NHS ROTHERHAM
CLINICAL COMMISSIONING GROUP

CONSTITUTION

We can confirm that this constitution is based upon the Model Constitution Framework for Clinical Commissioning Groups issued by the NHS Commissioning Board in April 2012 and complies with the requirements of Part 1 of Schedule 1A to the National Health Service Act 2006 (as amended) and also reflects the functions and powers ascribed to the Clinical Commissioning Group under the Health and Social Care Act 2012. This constitution sets out the governance arrangements by which the Group proposes to comply with all its statutory responsibilities including how the Group intends to:

- *comply with its statutory responsibilities regarding promoting research;*
- *have regard to and promote the NHS Constitution;*
- *act with a view to enabling patients to make choices with respect to aspects of their care and to promote the involvement of individual patients, and their carers and representatives, in decisions about their care and treatment;*
- *comply with the public sector equality duty;*
- *comply with current procurement requirements and have systems in place to discharge these requirements including its duties as a statutory body to conduct a formal procurement*
- *for any commissioning support it wishes to use;*
- *work in partnership with the local education & training boards to ensure that the system for the planning, commissioning and delivery of education and training is able to respond to service commissioning priorities;*
- *promote environmental and social sustainability through its actions as a corporate body as well as a commissioner;*
- *have robust arrangements in place to champion innovation and adoption of innovation; and*
- *have the capability and the capacity to commission key areas of care for which it is responsible.*

DAC Beachcroft LLP - 29 June 2012

Version 5 June 2015

CONTENTS

FOREWORD

NHS Rotherham Clinical Commissioning Group (the Group) is a membership organisation of 36 practices who are responsible for commissioning a range of health services on behalf of people in Rotherham.

The constitution sets out our arrangements to meet these responsibilities to ensure that decisions are made in and open and transparent way and that the interests of patients and the public are central. The constitution covers the responsibilities of individual member practices, the GP Members Committee and the Governing Body and committees of the Governing Body.

It includes the Group's duties to manage conflicts of interest and maintain a register of interests of its members and employees.

The Group's mission is '***Working with the people of Rotherham to sustain and improve health services, to improve health and to reduce health inequalities'***.

The Group's values are ***in everything we do we believe in:***

- Clinical leadership
- Putting people first, ensuring that patient and public views impact on the decisions we make
- Working in partnership
- Continuously improving quality of care whilst ensuring value for money
- Showing compassion, respect and dignity
- Listening and learning
- Taking responsibility and being accountable

The services we are responsible for include acute hospital and mental health services, community health services, GP out of hours and walk in centre, and GP prescribing. The Group has delegated authority to commission GP primary care services from April 2015. The Group does not commission pharmacy, opticians or dentistry and specialist services (which are the responsibility of NHS England) or public health services (which are the responsibility of Rotherham Metropolitan Borough Council).

The constitution applies to the following:

- The Group's member practices
- The Group's employees
- All members of the Group's Governing Body and Committees of the Governing Body
- Anyone who is working on behalf of the Group (including people working on the Group's behalf employed by Yorkshire and Humber Commissioning Support.

Dr Julie Kitlowski
Chairman
NHS Rotherham Clinical Commissioning Group

1 INTRODUCTION AND COMMENCEMENT

1.1 Name

The name of this clinical commissioning group is NHS Rotherham Clinical Commissioning Group.

1.2 Statutory Framework

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

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

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

1.3 Status of this Constitution

This constitution is made between the members of NHS Rotherham Clinical Commissioning Group and has effect from 1st day of April 2013, when NHS England established the Group.[8] The constitution is published on the Group's website.

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.

c. The Constitution will be reviewed on a regular basis at least every other year by the GP Members Committee and the Governing Body.

1.4.2 When the Group makes an application for a change to the constitution this will first be discussed with the chair of the GP Members Committee. The chair will advise on the degree of consultation required among the members (by reference to the values of the organisation and best practice including consultation with members who are affected by the proposed change) for example the chair of the Members Committee might decide that minor changes such as a change of name of a constituent practice

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

may not require consultation but substantive changes to the structure or organisation of the Group such as the addition of new joint arrangements with other lead stakeholders or of an additional member would do.

1.4.3 When the NHS Clinical Commissioning Group makes a change to the constitution this will be consulted upon with the GP Members Committee by the Governing Body of the Group who will advise on the need for further dissemination to members.

2 AREA COVERED

2.1 The geographical area covered by NHS Rotherham Clinical Commissioning Group is fully coterminous with the geographical area of Rotherham Metropolitan Borough Council.

2.2 A map of the geographical area covered by the Group showing the main general practices and their associated locality areas is attached at Appendix B.

3 MEMBERSHIP

3.1 Membership of the Clinical Commissioning Group

3.1.1 The following practices comprise the members of NHS Rotherham Clinical Commissioning Group.

NACS Number	Practice Name	Address
C87002	Dinnington Group Practice	Dinnington Group Practice New Street Dinnington Sheffield S25 2EZ
C87003	Woodstock Bower Group Practice	Woodstock Bower Group Practice Kimberworth Road Rotherham S61 1AH
C87004	Kiveton Park Medical Practice	Kiveton Park Primary Care Centre Chapel Way Kiveton Park Sheffield S26 6QU
C87005	St Ann's Medical Centre	St Ann's Medical Centre Rotherham Health Village Doncaster Gate Rotherham S65 1DA
C87006	Magna Group Practice	*(from 22nd June 2015)* Valley Health Centre Saville Street Dalton Rotherham S65 3HD.
C87007	Stag Medical Centre	Stag Medical Centre 162 Wickersley Road Rotherham S60 4JW
C87008	Swallownest Health Centre	Swallownest Health Centre Worksop Road Swallownest Sheffield S26 4WD
C87009	Brinsworth Medical Centre	Brinsworth Medical Centre 171 Bawtry Road Brinsworth Rotherham S60 5ND

NACS Number	Practice Name	Address
C87010	York Road Surgery	York Road Surgery York Road Eastwood Rotherham S65 1PW
C87012	Broom Lane Medical Practice	Broom Lane Medical Centre 70 Broom Lane Rotherham S60 3EW
C87013	Parkgate Medical Centre	Parkgate Medical Centre Netherfield Lane Rotherham S62 6AW
C87014	Treeton Medical Centre	Treeton Medical Centre 10 Arundel Street Treeton Rotherham S60 5PW
C87015	Wickersley Health Centre	Wickersley Health Centre Wickersley Rotherham S66 2JQ
C87016	Morthen Road Surgery	Morthen Road Surgery Wickersley Rotherham S66 1EU
C87017	Clifton Medical Centre	Clifton Medical Centre Rotherham Health Village Doncaster Gate Rotherham S65 1DA
C87018	High Street Surgery	High Street Surgery High Street Rawmarsh Rotherham S62 6LW
C87020	Greenside Surgery	Greenside Surgery Greasbrough Rotherham S61 4PT
C87022	Village Surgery	Village Surgery 24-28 Laughton Road Thurcroft Rotherham S66 9LP
C87023	Dalton Health Centre	Dalton Health Centre Magna Lane Dalton Rotherham S65 4HH
C87024	Rawmarsh Health Centre	Rawmarsh Health Centre Rawmarsh Customer Services Centre Barbers Avenue Rawmarsh Rotherham S62 6AE
C87029	Market Surgery	Market Surgery Warehouse Lane Wath-On-Dearne Rotherham S63 7RA
C87030	Crown St Surgery	Crown Street Surgery 17 Crown Street Swinton Rotherham S64 8NB

NACS Number	Practice Name	Address
C87031	Maltby Services Centre	Maltby Services Centre Braithwell Road Maltby Rotherham S66 8LE
C87603	Greasbrough Medical Centre	Greasbrough Medical Centre Munsbrough Rise Greasbrough Rotherham S61 4RB
C87604	Thorpe Hesley Surgery	Thorpe Hesley Surgery Sough Hall Avenue Thorpe Hesley Rotherham S61 2QP
C87606	Queens Medical Centre	Queens Medical Centre Muglet Lane Maltby Rotherham S66 7NA
C87608	Shakespeare Road Personal Medical Services Centre	Shakespeare Road Personal Medical Services Centre 50 Shakespeare Road Eastwood Rotherham S65 1QY
C87609	Rosehill Medical Centre	Rosehill Medical Centre RCHS 52 Rosehill Road Rawmarsh Rotherham S62 7BT
C87610	Canklow Road Surgery	Canklow Road Surgery RCHS 245/247 Canklow Road Canklow Rotherham S60 2JH
C87612	Surgery of Light	Surgery of Light Hunger Hill Lane Whiston Rotherham S60 4BD
C87616	Blyth Rd Medical Centre	Blyth Road Medical Centre 8 Blyth Road Maltby Rotherham S66 8JD
C87617	Thrybergh Medical Centre	Thrybergh Medical Centre 21 Park Lane Thrybergh Rotherham S65 4BT
C87620	Manor Field Surgery	Manor Field Surgery Maltby Services Centre Braithwell Road Maltby Rotherham S66 8LE
C87621	Broom Valley Rd Surgery	Broom Valley Road Surgery 102-104 Broom Valley Road Rotherham S60 2QY
C87622	The Gate Surgery	The Gate Surgery Chatham House Doncaster Gate Rotherham S65 1DA

NACS Number	Practice Name	Address
Y02616	The Chantry Bridge Medical Centre	Chantry Bridge Medical Centre Rotherham Community Health Centre Greasbrough Road Rotherham S60 1RY

3.1.2 Appendix C of this constitution contains the list of practices and the locality group which the practice sits within, together with the signatures of the practice representatives confirming their agreement to this constitution.

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 area that meet the requirements of the Regulations, will be eligible to apply for membership of this Group[10].

3.2.2 The Group comprises all the providers, as set out in 3.2.1, based in the geographic area of Rotherham Metropolitan Borough Council and designated into eight localities. Providers that are based outside of that area but have branch surgeries with in it, are not members of the Group. Unregistered patients within this geographic area are the responsibility of the Group.

3.3 Application for membership

3.3.1 No practice shall become a Member of the Group unless that practice:

a. is eligible to become a Member in accordance with paragraph 3.2 above;

b. has confirmed its acceptance of this constitution;

c. following approval of its application by NHS England has been entered into the Register of Members set out in Appendix C to this constitution.

3.3.2 Any dispute between a practice and the Group in respect of eligibility for membership of the Group shall be referred to NHS England for determination.

3.4 Cessation of Membership

3.4.1 A Member ceases to be a Member if they are no longer eligible for Membership through non-compliance with paragraph 3.2 above.

3.4.2 The Group shall notify NHS England in the event that it becomes aware that any Member no longer meets the requirements of paragraph 3.2 or is proposing to merge with another Member or a member of another clinical commissioning group and shall propose any such amendments to this constitution under the terms of paragraph 1.4 as are appropriate to reflect the circumstances.

3.4.3 Membership of the Group is not transferable and any proposed changes to the membership (including those arising from a merger of Members) shall be subject to the approval of NHS England.

3.5 Disputes

Any dispute between the practice and the Group in respect of eligibility for membership of the Group shall be referred to NHS England for determination. The Governing Body shall determine any disputes in terms of allocation of the practices to a locality.

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

4 MISSION AND VALUES

4.1 Mission

4.1.1 The mission of NHS Rotherham Clinical Commissioning Group is:

'**Working with the people of Rotherham to sustain and improve local health services, to improve health and to reduce health inequalities'.**

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

4.2 Values

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

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

In **everything** we do we believe in:

a. Clinical leadership

b. Putting people first, ensuring that patient and public views impact on the decisions we make

c. Working in partnership

d. Continuously improving quality of care whilst ensuring value for money

e. Showing compassion, respect and dignity

f. Listening and learning

g. Taking responsibility and being accountable.

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" 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. the Standards for Members of NHS Boards and Governing Bodies in England.[16]

g. NHS clinical commissioning groups code of governance.

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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 G

14 See Appendix H

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

16 Available in draft, currently consulting until 10 April, available from http://chre.org.uk/satellite/413/

4.4 Accountability

4.4.1 The Group will demonstrate its accountability to its members through the GP Members Committee, 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 Rotherham Metropolitan Borough Councils health overview and scrutiny requirements;

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

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

h. having a published and clear complaints process;

i. having a published transparent dispute resolution procedure for all providers;

j. complying with the Freedom of Information Act 2000;

k. providing information to NHS England as required.

4.4.2 In addition to these statutory requirements, the Group will demonstrate its accountability to patients and public by:

a. Identifying a named GP and named lay member with responsibility for patient and public engagement

b. Holding meetings with the public at least annually to present the annual report and discuss commissioning plans

c. Holding meetings with the public in partnership with Health and Well Being Board members to discuss the Health and Wellbeing Strategy

d. Supporting a CCG patient engagement forum with representation from members of member practice patient engagement groups

e. Producing an annual plan for public and patient engagement and accountability which will take into account best practice in actively seeking patient views

f. Publishing its strategic plans and key policies on the internet

g. Publishing an Annual Report.

4.4.3 The Group will demonstrate its accountability to members by:

a. Through the GP Members Committee (as set out in paragraph 6.7)

b. The GP Members Committee will produce an annual report to members which will contain its assessment on how well the Strategic Clinical Executive and the Group have performed their commissioning duties

c. The Group will hold an annual vote of confidence of all members on the direction of travel

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

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

b. all people registered with member GP practices, and

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

d. commissioning emergency care for anyone present in the Group's area;

e. 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;

f. 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[17], 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*[18] *and* with the objectives and requirements placed on NHS England through *the mandate*[19] published by the Secretary of State before the start of each financial year by:

the Governing Body will delegate to officers the requirement to produce an Annual Commissioning Plan to promote a comprehensive health service and to respond to the mandate published on an annual basis by the Secretary of State. This plan will be agreed by the Governing Body on an annual basis and the Governing Body will be responsible for its performance management.

b. meet the public sector equality duty[20] by:

- the Governing Body will delegate to officers the requirement to produce an equality plan to meet the public sector equality duty. This plan will be agreed by the Governing Body on an annual basis and the Governing Body will be responsible for its performance management.
- the plan will set out how the Governing Body, for the nine protected characteristics, will have due regard to the need to:
- eliminate unlawful discrimination harassment and victimisation and other conduct prohibited by the 2010 Act;
- advance equality of opportunity between people who share a protected characteristic and those who do not;

17 See section 3(1F) of the 2006 Act, inserted by section 13 of the 2012 Act
18 See section 1 of the 2006 Act, as amended by section 1 of the 2012 Act
19 See section 13A of the 2006 Act, inserted by section 23 of the 2012 Act
20 See section 149 of the Equality Act 2010, as amended by paragraphs 184 and 186 of Schedule 5 of the 2012 Act

- foster good relations between people who share a protected characteristic and those who do not

The plan will also include requirements to:

- publish, at least annually, sufficient information to demonstrate compliance with this general duty across all their functions; and
- prepare and publish specific and measurable equality objectives, revising these at least every four years

c. work in partnership with Rotherham Metropolitan Borough Council to *joint strategic needs assessments*[21] and *joint health and wellbeing strategies*[22] by:

being an active member of the Health and Wellbeing Board. Group membership of this will be the Chief Officer, the Chair of the Group and one other Strategic Clinical Executive GP member designated by the Governing Body. The Health and Wellbeing Strategy and the Joint Strategic Needs Assessment will be reported to the Governing Body as will all subsequent revisions.

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[23] by:

Operating in accordance with the following four principles:

a. Working in partnership with patients and the local community to secure the best care for them;

b. Adapting engagement activities to meet the specific needs of the different patient groups and communities;

c. Publishing information about health services on the Group website; and

d. Encouraging and acting upon feedback received.

The Governing Body will monitor and report compliance against the above principles by:

- Publishing a communication and engagement strategy that is approved and monitored by the Governing Body;
- Establishing a Patient Engagement Forum and Stakeholder Engagement Forum;
- Meeting annually in public to publish and present the Group's Annual Report;
- Delegating a named GP, a named lay member together with the Chief Nurse with responsibility for patient and public engagement;
- Complying with Rotherham Metropolitan Borough Councils health overview and scrutiny requirements; and
- Taking account of national requirements and guidance and the local compact between the voluntary sector and the public sector.

5.2.2 Promote awareness of, and act with a view to securing that health services are

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

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

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

provided in a way that promotes awareness of, and have regard to the NHS Constitution[24] by:

The Governing Body will be responsible for preparing the Group's annual Commissioning Plan which will set out how the Group will promote awareness and have regard to the NHS Constitution. The Group work will be done in light of the NHS Constitution. The integrated performance report will highlight any issues to the Governing Body so that they are aware of any performance issues in this area. The Group's annual report will summarise how the Group has delivered against its intentions in this area.

5.2.3 Act effectively, efficiently and economically[25] by:

The Governing Body will be responsible for preparing the Group's annual Commissioning Plan which will set out the Group's plans to commission effectively, efficiently and economically and will detail the multi-agency governance arrangements.

Performance against the annual commissioning plan will be reported to the Governing Body on a monthly basis through the integrated performance report.

All business cases will analyse return on investment and all complex strategic issues will be supported by an options appraisal.

5.2.4 Act with a view to securing continuous improvement to the quality of services[26] by:

The Governing Body will delegate responsibility for the assurance of continuous improvement of quality within commissioned services to the Audit and Quality Assurance Committee. The Chief Nurse is responsible for overall quality assurance of the quality of commissioned services, including Serious Incidents, Never Events, patient safety, patient experience and responsibility for regular reporting to the National Reporting and Learning System, also working closely with designated Strategic Clinical Executive GPs who have specific responsibilities for GP oversight of quality assurance for mental health, acute services and general practice respectively and with the GP Members Committee. A lay member of the Governing Body has delegated responsibility for lay member oversight of quality assurance.

5.2.5 Assist and support NHS England in relation to the Governing Body's duty to *improve the quality of primary medical services*[27] by:

The Governing Body will delegate the responsibility for securing continuous improvement to the quality of services to the Audit and Quality Assurance Committee. The Groups Chief Nurse is responsible for overall quality improvement, and works closely with the designated GP who leads on quality in general practice and with the Strategic Clinical Executive and GP Members Committee.

5.2.6 Have regard to the need to *reduce inequalities*[28] by:

The Governing Body will be responsible for preparing the Group's annual Commissioning Plan which will set out how the Group will reduce inequalities and will link with the overall Health and Wellbeing Strategy for Rotherham. The Health and Wellbeing Strategy sets out the combined actions of partners across health and social care, including Rotherham Metropolitan Borough Council and Public Health.

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

[24] 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)
[25] See section 14Q of the 2006 Act, inserted by section 26 of the 2012 Act
[26] See section 14R of the 2006 Act, inserted by section 26 of the 2012 Act
[27] See section 14S of the 2006 Act, inserted by section 26 of the 2012 Act
[28] See section 14T of the 2006 Act, inserted by section 26 of the 2012 Act

about their healthcare[29] by:

The Governing Body will be responsible for:

a. embedding the principles of "No Decision About Me Without Me"[30] and "Shared Decision Making" throughout the organisation and ensuring that this informs commissioning, service development, service redesign, guideline and pathway development, while understanding and taking account of the limitations necessary for some aspects of urgent care.

b. ensuring that information from patient feedback, complaints and incidents is used to continuously improve patient experience of commissioned services.

c. contributing to a carers strategy which supports the needs and aspirations of carers in Rotherham.

d. maintaining close links with local Healthwatch, Health and Wellbeing Board and the Local Authority.

5.2.8 Act with a view to enabling patients to make choices[31] by:

The Governing Body will be responsible for preparing the Group's Annual Commissioning Plan which will set out how the Group will enable patients to make choices. This will include how information will be provided to patients at the point they make choices for example through the use of choose and book and also choice in terms of services available for example through services provided by any qualified provider.

5.2.9 *Obtain appropriate advice*[32] from persons who, taken together, have a broad range of professional expertise in healthcare and public health including:

a. having a secondary care consultant and a nurse on the Governing Body's membership.

b. the Rotherham Director of Public Health will be in attendance at Governing Body meetings. The Group will obtain appropriate public health advice for health improvement and addressing health inequalities from RMBC through a memorandum of understanding.

c. the Chair of the Health & Wellbeing Board will be in attendance at the Governing Body meetings. The Group will access advice through the Health & Wellbeing Board and HealthWatch.

d. the Governing Body will collaborate with other clinical commissioning groups through the South Yorkshire & Bassetlaw and Hardwick & North Derbyshire CCGs Commissioning Network (CCG COM) through which it will access a wide range of specialist clinical advice and will engage with any relevant clinical senates once established.

5.2.10 Promote innovation[33] by:

The Governing Body will be responsible for preparing the Group's annual Commissioning Plan which will pay due regard to promoting innovation and to innovation developed elsewhere. Contracts will specify, for example via CQUINS, the innovations the Group has decided to accelerate.

5.2.11 Promote research and the use of research[34] by:

29 See section 14U of the 2006 Act, inserted by section 26 of the 2012 Act
30 See section 2.6 of the consultation document 'no decision about me without me' published 23.05.12
31 See section 14V of the 2006 Act, inserted by section 26 of the 2012 Act
32 See section 14W of the 2006 Act, inserted by section 26 of the 2012 Act
33 See section 14X of the 2006 Act, inserted by section 26 of the 2012 Act

The Governing Body will be responsible for actively promoting research and the introduction of research findings into clinical practice for example by participating is such alliances as the South Yorkshire Comprehensive Local Research Network and South Yorkshire Collaboration for Leadership and Applied Health Research.

5.2.12 Have regard to the need to promote education and training[35] 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[36] by:

The Governing Body will approve a policy for the Group's own employed staff to promote education and training. The Group will promote shared learning activities for its Members such as the current Protected Learning Time (PLT) programme. The Group will ensure that its contracts and contract monitoring arrangements require contracted providers to promote education and training.

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[37] by:

Active membership of the Health and Wellbeing Board and of South Yorkshire & Bassetlaw and Hardwick & North Derbyshire CCGs Commissioning Network (CCG COM) and setting out our specific plans in its annual commissioning plan (where appropriate).

5.2.14 Act with a view to ensuring robust, appropriate arrangements for safeguarding children and adults by:

a. The Governing Body delegates responsibility for the assurance of safeguarding children and adults to the Audit and Quality Assurance Committee. The Chief Nurse is responsible for the assurance of the safeguarding arrangements within commissioned services and works closely with designated Strategic Clinical Executive GPs who have specific responsibilities for GP oversight of safeguarding children and safeguarding adults respectively and with the GP Members Committee. The Chief Nurse will be a member of the Rotherham Local Safeguarding Children's Board and the Rotherham Safeguarding Adults Board.

b. a lay member of the Governing Body will have delegated responsibility for lay member oversight of safeguarding children and adults.

5.2.15 The Group will demonstrate commitment to promoting environmental and social sustainability through its actions as a corporate body and a commissioner.

The Governing Body will approve and keep updated a sustainable development plan.

5.3 General Financial Duties

The Group will perform its functions set out in 5.3.1 – 5.3.4 by delegating responsibility for delivery to the Chief Finance Officer and the responsibility for assurance to the Audit and Quality Assurance Committee. 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[38] by

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34 See section 14Y of the 2006 Act, inserted by section 26 of the 2012 Act
35 See section 14Z of the 2006 Act, inserted by section 26 of the 2012 Act
36 See section 1F(1) of the 2006 Act, inserted by section 7 of the 2012 Act
37 See section 14Z1 of the 2006 Act, inserted by section 26 of the 2012 Act
38 See section 223H(1) of the 2006 Act, inserted by section 27 of the 2012 Act

a. the Governing Body will delegate responsibility for delivery to the Group's Chief Finance Officer.

b. the policy which sets out how the Group intends to discharge this duty is set out in the Standing Orders, Standing Financial Instructions and Scheme of Delegation.

c. progress of the delivery of the duty will be monitored through the Integrated Performance Report.

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[39] by

a. the Governing Body will delegate responsibility for delivery to the Group's Chief Finance Officer.

b. the policy which sets out how the Group intends to discharge this duty is set out in the Standing Orders, Standing Financial Instructions and Scheme of Delegation.

c. progress of the delivery of the duty will be monitored through the Integrated Performance Report.

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[40] by

a. the Governing Body will delegate responsibility for delivery to the Group's Chief Finance Officer.

b. the policy which sets out how the Group intends to discharge this duty is set out in the Standing Orders, Standing Financial Instructions and Scheme of Delegation.

c. progress of the delivery of the duty will be monitored through the Integrated Performance Report.

5.3.4 Publish an explanation of how the Group spent any payment in respect of quality made to it by NHS England[41] by

a. the Governing Body will delegate responsibility for delivery to the Group's Chief Finance Officer.

b. the policy which sets out how the Group intends to discharge this duty is set out in the Standing Orders, Standing Financial Instructions and Scheme of Delegation.

c. progress of the delivery of the duty will be monitored through the Integrated Performance Report.

5.4 Information Governance

The Group will perform its functions so as to ensure that duties in regard to Information Governance are met by:

5.4.1 the Accountable Officer will be responsible for Information Governance within the Group. This will include ensuring that the Group complies with the Data Protection Act and any related guidance, identifies a Caldicott Guardian and complies with information governance requirements set out by NHS England.

5.4.2 an effectively supported Senior Information Risk Owner will take ownership of the organisation's information risk policy and information risk management strategy. The Group will carry out an annual programme of work to review and develop its Information Governance capabilities and report annually to the Audit and Quality

[39] See sections 223I(2) and 223I(3) of the 2006 Act, inserted by section 27 of the 2012 Act
[40] See section 223J of the 2006 Act, inserted by section 27 of the 2012 Act
[41] See section 223K(7) of the 2006 Act, inserted by section 27 of the 2012 Act

Assurance Committee.

5.5 Other Relevant Regulations, Directions and Documents

5.5.1 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.

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

5.5.3 The Group will consult with local representative bodies for stakeholders and healthcare providers within the Area as the Group considers appropriate for the effective discharge of its functions.

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[42]

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

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

b. those decisions that are the responsibilities of its Governing Body (and its committees), the Group's committees and sub-committees, individual members and employees.

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

6.3 General

6.3.1 In discharging functions of the Group that have been delegated to its Governing Body, committees, joint committees, sub committees and individuals must:

a. comply with the Group's principles of good governance,[43]

b. operate in accordance with the Group's scheme of reservation and delegation,[44]

[42] See Appendix E

[43] See section 4.4 on Principles of Good Governance above

c. comply with the Group's standing orders,[45]

d. comply with the Group's arrangements for discharging its statutory duties,[46]

e. where appropriate, ensure that all member practices have had the equal opportunity to contribute to the Group's decision making process irrespective of size.

