NHS
Wolverhampton
Clinical Commissioning Group

A meeting of the Wolverhampton Clinical Commissioning Group Governing Body will take place on Tuesday 11th October 2016 commencing at 1.00 pm

LATE PAPERS

		8	Constitution Variation Mr P McKenzie		1 - 102

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NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

GOVERNING BODY 11 OCTOBER 2016

Agenda item 8

Title of Report:	**Constitution Variation**
Report of:	Corporate Operations Manager
Contact:	Peter McKenzie
Governing Body Action Required:	☒ **Decision** ☐ **Assurance**
Purpose of Report:	To ask the Governing Body to agree to making an application to vary the CCG Constitution in preparation for the application for full delegation of Primary Care Co-Commissioning from April 2017 and to give effect to previously reported changes to Governing Body Membership to meet new requirements for managing Conflicts of Interest.
Public or Private:	This Report is intended for the public domain
Relevance to CCG Priority:	Developing and Strengthening Leadership Capacity and Capability as a CCG.
Relevance to Board Assurance Framework (BAF):	Outline which Domain(s) the report is relevant to and why
• **Domain 1:** A Well Led Organisation	The Constitution underpins the CCG's Governance Framework and ensuring that it is robust and up to date is fundamental to the CCG's leadership priorities.
• **Domain 3:** Financial Management	The constitution includes the high level framework for the CCG's financial management arrangements (Prime Financial Policies), which are essential for delivering the CCG's financial duties.
• **Domain 5:** Delegated Functions	The proposed amendments incorporate the Terms of Reference for the Joint Committee for exercising delegated functions with NHS England

1. BACKGROUND AND CURRENT SITUATION

1.1. As previously reported, NHS England have been clarifying the process for applying for fully delegated co-commissioning of Primary Care from April 2017. Now more details are available, work has begun to prepare the CCG's application, including the variation of the constitution.

1.2. Other changes to the constitution are required to give effect to the change of membership of the Governing Body in response to statutory guidance on conflict of interests and following reviews of Prime Financial Policies (PFPs) and the Scheme of Reservation and Delegation.

2. PRIMARY CARE CO-COMMISSIONING

2.1. Details of the application documentation required for submission to NHS England have now been made available which have clarified the changes in respect of the Governance arrangements that the CCG will need to have in place. As previously reported, the CCG will be required to establish a Primary Care Committee to exercise the functions delegated to it that complies with the membership requirements in the statutory guidance for managing conflicts of interest.

2.2. The main body of the constitution has been amended to include the appropriate references to the new committee and terms of reference have been drafted based on the current Primary Care Joint Commissioning Committee terms of reference and the model terms of reference supplied by NHS England. The terms of reference will be accompanied by a delegation agreement from NHS England that will set out in more detail the activities and functions that the CCG will be undertaking on their behalf. This agreement will be developed in consultation with NHS England and may result in minor amendments being required to the draft terms of reference prior to the submission of the application by 5 December 2016.

2.3. Work will continue to develop the application for full delegation prior to 5 December 2016 and the Governing Body will receive further details as this work goes on. At this stage, the Governing Body is asked to formally confirm its intention to make an application and to make a recommendation to the CCG membership meeting on 19 October that it be authorised to do so.

3. CONFLICTS OF INTEREST MANAGEMENT – CHANGE TO GOVERNING BODY MEMBERSHIP

3.1. Following the changes to the CCG's arrangements for managing conflicts of interest, in response to new national guidance, the Governing Body has agreed to the appointment of an additional Lay Member for Finance and Performance. The constitution, Standing Orders and Terms of Reference for the Finance and Performance Committee have been updated to reflect this.

3.2. Further minor changes have also been made to the constitution to ensure it remains is consistent with the operational policies. In particular, the categories of relevant interests have been amended to reflect the new national guidance and standing orders have been updated to clarify the arrangements in place when Governing Body meetings cannot be quorate due to clinical conflicts of interest. These changes (along with all of the other changes referenced in this report) are tracked in the updated document.

4. REVIEW OF PRIME FINANCIAL POLICIES AND SCHEME OF RESERVATION AND DELEGATION

4.1. As previously reported, in line with the documented procedure, the CCG's PFPs and Scheme of Reservation and Delegation have been reviewed by the Finance and Performance and Audit and Governance Committees in July 2016. A number of minor, presentational amendments have been made to Sections 1.1.4, 3.4, 3.5, 12.1(c) & 13.4 of the PFPs and the following additions have been made to the Scheme of Reservation and Delegation:-

- Additional item added to include the arrangements for the procurement of external auditors which has recently been delegated to CCGs;
- Additional item added to reflect the Commissioning Committee's role in approving business cases and service developments. This is to replace the item previously included within the Detailed Scheme of Delegation.
- In addition, there has been one presentational amendment to substitute 'the NHS Commissioning Board' for 'NHS England'.

4.2. As with the terms of reference for the Primary Care Commissioning Committee, the Scheme of Reservation and Delegation may require further minor amendment to reflect the delegation agreement with NHS England for full delegation. This will be discussed as the agreement is developed.

5. NEXT STEPS

5.1. As highlighted above, the Governing Body is asked to formally agree to make an application for fully delegated commissioning and to seek the agreement of the CCG Membership to this course of action. In addition, the making of an application to vary the constitution is reserved to the Membership so the Governing Body is also asked to recommend to the Membership that an application is made that includes the above amendments.

5.2. As highlighted above, a number of further amendments may be required to the current drafts of the constitution and appendices attached to this report as a result of preparation for the application for full delegation of Primary Care. The Governing Body is asked to authorise the Chair and Interim Accountable Officer to agree the final versions for submission once the delegation agreement with NHS England is reached.

5.3. NHS England requires the CCG to follow a prescribed process for making an application for a variation, including the completion of an impact assessment that covers issues such as stakeholder engagement and the financial impact of the amendment. This will be signed off by the Accountable Officer and Chair prior to the application being made.

6. CLINICAL VIEW

6.1. Whilst the changes do not have specific clinical implications, this will be discussed at the Membership meeting on 19 October 2016.

7. PATIENT AND PUBLIC VIEW

7.1. Patient and Public input will be detailed as part of the Impact assessment process prior to the application being made. The CCG has previously sought views on the Primary Care strategy which set out the CCG's aspiration to move to full delegation by 2017.

8. RISKS AND IMPLICATIONS

Key Risks

8.1. The risks associated with the application for fully delegated commissioning are being managed through the application process. NHS England require assurance that the CCG will be able to deliver fully delegated commissioning and will be assessed through the proforma provided.

8.2. The other amendments to the Constitution mitigate risks associated with the CCG not having up to date arrangements or, in the case of the changes relating to the management of conflict of interests, arrangements that reflect statutory guidance.

