NHS TAMESIDE AND GLOSSOP CLINICAL COMMISSIONING GROUP

CONSTITUTION

Version: 12.0 (September2017)

NHS Commissioning Board Effective Date: 9 March 2018

CONTENTS

FOREWORD

The Clinical Commissioning Group (CCG) is the collective of General Practices in Tameside and Glossop. This Constitution is the mechanism for binding these practices together, and for supporting them all to come together to determine the work of the CCG. Our aim is to ensure that the commissioning of services for our Practice populations meets our agreed objectives and values, being quality-driven with a focus on clinical engagement, and is informed by clinical and patient outcomes. By signing the membership agreement, and through subsequent participation in the commissioning process within the structures set out in this document, it is intended that Practices in Tameside and Glossop will be fully engaged in the planning and delivery of local health strategy and the commissioning of services.

ALAN DOW
CHAIR

STEVEN PLEASANT
CHIEF OPERATING OFFICER

1. INTRODUCTION AND COMMENCEMENT

1.1. Name

1.1.1. The name of this clinical commissioning group is NHS Tameside and Glossop 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 National Health Service (Clinical Commissioning Groups) Regulations 2012 (2012 No. 1631).[3]

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

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

1.3. Status of this Constitution

1.3.1. This constitution is made between the members of NHS Tameside and Glossop Clinical Commissioning Group and has effect from the first day of April 2013, when NHS England established the group.[8] The constitution is published on the group's website at www.tamesideandglossopccg.org and is available for reference at, or by post from, the CCG's headquarters: Dukinfield Town Hall, King Street, Dukinfield, SK16 4LA.

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

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

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

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

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

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

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

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

1.4. Amendment and Variation of this Constitution

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

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

b) where, in the circumstances set out in legislation, NHS England varies the group's constitution other than on application by the group.

[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

The geographical area of NHS Tameside and Glossop Clinical Commissioning Group is that covered by the Borough of Tameside and Lower Super Output Areas (LSOA) High Peak 001, High Peak 002, High Peak 003, and High Peak 004 within the Borough of High Peak.

3. MEMBERSHIP

3.1. Membership of the Clinical Commissioning Group

3.1.1. The following practices comprise the members of NHS Tameside and Glossop Clinical Commissioning Group as at December 2016:

Practice Name	Address
Albion Medical Practice	1 Albion Street, Ashton-under-Lyne, Lancashire OL6 6HF
Ashton GP Service	193 Old Street, Ashton-under-Lyne, Lancashire, OL6 7SR
Awburn House Medical Practice	Awburn House, Mottram Moor, Mottram In Longdendale, Hyde SK14 6LA
Bedford House Medical Centre	Glebe Street, Ashton-under-Lyne, Lancashire OL6 6HD
Brooke Surgery	20 Market Street, Hyde, Cheshire SK14 1AT
Chapel Street Medical Practice	Chapel Street, Ashton Under Lyne, Lancashire OL6 6EW
Clarendon Medical Centre	Clarendon Street, Hyde, Cheshire SK14 2AQ
Cottage Lane Surgery	47 Cottage Lane, Gamesley, Glossop, Derbyshire SK13 6EQ
Dukinfield Medical Centre	Davaar Site: 20-22 Concord Way, Dukinfield, Cheshire SK16 4DB Hollies Site: 83 Birch Lane, Dukinfield, Cheshire, SK16 4AJ
Denton Medical Practice	100 Ashton Road, Denton, Manchester M34 3JE
Donneybrook Medical Centre	Clarendon Street, Hyde, Cheshire SK14 2AH
Droylsden Medical Practice	1-3 Albion Drive, Droylsden, Manchester M43 7NP

Gordon Street Medical Centre	171 Mossley Road, Ashton-under-Lyne, Lancashire OL6 6NE
Grosvenor Medical Centre	62 Grosvenor Street, Stalybridge, Cheshire SK15 1RZ
Guide Bridge Medical Practice	Guide Lane, Audenshaw, Manchester M34 5HY
Hadfield Medical Centre	82 Brosscroft, Hadfield, Glossop SK13 1DS
Hattersley Group Practice	Hattersley Road East, Hattersley, Hyde, Cheshire SK14 3EH
Haughton/Thornley Medical Centre	Haughton Green Site: Haughton Vale Surgery, Tatton Road, Haughton Green, Denton, M34 7PL Thornley House Site: 9 Thornley Street, Hyde, Cheshire SK14 1JY
Highlands/Trafalgar Practice	193 Old Street, Ashton-under-Lyne, Lancashire, OL6 7SR
Howard Street Medical Practice	Howard Street, Glossop, Derbyshire SK13 7DE
King Street Medical Centre	96 - 98 King Street, Dukinfield, Cheshire SK16 4JZ
Lambgates Health Centre	Wesley Street, Hadfield, Glossop, Derbyshire SK13 1DJ
Lockside Medical Centre	85 Huddersfield Road, Stalybridge, Cheshire SK15 2PT
Manor House Surgery	Manor Street, Glossop, Derbyshire SK13 8PS
Market Street Medical Practice	76 Market Street, Droylsden, Manchester M43 6DE
Medlock Vale Medical Practice	58 Ashton Road, Droylsden, Manchester M43 7BW
Millbrook Medical Practice	Hollybank, Off Grove Road, Stalybridge, Lancs SK15 3BJ
Millgate Healthcare Partnership	Churchgate Site: 119 Manchester Road, Denton, Manchester M34 3RA Windmill Site: Ann Street Health Centre, Ann Street, Denton, Manchester M34 2AJ
Mossley Medical Practice	187 Manchester Road, Mossley, Lancs OL5 9AB

Pike Practice	Mossley Health Centre, Market Place, Mossley, Lancashire OL5 0HE
Simmondley Medical Practice	15a Pennine Road, Glossop, Derbyshire, SK13 6NN
Smithy Surgery	4 Market Street, Hollingworth, Hyde, Cheshire SK14 8LN
St Andrews House	Waterloo Road, Stalybridge, Cheshire SK15 2AU
Stamford House	2 Princess Street, Ashton Under Lyne, Lancashire OL6 9QH
Staveleigh Medical Centre	King Street, Stalybridge, Cheshire SK15 2AE
Tame Valley Medical Centre	Glebe Street, Ashton Under Lyne, Lancashire OL6 6HD
Town Hall Surgery	112 King Street, Dukinfield, Cheshire SK16 4LD
Waterloo Medical Centre	1 Dunkerley Street, Ashton-under-Lyne, Lancashire OL7 9EJ
West End Medical Centre	98-102 Stockport Road, Ashton Under Lyne, Lancashire OL7 0LH

3.1.2. All member practices are asked to sign a "Memorandum of Understanding", confirming their understanding of the benefits and responsibilities of membership (Appendix B – page 48).

3.2. Eligibility

3.2.1. Providers of primary medical services to a registered list of patients under a General Medical Services, Personal Medical Services or Alternative Provider Medical Services contract, within the boundary set out in section 2 above, will be eligible to apply for membership of this group[10].

3.2.2. Subject to the agreement of NHS England a practice will cease to be a member of the CCG if it ceases to meet the eligibility criteria set out in paragraph 3.2.1.

[10] See section 14A(4) of the 2006 Act, inserted by section 25 of the 2012. Regulations to be made

4. MISSION, VALUES AND AIMS

4.1. Mission

4.1.1 The mission of NHS Tameside and Glossop Clinical Commissioning Group is as follows: ***"Your CCG is led by local GPs. By inspiring all NHS colleagues, and working closely with partners, we will ensure the development of excellent, compassionate, cost-effective care leading to longer, healthier lives with better physical, social, mental, and environmental health."***

4.2.2 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 and Aims

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

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

Listening to Patients: We will listen to and act upon patients' feedback: proactively engaging patients in decision making. This will ensure that we commission high-quality health services that meet the needs of <u>all</u> Tameside and Glossop residents.

Developing innovative services closer to home: Where possible we will develop and deliver a range of health services closer to patients' homes including where possible the support to allow patients who wish so to die at home. This will be achieved through commissioning innovative services that have been proven to be effective, working with our partners to ensure appropriate integrated health and social care services

Increasing taxpayer value for money: We will use every pound of taxpayers' money available to us as effectively as possible to deliver high quality health services that meet the needs of the local population.

Improving health indicators: We will focus on prevention and health improvement; implementing strategies for promoting social justice and closing the opportunity gap, tackling health inequalities across the Tameside and Glossop area. This commitment to improving health, integrated with the pursuit of social justice, includes the need to bridge the opportunity gap for all equally, regardless of age, gender, sexual orientation, geographical or economic position, ethnicity, disability, or faith.

4.2.3 We will carry out our work applying values of care, compassion, competence, communication, courage, and commitment.

4.3. Principles of Good Governance

4.3.1. In accordance with section 14L(2)(b) of the 2006 Act,[11] the group will at all times observe "such generally accepted principles of good governance as are relevant to it" 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) *The Good Governance Standard for Public Services,*[12]

c) the standards of behaviour published by the *Committee on Standards in Public Life (1995)* known as the 'Nolan Principles,'[13]

d) the seven key principles of the *NHS Constitution,*[14]

e) the Equality Act 2010,[15]

f) Standards for Members of NHS Boards and Governing Bodies in England,

g) Department of Health's Code of Conduct and Code of Accountability.

4.4. Accountability

4.4.1. 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,

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11 Inserted by section 25 of the 2012 Act

12 *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

13 See Appendix F

14 See Appendix G

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

f) meeting annually in public to 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,

k) its membership of Derbyshire and Tameside Health and Wellbeing Boards.

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

a) Publishing its plans and policies as appropriate,

b) Holding public meetings to present and discuss service commissioning proposals,

c) Engagement with stakeholders including service providers, service users, carers, voluntary organisations, and other public sector organisations. This will encompass the accountability surrounding partnership and joint service arrangements,

d) Engagement with statutory representative bodies including West Pennine Local Medical Committee (LMC). Additionally, specific consultation with the LMC may take place, for example, on some commissioning decisions affecting Member Practices.