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 who are working together;

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

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

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

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

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

6.4 Committees of the Group

6.4.1 The following committees have been established by the Group:

a. GP Members Committee which shall be accountable to the Members;

b. Audit and Quality Assurance Committee which shall be accountable to the Governing Body;

c. Remuneration Committee which shall be accountable to the Governing Body;

d. Strategic Clinical Executive which shall be accountable to the Governing Body; and

e. Operational Executive which shall be accountable to the Governing Body.

f. Primary Care Commissioning committee

g. Patient & public engagement & communications sub committee

h. CCGCOM and Working Together are collaboratives of the South Yorkshire &, Bassetlaw CCGs, Hardwick & North Derbyshire CCGs & Wakefield CCG

6.4.2 Committees will only be able to establish their own sub-committees, to assist them in discharging their respective responsibilities, for a responsibility that has been delegated to them by the Group or the committee they are accountable to.

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44 See appendix E

45 See appendix D

46 See chapter 5 above

6.5 Joint Arrangements

6.5.1 The Group has entered into joint arrangements with the following clinical commissioning groups:

Sheffield CCG; Doncaster CCG; Barnsley CCG; Bassetlaw CCG; Hardwick & North Derbyshire and Wakefield CCGs for the CCG Collaborative Commissioning Arrangements (CCGCOM.) and 'Working together'[47].

6.5.2 The Group has joint arrangements with the following local authorities:

the 2012 Act makes provision for clinical commissioning groups to make section 75 agreements with local authorities and the Group has joint arrangements with Rotherham Metropolitan Borough Council which are managed through partnership arrangements. The Group does not have a formal joint committee with Rotherham Metropolitan Borough Council.

6.6 Joint Commissioning:

6.6.1 Joint commissioning arrangements with other Clinical Commissioning Groups

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

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

- delegating any of the CCG's commissioning functions to another CCG;
- exercising any of the commissioning functions of another CCG; or
- exercising jointly the commissioning functions of the CCG and another CCG

c. For the purposes of the arrangements described at paragraph [b], the CCG may:

- make payments to another CCG;
- receive payments from another CCG;
- make the services of its employees or any other resources available to another CCG; or
- receive the services of the employees or the resources available to another CCG.

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

e. For the purposes of the arrangements described at paragraph [b] above, the CCG may establish and maintain a pooled fund made up of contributions by any of the CCGs working together pursuant to paragraph (biii) 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.

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

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

[47] Note – the Group has an outline paper on its website and full terms of reference will be developed prior to authorisation

- 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.

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

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

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

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

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

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

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

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

c. The arrangements referred to in paragraph [b] above may include other CCGs.

d. Where joint commissioning arrangements pursuant to [b] above are entered into, the parties may establish a joint committee to exercise the commissioning functions in question.

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

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

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

and equipment to be used under the joint working arrangements; and

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

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

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

j. The governing body of the CCG shall require, in all joint commissioning arrangements that Chief Officer of the CCG make a quarterly written report to the governing body and hold at least annual engagement events to review aims, objectives, strategy and progress and publish an annual report on progress made against objectives.

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

6.6.3 Joint commissioning arrangements with NHS England for the exercise of NHS England's functions

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

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

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

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

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

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

f. Where the CCG enters into arrangements with NHS England as described at paragraph [b] 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.

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

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

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

j. The governing body of the CCG shall require, in all joint commissioning arrangements that the Chief officer of the CCG make a quarterly written report to the governing body and hold at least annual engagement events to review aims, objectives, strategy and progress and publish an annual report on progress made against objectives.

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

6.7 The Governing Body

6.7.1 *Functions* - the Governing Body has the following functions conferred on it by sections 14L(2) and (3) of the 2006 Act, together with any other functions connected with its main functions as may be specified in regulations or in this constitution[48]. Additional functions conferred on the Governing Body, by the Group, connected with its main functions are set out from paragraph 6.6.1(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 Group's principles of good governance[49] (its main function). The Group will continue to discuss specialised commissioning arrangements with NHS England;

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;

c. approving any functions of the Group that are specified in regulations;[50]

d. additional functions conferred on the Governing Body, by the Group, connected with its main functions are:

- lead the setting of vision and strategy
- approve consultation arrangements for the Commissioning Plan
- prepare and approve annual Commissioning Plans
- monitor performance against delivery of the annual Commissioning Plan
- provide assurance of strategic risk
- ensure the public sector equality duty is met

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

[49] See section 4.4 on Principles of Good Governance above

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

- ensure active membership of Health and Wellbeing Board
- secure public involvement
- promote the NHS Constitution
- delegate assurance of continuous improvement in quality to the Audit and Quality Assurance Committee
- promote improvement in the quality of primary care medical services
- have regard to the need to reduce health inequalities
- promote involvement of patients, their carers and representatives in decisions about their healthcare
- act with a view to enable patients to make choices
- promote innovation
- promote research
- promote education and training
- promote integration of health services where this would improve quality or reduce inequalities
- responsibility for all financial duties

6.7.2 *Composition of the Governing Body* - the Governing Body shall not have less than thirteen members and comprises of:

a. the chair (who shall also be a member of the Strategic Clinical Executive);
b. two representatives of member practices from the GP Members Committee;
c. one other GP representative designated by the Strategic Clinical Executive;
d. one additional Rotherham GP
e. three lay members (one of whom shall be the deputy chair in accordance with paragraph 7.5.1):
    - one to lead on audit, remuneration and conflict of interest matters,
    - one to lead on patient and public participation matters;
    - one to lead on Primary Care Commissioning
f. a registered nurse;
g. a secondary care specialist doctor;
h. the accountable officer;
i. the chief finance officer;
j. the deputy chief officer.

6.7.3 *Committees of the Governing Body* - the Governing Body has appointed the following committees and sub-committees:

a. Audit and Quality Assurance Committee – which is accountable to the Group's Governing Body, provides the Governing Body with an independent and objective view of the Group's financial systems, financial information and compliance with laws, regulations and directions governing the Group in so far as they relate to finance. It provides assurance on the quality of services commissioned and promotes a culture of continuous improvement and innovation with respect to

safety of services, clinical effectiveness and patient experience. The Governing Body has approved and keeps under review the terms of reference for the audit and quality assurance committee, which includes information on the membership of the audit and quality assurance committee[51].

b. Remuneration Committee – which is accountable to the Group's Governing Body, makes recommendations to the Governing Body on determinations about the remuneration, fees and other allowances for employees and for people who provide services to the Group and on determinations about allowances under any pension scheme that the Group may establish as an alternative to the NHS pension scheme. The Governing Body has approved and keeps under review the terms of reference for the remuneration committee, which includes information on the membership of the remuneration committee[52].

c. the Strategic Clinical Executive, which is accountable to the Group's Governing Body, provides a forum for the Commissioning lead-GPs to give to employees and non-clinical members of the Group a clinical perspective in progressing the business of the Group, and to be the 'engine house' of the Governing Body with regards to producing its plans and leading on their delivery. The Governing Body has approved and keeps under review the terms of reference for the Strategic Clinical Executive, which includes information on the membership of the Strategic Clinical Executive [53].

d. the Operational Executive, which is accountable to the Group's Governing Body, to receive information and to manage actions on; operational delivery for the Group; support for the Governing Body; corporate policy and strategy; corporate assurance and risk management; oversight or progress with vision, strategy and operating plan; performance review and improvement and partner and market relations. The Governing Body has approved and keeps under review the terms of reference for the Operational Executive, which includes information on the membership of the Operational Executive [54].

e. The Primary Care Commissioning Committee, which is accountable to the Group's Governing Body.

   The Committee has been established to enable the members to make collective decisions on the review, planning and procurement of primary care services in Rotherham, under delegated authority from NHS England.

   In performing its role the Committee will exercise its management of the functions in accordance with the agreement entered into between NHS England and Rotherham CCG, which will sit alongside the delegation and terms of reference.

   The role of the Committee shall be to carry out the functions relating to the commissioning of primary medical services under section 83 of the NHS Act.

   This includes the following:

   - GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action such as issuing branch/remedial notices, and removing a contract);
   - Newly designed enhanced services ("Local Enhanced Services" and "Directed Enhanced Services");

[51] See appendix K for the terms of reference of the Audit and Quality Assurance Committee
[52] See appendix L for the terms of reference of the remuneration committee
[53] See appendix M for the terms of reference of the SCE Committee
[54] See appendix N for the terms of reference of the Operational Executive Committee

- Design of local incentive schemes as an alternative to the Quality Outcomes Framework (QOF);
- Decision making on whether to establish new GP practices in an area;
- Approving practice mergers; and
- Making decisions on 'discretionary' payment (e.g., returner/retainer schemes).

The CCG will also carry out the following activities:

- To plan, including needs assessment, primary medical care services in Rotherham;
- To undertake reviews of primary medical care services in Rotherham;
- To co-ordinate a common approach to the commissioning of primary care services generally;
- To manage the budget for commissioning of primary medical care services in Rotherham.

f. Patient and public engagement and communication sub-committee, which is accountable to the Group's Governing Body. Provides strategic and operational leadership, for the development of effective Public and Patient Engagement.

6.8 GP Members Committee

6.8.1 The GP Members Committee is to be a strong advisory group to the Strategic Clinical Executive and Clinical Commissioning Group Governing Body and to ensure that the member practices are linked into all of the wider commissioning decisions of the Clinical Commissioning Group (the Group).

6.8.2 It is representative of all of the GP Practices in Rotherham and is mandated by them. The committee's key role is to support the GPs on the Strategic Clinical Executive and to hold the Strategic Clinical Executive to account for its commissioning activities. It should provide a 'reference' point for all commissioning developments.

6.8.3 The GP Members Committee, which is accountable to the members of the Group (who approve and keep under review the committee's terms of reference[55]), is responsible for the following functions delegated to it:

a. To ensure that the opinions of the wider GP Community on strategic commissioning decisions are communicated to the Strategic Clinical Executive through the locality representatives including agreeing the Annual Commissioning Plan.

b. To ensure that communication from the Strategic Clinical Executive is discussed at both locality and practice level through the locality representatives on the reference committee.

c. To promote the involvement of Rotherham GPs in the quality and efficiency agenda via the Commissioning Local Incentive Scheme.

d. Each member of the GP Members Committee will be informally linked to a specific member of Strategic Clinical Executive (and the area of work).

e. To help the Group identify other GPs interested in becoming more involved in commissioning and to assist with succession planning.

f. To encourage patient engagement in commissioning decisions.

[55] See appendix J for the terms of reference of the GP Members Committee

g. To provide a forum for the discussion and recommendation of ideas to the Strategic Clinical Executive and the Governing Body.

h. To agree the annual commissioning plan before being submitted to the Governing Body.

i. To propose amendments to the constitution to NHS England on behalf of member practices.

j. To keep under review the locality boundaries and to make recommendations to members, as appropriate.

k. To make recommendations to the Governing Body with a view to securing continuous improvement to the quality of services.

l. To assist and support NHS England in relation to the Governing Body's duty to improve the quality of Primary Medical Services as set out at paragraph 5.2.5 above.

7 ROLES AND RESPONSIBILITIES

7.1 Practice Representatives

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

7.1.1 Practice representative

Practice representatives have two way responsibilities to their practice and the Group. To liaise and gather views from other members of their practice so they can inform the Group of the collective views of their practice. To explain and disseminate policies agreed by the Group to other members in their practice. To represent the views of their practice to the Group through surveys, at locality meetings and to the GP Members Committee and Strategic Clinical Executive members. Practice representatives are expected to speak on behalf of their patients and the patients of their partners in their practices and to represent patient views to the Practice representatives will maintain a conflict of interest register for their practice and communicate this to the Group.

7.1.2 GP Members Committee member

GP Members Committee and member practices have two way responsibilities to their locality and to the Group. To liaise and gather views from member practice representatives so they can inform the Group of the collective views of Group Members. To inform and disseminate policies agreed by the Group to member practices especially to those practices in their locality. To represent the views of their locality to the GP Members Committee and to disseminate and explain to locality groups and member practices.

7.2 Other GP and Primary Care Health Professionals

In addition to the practice representatives identified in paragraph 7.1 above, the Group has identified a number of other GPs / primary care health professionals from member practices to either support the work of the Group and / or represent the Group rather than represent their own individual practices. These GPs and primary care health professional undertake the following roles on behalf of the Group:

Strategic Clinical Executive members - Strategic Clinical Executive members are selected on the basis of competency in accordance with the Standing Orders and are responsible for clinical leadership of specific portfolios agreed in collaboration with the Chair, Chief Officer other Strategic Clinical Executive members. Collectively the Strategic Clinical Executive members will form the 'engine house' of the Group producing plans and leading on their

delivery. Strategic Clinical Executive members are required to act in the best interests of the patients of Rotherham rather than represent the specific interests of individual practices.

7.3 All Members of the Group's Governing Body

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.

7.4 The Chair of the Governing Body

The chair of the Governing Body is also the senior clinical voice of the Group and responsible for:

7.4.1 leading the Governing Body, ensuring it remains continuously able to discharge its duties and responsibilities as set out in this constitution;

7.4.2 building and developing the Group's Governing Body and its individual members;

7.4.3 ensuring that the Group has proper constitutional and governance arrangements in place;

7.4.4 ensuring that, through the appropriate support, information and evidence, the Governing Body is able to discharge its duties;

7.4.5 supporting the accountable officer in discharging the responsibilities of the organisation;

7.4.6 contributing to building a shared vision of the aims, values and culture of the organisation;

7.4.7 leading and influencing to achieve clinical and organisational change to enable the Group to deliver its commissioning responsibilities;

7.4.8 overseeing governance and particularly ensuring that the Governing Body and the wider Group behaves with the utmost transparency and responsiveness at all times;

7.4.9 ensuring that public and patients' views are heard and their expectations understood and, where appropriate as far as possible, met;

7.4.10 ensuring that the organisation is able to account to its local patients, stakeholders and NHS England;

7.4.11 ensuring that the Group builds and maintains effective relationships, particularly with the individuals involved in overview and scrutiny from Rotherham Metropolitan Borough Council;

7.4.12 take the lead in interactions with stakeholders, including NHS England.

7.5 The Vice Chair of the Governing Body

The vice chair of the Governing Body, is the lay member with a lead role in overseeing key elements of governance and deputises for the chair of the Governing Body where he or she has a conflict of interest or is otherwise unable to act.

7.6 Role of the Accountable Officer

7.6.1 The accountable officer of the Group is a member of the Governing Body.

7.6.2 The role of accountable officer includes:

a. being responsible for ensuring that the clinical commissioning group fulfils its duties to exercise its functions effectively, efficiently and economically thus ensuring improvement in the quality of services and the health of the local population whilst maintaining value for money;

b. at all times ensuring that the regularity and propriety of expenditure is discharged, and that arrangements are put in place to ensure that good practice 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 meet its duties and responsibilities. This will include arrangements for the on-going developments of its members and staff.

7.7 Role of the Chief Finance Officer

7.7.1 The chief finance officer is a member of the Governing Body and is responsible for providing financial advice to the Group and for supervising financial control and accounting systems.

7.7.2 The role of chief finance officer includes:

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

b. making appropriate arrangements to support and monitor the Group's finances;

c. overseeing robust audit and governance arrangements leading to propriety in the use of the Group's resources;

d. being able to advise the Governing Body on the effective, efficient and economic use of the Group's allocation in order to remain within that allocation and deliver required financial targets and duties; and

e. producing the financial statements for audit and publication in accordance with the statutory requirements to demonstrate effective stewardship of public money and accountability to NHS England;

7.8 Role of the Deputy Chief Officer

The Deputy Chief Officer is responsible for:

7.8.1 co-ordinating the clinical leaders in the Strategic Clinical Executive to produce a clear and clinically credible annual commissioning plan so that it takes into account views of member practices, patients and the public, stakeholders views, the requirement to secure continuous quality improvements, efficiency requirements, NHS England's annual mandate, Rotherham's JSNA and Health and Wellbeing Strategy , the public sector equality duty, the NHS constitution and the need to reduce inequalities in access to, and the outcomes from healthcare;

7.8.2 co-ordinating the presentation to the Governing Body of monthly integrated performance reports of delivery against the plan; and

7.8.3 co-ordinating the production of the Group's annual report

7.8.4 to lead on the performance management of Yorkshire and Humber Commissioning Support service level agreement.

7.9 Role of the Lay members of the Governing Body

7.9.1 Lay member with a lead role in overseeing key elements of governance

a. The role of this lay member will be to bring specific expertise and experience to the work of the Governing Body. Their focus will be strategic and impartial, providing an external view of the work of the Group that is removed from the day-

to-day running of the organisation. Their role will be to oversee key elements of governance including audit, remuneration and managing conflicts of interest. They will need to be able to chair the audit committee.

b. As Chair of the Audit Committee, this lay member would be precluded from being the Chair of the Governing Body – although they could be the Deputy Chair.

c. They will have a lead role in ensuring that the Governing Body and the wider Group behaves with the utmost probity at all times.

d. They will also have a specific role in ensuring that appropriate and effective whistle blowing and anti-fraud systems are in place.

7.9.2 Lay member with a lead role in championing patient and public involvement

a. As well as sharing responsibility with the other members for all aspects of Governing Body business, as a lay member on the Governing Body this lay member's role will be to bring specific expertise and experience, as well as their knowledge as a member of the local community, to the work of the Governing Body. Their focus will be strategic and impartial, providing an independent view of the work of the Group that is external to the day-to-day running of the organisation.

b. They will help to provide assurance that, in all aspects of the Group's business the public voice of the local population is heard and that opportunities are created and protected for patient and public empowerment in the work of the Group. In particular, they will look to provide assurance that:

- public and patients' views are heard and their expectations understood and met as appropriate;
- the Group builds and maintains an effective relationship with Local Healthwatch and draws on existing patient and public engagement and involvement expertise; and
- the Group has appropriate arrangements in place to secure public and patient involvement and responds in an effective and timely way to feedback and recommendations from patients, carers and the public.

7.9.3 Lay member with a lead role in overseeing key elements of Primary Care Commissioning.

As well as sharing responsibility with the other members for all aspects of Governing Body business, as a lay member on the Governing Body this lay member's role will hold the portfolio for Primary Care. Their focus will be strategic and impartial, providing an external view of the work of the CCG that is removed from the day-to-day running of the organisation.

7.10 Role of the Registered Nurse Governing Body representative

7.10.1 As well as sharing responsibility with the other members for all aspects of the Governing Body's 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 Group especially the contribution of nursing to patient care.

7.10.2 Specific attributes and competencies

a. be a registered nurse who has developed a high level of professional expertise and knowledge;

b. be competent, confident and willing to give an independent strategic clinical view on all aspects of CCG business;

c. be highly regarded as a clinical leader, probably across more than one clinical discipline and/or specialty – demonstrably able to think beyond their own professional viewpoint; be able to take a balanced view of the clinical and management agenda and draw on their specialist skills to add value;

d. be able to contribute a generic view from the perspective of a registered nurse whilst putting aside specific issues relating to their own clinical practice or employing organisation's circumstances; and be able to bring detailed insights from nursing and perspectives into discussions regarding service re-design, clinical pathways and system reform.

7.10.3 Further points

a. The registered nurse cannot be employed by a body which provides any relevant service to a person for whom the CCG has responsibility. There are two exceptions: a service provided as a result of a patient exercising choice about where to receive a service or a specialist service provided pursuant to a special arrangement made by the CCG in the person's particular case[56].

b. The individual should bring additional perspectives beyond primary care and cannot be a general practice employee. This is especially in relation to this particular role and does not preclude practice nurses from being members of the governing body in other capacities, for instance as the health professionals acting on behalf of member practices.

7.11 Role of the Secondary Care Specialist Doctor Governing Body representative

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

7.11.2 Specific attributes and competencies

a. The Secondary Care Doctor is required to be a secondary care specialist, who has a high level of understanding of how care is delivered in a secondary care setting

b. be competent, confident and willing to give an independent strategic clinical view on all aspects of CCG business;

c. be highly regarded as a clinical leader, preferably with experience working as a leader across more than one clinical discipline and/or specialty with a track record of collaborative working;

d. be able to take a balanced view of the clinical and management agenda, and draw on their in depth understanding of secondary care to add value;

e. be able to contribute a generic view from the perspective of a secondary care doctor whilst putting aside specific issues relating to their own clinical practice or their employing organisation's circumstances; and

f. be able to provide an understanding of how secondary care providers work within the health system to bring appropriate insight to discussions regarding service redesign, clinical pathways and system reform.

Whilst it is desirable to have a practicing clinician, the individual may well no longer practice medicine, they will need to demonstrate that they still have a relevant understanding of care in the secondary setting and not be more than two years retired.

[56] CCG Regulations 2012

The secondary care doctor cannot be employed by a body which provides any relevant service to a person for whom the CCG has responsibility. There are two exceptions: a service provided as a result of a patient exercising choice about where to receive a service or a specialist service provided pursuant to a special arrangement made by the CCG in the person's particular case[57].

7.12 Role of the additional GP to the Governing Body

The additional GP member is responsible for:

as well as sharing responsibility with the other members for all aspects of the Governing body's business, this clinical member will bring a broader view on health and care issues to underpin the work of the group. In particular, they will bring to the governing body specific understanding of patient care/engagement in the primary care setting in Rotherham.

7.13 Indemnity for Members

7.13.1 Members of the Group, the Governing Body, its committees and sub-committees in the execution of their duties as a member of the Group, who act in good faith will not have to meet out of their personal resources any personal civil liability which is incurred in the execution or purported execution of their Group functions, save where they have acted recklessly.

7.13.2 These representatives may be removed from office in accordance with the post holders contract of employment, employment legislation and the normal NHSE/CCG conditions of service/HR procedures or in accordance with the standing order policy at Appendix D.

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 G and are noted in the Standards of Business Conduct Web link

8.1.2 They must comply with the Group's policy on Standards of Business Conduct, including the requirements set out in the policy for managing conflicts of interest. This policy is available on the Group's website.

8.1.3 Individuals contracted to work on behalf of the Group or otherwise providing services or facilities to the Group (a "contracted individual") will be made aware of their obligation with regard to declaring conflicts or potential conflicts of interest. This requirement will be written into their contract for services.

8.2 Conflicts of Interest

8.2.1 As required by section 140 of the 2006 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, contracted individual, as per 8.1.3 Group

[57] CCG Regulations 2012

member, member of the Governing Body, or a member of a committee or a sub-committee of the Group or its Governing Body has an interest, or becomes aware of an interest which could lead to a conflict of interests - in the event of the Group considering an action or decision in relation to that interest - that must be considered as a potential conflict, and is subject to the provisions of this constitution.

8.2.3 A conflict of interest will be considered as set out in the definition in the conflicts of interest procedure appended to this constitution at Appendix I.

8.2.4 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:

a. the members of the Group;

b. the members of the Group's Governing Body;

c. the members of the Group's committees or sub-committees and the committees or sub-committees of its Governing Body; and

d. its employees.

8.3.2 The registers will all be published on the Group's website Declarations of interest and maintained by the Accountable Officer.

8.3.3 individuals declare any conflict or potential conflict in relation to a decision to be made by the group as soon as they become aware of it, and in any event within 28 days

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

8.3.5 When entering an interest on the register of interests, the CCG will ensure that it includes sufficient information about the nature of the interest and the details of those holding the interest.

8.3.6 The Accountable Officer will ensure that the register(s) of interest are reviewed annually, and updated as necessary.

8.4 Managing Conflicts of Interest: general

8.4.1 Individual members of the Group, the Governing Body, committees or sub-committees, the committees or sub-committees of its Governing Body, contracted individuals and employees will comply with the arrangements determined by the Group for managing conflicts or potential conflicts of interest.

8.4.2 The CCG will ensure that, when members declare interests, this includes the interests of all relevant individuals within their own organisations (e.g. partners in a GP practice), who have a relationship with the CCG and who would potentially be in a position to benefit from the CCG's decisions.

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

8.4.4 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.

8.4.5 Arrangements for the management of conflicts of interest are to be determined and managed by the Accountable Officer. The procedure appended to this constitution covers situations in which:-

a. the conflict is relevant to situations other than meetings, and advice is needed by that individual about managing that risk.

b. the conflict is to arise in a meeting and the individual's contribution or otherwise to that discussion needs determining.

c. the declaration is made by the chair of a meeting.

d. exclusion from a discussion makes a meeting non-quorate.

8.4.6 The Accountable Officer will take such steps as deemed appropriate, and request from individuals information deemed appropriate, to ensure that all conflicts of interest and potential conflicts of interest are declared.

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

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

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

8.5.2 Anyone contracted to provide services or facilities directly to the clinical commissioning group will be subject to the same provisions of this constitution incorporating the procedures as appended in Appendix I in relation to managing conflicts of interests. This requirement will be set out in the contract for their services.

8.6 Transparency in Procuring Services

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

8.6.2 The Group will publish a Procurement policy approved by the Governing Body which will ensure that:

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

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

9 THE GROUP AS EMPLOYER

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

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

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

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

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

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

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

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

9.9 The Group has adopted the Standards of Business Conduct Policy and will maintain and promote effective 'whistleblowing' 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."

9.10 Copies of this Code of Conduct, together with the other policies and procedures outlined in this chapter, are available on the Group's website.

10 TRANSPARENCY, WAYS OF WORKING AND STANDING ORDERS

10.1 General

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

10.1.2 Key communications issued by the Group, including the notices of procurements, public consultations, Governing Body meeting dates, times, venues, and certain papers will be published on the Group's website.

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

10.2 Standing Orders

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

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

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

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

10.3 Dispute Resolution

The Group shall apply the Dispute Resolution Protocol set out at Appendix Q to this constitution for disputes between Members in relation to the Group.