Financial and Resource Implications

8.3. There are no financial implications arising from this report. The resource implications of fully delegated commissioning will be considered through the application process and up to assuming responsibility in April 2017.

Quality and Safety Implications

8.4. There are no Quality and Safety implications arising from this report.

Equality Implications

8.5. There are no equality implications arising from this report.

Medicines Management Implications

8.6. There are no Medicines Management implications arising from this report.

Legal and Policy Implications

8.7. The application will be submitted in line with the nationally prescribed process and statutory guidance for constitutional review. This will result in an update to the CCG's published constitution.

9. RECOMMENDATIONS

9.1. That the Governing Body:-

- **Agrees** to make an application for full delegation of Primary Care Commissioning.
- **Recommends** to the Membership that an application for full delegation of Primary Care Commissioning and consequent variation of the Constitution is made, also including the inclusion of the additional Lay Member of the Governing Body, the and amendments to Prime Financial Policies and the Scheme of Reservation and Delegation highlighted in the report.
- **Authorises** the Interim Accountable Officer and the Chair to agree the final versions of the amended constitution and associated documents in line with the agreement that will be reached with NHS England in respect of the delegated powers.

Name Peter McKenzie
Job Title Corporate Operations Manager
Date: September 2016

RELEVANT BACKGROUND PAPERS

NHS England webpage on delegated commissioning
https://www.england.nhs.uk/commissioning/pc-co-comms/pb-cc-approval/

ATTACHED DOCUMENTS

Amended Constitution
Amended Standing Orders
Amended Scheme of Reservation and Delegation
Amended Terms of Reference – Finance and Performance Committee
Draft Terms of Reference – Primary Care Commissioning Committee

REPORT SIGN-OFF CHECKLIST

This section must be completed before the report is submitted to the Admin team. If any of these steps are not applicable please indicate, do not leave blank.

	Details/ Name	Date
Clinical View	**N/a**	
Public/ Patient View	**N/a**	
Finance Implications discussed with Finance Team	**N/a**	
Quality Implications discussed with Quality and Risk Team	**N/a**	
Medicines Management Implications discussed with Medicines Management team	**N/a**	
Equality Implications discussed with CSU Equality and Inclusion Service	**N/a**	
Information Governance implications discussed with IG Support Officer	**N/a**	
Legal/ Policy implications discussed with Corporate Operations Manager	Report Author	**29/09/2016**
Signed off by Report Owner (Must be completed)	**Peter McKenzie**	**29/09/2016**

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NHS WOLVERHAMPTON
CLINICAL COMMISSIONING GROUP

CONSTITUTION

Version: [~~7~~8]

NHS England Effective Date: 1 ~~December 2015~~ April 2017

CONTENTS

The following separate documents with their own page numbering are also deemed to be part of this Constitution

FOREWORD

NHS Wolverhampton Clinical Commissioning Group ('WCCG') aims to commission the highest quality, evidence-based care on behalf of its patients by investing in skills available locally and otherwise to design new and improved care pathways.

The clinical commissioning group will address health inequalities by being responsive to both patients and constituent practices. The engagement and support of its member practices will promote effective dialogue with providers aimed at bringing about the delivery of improved, cost effective health care.

WCCG will maintain a focus on health needs in Wolverhampton and commission cost effective services within the resources available.

The clinical commissioning group will adopt a culture in which individual practices engage in designing pathways and incorporate the needs of their practice population. The sum of these locally based approaches will help us to deliver our strategic commissioning objectives.

Practices will be supported through structured education and a quality improvement programme. This will help us to achieve common strategic objectives and standardise delivery of care for all of our patients.

The clinical commissioning group will share appropriate information with our constituent practices so that we can develop a better understanding of the needs in the locality for provision of different care patterns and the requirements of our constituent practices.

Appropriate governance mechanisms and information management tools will also be continuously developed. This will allow WCCG to share selective and essential data reflecting the achievements and shortcomings of the group, which can be shared with NHS England, the local authority public health function, Health and Wellbeing Board and – last but not least - patient groups.

The clinical commissioning group will maintain clear definitions and profiles for the roles and responsibilities of all governing body members and office holders. The corporate governance mechanisms will ensure that the Chair, Accountable Officer and all other Governing Body members have a clear brief. The objectives of all WCCG officers and Clinical Leads will be well defined through the Terms of Reference of our Committees and other documents and policies.

The clinical commissioning group works with third parties including the local authority and other statutory bodies in developing and implementing appropriate agreements in order to improve and develop local services. The group also works with NHS England to ensure that the services commissioned by it are an efficient and cost-effective part of the overall range of services available to the people of Wolverhampton.

Our focus will primarily be on maintaining and improving services for patients.

1. INTRODUCTION AND COMMENCEMENT

1.1. Name

1.1.1. The name of this clinical commissioning group is NHS Wolverhampton 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, has failed to discharge any of its functions or 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 governance arrangements for their organisations, which they are required to set out in a constitution.[7]

1.3. Status of this Constitution

1.3.1. This constitution has been approved by the members of NHS Wolverhampton Clinical Commissioning Group and has effect from 1 April 2015[8] The constitution is published on the group's website at www.wolverhamptonccg.nhs.uk.

1.3.2. Copies of the constitution are available for inspection at the WCCG headquarters: Wolverhampton Science Park, Glaisher Drive, Wolverhampton WV10 9RU. Alternatively, on request, a copy will be posted or sent by email to any enquirer who may wish to receive this.

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

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

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

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

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

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

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

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

1.4. Amendment and Variation of this Constitution

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

a) where the group applies to NHS England and that variation 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.

2. AREA COVERED

2.1. The geographical area covered by NHS Wolverhampton Clinical Commissioning Group is the City of Wolverhampton.

3. MEMBERSHIP

3.1. Membership of the Clinical Commissioning Group

3.1.1. The practices listed in Appendix B comprise the members of NHS Wolverhampton Clinical Commissioning Group.

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 will be eligible to apply for membership of this group[10].

4. MISSION, VISION, VALUES AND AIMS

4.1. Mission

4.1.1. The mission of NHS Wolverhampton Clinical Commissioning Group is:

> We will be an expert clinical commissioning organisation, working collaboratively with our patients, practices and partners across health and social care to ensure evidence-based, equitable, high quality and sustainable services for all of our population.

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.

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

10 See section 14A(4) of the 2006 Act, inserted by section 25 of the 2012 Act and any regulations issued

4.2. Vision

4.2.1. Our vision is for the right care in the right place at the right time for all of our population. Our aim is to ensure that patients will experience seamless care, integrated around their needs, and they will live longer with improved quality of life.