4.4.3. The Governing Body of the group will throughout each year have an on-going 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 which 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 other clinical commissioning group,

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

c) co-commissioning services with NHS England where that is in the best interests of those people for whom the CCG is responsible; for example in respect of primary care services,

d) 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,

e) 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[16], when exercising its functions to commission health services, consistently with the discharge by the Secretary of State and NHS England of their duty to ***promote a comprehensive health service***[17] *and* with the objectives and requirements placed on NHS England through *the mandate*[18] published by the Secretary of State before the start of each financial year by:

   i) delegating responsibility to the Governing Body, which in turn shall have the power to delegate responsibilities to a committee or individual to oversee their discharge. The CCG's committee structure is set out separately within this document. Progress on tasks/responsibilities delegated by the Governing Body will be monitored regularly by the Governing Body. This includes the quality of services commissioned. The CCG's Standing Orders and Scheme of Delegation specify these arrangements in further detail. The CCG will comply with its statutory functions to safeguard children and young people as set out in section 11 of The Children's Act and comply with the requirements of Working

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

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

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

Together to Safeguard Children 2013. The CCG will ensure that throughout its functions it pays due regard to the needs of Adults at Risk of Safeguarding as laid out in No Secrets 2000. The CCG will ensure it is compliant with the NHS Safeguarding Assurance Framework 2013.

b) ***meet the public sector equality duty***[19] by:

implementing the requirements of the Equality Act 2010 having due regard to the need to eliminate unlawful discrimination, harassment, and victimisation and other conduct prohibited by the 2010 Act; advancing equality of opportunity between people who share a protected characteristic and those who do not; fostering good relations between people who share a protected characteristic and those who do not,

c) work in partnership with its local authorities to develop ***joint strategic needs assessments***[20]***, joint health and wellbeing strategies***[21]***,*** and to implement improvements to public services through Health and Social Care Integration arrangements by:

i) active membership of the local Health and Wellbeing Boards (Tameside and Derbyshire). See also paragraphs 5.2.13
ii) Other sub-groups and formal governance arrangements that may be set up in order to discharge duties.

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[22] by ensuring that individuals to whom services are being or may be provided are involved (whether by being consulted or provided with information in other ways) in the planning of the commissioning arrangements by the group; in the development and consideration of proposals by the CCG for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which services are delivered to the individuals or the range of service available to them; and in the decisions of the group affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact.

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

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

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

22 See section 14Z2 of the 2006 Act, inserted by section 26 of the 2012 Act

The principles that the CCG will follow in implementing these arrangements are as follows:

- working in partnership with patients and the local community to secure the best care for them,
- adapting engagement activities to meet the specific needs of the different patient groups and communities,
- publishing information about health services on the group's website and through other media, and
- encouraging and acting on feedback.

The group will monitor and report its compliance against this statement of principles via the Governing Body.

Where the CCG has under consideration any proposal for a substantial development of the health service in the area of a local authority or for a substantial variation in the provision of such service the CCG will consult with that local authority.

The CCG will have regard to any guidance published by NHS England on the discharge of its functions relating to public involvement. The CCG will also engage with statutory representative organisations as appropriate.

5.2.2. ***As a membership organisation 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***[23] by:

a) delegating relevant decision making responsibility to the Governing Body and as appropriate via the Governing Body through a clinical leadership approach to appropriate committees or individuals ensuring that progress is monitored by the Governing Body.

5.2.3. Act ***effectively, efficiently, and economically***[24] by:

a) conducting business in accordance with Standing Orders and Standing Financial Instructions and other relevant guidance and policies governing the CCG's activities. This will be monitored on an on-going basis by the Governing Body.

5.2.4. Act with a view to ***securing continuous improvement to the quality of services***[25] by:

a) delegating relevant decision-making responsibility to the Governing Body and as appropriate via the Governing Body through a clinical leadership

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23 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)

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

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

approach to appropriate committees or individuals, ensuring that progress is monitored by the Governing Body.

5.2.5. Assist and support NHS England in relation to the Governing Body's duty to ***improve the quality of primary medical services***[26] and specialised services by:

a) delegating relevant decision-making responsibility to the Governing Body and as appropriate via the Governing Body through a clinical leadership approach to appropriate committees or individuals, ensuring that progress is monitored by the Governing Body.

5.2.6. Have regard to the need to ***reduce inequalities***[27] by:

a) delegating relevant decision-making responsibility to the Governing Body and as appropriate via the Governing Body through a clinical leadership approach to appropriate committees or individuals, ensuring that progress is monitored by the Governing Body.

5.2.7. ***Promote the involvement of patients, their carers, and their representatives in decisions about their healthcare***[28] by:

a) delegating relevant decision-making responsibility to the Governing Body and as appropriate via the Governing Body through a clinical leadership approach to appropriate committees or individuals, ensuring that progress is monitored by the Governing Body.

5.2.8. Act with a view to ***enabling patients to make choices***[29] by:

a) delegating relevant decision-making responsibility to the Governing Body and as appropriate via the Governing Body through a clinical leadership approach to appropriate committees or individuals, ensuring that progress is monitored by the Governing Body.

5.2.9. ***Obtain appropriate advice***[30] from persons who, taken together, have a broad range of professional expertise in healthcare and public health by:

a) delegating relevant decision-making responsibility to the Governing Body and via the Governing Body, as it deems appropriate, to its committees and/or individuals (in addition to internal expertise this may also include individuals external to the CCG who have expertise in the fields of acute medical specialties, nursing, or public health for instance). Monitoring will be by the Governing Body on behalf of the CCG.

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

27 See section 14T of the 2006 Act, inserted by section 26 of the 2012 Act

28 See section 14U of the 2006 Act, inserted by section 26 of the 2012 Act

29 See section 14V of the 2006 Act, inserted by section 26 of the 2012 Act

30 See section 14W of the 2006 Act, inserted by section 26 of the 2012 Act

5.2.10. ***Promote innovation***[31] by:

a) delegating relevant decision-making responsibility to the Governing Body and as appropriate via the Governing Body through a clinical leadership approach to appropriate committees or individuals, ensuring that progress is monitored by the Governing Body.

5.2.11. ***Promote research and the use of research***[32] by:

a) delegating relevant decision-making responsibility to the Governing Body and as appropriate via the Governing Body through a clinical leadership approach to appropriate committees or individuals, ensuring that progress is monitored by the Governing Body.

5.2.12. Have regard to the need to ***promote education and training***[33] 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[34] by:

a) delegating relevant decision-making responsibility to the Governing Body and as appropriate via the Governing Body through a clinical leadership approach to appropriate committees or individuals, ensuring that progress is monitored by the Governing Body.

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[35] by:

a) delegating relevant decision-making responsibility to the Governing Body and as appropriate via the Governing Body through a clinical leadership approach to appropriate committees or individuals, ensuring that progress is monitored by the Governing Body,

b) Establishing appropriate governance and joint committee arrangements with Health and Social Care representation having clear authority and power to act including on joint funding and budgets.

5.2.14 Act with a view to promoting environmental and social sustainability through our actions as a corporate body and as a commissioner by:

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31 See section 14X of the 2006 Act, inserted by section 26 of the 2012 Act

32 See section 14Y of the 2006 Act, inserted by section 26 of the 2012 Act

33 See section 14Z of the 2006 Act, inserted by section 26 of the 2012 Act

34 See section 1F(1) of the 2006 Act, inserted by section 7 of the 2012 Act

35 See section 14Z1 of the 2006 Act, inserted by section 26 of the 2012 Act

a) delegating relevant decision-making responsibility to the Governing Body and as appropriate via the Governing Body through a clinical leadership approach to appropriate committees or individuals, ensuring that progress is monitored by the Governing Body.

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

5.3.1. ***Ensure its expenditure does not exceed the aggregate of its allotments for the financial year***[36] by:

a) delegating relevant decision-making responsibility to the Governing Body and as appropriate via the Governing Body through a clinical leadership approach to appropriate committees or individuals, ensuring that progress is monitored by the Governing Body,

b) Having due regard to any joint funding / budget arrangement in place.

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***[37] by:

a) delegating relevant decision-making responsibility to the Governing Body and as appropriate via the Governing Body through a clinical leadership approach to appropriate committees or individuals, ensuring that progress is monitored by the Governing Body,

b) Having due regard to any joint funding / budget arrangements in place.

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*** [38] by:

a) delegating relevant decision-making responsibility to the Governing Body and as appropriate via the Governing Body through a clinical leadership approach to appropriate committees or individuals, ensuring that progress is monitored by the Governing Body,

b) Having due regard to any joint funding / budget arrangements in place.

5.3.4. ***Publish an explanation of how the group spent any payment in respect of quality*** made to it by NHS England [39] by:

a) delegating relevant decision-making responsibility to the Governing Body and as appropriate via the Governing Body through a clinical leadership approach to appropriate committees or individuals, ensuring that progress is

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

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

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

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

monitored by the Governing Body,

b) Having due regard to any joint funding / budget arrangements in place.

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, and

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

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, in its scheme of reservation and delegation, and in other relevant group policies and procedures.

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[40]

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 under its clinical leadership model), of the group's committees and sub-committees, of individual members of the CCG, of members of the CCG's Governing Body, of employees, and of other individuals.

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 the functions of the group that have been delegated to them the group's committees, the group's Governing Body (and its committees and sub-committees), and individuals must:

a) comply with the group's principles of good governance,[41]

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40 See Appendix D

41 See section 4.3 on Principles of Good Governance above

b) operate in accordance with the group's scheme of reservation and delegation,[42]

c) comply with the group's standing orders,[43]

d) comply with the group's arrangements for discharging its statutory duties,[44]

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 committees, sub-committees, and joint 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 and other relevant organisations (such as Local Authorities) which are working together,

b) identify any pooled budget arrangements and procedures and how these will be managed, reported upon, and reflected in annual accounts,

c) specify under which organisation'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 amend or terminate the working arrangements,

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

6.4. Committees of the Group

6.4.1. The Governing Body may, on behalf of the group, appoint such committees of the group as it considers appropriate and delegate to them the exercise of any functions of the group which in its discretion it considers to be appropriate except insofar as this constitution has reserved or delegated the exercise of the group's functions to members, employees, or a committee or sub-committee of the group or Governing Body.

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42 See appendix D

43 See appendix C

44 See chapter 5 above

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 to which they are accountable.

6.4.3. A committee or sub-committee of the group may consist of or include members or employees of the group and/or persons other than members or employees of the group.

6.4.4. A committee of the group includes a joint committee of the group and one or more other clinical commissioning groups and/or one or more local authorities and/or NHS England.

6.4.5. All decisions taken in good faith at a meeting of any committee or sub-committee shall be valid even if there is any vacancy in its membership or it is discovered subsequently that there was a defect in the calling of the meeting or the appointment of a member attending the meeting.

6.5. Joint Commissioning arrangements with other Clinical Commissioning Groups

6.5.1. The group may work together with other clinical commissioning groups in the exercise of its commissioning functions.

6.5.2. The group may make arrangements with one or more clinical commissioning groups in respect of:

a) delegating any of the group's commissioning functions to another clinical commissioning group,

b) exercising any of the commissioning functions of another clinical commissioning group, or

c) exercising jointly the commissioning functions of the group and another clinical commissioning group.

6.5.3. For the purposes of the arrangements described at paragraph 6.5.2 the group may:

a) make payments to another clinical commissioning group,

b) receive payments from another clinical commissioning group,

c) make the services of its employees or any other resources available to another clinical commissioning group, or

d) receive the services of the employees or any other resources made available by another clinical commissioning group.