APPENDIX A - INTERPRETATION AND DEFINITIONS FOR STANDING ORDERS AND STANDING FINANCIAL INSTRUCTIONS

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 the Board for that purpose; • exercises its functions in a way which provides good value for money.
Area	the geographical area that the group has responsibility for, as defined in Chapter 2 of this constitution
Audit and Quality Assurance Committee	a committee of the Governing Body
Board	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.
Board member	any member appointed to the Board of the group
Budget	a resource, expressed in financial terms, proposed by the Board for the purpose of carrying out, for a specific period, any or all of the functions of the CCG.
Budget holder	the Director or employee with delegated authority to manage finances (Income and Expenditure) for a specific area of the organisation.
CCG COM	South Yorkshire and Bassetlaw CCG Commissioning Network
Chair of the Board	the individual appointed by the group to act as chair of the Board
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)

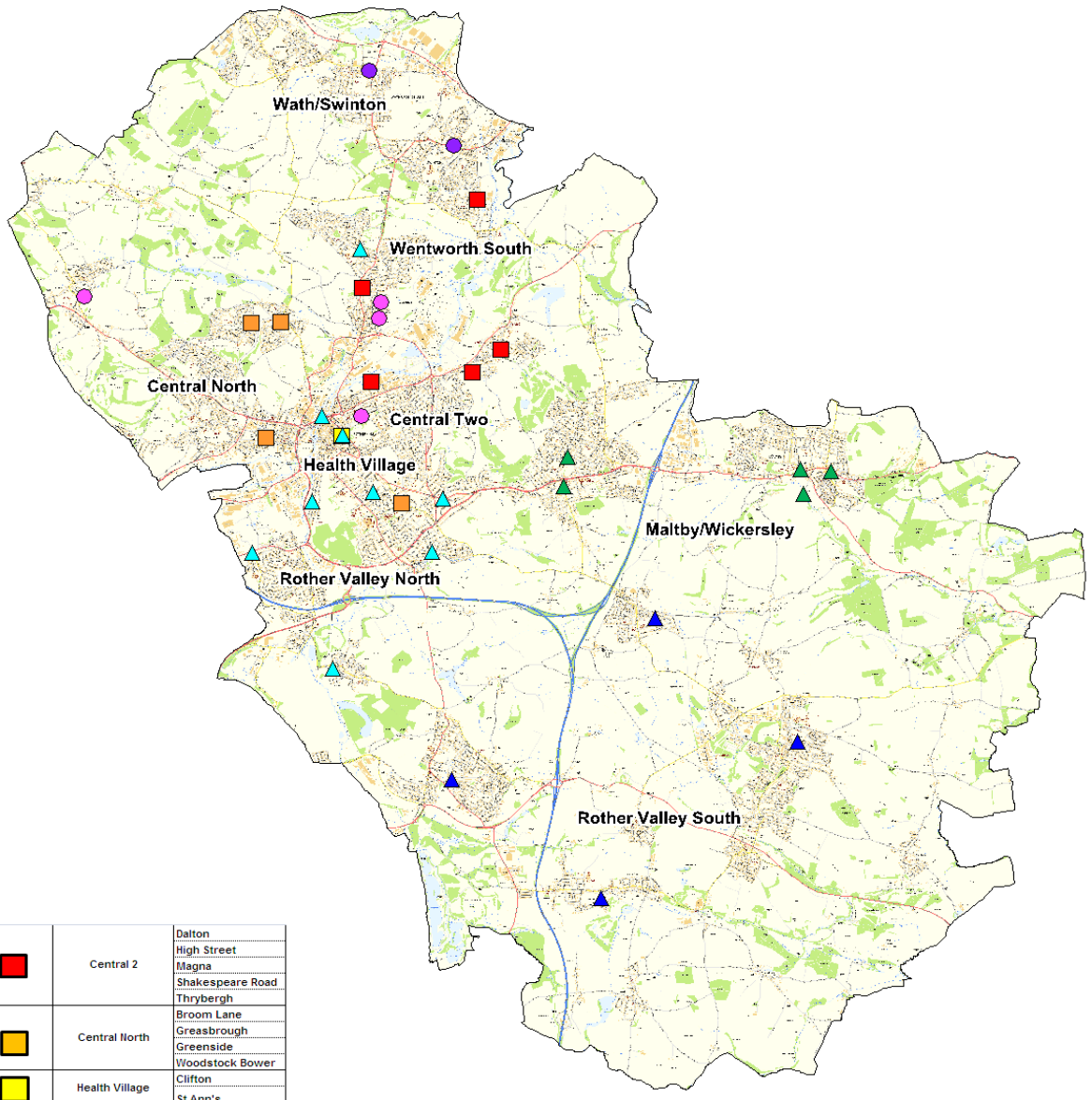
Commissioning	the process for determining the need for and for obtaining the supply of healthcare and related services by the CCG within available resources.
Committee	a committee or sub-committee created and appointed by: • the membership of the group • a committee / sub-committee created by a committee created / appointed by the membership of the group • a committee / sub-committee created / appointed by the Board.
Committee members	persons formally appointed by the Board sit on or to chair specific committees.
Constitution	this constitution as amended from time to time in accordance with its terms
Corporate Secretary	a person appointed to act independently of the Board to provide advice on corporate governance issues to the Governing Body and the Chair and monitor the CCG's compliance with the law, Standing Orders, and Department of Health guidance.
Contracting and procuring	the systems for obtaining the supply of goods, materials, manufactured items, services, building and engineering services, works of construction and maintenance and for disposal of surplus and obsolete assets.
Director of Public Health	a health care professional who is a specialist in Public Health or a consultant in Public Health medicine may hold the post of Director of Public Health.
Financial Directions	any and all Directions made by the Secretary of State from time to time which relate to financial entitlements and or requirements.
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 Rotherham Clinical Commissioning Group, whose constitution this is
Governing Body	The Governing Body within this Constitution is referred to as the Board. The group comprised to fulfill the functions of the Board as set out in the 2006 Act and also as further set out in the Constitution
GP	a medical practitioner whose name is included in the General Practice Register kept by the General Medical Council who is either a Member or engaged by a Member of the CCG
GP Members Committee	A strong advisory group to the Strategic Clinical Executive and CCG Governing Body. It represents all GP practices in Rotherham.
Health and Wellbeing Board	the health and wellbeing of the people in its area and encouraging persons who arrange for the provision of any health or social care services in that area to work in an integrated manner

Health and Wellbeing Strategy	a strategy developed with Rotherham Metropolitan Borough Council for the purpose of purpose of advancing the health and wellbeing of the people in its area and implemented by the Health and Wellbeing Board
Healthcare Professional*;*	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
Independent Members	those members of the Governing Body that are independent of the Members and which shall comprise of two (2) Lay Members
Lay member	a lay member of the Board, appointed by the group. A lay member is an individual who is not a member of the group or a healthcare professional (i.e. an individual who is a member of a profession regulated by a body mentioned in section 25(3) of the National Health Service Reform and Health Care Professions Act 2002) or as otherwise defined in regulations
Member	a provider of primary medical services to a registered patient list, who is a member of this group
NHS Commissioning Board	the National Health Service Commissioning Board (operating as the National Health Service Commissioning Board Authority prior to its formal establishment as a non-departmental public body)
Nominated officer	an officer charged with the responsibility for discharging specific tasks within Standing Orders and Standing Financial Instructions.
Non-officer member	a member of the CCG who is not an officer of the CCG.
Officer	employee of the CCG or any other person holding a paid appointment or office with the CCG.
Officer member	a member of the CCG who is either an officer of the CCG or is to be treated as an officer (i.e. the Chair of the CCG, Clinical Commissioning Group or any person nominated by such a Committee for appointment as a CCG member).
Patient & public engagement and communication committee	A Committee of the Governing Body
Practice	a provider of primary medical services in accordance with section 14A of the 2006 Act
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)
Primary care commissioning committee	A Committee of the Governing Body

Registers of interests	The 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 Board; • the members of its committees or sub-committees and committees or sub-committees of its Board; and • its employees.
Remuneration Committee	a committee of the Governing Body
Scheme of Reservation and Delegation	Delegates powers and authority to the various elements of the organisation set out at Appendix E of this document.
Shadow Health and Wellbeing Board	the Health and Wellbeing Board at any time before it becomes statutorily operational
Standing Orders	the standing orders of the CCG from time to time set out in Appendix D of this document.
Vice-Chair	the non-officer member appointed by the Board to take on the Chair's duties if the Chair is absent for any reason.

APPENDIX B -
MAP OF ROTHERHAM CCG SHOWING PRACTICES AND RELATED LOCALITIES

NHS Rotherham CCG Commissioning Practices & Localities



Central 2	Dalton
	High Street
	Magna
	Shakespeare Road
	Thrybergh
Central North	Broom Lane
	Greasbrough
	Greenside
	Woodstock Bower
Health Village	Clifton
	St Ann's
Maltby/Wickersley	Blyth Road
	Manor Field
	Morthen Road
	Queen's
	Shrivastava
	Wickersley
Rother Valley North	Brinsworth
	Broom Valley Road
	Canklow Road
	Chantry Bridge
	Rosehill
	Stag
	Surgery of Light
	The Gate
	Treeton

Rother Valley South	Dinnington
	Kiveton Park
	Swallownest
	Village
Wath/Swinton	Crown Street
	Market
Wentworth South	Parkgate
	Rawmarsh
	Thorpe Hesley
	York Road

Sue Marriott, Intelligence Administrator,
Performance & Primary Care Improvement, Oak House
Sue.marriott@rotherham.nhs.uk

APPENDIX C -
LIST OF MEMBER PRACTICES

The Group holds signed letters from each of its member practices listed below.

	NACS No.	Practice Name	Address	Locality
1	C87002	Dinnington Group Practice	Dinnington Group Practice New Street Dinnington Sheffield S25 2EZ	Rother Valley South
2	C87003	Woodstock Bower Group Practice	Woodstock Bower Group Practice Kimberworth Road Rotherham S61 1AH	Central North
3	C87004	Kiveton Park Primary Care Centre	Kiveton Park Primary Care Centre Chapel Way Kiveton Park Sheffield S26 6QU	Rother Valley South
4	C87005	St Ann's Medical Centre	St Ann's Medical Centre Rotherham Health Village Doncaster Gate Rotherham S65 1DA	Health Village
5	C87006	Magna Group Practice	*(from 22nd June 2015)* Valley Health Centre Saville Street Dalton Rotherham S65 3HD.	Central Two
6	C87007	Stag Medical Centre	Stag Medical Centre 162 Wickersley Road Rotherham S60 4JW	Rother Valley North
7	C87008	Swallownest Health Centre	Swallownest Health Centre Worksop Road Swallownest Sheffield S26 4WD	Rother Valley South
8	C87009	Brinsworth Medical Centre	Brinsworth Medical Centre 171 Bawtry Road Brinsworth Rotherham S60 5ND	Rother Valley North
9	C87010	York Road Surgery	York Road Surgery York Road Eastwood Rotherham S65 1PW	Wentworth South
10	C87012	Broom Lane Medical Practice	Broom Lane Medical Centre 70 Broom Lane Rotherham S60 3EW	Central North
11	C87013	Parkgate Medical Centre	Parkgate Medical Centre Netherfield Lane Rotherham S62 6AW	Wentworth South
12	C87014	Treeton Medical Centre	Treeton Medical Centre 10 Arundel Street Treeton Rotherham S60 5PW	Rother Valley North

	NACS No.	Practice Name	Address	Locality
13	C87015	Wickersley Health Centre	Wickersley Health Centre Wickersley Rotherham S66 2JQ	Maltby Wickersley
14	C87016	Morthen Road Surgery	Morthen Road Surgery 2 Morthen Road Wickersley Rotherham S66 1EU	Maltby Wickersley
15	C87017	Clifton Medical Centre	Clifton Medical Centre Rotherham Health Village Doncaster Gate Rotherham S65 1DA	Health Village
16	C87018	High Street Surgery	High Street Surgery High Street Rawmarsh Rotherham S62 6LW	Central Two
17	C87020	Greenside Surgery	Greenside Surgery Greasbrough Rotherham S61 4PT	Central North
18	C87022	Village Surgery	Village Surgery 24-28 Laughton Road Thurcroft Rotherham S66 9LP	Rother Valley South
19	C87023	Dalton Health Centre	Dalton Health Centre Magna Lane Dalton Rotherham S65 4HH	Central Two
20	C87024	Rawmarsh Health Centre	Rawmarsh Health Centre Rawmarsh Customer Services Centre Barbers Avenue Rawmarsh Rotherham S62 6AE	Wentworth South
21	C87029	Market Surgery	Market Surgery Warehouse Lane Wath-On-Dearne Rotherham S63 7RA	Wath Swinton
22	C87030	Crown St Surgery	Crown Street Surgery 17 Crown Street Swinton Rotherham S64 8NB	Wath Swinton
23	C87031	Maltby Services Centre	Maltby Services Centre Braithwell Road Maltby Rotherham S66 8LE	Maltby Wickersley
24	C87603	Greasbrough Medical Centre	Greasbrough Medical Centre Munsbrough Rise Greasbrough Rotherham S61 4RB	Central North

	NACS No.	Practice Name	Address	Locality
25	C87604	Thorpe Hesley Surgery	Thorpe Hesley Surgery Sough Hall Avenue Thorpe Hesley Rotherham S61 2QP	Wentworth South
26	C87606	Queens Medical Centre	Queens Medical Centre Muglet Lane Maltby Rotherham S66 7NA	Maltby Wickersley
27	C87608	Shakespeare Road Personal Medical Services	Shakespeare Road Personal Medical Services 50 Shakespeare Road Eastwood Rotherham S65 1QY	Central Two
28	C87609	Rosehill Medical Centre	Rosehill Medical Centre RCHS 52 Rosehill Road Rawmarsh Rotherham S62 7BT	Rother Valley North
29	C87610	Canklow Road Surgery	**Canklow Road Surgery** **RCHS** 245/247 Canklow Road Canklow Rotherham S60 2JH	Rother Valley North
30	C87612	Surgery of Light	Surgery of Light Hunger Hill Lane Whiston Rotherham S60 4BD	Rother Valley North
31	C87616	Blyth Road Medical Centre	Blyth Road Medical Centre 8 Blyth Road Maltby Rotherham S66 8JD	Maltby Wickersley
32	C87617	Thrybergh Medical Centre	Thrybergh Medical Centre 21 Park Lane Thrybergh Rotherham S65 4BT	Central Two
33	C87620	Manor Field Surgery	Manor Field Surgery Maltby Services Centre Braithwell Road Maltby Rotherham S66 8LE	Maltby Wickersley
34	C87621	Broom Valley Road Surgery	Broom Valley Road Surgery 102-104 Broom Valley Road Rotherham S60 2QY	Rother Valley North
35	C87622	The Gate Surgery	The Gate Surgery Chatham House Doncaster Gate Rotherham S65 1DA	Rother Valley North

	NACS No.	Practice Name	Address	Locality
36	Y02616	The Chantry Bridge Medical Centre	Chantry Bridge Medical Centre Rotherham Community Health Centre Greasbrough Road Rotherham S60 1RY	Rother Valley North

APPENDIX D - STANDING ORDERS

1 STATUTORY FRAMEWORK AND STATUS

1.1 Introduction

1.1.1 The constitution contains high level standing orders, scheme of reservation and delegation and prime financial policies. This document sets out in greater detail those powers and decisions reserved to the members, the board, the Chief Officer and other committees and officer positions.

1.1.2 These standing orders have been drawn up to regulate the proceedings of the NHS Rotherham 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.

1.1.3 The standing orders, together with the group's scheme of reservation and delegation[58] and the group's prime financial policies[59], provide a procedural framework within which the group discharges its business. They set out:

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

b. the appointment of member practice representatives;

c. the procedure to be followed at meetings of the group, the Board and any committees or sub-committees of the group or the Board;

d. the process to delegate powers,

e. the declaration of interests and standards of business 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[60] of any relevant guidance.

1.1.4 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 Board, members of the Board's committees and sub-committees, members of the group's committees and sub-committees and persons working on behalf of the group should be aware of the existence of these documents and, where necessary, be familiar with their detailed provisions. Failure to comply with the standing orders, scheme of reservation and delegation and prime financial policies may be regarded as a disciplinary matter that could result in dismissal.

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

1.2.1 The 2006 Act provides the group with powers to delegate the group's functions and those of the Board 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 E).

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58 See Appendix D

59 See Appendix F

60 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.

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 C).

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 Board, including the role of practice representatives (section 7.1 of the constitution).

2.2 Key Roles

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

2.2.2 GP Members Committee, as listed in paragraph 7.1.1 of the group's constitution, is subject to the following appointment process:

- Nominations – Each locality to accept nominations from currently practicing clinicians of member practices;
- Eligibility – currently practicing clinicians of member practices in locality;
- Appointment process – Election from practice representative of locality practices, by simple majority;
- Term of office - Annual;
- Eligibility for reappointment - Members are eligible for re-appointment;
- Grounds for removal from office –
    - If ceases to be a clinician in locality.
    - Any member practice in a locality can petition for re-election of a locality representative.
- Notice period – 3 months.

2.2.3 Strategic Clinical Executive members, as listed in paragraph 7.2.1 of the group's constitution, is subject to the following appointment process:

a. Nominations – CO to administer nomination process;

b. Eligibility – GP member (Partner or Salaried GP) of a GP member practice; and practicing Clinician

c. Appointment process - Selection against competencies by a panel which must include a member of the GP Membership Committee. Term of office - 4 years but in 2013, 14, 15 SCE will chose two members each year to resign/stand for reselection;

d. Eligibility for reappointment – Yes;

e. Grounds for removal from office –

- Annual vote of confidence in commissioning arrangements from all Rotherham GPs. If more than 65% of voters show no confidence immediate recall of SCE and Reference Committee chair and vice chair. If vote of 40-60% of voters Immediate consultation and review of SCE and Reference Committee to identify issues with report back and repeat vote

within one month.

- Competency as per CCG competencies policy.
- Ceases to be a clinician in member practice;

f. Notice period – 3 months.

2.2.4 The chair of the CCG, as listed in paragraph 7.4.1 of the group's constitution, is subject to the following appointment process:

a. Nominations – Member of SCE;

b. Eligibility – Member of SCE. Have passed national assessment centre for CCG clinical leaders;

c. Appointment process - Vote of GP member of SCE, by simple majority;

d. Term of office – annually;

e. Eligibility for reappointment – Yes;

f. Grounds for removal from office –

   a. Any SCE member can petition for a re-election for chair.

   b. Competency as per CCG competencies policy.

   c. Ceases to be a clinician in member practice;

g. Notice period – 3 months

2.2.5 Governing Body representatives from member practices, as listed in paragraph 7.1.1 of the group's constitution, is subject to the following appointment process:

a. Nominations – Chairs and vice chair of GPMC;

b. Eligibility – Member of members Committee;

c. Appointment process - GPMC to elect chair and vice chair 3 yearly by votes of GP members of the groups;

d. Term of office – 3 yearly; - Annual vote of confidence

e. Eligibility for reappointment – Yes;

f. Grounds for removal from office –

   a. Any GP Members Committee member can petition for re-election;

g. Notice period – 3 months.

2.2.6 Additional GP representative from member practice, as listed in paragraph 7.12 of the group's constitution, is subject to the following appointment process.

a. Nominations requested from all member practices

b. Eligibility – GP partner member practice

c. Appointment process – Selection against competencies by a panel which must include a member of the GP Membership Committee.

d. Terms of office – 3 years

e. Eligibility for reappointment – yes

f. Grounds for removal from office –

   a. Competency as per CCG competencies policy

b. Ceases to be a clinician in member practice

c. Serial non-attendance,- 80% attendance minimum

g. Notice period – 3 months

2.2.7 Board representatives from SCE, as listed in paragraph 7.2.1 of the group's constitution, is subject to the following appointment process:

a. Nominations – Chairs and vice chair of SCE;

b. Eligibility – Member of or SCE;

c. Appointment process - SCE to elect annually chair and vice chair by votes of GP members of the groups;

d. Term of office – annually;

e. Eligibility for reappointment – Yes;

f. Grounds for removal from office – Any SCE members can petition for re-election of chair or vice-chair of the SCE;

g. Notice period 1 Month

2.2.8 Lay members of the Board as listed in paragraph 7.9 of the group's constitution, is subject to the following appointment process:

a. Nominations – n/a;

b. Eligibility – Initial appointments to be from a pool;

c. Appointment process - Selection against competencies by a panel which must include a member of the GP Membership Committee. (chair and vice chair or deputies chosen by them) and current chair of SCE or deputy chosen by him/her.

d. Term of office - 3 years;

e. Eligibility for reappointment – Yes;

f. Grounds for removal from office –

- Gross misconduct including breach of Nolan principle.
- Serial non-attendance, 3 consecutive meetings unless apologies accepted by committee chair;

g. Notice period 3 Months

2.2.9 Registered Nurse Board representative, as listed in paragraph 7.10 of the group's constitution, is subject to the following appointment process:

a. Nominations – n/a;

b. Eligibility – Current registered nurse. No conflicts of interest as defined by national guidance on NHS England's website;

c. Appointment process – Appointment made by open advert. Selection against competencies by a panel which must include a member of the GP Membership Committee. (chair and vice chair or deputies chosen by them) and current chair of SCE or deputy chosen by them. Selection against competencies by a committee including two Reference Committee members (chair and vice chair or deputies chosen by them) and the Chief Officer;

d. Term of office Substantive appointment

e. Eligibility for reappointment – N/A;

f. Grounds for removal from office –

g. Gross misconduct.

h. Competency as per CCG competencies policy;

i. Notice period – 3 months.

2.2.10 Secondary Care Specialist Doctor Board representative, as listed in paragraph 7.11 of the group's constitution, is subject to the following appointment process:

a. Nominations – n/a;

b. Eligibility – Current registered doctor. Current or recent secondary care experience as defined by national guidance on NHCCB website. No conflicts of interest as defined by national guidance on NHS England's website;

c. Appointment process - Selection against competencies by a panel which must include a member of the GP Membership Committee. (chair and vice chair or deputies chosen by them) and current chair of SCE or deputy chosen by him/her:

d. Term of office 2 years

e. Eligibility for reappointment – Yes;

f. Grounds for removal from office –

g. Removal from professional registration.

- Gross misconduct including breach of Nolan principle.
- Serial non-attendance, 3 meetings per year unless apologies accepted by committee chair;

h. Notice period 3 months

2.2.11 Accountable Officer, as listed in paragraph 7.6 of the group's constitution, is subject to the following appointment process:

a. Nominations – n/a;

b. Eligibility – Initial appointment to be from pool of people in current VSM posts as advised by NHS SY&B, who have passed national assessment centre process. Appointment to be ratified by NHS England. Subsequent appointments to be via open advert;

c. Appointment process - Advert. Appointment to be by committee including chair and vice chair of GPMC or deputies chosen by them and chair of SCE or deputy chosen by him/her. Subsequent appointments to be via open advert.

d. Term of office - Substantive appointment;

e. Eligibility for reappointment – n/a;

f. Grounds for removal from office –

- Gross misconduct.
- Competency as per CCG competencies policy.

g. Process overseen by lay member for audit, remuneration and conflict of interest;

h. Notice period 6 months.

2.2.12 Chief Finance Officer, as listed in paragraph 7.7 of the group's constitution, is subject to the following appointment process:

a. Nominations – n/a;

b. Eligibility – Initial appointment to be from pool of people as advised by NHS SY&B, who have passed national assessment centre process. Subsequent appointments to be via open advert;

c. Appointment process – Advert. Appointment to be by committee including chair and vice chair of GPMC or deputies chosen by them and chair of SCE or deputy chosen by him/her and Chief Officer. Subsequent appointments to be via open advert:

d. Term of office - Substantive appointment;

e. Eligibility for reappointment – n/a;

f. Grounds for removal from office –

- Gross misconduct.
- Competency as per CCG competencies policy;

g. Notice period 6 months

2.2.13 Deputy Chief Officer, as listed in paragraph 7.8 of the group's constitution, is subject to the following appointment process:

a. Nominations – n/a;

b. Eligibility – Initial appointment to be from pool of people as advised by NHS SY&B, Subsequent appointments to be via open advert;

c. Appointment process - via open advert;

d. Term of office - Substantive appointment;

e. Eligibility for reappointment – n/a;

f. Grounds for removal from office –

- Gross misconduct.
- Competency as per CCG competencies policy;

g. Notice period – 3 months.

2.2.14 The roles and responsibilities of each of these key roles are set out in this document or Chapter 7 of the group's constitution

2.2.15 All Members of the Group's Board

Each member of the Board should share responsibility as part of a team to ensure that the group exercises its functions effectively, efficiently and economically, with good governance and in accordance with the terms of this constitution. Each brings their unique perspective, informed by their expertise and experience.

2.2.16 The Chair of the Board

The chair of the Board is also the senior clinical voice of the group and responsible for:

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

b. building and developing the group's Board and its individual members;

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

d. ensuring that, through the appropriate support, information and evidence, the Board 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 Board and the wider group behaves with the utmost transparency and responsiveness at all times;

i. ensuring that public and patients' views are heard and their expectations understood and, where appropriate as far as possible, met;

j. ensuring that the organisation is able to account to its local patients, stakeholders and NHS England;

k. ensuring that the group builds and maintains effective relationships, particularly with the individuals involved in overview and scrutiny from Rotherham Metropolitan Borough Council;

l. take the lead in interactions with stakeholders, including NHS England.

2.2.17 The Deputy Chair of the Board

The deputy chair of the Board is the lay member with a lead role in overseeing key elements of governance and deputises for the chair of the Board where he or she has a conflict of interest or is otherwise unable to act.

2.2.18 Role of the Accountable Officer

The accountable officer of the group is a member of the Board.

This role of accountable officer is 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 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 is embodied and that safeguarding of funds is ensured through effective financial and management systems.

c. working closely with the chair of the Board, the accountable officer will ensure that proper constitutional, governance and development arrangements are put in place to assure the members (through the Board) of the organisation's on-going capability and capacity to meet its duties and responsibilities. This will include arrangements for the on-going developments of its members and staff.

2.2.19 Role of the Chief Finance Officer

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

This role of chief finance officer is as:

a. being the Board's professional expert on finance and ensuring, through robust systems and processes, the regularity and propriety of expenditure is fully discharged;

b. making appropriate arrangements to support, monitor on the group's finances;

c. overseeing robust audit and governance arrangements leading to propriety in the

use of the group's resources;

d. being able to advise the Board on the effective, efficient and economic use of the group's allocation in order to remain within that allocation and deliver required financial targets and duties; and

e. producing the financial statements for audit and publication in accordance with the statutory requirements to demonstrate effective stewardship of public money and accountability to NHS England.

2.2.20 Role of the Deputy Chief Officer

The Deputy Chief Officer is responsible for co-ordinating the clinical leaders in the SCE to produce a clear and clinically credible annual commissioning plan so that it takes into account views of member practices, patients and the public, stakeholders views, the requirement to secure continuous quality improvements, efficiency requirements, NHS England's annual mandate, Rotherham's JSNA and Health and Wellbeing Strategy , the public sector equality duty and the NHS constitution and the need to reduce inequalities in access to, and the outcomes from healthcare. To co-ordinate the presentation to the Board of monthly integrated performance reports of delivery against the plan. To co-ordinate the production of the CCG annual report and to lead on the performance management of Yorkshire and Humber Commissioning Support Unit service level agreement.

2.2.21 Role of the Lay members of the Board

a. Lay member with a lead role in overseeing key elements of governance

1. The role of this lay member will be to bring specific expertise and experience to the work of the Board. Their focus will be strategic and impartial, providing an external view of the work of the CCG that is removed from the day-to-day running of the organisation. Their role will be to oversee key elements of governance including audit, remuneration and managing conflicts of interest. They will need to be able to chair the audit committee.