4.3. Values

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

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

a) to be a dynamic, responsive and innovative organisation;
b) to drive the commissioning agenda in Wolverhampton ;
c) to be a trusted and valued partner contributing positively to the health and social care economy;
d) to have a proactive, inclusive, equitable and professional approach that will secure best value for money and high quality in all that we do;
e) to be open and responsive to the local population, patients and clinicians;
f) to have ways of working that encourage people to want to work for and with us.

4.4. Aims

4.4.1. The group's aims are to:

a) improve and simplify arrangements for urgent care;
b) address variations in the quality of planned care;
c) improve the care of those with chronic conditions;
d) reduce health inequalities across Wolverhampton ;
e) commission the highest quality of services within available resources.

4.5. Principles of Good Governance

4.5.1. 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]

[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

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]

4.6. Accountability

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

a) publishing its constitution;

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

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

d) publishing annually a commissioning plan;

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

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

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

h) having a published and clear complaints process;

i) complying with the Freedom of Information Act 2000;

j) providing information to NHS England as required.

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

a) making its principal commissioning policies available on its internet site;
b) holding public engagement events.

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

13 See Appendix C
14 See Appendix D
15 See http://www.legislation.gov.uk/ukpga/2010/15/contents

5. FUNCTIONS AND GENERAL DUTIES

5.1. Functions

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

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

b) commissioning emergency care for anyone present in our area;

c) meeting the costs of prescriptions written by our member practices;

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

e) determining the remuneration and travelling or other allowances of members of our governing body.

5.1.2. In discharging its functions the group will:

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

   i) delegating responsibility for delivering this duty to the governing body;
   ii) establishing a Commissioning Committee to support the governing body in meeting that responsibility;
   iii) agreeing a Commissioning Policy consistent with this duty;
   iv) requiring our performance in delivery of this duty to be monitored by the Audit and Governance Committee.

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

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

i) delegating responsibility for delivering this duty to the Accountable Officer, who will discharge it using the Equality Delivery System toolkit;
ii) agreeing an Equality and Diversity policy that, inter alia, requires all policies to be written with due regard for the group's responsibilities under the Equality Act 2010;
iii) publishing at least annually sufficient information to demonstrate our compliance with this general duty across all our functions;
iv) preparing, publishing and revising at least every four years our specific and measurable equality objectives;
v) requiring our performance in delivery of this duty to be monitored by the Quality and Safety Committee.

c) work in partnership with our local authority to develop *joint strategic needs assessments*[20] and *joint health and wellbeing strategies*[21] by:

i) ensuring that we are an effective member of the Wolverhampton Health and Wellbeing Board, on which we will be represented by an elected member of the governing body;
ii) requiring our representatives on that Board to report to the governing body, as well as the Finance and Performance and Quality and Safety Committees as appropriate, with regard to development of the joint assessments and strategies and delivery of the latter;
iii) delivering our duty under 5.2.13 below to integrate health services with health-related and social care services when appropriate to do so.

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

5.2.1. Make arrangements to *secure public involvement in the planning, development and consideration of proposals for changes and decisions affecting the operation of commissioning arrangements*[22] by:

a) delegating responsibility for delivering this duty to the Accountable Officer;
b) working in partnership with patients and the local community to secure the best care for them;
c) publishing information about health services on our website and adopting engagement activities that meet the specific needs of our different patient groups and communities;
d) ensuring that, as part of any of our processes for potential or actual changes to commissioning arrangements, there is appropriate consultation with or provision of information to the individuals for whom those changes could or would have an impact on the manner in which services are delivered to them or the range of services available to them;
e) encouraging and acting on feedback;
f) thus delivering the *Statement of Principles* below;

[20] See section 116 of the Local Government and Public Involvement in Health Act 2007, as amended by section 192 of the 2012 Act
[21] See section 116A of the Local Government and Public Involvement in Health Act 2007, as inserted by section 191 of the 2012 Act
[22] See section 14Z2 of the 2006 Act, inserted by section 26 of the 2012 Act

g) requiring our compliance with this *Statement* to be monitored by the Quality and Safety Committee.

Statement of Principles

We will:

- commission high quality, patient-centred care;
- improve patient care by focussing on quality, including outcomes;
- adhere to evidenced based decision making;
- treat patients, carers and their representatives with respect;
- be open about what is possible, what cannot be changed and why;
- involve local people in decision making;
- respond to concerns and views and demonstrate how we have responded and what impact this has had;
- include those who are marginalised and considered 'hard to reach', by understanding our communities and stakeholders and valuing partnership working;
- undertake decision making in a fair way so that no group is significantly disadvantaged by the decisions we take;
- demonstrate a commitment to learning and development, exploring different ways of working and evaluating and implementing our learning for continual improvement.

5.2.2. *Promote awareness of, and act with a view to securing that health services are provided in a way that promotes awareness of, and have regard to the NHS Constitution*[23] by:

a) delegating responsibility for delivering this duty to the Accountable Officer, who will ensure that our arrangements for public engagement promote awareness of the *NHS Constitution*;
b) encouraging and supporting our constituent practices to provide health services in a manner that is consistent with this duty;
c) including within our Commissioning Policy a requirement to ensure that the health services we commission are provided in a manner that is consistent with this duty;
d) requiring our performance in delivery of this duty to be monitored by the Quality and Safety Committee.

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

a) delegating responsibility for delivering this duty to the governing body;
b) establishing a Finance and Performance Committee to support the governing body in meeting that responsibility;

[23] See section 14P of the 2006 Act, inserted by section 26 of the 2012 Act and section 2 of the Health Act 2009 (as amended by 2012 Act)
[24] See section 14Q of the 2006 Act, inserted by section 26 of the 2012 Act

c) using our Standing Orders, Scheme of Reservation and Delegation and Prime Financial Policies as the policy framework through which this duty will be delivered;
d) requiring our performance in delivery of this duty to be monitored by the Audit and Governance Committee.

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

a) delegating responsibility for delivering this duty to the Executive Nurse, who will ensure that we are a learning organisation;
b) establishing a Commissioning Committee to support the Executive Nurse in meeting that responsibility;
c) including within our Commissioning and Contract Management Policies the requirement to ensure that services are commissioned and their delivery monitored in a manner that strives for continuous improvement in effectiveness, safety and quality;
d) requiring our performance in delivery of this duty to be monitored by the Quality and Safety Committee.

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

a) delegating responsibility for delivering this duty to the Accountable Officer;
b) agreeing with each of the constituent practices an Improving Quality of Primary Medical Services Policy that ensures the delivery of this duty in a manner so as to achieve a caring and responsible culture and environment;
c) requiring our performance in delivery of this duty to be monitored by the Quality and Safety Committee.