6.5.4. Where the group makes arrangements with one or more clinical commissioning groups which involve all of the clinical commissioning groups exercising any of their commissioning functions jointly a joint committee may be established to exercise those functions.

6.5.5. For the purposes of the arrangements described at paragraph 6.5.2 above the group may establish and maintain a pooled fund made up of contributions by all of the clinical commissioning groups working together pursuant to paragraph 6.5.2 c) above. Any such pooled fund may be used to make payments towards expenditure incurred in the discharge of any of the commissioning functions in respect of which the arrangements are made.

6.5.6. Where the group makes arrangements with one or more other clinical commissioning groups as described at paragraph 6.5.2 above the group shall develop and agree with that clinical commissioning group / those clinical commissioning groups an agreement setting out the arrangements for joint working including details of:

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

6.5.7. Arrangements made pursuant to paragraph 6.5.2 above do not affect the liability of the group for the exercise of any of its functions.

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

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

6.5.10. The Governing Body shall determine, in respect of each joint commissioning arrangement into which the group enters with other clinical commissioning groups, how the group will monitor:

a) The delivery of the aims and objectives of the joint commissioning arrangement,

b) The effectiveness of the joint commissioning arrangement, and

c) Compliance with the group's statutory duties.

6.5.11. The Governing Body may decide that the monitoring will include:

a) requiring the lead clinical commissioning group to submit a written report to the Governing Body at a frequency stipulated by the Governing Body,

b) holding engagement events or carrying out involvement activities with members of the public and other stakeholders to seek their views on the effectiveness of the joint commissioning arrangement,

c) producing a written report and/or including information in the group's annual report on the effectiveness of the joint commissioning arrangement.

6.5.12. Should the joint commissioning arrangement prove unsatisfactory the Governing Body may decide that the group will withdraw from the joint commissioning arrangement. In this case the group shall:

a) Give notice to the other clinical commissioning groups in accordance with the terms of the agreement entered into by the clinical commissioning groups, and

b) work with the other clinical commissioning groups to ensure an orderly exit from the arrangement.

6.6. Joint Commissioning Arrangements with NHS England for the Exercise of Clinical Commissioning Group Functions

6.6.1. The group may work together with NHS England in the exercise of its commissioning functions.

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

6.6.3. The arrangements referred to in paragraph 6.6.2 above may include other clinical commissioning groups.

6.6.4. Where joint commissioning arrangements pursuant to paragraph 6.6.2 above are entered into the parties may establish a joint committee to exercise the commissioning functions in question.

6.6.5. Arrangements made pursuant to paragraph 6.6.2 above may be on such terms and conditions (including terms as to payment) as may be agreed between NHS England and the group.

6.6.6. Where the group makes arrangements with NHS England (and one or more other clinical commissioning groups if relevant) as described at paragraph 6.6.2 above the group shall develop and agree with NHS England a framework setting out the arrangements for joint working, including details of:

- How the parties will work together to carry out their commissioning functions,

- The duties and responsibilities of the parties,

- How risk will be managed and apportioned between the parties,

- Financial arrangements including, if applicable, payments towards a pooled fund and management of that fund,

- Contributions from the parties including details around assets, employees, and equipment to be used under the joint working arrangements.

6.6.7. Arrangements made pursuant to paragraph 6.6.2 above do not affect the liability of the group for the exercise of any of its functions.

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

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

6.6.10. The Governing Body shall determine, in respect of each joint commissioning arrangement that the group enters into with NHS England (and one or more other clinical commissioning groups, if relevant), how the group will monitor:

a) The delivery of the aims and objectives of the joint commissioning arrangement,

b) The effectiveness of the joint commissioning arrangement, and

c) Compliance with the group's statutory duties.

6.6.11 The Governing Body may decide that the monitoring will include:

a) Requiring:
   i) An officer and/or Governing Body member of the group,
   ii) NHS England,
   iii) Another clinical commissioning group (if relevant), or
   iv) Any committee established by the group and NHS England (and one or more other clinical commissioning groups if relevant),

To submit a written report to the Governing Body at a frequency stipulated by the Governing Body,

b) Holding engagement events or carrying out involvement activities with members of the public and other stakeholders to seek their views on the effectiveness of the joint commissioning arrangement,

c) Producing a written report and/or including information in the group's annual report on the effectiveness of the joint commissioning arrangement.

6.6.12 Should the joint commissioning arrangement prove unsatisfactory the Governing Body may decide that the group will withdraw from the joint commissioning arrangement. In this case the group shall:

a) give notice to the other parties in accordance with the terms of the framework agreed by them, and

b) work with the other parties to ensure an orderly exit from the arrangement.

6.7. Joint Commissioning Arrangements with NHS England for the Exercise of NHS England's Functions

6.7.1. The group may work with NHS England and, where applicable, other clinical commissioning groups to exercise specified NHS England functions.

6.7.2. The group may enter into arrangements with NHS England and, where applicable, other clinical commissioning groups to:

a) Exercise such functions as specified by NHS England under delegated arrangements,

b) Jointly exercise such functions as specified with NHS England.

6.7.3. Where arrangements are made for the group and, where applicable, other clinical commissioning groups to exercise functions jointly with NHS England a joint committee may be established to exercise the functions in question.

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

6.7.5. For the purposes of the arrangements described at paragraph 6.7.2 above NHS England and the group may establish and maintain a pooled fund made up of contributions by the parties working together. Any such pooled fund may be used to make payments towards expenditure incurred in the discharge of any of the commissioning functions in respect of which the arrangements are made.

6.7.6. Where the group enters into arrangements with NHS England as described at paragraph 6.7.2 above the parties will develop and agree a framework setting out the arrangements for joint working including details of:

- How the parties will work together to carry out their commissioning functions,
- The duties and responsibilities of the parties,
- How risk will be managed and apportioned between the parties,
- Financial arrangements including payments towards a pooled fund and management of that fund,

- Contributions from the parties including details around assets, employees, and equipment to be used under the joint working arrangements.

6.7.7. Arrangements made pursuant to paragraph 6.7.2 above do not affect the liability of NHS England for the exercise of any of its functions.

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

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

6.7.10. The Governing Body shall determine, in respect of each joint commissioning arrangement into which the group enters with NHS England, how the group will monitor:

a) The delivery of the aims and objectives of the joint commissioning arrangement,

b) The effectiveness of the joint commissioning arrangement, and

c) Compliance with the group's statutory duties

6.7.11 The Governing Body may decide that the monitoring will include;

a) requiring :
   i) An officer and/or Governing Body member of the group,
   ii) NHS England,
   iii) Another clinical commissioning group (if relevant), or
   iv) Any committee established by the group and NHS England (and one or more other clinical commissioning groups if relevant),

To submit a written report to the Governing Body at a frequency stipulated by the Governing Body,

b) Holding engagement events or carrying out involvement activities with members of the public and other stakeholders to seek their views on the effectiveness of the joint commissioning arrangement,

c) producing a written report and/or including information in the group's annual report on the effectiveness of the joint commissioning arrangement.

6.7.12 Should the joint commissioning arrangement prove unsatisfactory, the Governing Body may decide that the group will withdraw from the joint commissioning arrangement. In this case, the group shall:

a) give notice to NHS England in accordance with the terms of the framework agreed by them, and

b) work with NHS England to ensure an orderly exit from the arrangement.

6.8. Joint Commissioning Arrangements with Local Authorities

6.8.1. The group may enter into joint commissioning arrangements with one or more local authorities pursuant to Section 75 of the 2006 Act.

6.8.2. The group may enter into joint commissioning arrangements with one or more local authorities including establishing and maintaining a pooled fund pursuant to the Cities and Local Government Devolution Act 2016.

6.9. The Governing Body and Committees

6.9.1. ***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 regulations or in this constitution.[45] The Governing Body has functions of the clinical commissioning group delegated to it by the group. These are set out from paragraph 6.9.1(d) below. The Governing Body has responsibility for:

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*[46] (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,[47]

d) Setting overall CCG strategy and monitoring delivery; supporting and co-ordinating the local and joint commissioning work undertaken in neighbourhoods through the Council of Members; ensuring the CCG operates within its financial allocations through good financial management operated at practice, neighbourhood, and locality level; and ensuring statutory and regulatory obligations are met,

e) Exercising any other functions of the group which are not otherwise reserved or delegated.

6.9.2. ***Composition of the Governing Body*** - the Governing Body has thirteen members and comprises of:

a) Five representative roles elected by GPs included on the relevant NHS England Performers List practising as a GP within the CCG's area. One of

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

46 See section 4.3 on Principles of Good Governance above

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

their number shall be elected as Chair. A Clinical Vice-chair shall also be elected. The voting arrangements for the appointment of Chair and Clinical Vice-chair are set out in the Standing Orders,

b) One Post-CCT Fellowship Governing Body Member

c) Three Lay Members:

i) one to lead on audit, remuneration, and conflict of interest matters who must have qualifications, expertise, or experience such as to enable the person to express informed views about financial management and audit matters,

ii) one to lead on patient and public participation and quality matters who must be a person who has knowledge about Tameside and Glossop such as to enable the person to express informed views about the discharge of the CCG's functions,

iii) one further Lay Member to support the CCG's expanding role in primary care co-commissioning.

One of the above Lay Members will be the Deputy Chair of the CCG,

d) One registered nurse. As well as sharing responsibility with the other members for all aspects of the CCG Governing Body business as a registered nurse on the Governing Body this person will bring a broader view, from their perspective as a registered nurse, on health and care issues to underpin the work of the CCG especially the contribution of nursing to patient care,

e) One secondary care specialist doctor. As well as sharing responsibility with the other members for all aspects of the CCG Governing Body business this clinical member will bring a broader view on health and care issues to underpin the work of the CCG. In particular they will bring to the Governing Body an understanding of patient care in the secondary care setting,

f) the Accountable Officer/Chief Operating Officer (see role description at 7.6 below),

g) the Chief Finance Officer (see role description at 7.7 below).

6.9.3. ***Committees of the Governing Body*** - the Governing Body has appointed the following committees:

a) **Primary Care Committee –** the Primary Care Committee, which is accountable to the group's Governing Body, makes decisions on the review, planning, and procurement of primary care services for NHS Tameside and Glossop CCG under delegated authority from NHS England.