2. As Chair of the Audit Committee, this lay member would be precluded from being the Chair of the Board – although they could be the Deputy Chair.

3. This person will have a lead role in ensuring that the Board and the wider CCG behaves with the utmost probity at all times.

4. Good practice would also suggest that this person would also have a specific role in ensuring that appropriate and effective whistle blowing and anti-fraud systems are in place.

b. Lay member with a lead role in championing patient and public involvement

1. As well as sharing responsibility with the other members for all aspects of the Board's business, as a lay member on the Board this lay member will bring specific expertise and experience, as well as their knowledge as a member of the local community, to the work of the Board. Their focus will be strategic and impartial, providing an independent view of the work of the CCG that is external to the day-to-day running of the organisation.

2. This person will help to ensure that, in all aspects of the CCG's business the public voice of the local population is heard and that opportunities are created and protected for patient and public empowerment in the work of the CCG. In particular, they will ensure that:

c. public and patients' views are heard and their expectations understood and met as appropriate;

d. the CCG builds and maintains an effective relationship with Local Healthwatch and draws on existing patient and public engagement and involvement expertise; and

e. the CCG has appropriate arrangements in place to secure public and patient involvement and responds in an effective and timely way to feedback any recommendations from patients, carers and the public.

1. Lay member with a lead role in overseeing key elements of Primary Care Commissioning.

2. As well as sharing responsibility with the other members for all aspects of Governing Body business, as a lay member on the Governing Body this lay member's role will hold the portfolio for Primary Care. Their focus will be strategic and impartial, providing an external view of the work of the CCG that is removed from the day-to-day running of the organisation.

3. This person will Chair the primary care commissioning committee

2.2.22 Role of the Registered Nurse Board representative

As well as sharing responsibility with the other members for all aspects of the Board's business, as a registered nurse on the Board, 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.

2.2.23 Role of the Secondary Care Specialist Doctor Board representative

As well as sharing responsibility with the other members for all aspects of the Board 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 Board an understanding of patient care in the secondary care setting.

3 MEETINGS OF THE CLINICAL COMMISSIONING GROUP

3.1 Calling meetings

3.1.1 Ordinary meetings of both the GP Members Committee and Board will be held at regular intervals and meet no less than 10 times per year at such times and places as the group may determine.

3.1.2 An extra-ordinary meeting of the GP Members Committee, Board, committees or sub-committees can be called at the request of the respective chair of the meetings, the Chief Officer, the chief finance officer or lay member with the responsibility for governance.

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 the GP Members Committee and Board need to be notified to the chair of the meeting at least 7 working days (i.e. excluding weekends and bank holidays) before the meeting takes place. Supporting papers for such items need to be submitted at least 5 working days before the meeting takes place. The agenda and supporting papers will be circulated to all members of a meeting at least 5 working days before the date the meeting will take place.

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

3.3 Petitions

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

3.4 Chair of a meeting

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

3.4.2 If the chair is absent temporarily on the grounds of a declared conflict of interest the deputy chair, if present, shall preside. If both the chair and deputy chair are absent, or are disqualified from participating, or there is neither a chair or deputy a member of the group, Board, 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

The decision of the chair of the Board 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 GP Members Committee – there are 8 GP voting members. Quorum is 5 GPs. Nominated deputies are accepted as voting members if this is clarified by the chair at the start of the meeting.

3.6.2 The Governing Body - there are 13 voting members. The quorum is 7 members which must include 1 Lay member and 1 GP Members Committee member or nominated representative, the accountable officer or nominated representative and the chief financial officer or nominated representative.

3.6.3 In situations where all 5 GPs have conflicts of interest the chair or vice chair will decide whether they can take part in discussions prior to being excluded for voting. In the case of these 5 members being excluded because of conflict of interest the quorum is 5 which must include the accountable officer or nominated representative and the chief financial officer or nominated representative and a lay member.

3.6.4 For all other of the group's committees and sub-committees, including the Governing Body 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 – GP Members Committee - 8 GP members. The Board – 13 voting members.

b. Majority necessary to confirm a decision – simple majority of those present at the meeting;

c. Casting vote – the chair; (The chair will have a vote but also a casting vote in times of deadlock)

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

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

3.8 Emergency powers and urgent decisions

3.8.1 Emergency meetings of the GP Members Committee, Governing Body, committees or sub-committees can be called at the request of the respective chair of the meetings, the Chief Officer, the chief finance officer or lay member with the responsibility for governance.

3.8.2 The need for an urgent decision exceeding individuals' delegated authority can be agreed by the Accountable Officer or deputy (CFO or DCO) and the chair or SCE or vice –chair. Such decisions must be reported to the next Governing Body and next SCE meeting.

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 majority group 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 and Quality Assurance Committee for review of the reasonableness of the decision to suspend standing orders.

3.10 Record of Attendance

The names of all members of the meeting 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

The names and designation of all members of the Governing Body, the Governing Body's committees / sub-committees present shall be recorded in the minutes of the respective Governing Body, Governing Body's committee / sub-committee meetings. The minutes of the Governing Body, Governing Body's committee / sub-committee meetings will be formally signed off by the respective Governing Body, Governing Body's committee / sub-committee at their next meeting and be made available on the group's website. Minutes of a confidential nature will not be made available on the group's website.

3.12 Admission of public and the press

3.12.1 The Group recognises the need to ensure that decisions are taken in an open and transparent way. Save expressly provided in this constitution. The GP members committee meetings which do not involve a decision making process will not generally be held in public unless the chair determines otherwise, having considered the nature of the subject matter of such meeting and whether such meeting would in any event be subject to disclosure under the Freedom of Information Act 2000.

3.12.2 The press and public should be excluded from Governing Body meetings in the following circumstances and discussion and decisions shall be recorded in Part Two Minutes. Governing Body members will be required not to disclose confidential contents of papers or minutes, or content of any discussion at meetings without permission from the chair:

- To prevent disruption;

- Where discussion of a confidential issue is to take place;
- Where publicity on a matter would be prejudicial to the public interest.

3.12.3 Meetings of the GP Members Committee will be held in private.

3.12.4 Meetings of the Governing Body will be held in public – other than for business deemed to be confidential. Arrangements will accord with the Public Bodies (Admission to Meetings) Act 1960.

3.12.5 The public meetings of the Governing Body will be announced for the period ahead via the Group's website. The agenda papers of upcoming meetings and past ones (including minutes as approved) will be available from the website.

3.12.6 Rooms used for Governing Body meetings will allow for the presence of as many members of the public as have attended previously. Those who attend have no right to speak other than by invitation from the Chair.

3.12.7 The Governing Body must pass the following resolution to exclude the public on the grounds of confidentiality:

"That representatives of the press and other members of the public be excluded from the remainder of this meeting due to the confidential nature of the business to be transacted - publicity on which would be prejudicial to the public interest".

3.12.8 Where exclusion is anticipated, due to the nature of the business scheduled for a meeting, the public agenda will identify what the topic is for such an exclusion to be considered.

3.12.9 The meeting can consider an emergency resolution to exclude the public/press, or to adjourn to a private place, if any of those present are disrupting its business and will not leave on request.

3.12.10 When the public/press are excluded, group members, employees, and committee members will be required not to disclose the contents of papers or discussions without the express permission of the group's chair. The discussion can identify a future point at which the contents are no longer confidential and the minutes shall record this.

3.12.11 One meeting per annum of the GP Members Committee – with members of the Governing Body present - will be held in public for presentation of the Annual Report and Annual Accounts. A substantial proportion of this meeting's time will be given over to hearing and responding to the views and questions of the public.

4 ARRANGEMENTS FOR THE EXERCISE OF CCG FUNCTIONS BY DELEGATION TO COMMITTEES AND/OR OFFICERS

4.1 Delegation of Functions to Committees, Officers or other bodies

4.1.1 Delegation to Committees

a. The Governing Body shall agree from time to time to the delegation of executive powers to be exercised by other committees, or sub-committees which it has formally constituted. The constitution and terms of reference of these committees, or sub-committees, are within this constitution, amendments to which shall be approved by NHS England.

b. When the Governing Body is not meeting in public session it shall operate as a committee and may only exercise such powers as may have been delegated to it by the CCG in public session.

4.1.2 Delegation to Officers

Those functions of the CCG which have not been retained as reserved by the

Governing Body or delegated other committees or sub-committees shall be exercised on behalf of the CCG by the Chief Officer. The Chief Officer shall determine which functions he/she will perform personally and shall nominate officers to undertake the remaining functions for which he/she will still retain accountability to the CCG.

The Chief Officer shall prepare a Scheme of Delegation identifying his/her proposals which shall be considered and approved by the Governing Body. The Chief Officer may periodically propose amendment to the Scheme of Delegation which shall be considered and approved by the Governing Body.

Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Governing Body of the Chief Finance Officer to provide information and advise the Governing Body in accordance with statutory or NHS England requirements. Outside these statutory requirements the roles of the Chief Finance Officer shall be accountable to the Chief Officer for operational matters.

4.2 Schedule of Matters Reserved to the CCG and Scheme of Delegation of powers

The arrangements made by the Governing Body as set out in the "Schedule of Matters Reserved to the Governing Body" and "Scheme of Delegation" of powers shall have effect as if incorporated in these Standing Orders.

4.3 Duty to report non-compliance with Standing Orders and Standing Financial Instructions

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.

5 OVERLAP WITH OTHER CCG POLICY STATEMENTS/PROCEDURES, REGULATIONS AND THE STANDING FINANCIAL INSTRUCTIONS

5.1 Policy statements: general principles

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 Rotherham 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.

5.2 Specific Policy statements

These Standing Orders and Standing Financial Instructions must be read in conjunction with the following Policy statements:

5.2.1 The Standards of Business Conduct and Conflicts of Interest Policy for CCG staff;

5.2.2 Code of Conduct for NHS Managers 2002;

5.2.3 ABPI Code of Practice for Professionals 2008 relating to hospitality/gifts from pharmaceutical/external industry;

5.2.4 NHS National Terms and Conditions

5.3 Standing Financial Instructions

Standing Financial Instructions adopted by the Governing Body in accordance with the Financial Regulations shall have effect as if incorporated in these Standing Orders.

5.4 Specific guidance

These Standing Orders and Standing Financial Instructions must be read in conjunction with the following legislation and guidance issued by the Secretary of State for Health:

5.4.1 Caldicott Guardian 1997;

5.4.2 Confidentiality: NHS Code of Practice 2003;

5.4.3 Human Rights Act 1998;

5.4.4 Freedom of Information Act 2000; and

5.4.5 Equality Act 2010.

6 DUTIES AND OBLIGATIONS OF GOVERNING BODY MEMBERS/DIRECTORS AND SENIOR MANAGERS UNDER THESE STANDING ORDERS

6.1 Requirements for Declaring Interests and applicability to Governing Body and Clinical Commissioning Group Members

The NHS Code of Accountability requires Clinical Commissioning Group members and Governing Body members to declare any personal or business interest which may influence or may be perceived to influence their judgement, including without limitation interests which are “relevant and material”. All existing Governing Body members should declare such interests. Any Governing Body members appointed subsequently should do so on appointment. References here to Governing Body members shall mean both Governing Body members, Clinical Commissioning Group members and employees.

The full policy document is included in the constitution at Appendix I.

6.2 Materiality of interests

The CCG’s Standing Orders state that interests which should be regarded as "relevant and material" are:

6.2.1 Directorships, including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies);

6.2.2 Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS;

6.2.3 Majority or controlling share holdings in organisations doing or possibly seeking to do business with the NHS;

6.2.4 A position of authority in another health or social care body or a charity or voluntary organisation in the field of health and social care;

6.2.5 Any connection with a voluntary or other organisation contracting for NHS services;

6.2.6 Research funding/grants that may be received by an individual or their department;

6.2.7 Interests in pooled funds that are under separate management (any relevant company included in this fund that has a potential relationship with the CCG must be declared);

6.2.8 Membership of an organisation that may seek to influence how health care is managed;

6.2.9 Potential employment by a body that could result from organisational change in the NHS.

Doubts about the relevance of an interest should be discussed with the line manager, or the Accountable Officer (or the latter’s nominee) or the chair of the meeting.

6.3 Procedure and actions

6.3.1 Each individual involved in the CCG’s commissioning work:-

a. should work in accord with *The Seven Principles of Public Life* (also known as the Nolan Principles). See appendix G in the CCG's Constitution.

b. should work in accord with their professional code of conduct.

c. should declare all interests that might have any bearing on the work of the CCG

    a. at the commencement of such work

    b. at least once a year

    c. when those interests change

    d. if they come to know that the CCG has entered into (or proposes to enter into) a financial arrangement in which he or any person connected with him has any interest, direct or indirect.

The declarations in (i), (iii) and (iv) should be made as soon as practicable and within 14 days.

If the individual has any doubt about the relevance of an interest, it should be discussed with their line manager or the Accountable Officer (or the latter's nominee) or the chair of the meeting.

6.3.2 Arrangements for the management of conflicts of interest are determined by the Accountable Officer, but there is a requirement to write to the declarer - within a fortnight of declaration – giving the arrangements for managing the conflict of interests or potential conflicts of interests. Such arrangements will specify:

a) whether and when an individual should withdraw from a specified activity, on a temporary or permanent basis;

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

6.3.3 Where an individual has not had confirmation of the arrangements for managing the interest, they must declare their interest at the earliest possible opportunity in each stage of that transaction. The individual must also inform their line manager (in the case of employees) or the Accountable Officer (if not an employee) of the transaction.

6.3.4 Registers will be maintained on the interests of:

- the members of the group;
- the members of the group's Governing Body
- the members of the group's committees or sub-committees;
- Governing Body committees or sub-committees, and
- the group's employees

The registers for all the above will be published on the group's website and maintained by the Accountable Officer. For registers (i) and (iv) individuals will have the option to keep their declaration off the public register, but it must be documented on the Accountable Officer's record of the register.

The Accountable Officer will ensure that the register(s) of interest are reviewed annually, and updated as necessary. For a new declaration, the relevant register will be updated inside 28 days.

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

The Accountable Officer will ensure that the register(s) of interest are reviewed annually, and updated as necessary. For a new declaration, the relevant register will be updated inside 28 days.

6.3.5 Declarations of interests will be a standing item on all meeting agendas. Attenders who have any direct / indirect financial or personal interest in a specific agenda item (or if they are potentially a provider in relation to that agenda item) should take no part in, or influence, the decision.

It will be at the discretion of the meeting's chair to decide whether exclusion from the discussion prior to a decision (and/or exclusion during the making of a decision) would be appropriate.

A meeting will agree who will take over chairing the meeting if the chair has a conflict of interest in an agenda item. Where arrangements have been previously confirmed for the chair's conflicts, the meeting must follow these.

The minutes will record all declarations of interest and actions taken in mitigation.

6.3.6 Where over half of members withdraw from a part of a meeting - due to the arrangements agreed for the management of conflicts of interests - the chair (or deputy) will determine whether or not the discussion can proceed. In making this decision the chair will consider whether the meeting is quorate in accordance with the required number /balance of membership.

6.3.7 Where the meeting is not quorate the discussion will be deferred until such time as a quorum can be convened. Where a quorum cannot be convened from the membership of the meeting, owing to the arrangements for managing conflicts of interest or potential conflicts of interests, the chair of the meeting shall consult with the Accountable Officer (or their nominee) on the action to be taken.

This may include:

- requiring another committee or sub-committee which can be quorate to progress the item of business,

or if this is not possible,

- inviting on a temporary basis one or more of the following to make up the quorum (where these are permitted members of the Governing Body or committee / sub-committee in question) so that the group can progress the item of business:
    a. a member of the clinical commissioning group who is interest free;
    b. an individual nominated by a member to act on their behalf in the dealings between it and the clinical commissioning group;
    c. a member of a relevant Health and Wellbeing Board;
    d. a member of a Governing Body for another clinical commissioning group.

The arrangements used must be recorded in the minutes.

6.3.8 The Accountable Officer will take such steps as judged by them to be appropriate, and request information deemed appropriate from individuals, to ensure that all conflicts of interest and potential conflicts of interest are declared.

7 CUSTODY OF SEAL, SEALING OF DOCUMENTS AND SIGNATURE OF DOCUMENTS

7.1 Register of Sealing

The Chief Officer shall keep a register in which he/she, or another manager of the CCG authorised by him/her, shall enter a record of the sealing of every document.

7.2 Use of Seal – General guide

7.2.1 All contracts for the purchase/lease of land and/or building;

7.2.2 All new lease agreements where the annual lease charge exceeds £100,000 per annum and the period of the lease exceeds beyond five years;

7.2.3 Any other lease agreement where the total payable under the lease exceeds £100,000; and

7.2.4 Any contract or agreement with organisations other than NHS or other government bodies including local authorities where the annual costs exceed or are expected to exceed £100,000.

7.3 Authorising Officers.

The following individuals or officers are authorised to authenticate its use by their signature:

7.3.1 the accountable officer;

7.3.2 the chair of the Governing Body;

7.3.3 the chief finance officer;

7.3.4 the deputy Chief Officer

7.4 Execution of a document by signature

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

7.4.1 the accountable officer

7.4.2 the chair of the Board

7.4.3 the chief finance officer

7.4.4 the deputy Chief Officer.

7.5 Signature of documents

7.5.1 Where any document will be a necessary step in legal proceedings on behalf of the CCG, it shall, unless any enactment otherwise requires or authorises, be signed by the Chief Officer and another Governing Body member.

7.5.2 In land transactions, the signing of certain supporting documents will be delegated to Managers and set out clearly in the Scheme of Delegation but will not include the main or principal documents effecting the transfer (e.g. sale/purchase agreement, lease, contracts for construction works and main warranty agreements or any document which is required to be executed as a deed).

APPENDIX E -
SCHEME OF RESERVATION AND DELEGATION FOR THE GOVERNING BODY

THE MEMBERSHIP	**Regulations and Control** • Determine the arrangements by which the members of the group approve those decisions that are reserved for the membership. • 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 Board, its committees, membership of committees, the overarching scheme of reservation and delegated powers, arrangements for taking urgent decisions, standing orders and prime financial policies. • Approve the arrangements for: • identifying practice members to represent practices in matters concerning the work of the group; and • appointing clinical leaders to represent the group's membership on the group's Board, for example through election • Approve the appointment of Governing Body members, the process for recruiting and removing non-elected members to the Board (subject to any regulatory requirements) and succession planning. • Approve arrangements for identifying the group's proposed accountable officer.
THE MEMBERSHIP	**Strategy, Annual Plan and Budgets** Agree the vision, values and overall strategic direction of the group.
THE BOARD	**Decisions Reserved to the Board**
THE BOARD	**General Enabling Provision** The Board determines any matter, for which it has delegated or statutory authority, it wishes in full session within its statutory powers.

THE BOARD	**Regulations and Control** • Approve Standing Orders (SOs), a schedule of matters reserved to the Board and Standing Financial Instructions for the Regulation of its proceedings and business. • Suspend Standing Orders. • Vary or amend the Standing Orders. • Approve a scheme of delegation of powers from the Clinical Commissioning Group to the Board and other committees. • Require and receive the declaration of the Board members' interests and review in accordance with the conflict of interests policy. • Require and receive the declaration of officers' interests and review in accordance with the conflict of interests policy. • Approve arrangements for dealing with complaints. • Approval of the arrangements for ensuring appropriate and safekeeping and confidentiality of records and for the storage, management and transfer of information and data. • Adopt the organisation structures, processes and procedures to facilitate the discharge of business by the CCG and to agree modifications thereto. • Approval of the arrangements for discharging the group's statutory financial duties. • Receive reports from committees including those that the CCG is required by NHS England or other Regulation to establish and to action appropriately. • Confirm the recommendations of the CCG's committees where the committees do not have executive powers. • Establish terms of reference and reporting arrangements of all committees and sub-committees that are established by the Board. • Ratify use of the seal. • Discipline members of the Board or Clinical Commissioning Group(s) or employees who are in breach of statutory requirements or SOs. • Approve any urgent decisions taken by the Chair of the CCG and Chief Officer for ratification by the CCG in public session.
THE BOARD	**Human Resources** • Ratify the appointment and dismissal of other committees (and individual members) that are directly accountable to the Board. • Appoint, appraise, discipline and dismiss officer members. • Confirm appointment of members of any committee of the CCG who act as CCG representatives on outside bodies.

THE BOARD	**Strategy, Annual Plan and Budgets** • Define the strategic aims and objectives of the CCG. • Identify the key strategic risks, evaluate them and ensure adequate responses are in place and are monitored. • Approve proposals for ensuring quality and developing clinical governance in services commissioned by the CCG, having regard to any guidance issued by NHS England. • Approve (with any necessary appropriate modification) the CCG's annual plan and annual finance plan. Approve the CCG's policies and procedures for the management of risk. • Approve budgets. • Approval of the group's contracts for any commissioning support. • Approval of the group's contracts for corporate support (for example finance provision). • Approve Outline and Final Business Cases for Capital Investment if this represents a variation from the plan. • Approve annually CCG's proposed organisational development proposals. • Ratify proposals for acquisition, disposal or change of use of land and/or buildings. • Approve PFI proposals. • Approve the opening of bank accounts. • Approve individual contracts of a capital or revenue nature amounting to, or likely to amount to over £500,000 over the period of the contract. • Approve proposals in individual cases for the write off of losses or making of special payments above the limits of delegation to the Chief Officer (for losses and special payments) previously approved by the Board. • Approve individual compensation payments above the limits of delegation to the Chief Officer. • Approve proposals for action on litigation against or on behalf of the CCG. • Approve proposals for CCG or practice incentive schemes, having regard to guidance by NHS England. • Decisions relating to service reconfiguration i.e. service changes requiring formal consultation and in relation to proposals from the Specialised Commissioning Group. • Formal adoption of a commissioning policy which has legal or budget implications e.g. restricted procedures policy.

THE BOARD	**Operational And Risk Management** • Prepare and recommend an operational scheme of delegation that sets out who has responsibility for operational decisions within the group. • 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. • Approve decisions delegated to joint committees established under section 75 of the 2006 Act. • 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. • Approve arrangements for co-ordinating the commissioning of services with other groups and or with the local authority where appropriate. • Approve the group's counter fraud and security management arrangements. • Approval of the group's risk management arrangements. • 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). • Approval of a comprehensive system of internal control, including budgetary control that underpins the effective, efficient and economic operation of the group. • Approve proposals for action on litigation against or on behalf of the clinical commissioning group. • Approve the group's arrangements for business continuity and emergency planning.
THE BOARD	**Communications** • Approving arrangements for handling Freedom of Information requests • Determining arrangements for handling Freedom of Information requests

THE BOARD	**Commissioning** • Commission health services for all the population in accordance with the requirements of the NHS Operating Framework and all other relevant national policy and guidance. • Ensure GPs and other clinicians are engaged in the development and implementation of the single integrated plan. • Prepare, recommend and implement the single integrated plan. • Ensure contracts with all providers reflect the requirements of the NHS Operating Framework and single integrated plan. • Ensure required performance against all NHS Operating Framework requirements, all single integrated plan requirements and all contract requirements is achieved. • Ensure all financial duties are achieved. • Ensure all QIPP programme requirements are achieved. • Ensure effective performance against agreed contracts of all healthcare providers.
THE BOARD	**Policy Determination** Approve management policies including personnel policies incorporating the arrangements for the appointment, removal and remuneration of staff. These will be posted on the CCG's website.
THE BOARD	**Audit** • Receive the annual governance letter from the External Auditor and agreement of proposed action, taking account of the advice, where appropriate, of the Audit Committee. • Receive an annual report from the Internal Auditor and agree action on recommendations where appropriate of the Audit Committee. • To receive reports from the Audit Committee and take appropriate action. • Approve the appointment (and where necessary change or removal) of internal audit service providers.
THE BOARD	**Annual Reports and Accounts** • Receipt and approval of the CCG's Annual Report and Annual Accounts.
THE BOARD	**Monitoring** • Receipt of such reports as the Board sees fit from the Clinical Commissioning Group and other committees in respect of its exercise of powers delegated.

DECISIONS DELEGATED BY THE GOVERNING BODY TO, AND RESERVED BY, THE CHIEF OFFICER

CHIEF OFFICER	DECISIONS DELEGATED BY THE BOARD TO, AND RESERVED BY, THE CHIEF OFFICER

CHIEF OFFICER	**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 Board or other committee or sub-committee or [specified] member or employee.
	• Advise on risk, quality and governance, having regard to any guidance by NHS England, and including preparation of proposals to develop and monitor clinical standards in the CCG and its constituent practices.
	• Ratify or otherwise instances of failure to comply with Standing Orders brought to the Chief Officer's attention. Such failures to be reported to the CCG in formal session.
	• 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 Board
	  • committees and sub-committees of the group, or
	  • its members or employees and sets out those decisions of the Board reserved to the Board and those delegated to the
	  • Board's committees and sub-committees,
	  • members of the Board,
	• An individual who is member of the group but not the Board or a specified person for inclusion in the group's constitution.

CHIEF OFFICER	**Operational Decisions** • Advise on acquisition, disposal or change of use of land and/or buildings. • The introduction or discontinuance of any activity or operation which has a gross annual income or expenditure (that is before any set off) in excess of £1 million over a 3 year period or the period of the contract if longer. • Approval of individual contracts of a capital or revenue nature amounting to, or likely to amount to under £500,000 over the period of the contract. • Advise on approval of individual compensation payments. • Consider and make recommendations to the Board on action on litigation against or on behalf of the CCG. • Advise on individual cases for the write off of losses or making of special payments above the limits of delegation to the Chief Officer and Chief Finance Officer (for losses and special payments) previously approved by the Board. • Approve Outline and Final Business Cases for capital investment where the case is within the objectives in the plan.

CHIEF OFFICER	DECISIONS DELEGATED BY THE BOARD TO, AND RESERVED BY, THE CHIEF OFFICER
CHIEF OFFICER	**Financial and Performance Reporting Arrangements** • Continuous appraisal of the affairs of the CCG by means of the provision of information to the Board as the Board may require from directors, committees, and officers of the CCG as set out in management policy statements. All monitoring returns required by NHS England shall be reported, at least in summary, to the Board. • Recommend the opening or closing of any bank account to the Board. • Prepare the CCG's draft Annual Report (including the annual accounts) for approval by the Board.