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

a) delegating responsibility for delivering this duty to the Accountable Officer, who will discharge it in a manner consistent with our public sector equality duty at 5.1.2(b) above;
b) including within our Commissioning Policy the requirement to deliver our aim to reduce inequalities in patients' ability to access services and/or in the outcomes being delivered by the services they do use;
c) developing commissioning strategies and plans consistent with that policy requirement;
d) requiring our performance in delivery of this duty to be monitored by the Finance and Performance Committee.

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

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

a) delegating responsibility for delivering this duty and those stated at b) to d) below to the Executive Nurse, who will be required to ensure its application with regard to prevention, diagnosis and treatment;
b) encouraging and supporting our constituent practices to provide health services in a manner that is consistent with this duty;
c) including within our Commissioning Policy a requirement to ensure that the health services we commission are provided in a manner that is consistent with this duty;
d) requiring our performance in delivery of this duty to be monitored by the Quality and Safety Committee.

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

a) delegating responsibility for delivering this duty and those at b) to e) below to the Executive Nurse ;
b) encouraging and supporting our constituent practices to provide health services and refer patients to secondary health services in a manner that is consistent with this duty;
c) including within our Commissioning Policy a requirement to ensure that we commission services in a manner that is consistent with this duty;
d) including within our Commissioning Policy a requirement to ensure that the health services we commission are provided in a manner that is consistent with this duty;
e) requiring our performance in delivery of this duty to be monitored by the Quality and Safety Committee.

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

a) delegating responsibility for delivering this duty to the Accountable Officer, who will be required to ensure its application with regard to needs assessments, overall strategies and plans and any specific changes proposed for commissioning arrangements;
b) ensuring that, as part of any of our processes for potential or actual changes to commissioning arrangements, appropriate advice is obtained with regard to the relevant aspects of prevention, diagnosis and treatment of individual patients and/or the protection and improvement of public health in the community;
c) requiring our performance in achieving (b) above to be monitored by the Audit and Governance Committee.

5.2.10. *Promote innovation*[31] by:

a) delegating responsibility for delivering this duty to the Executive Nurse and providing he/she with support from other appropriate health professionals;

28 See section 14U of the 2006 Act, inserted by section 26 of the 2012 Act
29 See section 14V of the 2006 Act, inserted by section 26 of the 2012 Act
30 See section 14W of the 2006 Act, inserted by section 26 of the 2012 Act
31 See section 14X of the 2006 Act, inserted by section 26 of the 2012 Act

b) requiring the Executive Nurse to prepare an annual report to the governing body on how the group has promoted innovation in the provision of health services during the previous year.

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

a) delegating responsibility for delivering this duty to the Executive Nurse and providing he/she with support from other appropriate health professionals;
b) requiring the Executive Nurse to prepare an annual report to the governing body on how the group has promoted relevant research and the use of evidence obtained from research during the previous year.

5.2.12. Have regard to the need to *promote education and training*[33] for persons who are employed, or who are considering becoming employed, in an activity which involves or is connected with the provision of services as part of the health service in England so as to assist the Secretary of State for Health in the discharge of his related duty[34] by:

a) delegating responsibility for delivering this duty to the Executive Nurse; and providing them with support from other appropriate health professionals;
b) requiring the Executive Nurse to prepare an annual report to the governing body on how the group has promoted relevant education and training during the previous year.

5.2.13. Act with a view to *promoting integration* of both health services with other health services and health services with health-related and social care services where the group considers that this would improve the quality of services or reduce inequalities[35] by:

a) delegating responsibility for delivering this duty to the Accountable Officer, who will be required to ensure consistency with the related duties at 5.1.2(c), 5.2.4 and 5.2.6 above;
b) requiring the Accountable Officer to prepare an annual report to the governing body on how the group has promoted integration in order to improve quality and reduce inequalities with regard to access to services and outcomes during the previous year.

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

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

a) delegating responsibility for delivering this duty to the Chief Finance Officer;
b) establishing a Finance and Performance Committee to support the Chief Finance Officer in meeting that responsibility within a financial framework that gives priority to the quality of service provision;

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

c) using our Standing Orders, Scheme of Reservation and Delegation and Prime Financial Policies as the policy framework through which this duty will be delivered;
d) documenting accounting and budgetary control processes that enable all officers and employees of the group to comply with this policy framework;
e) requiring our performance in delivery of this duty to be monitored by the Audit and Governance Committee.

5.3.2. *Ensure its use of resources (both its capital resource use and revenue resource use) does not exceed the amount specified by NHS England for the financial year*[37] by

a) delegating responsibility for delivering this duty to the Chief Finance Officer;
b) establishing a Finance and Performance Committee to support the Chief Finance Officer in meeting that responsibility;
c) using our Standing Orders, Scheme of Reservation and Delegation and Prime Financial Policies as the policy framework through which this duty will be delivered;
d) documenting accounting, resource control and budgetary control processes that enable all officers and employees of the group to comply with this policy framework;
e) requiring our performance in delivery of this duty to be monitored by the Audit and Governance Committee.

5.3.3. *Take account of any directions issued by NHS England , in respect of specified types of resource use in a financial year, to ensure the group does not exceed an amount specified by NHS England* [38] by

a) delegating responsibility for delivering this duty to the Chief Finance Officer;
b) establishing a Finance and Performance Committee to support the Chief Finance Officer in meeting that responsibility;
c) using our Standing Orders, Scheme of Reservation and Delegation and Prime Financial Policies as the policy framework through which this duty will be delivered;
d) documenting accounting, resource control and budgetary control processes that enable all officers and employees of the group to comply with this policy framework;
e) requiring our performance in delivery of this duty to be monitored by the Audit and Governance Committee.

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

a) delegating responsibility for delivering this duty to the Chief Finance Officer, who will be required to ensure that it is achievable by virtue of meeting the duties at 5.3.1 to 5.3.3 above

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

b) requiring the Chief Finance Officer to prepare an annual report to the governing body on how the group has spent any funds received from NHS England in respect of quality.

5.4. Other Relevant Regulations, Directions and Documents

5.4.1. The group will

a) comply with all relevant regulations;

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

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

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

6. DECISION MAKING: THE GOVERNING STRUCTURE

6.1. Authority to act

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

a) any of its members;

b) its governing body;

c) employees;

d) a committee or sub-committee of the group.

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

a) the group's Scheme of Reservation and Delegation; and

b) for committees, their Terms of Reference.