This includes GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, the monitoring of contracts, the taking of contractual action such as issuing breach or remedial notices, and removing a contract). The Governing Body has approved and keeps under review the terms of reference for the Primary Care Committee, which includes information on the membership of the Primary Care Committee,

b) **Strategic Commissioning Board** – this is a Joint Committee with Tameside Metropolitan Borough Council. This Joint Committee, which is jointly accountable to the CCG's Governing Body and to Tameside Metropolitan Borough Council's Cabinet, makes decisions on the design, on the commissioning, and on the overall delivery of health and care services in Tameside and Glossop including the oversight of their quality and performance. The Governing Body has approved and keeps under review the terms of reference for the Strategic Commissioning Board which includes information on the membership of the Strategic Commissioning Board,

c) **Remuneration and Terms of Service Committee** – the Remuneration and Terms of Service 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 all relevant 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 Committee also consider any required severance payments in support of NHS England arrangements. The Governing Body has approved and keeps under review the terms of reference for the Remuneration and Terms of Service committee which includes information on the membership of the Remuneration and Terms of Service committee,

d) **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 matters of finance and good governance. 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 group or the Governing Body has conferred or delegated the following functions connected with the Governing Body's main function[48] to its Audit Committee:

i) Governance and Risk Management,

[48] See section 14L(2) of the 2006 Act, inserted by section 25 of the 2012 Act

ii) Conflict of Interest policy and arrangements.

6.9.4. The Governing Body may appoint such other committees as it considers may be appropriate.

6.9.5. The Remuneration and Terms of Service Committee shall be comprised solely of members of the Governing Body. The Audit Committee may include individuals who are not members of the Governing Body. The other committees of the Governing Body may include individuals who are:

a) members, officers, or Governing Body members of the group or of another Clinical Commissioning Group,

b) partners or employees of members of the group or of another Clinical Commissioning Group,

c) officers of NHS England,

d) individuals who are ordinarily resident in the UK.

6.9.6. All decisions taken in good faith at a meeting of the Governing Body or any committee or sub-committee of it shall be valid even if there is any vacancy in its membership or it is discovered subsequently that there was a defect in the calling of the meeting or the appointment of a member attending the meeting.

6.9.7. The CCG has in place a Single Leadership Team (jointly with Tameside Metropolitan Borough Council) and a Business Implementation Group. Neither are executive decision-making committees of the Governing Body but are there to oversee and ensure the day-to-day running of the CCG, to ensure the Committees and Governing Body are appropriately supported and informed in their decision-making, and that the strategy, policies, and decisions of the Governing Body are executed and reviewed.

6.9.8. The Governing Body may agree that individuals working on behalf of the Greater Manchester Shared Service may take decisions on the Governing Body's behalf in relation to the exercise of the group's commissioning functions. Where individuals are so authorised they will be required to take decisions in accordance with group policies and such decisions may be reviewed by the group.

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 member practice is as follows:

Member practices are the foundation of the Clinical Commissioning Group, shaping it by:

- Treating patients with dignity and respect according to need not cost, promoting equity and valuing diversity,
- Being innovative, and bringing forward ideas for improvement in their locality and across the CCG and the wider economy,
- Supporting the CCG's public and patient engagement work, including through their own practice Patient Reference Groups,
- Working with and through their neighbourhood groups to support the service re-design and commissioning work of the CCG. This will mean giving a commitment for example to: appropriate practice representation (such as GP or senior nurse / manager) at the majority of their Neighbourhood meetings; sharing their specialist skills and expertise, and making clinical and other staff available to support commissioning project work; working within the commissioning decisions of the Clinical Commissioning Group, particularly in relation to commissioned care pathways and service and prescribing policy,
- Managing their fair shares practice budgets by: ensuring mechanisms are in place for reviewing and managing information and budgets within the practice; overseeing spend and activity at a practice level against the funding allocated to practices; sharing referral information and prescribing information electronically; engaging in the GP appraisal and revalidation process; engaging in CCG and Commissioning/Performance improvement schemes.

Each Member is entitled to a range of benefits from being a Member of the Group. These are set out in the Memorandum of Understanding at Appendix B (page 48). Each Member is required to comply with a range of Member obligations as a responsibility of membership of the Group. These are also set out in the Memorandum of Understanding.

7.2. Other GP and Primary Care Health Professionals

In addition to the practice representatives identified in section 7.1 above, the group may identify a number of other GPs and/or primary care health professionals to either support the work of the group and / or to represent the group rather than represent their own individual practices.

7.3. All Members of the Group's Governing Body

7.3.1. Guidance on the roles of members of the group's Governing Body is set out in a separate document[49]. In summary each member of the Governing Body should share responsibility as part of a team to ensure that the group exercises its functions effectively, efficiently, and economically with good governance and in accordance with the terms of this constitution. Each brings their unique perspective informed by their expertise and experience. In addition to the specific role descriptions set out in 7.4 – 7.7 below the CCG will ensure that the role descriptions for the other statutory members of its Governing Body (GP Members, Lay Members, Secondary Care Doctor, and Registered Nurse) also reflect the guidance referenced above (see also 6.9.2 above).

7.4. The Chair of the Governing Body

7.4.1. 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, their expectations understood and, as far as is appropriate and possible, met,

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[49] *Clinical commissioning group Governing Body Members – Roles Attributes and Skills,* NHS Commissioning Board Authority, March 2012

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.

7.4.2. Where the Chair of the Governing Body is also the senior clinical voice of the group they will take the lead in interactions with stakeholders including NHS England.

7.5. The Deputy Chair of the Governing Body and the Clinical Vice-chair of the Governing Body

7.5.1. The Deputy Chair of the Governing Body deputises for the Chair of the Governing Body where he or she has a conflict of interest or is otherwise unable to act. The Deputy Chair shall be a Lay Member.

7.5.2. There shall also be elected a Clinical Vice-chair from within the Governing Body GP members.

7.6. Role of the Accountable Officer

7.6.1. The Accountable Officer / Chief Operating Officer of the group is a member of the Governing Body.

7.6.2. This role of Accountable Officer has been summarised in a national document[50] as:

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 in 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 relevant national bodies and agencies) 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 on-going capability and capacity to

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

meet its duties and responsibilities. This will include arrangements for the on-going development of its members and staff.

7.7. Role of the Chief Finance Officer

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

7.7.2. This role of Chief Finance Officer has been summarised in a national document[51] as:

a) being the Governing Body's professional expert on finance and ensuring, through robust systems and processes, that the regularity and propriety of expenditure is fully discharged,

b) making appropriate arrangements to support, monitor, and report on the group's finances,

c) overseeing robust audit and governance arrangements leading to propriety in the use of the group's resources,

d) being able to advise the Governing Body on the effective, efficient, and economic use of the group's allocation, to remain within that allocation, and to 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.

7.8. Joint Appointments with other Organisations

7.8.1. The group may agree joint appointments with other organisations as it considers may be appropriate.

7.8.2. All joint appointments shall be supported by a memorandum of understanding between the organisations who are party to them.

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

7.9 Role of the Neighbourhoods

Each Neighbourhood Group will have responsibility for:

- Providing a forum within which member practices can work together to manage their practice and neighbourhood fair shares budgets by promoting the use of best practice pathways and prescribing,
- Sharing best practice between member practices,
- Working within the Clinical Commissioning Group's strategy and national policy guidelines to design services to address the needs of their population by: undertaking local service re-design for services within the CCG geographic locality; and by contributing to wider Health and Social Care service re-design both at Clinical Commissioning Group, economy-wide, and regional levels,
- Supporting member practices' development including for referral management, clinical practice, and prescribing activity,
- Providing a forum for patient participation group cluster representatives to share their views on clinical and commissioning initiatives and innovations.

8. STANDARDS OF BUSINESS CONDUCT AND MANAGING CONFLICTS OF INTEREST

8.1. Standards of Business Conduct

8.1.1. Employees, members, committee and sub-committee members of the Group and members of the 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.

8.1.2. They must comply with the Group's policy on standards of business conduct and declaration of interest, 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. ccg.nhs.uk/ and will be made available on request.

8.1.3. Individuals contracted to work on behalf of the Group or otherwise providing services or facilities to the Group will be made aware of their obligation with regard to declaring conflicts or potential conflicts of interest. This requirement will be written into their contract for services and is also outlined in the Group's Standards of Business Conduct and Declaration of Interest policy.

8.2. Conflicts of Interest

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

8.2.2. Where an individual, i.e. an employee, member of the CCG's Governing Body, member of its committee or sub-committee Group Member i.e. GP partners (or where the practice is a company, each director) and any individual directly involved with the business or decision-making of the CCG, 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 and the Standards of Business Conduct and Conflictsof Interest policy.

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

8.3. Declaring and Registering Interests

8.3.1. The Group will maintain one or more registers of the interests of those individuals listed in the CCG'S Standards of Business Conduct and Conflicts of Interest Policy.

8.3.2. As a minimum, CCGs should publish the registers of Conflicts of interest and gifts and hospitality of decision making staff at least annually in a prominent place on the Group's website at www. ccg.nhs.uk/ and make them available at their headquarters upon request.

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

8.3.4 All persons referred to in paragraph 45 of the Managing conflicts of interest: revised statutory guidance for CCG's must declare any interests. Declarations should be made as soon as reasonably practicable and by law within 28 days after the interest arises. This could include interests an individual is pursuing.

8.3.5 The CCG ensures that, as a matter of course, declarations of interest are made and confirmed or updated at least annually. All persons required to, must declare any interests as soon as reasonable practicable and by law within 28 days after the interest arises.

8.3.6 Interests (including gifts and hospitality) of decision making staff should remain on the public register for a minimum of six months. In addition the CCG must retain a record of historic interests and offers/receipt of gifts and hospitality for a minimum of 6 years after the date on which it expired. The CCG's published register of interests should state that historic interests are retained by the CCG for the specified timeframe and details of whom to contact to submit a request for this information.

8.4 Managing Conflicts of Interest: general

8.4.1 Individual members of the Governing Body, committees or sub-committees, the committees or sub-committees of its Governing Body, Group Member i.e. GP partners (or where the practice is a company, each director) and any individual directly involved with the business or decision-making of the CCG, and employees will comply with the arrangements determined by the Group for managing conflicts or potential conflicts of interest.

8.4.2 The Accountable 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.

8.4.3 The CCG manages conflicts of interest of members, employees and contractors in line with statutory guidance, as outlined in its Standards of Business Conduct and Conflicts of Interest Policy available on its website. http://www. ccg.nhs.uk/

8.5 Transparency in Procuring Services

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

8.5.2 The Group will publish a Procurement Strategy approved by its Governing Body which will ensure that:

8.5.3 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.

8.5.4 Service redesign and procurement processes are conducted in an open, transparent, non-discriminatory and fair way.

8.5.5 Copies of this Procurement Strategy will be available on the Group's website at www. ccg.nhs.uk/ and will be made available on request.