DECISIONS/DUTIES DELEGATED BY THE GOVERNING BODY TO COMMITTEES

COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
AUDIT & QUALITY ASSURANCE COMMITTEE (AQUA)	The Committee will: • Review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives; • Ensure that there is an effective internal audit function that meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the AQuA Committee, Chief Officer and Board. • Review the work and findings of the External Auditor and consider the implications and responses to their work. • Review the findings of other significant assurance functions, both internal and external to the organisation and consider the implications to the governance of the organisation. • Review the work of other committees within the organisation, including sub AQuA (quality and patient safety) and groups providing assurance to the clinical commissioning group. • Ensure there are adequate arrangements in place for counter fraud. • Review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control. • Monitor the integrity of the financial statements of the CCG. • Review the CCG's annual report and financial statements. • Monitor compliance with Standing Orders and Standing Financial Instructions. • Review schedules of losses and compensations and make recommendations to the Board. • Review the annual financial statements prior to submission to the Board. • Undertake any other duties as listed in the Terms of Reference. Ensure significant clinical risks are identified and reported on the risk register, escalating to the assurance framework. • Receive reports from regulatory and other competent bodies and ensure actions plans are delivered. • Receive periodic thematic exception reports regarding quality and safety legislative and contractual requirements. • Receive annual appraisal reports. • Note clinical policies and clinical pathways for adoption across the clinical commissioning groups. • Maintain an overview of the quality of services provided by care homes in the CCG area.

COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
REMUNERATION, APPOINTMENTS AND TERMS OF SERVICE COMMITTEE	The Committee will: • Advise the Board on all aspects of salary (including performance related pay elements, bonuses and allowances), provision for other benefits including pensions and cars as well as arrangements for termination of employment and other contractual terms and conditions. • Approve the terms and conditions, remuneration and travelling or other allowances for Board members, including pensions and gratuities. • Approve terms and conditions of employment for all employees of the group including, pensions, remuneration, and fees and travelling or other allowances payable to employees and to other persons providing services to the group. • Determine pensions, remuneration, fees and allowances payable to employees and to other persons providing services to the group. • Recommend pensions, remuneration, fees and allowances payable to employees and to other persons providing services to the group. • Advise the Board on the remuneration, allowances and terms of service of other senior managers and Executive Members as appropriate, to ensure they are fairly rewarded. • Monitor and evaluate the performance of individual Executive members. • Advise and oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments taking into account such national guidance as appropriate. • Advise the Board on the remuneration, allowances and terms of service for the chair, lay members and members of the Board and GP members of the Strategic Clinical Executive. • Report to the Board that it has met and performed its function, within recognised national guidelines.
PRIMARY CARE COMMISSIONING COMMITTEE	The Committee will: Strategic direction • oversee the part of the commissioning plan that relates to Primary Care, including needs assessment for safe and sustainable Primary Care Commissioning. • oversee the development and agreement of primary care contracts for 15/16 • oversee the development of the Primary care workforce • identify priorities for consideration by the Local Professional Networks • consider implications and oversee implementation of issues arising from the national, regional and local reviews • make recommendation to the Governing Body on all issues relating to Primary Care Development. Quality & Performance Management • oversee the management of the annual budget for the commissioning of Primary Care services in the relevant area. • oversee individual contract performance on a regular basis – activity, finance and quality.

COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
	• Oversee the Quality Outcome framework (QOF)or local incentive scheme (LIS) • agree contract variations and to undertake reviews of primary care services where appropriate, within delegated limits • consider contract breaches and appropriate enforcement actions and make recommendation to the Governing Body, on all issues to do with Primary Care Development. • oversee programme management and delivery of the QIPP programme • oversee the financial management of GP contracts for Core and enhanced services. • monitor the Primary Care section of the Commissioning plan • In partnership with AQuA monitor delivery against range of KPIs relating to quality • consider independent reports e.g. CQC, Professional alerts, domestic homicide reviews etc., relating to services commissioned • In partnership with AQuA consider trends relating to SI's, complaints and MP enquiries relating to services commissioned • report to the Governing Body as appropriate on issues that need escalation.
CCGCOM	CCGCOM is a collaborative of the South Yorkshire and Bassetlaw CCG, Hardwick & North Derbyshire CCGs and Wakefield CCG which has been formed to make collective decisions on planning, procurement and review of services for populations larger than an individual CCG. The Board delegates responsibility for this work as a committee of the Board within the relevant CCGCOM establishment agreements and scheme of delegation.

SCHEME OF DELEGATION DERIVED FROM THE ACCOUNTABLE OFFICER MEMORANDUM

RESPONSIBILITY OF	DUTIES DELEGATED	DELEGATED TO
CHIEF OFFICER (CO) AND CHIEF FINANCE OFFICER (CFO)	Ensure the accounts of the CCG are prepared under principles and in a format directed by NHS England. Accounts must disclose a true and fair view of the CCG's income and expenditure and its state of affairs. Sign the accounts on behalf of the Board.	Not Delegated
CO	Sign a statement in the accounts outlining responsibilities as the Accountable Officer. Sign a statement in the accounts outlining responsibilities in respect of Governance and Internal Control.	Not Delegated
CO	**Strategy, Plans and Budgets** • Prepare Strategy and Plans and Budgets for approval by the Board. • Advise the Board and the CCG members on the strategic aims and objectives of the CCG. • Prepare and review annually draft plans in respect of the application of available financial resources to support the agreed annual plans for approval by the Board. • Prepare and review annually the draft CCG annual commissioning strategy or plan for approval by the Board. • Prepare proposals (having regard to any guidance by NHS England) for CCG or practice incentive schemes. Monitor and review any such schemes. • Approve Outline and Final Business Cases for Capital Investment.	Not Delegated
CO	Ensure effective management systems that safeguard public funds and assist CCG Chair to implement requirements of integrated governance including ensuring managers: • have a clear view of their objectives and the means to assess achievements in relation to those objectives; • be assigned well defined responsibilities for making best use of resources; • have the information, training and access to the expert advice they need to exercise their responsibilities effectively.	Not Delegated
CHAIR	Implement requirements of corporate governance.	CO
CO	Achieve value for money from the resources available to the CCG and avoid waste and extravagance in the organisation's activities.	Not Delegated

RESPONSIBILITY OF	DUTIES DELEGATED	DELEGATED TO
	Follow through the implementation of any recommendations affecting good practice as set out in reports from such bodies as the Audit Commission and the National Audit Office (NAO). Use to best affect the funds available for commissioning healthcare, developing services and promoting health to meet the needs of the local population.	
CFO	Operational responsibility for effective and sound financial management and information.	Not Delegated
CO	Primary duty to see that the CFO discharges this function.	Not Delegated
CO	Ensuring that expenditure by the CCG complies with Parliamentary requirements.	Not Delegated
CO	The Codes of Conduct and Accountability incorporated in the Corporate Governance Framework issued to NHS Boards by NHS England are fundamental in exercising their responsibilities for regularity and probity. As a Board member or member of a committee they have explicitly subscribed to the Codes; and should promote observance by all staff.	Not Delegated
CO AND CFO	Chief Officer, supported by Chief Finance Officer, to ensure appropriate advice is given to the Board and Clinical Commissioning Group on all matters of probity, regularity, prudent and economical administration, efficiency and effectiveness.	Not Delegated
CO	If the CO considers the Board, Chair or Clinical Commissioning Group is doing something that might infringe probity or regularity; he/she should set this out in writing to the Chair and the Board. If the matter is unresolved, he/she should ask the Audit Committee to inquire and if necessary NHS England.	Not Delegated
CO	If the Board is contemplating a course of action that raises an issue not of formal propriety or regularity but affects the CO's responsibility for value for money, the CO should draw the relevant factors to the attention of the Board. If the outcome is an over-ruling it is normally sufficient to ensure that the advice and the overruling of it are clearly apparent from the papers. Exceptionally, the CO should inform NHS England. In such cases, and in those described in reference 24, the CO should as a member of the Board vote against the course of action rather than merely abstain from voting.	Not Delegated

SCHEME OF DELEGATION DERIVED FROM THE CODES OF CONDUCT AND ACCOUNTABILITY

DELEGATED TO	AUTHORITIES/DUTIES DELEGATED	DELEGATED TO
BOARD	Approve procedure for declaration of hospitality and sponsorship.	Not Delegated
BOARD	Ensure proper and widely publicised procedures for voicing complaints, concerns about maladministration, breaches of Code of Conduct, and other ethical concerns.	Not Delegated
BOARD MEMBERS AND CCG MEMBERS	Subscribe to Code of Conduct	Not Delegated
BOARD	Board members share corporate responsibility for all decisions of the Board.	Not Delegated
CHAIR AND NON-OFFICER MEMBERS	Chair and non-officer members are responsible for monitoring the executive management of the organisation and are responsible to NHS England for the discharge of those responsibilities.	Not Delegated
BOARD	The Board has six key functions for which it is held accountable by NHS England: • To ensure effective financial stewardship through value for money, financial control and financial planning and strategy; • To ensure that high standards of integrated governance and personal behaviour are maintained in the conduct of the business of the whole organisation; • To appoint, appraise and remunerate senior executives; • To ratify the strategic direction of the organisation within the overall policies and priorities of the Government and the NHS, define its annual and longer term objectives and agree plans to achieve them; • To oversee the delivery of planned results by monitoring performance against objectives and ensuring corrective action is taken when necessary; • To ensure that the Clinical Commissioning Group leads an effective dialogue between the organisation and the local community on its plans and performance and that these are responsive to the community's needs.	Not Delegated
BOARD	It is the Board's duty to:	Not Delegated

DELEGATED TO	AUTHORITIES/DUTIES DELEGATED	DELEGATED TO
	• Act within statutory financial and other constraints; • Be clear what decisions and information are appropriate to the Board and draw up Standing Orders, a Schedule of Decisions Reserved to the Board or CCG members and Standing Financial Instructions to reflect these; • Ensure that management arrangements are in place to enable responsibility to be clearly delegated to senior executives for the main programmes of action and for performance against programmes to be monitored and senior executives held to account; • Establish performance and quality measures that maintain the effective use of resources and provide value for money; • Specify its requirements in organising and presenting financial and other information succinctly and efficiently to ensure the Board can fully undertake its responsibilities; • Establish Audit & Integrated Governance and Remuneration, Appointments and Terms of Service Committees on the basis of formally agreed terms of reference which set out the membership of the sub-committee, the limit to their powers, and the arrangements for reporting back to the main Board.	
CHAIR	It is the Chair's role to: • Provide leadership to the Board; • Enable all Board members to make a full contribution to the Board's affairs and ensure that the Board acts as a team; • Ensure that key and appropriate issues are discussed by the Board in a timely manner; • Ensure the Board has adequate support and is provided efficiently with all the necessary data on which to base informed decisions; • Lead Lay members through a formally-appointed Remuneration, Appointments and Terms of Service Committee of the main Board on the appointment, appraisal and remuneration of the Chief Officer and (with the latter) other executive Board members; • Advise the members of the Clinical Commissioning Group on the performance of Lay members.	Not Delegated
CO	The Chief Officer is accountable to the Chair and non-executive members of the Board for ensuring that its decisions are implemented, that the organisation works effectively, in accordance with Government	Not Delegated

DELEGATED TO	AUTHORITIES/DUTIES DELEGATED	DELEGATED TO
	policy and public service values and for the maintenance of proper financial stewardship. The Chief Officer should be allowed full scope, within clearly defined delegated powers, for action in fulfilling the decisions of the Board. The other duties of the Chief Officer as Accountable Officer are laid out in the Accountable Officer Memorandum.	
LAY MEMBERS	Lay members are appointed by the CCG members, the strategic clinical executive members and the Chair of the Health and Well Being Board to bring independent judgement to bear on issues of strategy, performance, key appointments and accountability.	Not Delegated
CHAIR AND BOARD MEMBERS	Declaration of conflict of interests.	Not Delegated
BOARD	NHS Boards must comply with legislation and guidance issued by NHS England, respect agreements entered into by themselves or on their behalf and establish terms and conditions of service that are fair to the staff and represent good value for taxpayers' money.	Not Delegated

SCHEME OF DELEGATION FROM STANDING ORDERS

RESPONSIBILITY OF	AUTHORITIES/DUTIES DELEGATED	DELEGATED TO
CHAIR	Final authority in interpretation of Standing Orders.	Not Delegated
BOARD	Appointment of Vice-Chair.	Not Delegated
CHAIR	Calling meetings.	Not Delegated
CHAIR	Chair all Board meetings and associated responsibilities.	Not Delegated
CHAIR	Give final ruling in questions of order, relevancy and regularity of meetings.	Not Delegated
CHAIR	Having a second or casting vote.	Not Delegated
BOARD	Suspension of Standing Orders.	Not Delegated
AUDIT COMMITTEE	Audit Committee to review every decision to suspend Standing Orders (power to suspend Standing Orders is reserved to the Board).	Not Delegated
BOARD	Variation or amendment of Standing Orders.	Not Delegated
CHAIR	Approve one of the members of the Clinical Commissioning Group as Chair of the Clinical Commissioning Group, and another member as Vice-Chair, following nomination by that committee.	Not Delegated
BOARD	The Board shall approve the appointments to each of the committees which it has formally constituted	Not Delegated
CHAIR & CO	The powers which the Board has retained to itself within these Standing Orders may in emergency be exercised by the Chair and Chief Officer after having consulted at least two non-officer members.	Not Delegated
BOARD	Formal delegation of powers to sub-committees and other committees and approval of their constitution and terms of reference. (The Chief Officer may approve Constitution and terms of reference of sub-committees.)	Not Delegated
CO	The Chief Officer shall prepare a Scheme of Delegation, which shall be considered and approved by the Board, subject to any amendment agreed during the discussion.	Not Delegated
ALL	Disclosure of non-compliance with Standing Orders to the Chief Officer as soon as possible.	All
BOARD MEMBERS AND CCG MEMBERS	Declare relevant and material interests.	ALL COMMITTEE

RESPONSIBILITY OF	AUTHORITIES/DUTIES DELEGATED	DELEGATED TO
		MEMBERS
CO	Maintain Register(s) of Interests.	Corporate Secretary
CHAIR	Making a ruling on a declared interest.	Not Delegated
ALL STAFF	Comply with national guidance contained in "Standards of Business Conduct for NHS Staff" and the Code of Conduct for NHS Managers 2002.	**ALL STAFF**
ALL	Disclose relationship between self and candidate for staff appointment. (CO to report the disclosure to the Board).	**ALL**
CO	Keep seal in safe place and maintain a register of sealing.	Corporate Secretary
CO & OFFICER MEMBER	Approve and sign all documents which will be necessary in legal proceedings.	Not Delegated

SCHEME OF DELEGATION FROM STANDING FINANCIAL INSTRUCTIONS

RESPONSIBILITY OF	AUTHORITIES/DUTIES DELEGATED	DELEGATED TO
CFO	Approval of all financial procedures.	Not delegated
CFO	Advice on interpretation or application of SFIs.	Not delegated
ALL MEMBERS OF THE BOARD AND EMPLOYEES	Have a duty to disclose any non-compliance with these Standing Financial Instructions to the Chief Finance Officer as soon as possible.	**ALL MEMBERS OF THE GOVERNING BODY AND EMPLOYEES**
CO	Responsible as the Accountable Officer to ensure financial targets and obligations are met and has overall responsibility for the System of Internal Control.	Not Delegated
CO & CFO	Accountable for financial control but will, as far as possible, delegate their detailed responsibilities.	CFO
CFO	To ensure all Board members, officers and employees, present and future, are notified of and understand Standing Financial Instructions.	Not Delegated
CFO	Responsible for: • implementing the CCG's financial policies and co-coordinating corrective action; • maintaining an effective system of financial control including ensuring detailed financial procedures and systems are prepared and documented; • ensuring that sufficient records are maintained to explain CCG's transactions and financial position; • providing financial advice to members of the Board and staff; • maintaining such accounts, certificates etc. as are required for the CCG to carry out its statutory duties; • the design, implementation and supervision of systems of internal control.	Not Delegated
ALL MEMBERS OF THE BOARD AND EMPLOYEES	Responsible for security of the CCG's property, avoiding loss, exercising economy and efficiency in using resources and conforming to Standing Orders, Standing Financial Instructions and financial procedures.	**ALL MEMBERS OF THE GOVERNING BODY AND**

RESPONSIBILITY OF	AUTHORITIES/DUTIES DELEGATED	DELEGATED TO
		EMPLOYEES
CO	Ensure that any contractor or employees of a contractor who is empowered by the CCG to commit the CCG to expenditure or who is authorised to obtain income are made aware of these instructions and their requirement to comply.	CFO
AUDIT & QUALITY ASSURANCE COMMITTEE (AQUA)	Provide independent and objective view on internal control and probity.	Not Delegated
CHAIR	Raise the matter at the Board meeting where Chair of **AQUA** considers there is evidence of ultra vires transactions or improper acts.	Not Delegated
CFO	• Ensure an adequate internal audit service, for which he/she is accountable, is provided (and involve the AQuA in the selection process when/if an internal audit service provider is changed.) • Ensure the annual audit report is prepared for consideration by the AQuA.	Not Delegated
CFO	Decide at what stage to involve police in cases of misappropriation and other irregularities not involving fraud or corruption.	Not Delegated
HEAD OF INTERNAL AUDIT	Review, appraise and report in accordance with NHS Internal Audit Standards and best practice.	Not Delegated
AQUA	Ensure cost-effective External Audit.	Not Delegated
CO & CFO	Monitor and ensure compliance with the latest directions on fraud and corruption including the appointment of the Local Counter Fraud Specialist.	Not Delegated
CO	Monitor and ensure compliance with the latest directions on NHS security management including appointment of the Local Security Management Specialist.	Not Delegated
CO	Has overall responsibility for the CCG's activities and ensuring the CCG stays within its resource limit.	Not Delegated
CFO	Will provide monthly reports to NHS England, ensure draw down is for approved expenditure and timely and follows best practice in cash management.	Not Delegated
CFO	Ensure monitoring systems are in place to enable the CCG not to exceed its limits.	Not Delegated
CFO	Periodically review assumptions, submit a report to the CCG annually showing total allocations received and their proposed distribution.	Not Delegated

RESPONSIBILITY OF	AUTHORITIES/DUTIES DELEGATED	DELEGATED TO
CFO	Regularly update the CCG on significant changes to the initial allocation and the uses of such funds.	Not Delegated
CO	Compile and submit to the Board a strategic Plan which takes into account financial targets and forecast limits of available resources. The plan will contain: a statement of the significant assumptions on which the plan is based; details of major changes in workload, delivery of services or resources required to achieve the plan.	Not Delegated
CO	Complete and submit to the Board plans for the improvement of health and health services	Not Delegated
CFO	Submit budgets to the Board for approval. Monitor performance against budget; submit to the Board financial estimates and forecasts.	Not Delegated
CFO	Ensure adequate training is delivered on an ongoing basis to budget holders.	Not Delegated
CO	Delegate budget to budget holders.	Budget Holders
CO & BUDGET HOLDERS	Must not exceed the budgetary total or virement limits set by the Board.	**CO & BUDGET HOLDERS**
CFO	Devise and maintain systems of budgetary control.	Not Delegated
BUDGET HOLDERS	Ensure that: • No overspend or reduction of income that cannot be met from virement is incurred without prior consent of the CO; • Approved budget is not used for any other than specified purpose subject to rules of virement; • No permanent employees are appointed without the approval of the CO other than those provided for within available resources and manpower establishment.	Not Delegated
CO	Identify and implement QIPP plans	ALL
CO	Submit monitoring returns.	CFO
CFO	Preparation of annual accounts and reports.	CFO
CFO	Managing banking arrangements, including provision of banking services, operation of accounts, preparation of instructions and list of cheque signatories.	Head of Finance

RESPONSIBILITY OF	AUTHORITIES/DUTIES DELEGATED	DELEGATED TO
CFO	Review the banking arrangements of the CCG at regular intervals to ensure they reflect best practice and represent best value for money.	Not Delegated
CFO	Income systems, including system design, prompt banking, review and approval of fees and charges, debt recovery arrangements, design and control of receipts, provision of adequate facilities and systems for employees whose duties include collecting or holding cash.	CFO
ALL EMPLOYEES	Duty to inform CFO of money due from transactions which they initiate/deal with.	All
CO	Tendering and contracting procedure.	CFO
CO	In-house services: Decision to tender for services.	Not Delegated
CO	Formal tendering procedures to be waived.	Not Delegated
CORPORATE SECRETARY	Fees payable for the provision of legal advice / services.	Not Delegated
CO	Review of contract opportunity reported to the CO and maintenance of record of such contract opportunity.	Not Delegated
CO	Report waivers of tendering procedures to the Audit Committee.	Not Delegated
CO	Responsible for the receipt, endorsement and safe custody of tenders received.	Not Delegated
CO	Designation of senior officers/managers to open tenders.	Not Delegated
ALL EXECUTIVE DIRECTORS & MEMBERS	Opening tenders.	**ALL EXECUTIVE DIRECTORS & MEMBERS**
CORPORATE SECRETARY	Opening tenders.	Not Delegated
CO	Shall maintain a register to show each set of competitive tender invitations dispatched.	**CORPORATE SECRETARY**
CO	Admissibility of tenders.	CO / CFO
CO & CFO	Where one tender is received will assess for value for money and fair price.	CO / CFO
CO	Responsible for treatment of 'late tenders'.	CO / CFO

RESPONSIBILITY OF	AUTHORITIES/DUTIES DELEGATED	DELEGATED TO
CO	Electronic Auctions and Dynamic Purchasing Systems.	CO / CFO
CO & CCG OFFICERS	Draft specification.	Not delegated
CO & CCG OFFICERS	Draft and submit in-house tender submission.	Not Delegated
CFO & THE EVALUATION GROUP	Shortlist expressions of interest and evaluate tenders received.	Not Delegated
CO	Nomination of officer to oversee and manage the contract awarded on behalf of the CCG.	Not Delegated
CO	Quotations: Competitive and Non-Competitive; decision re requirement to obtain quotation in writing, evaluation of quotations and source of goods from alternative suppliers.	CFO/CO
CO or CFO	No quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the CCG and/or which is not in accordance with these Standing Financial Instructions except with the authorisation of the Chief Officer.	Not Delegated
CO	Overriding duty to achieve best value for money.	CO
CO	Shall ensure that appropriate evaluation criteria are adopted to assess the technical and financial capability of those firms that are invited to tender or quote.	CFO
CFO	No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the CCG and/or which is not in accordance with these Instructions except with the authorisation of the Chief Officer.	Not Delegated
CO OR CFO	Acceptability of tenders.	Not Delegated
DESIGNATED BUDGET HOLDER	Award of contracts up to the amount specified in the budgetary scheme of delegation	Not Delegated
CHIEF OFFICER & DIRECTORS	Award of contracts up to the amount specified in the budgetary scheme of delegation.	Not Delegated
CO	Award of contracts up to the amount specified in the budgetary scheme of delegation.	Not Delegated
BOARD	Award of contracts over the amount specified in the budgetary scheme of delegation.	Not Delegated
CFO	Use of correct form of contract.	Not Delegated
CO	The Chief Officer shall nominate officers with delegated authority to enter into contracts of employment,	Not Delegated

RESPONSIBILITY OF	AUTHORITIES/DUTIES DELEGATED	DELEGATED TO
	regarding staff, agency staff or temporary staff service contracts.	
CO	The Chief Officer shall nominate an officer who shall oversee and manage each contract on behalf of the CCG.	CO / CFO
CO	Use of competitive tendering or quotation procedures.	CO / CFO
CO	Must ensure the CCG enters into suitable contracts with service providers for the provision of NHS services and consider the extent to which any NHS standard contract conditions are mandatory.	CO / CFO
CO	Ensure that regular reports are provided to the Board detailing actual and forecast expenditure against the contract.	n/a
CO	As the Accountable Officer, ensure services are commissioned in line with the Plan and reach the required standards.	CO / CFO
CO	The Chief Officer shall use NHS standard commissioning contracts (where applicable).	CO
CO	Ensure regular reports are provided to the Board detailing actual and forecast expenditure for each contract.	Not Delegated
CO	Ensure that all agreements for provision of services with non-NHS providers achieve quality and are cost effective.	CO / CFO
CFO	Will maintain a system of control to ensure effective accounting of expenditure against each contract.	CO / CFO
CFO	Must account for Out of Area Treatments/Non Contract Activity in accordance with national guidelines.	CO / CFO
GOVERNING BODY	Establish a Remuneration, Appointments & Terms of Reference Committee.	CCG
REMUNERATION, APPOINTMENTS AND TERMS OF SERVICE COMMITTEE (RATS)	Advise the Board on and make recommendations on the remuneration and terms of service of the CO, other officer members, GP members of the strategic clinical executive and senior employees to ensure they are fairly rewarded having proper regard to the CCG's circumstances and any national agreements. Monitor and evaluate the performance of individual senior employees. Advise on and oversee appropriate contractual arrangements for such staff, including proper calculation and scrutiny of termination payments.	n/a
RATS	Report in writing to the Board its advice and its bases about remuneration and terms of service of directors and senior employees.	n/a
BOARD	Approve proposals presented by the Chief Officer for setting of remuneration and conditions of service for	n/a

RESPONSIBILITY OF	AUTHORITIES/DUTIES DELEGATED	DELEGATED TO
	those employees and officers not covered by the RATS Committee.	
CO	Approval of variation to funded establishment of any department.	CO
CO	Approval of appointment of staff, including agency staff, appointments and re-grading within approved budget and funded establishment.	CO
CFO	Ensure that the chosen method for payroll processing is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.	CO
CO	Submit time records in line with timetable. Complete time records and other notifications in required form. Submitting termination forms in prescribed form and on time.	CO
CO	Ensure that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation; Deal with variations to, or termination of, contracts of employment.	Not applicable
BOARD	The Board will approve the level of non-pay expenditure on an annual basis.	Not applicable
CO	Determine, and set out, level of delegation of non-pay expenditure to budget managers, including a list of managers authorised to place requisitions, the maximum level of each requisition and the system for authorisation above that level.	CCG
CO	Set out procedures on the seeking of professional advice regarding the supply of goods and services.	CFO
REQUISITIONER	In choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the CCG. In so doing, the advice of the CCG's adviser on supply shall be sought.	Not Delegated
CFO	Shall be responsible for the prompt payment of accounts and claims.	Not Delegated
CFO	Advise the Board regarding 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 standing orders and regularly reviewed; Prepare procedural instructions on the obtaining of goods, works and services incorporating the thresholds; Be responsible for the prompt payment of all properly authorised accounts and claims; Be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable;	Not Delegated