6.2. Scheme of Reservation and Delegation[40]

6.2.1. The group's Scheme of Reservation and Delegation sets out:

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

[40] See Appendix F

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

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

6.3. General

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

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

b) operate in accordance with the group's Scheme of Reservation and Delegation,[42]

c) comply with the group's Standing Orders,[43]

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

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

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

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

a) identify the roles and responsibilities of those clinical commissioning groups who are working together and the responsibilities delegated by each group to the individuals representing them;

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;

41 See section 4.4 on Principles of Good Governance above
42 See Appendix F
43 See Appendix E
44 See chapter 5 above

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 and/or governing body

6.4.1. The group has not established any committees. The following committees have been established by the governing body:-

- The Audit and Governance Committee;
- Remuneration Committee;
- Quality and Safety Committee;
- Finance and Performance Committee; and
- Commissioning Committee
- Primary Care Commissioning Committee

6.4.2 Committees will only be able to establish their own sub-committees, to assist them in discharging their respective responsibilities, if this responsibility has been delegated to them by the group or governing body to which the committee is accountable and the group or governing body has approved the sub-committee's Terms of Reference.

6.5. Joint commissioning arrangements with other Clinical Commissioning Groups

6.5.1. The Group may wish to work together with other CCGs in the exercise of its commissioning functions.

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

a) delegating any of the Group's commissioning functions to another CCG;
b) exercising any of the commissioning functions of another CCG; or
c) exercising jointly the commissioning functions of the Group and another CCG

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

a) make payments to another CCG;
b) receive payments from another CCG;
c) make the services of its employees or any other resources available to another CCG; or
d) receive the services of the employees or the resources available to another CCG.

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

6.5.5. For the purposes of the arrangements described at paragraph 6.5.2 above, the Group may establish and maintain a pooled fund made up of contributions by any of the CCGs working together pursuant to paragraph 6.5.3 above. Any such

pooled fund may be used to make payments towards expenditure incurred in the discharge of any of the commissioning functions in respect of which the arrangements are made.

6.5.6. Where the Group makes arrangements with another CCG as described at paragraph 6.5.2 above, the Group shall develop and agree with that CCG an agreement setting out the arrangements for joint working, including details of:

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

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

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

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

6.5.10. The governing body of the Group 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.

6.5.11. Should a joint commissioning arrangement prove to be unsatisfactory the governing body of the Group 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. Joint commissioning arrangements with NHS England for the exercise of CCG functions

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

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

6.6.3. The arrangements referred to in paragraph 6.62 above may include other CCGs.

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

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

6.6.6. Where the Group makes arrangements with NHS England (and another CCG if relevant) as described at paragraph 6.6.2 above, the Group shall develop and agree with NHS England a framework setting out the arrangements for joint working, including details of:

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

6.6.7. The liability of the Group to carry out its functions will not be affected where the Group enters into arrangements pursuant to paragraph 6.6.2 above.

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

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

6.6.10. The governing body of the Group shall require, in all joint commissioning arrangements that the Director of Strategy and Transformation 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.

6.6.11. Should a joint commissioning arrangement prove to be unsatisfactory the governing body of the Group 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. Joint commissioning arrangements with NHS England for the exercise of NHS England's functions

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

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

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

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

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

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

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

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

6.7.7. The liability of NHS England to carry out its functions will not be affected where it and the Group enter into arrangements pursuant to paragraph 6.7.2 above.

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

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

6.7.10. The governing body of the Group shall require, in all joint commissioning arrangements that the Director of Strategy and Transformation 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.

6.7.11. Should a joint commissioning arrangement prove to be unsatisfactory the governing body of the Group 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.

6.8. Joint Arrangements with the Local Authority

6.8.1. The group may form collaborative arrangements with Wolverhampton City Council in order to manage pooled budgets and make delegated decisions under Section 75 of the 2006 Act.

6.9. The Governing Body

6.9.1. *Functions* - the governing body has the following functions conferred on it by sections 14L(2) and (3) of the 2006 Act, inserted by section 25 the 2012 Act, together with any other functions connected with its main functions as may be specified in regulations or in this constitution.[45] The governing body may also have functions of the clinical commissioning group delegated to it by the group. Where the group has conferred additional functions on the governing body connected with its main functions, or has delegated any of the group's functions to its governing body, these are set out from paragraph 6.9.1(d) below. The governing body has responsibility for:

a) ensuring that the group has appropriate arrangements in place to exercise its functions *effectively, efficiently and economically* (see 5.2.3 above) and in accordance with the group's *principles of good governance*[46] (its main function);

b) approving any functions of the group that are specified in regulations;[47]

c) leading the setting of vision and strategy, approving budgets and commissioning plans (Prime Financial Policy 7), monitoring performance against budgets, plans and contracts (PFP 14), providing assurance with regard to strategic risk management (PFP 15.3);

d) delivering the group's duty with regard to commissioning health services consistently with the duty of the Secretary of State and NHS England to promote a comprehensive health service and the objectives and requirements placed on NHS England through the Secretary of State's mandate (see 5.1.2(a) above);

e) approving the group's detailed scheme of delegation, operating structure, annual report and accounts, any grants and loans to voluntary organisations (PFP 12.1(e)(i));

f) agreeing changes to the terms of reference of its committees, other than with regard to membership, prior to their inclusion in an application to NHS England;

g) deciding to ratify any reported non-compliance with Standing Orders or upon the course of action required as a result of it (Standing Order 5).

6.9.2. *Composition of the Governing Body* - the governing body will comprise the following 16 members:

a) the chair, who will be an elected GP, appointed to a three year term (subject to re-election) by the members of the Governing Body

45 See section 14L(3)(c) of the 2006 Act, as inserted by section 25 of the 2012 Act
46 See section 4.4 on Principles of Good Governance above
47 See section 14L(5) of the 2006 Act, inserted by section 25 of the 2012 Act

b) other elected GPs, who shall be their practices representatives, such that the total number of members in 6.9.2 (a) and (b) is 8. 3 GPs will be elected by the localities (one from each locality) as the locality chairs responsible for formally representing their locality's views to the Governing Body. The remaining four GPs will be responsible for the clinical leadership of core areas including commissioning, quality and safety and finance and performance;

c) two lay members as defined by regulations, one of whom will chair the Remuneration Committee:

i) one with qualifications, expertise or experience enabling them to express informed views about financial management, conflicts of interests and audit matters, who will chair the Audit and Governance Committee;

ii) one who has knowledge about the City of Wolverhampton enabling them to express informed views about the discharge of the Group's functions, who will be deputy chair, ~~and~~ the governing body lead for Equality and Diversity and Chair the Primary Care Commissioning Committee;

d) A lay member with knowledge of Finance and Performance matters who will chair the Finance and Performance Committee and act as deputy chair of the Primary Care Commissioning Committee.

~~d)~~e) one registered nurse who will be employed as the group's Executive Nurse;

~~e)~~f) one secondary care specialist doctor;

~~f)~~g) the Accountable Officer who will be employed as the group's Chief Officer and will act as the group's Caldicott Guardian;

~~g)~~h) the Chief Finance Officer, an individual with a recognised accountancy qualification who will be employed by the group and will act as the group's Senior Information Risk Owner;

~~h)~~i) the group's Director for Strategy and Transformation;

~~i)~~j) one practice manager representative.