7.8.9. The CCG as an Employer

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

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

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

9.4. The group will maintain and publish policies and procedures (as appropriate) on the recruitment and remuneration of staff to ensure it can recruit, retain, and

develop staff of an appropriate calibre. The group will also maintain and publish policies on all aspects of human resources management including grievance and disciplinary matters

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

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

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

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

9.8. The group will adopt a Code of Conduct for staff and will maintain and promote effective 'whistle blowing' procedures to ensure that concerned staff have means through which their concerns can be voiced. The group recognises and confirms that nothing in or referred to in this constitution (including in relation to the issue of any press release or other public statement or disclosure) will prevent or inhibit the making of any protected disclosure (as defined in the Employment Rights Act 1996, as amended by the Public Interest Disclosure Act 1998) by any member of the group, any member of its Governing Body, any member of any of its committees or sub-committees or the committees or sub-committees of its Governing Body, or any employee of the group or of any of its members, nor will it affect the rights of any worker (as defined in that Act) under that Act.

9.9. 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.

10. TRANSPARENCY, WAYS OF WORKING, AND STANDING ORDERS

10.1. General

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

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 www.tamesideandglossopccg.org/

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

10.2. Disputes Resolution Process

10.2.1 This is attached at Appendix I.

10.3. Standing Orders

10.3.9. 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 set 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

2006 Act	National Health Service Act 2006
2012 Act	Health and Social Care Act 2012 (this Act amends the 2006 Act)
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: o sections 14Q and 14R of the 2006 Act (as inserted by section 26 of the 2012 Act), o sections 223H to 223J of the 2006 Act (as inserted by section 27 of the 2012 Act), o paragraphs 17 to 19 of Schedule 1A of the NHS Act 2006 (as inserted by Schedule 2 of the 2012 Act), and o any other provision of the 2006 Act (as amended by the 2012 Act) specified in a document published by NHS England 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
CCG Regulations	The National Health Service (Clinical Commissioning Group) Regulations 2012.
Chair of the Governing Body	the individual appointed by the group to act as Chair of the Governing Body
Chief 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 Tameside and Glossop 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 and therefore is not 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). This definition covers any GP partner, salaried GP, and locum GP working at a member practice within Tameside and Glossop
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	the 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

NHS TAMESIDE & GLOSSOP CLINICAL COMMISSIONING GROUP

MEMBER PRACTICE AND GOVERNING BODY MEMORANDUM OF UNDERSTANDING

PRACTICE NAME:
PRACTICE LEAD GP:
PRACTICE NUMBER:

I hereby confirm that the practice is a Member of NHS Tameside & Glossop Clinical Commissioning Group.

I confirm that the practice is located within the Tameside MBC and/or Glossopdale (as part of Derbyshire CC/High Peak BC) areas.

I confirm that the nominated Member Representative is a registered GP and partner.

MEMBER REPRESENTATIVE NOMINATION:

Title: Dr/Miss/Mrs/Mr/Other (delete as appropriate)

Forenames: .....

Surname: .....

Address: (Practice stamp)

Telephone: ..... Email: .....

NOMINATED BY:
(A partner of the practice or the Sole Practitioner)

Dr: .....

Address: (Practice stamp)

Telephone: ..... Email: .....

1 MEMBERSHIP BENEFITS

Members are entitled to the following benefits:

1.1 To shape and influence the development of the CCG and Governing Body,

1.2 To shape and influence all plans that significantly affect their commissioning and budget,

1.3 Access to training schemes and on-going skills development,

1.4 Access to a pooled budget for management of high risk and high cost patients,

1.5 Access to information and analytical support,

1.6 Access to management skills to improve commissioning effectiveness and efficiency,

1.7 To receive notice of and attend membership meetings,

1.8 Representation of interests via Neighbourhood Lead to the Governing Body,

1.9 Meetings with a Governing Body member and/or Chair at your practice, as required,

1.10 Access to any Commissioning Improvement Scheme funds as part of engagement in the schemes,

1.11 Support for unified budget and contractual/quality performance.

The right to make changes to the Memorandum of Understanding is reserved to AGM/EGM to which all member practices are invited. Proposals to amend the Memorandum of Understanding will be undertaken in consultation with the LMC.

2 MEMBERSHIP RESPONSIBILITIES

By signing below and upon acceptance of my application by NHS Tameside & Glossop Clinical Commissioning Group I agree, on behalf of my practice, subject to appropriate resources being made available, that:

2.1 I agree to be a responsible Member of the CCG by:

- 2.1.1 Working in accordance with the CCG Constitution,
- 2.1.2 Nominating a Member Representative,
- 2.1.3 Attending via my Member Representative (or appointed deputy) Neighbourhood Meetings and the General Meetings of the Members,
- 2.1.4 Endeavouring to manage patient care within the practice delegated budget and work with other neighbourhood Members as well as support from the CCG to put in place plans to attend to any over spend*,
- 2.1.5 Working with the CCG to identify any significant variation in unified budget performance, the likely causes, and develop an appropriate response*,
- 2.1.6 Engaging in any Commissioning Improvement Schemes,
- 2.1.7 Attending training or otherwise ensure education appropriate to CCG and practice plans,
- 2.1.8 Nominating and electing GP Governing Body members whose remit will include the role of Commissioning Neighbourhood Clinical Leads,

2.1.9 Disseminating information to and consulting with practice staff both clinical (including locums) and non-clinical to represent the practice at Neighbourhood meetings,

2.1.10 Meeting with the Neighbourhood Clinical Lead, Governing Body Members and Chair (and/or CCG Executive Directors), as reasonably requested,

2.1.11 Actively engaging and promoting public and patient participation in the delivery of care and development of services, supporting the CCG's drive for patient centred compassionate care.

** Member practices need to include regular commissioning reviews within the practice meetings in order to understand and assess the care needs of their registered populations, while strongly challenging current activity to ensure appropriateness. The practices and the CCG will work to ensure they jointly secure services against that need in the most cost efficient way The minimum requirements of practices is that they:*

- *Internally review overall demand, performance against national and local benchmarks, and consumption of NHS resource, and understand how the practice compares to other practices, for example. prescribing and provider contracts,*
- *Agree to non-patient identifiable practice data sharing across practices within the neighbourhood and at CCG level,*
- *Adhere to accredited pathways, policies, and protocols including prescribing formulary as agreed by the CCG, unless otherwise clinically indicated,*
- *Ensure understanding of all community-based services available and how to access them.*

3 DISPUTE PROCESS AND CONFLICTS OF INTEREST

3.1 Each Member of the CCG has the right to raise concerns and disputes as set out in the Constitution. (Section 10.2 and Appendix I).

3.2 In addition, should these mechanisms not resolve specific issues or where a Member practice feels that the operation of the CCG is prejudicial to their interests or those of their patients they have the right to raise a dispute in the following manner:

3.2.1 Either by putting in writing their issue to the Chair of the CCG, or if the Chair of the CCG is implicated in the dispute, to the Vice or Deputy Chair. The letter should set out in detail the decision which has prejudiced the Member practice or its patients, or the specific breach of the Constitution that the Member believes to have occurred,

3.2.2 On receiving such a dispute the Chair (or Vice/Deputy Chair) shall acknowledge the dispute and arrange a meeting with the complainant within 10 working days,

3.2.3 Should such a meeting not resolve the dispute in a manner satisfactory to all parties the Chair (or Vice/Deputy Chair) shall, in agreement with the complainant, identify and nominate an individual or small group of sufficient independence and expertise to investigate the issue raised and propose a way forward. Both parties will agree to abide by the decision of the independent person or group.

3.2 Each Member and the Governing Body must ensure that, should any conflicts of interest arise relating to commissioning (and associated provision of care) decisions these are managed immediately as set out in the Constitution (Sections 8.2 to 8.5 inclusive).

I have read and understood the responsibilities of my practice's Membership as set out above and further detailed in the Constitution. I understand that the terms and benefits of my Membership may only be updated by the AGM/EGM of NHS Tameside & Glossop Clinical Commissioning Group.

Signed: ..... Date: .....

APPENDIX C – STANDING ORDERS

1. STATUTORY FRAMEWORK AND STATUS

1.1. Introduction

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

1.1.2. The standing orders, together with the group's scheme of reservation and delegation[52] and the group's prime financial policies[53], 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, of the Governing Body, and of any committees or sub-committees of the group or the Governing Body,

d) the process to delegate powers,

e) the requirements for 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[54] 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.

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52 See Appendix D

53 See Appendix E

54 Under some legislative provisions the group is obliged to have regard to particular guidance but under other circumstances guidance is issued as best practice guidance.

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 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 (see Appendix D).

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 6.9.2 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 roles as listed in section 7 of the group's constitution are subject to the following appointment process:

a) Nominations and eligibility

Individuals will only be eligible to be a member of the group's Governing Body if they are not disqualified from membership of a CCG's Governing Body pursuant to Schedule 5 of the CCG Regulations.

i. Chair - any individual within the CCG who is on the relevant NHS England Performers List practising as a GP within the CCG's area may nominate themselves for a clinical Governing Body position when advertised. The Chair must be nationally approved and accredited.

ii. Deputy Chair - any individual lay member of the CCG Governing Body may nominate themselves for this position.

iii. Clinical Vice-chair - any GP member of the Governing Body may nominate themselves for this position, and should an election be necessary the electorate shall be the full Governing Body membership.

iv. GP Governing Body members - any individual member within the CCG who is on the relevant NHS England Performers List practising as a GP within the CCG's area may nominate themselves for a clinical Governing Body position when advertised.

v. Secondary care clinician – any secondary care specialist within the meaning of the CCG Regulations who does not fall within Regulation 12(1) of the CCG Regulations may nominate themselves for the position of secondary care clinician when advertised.

vi. Lay member –

- who leads on audit, remuneration and conflict of interest matters – any individual who has qualifications, expertise, or experience such as to enable him/her to express informed views about financial management and its matters may nominate themselves for the position when advertised,
- who leads on patient and public participation matters – any individual who has knowledge about the areas specified in paragraph 2 of this Constitution such as to enable him/her to express informed views about the discharge of the group's functions may nominate themselves for the position when advertised
- who leads on commissioning – any individual who has expertise to enable her / him to express informed views about the discharge of the group's commissioning responsibilities may nominate themselves for this position when advertised.

