiries and Health Watch to identify lessons learned and inform commissioning
- ensure engagement with GP Federations and practices, and establish feedback mechanisms so that lessons learnt from complaints and incidents are shared in order to improve and inform services
- to receive reports on the quality and safety of services jointly commissioned with Somerset County Council

2 MEMBERSHIP

2.1 The core membership of the Committee will consist of the following, or their nominated deputies:

- Registered Nurse – Governing Body - Chair
- Director of Quality and Nursing
- Chief Operating Officer
- Director of Finance, Performance and Contracting
- GP Lead for Patient Safety
- GP Quality Lead from the Clinical Executive Committee
- Secondary Care Clinician
- Governing Body Lay Member
- Ad-hoc subject matter experts, when required, including from provider services

2.2 The following officers will attend the Committee to present their reports:

- Deputy Director of Quality and Nursing
- Associate Director of Safety and Quality Improvement
- Deputy Director of Clinical Effectiveness & Medicines Management
- Quality Lead – Community, Mental Health, LD and Patient Experience
- Designated leads for Safeguarding
- Lead for Infection Prevention and Control
- Quality Improvement Team
- Quality Assurance Team

2.3 The Committee will be serviced by the Patient Safety Team.

Expectations of Members

2.4 Core members are expected to attend all meetings. If they are unable to attend,

they should identify an appropriate deputy and seek the agreement of the Chair, for the deputy to attend.

- 2.5 When the Governing Body Registered Nurse is unavailable to Chair, the Secondary Care Clinician will Chair.

Authority

- 2.6 The committee is authorised by the Governing Body to undertake activity within its terms of reference.

Accountability

- 2.7 The Committee is accountable to the Governing Body.
- 2.8 Members of the Committee are responsible for communicating decisions made by them through their management lines.

3 REPORTING ARRANGEMENTS

- 3.1 The Committee will provide a report to every Governing Body meeting. The Committee will provide a report to the Clinical Executive Committee when required.
- 3.2 Updates will be presented in a composite format to include areas of learning and areas of concern.

4 FREQUENCY OF MEETINGS

- 4.1 Meetings will be held bimonthly. Extraordinary meetings may be called by the Chairman with seven working days' notice, as required.

5 COMMITTEE PAPERS

- 5.1 Details of the reports to be reviewed by the committee and the frequency of presentations are listed at Appendix 1 of this document.
- 5.2 Detailed guidance and standard templates for the presentation of reports to the Committee and the frequency of reporting requirements are available from the Quality Improvement Manager – Patient Safety, at Somerset Clinical Commissioning Group.

6 QUORUM

- 6.1 To be quorate there is a requirement for a minimum of three officers of Somerset Clinical Commissioning Group and a Governing Body member. The Chair or Deputy chair must be present.

7 REVIEW

- 7.1 The Terms of Reference will be reviewed after six months of the new Committee being established and thereafter on an annual basis.