The group's Standing Orders define how the group will, in accordance with any relevant regulations, appoint the various categories of members of the governing body, their tenure of office, how a person would resign from their post and the grounds for their removal from office. They also specify those persons who will be invited to attend meetings of the governing body as well as the arrangements for admission of the public and press.

6.9.3 **The Locality Boards**

Functions - the Locality Boards covering North East, South East and South West Wolverhampton are to be established as advisory Boards only and regulated by their terms of reference which shall initially have the following functions, (which

may alter from time to time as reflected in their terms of reference to be determined by the governing body). The Locality Board(s) may also have functions of the group delegated to it by the governing body. The Locality Boards have responsibility for:

a) ensuring that the localities have appropriate arrangements in place to exercise their functions *effectively, efficiently and economically* (see 5.2.3 above) and in accordance with the group's *principles of good governance*[48];

b) helping the governing body in leading the setting of vision and strategy and commissioning plans (Prime Financial Policy 7), monitoring performance against budgets, plans and contracts (PFP 14) and providing assurance with regard to strategic risk management (PFP 15.3);

c) helping the governing body in delivering the group's duty with regard to commissioning health services consistently with the duty of the Secretary of State and NHS England to promote a comprehensive health service and the objectives and requirements placed on NHS England through the Secretary of State's mandate (see 5.1.2(a) above);

d) representing the views of local people and practices in order to develop locally sensitive services, thereby creating local ownership of the Group's vision and values;

e) promoting a sense of locality and care closer to home in a patient-centred way

f) helping to promote high quality primary care via quality monitoring and peer support in a facilitative way via mentoring, buddying and practical support.

6.9.4 *Composition of the Locality Boards* – when established the locality boards will be comprised of the nominated representatives from each practice and the group's support staff

a) the chair, will be a democratically elected by the locality to a three year term by the GP members across the locality
b) the Chair will be supported by the group's management staff, namely,
    - the finance lead;
    - data and informatics lead;
    - quality lead; and
    - other staff as necessary;
c) practice representatives either GP or other healthcare professional.

6.9.5 *Committees of the Governing Body* - the governing body has appointed the following committees:

(a) the *Audit and Governance Committee*, which is accountable to the governing body and provides it with an independent and objective view of the group's financial systems, financial information and compliance with laws,

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

regulations and directions governing the group, so far as they relate to finance and governance. The governing body has approved and annually reviews the terms of reference for the committee, which include information on its membership[49]. In addition the group or the governing body has conferred upon or delegated the following functions, connected with the governing body's main function[50], to the Audit and Governance Committee:

i) reviewing the group's adherence to the generally accepted principles of good governance (4.4.1 above);
ii) monitoring the group's performance in delivering the duty to act effectively, efficiently and economically (5.2.3 above);
iii) monitoring the group's performance in the delivery of the duties described at 5.1.2(a), 5.2.9 and the general financial duties at 5.3.1 – 5.3.3;
iv) reviewing the reasonableness of any decision to suspend Standing Orders (SO 3.9), considering reports on non-compliance with Prime Financial Policies (PFP 1.2.1) and scrutinising any proposed changes thereto (PFP 1.5.1);
v) reviewing the group's arrangements to manage all risks and receive appropriate assurance thereon through an integrated governance framework[51];
vi) satisfying itself that there is an effective internal audit service (PFP 3) and adequate arrangements for countering fraud (PFP 4), reviewing the work and findings of the external auditors, approving any changes to the provision or delivery of assurance services (PFP 3.4 (b));
vii) reviewing the annual report and financial statements before submission to the governing body and group.

(b) the *Remuneration Committee*, which is accountable to the governing body and makes binding and final 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 committee, which include information on its membership[52]. In addition, the group or the governing body has conferred or delegated the following functions, connected with the governing body's main function, to the Remuneration Committee:

i) determining the remuneration, fees and other allowances payable to group and governing body members, employees or other persons providing services to the group, including the remuneration and conditions of service of the senior team and the allowances payable under any pension scheme it may establish under paragraph 11(4) of Schedule 1A of the 2006 Act, inserted by Schedule 2 of the 2012 Act;

49 See Appendix H1 Terms of Reference of the Audit and Governance Committee
50 See section 14L(2) of the 2006 Act, inserted by section 25 of the 2012 Act
51 NHS Audit Committee Handbook, Department of Health / Healthcare Financial Management Association, 2011
52 See Appendix H2 Terms of Reference of the Remuneration Committee

ii) determining the performance, remuneration and terms and conditions of the Accountable Officer and other senior team members and determining annual salary awards, if appropriate.
iii) considering any severance payments of the Accountable Officer and other senior staff, seeking HM Treasury approval as appropriate in accordance with the guidance 'Managing Public Money' (available on the HM Treasury.gov.uk website);
iv) approving human resources policies (9.4 below);and ,
v) approving the group's terms and conditions and remuneration of employees and those providing services to the group.

(c) the *Quality and Safety Committee,* which is accountable to the governing body and provides it with assurance on the quality of services commissioned and monitors on its behalf the group's performance in the delivery of the duties described at 5.1.2(b), 5.2.1, 5.2.2, 5.2.4, 5.2.5, 5.2.7 and 5.2.8. The governing body has approved and keeps under review the terms of reference for the committee, which include information on its membership[53]. In addition the group or the governing body has conferred or delegated the following functions, connected with the governing body's main function, to the Quality and Safety Committee:

i) receiving reports from the group's representative on the Wolverhampton Health and Wellbeing Board (see 5.1.2 (c)(ii) above);
ii) approving policies for risk management including assurance (Prime Financial Policy 15.2), information governance (PFP 19.2), business continuity, emergency planning , security and complaints handling;
iii) endorsing action plans to address high scoring risks in the group's risk register (PFP 15.4).

d) the *Finance and Performance Committee,* which is accountable to the governing body and provides it with assurance on issues related to the finances and performance of the group and monitors on its behalf the group's performance in the delivery of the duties described at 5.2.3 and 5.2.6. The governing body has approved and keeps under review the Terms of Reference for the committee, which include information on its membership[54]. In addition the group or the governing body has conferred or delegated the following functions, connected with the governing body's main function, to the Finance and Performance Committee:

i) supporting the Chief Finance Officer in the delivery of the general financial duties (5.3.1 -5.3.3 above);
ii) receiving reports from the group's representative on the Wolverhampton Health and Wellbeing Board (see 5.1.2 (c)(ii) above);
iii) reviewing proposed changes to Prime Financial Policies (PFP 1.5.1) and approving detailed financial policies (PFP 1.1.3);
iv) considering reports from the Chief Finance Officer and other managers regarding significant variances from budgeted performance (PFP7.3) and planned performance targets respectively;