Individuals applying for any of the lay member positions must not be excluded from being a lay member of a CCG Governing Body under CCG Regulations.

vii. Accountable Officer/Chief Operating Officer - this appointment will be subject to national NHS recruitment and selection policies and guidance. It is not subject to fixed term appointments. The candidate must be nationally approved and accredited.

viii. Chief Finance Officer - this appointment will be subject to national NHS recruitment and selection policies and guidance. It is not subject to fixed term appointments. The candidate must be nationally approved and accredited.

ix. Registered nurse - any registered nurse who does not fall under regulation 12(1) of the CCG Regulations.

b) <u>Appointment process</u>

i. Chair – election by the full Governing Body membership (or endorsement where only one candidate). Only current GP members of the Governing Body may nominate themselves for the position of Chair

ii. Deputy Lay Chair – election (or endorsement if only one candidate) by the full voting membership of the Governing Body

iii. Clinical Vice-chair - Election (or endorsement if only one candidate) by the full voting membership of the Governing Body

iv. GP Governing Body members - nomination and election by GPs on the relevant NHS England Performers List practising as a GP within the CCG's area

v. Secondary care clinician – advert and interview or national guidelines if otherwise specified

vi. Lay members – advert and interview or subject to national guidelines if otherwise specified

vii. Accountable Officer/Chief Operating Officer - this appointment will be subject to national NHS recruitment and selection policies and guidance. It is not subject to fixed term appointments. The candidate must be nationally approved and accredited

viii. Chief Finance Officer - this appointment will be subject to national NHS recruitment and selection policies and guidance. It is not subject to fixed term appointments. The candidate must be nationally approved and accredited

ix. Registered nurse – advert and interview or national guidelines if otherwise specified.

c) <u>Terms of office</u>

i. Chair – two years, after which time elections will be held.

ii. Deputy Chair - two years.

iii. Clinical Vice-chair – two years, but not to be concurrent with the Chair's term of office.

iv. GP Governing Body members – 3 years.

Managing Succession Planning
The CCG will organise as best as possible the timing and number of Governing Body GP representative roles put to the electorate together with the length of term for each (if this is to be varied from three years), to achieve and maintain two cohorts each of three GP representatives with three year terms of office that expire 12-months apart. Proposals will be discussed openly in advance to include engagement of the LMC and a final decision taken in public at a meeting of the Governing Body before each role is put forward.

v. Secondary care clinician – three years.

vi. Lay members – two years.

vii. Accountable Officer/Chief Operating Officer - employee.

viii. Chief Finance Officer - employee.

ix. Registered nurse – three years.

d) Eligibility for reappointment

Members of the Governing Body will only be eligible for re-election/re-appointment to the Governing Body provided that they continue to meet the eligibility requirements for their respective positions as set out in paragraph 2.2.2a.

i. Chair – the Chair of the CCG can nominate themselves to stand for reappointment. They will be expected to have upheld the Nolan Principles and their professional Codes of Conduct. Even if nominating themselves the Chair, Deputy Chair, and Clinical Vice-chair will be subject to re-election by the full Governing Body membership (or endorsement where only one candidate). The Chair must be nationally approved and accredited.

ii. Deputy Chair – the Deputy Chair of the CCG can nominate themselves to stand for reappointment. They will be expected to have upheld the Nolan Principles and their professional Codes of Conduct. Election (or endorsement if only one candidate) is by the full voting membership of the Governing Body.

iii. Clinical Vice-chair - the Clinical Vice-chair of the CCG can nominate themselves to stand for reappointment. They will be expected to have upheld the Nolan Principles and their professional Codes of Conduct. Election (or endorsement if only one candidate) is by the full voting membership of the Governing Body.

iv. GP Governing Body members – GP Governing Body members within the CCG can nominate themselves to stand for reappointment. They will be expected to have upheld the Nolan Principles and their professional Codes of Conduct. Even if nominating themselves the GP Governing Body members will be subject to re-election by the membership on the relevant NHS England Performers List practising as a GP within the CCGs area.

v. Secondary care clinician - the secondary care clinician for the CCG can nominate themselves to stand for reappointment. They will be expected to have upheld the Nolan Principles and their professional Codes of Conduct. Even if nominating themselves the secondary care clinician will be subject to appropriate appointment procedures in line with national guidelines.

vi. Lay members – lay members for the CCG can nominate themselves to stand for reappointment. They will be expected to have upheld the Nolan Principles and their professional Codes of Conduct. Even if nominating themselves the Lay Members will be subject to appropriate appointment procedures in line with national guidelines.

vii. Accountable Officer/Chief Operating Officer – not applicable.

viii. Chief Finance Officer – not applicable.

ix. Registered nurse – can reapply for reappointment. They will be expected to have upheld the Nolan Principles and their professional Codes of Conduct.

e) Grounds for removal from office / post

i. Chair – gross misconduct; becoming disqualified from office under CCG Regulations, losing clinical registration, bankruptcy, not attending Governing Body meetings for 3 months (except under extenuating circumstances, such as illness), failing to disclose a pecuniary interest regarding matters under discussion within the organisation, continuation in office is not in the interests of the body or the public.

ii. Deputy Chair - gross misconduct; becoming disqualified from office under CCG Regulations, bankruptcy, not attending Governing Body meetings for 3 months (except under extenuating circumstances, such as illness), failing to disclose a pecuniary interest regarding matters under discussion within the organisation, continuation in office is not in the interests of the body or the public.

iii. Clinical Vice-chair – gross misconduct; becoming disqualified from office under CCG Regulations, losing clinical registration, bankruptcy, not attending Governing Body meetings for 3 months (except under extenuating circumstances., such as illness), failing to disclose a pecuniary interest regarding matters under discussion within the organisation, continuation in office is not in the interests of the body or the public.

iv. GP Governing Body members – gross misconduct; becoming disqualified from office under CCG Regulations, losing clinical registration, bankruptcy, not attending Governing Body meetings for 3 months (except under extenuating circumstances, such as illness), failing to disclose a pecuniary interest regarding matters under discussion within the organisation, continuation in office is not in the interests of the body or the public, ceasing to meet the eligibility requirements for the post.

v. Secondary care clinician – gross misconduct; becoming disqualified from office under CCG Regulations, losing clinical registration, ceasing to be eligible for the position under CCG Regulations, bankruptcy, not attending Governing Body meetings for 3 months (except under extenuating circumstances, such as illness), failing to disclose a pecuniary interest regarding matters under discussion within the organisation, continuation in office is not in the interests of the body or the public.

vi. Lay members – gross misconduct; becoming disqualified from office under CCG Regulations, becoming excluded from being a lay member of a CCG Governing Body under CCG Regulations, bankruptcy, not attending Governing Body meetings for 3 months (except under extenuating circumstances, such as illness), failing to disclose a pecuniary interest regarding matters under discussion within the organisation, continuation in office is not in the interests of the body or the public.

vii. Accountable Officer/Chief Operating Officer - The grounds for removing the person from this post are set out in the contracts of employment of the individuals holding this position.

viii. Chief Finance Officer - The grounds for removing the person from this post are set out in the contracts of employment of the individuals holding this position.

ix. Registered Nurse - gross misconduct; becoming disqualified from office under CCG Regulations, losing clinical registration, ceasing to be eligible for the position under CCG Regulations, not attending Governing Body meetings for 3 months (except under extenuating circumstances, such as illness), failing to disclose a pecuniary interest regarding matters under discussion within the organisation, continuation in office is not in the interests of the body or the public.

f) Notice period (unless grounds to remove the individual from the role apply in which case no notice period will need to be given by the group)

i. Chair – 3 months' notice in writing.

ii. Deputy Chair - 3 months' notice in writing.

iii. Clinical Vice-chair – 3 months' notice in writing.

iv. GP Governing Body members - 3 months' notice in writing.

v. Secondary care clinician - 3 months' notice in writing.

vi. Lay members - 3 months' notice in writing.

vii. Accountable Officer/Chief Operating Officer - as determined by contract.

viii. Chief Finance Officer - as determined by contract.

ix. Registered Nurse – 3 months' notice in writing.

2.2.3. The roles and responsibilities of each of these key roles are set out either in paragraph 6.9.2 or Chapter 7 of the group's constitution.

2.2.4 A Governing Body member may be suspended from office in the event that the Governing Body decides that they should be subject to investigation for adverse conduct or potential disqualification.

3. MEETINGS OF THE CLINICAL COMMISSIONING GROUP

3.1. Calling meetings

3.1.1. Ordinary meetings of the group shall be held at regular intervals and at such times and places as the group may determine.

3.1.2. The Chair of the CCG may call a meeting of the Governing Body at any time.

3.1.3. One-third or more members of the Governing Body may requisition a meeting in writing. If the Chair refuses, or fails to call a meeting within fourteen days of a requisition being presented, the members signing the requisition may forthwith call a meeting (where motions of no confidence can be discussed and voted on).

3.1.4. Before each meeting of the Governing Body a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed at the Governing Body's principal offices at least three clear days before the meeting. This can be considered as achieved in the event that such information is published on the CCG's website.

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 at least 15 working days (excluding weekends and bank holidays) before the meeting takes place. Supporting papers for such items need to be submitted at least ten working days before the meeting takes place. The agenda and supporting papers will be circulated to all members of a meeting at least five working days before the date the meeting will take place.

3.2.2. Agendas and certain papers for the group's Governing Body meetings – including details about meeting dates, times, and venues - will be published on the group's website.

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 a meeting, the Deputy Chair of the committee or sub-committee, if any and if present, shall preside. The exception to this is the meetings of the Governing Body when, if the Chair is absent, the Clinical Vice-chair will preside. In the absence also of the Clinical Vice-chair another Governing Body GP Member would be selected to preside.

3.4.2. If the Chair is absent temporarily on the grounds of a declared conflict of interest the Clinical Vice-chair, if present, shall preside. If both the Chair and the Clinical Vice-chair are absent, or are disqualified from participating, or there is neither a Chair nor a Clinical Vice-chair, the Deputy Chair shall take the Chair. If the Chair,

Deputy Chair and Clinical Vice-chair are not able to chair the meeting 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. A meeting of the Governing Body will be quorate when at least 50% of the GP members are present and at least 3 non-GP voting members of the Governing Body are present. Decisions will be made based on a simple majority of voting members. In the case of an equal vote the Chair will have a casting vote in the event of a tied vote. There will be no proxy votes.

3.6.2. 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.

3.7. Decision making

3.7.1. Chapter 6 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. Generally it is expected that at the group's / Governing Body's meetings decisions will be reached by consensus. Should this not be possible then a vote of members will be required the process for which is set out below:

a) Eligibility – the members of the Governing Body, including those with voting rights, are set out in section 6.9.2 of the Constitution. There will be no proxy voting under any circumstances,

b) Majority necessary to confirm a decision - decisions will be made based on a simple majority of voting members,

c) Casting vote - in the case of an equal vote the Chair will have a casting vote,

d) Dissenting views – members taking a dissenting view to the result of the vote may request for their dissent to be recorded in the minutes of the meeting.

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 voting are set out in the appropriate terms of reference.

3.8. Emergency powers and urgent decisions

3.8.1. The powers which the Governing Body has reserved to itself within these Standing Orders may in emergency or for an urgent decision be exercised by the Chair and Accountable Officer/Chief Operating Officer after having consulted at least two GP members and two non-GP members of the group's Governing Body. The exercise of such powers by the Chair and Accountable Officer/Chief Operating Officer shall be reported to the next formal meeting of the Governing Body in public session for formal ratification.