RESPONSIBILITY OF	AUTHORITIES/DUTIES DELEGATED	DELEGATED TO
	Be responsible for ensuring that payment for goods and services is only made once the goods and services are received.	
OFFICER MEMBER	Make a written case to support the need for a pre-payment.	Not Delegated
CFO	Approve proposed pre-payment arrangements.	Not Delegated
BUDGET HOLDER	Ensure that all items due under a prepayment contract are received (and immediately inform Chief Finance Officer if problems are encountered).	Budget holder
CO	Authorise who may use and be issued with official orders.	Budgetary Scheme of Delegation
MANAGERS AND OFFICERS	Ensure that they comply fully with the guidance and limits specified by the Chief Finance Officer	Managers and officers
CO & CFO	Ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within CONCODE, ESTATECODE, Procure 21, NHS LIFT and PFI Guidance manual. The technical audit of these contracts shall be the responsibility of the relevant Director.	Not Delegated
CFO	Lay down procedures for payments to local authorities and voluntary organisations made under the powers of section 75 or 256 of the NHS ACT 2004.	Not Delegated
CFO	Ensure that Board members are aware of the Financial Framework and ensure compliance	Not Delegated
CO	Capital investment programme: Ensure that there is adequate appraisal and approval process for determining capital expenditure priorities and the effect that each has on plans; Responsible for the management of capital schemes and for ensuring that they are delivered on time and within cost; Ensure that capital investment is not undertaken without availability of resources to finance all revenue consequences; Ensure that a business case is produced for each proposal.	n/a
CFO	Certify professionally the costs and revenue consequences detailed in the business case for capital investment.	Not Delegated

RESPONSIBILITY OF	AUTHORITIES/DUTIES DELEGATED	DELEGATED TO
CO	Issue procedures for management of contracts involving stage payments.	CFO
CFO	Issue procedures for the regular reporting of expenditure and commitment against authorised capital expenditure.	Not Delegated
CO	Shall issue to the manager responsible for any scheme specific authority to commit expenditure, proceed to tender and accept a successful tender.	CFO
CO	Issue a scheme of delegation for capital investment management in accordance with Estate code and Standing Orders.	CFO
CFO	Issue procedures governing financial management, including variation to contract, of capital investment projects and valuation for accounting purposes.	Not Delegated
CFO	Demonstrate that the use of private finance represents value for money and genuinely transfers significant risk to the private sector.	Not Delegated
Board	Proposal to use PFI must be specifically agreed by the Board.	Not Delegated
CO	Maintenance of asset registers (on advice from CFO).	CFO
CFO	Approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.	Not Delegated
CFO	Calculate and pay capital charges in accordance with NHS England requirements.	Not Delegated
CO	Overall responsibility for fixed assets.	Not Delegated
CFO	Approval of fixed asset control procedures.	Not Delegated
BOARD, EXECUTIVE MEMBERS AND ALL SENIOR STAFF	Responsibility for security of CCG assets including notifying discrepancies to CFO, and reporting losses in accordance with CCG procedure.	Not Delegated
CO	Delegate overall responsibility for control of stores (subject to CFO responsibility for systems of control). Further delegation for day-to-day responsibility subject to such delegation being recorded.	CFO
CFO	Responsible for systems of control over stores and receipt of goods.	Not Delegated
CFO	Security arrangements and custody of keys.	LSMO
CFO	Set out procedures and systems to regulate the stores including stocktaking arrangements or approve	Not Delegated

RESPONSIBILITY OF	AUTHORITIES/DUTIES DELEGATED	DELEGATED TO
	alternative arrangements where a complete system of stores control is not justified.	
CFO	Approve system for review of slow moving and obsolete items and for condemnation, disposal and replacement of all unserviceable items.	Not Delegated
CO	Identify persons authorised to requisition goods from NHS Supply Chain.	Budgetary Scheme of Delegation
CFO	Prepare detailed procedures for disposal of assets including condemnations and ensure that these are notified to managers.	Not Delegated
CFO	Prepare procedures for recording and accounting for losses, special payments.	Not Delegated
ALL STAFF	Adhere to procedures for the discovery or suspicion of loss.	All staff
CFO	Ensure that where a criminal offence is suspected the police must be informed if theft or arson is involved. In cases of fraud and corruption the relevant Local Counter Fraud Specialist (LCFS) and NHS Protect Operational Fraud Team must be informed in line with NHS Commissioning Board Directions.	Not Delegated
CFO	Notify NHS Protect, LCFS and External Audit of all frauds.	Not Delegated
CFO	Notify the Board and External Auditor of non-trivial losses through theft, arson, neglect of duty or gross carelessness.	Not Delegated
BOARD	Approve write off of losses (within limits delegated by NHS ENGLAND).	Not Delegated
CFO	Consider whether any insurance claim can be made.	Not Delegated
CFO	Maintain losses and special payments register.	Not Delegated
CFO	Responsible for accuracy and security of computerised financial data.	Not Delegated
CFO	Provide assurance 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.	Not Delegated
CO	Shall publish and maintain a Freedom of Information Scheme.	Assistant CO
OFFICERS	Send proposals for general computer systems to Chief Finance Officer.	Not Delegated
CFO	Ensure that contracts with other bodies for the provision of computer services for financial applications	Not Delegated

RESPONSIBILITY OF	AUTHORITIES/DUTIES DELEGATED	DELEGATED TO
	clearly define responsibility of all parties for security, privacy, accuracy, completeness and timeliness of data during processing, transmission and storage, and allow for audit review. Seek periodic assurances from the provider that adequate controls are in operation.	
CO	Ensure all staff are made aware of the CCG policy on the acceptance of gifts and other benefits in kind by staff.	Corporate Secretary
CFO	Ensure lists of all contractors are maintained up to date and systems are in place to deal with applications, resignations, inspection of premises etc. within contractors' terms of service.	Not Delegated
CFO	Ensure only contractors included on the CCG lists receive payments; maintain a system of control to ensure prompt and accurate payments and validation of same.	Not Delegated
CO	Retention of document procedures in accordance with latest guidance.	Not Delegated
CO	Assurance Framework	Deputy CO
BOARD	Approve and monitor the Assurance Framework	Not applicable
BOARD	Decide whether the CCG will use the risk pooling schemes administered by the NHS Litigation Authority or self-insure for some or all of the risks (where discretion is allowed). Decisions to self-insure should be reviewed annually.	Not applicable
CFO	Where the Board decides to use the risk pooling schemes administered by the NHS Litigation Authority the Chief Finance Officer shall ensure that the arrangements entered into are appropriate and complementary to the Assurance Framework. The Chief Finance Officer shall ensure that documented procedures cover these arrangements. Where the Board decides not to use the risk pooling schemes administered by the NHS Litigation Authority for any one or other of the risks covered by the schemes, the Chief Finance Officer shall ensure that the Board is informed of the nature and extent of the risks that are self-insured as a result of this decision. The Chief Finance Officer will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses that will not be reimbursed.	Not Delegated

APPENDIX F - FINANCIAL POLICIES

1 INTRODUCTION

1.1 The financial policies are part of the CCG's control environment for managing the organisation's financial affairs. They contribute to good corporate governance, internal control and managing risks. They enable sound administration; lessen the risk of irregularities and support commissioning and delivery of effective, efficient and economical services. They also help the accountable officer and chief finance officer to effectively perform their responsibilities. They should be used in conjunction with the scheme of reservation and delegation.

1.2 They do not provide detailed procedural advice – procedures will be held separately to support specific activities within the organisation.

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 and Quality Assurance Committee with terms of reference agreed by the Governing Body (see paragraph 6.6.3 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:

2.3.1 financial policies are considered for review and update every two years;

2.3.2 a system is in place for proper checking and reporting of all breaches of financial policies; and

2.3.3 a proper procedure is in place for regular checking of the adequacy and effectiveness of the control environment.

3 AUDIT

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

3.1 In line with the terms of reference for the Governing Body's Audit and Quality Assurance Committee, the person appointed by the Group to be responsible for internal audit and the Audit Commission appointed external auditor will have direct and unrestricted access to Audit and Quality Assurance 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 and Quality Assurance Committee and the accountable officer to review audit issues as appropriate. All Audit and Quality Assurance 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:

3.3.1 the Group has a professional and technically competent internal audit function;

and

3.3.2 the Governing Body 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 and Quality Assurance 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 and Quality Assurance 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 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.

5.2.1 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

The Group's chief finance officer will:

6.1 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;

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

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

7 COMMISSIONING STRATEGY, BUDGETS, BUDGETARY CONTROL AND MONITORING

POLICY – the Group will produce and publish an annual commissioning plan that explains how it proposes to discharge its financial duties. The Group will support this with comprehensive medium term financial plans and annual budgets

7.1 The accountable officer will compile and submit to the Governing Body a commissioning strategy which takes into account financial targets and forecast limits of available resources.

7.2 Prior to the start of the financial year the chief finance officer will, on behalf of the accountable officer, prepare and submit budgets for approval by the Governing Body.

7.3 The chief 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 Governing Body will approve consultation arrangements for the Group's commissioning plan.

8 ANNUAL ACCOUNTS AND REPORTS

POLICY – the Group will produce and submit to NHS England accounts and reports in accordance with all statutory obligations, relevant accounting standards and accounting best practice in the form and content and at the time required by NHS England

The chief finance officer will ensure the Group:

8.1 prepares a timetable for producing the annual report and accounts and agrees it with external auditors and the Governing Body;

8.2 prepares the accounts according to the timetable approved by the Governing Body;

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

8.4 considers the external auditor's management letter and fully address all issues within agreed timescales; and

8.5 publishes the external auditor's management letter on the Group's website.

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

9.1.1 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;

9.1.2 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;

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

9.1.4 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 ensure that there is access to an accounting system that creates management and financial accounts

The chief finance officer will ensure that where another health organisation or any other agency provides a computer service for financial applications, the chief finance officer shall periodically seek assurances that adequate controls are in operation.

11 BANK ACCOUNTS

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

11.1 The chief finance officer will:

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

11.1.2 manage the Group's banking arrangements and advise the Group on the provision of banking services and operation of accounts;

11.1.3 prepare detailed instructions on the operation of bank accounts.

11.2 The Audit and Quality Assurance 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
- ensure its power to make grants and loans is used to discharge its functions effectively

The Chief Financial Officer is responsible for:

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

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

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

12.4 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 that only budgeted, approved and necessary spending is incurred
- will seek value for money for all goods and services
- shall ensure that competitive tenders are invited in line with the latest procurement and tendering guidance.

13.1 The Group shall ensure that the firms / individuals invited to tender (and where appropriate, quote) are among those on approved lists or where necessary a framework agreement. Where in the opinion of the chief finance officer it is desirable to seek tenders from firms not on the approved lists, the reason shall be recorded in writing to the Audit and Quality Assurance Committee.

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

13.2.1 the Group's standing orders;

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

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

13.3 In all contracts entered into, the Group shall endeavour to obtain best value for money. The accountable officer (or Governing Body) shall nominate an individual who shall oversee and manage each contract on behalf of the Group.

14 COMMISSIONING

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

14.1 The Group will coordinate its work with the NHS Commissioning Board, other clinical commissioning groups, local providers of services, Rotherham Metropolitan Borough Council, 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 Governing Body has a responsibility to ensure that the organisation is properly governed in accordance with best practice corporate, clinical and financial governance.

15.2 The Integrated Risk Management Policy enables the organisation to have a clear view of the risks affecting each area of its activity; how those risks are being managed, the likelihood of occurrence and their potential impact on the successful achievement of the Group objectives.

15.3 The Assurance Framework supports the evaluation and management of risk within the Group, it summarises the Group's principal objectives and the risks that threaten their achievement. It identifies the key controls in place to manage the risks and what assurances, both internal and external are available to demonstrate their effectiveness.

15.4 The Assurance Framework is updated regularly and reported to Audit and Quality Assurance Committee on a quarterly basis and to the GP Reference Committee annually.

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:

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

16.1.2 has adequate internal controls and audit review processes;

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

17 NON-PAY EXPENDITURE

POLICY – the Group will seek to obtain the best value for 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 Chief Finance 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:

17.3.1 advise the Governing Body on the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in the scheme of reservation and delegation;

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

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

18 CAPITAL INVESTMENT, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

POLICY – the Group will put arrangements in place to manage capital investment, maintain an asset register recording fixed assets and put in place polices to secure the safe storage of the Group's fixed assets

18.1 The Chief Finance Officer will

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

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

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

18.1.4 be responsible for the maintenance of registers of assets, taking account of the advice of the chief finance officer concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted once a year.

18.2 The chief finance officer will prepare detailed procedures for the disposals of assets.

19 RETENTION OF RECORDS

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

The Accountable Officer shall:

19.1 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;

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

19.3 publish and maintain a Freedom of Information Publication Scheme.

APPENDIX G - NOLAN PRINCIPLES

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)[61]

[61] Available at http://www.public-standards.gov.uk/

APPENDIX H -
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 Rotherham Metropolitan Borough Council and a wide range of other private, public and third sector organisations at national and local level to provide and deliver improvements in health and well-being.
6. The NHS is committed to providing best value for taxpayers' money and the most cost-effective, fair and sustainable use of finite resources - public funds for healthcare will be devoted solely to the benefit of the people that the NHS serves.
7. The NHS is accountable to the public, communities and patients that it serves - the NHS is a national service funded through national taxation, and it is the Government which sets the framework for the NHS and which is accountable to Parliament for its operation. However, most decisions in the NHS, especially those about the treatment of individuals and the detailed organisation of services, are rightly taken by the local NHS and by patients with their clinicians. The system of responsibility and accountability for taking decisions in the NHS should be transparent and clear to the public, patients and staff. The Government will ensure that there is always a clear and up-to-date statement of NHS accountability for this purpose.

Source: *The NHS Constitution: The NHS belongs to us all* (March 2012)[62]

[62] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_132961

APPENDIX I - Conflict of Interest Policy and Procedure

Purpose

Clinical commissioning groups (CCGs) manage conflicts of interest as part of their day-to-day activities. Effective handling of such conflicts is crucial for the maintenance of public trust in the commissioning system. Importantly, it also serves to give confidence to patients, providers, parliament and tax payers that CCG commissioning decisions are robust, fair, transparent and offer value for money.

Equality and diversity is at the heart of the NHS. Throughout the development of this policy and procedure, we have given due regard to the need to:

- Reduce health inequalities in access and outcomes of healthcare services
- Integrate services where this might reduce health inequalities
- Eliminate discrimination, harassment and victimisation
- Advance equality of opportunity and foster good relations between people who share a relevant protected characteristic (as cited in under the Equality Act 2010) and those who do not share it.

1 Introduction and definitions

This document gives an overview on conflicts of interest; references a number of relevant publications, and sets out a procedure to mitigate the risks.

A conflict of interest is:

'A conflict of interest occurs where an individual's ability to exercise judgement, or act in a role, is or could be impaired or otherwise influenced by his or her involvement in another role or relationship. The individual does not need to exploit his or her position or obtain an actual benefit, financial or otherwise, for a conflict of interest to occur'.

"For the purposes of Regulation 6 (NHS Procurement, Patient Choice and Competition) (No.2) Regulations 2013), a conflict will arise where an individual's ability to exercise judgement or act in their role in the **commissioning of services** is impaired or influenced by their interests in the **provision of those services**."

A range of interests in the provision of services may give rise to a conflict with the interests in commissioning them, including:

- **Direct financial interest** - for example, a member of a CCG who has a financial interest in a provider that is interested in providing the services being commissioned or that has an interest in other competing providers not being awarded a contract to provide those services. Financial interests will include, for example, being a shareholder, director, partner or employee of a provider, acting as a consultant for a provider, being in receipt of a grant from a provider and having a pension that is funded by a provider (where the value of this might be affected by the success or failure of the provider).
- **Indirect financial interest** - for example, a member of a CCG whose spouse has a financial interest in a provider that may be affected by a decision to reconfigure services. Whether an interest held by another person gives rise to a conflict of interests will depend on the nature of the relationship between that person and the member of the CCG. Depending on the circumstances, interests held by a range of individuals could give rise to a conflict including, for example, the interests of a parent, child, sibling, friend or business partner.
- **Non-financial or personal interests** - for example, a member of a CCG whose reputation or standing as a practitioner may be affected by a decision to award a contract for services or who is an advocate or representative for a particular group of patients.
- **Professional duties or responsibilities.** For example, a member of a CCG who has an interest in the award of a contract for services because of the interests of a particular patient at that member's practice.

For a commissioner, a conflict of interest may therefore arise when their judgment as a commissioner could be, or be perceived to be, influenced and impaired by their own concerns and obligations as a provider. In the case of a GP involved in commissioning, an obvious example is the award of a new contract to a provider in which the individual GP has a

financial stake. However, the same considerations, and the approaches set out in this policy, apply when deciding whether to extend a contract.

The NHS Clinical Commissioners, the Royal College of General Practitioners and the British Medical Association, has developed a set of key principles. These principles are:

- If CCGs are doing business properly (needs assessments, consultation mechanisms, commissioning strategies and procurement procedures), then the rationale for what and how they are commissioning is clearer and easier to withstand scrutiny. Decisions regarding resource allocation should be evidence-based, and there should be robust mechanisms to ensure open and transparent decision making.
- CCGs must have robust governance plans in place to maintain confidence in the probity of their own commissioning, and maintain confidence in the integrity of clinicians.
- CCGs should assume that those making commissioning decisions will behave ethically, but individuals may not realise that they are conflicted, or lack awareness of rules and procedures. To mitigate against this, CCGs should ensure that formal prompts, training and checks are implemented to make sure people are complying with the rules. As a rule of thumb, 'if in doubt, disclose'.
- CCGs should anticipate many possible conflicts when electing/selecting individuals to commissioning roles, and where necessary provide commissioners with training to ensure individuals understand and agree in advance how different scenarios will be dealt with.
- It is important to be balanced and proportionate – the purpose of these tools is not to constrain decision-making to be complex or slow.

There has been much debate nationally and locally about potential conflicts of interest for those involved in Clinical Commissioning Groups (CCGs).

Those involved need systems and processes to manage real and perceived conflicts of interest. If conflicts of interest are not managed effectively confidence in the probity of decisions and the integrity of those involved could be undermined.

The CCG recognises that there will be conflicts of interest, but these need not debar someone from working on CCG business. Procedures are designed to strike a balance between the CCG need for probity and the need for engagement to conclude tasks and decisions. They protect the work of the CCG and the person.

A perception of wrongdoing, impaired judgement or undue influence can be as detrimental as any of them actually occurring;

If in doubt, it is better to assume the existence of a conflict of interest and manage it appropriately rather than ignore it;

For a conflict of interest to exist, financial gain is not necessary.

2 Legislative Framework

In section 140 of the Health Act sets out the minimum requirements in terms of what CCGs must do in terms of managing conflicts of interest. For Rotherham CCG, this means that we must:

- Maintain appropriate registers of interests;
- Publish or make arrangements for the public to access those registers;
- Make arrangements requiring the prompt declaration of interests by the persons specified (members and employees) and ensure that these interests are entered into the relevant register;
- Make arrangements for managing conflicts and potential conflicts of interest (e.g. developing appropriate policies and procedures); and
- Have regard to guidance published by NHS England and Monitor in relation to conflicts of interest.

The NHS (Procurement, Patient Choice and Competition) (No.2) Regulations 20139. In particular, regulation 6 requires the following:

- CCGs must not award a contract for the provision of NHS health care services where conflicts, or potential conflicts, between the interests involved in commissioning such

services and the interests involved in providing them affect, or appear to affect, the integrity of the award of that contract; and
- CCGs must keep a record of how it managed any such conflict in relation to NHS commissioning contracts it enters into.

This Policy & procedure is relevant to all:-
- a member of the CCG;
- a member of the governing body of the CCG;
- a member of the CCGs committees or sub-committees or committees or sub-committees of its governing body; or
- an employee of the CCG.

3 Principles and general safeguards:

The following principles will need to be integral to the commissioning of all services, including decisions on whether to continue to commission a service, such as by contract extension.

Conflicts of interest can be managed by:
- **Doing business appropriately.** When commissioners get their needs assessments, consultation mechanisms, commissioning strategies and procurement procedures right from the outset, then conflicts of interest become much easier to identify, avoid and/or manage, because the rationale for all decision-making will be clear and transparent and should withstand scrutiny;
- **Being proactive, not reactive.** Commissioners should seek to identify and minimise the risk of conflicts of interest at the earliest possible opportunity, for instance by:
  - ✓ considering potential conflicts of interest when electing or selecting individuals to join the governing body or other decision-making bodies;
  - ✓ ensuring individuals receive proper induction and training so that they understand their obligations to declare conflicts of interest.

The CCG will establish and maintain registers of interests, and agree in advance how a range of possible situations and scenarios will be handled, rather than waiting until they arise;
- **Assuming that individuals will seek to act ethically and professionally, but may not always be sensitive to all conflicts of interest.** Rules should assume people will volunteer information about conflicts and, where necessary, exclude themselves from decision-making, There will be prompts and checks to reinforce this;
- **Being balanced and proportionate.** Rules should be clear and robust but not overly prescriptive or restrictive. They should ensure that decision-making is transparent and fair, but not constrain people by making it overly complex or cumbersome;
- **Openness.** Ensuring early engagement with patients, the public, clinicians and other stakeholders, including local Healthwatch and Health and Wellbeing Board, in relation to proposed commissioning plans;
- **Responsiveness and best practice.** Ensuring that commissioning intentions are based on local health needs and reflect evidence of best practice – securing 'buy in' from local stakeholders to the clinical case for change;
- **Transparency.** Documenting clearly the approach taken at every stage in the commissioning cycle so that a clear audit trail is evident;
- **Securing expert advice.** Ensuring that plans take into account advice from appropriate health and social care professionals, e.g. through clinical senates and networks, and draw on commissioning support, for instance around procurement processes;
- **Engaging with providers.** Early engagement with both incumbent and potential new providers over potential changes to the services commissioned for a local population;
- **Creating clear and transparent commissioning specifications** that reflect the depth of engagement and set out the basis on which any contract will be awarded;
- **Following proper procurement processes and legal arrangements**, including even-handed approaches to providers;
- **Ensuring sound record-keeping, including up to date registers of interests;** and
- **A clear, recognised and easily enacted system for dispute resolution.**

These general processes and safeguards should apply at all stages of the commissioning process, but will be particularly important at key decision points, e.g., whether and how to go out to procurement of new or additional services.

4 Maintaining a register of interests and a register of decisions

Statutory requirements

'CCGs must maintain one or more registers of interest of: the members of the group, members of its governing body, members of its committees or sub-committees of its governing body, and its employees. CCGs must publish, and make arrangements to ensure that members of the public have access to these registers on request'.

'CCGs must make arrangements to ensure individuals declare any conflict or potential conflict in relation to a decision to be made by the group as soon as they become aware of it, and in any event within 28 days. CCGs must record the interest in the registers as soon as they become aware of it'.

The CCG will ensure that, when members declare interests, this includes the interests of all relevant individuals within their own organisations (e.g. partners in a GP practice), who have a relationship with the CCG and who would potentially be in a position to benefit from the CCG's decisions.

When entering an interest on the register of interests, the CCG will ensure that it includes sufficient information about the nature of the interest and the details of those holding the interest.

The CCG will ensure that, as a matter of course, declarations of interest are made and regularly confirmed or updated. This includes the following circumstances:

- **On appointment:** Applicants for any appointment to the CCG or its governing body will be asked to declare any relevant interests. When an appointment is made, a formal declaration of interests will again be made and recorded.
- **At meetings:** All attendees will be asked to declare any interest they have in any agenda item before it is discussed or as soon as it becomes apparent. Even if an interest is declared in the register of interests, it will be declared in meetings where matters relating to that interest are discussed. Declarations of interest will be recorded in minutes of meetings.
- **Quarterly:** The CCG will have systems in place to satisfy themselves on a quarterly basis that their register of interests is accurate and up to date.
- **On changing role or responsibility:** Where an individual changes role or responsibility within the CCG or governing body, any change to the individual's interests should be declared.
- **On any other change of circumstances:** Wherever an individual's circumstances change in a way that affects the individual's interests (e.g. where an individual takes on a new role outside the CCG or sets up a new business or relationship), a further declaration should be made to reflect the change in circumstances. This could involve a conflict of interest ceasing to exist or a new one materialising.

In keeping with the regulations, individuals who have a conflict should declare this as soon as they become aware of it, and in any event not later than 28 days after becoming aware.

If the individual has any doubt about the relevance of an interest, it should be discussed with their line manager or the Accountable Officer.

Whenever interests are declared, they should be reported to the Board Secretary for the register of interests (as identified by the CCG or its governing body), who should then update the register accordingly.

The CCG will update its register of interests whenever a new or revised interest is declared.

If an individual fails to comply with this policy on managing 'conflicts of interest' as set out in its constitution. The Managing Concerns with Performance at Work Policy will be followed. This could include that individual being removed from office.

Register of procurement decisions

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

- the details of the decision;
- who was involved in making the decision (i.e. governing body or committee members and others with decision-making responsibility); and
- a summary of any conflicts of interest in relation to the decision and how this was managed by the CCG.

The register will be updated whenever a procurement decision is taken.

In the interests of transparency, the register of interests and the register of decisions will be publicly available and easily accessible to patients and the public by:

- ensuring that both registers are available on the CCG's website; and
- the CCG making both registers available upon request for inspection.

The registers will form part of the CCG's annual accounts and will be signed off by external auditors.

Procurement issues

The CCG needs to recognise and manage any conflicts or potential conflicts of interest that may arise in relation to procurement.

The Procurement, Patient Choice and Competition Regulations place requirements on commissioners to ensure that they adhere to good practice in relation to procurement, do not engage in anti-competitive behaviour that is against the interest of patients, and protect the right of patients to make choices about their healthcare.

The CCG will:

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

The CCG will evidence the deliberations on conflicts and make publicly available.

The CCG will seek and encourage scrutiny of its decision-making process; to the Health and Wellbeing Board, local Healthwatch and to local communities that the proposed service meets local needs and priorities; it will enable them to raise questions if they have concerns about the approach being taken;

- to the Audit, Quality and Assurance committee and, where necessary, external auditors, that a robust process has been followed in deciding to commission the service, in selecting the appropriate procurement route, and in addressing potential conflicts; and
- to NHS England in their role as assurers of the co-commissioning arrangements.

5 Designing service requirements

It is good practice to engage relevant providers, especially clinicians, in confirming that the design of service specifications will meet patient need. Such engagement, done transparently and fairly, is legal. However, conflicts of interest can occur if a commissioner engages selectively with only certain providers in developing a service specification for a contract for which they may later bid.

The CCG will seek, as far as possible, to specify the outcomes that we wish to see delivered through a new service, rather than the process by which these outcomes are to be achieved. As well as supporting innovation, this helps prevent bias towards particular providers in the specification of services.