[53] See Appendix H3 Terms of Reference of the Quality and Safety Committee
[54] See Appendix H4 Terms of Reference of the Finance and Performance Committee

v) agreeing the timetable for producing the annual accounts and report (PFP8.1(a));
vi) approving the group's overall banking arrangements (PFP 11.2);
vii) receiving reports detailing actual and forecast expenditure and activity for all healthcare contracts (PFP 14.3).

e) the *Commissioning Committee*, which is accountable to the governing body and will support it, the Director of Strategy and Transformation and the Executive Nurse in meeting the responsibilities of the group as a commissioner of healthcare, specifically delivery of the duties described at 5.1.2(a) and 5.2.4. The governing body has approved and keeps under review the Terms of Reference for the committee, which include information on its membership[55]. In addition the group or the governing body has conferred or delegated the following functions, connected with the governing body's main function, to the Commissioning Committee:

i) developing appropriate policies, strategies and plans;
ii) co-ordinating the work of the group with other parties in order to develop robust commissioning plans (PFP 14.1).

~~ii)~~f) the *Primary Care Commissioning Committee*, which is accountable to the governing body for the exercise of the functions delegated to the group by NHS England relating to the commissioning of primary medical services under Section 86 of the NHS Act 2006.

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7. ROLES AND RESPONSIBILITIES

7.1. Practice Representatives

7.1.1. Practice representatives will be GPs or other healthcare professionals who represent their practice's views and act on behalf of the practice in matters relating to their specific locality and the group as a whole. The role of each practice representative is to assist the group in securing the effective participation of each member of the group in exercising the group's functions by:

a) providing effective liaison between the practice and the rest of the locality and group;
b) promoting the work of the locality and group within the practice and to its patients as far as possible;
c) actively seeking the views of the practice and its patients and providing feedback to the rest of the locality and group;
d) arranging for the implementation of agreed locality and group directives within the practice or informing the rest of the locality and group as soon as possible of any obstacles to doing so;
e) attending meetings of the locality and group so that the practice is represented and its voice heard, or ensuring that a deputy does so.

Details as to how practice representatives will be selected are included in the group's Standing Orders, which also specify the officer of the group that practices must inform as to who their representative is.

[55] See Appendix H5 Terms of Reference of the Commissioning Committee

7.2. Other GPs and Primary Care Health Professionals

7.2.1. In addition to the practice representatives identified in section 7.1 above, the group has identified a number of other GPs/primary care health professionals from member practices to 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, reporting in each case to the member of the governing body with responsibility for the particular work area:

a) developing proposals for changes to care pathways;
b) developing proposals for other significant changes to the group's commissioning portfolio;
c) monitoring a provider's delivery against its contract with the group in terms of activity or quality;
d) liaising with practices and consulting with patients/carers in support of these activities;
e) education and research in support of these activities.

7.3. All Members of the Group's Governing Body

7.3.1. Guidance on the roles of members of the group's governing body is set out in a separate document[56]. In summary, each member of the governing body should share responsibility as part of a team to ensure that the group exercises its functions effectively, efficiently and economically, with good governance and in accordance with the terms of this constitution. Each brings their unique perspective, informed by their expertise and experience.

7.3.2. All members will be able to demonstrate the leadership skills necessary to fulfil the responsibilities of these key roles and establish credibility with all stakeholders and partners. Especially important is that the governing body remains in tune with the group's member practices and secures their confidence and engagement.

7.4. The Chair of the Governing Body

7.4.1. The Chair of the governing body is responsible for:

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

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

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

[56] *Clinical commissioning group Governing Body Members – Role outlines, Attributes and Skills,* NHS Commissioning Board , October 2012

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

e) supporting the accountable officer in discharging the responsibilities of the organisation;

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

g) leading and influencing to achieve clinical and organisational change to enable the group to deliver its commissioning responsibilities;

h) overseeing governance and particularly ensuring that the governing body and the wider group behaves with the utmost transparency and responsiveness at all times;

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

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

k) ensuring that the group builds and maintains effective relationships, particularly with the individuals involved in overview and scrutiny from Wolverhampton City Council.

7.5. The Deputy Chair of the Governing Body

7.5.1. The Deputy Chair of the governing body deputises for the Chair of the governing body where he or she has a conflict of interest or is otherwise unable to act.

7.5.2. Details of how they will be appointed, their tenure of office and resignation or removal are included in the group's Standing Orders.

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. This role of Accountable Officer has been summarised in a national document[57] and this is reflected in (a) to (c) below:

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;

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

b) at all times ensuring that the regularity and propriety of expenditure is discharged and that arrangements are put in place to ensure that good practice (as identified though the relevant agencies and, in particular, the auditors of the group) is embodied and that safeguarding of funds is ensured through effective financial and management systems;

c) working closely with the Chair of the governing body, the Accountable Officer will ensure that proper constitutional, governance and development arrangements are put in place to assure the members (through the governing body) of the organisation's ongoing capability and capacity to meet its duties and responsibilities. This will include arrangements for the ongoing developments of its members and staff.

d) the group has specifically delegated responsibility to the Accountable Officer for the delivery of its duties as described at 5.1.2(b), 5.2.1, 5.2.2, 5.2.5, 5.2.6 and 5.2.8 and for the role of Caldicott Guardian.

7.7. Role of the Chief Finance Officer

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

7.7.2. This role of the Chief Finance Officer has been summarised in a national document[58] and this is reflected in (a) to (e) below:

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, monitor and report on the group's finances;

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

d) being able to advise the governing body on the effective, efficient and economic use of the group's allocation to remain within that allocation and 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;

f) the group has accordingly delegated responsibility to the Chief Finance Officer for the delivery of its financial duties described at 5.3 above and as the Senior Information Risk Owner.

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

7.8. Joint Appointments with other Organisations

7.8.1. The group has not yet made any joint appointments with other organisations.

7.9. Responsibilities of member practices to the group and of the group to its member practices

7.9.1. The group is a membership organisation and the effective participation of each and every member practice will be essential in developing and sustaining cost effective commissioning arrangements that ensure high quality services for all relevant patients and service users.

7.9.2. Each member practice will:

a) appoint a practice representative in line with 7.1 above and Standing Order 2.2.5;

b) undertake regular, at least quarterly, practice meetings to monitor performance against the commissioning indicators as set out in the group's commissioning performance reports;

c) meet with the relevant locality chair and/or GP engagement lead and agree plans to support delivery of the group's commissioning strategies;

d) support the relevant locality board and group's commissioning intentions and strategies by using, as appropriate and in accordance with patient choice, services and pathways as commissioned by the group;

e) access relevant commissioning information including that relating to pathways and referral guidelines via agreed group systems;

f) take all reasonable efforts to ensure that it remains within its commissioning budget;

g) support the relevant, locality board and the group in meeting its quality and productivity targets as set out within the group's commissioning strategies;

h) take account of all duties, rights, pledges and values set out in this constitution;

i) respond in a timely manner to reasonable information requests from the group.