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 two-thirds of the Governing Body's members 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 present at the meeting shall be recorded in the minutes of the group's meetings. The names of all members of the Governing Body present shall be recorded in the minutes of the Governing Body meetings. The names of all members of the Governing Body's committees / sub-committees present shall be recorded in the minutes of the respective Governing Body committee / sub-committee meetings.

3.11. Minutes

3.11.1. The names of the Chair and members present at the meeting shall be recorded.

3.11.2. 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. No discussion shall take place upon the minutes except upon their accuracy or where the Chairman 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 the Code of Practice on Openness in the NHS.

3.12. Admission of public and the press

3.12.1. Subject to Standing Order 3.12.2 below meetings of the Governing Body shall be open to the public. Additionally, representatives of the CCG's partner statutory agencies shall be accorded attendance rights with speaking rights at the discretion of the Chair.

3.12.2. The Governing Body may, by resolution, exclude the public and partner statutory agency representatives from a meeting that is open to the public (whether during the whole or part of the proceedings) wherever 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.

3.12.3. In the event the public could be excluded from a meeting of the Governing Body pursuant to Standing Order 3.12.2 above, the group shall consider whether the subject matter of the meeting would in any event be subject to disclosure under the Freedom of Information Act 2000, and if so, whether the public should be excluded in such circumstances.

3.12.4. 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 Governing Body's business shall be conducted without interruption and disruption.

3.12.5. Without prejudice to the power to exclude the public pursuant to Standing Order 3.12.2 above the Governing Body may resolve to exclude the public from a meeting (whether during whole or part of the proceedings) to suppress or prevent disorderly conduct or behaviour.

3.12.6. Matters to be dealt with by the Governing Body following the exclusion of representatives of the press and other members of the public shall be confidential to the members of the Governing Body.

3.12.7. Members and officers or any employee of the Governing Body in attendance shall not reveal or disclose the contents of papers marked 'In Confidence' or minutes headed 'Items Taken in Private' outside of the Governing Body without the express permission of the Governing Body. This prohibition shall apply

equally to the content of any discussion during the Governing Body meeting which may take place on such reports or papers.

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 (See section 14N of the 2006 Act, inserted by section 25 of the 2012 Act) and make provision for the appointment of committees and sub-committees of its Governing Body.

4.1.2. Other than where there are statutory requirements, such as in relation to the Governing Body's audit committee or remuneration committee, the group shall determine the membership and terms of reference of committees and sub-committees and shall, if it requires, receive and consider reports of such committees at the next appropriate meeting of the group.

4.1.3. The provisions of these standing orders shall apply where relevant to the operation of the Governing Body, the Governing Body's committees and sub-committee, and all committees and sub-committees unless stated otherwise in the committee's 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 group.

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 as soon as possible.

6. USE OF SEAL AND AUTHORISATION OF DOCUMENTS

6.1. Clinical Commissioning Group's seal

6.1.1. 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/Chief Operating Officer,

b) the Chair or Deputy Chair of the Governing Body,

c) the Chief Finance Officer.

6.2. Execution of a document by signature

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

a) the Accountable Officer/Chief Operating Officer,

b) the Chair or Deputy 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 group will from time to time agree and approve policy statements / procedures which will apply to all or specific groups of staff employed by NHS Tameside and Glossop 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. Detailed delegation arrangements are set out below.

1.3. A schedule of detailed authorisation limits will be overseen by the Audit Committee on behalf of the Governing Body. This schedule will be maintained and held by the Chief Finance Officer.

Policy Area	Decision	Reserved to the Membership	Reserved or delegated to Governing Body	Accountable Officer / Chief Operating Officer	Chief Financial Officer	Remuneration and Terms of Service Committee
REGULATION AND CONTROL	Determine the arrangements by which the members of the group approve those decisions that are reserved for the membership.	✓				
REGULATION AND CONTROL	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.	✓				
REGULATION AND CONTROL	Exercise or delegation of those functions of the clinical commissioning group which have not been retained as reserved by the group, delegated to the Governing Body or other committee or sub-committee or specified member or employee		✓			

Policy Area	Decision	Reserved to the Membership	Reserved or delegated to Governing Body	Accountable Officer / Chief Operating Officer	Chief Financial Officer	Remuneration and Terms of Service Committee
REGULATION AND CONTROL	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 • group's Governing Body, • committees and sub-committees of the group, or • its members or employees and sets out those decisions of the Governing Body reserved to the Governing Body and those delegated to the • Governing Body's committees and sub-committees, • members of the Governing Body, • an individual who is member of the group but not the Governing Body or a specified person for inclusion in the group's constitution.		✓			
REGULATION AND CONTROL	Approval of the group's overarching Scheme of Reservation and Delegation.				✓	
REGULATION AND CONTROL	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.				✓	

Policy Area	Decision	Reserved to the Membership	Reserved or delegated to Governing Body	Accountable Officer / Chief Operating Officer	Chief Financial Officer	Remuneration and Terms of Service Committee
REGULATION AND CONTROL	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.				✓	
REGULATION AND CONTROL	Prepare detailed financial policies that underpin the clinical commissioning group's prime financial policies.				✓	
REGULATION AND CONTROL	Approve detailed financial policies.				✓	
REGULATION AND CONTROL	Approve arrangements for managing exceptional funding requests.			✓		
REGULATION AND CONTROL	Set out who can execute a document by signature / use of the seal			✓		
PRACTICE MEMBER REPRESENTATIVES AND MEMBERS OF THE GOVERNING BODY	Approve the arrangements for • identifying practice members to represent practices in matters concerning the work of the group; and	✓				

Policy Area	Decision	Reserved to the Membership	Reserved or delegated to Governing Body	Accountable Officer / Chief Operating Officer	Chief Financial Officer	Remuneration and Terms of Service Committee
PRACTICE MEMBER REPRESENTATIVES AND MEMBERS OF THE GOVERNING BODY	Approve the arrangements for • Appointing clinical leaders to represent the group's membership on the group's Governing Body, for example through election (if desired).	✓				
PRACTICE MEMBER REPRESENTATIVES AND MEMBERS OF THE GOVERNING BODY	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.	✓				
PRACTICE MEMBER REPRESENTATIVES AND MEMBERS OF THE GOVERNING BODY	Approve arrangements for identifying the group's proposed Accountable Officer.	✓				
Strategy and Planning	Agree the vision, values and overall strategic direction of the group.		✓			
Strategy and Planning	Approval of the group's operating structure.		✓			

Policy Area	Decision	Reserved to the Membership	Reserved or delegated to Governing Body	Accountable Officer / Chief Operating Officer	Chief Financial Officer	Remuneration and Terms of Service Committee
Strategy and Planning	Approval of the group's commissioning plan (including input into the wider economy Integration Plans as required under agreed governance arrangements).		✓			
Strategy and Planning	Approval of the group's corporate budgets (with appropriate joint resource strategy arrangements as necessary) that meet the financial duties as set out in section 5.3 of the main body of the constitution.		✓			
Strategy and Planning	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.		✓			
Annual Reports and Accounts	Approval of the group's annual report and annual accounts.		✓			
Annual Reports and Accounts	Approval of the arrangements for discharging the group's statutory financial duties.		✓			
Human Resources	Approve the terms and conditions, remuneration and travelling or other allowances for Governing Body members, including pensions and gratuities.		✓			

Policy Area	Decision	Reserved to the Membership	Reserved or delegated to Governing Body	Accountable Officer / Chief Operating Officer	Chief Financial Officer	Remuneration and Terms of Service Committee
Human Resources	Approve terms and conditions of employment for all employees of the group including, pensions, remuneration, severance payment fees and travelling or other allowances payable to employees and to other persons providing services to the group.		✓			
Human Resources	Approve any other terms and conditions of services for the group's employees.		✓			
Human Resources	Determine the terms and conditions of employment for all employees of the group.		✓			
Human Resources	Determine pensions, remuneration, fees and allowances payable to employees and to other persons providing services to the group.		✓			
Human Resources	Recommend pensions, remuneration, fees and allowances payable to employees and to other persons providing services to the group.					✓

Policy Area	Decision	Reserved to the Membership	Reserved or delegated to Governing Body	Accountable Officer / Chief Operating Officer	Chief Financial Officer	Remuneration and Terms of Service Committee
Human Resources	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.		✓			
Human Resources	Review disciplinary arrangements where the Accountable Officer is an employee or member of another clinical commissioning group		✓			
Human Resources	Approval of the arrangements for discharging the group's statutory duties as an employer.			✓		
Human Resources	Approve human resources policies for employees and for other persons working on behalf of the group			✓		
Quality and Safety	Approve arrangements, including supporting policies, to minimise clinical risk, maximise patient safety and to secure continuous improvement in quality and patient outcomes.		✓			

Policy Area	Decision	Reserved to the Membership	Reserved or delegated to Governing Body	Accountable Officer / Chief Operating Officer	Chief Financial Officer	Remuneration and Terms of Service Committee
Quality and Safety	Approve arrangements for supporting NHS England in discharging its responsibilities in relation to securing continuous improvement in the quality of general medical services.		✓			
Operational and Risk Management	Prepare and recommend an operational Scheme of Delegation that sets out who has responsibility for operational decisions within the group.				✓	
Operational and Risk Management	Approve the group's counter fraud and security management arrangements.				✓	
Operational and Risk Management	Approval of the group's risk management arrangements.				✓	
Operational and Risk Management	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 with Local Authorities).				✓	
Operational and Risk Management	Approval of a comprehensive system of internal control, including budgetary control that underpins the effective, efficient and economic operation of the group.				✓	

Policy Area	Decision	Reserved to the Membership	Reserved or delegated to Governing Body	Accountable Officer / Chief Operating Officer	Chief Financial Officer	Remuneration and Terms of Service Committee
Operational and Risk Management	Approve proposals for action on litigation against or on behalf of the clinical commissioning group.				✓	
Operational and Risk Management	Approve the group's arrangements for business continuity and emergency planning.			✓		
Information Governance	Approve the group's arrangements for handling complaints.			✓		
Information Governance	Approval of the arrangements for ensuring appropriate and safekeeping and confidentiality of records and for the storage, management and transfer of information and data.				✓	
Tendering and Contracting	Approval of the group's contracts for any commissioning support.		✓			
Tendering and Contracting	Approval of the group's contracts for corporate support (for example finance provision). The approval of other contracts, e.g. advertising, will also follow the approved Scheme of Reservation.			✓		

Policy Area	Decision	Reserved to the Membership	Reserved or delegated to Governing Body	Accountable Officer / Chief Operating Officer	Chief Financial Officer	Remuneration and Terms of Service Committee
Partnership Working	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.			✓		
Partnership Working	Approve decisions delegated to joint committees established under section 75 of the 2006 Act.			✓		
Commissioning and Contracting for Clinical Services	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.			✓		
Commissioning and Contracting for Clinical Services	Approve arrangements for co-ordinating the commissioning of services with other groups, NHS England and/ or with the local authority(ies), where appropriate		✓			
					✓	
Communications	Determining arrangements for handling Freedom of Information requests.				✓	

APPENDIX E – PRIME FINANCIAL POLICIES

1. INTRODUCTION

1.1. General

1.1.1. These prime financial policies and the 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 the 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 D.