Such engagement should follow the three main principles of procurement law, namely equal treatment, non-discrimination and transparency. This includes ensuring that the same information is given to all.

Other steps include:

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

The CCG will ensure that a system is in place for managing conflicts of interest on an on-going basis, for instance, by monitoring a contract that has been awarded to a provider in which an individual commissioner has a vested interest.

6 Governance and decision-making processes

Statutory requirement

'CCGs must make arrangements for managing conflicts of interest, and potential conflicts of interest, in such a way as to ensure that they do not, and do not appear to, affect the integrity of the group's decision-making'.

The CCG will consider the following when reviewing governance structures.

- the make-up of the governing body and committee structures.
- whether there are sufficient management and internal controls to detect breaches of the CCG's conflicts of interest policy, including appropriate external oversight and adequate provision for whistleblowing;
- how non-compliance with policies and procedures relating to conflicts of interest will be managed (including how this will be addressed when it relates to contracts already entered into). As well as actions to address non-compliance, the CCG will also have procedures in place to review any lessons to be learned from such cases, e.g., by the CCG's Audit, Quality and Assurance committee conducting an incident review;
- reviewing and revising approaches to the CCG's registers of interest, together with the introduction of a record of decisions;
- Whether any training or other programmes are required to assist with compliance.

7 Appointing governing body or committee members

The CCG will consider whether conflicts of interest should exclude individuals from being appointed to the governing body or to a committee or sub-committee of the CCG or governing body. These will need to be considered on a case-by-case basis but the CCG's constitution reflects the CCG's general principles.

The CCG will assess the materiality of the interest, in particular whether the individual (or a family member or business partner) could benefit from any decision the governing body might make. This will be particularly relevant for any profit sharing member of any organisation but should also be considered for all employees and especially those operating at senior or governing body level.

The CCG will determine the extent of the interest. If it is related to an area of business significant enough that the individual would be unable to make a full and proper contribution to the governing body, that individual should not become a member of the governing body.

Any individual who has a material interest in an organisation which provides, or is likely to provide, substantial services to a CCG (either as a provider of healthcare or commissioning support services) should not be a member of the governing body if the nature of their interest is such that they are likely to need to exclude themselves from decision-making on so regular

a basis that it significantly limits their ability to effectively operate as a governing body member.

8 Decision-making when a conflict of interest arises: general approaches

Where certain members of a decision-making body (be it the governing body, its committees or sub-committees) have a material interest, they should either be excluded from relevant parts of meetings, or join in the discussion but not participate in the decision-making itself (i.e., not have a vote).

The chair of the meeting has responsibility for deciding whether there is a conflict of interest and the appropriate course of corresponding action. In making such decisions, the chair may wish to consult the member of the governing body who has responsibility for issues relating to conflicts of interest. All decisions, and details of how any conflict of interest issue has been managed, should be recorded in the minutes of the meeting and published in the registers.

The CCG will decide in advance who will take the chair's role for discussions and decision-making in the event that the chair of a meeting is conflicted, or how that will be decided at a meeting where that situation arises.

Depending on the nature of the conflict, GPs or other practice representatives could be permitted to join in discussions by the governing body, or such other decision-making body as the CCG has created, about the proposed decision, but should not take part in any vote on the decision.

In many cases, e.g., where a limited number of GPs have an interest, it should be straightforward for relevant individuals to be excluded from decision-making. In the context of delegated commissioning, the committee structure set out below in relation to decision making for primary medical care below has been designed to ensure that lay member and executive involvement ensures that robust decisions can be taken even where there are actual or potential conflicts of interest identified.

In some cases, all of the GPs or other practice representatives on a decision-making body could have a material interest in a decision, e.g., where the CCG is proposing to commission services on a direct award basis from all GP practices in the area, or where it is likely that all or most practices would wish to be qualified providers for a service under AQP.

Where such a situation relates to primary medical services, the arrangements set out below provide a mechanism for decision-making. (It could also be used for any other CCG responsibilities where decision-making has been delegated to the committee responsible for primary medical care decision making and where such a conflict of interest arises).

For decision making where such a conflict arises and which are not covered by the primary medical care arrangements, the CCG will:

- where the initial responsibility for the decision does not rest with the governing body, refer the decision to the governing body and exclude all GPs or other practice representatives with an interest from the decision-making process, i.e., so that the decision is made only by the non-GP members of the governing body including the lay and executive members and the registered nurse and secondary care doctor;
- where the decision rests with the governing body, consider inviting the Health and Wellbeing Board or another CCG to review the proposal – to provide additional scrutiny. Any such arrangements would need to be compliant with the CCG's constitution; and ensure that rules on quoracy (set out in the CCG's constitution) enable decisions to be made.

9 Decision-making when a conflict of interest arises: primary medical care

Procurement decisions relating to the commissioning of primary medical services should be made by The Primary Care Commissioning Committee.

The membership of the committee will be constituted so as to ensure that the majority is held by lay and executive members. In addition to existing CCG lay members, members may be drawn from the CCG's executive members, except where these members may themselves

have a conflict of interest (e.g. if they are GPs or have other conflicts of interest). Provision could be made for the committee to have the ability to call on additional lay members or CCG members when required, for example where the committee would not be quorate because of conflicts of interest. It could also include GP representatives from other CCG areas and non-GP clinical representatives (such as the CCG's secondary care specialist and/or governing body nurse lead).

Any conflicts of interest issues will be considered on an individual basis. The chair and vice-chair will always be lay members of the committee.

A standing invitation will be made to the CCG's local Healthwatch and Health and Wellbeing Board to appoint representatives to attend the Primary Care Commissioning Committee meetings, including, where appropriate, for items where the public is excluded from a particular item or meeting for reasons of confidentiality. These representatives would not form part of the membership of the committee.

As a general rule, meetings of these committees, including the decision-making and the deliberations leading up to the decision, should be held in public (unless the CCG has concluded it is appropriate to exclude the public).

The CCG may wish to include decisions on other commissioning issues within the remit of the committee. It also may wish to designate an existing committee to incorporate the above responsibilities within their remit. Where the CCG does this, they should ensure that the membership and chairing arrangements are compliant with the above requirements, or that, when dealing with primary care procurement issues, the participating membership and chairing arrangements are adjusted to meet these requirements. Where an existing committee is so designated, the above requirements on Healthwatch and Health and Wellbeing Board participation and on meeting in public would apply for co-commissioning decisions.

The arrangements for primary medical care decision making do not preclude GP participation in strategic discussions on primary care issues, subject to appropriate management of conflicts of interest. They apply to decision-making on procurement issues and the deliberations leading up to the decision.

10 Record keeping

As set out above, a clear record of any conflicts of interest will be kept by the CCG in its register of interests. The CCG will ensure that it records procurement decisions made, and details of how any conflicts that arose in the context of the decision have been managed. These registers will be available for public inspection as detailed above.

The CCG will ensure that details of all contracts, including the contract value, are published on their website as soon as contracts are agreed.

Where the CCG decides to commission services through Any Qualified Provider (AQP), we will publish on the website the type of services we are commissioning and the agreed price for each service. Further, the CCG will ensure that such details are set out in their annual report. Where services are commissioned through an AQP approach, the CCG will ensure that there is information publicly available about those providers who qualify to provide the service.

Declaration of conflict of interests for bidders/contractors template

NHS Rotherham Clinical Commissioning Group Bidders/potential contractors/service provider's declaration form: financial and other interests

This form is required to be completed in accordance with the CCG's Constitution, and is140 of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) and the NHS (Procurement, Patient Choice and Competition) (No2) Regulations 2013 and related guidance

Notes:

- All potential bidders/contractors/service providers, including sub-contractors, members of a consortium, advisers or other associated parties (Relevant Organisation) are required to identify any potential conflicts of interest that could arise if the Relevant Organisation were to take part in any procurement process and/or provide services under, or otherwise enter into any contract with, the CCG, in circumstances where the CCG is jointly commissioning the service with, or acting under a delegation from, NHS England. If any assistance is required in order to complete this form, then the Relevant Organisation should contact the board secretary of the CCG.
- The completed form should be sent to the board secretary.
- Any changes to interests declared either during the procurement process or during the term of any contract subsequently entered into by the Relevant Organisation and the CCG must notified to the CCG by completing a new declaration form and submitting it to board secretary.
- Relevant Organisations completing this declaration form must provide sufficient detail of each interest so that the CCG, NHS England and also a member of the public would be able to understand clearly the sort of financial or other interest the person concerned has and the circumstances in which a conflict of interest with the business or running of the CCG (including the award of a contract) might arise.
- If in doubt as to whether a conflict of interests could arise, a declaration of the interest should be made.

Interests that must be declared (whether such interests are those of the Relevant Person themselves or of a family member, close friend or other acquaintance of the Relevant Person), include the following:

- the Relevant Organisation or any person employed or engaged by or otherwise connected with a Relevant Organisation (Relevant Person) has provided or is providing services or other work for the CCG;
- a Relevant Organisation or Relevant Person is providing services or other work for any other potential bidder in respect of this project or procurement process;
- the Relevant Organisation or any Relevant Person has any other connection with the CCG, whether personal or professional, which the public could perceive may impair or otherwise influence the CCG's or any of its members' or employees' judgements, decisions or actions.

Declaration of conflict of interests for bidders/contractors

Declarations:

Name of Relevant Organisation	*Your own organisation*
Interests	
Type of Interest	*Please give details*
Provision of services or other work for the CCG	
Provision of services or other work for any other potential bidder in respect of this project or procurement process	
Any other connection with the CCG, whether personal or professional, which the public could perceive may impair or otherwise influence the CCG's or any of its members' or employees' judgements, decisions or actions	

Declaration of conflict of interests for bidders/contractors template

Name of Relevant Person	*complete for all Relevant Persons*	
Interests		
Type of Interest	*Details*	Personal interest or that of a family member, close friend or other acquaintance? – *please specify*
Provision of services or other work for the CCG		
Provision of services or other work for any other bidder in in respect of this project or procurement process		
Any other connection with the CCG, whether personal or professional, which the public could perceive may impair or otherwise influence the CCG's or any of its members' or employees judgements, decisions or actions		

To the best of my knowledge and belief, the above information is complete and correct. I undertake to update as necessary the information.

Signed:

On behalf of:

Date:

Declaration of interests for members/employees template

NHS Rotherham Clinical Commissioning Group

Member / employee / governing body member / committee or sub-committee member [*delete as appropriate*] declaration form: financial and other interests

This form is required to be completed in accordance with the CCG's Constitution and section 14O of *The National Health Service Act 2006, the NHS (Procurement, Patient Choice and Competition) regulations 2013 and the Substantive guidance on the Procurement, Patient Choice and Competition Regulations*

Notes:

- NHS Rotherham Clinical Commissioning Group has made arrangements to ensure that the persons mentioned above declare any interest which may lead to a conflict with the interests of the CCG and the public for whom we commission services in relation to a decision to be made by the CCG which may affect or appear to affect the integrity of the award of any contract by the CCG.
- A declaration must be made of any interest likely to lead to a conflict or potential conflict as soon as the individual becomes aware of it, and within 28 days.
- If any assistance is required in order to complete this form, then the individual should contact The board secretary of the CCG.
- The completed form should be sent by both email and signed hard copy to the Governance officer of the CCG sue.hart@rotherhamccg.nhs.uk.
- Any changes to interests declared must also be registered within 28 days by completing and submitting a new declaration form.
- The register will be published on the Groups website.
- Any individual – and in particular members and employees of the CCG must provide sufficient detail of the interest, and the potential for conflict with the interests of the CCG and the public for whom they commission services, to enable a lay person to understand the implications and why the interest needs to be registered.
- If there is any doubt as to whether or not a conflict of interests could arise, a declaration of the interest must be made.

Interests that must be declared (whether such interests are those of the individual themselves or of a family member, close friend or other acquaintance of the individual) include:

- roles and responsibilities held within member practices;
- directorships, including non-executive directorships, held in private companies or PLCs;
- ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the CCG;
- shareholdings (more than 5%) of companies in the field of health and social care;
- a position of authority in an organisation (e.g. charity or voluntary organisation) in the field of health and social care;
- any connection with a voluntary or other organisation (public or private) contracting for NHS services;
- research funding/grants that may be received by the individual or any organisation in which they have an interest or role;
- any other role or relationship which the public could perceive would impair or otherwise influence the individual's judgment or actions in their role within the CCG.

If there is any doubt as to whether or not an interest is relevant, a declaration of the interest must be made.

Declaration of interests for members/employees template

Name: **Position within or relationship with, the CCG:**	*complete for all Persons*	
Interests		
Type of Interest	*Details*	*Personal interest or that of a family member, close friend or other acquaintance?* *Please specify*
Roles and responsibilities held within member practices		
Directorships, including non-executive directorships, held in private companies or PLCs		
Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the CCG		
Shareholdings (more than5%) of companies in the field of health and social care		
Positions of authority in an organisation (e.g. charity or voluntary organisation (e.g. charity or voluntary organisation) in the field of health and social care		

Any connection with a voluntary or other organisation contracting for NHS services		
Research funding/grants that may be received by the individual or any organisation they have an interest or role in		
Other specific interests		
Any other role or relationship which the public could perceive would impair or otherwise influence the individual's judgment or actions in their role within the CCG.		

To the best of my knowledge and belief, the above information is complete and correct. I undertake to update as necessary the information provided and to review the accuracy of the information provided regularly and no longer than annually. I give my consent for the information to be used for the purposes described in the CCG's Constitution and published accordingly.

Signed:

Date:

Procurement template

To be used when commissioning services from GP practices, including provider consortia or organisations in which GPs have a financial interest.

Service:	
Question	**Comment/Evidence**
How does the proposal deliver good or improved outcomes and value for money – what are the estimated costs and the estimated benefits? How does it reflect the CCG's proposed commissioning priorities? How does it reflect the CCG's commissioning obligations?	
How have you involved the public in the decision to commission this service?	
What range of health professionals have been involved in designing the proposed service?	
What range of potential providers have been involved in considering the proposal	
How have you involved your Health and Wellbeing Board? How does the proposal support the priorities in the relevant joint health and wellbeing strategy (or strategies)?	
What are the proposals for monitoring the quality of the service?	
What systems will there be to monitor and publish data on referral patterns?	
Have all conflicts and potential conflicts of interests been appropriately declared and entered in registers which are publicly available? Have you recorded how you have managed any conflict or potential conflict?	

Why have you chosen this procurement route[63]? What additional external involvement will there be in scrutinising the proposed decisions? How will the CCG make its final commissioning decision in ways that preserve the integrity of the decision-making process and award of any contract?	
Additional question when qualifying a provider on a list or framework or pre selection for tender (including but not limited to any qualified provider) or direct award (for services where national tariffs do not apply).	
How have you determined a fair price for the service?	
Additional questions when qualifying a provider on a list or framework or pre selection for tender (including but not limited to any qualified provider) where GP practices are likely to be qualified providers.	
How will you ensure that patients are aware of the full range of qualified providers from whom they can choose?	
Additional questions for proposed direct awards to GP providers.	
What steps have been taken to demonstrate that the services to which the contract relates are capable of being provided by only one provider?	
In what ways does the proposed service go above and beyond what GP practices should be expected to provide under the GP contract?	
What assurance will there be that a GP practice is providing high-quality services under the GP contract before it has the opportunity to provide any new services?	

[63] Taking into account all relevant regulations (e.g. the NHS (Procurement, patient choice and competition) (No 2) Regulations 2013 and guidance (e.g. that of Monitor).

APPENDIX J –
GP Members Committee Terms of Reference

NHS
Rotherham
Clinical Commissioning Group

GP Members Committee
TERMS OF REFERENCE

Contact Details:			
Lead O.E. / Clinician:	Leonard Jacob	**Lead Officer:**	Robin Carlisle
Title:	Chair (GPMC)	**Title:**	Deputy CO

Purpose:
The GP Members Committee's main function is to be a strong advisory group to the Strategic Clinical Executive and Clinical Commissioning Group Governing Body and to ensure that the member practices are linked into all of the wider commissioning decisions of the Clinical Commissioning Group (the Group). It is representative of all of the GP Practices in Rotherham and is mandated by them. The committee's key role is to support the GPs on the Strategic Clinical Executive and to hold the Strategic Clinical Executive to account for its commissioning activities. It should provide a 'reference' point for all commissioning developments.
Responsibilities:
• To ensure that the opinions of the wider GP Community on strategic commissioning decisions are communicated to the Strategic Clinical Executive through the locality representatives including agreeing the Annual Commissioning Plan. • To ensure that communication from the Strategic Clinical Executive is discussed at both locality and practice level through the locality representatives on the reference committee. • To promote the involvement of Rotherham GPs in the quality and efficiency agenda via the Commissioning Local Incentive Scheme. • To help the Group identify other GPs interested in becoming more involved in commissioning and to assist with succession planning. • To encourage patient engagement in commissioning decisions. • To provide a forum for the discussion and recommendation of ideas to the Strategic Clinical Executive and the Governing Body. • To agree the annual commissioning plan before being submitted to the Governing Body. • To propose amendments to the constitution to the NHS England on behalf of member practices. • To keep under review the locality boundaries and to make recommendations to members, as appropriate. • To make recommendations to the Governing Body with a view to securing continuous improvement to the quality of Services. • To assist and support the NHS England in relation to the Governing Body's duty to improve the quality of Primary Medical Services.
Chair:
One of the members of the Group
Composition of group:
GPs (8 members including Chair and Vice Chair) GP Chair/ Locality representative- Main communication between Reference Committee, Governing Body and Strategic Clinical Executive. Post to be reviewed on a 3 yearly basis. Annual Vote of Confidence GP Vice Chair/ Locality representative- Post to be reviewed on a 3 yearly basis. Annual vote of confidence GP Representative from each locality- Ensure wider clinical/ management engagement from commissioning localities.

In Attendance:
Chair of Strategic Clinical Executive - To ensure relevant issues communicated to and from Strategic Clinical Executive. CCG OFFICERS Chief Officer Chief Finance Officer Deputy Chief Officer LMC Representative – To ensure effective communication links into /from LMC and localities Administration Invitation only: - Relevant members of Strategic Clinical Executive or other individuals relevant to the commissioning area that is being discussed.
Deputising:
Each voting member will have a nominated deputy from their locality.
Quorum:
To be quorate the meetings must be attended by at least five GP members (or their respective deputies). It is expected that matters will be resolved by consensus and that votes will only be taken when necessary. The Chair will be empowered to exercise a casting vote.
Accountability:
This committee will be accountable to its constituent practices. The committee will produce an annual report for its member practices detailing its activities for that year and also making recommendations to members about the annual vote of confidence in members of the Strategic Clinical Executive. The committee will submit minutes to Strategic Clinical Executive and the Governing Body on a monthly basis and the Chair and Vice Chair of the Reference committee will also attend the Governing Body. Minutes will also be included on the intranet and internet.
Frequency of meetings:
Monthly
Order of business:
Normal order of business, which may vary at the discretion of the chair will be: 1. To approve the minutes of the previous meeting as a correct record. 2. To consider any outstanding business from a previous meeting. 3. To consider business on the agenda 4. To invite speakers/experts to talk about relevant specialised areas of commissioning. The committee will receive the public minutes of the Governing Body.
Agenda deadlines:
Any items for discussion on meeting agendas are to be submitted at two weeks in advance of the meeting. Papers will be circulated to the committee at least one week in advance. It will be at the discretion of the Chair whether items submitted less than 2 weeks before the meeting will be allowed onto the agenda.
Minutes:
The decisions of the committee will be recorded and submitted to the next meeting for approval. A summary of the actions and decisions made at the meeting will be distributed to all members within a week of the meeting. Copies of the draft minutes will be sent to Strategic Clinical Executive and LMC. Minutes will also be available on the Intranet and Document Management Console.
Administration:
Administration will be undertaken by the CCG Administration Team. This will include the agreement of the agenda with the Chair and collation of papers, taking the minutes and keeping a record of matters arising and issues to be carried forward.
Attendance:
Each core member or their deputy to attend 80% of meetings annually, to be audited on an annual basis.

Confidentiality:
Members of the GP Members Committee will be required to sign a code of conduct for the committee to keep any sensitive materials or discussions provided to or held within the committee confidential.
Review date:
Review Date May 2016

Membership List

APPENDIX K –
Audit & Quality Assurance Committee Terms of Reference

NHS
Rotherham
Clinical Commissioning Group

Audit & Quality Assurance Committee
TERMS OF REFERENCE

Contact Details:			
Lead O.E. / Clinician:	Lay Member	**Lead Officer:**	Sarah whittle
Title:	Lay Member	**Title:**	Assistant chief Officer

The Governing Body of the Clinical Commissioning Group has established a committee to support its work. Known as the Audit & Quality Assurance Committee (AQuA), it has no powers other than as specifically delegated in these terms of reference.

The Committee is authorised by the Governing Body to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee.

The Committee is authorised to create sub-committees as are necessary to fulfil its responsibilities within its terms of reference. It may not delegate responsibilities from these terms of reference (unless expressly authorised by the Governing Body) and thus remains accountable for the work of any such sub-committee.

Purpose:

To obtain assurance that:-

- there is an effective and consistent process in commissioning for quality and safety across the Clinical Commissioning Group
- high standards of care and treatment are delivered. This will include areas regarding patient safety, effectiveness of care and patient experience.
- an effective system of integrated governance, risk management and assurance across the Governing Body activities is established and maintained.
- risks to the achievement of Governing Body objectives are identified and assurances obtained that appropriate mitigating action is being taken.

Responsibilities:

In regard to Quality & Patient Safety, the Committee will:-

- Receive reports from regulatory and other competent bodies and monitor delivery of action plans – for e.g. Care Quality Commission, Monitor, external auditors.
- Receive quarterly thematic exception reports from the directly commissioned and contracted services regarding quality and safety legislative and contractual requirements:
- Receive annual reports on GP quality from NHS England
- Receive exception reports on any other significant quality and patient safety concerns regarding providers
- Ensure significant clinical risks are identified and reported on the risk register, escalating to the Assurance Framework where necessary
- Oversee the Strategic Clinical Executive's work in approving clinical policies and clinical pathways for adoption by the Group.

Quality includes though not exclusively;
"Patient Safety",

- Serious Incidents, Never Events and Domestic Homicide investigations
- Infection prevention and control
- Safeguarding adults and children and domestic violence

- Mental Capacity and Deprivation of Liberty Safeguards
- Medicines safety, Controlled Drugs Management and prescribing (including assurance of the effectiveness of the Area Prescribing Committee)
- Deaths in custody
- Patient Safety Alerts

"Effectiveness"
- NICE Technology Appraisal, guidance and Quality Standards compliance
- Clinical Audit performance
- Research governance and implementation
- CQUIN performance

"Patient /Public Experience"
- Annually identified Patient surveys
- Eliminating Mixed Sex Accommodation
- Complaints
- Staff Survey information e.g. infection control and hand washing facilities
- Professional issues and whistle-blowing.

In regard to Governance, Risk Management and Assurance, the Committee will review the adequacy and effectiveness of:-
- All risk and assurance-related disclosure statements together with any appropriate assurances from Internal Audit or other independent sources.
- Underlying assurance processes that indicate the degree of the achievement of Group objectives; the effectiveness of the management of principal risks, and the appropriateness of the above disclosure statements.
- The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certification.
- The policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by NHS Protect.
- Compliance with Information Governance requirements
- In reviewing these, the Committee will primarily utilise the work of Internal Audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from staff of the Group (and its agencies), concentrating on the over-arching systems of integrated governance, risk management and assurance, together with indicators of their effectiveness.

This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

In regard to External Audit, the Committee will:-
- Consider the findings of external audit work - national and local.
- Receive the Auditor's Annual Letter.
- Discuss problems arising in the work of External Audit.
- Monitor progress with delivery of the audit plan.

In regard to Internal Audit, the Committee will:-
- Review the Internal Audit programme of work, ensuring that this is consistent with the audit needs of the Group as identified in the Group's Assurance Framework.
- Consider the findings of internal audit work, including the opinion given on the Annual Governance Statement.
- Monitor the responsiveness to the findings and recommendations of Internal Audit.
- Discuss problems and reservations arising from the work of Internal Audit.

In regard to Counter-Fraud, the Committee will:-

- Satisfy itself that the Group has adequate arrangements in place for countering fraud.
- Review the outcomes of counter-fraud work.

In regard to Management, the Committee will:-

- Request and review reports and assurances from staff on the overall arrangements for governance, risk management and assurance.
- Be able to require specific reports from individual functions within the Group and chosen commissioning support service (e.g. clinical audit) as they may be appropriate to the overall arrangements.

In regard to Financial Reporting, the Committee will:-

- Monitor the integrity of the financial statements of the Group and any formal announcements relating to the Group's financial performance.
- Ensure that the systems for financial reporting to the Group, including those of budgetary control are subject to review as to completeness and accuracy of the information provided.
- Review schedules of debtor and creditor balances over 6 months old exceeding £5,000 and consider explanations and action plans.

In regard to Annual Accounts and disclosure statements, the Committee will:-

- Receive and review the Annual Accounts.
- Receive and review the Annual Report.
- Receive and review the Annual Governance Statement.
- Receive and review the external auditors "Audit Highlights Memorandum" (ISA260)
- Receive and review the Head of Internal Audit Opinion.
- Receive and review the "Letter of Representation"
- The AQuA chair will recommend to the Governing Body that they approve the documents prior to the national submission deadlines.

In regard to Other Assurance Functions, the Committee will:-

- review the findings of other significant assurance functions, both internal and external to the Group, and consider the implications for the governance of the Group.
- These will include, but will not be limited to, any reviews by Department of Health Arm's Length Bodies or Regulators/Inspectors (e.g. Care Quality Commission, NHS Litigation Authority, etc.) and professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc.)
- will review the work of any other Committees under the Governing Body, whose work can provide relevant assurance to the Committee's own scope of work.

Chair:

lay member of the Clinical Commissioning Group

Composition of group:

The Committee shall consist of the following members:

- Chair of GP Members Committee
- GP lead on Governance and Finance
- Any and all Lay Members on the Governing Body one of whom will act as Chair and one as Deputy Chair

The Governing Body Chair and the Chief Finance Officer shall not be a member.
A quorum shall be at least two Governing Body Members.

In Attendance:

- Assistant Chief Officer shall normally attend meetings.
- The Accountable Officer shall attend at least once a year – ideally when the Annual Audit

Letter is considered. • Representatives from Internal Audit, External Audit and the local Counter Fraud Service (CFS) shall normally attend.(periodic attendance by the CFS is agreed by the Committee) • Chief Nurse – also acting as the lead for Safeguarding. • Other Governing Body or commissioning support services staff shall also attend by request of the Chair. Others will be invited to attend as appropriate for topics under discussion. These may include representatives from a commissioning support unit, specialist leads e.g. Safeguarding etc. Regular attenders are shown in #5 below
Deputising:
Quorum:
Accountability:
The minutes of Committee meetings shall be formally recorded and submitted to the Governing Body along with an updated actions log. The Chair of the Committee shall draw the attention of the Governing Body to key issues.
Frequency of meetings:
Meetings shall be held at least five times a year.
Order of business:
Responsibility of the Chair
Agenda deadlines:
The papers will go out 1 week prior to the meeting
Minutes:
The records of action points will be stored on the “Chief Officer” drive.
Administration:
The Committee shall be supported by an administrator whose duties in this respect will include: • Agreement of agenda with the Chair and attendees and collation of papers. • Taking the minutes & keeping a record of matters arising and issues to be carried forward in the actions log. • Advising the Committee on pertinent areas.
Attendance:
Review Date: July 2015
The effectiveness of the Committee will be monitored on an annual basis via: • Review of the terms of reference • Review of attendance rate of members • Review of the work plan. • Self-assessment review of effectiveness document The Committee will produce an annual report summarising its work and the above review will be incorporated. In addition, these terms of reference shall be reviewed at least annually and sooner if changing circumstances dictate

Membership List

APPENDIX L -
TERMS OF REFERENCE FOR REMUNERATION COMMITTEE

Lead Clinician:	**CCG Chair**	**Lead Officer:**	**Assistant Chief Officer**

Purposes:

The Committee will have delegated authority on behalf of the Governing Body to determine appropriate terms of service for the Chief Officer and any other senior managers placed within its remit. On behalf of the Governing Body, it will determine all aspects of salary - including any performance related payments, pensionable pay and car entitlements, as applicable.

It will also determine arrangements for termination of employment and other contractual terms for those staff.

It will also determine allowances payable to members of the Governing Body the Strategic Clinical Executive and GP Members Committee.

In undertaking these responsibilities it will operate within the provisions of the relevant contractual provisions for these staff groups and taking due account of relevant national guidance, directions & legislation and the conflict of interest policy.

Responsibilities

To ensure that its decisions on the remuneration and terms of service of–those within its remit fairly reward the individuals for their contribution to the organisation's circumstances and performance - subject to the provisions of any national arrangements for such staff.

For those within its remit, determine and oversee appropriate contractual arrangements including the proper calculation and scrutiny of termination payments taking into account the relevant national guidance, in line with the Group's Scheme of Delegation (for the approval of early retirement, redundancy, or termination settlements).

To determine the cost of living rise for those within its remit. This will normally take place either at a meeting in February if the level of pay awards for other similar staff can be readily predicted or around September if this is not the case.

Review the base salaries of posts within the remit of the Committee at the request of the Chief Officer.

Review the salaries for new appointments to posts within the remit of the Committee.

The committee has delegated authority to re-appoint non GP governing body members as appropriate.

The Chair of the CCG will report annually to the remuneration committee on the performance of the Accountable Officer based on the appraisal process.

Chair of meetings:

CCG Lay member - Governance

Composition:

The committee will comprise the:

- 3 lay members of the Governing Body (one of whom shall chair the Remuneration Committee)
- The GP Chair of the CCG

- The GP for finance and governance
- A GP from the GP Members Committee.

In Attendance:

- Administrative support will be from the Assistant Chief Officer
- HR Manager

The Chief Officer and Chief Finance Officer will be invited as appropriate to advise the Committee on relevant issues.

Deputising:

Deputising is not required.

Quorum:

- Any 3 members of the committee – taking into account Conflict of Interest agenda items

Accountability:

The Committee will update the Governing Body on its decisions through the Corporate Assurance Report. - Except where this would involve a breach of confidentiality concerning an individual.

The Committee has the delegated authority, and is accountable to the Governing Body as a whole, for its decisions on the remuneration and terms of service for those within its remit.

Frequency of meetings:

As and when business directs.

Order of business:

To be determined by the Chair/Assistant Chief Officer

Minutes:

The records of actions will be stored on the “Rotherham CCG (r:)” drive, in a restricted folder titled "Remuneration Committee".

Review Date:

April 2016

APPENDIX M -
TERMS OF REFERENCE FOR THE STRATEGIC CLINICAL EXECUTIVE COMMITTEE

Lead Clinician:	**CCG Chair**	**Lead Officer:**	**Chief Officer**
Purposes:			
To provide a forum for the Commissioning lead-GPs to give to *staff of the Group* a clinical perspective in progressing the business of the Group. To be the 'engine house' of the Governing Body with regards to producing its plans and leading on their delivery.			
Responsibilities:			
Specific functions include: operational delivery of individual GPs' lead areas preparing strategic plans for Governing Body approving changes to clinical pathways seeking the views of the GP Members Committee on all strategic matters and receive its recommendations. Decisions exceeding individual members' *and* Strategic Clinical Executive*'s* delegated limits should be referred to the *Governing Body* (with a Strategic Clinical Executive recommendation) as should issues which are unresolved due to conflicts of interests.			
Chair of meetings:			
CCG Chair			
Composition:			
GP members with voting rights All the Commissioning lead-GPs. Officer members with voting rights Chief Officer Chief Finance Officer Deputy Chief Officer Chief Nurse			
In Attendance:			
Admin support Other staff will be invited to attend as appropriate for specific agenda items.			
Deputising:			
Deputising is not required. Deputies, where it has been agreed with the Chair they attend, will not have voting rights.			
Quorum:			
As long as no more than three Commissioning lead-GPs are absent, the meeting will be quorate.			
Accountability:			
Is to the Clinical Commissioning Group's *Governing Body*. The Commissioning lead-GPs are collectively accountable to the GP Members Committee. The Strategic Clinical Executive must seek the latter's views on significant strategic matters prior to reaching decisions - unless urgency dictates otherwise.			
Frequency of meetings:			
Weekly			
Order of business:			
To be determined by the Chief Officer and/or the Chair.			
Agenda deadlines:			
Monday a.m. prior to the meeting.			
Minutes:			
The records of actions will be stored on the "Rotherham CCG (r:)" drive, in a restricted folder titled "Strategic CE". They will be circulated electronically to the chair and vice-chair of the GP Members Committee. The records need not be supplied to the Clinical Commissioning Group's Governing			

Body. The minutes are also circulated to the SCE circulation list.
Administration:
Administrative support will be provided by the staff of the *Assistant Chief Officer (Corporate Business & Partnerships)*. They will: - make the necessary arrangements for the meetings - assemble the agenda papers and circulate them - record action points and distribute them.
Attendance:
Each member to attend 70% of a year's meetings annually.
Review Date:
January 2015

APPENDIX N -
Operational Executive Terms of Reference

NHS
Rotherham
Clinical Commissioning Group

Operational Executive

TERMS OF REFERENCE

Contact Details:			
Lead O.E. / Clinician:	**Chris Edwards**	**Lead Officer:**	**Sarah Whittle**
Title:	**Chief Officer**	**Title:**	**Assistant Chief Officer**

Purpose:
To receive information and to manage actions on specified areas.
Responsibilities:
• Operational delivery for the Group • Support of Governing Body • Corporate policy and strategy • Corporate assurance and risk management • Oversight of progress with vision, strategy and operating plan • Performance review and improvement • Partner and market relations/management • Preparation for meetings of the Clinical Commissioning Group Governing Body and Strategic Clinical Executive • To agree which issues should be escalated to Strategic Clinical Executive or GP Members Committee
Chair:
Chief Officer
Composition of group:
Chief Officer Chief Finance Officer Deputy Chief Officer Chief Nurse Assistant Chief Officer Chair Chair of the CCG
In Attendance:
Other officers on a topic-specific basis only
Deputising:
Deputies to attend when necessary
Quorum:
Any one of: Chief Officer, Deputy Chief Officer or Chief Finance Officer
Accountability:
Clinical Commissioning Group
Frequency of meetings:
Weekly.
Order of business:
To be determined by the Chief Officer
Agenda deadlines:
Thursday a.m. prior to the meeting.
Minutes:

The records of action points will be stored on the “Chief Officer” drive. The action points record will be supplied to the Strategic Clinical Executive.
Administration:
Administrative support will be provided by the Assistant Chief Officer’s staff who will: • Make the necessary arrangements for the meetings • Assemble the agenda papers and circulate them • Record action points.
Attendance:
Each core member or their deputy to attend 90% of meetings annually.
Review Date:
July 2016

Membership List

Chris Edwards
Robin Carlisle
Keely Firth
Sue Cassin
Sarah Whittle
Julie Kitlowski

APPENDIX O -
Primary Care Commissioning Committee – Terms of Reference

NHS Rotherham
Clinical Commissioning Group

NHS Rotherham - **CCG Primary Care Commissioning Committee**

TERMS OF REFERENCE

Contact Details:			
Lead O.E. / Clinician:	Chris Edwards	**Lead Officer:**	Jacqui Tuffnell
Title:	Chief Officer	**Title:**	Head of Co-commissioning

Introduction

NHS England has delegated to the CCG authority to exercise the primary care commissioning functions set out in Schedule 2 in accordance with section 13Z of the NHS Act.

Arrangements made under section 13Z may be on such terms and conditions (including terms as to payment) as may be agreed between the Board and the CCG

Arrangements made under section 13Z do not affect the liability of NHS England for the exercise of any of its functions. However, the CCG acknowledges that in exercising its functions (including those delegated to it), it must comply with the statutory duties set out in Chapter A2 of the NHS Act and including:

- Management of conflicts of interest (section 14O);
- Duty to promote the NHS Constitution (section 14P);
- Duty to exercise its functions effectively, efficiently and economically (section 14Q);
- Duty as to improvement in quality of services (section 14R);
- Duty in relation to quality of primary medical services (section 14S);
- Duties as to reducing inequalities (section 14T);
- Duty to promote the involvement of each patient (section 14U);
- Duty as to patient choice (section 14V);
- Duty as to promoting integration (section 14Z1);
- Public involvement and consultation (section 14Z2).

The CCG will also need to specifically, in respect of the delegated functions from NHS England, exercise those set out below:

Duty to have regard to impact on services in certain areas (section 13O);
Duty as respects variation in provision of health services (section 13P).

The Committee is established as a committee of the NHS **Rotherham CCG Governing Body** in accordance with Schedule 1A of the "NHS Act".

The members acknowledge that the Committee is subject to any directions made by NHS England or by the Secretary of State.

Role of the committee

Simon Stevens, the Chief Executive of NHS England, announced on 1 May 2014 that NHS England was inviting CCGs to expand their role in primary care commissioning and to submit expressions of interest setting out the CCG's preference for how it would like to exercise expanded primary medical care commissioning functions. One option available was that NHS England would delegate the exercise of certain specified primary care commissioning functions to a CCG.

In accordance with its statutory powers under section 13Z of the National Health Service Act 2006 (as amended), NHS England has delegated the exercise of the functions specified in Schedule 2 to these Terms of Reference to NHS Rotherham CCG. The delegation is set out in Schedule 1.

The CCG has established the Rotherham CCG Primary Care Commissioning Committee ("Committee"). The Committee will function as a corporate decision-making body for the management of the delegated functions and the exercise of the delegated powers.

It is a committee comprising representatives of the following organisations:

Rotherham CCG
NHS England

Statutory framework

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

In performing its role the Committee will exercise its management of the functions in accordance with the agreement entered into between NHS England and Rotherham CCG, which will sit alongside the delegation and terms of reference.

The functions of the Committee are undertaken in the context of a desire to promote increased co-commissioning to increase quality, efficiency, productivity and value for money and to remove administrative barriers.

The role of the Committee shall be to carry out the functions relating to the commissioning of primary medical services under section 83 of the NHS Act.

This includes the following:

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

The CCG will also carry out the following activities:

To plan, including needs assessment, primary medical care services in Rotherham;
To undertake reviews of primary medical care services in Rotherham;
To co-ordinate a common approach to the commissioning of primary care services generally;
To manage the budget for commissioning of primary medical care services in Rotherham.

Geographical area

The Committee will comprise the Rotherham CCG

Responsibilities:

Strategic direction

To oversee the part of the commissioning plan that relates to Primary Care, including needs assessment for safe and sustainable Primary Care Commissioning.
To oversee the development and agreement of primary care contracts for 15/16
To oversee the development of the Primary care workforce
To identify priorities for consideration by the Local Professional Networks
To identify priorities for consideration by the PPE & Communications committee
To consider implications and oversee implementation of issues arising from the national, regional and local reviews
To make recommendation to the Governing Body on all issues relating to Primary Care Development.

Quality & Performance Management

To oversee the management of the annual budget for the commissioning of Primary Care services in the relevant area.
To oversee individual contract performance on a regular basis – activity, finance and quality.
To Oversee the Quality Outcome framework (QOF)or local incentive scheme (LIS)
To agree contract variations and to undertake reviews of primary care services where appropriate, within delegated limits
To consider contract breaches and appropriate enforcement actions offering support where appropriate and make recommendation to the Governing Body, on all issues to do with Primary Care Development.
To oversee programme management and delivery of the QIPP programme relevant to primary care
To oversee the financial management of GP contracts for Core and enhanced services.
To monitor the Primary Care section of the Commissioning plan
In partnership with AQuA monitor delivery against range of KPIs relating to quality
To consider independent reports eg CQC, Professional alerts, domestic homicide reviews etc, relating to services commissioned
In partnership with AQuA consider trends relating to SI's, complaints and MP enquiries relating to services commissioned
To report to the Governing Body as appropriate on issues that need escalation.

General Issues

To agree key risks for inclusion in Risk Register for primary care commissioning
To coordinate issues for/and oversee negotiations with the Representative Body
The Committee will produce an annual report summarising its work and present to the Governing body.
To consider and act on the 'conflict of interest' of General Practitioners with reference to Primary care Commissioning.

Membership:

The membership shall consist of:

- Three lay members
- The Chief Officer
- The Chief Finance Officer
- The Chief Nurse
- The Head of Co-Commissioning
- NHS England

Non-voting members

- The lead SCE-GP with the portfolio for Primary Care
- The lead SCE-GP for governance
- A member of the GP members committee

Chair:
Lay member – Primary Care
Vice chair: Lay member - Governance
In Attendance:
• HealthWatch Representative • Health & Wellbeing Board representative
Meetings and Voting
The Committee will operate in accordance with the CCG's Standing Orders. The Secretary to the Committee will be responsible for giving notice of meetings. This will be accompanied by an agenda and supporting papers and sent to each member representative no later than **7** days before the date of the meeting. When the Chair of the Committee deems it necessary in light of the urgent circumstances to call a meeting at short notice, the notice period shall be such as s/he shall specify. Each member of the Committee shall have one vote. The Committee shall reach decisions by a simple majority of members present, but with the Chair having a second and deciding vote, if necessary. However, the aim of the Committee will be to achieve consensus decision-making wherever possible. **Quorum** • Two Lay member • 2 Senior officers • 1 GP non-voting member or appropriate deputy Members or appropriate deputies to attend at least 80% of all meetings throughout the year. The Chair of the CCG to attend at least one meeting during the year. Internal Audit to attend at least one meeting during the year.
Deputising:
Chief Officer, Chief Finance Officer, Chief Nurse - Any appropriate nominated deputy. Non-voting GP's – nominated deputy
Administration
Frequency of meetings Monthly and otherwise when required.
Meetings of the Committee shall: • be held in public, subject to the application of 23(b); • the Committee may resolve to exclude the public from a meeting that is open to the public (whether during the whole or part of the proceedings) whenever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time. Members of the Committee have a collective responsibility for the operation of the Committee. They will participate in discussion, review evidence and provide objective expert input to the best of their knowledge and ability, and endeavour to reach a collective view. The Committee may delegate tasks to such individuals, sub-committees or individual members as it shall see fit, provided that any such delegations are consistent with the parties' relevant governance arrangements, are recorded in a scheme of delegation, are governed by terms of reference as appropriate and reflect appropriate arrangements for the management of conflicts of interest.. The Committee may call additional experts to attend meetings on an ad hoc basis to inform

discussions.

Members of the Committee shall respect confidentiality requirements as set out in the CCG's Constitution.

The Committee will present its minutes to NHS England (North) area team of NHS England and the governing body of Rotherham CCG each month for information, including the minutes of any sub-committees to which responsibilities are delegated under paragraph 27 above.

The CCG will also comply with any reporting requirements set out in its constitution.

It is envisaged that these Terms of Reference will be reviewed from time to time, reflecting experience of the Committee in fulfilling its functions. NHS England may also issue revised model terms of reference from time to time.

Accountability of the Committee

For the avoidance of doubt, in the event of any conflict between the terms of this Scheme of Delegation and Terms of Reference and the Standing Orders of Standing Financial Instructions of any of the members, the latter will prevail

Procurement of Agreed Services

Rotherham CCG will abide by our statutory responsibilities for all contractual relationships that fall under the Public Procurement Regulations (2006) and any subsequent legislation. This will include any clinical (healthcare) services defined as Part B under the regulations, of which primary care services are included. Rotherham CCG will consider the benefits of introducing choice and competition when re-commissioning any of these clinical services and will, at all times, follow Monitor's substantive guidance around the Procurement, Patient Choice and Competition Regulations for NHS funded services.

Decisions

The Committee will make decisions within the bounds of its remit and decisions will be aligned with the CCGs commissioning plan.

The decisions of the Committee shall be binding on NHS England and Rotherham CCG.

The Committee will produce an annual report which will be presented to NHS England (North) area team of NHS England and Rotherham CCGs Governing body

Minutes of the meeting will be issued within 3 working days of the meeting and will be supported by a live action log.

A verbal update from the Chair of the Primary Care Commissioning Committee will be given at the Rotherham CCG Governing Body supported by the minutes each month.

Delegated functions-to be added when final arrangements confirmed]

NHS England has delegated to NHS Rotherham CCG the following functions relating to the commissioning of primary medical services under section 83 of the NHS Act:

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

Delegated commissioning arrangements will exclude individual GP performance management (medical performers' list for GPs, appraisal and revalidation). NHS England will also be responsible for the administration of payments and list management.

List of Members-to be added when confirmed]

Lay / executive members:

- Lay Member for Primary Care (Chair)

• Lay Member for Governance • Lay Member for Public & Patient Engagement • Chief Officer / Accountable Officer • Chief Finance Officer • Chief Nurse • Head of Co-Commissioning • NHS England Non-voting member: • The lead SCE-GP with the portfolio for Primary Care • The lead SCE-GP for governance • A member of the GP members committee. In addition to the people stated above, a representative of Healthwatch Rotherham, a Local Authority member of the Health and Wellbeing Board, and other members (co-opted as necessary) will be invited to attend meetings and participate in the decision making discussions of the Primary Care Commissioning Committee as necessary in a non - voting capacity.
Review Date:
April 2016

APPENDIX P -
PPE (patient, public engagement) & Communications Sub-committee – Terms of Reference

NHS
Rotherham
Clinical Commissioning Group

PPE (Patient, Public Engagement) & Communications Sub Committee

TERMS OF REFERENCE

Contact Details:			
Lead O.E. / Clinician:	Sue Cassin	**Lead Officer:**	Helen Wyatt
Title:	Chief Nurse	**Title:**	Patient & Public Engagement manager

Purpose:
The PPE & Communications sub-committee (the Committee) is established in accordance with Rotherham Clinical Commissioning Group's (RCCG's) constitution. This sub-committee provides strategic and operational leadership for the development of effective public and patient engagement and communication

Responsibilities:

Strategic direction

- Oversee the development & implementation of the communications & engagement strategies and action plans.
- Ensure that Patient and Public Engagement is central to the business of the CCG, and that it is embedded in all decision making processes adopted by the CCG
- Advise the Governing Body on all matters relating to engagement and the process of formal consultation.
- Ensure that the CCG (and the services it commissions) engage in meaningful dialogue with its public, patients and partners
- Design the specification and quality standards relating to the process relating to engagement, communication and consultation that will be used by all members of the CCG and by its staff, in particular that which will be used in the process of service transformation and service redesign, at the earliest stages
- Address ways to increase wider patient & public involvement/engagement, scanning for and implementing new and innovative mechanisms for engagement, especially in regard to under-engaged communities
- Ensure the CCG has effective communications processes in place to manage its reputation as a local leader of the NHS.
- Ensure that Equality and Diversity is embedded across Communication and Engagement activities by having due regards to the 9 protected characteristics under the Equality Act 2010.

Quality and Performance Management

- Monitor delivery of the Communications and Engagement Plan
- Monitor delivery against a range of standards relating to engagement,

communications and consultation.

- Consider trends of complaints and MP enquiries relating to services commissioned
- Secure continuous improvement in the quality of engagement and communication
- Provide assurance to the Governing Body on communication and patient, carer and public engagement. This includes assurance that the needs, views and aspirations of patients, carers, local community groups and the general public have:
  - ✓ helped shape and influence service delivery.
  - ✓ are being used to develop priorities, strategies and plans
  - ✓ have helped to procure services
  - ✓ are being used to monitor services in terms of safety, quality and positive patient experience.

General Issues

- To agree key risks for inclusion in Risk Register

Chair:
CCG Lay Member for Public & Patient Engagement

Composition of group:
• CCG Lay Member for Public & Patient Engagement • Primary Care - Governing Body member, • Chief Nurse • Assistant Chief Officer • GPMC – GP • Patient and Public Engagement Manager, • Chief Executive, Voluntary Action Rotherham • Healthwatch • Representative from wider reference Group • Representative from Public health • Equality & diversity lead (CSU) • Communications Manager • Planning and Assurance Manager • RMBC Scrutiny rep (TBC) The Committee may also co-opt other senior clinicians or managers as necessary. These will be non-voting members of the committee. The Chair and Chief Executive of the CCG will attend one meeting of the sub-committee per year.

In Attendance:
The Sub-committee will be serviced by the admin team

Deputising:
Fully briefed deputies, with relevant and appropriate decision making authority shall be permitted, where necessary, with the agreement of the Chair.

Quorum:
The Committee will be quorate with 4 from the following 5 members: • The Chair (or another Lay member chairing the meeting)

- 1 CCG Senior Management representative
- 1 GP
- Patient and Public Engagement Manager
- Healthwatch representation

Accountability:
The PPE (Patient, Public Engagement) & Communications sub-committee will report directly to the CCG Governing Body but will also refer issues to the Audit and Quality Assurance Committee as appropriate.

Frequency of meetings:
Quarterly or four times a year

Order of business:
• Strategic direction • Quality & Performance Management • General issues

Agenda deadlines:
Agenda papers will be distributed at least 7 working days ahead of the meeting.

Minutes:
Minutes of the meeting will be issued within 3 working days of the meeting.

Administration:
The meetings will be serviced by the admin team which sits under the Assistant Chief Officer

Attendance:
Members to attend at least 3 meetings from 4 throughout the year and if attendance is not possible should be otherwise represented by their designated deputy. The Chair and Chief Officer of the CCG to attend at least One meeting during the year

Review Date:
April 2016

APPENDIX Q-
DISPUTE RESOLUTION PROTOCOL

Management of Disputes Protocol

1. **INTRODUCTION**

1.1 This protocol is to enable the Members of the Group ("Members" for the purposes of this protocol) to resolve any disputes that may arise between them promptly, efficiently and in line with the relevant regulatory frameworks.

1.2 The parties in dispute shall continue to comply with, observe and perform all their obligations under the constitution and to the Group regardless of the nature of the dispute and notwithstanding the referral of the dispute for resolution under this protocol and shall give effect forthwith to every decision delivered under this protocol.

1.3 Prior to the resolution of any disputes the affected Members will still be required to comply with any relevant obligations to the Group.

2. PRINCIPLES

2.1 In seeking to resolve any dispute that arises, the relevant Members will undertake to adopt the principles of:

2.1.1 Transparency - including clear communication, engagement of relevant stakeholders, enforcing declarations of interest;

2.1.2 Objectivity – including analysis and decision making on objective information and criteria and the maintenance of an audit trail and clear accountability;

2.1.3 Proportionality – only using the formal disputes process on matters of material importance to the Group and only requesting resources proportionate to the significance of the dispute; and

2.1.4 Non-discriminatory – adopting a fair and respectful approach throughout.

2.2 Before considering whether it is appropriate to refer to the disputes escalation procedure set out at paragraph 3 below, the Members should make every reasonable effort to communicate and cooperate with each other in good faith to attempt to come to an agreement in relation to the disputed matter without the need for formal intervention.

3. DISPUTE ESCALATION PROCEDURE

3.1 **Step 1 – Locality Level**

3.1.1 The disputed issue is clearly identified and formally raised to be discussed with the appropriate GP Members Committee Member for the locality (unless conflicted). Every effort is made to resolve the issue in good faith.

3.1.2 Timescale for resolution: five (5) Business Days.

3.2 **Step 2 – Petition Level**

3.2.1 If the issue is not resolved at step 1, a joint statement of the disputed issue and the precise matter(s) of dispute should be prepared and signed by the Members in dispute (and the Member reviewing the dispute at Step 1). Either party to the dispute shall then be entitled to submit a petition for the consideration of the issue to the GP Members Committee. The GP Members Committee will consider the petition and recommend a response (which may include referring the issue to stage 3 if appropriate).

3.2.2 Timescale for resolution: five (5) Business Days following consideration by the GP Members Committee.

3.3 **Step 3 – Chair or Senior Officer Level**

3.3.1 If the issue is not resolved through the consideration of the GP Members Committee at step 2, the joint statement of the disputed issue and the precise matter(s) of dispute may be formally raised to be discussed with an appropriate senior officer of the Group (which will be the Chair of the Group in the first instance unless they are conflicted). If the senior officer is able to find a way to resolve the dispute with the parties through discussion (which is agreed by the parties in dispute) then their decision will be communicated to the Governing Body and where appropriate implemented.

3.1.2 Timescale for resolution: five (5) Business Days.

3.4 Step 4 – NHSCB

3.4.1 If the issue is not resolved at Step 3, a joint statement of the disputed issue and the precise matter(s) of dispute should be prepared and signed by the Members in dispute (and the officer reviewing the dispute at Step 3) and sent jointly to the lead officer at the local office of the NHS Commissioning Board within five (5) working days.

If the lead officer of the local office of the NHS Commissioning Board is able to find a way to resolve the dispute with the parties through discussion (which is agreed by the parties in dispute) then their decision will be communicated to the Governing Body and where appropriate implemented.

3.4.2 Timescale for resolution: to be determined by the NHS Commissioning Board dependent on the nature of the issues in dispute.

4. CONCLUSION

4.1 A summary report outlining the nature of the dispute, the steps followed to reach resolution and the final outcome should be prepared by the Group and reported to the next meeting of the Governing Body. Any key learning points should be identified in this report.