1.1.3. In support of these prime financial policies the group has prepared more detailed policies, approved by the Chief Finance Officer, known as *detailed financial policies*. The group refers to these prime and detailed financial policies together as the clinical commissioning group's financial policies.

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.

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 these 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 D).

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 6.9.3(f) 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 the proper checking and reporting of all breaches of financial policies, and

c) a proper procedure is in place for the 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. In line with the terms of reference for the Governing Body's Audit Committee 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[55] 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, 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[56]

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 utilised on joint arrangements / Section 75 agreement or to be held in reserve, and

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

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55 See section 223H of the 2006 Act, inserted by section 27 of the 2012 Act

56 See section 223(G) of the 2006 Act, inserted by section 27 of the 2012 Act.

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

POLICY – the group will produce and publish an annual commissioning plan[57] that explains how it proposes to discharge its financial duties. The group will support this with comprehensive long and 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 Financial 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 Accountable Officer will approve consultation arrangements for the group's commissioning plan[58].

8. ANNUAL ACCOUNTS AND REPORTS

POLICY – the group will produce and submit to NHS England accounts and reports in accordance with all statutory obligations[59], 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 agrees it with external auditors and the Audit Committee,

b) prepares the accounts according to the timetable approved by the Audit Committee,

57 See section 14Z11 of the 2006 Act, inserted by section 26 of the 2012 Act.

58 See section 14Z13 of the 2006 Act, inserted by section 26 of the 2012 Act

59 See paragraph 17 of Schedule 1A of the 2006 Act, as inserted by Schedule 2 of the 2012 Act.

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

d) considers the external auditor's management letter and fully addresses all issues within agreed timescales, and

e) publishes the external auditor's management letter on the group's website at http://www.tamesideandglossopccg.org

9. INFORMATION TECHNOLOGY

POLICY – the group will ensure the accuracy and security of the group's computerised financial data

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 or, where use of a specific system is mandated by NHS England, the group complies with all relevant requirements,

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 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[60]and 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.

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[61]

60 See section 223H(3) of the NHS Act 2006, inserted by section 27 of the 2012 Act

61 See section 14Z5 of the 2006 Act, inserted by section 26 of the 2012 Act.

- ensure its power to make grants and loans is used to discharge its functions effectively[62]

12.1 The Chief Financial Officer is responsible for:

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

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

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

d) for developing effective arrangements for making grants or loans.

13. TENDERING AND CONTRACTING PROCEDURE

POLICY – the 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 in line with the Clinical Commissioning Group Financial Scheme of Delegation

13.1. 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, and

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

c) Such contracts shall also 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.

13.2. For 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.

62 See section 14Z6 of the 2006 Act, inserted by section 26 of the 2012 Act.

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 authorities, 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 CCG will maintain a Corporate Risk Register which will detail all significant risks that the CCG faces and the mitigation plans that are in place. The Corporate Risk Register will be reviewed regularly on the Governing Body's behalf by the Audit Committee (supported by the Business Implementation Group). The Governing Body will in turn receive assurance from the Audit Committee related to this process. The Governing Body will also review its Governing Body Assurance Framework regularly. The Governing Body Assurance Framework sets out the risks and mitigation of those risks related to the achievement of organisational strategic objectives. The CCG will secure insurance cover via the NHS Litigation Authority to protect itself financially in relation to claims in regard to clinical negligence, public liability, and employer liability.

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 (that is, contracted) terms and conditions,

b) has adequate internal controls and audit review processes,

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

16.2. In addition the Chief Finance Officer shall set out comprehensive procedures for the effective processing of payroll.

17. NON-PAY EXPENDITURE

POLICY – the 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 Audit Committee on the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained and, once approved, the thresholds should be incorporated in the Scheme of Reservation and Delegation,

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

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

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

POLICY – the group will put arrangements in place to manage capital investment, maintain asset controls and recording required with policies to secure the safe storage and management of the capital 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 where resources are available and the effect of each proposal upon plans,

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

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

d) be responsible for liaising with other organisations concerning the maintenance and recording of assets, taking account of the advice of the Chief Finance Officer.

18.2. The Chief Finance Officer will prepare required detailed procedures for the local management of capital assets and disposal 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)[63]

[63] 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 wellbeing

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)[64]

64 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_132961

APPENDIX H - TERMS OF REFERENCE OF GOVERNING BODY COMMITTEES

The current version of the CCG's Constitution and the Terms of Reference of the Governing Body's committees can be found on the CCG's website at:

http://www.tamesideandglossopccg.org/

APPENDIX I

NHS TAMESIDE AND GLOSSOP CCG

Disputes Resolution Process

1. Purpose

This document outlines the approach NHS Tameside and Glossop Clinical Commissioning Group (CCG) will adopt to address concerns or disputes raised by member practices relating to the CCG's approach to the delivery of its commissioning responsibilities.

The process also covers the following in the context of compliance with the CCG Constitution:

- Concerns/disputes relating to Governing Body members,
- Concerns about individual member practices.

2. Background

It is expected that dispute will be the route of last resort. The CCG and member practices will make all efforts to resolve issues locally in conjunction with the LMC (as appropriate), and demonstrate effective processes have been engaged at all levels in the CCG. This may include the following: escalating the seniority of the review process, for example by involving third parties to ensure that acceptable standards are met, who could also act as advisors, conciliators or arbitrators; externalising all or part of the review process, and using staff from another CCG.

Where agreement cannot be reached using informal resolution processes it will be necessary to invoke the local CCG resolution process outlined below.

3. Local Resolution Process

Stage 1 Informal Process

Individual member practice concerns should be raised in the first instance with the Chief Operating Officer. This should be in writing clearly stating the basis of the dispute, including where applicable the concerns and the rationale behind the dispute. The Chief Operating Officer will appoint a member of the CCG's Governing Body to endeavour to find an informal resolution to the problem through discussion and mediation, involving others as necessary. The person appointed by the Chief Operating Officer will review concerns/evidence relative to the dispute and will try to find a resolution within 28 working days. The member practice may submit evidence in support of the dispute or the CCG may request further evidence/clarification from them. If no resolution is found the matter is to be referred within a further five working days by either party for consideration by the Local Dispute Resolution Panel. At this stage the formal process will commence.

Stage 2 The Formal Local Process

If a member practice is not satisfied that their issues have been satisfactorily addressed through the informal process they may lodge a request for "Formal Local Dispute Resolution" in writing, including the grounds for the request, to the Chief Operating Officer of the CCG. Under these circumstances the CCG will set up a Local Dispute Resolution Panel (LDRP) to hear the dispute and resolve the dispute where possible. The local dispute panel should consist of:

- A Lay Member of the Governing Body to act as Chair of the Panel,
- Neighbourhood Clinical Lead from a different locality to that of the practice,
- Chief Finance Officer or Director of Commissioning or Director of Quality and Safeguarding,
- LMC Representative,
- Representative from an external CCG.

The panel may also seek advice from external bodies (limited to those not otherwise involved in this disputes procedure).

Should any members of the LDRP find it necessary to declare an interest in a dispute that is being considered the Chair will seek to approach another CCG/LMC representative to identify alternative panel members.

If a member practice requests a formal dispute resolution the CCG shall acknowledge receipt of the request in writing within two working days. The acknowledgement will explain the procedure to be carried out by the CCG.

The Hearing

The Chair of the LDRP, on being satisfied that all attempts at local resolution have been exhausted, will arrange a meeting of the LDRP to hear the dispute as soon is practically possible. All parties shall be notified of the date and time of the LDRP meeting. The hearing shall be held within 25 working days of the request being lodged (where possible) by the member practice to the CCG. The Chair of the LDRP will ensure that at least ten working days' notice of the date of the hearing will be given to all participants.

Documentation

All the relevant documentation, including the request for Formal Local Dispute Resolution, will be passed to the Chair and then to panel members before the hearing. The Chair will, where necessary, seek relevant documentation from the parties involved at least five working days before the hearing. Documentation that is received late will not be considered. Any documentation will be shared with all relevant panel members.

Procedure at LDRP Meeting

The Discussions of the panel shall remain confidential.

The Chair of the panel will ensure written record/minutes are kept of the meeting.

All written and verbal evidence will be considered.

Should the member practice choose to attend the LDRP they and the CCG presenting officer will be asked to present their cases and may call witnesses. Members of the panel will be given the opportunity to ask any questions relevant to the case.

Following the presentation of their case the member practice and CCG presenting officer shall withdraw and the panel will deliberate.

The panel will reach a decision on the case before them and notify the member practice in writing, including any recommendations, within five working days of the hearing.

Where appropriate the decision will be reported to a meeting of the CCG Governing Body for information.

Stage 3 Appeal/Mediation

The Appeals/Mediation Panel will be convened when necessary to consider appeals against LDRP decisions. An appeal should be registered by the member practice with the Chief Operating Officer within five working days of the decision being communicated. The Appeals Panel should consist of the following (none of whom should have been previously involved in the case):

• Chair of CCG Governing Body (or Lay member as nominated deputy),
• Chief Operating Officer (or nominated deputy),
• A Clinical member of the Governing Body,
• LMC Representative,
• Representative from an external CCG.

Process

The member practice wishing to appeal against a LDRP decision must notify the CCG Chief Operating Officer of their intention, in writing, within five days of their receipt of the decision.

The Panel will consider whether the original decision of the LDRP followed due process.

The Panel will only consider written evidence.

The Panel will consider whether the CCG correctly followed its own procedures (that all received documentation was available and considered within a reasonable timescale and/or all important facts were taken into account when the decision was made) if these criteria are met the Panel will dismiss the appeal; if the criteria are not met then the following actions are available:

- If the Panel finds that some aspect of the procedure was not followed, they will assess the significance of the procedural breach and decide on the appropriate action,

- If the Panel finds that important facts were not taken into account they shall refer the case back to the original LDRP for re-consideration,

- If the case is referred back to the LDRP then, following re-consideration of the case, the subsequent LDRP decision will then be final.

The Chair of the Panel will write to the member practice within five working days of the hearing setting out the Appeal Panel's decision.

The Panel, having considered 'due process' issues, may also consider whether there is scope for resolution of the disputed matters by mediation and will undertake this process as appropriate.

Stage 4 – NHS England

Should the issues remain unresolved then the dispute shall be referred to the Local Area Team of NHS England for final decision.