7.9.3. The group will ensure that:

a) all member practices receive at least one visit each year from representatives of the group to discuss practice level commissioning issues and priorities;

b) an annual survey of practices, designed and administered in conjunction with the Local Medical Committee (LMC), is undertaken to obtain feedback

on levels of satisfaction regarding practice involvement in the commissioning process;

c) member practices are kept informed of group business via their practice representatives and relevant locality board chair, the intranet site, specific events and other appropriate means;

d) the governing body provides information management tools, training and support to enable member practices to review information at patient level and support them in meeting their financial and quality targets.

7.10. Dispute Resolution Processes

7.10.1. This process will be used promptly, in a supportive and constructive manner, in the event of any dispute or disagreement being raised by:

a) member practices, regarding the governing body or general workings of the group;
b) the governing body and/or the rest of the group in relation to the behaviour of any member practice.

7.10.2. Member practices should, in the normal course of events, be able to raise any contentious issue with their relevant locality board chair or deputy chair, or if this is not possible, with another member of the governing body. In circumstances where this informal contact does not resolve the issue satisfactorily, the following process will be followed:

a) the practice will set out the issue in writing and submit this to the Accountable Officer;

b) the Accountable Officer will acknowledge receipt within ten working days unless the issue appears extremely urgent, in which case, the matter will be progressed with the utmost urgency;

c) the Chair and/or Accountable Officer will contact the practice to discuss the matter, involving those with relevant lead responsibilities within the group as appropriate, and agree in writing appropriate actions for resolution with a time-scale for actions by all involved parties;

d) if this fails to resolve the issue, the matter will be referred to a lay member of the governing body, who will be responsible for leading consideration of the matter in private session at a governing body meeting to which the practice will be able to make direct representation of its position and at which appropriate actions for resolution will be minuted;

e) if the matter still cannot be resolved, it will be referred by the member practice and/or the governing body to NHS England for a binding arbitration;

f) a member practice can involve the LMC or other external support, except legal representation, at any stage of this process.

7.10.3. In the normal course of events, any issues regarding a member practice's non-compliance with its responsibilities as a member of the group will be raised via routine reporting arrangements and discussion with the relevant locality board chair. When such issues cannot be resolved via this normal day to day contact, the following process will be followed:

a) on behalf of the governing body, the Chair of the governing body or Accountable Officer will set out the issue in writing and send this to the member practice;

b) the practice will acknowledge receipt within ten working days unless the issue appears extremely urgent, in which case, the matter will be progressed with the utmost urgency

c) the practice will be asked to meet with the Chair of the governing body and/or Accountable Officer to discuss the issue, involving those with relevant lead responsibilities within the group as appropriate, and put in writing appropriate actions against an agreed timescale;

d) the group will ensure that the member practice is provided with the appropriate information and assistance to support it in delivering the agreed plan;

e) if this approach fails to resolve the issue or the practice fails to deliver the actions agreed to address the non-compliance to the satisfaction of the governing body (meeting in private), the issue will be escalated to NHS England whose decision on the matter will be final;

f) a member practice can involve the LMC or other external support, except legal representation, at any stage of this process.

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 C.

8.1.2. They must comply with the group's policy on business conduct, including the requirements set out in the policy for meeting the group's duties with regard to registering interests and managing conflicts of interest.[59] This policy will be

[59] In accordance with Section 14O of the 2006 Act, inserted by Section 25 of the 2012 Act

available on the group's website at www.wolverhamptonccg.nhs.uk, available for inspection at the group's offices, and either by post or email on request.

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

8.1.4. Due consideration will be given to the available guidelines, protocols and the manner in which conflicts of interest are managed by statutory bodies, recognised national institutions such as the General Medical Council, General Practitioners Committee of the British Medical Association and, the Royal College of General Practitioners , and if appropriate, the group's policy amended from time-to-time to reflect these.

8.2. Conflicts of Interest

8.2.1. As required by section 14O of the 2006 Act, as inserted by section 25 of the 2012 Act, the group has made arrangements to manage actual and potential conflicts of interest to ensure that decisions made by the group will be taken and be seen to be taken without any possibility of the influence of external or private interest; the group maintains a register recording these

8.2.2. Where an individual, i.e. an employee, group member, member of the governing body, or a member of a committee or a sub-committee of the group or its governing body has an interest, or becomes aware of an interest, which could lead to a conflict of interest 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 include:

a) ~~**a direct pecuniary interest**~~**Financial Interests**: where an individual or somebody with whom they have a close association may financially benefit from the consequences of a commissioning decision (for example, as a provider of services);

b) ~~**an indirect pecuniary interest**: for example, where an individual is a partner, member or shareholder in an organisation that will benefit financially from the consequences of a commissioning decision~~**Non- Financial Professional Interests –** where an individual or somebody with whom they have a close association may obtain a non-financial professional benefit from the consequences of a group decision, such as increasing their professional reputation or status or promoting their professional career;

c) **Non-Financial Personal Interests** – where an individual or somebody with whom they have a close association may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit (for example, a reconfiguration of hospital services which might result in the closure of a busy clinic next door to an individual's house);~~a non-pecuniary interest: where an individual holds a non-~~

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

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

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

8.2.4. If in doubt, the individual concerned should assume that a potential conflict of interest exists and notify the ~~Chair of the Audit and Governance Committee~~CCG's Governance Lead or Conflicts of Interest Guardian (The Chair of the Audit and Governance Committee) ~~-~~accordingly.

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 its governing body;

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

d) its employees.

8.3.2. The registers are to be published on the group's website at www.wolverhamptonccg.nhs.uk. Upon request, these will also be available at the group's Head Office or, on application by post or email.

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

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

8.3.5. The ~~lay member who is chair of the Audit and Governance Committee~~Conflict of Interest Guardian will ensure that the registers of interest are reviewed quarterly, and updated as necessary.

8.3.6. Prior to any appointment being made to the Governing Body, individuals will make a declaration of their interests in order to assess whether any identified

conflicts would prevent the individual concerned making a full and proper contribution to the governing body. If such significant conflicts do exist, the individual concerned will be excluded from the appointment process.

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 and employees will comply with the arrangements determined by the group for managing actual or potential conflicts of interest.

8.4.2. The ~~lay member identified at 8.3.5~~Conflict of Interest Guardian will ensure that for every interest declared, either in writing or by oral declaration, arrangements are in place to manage the conflict of interests or potential conflict of interests, to ensure the integrity of the group's decision making processes.

8.4.3. Arrangements for the management of conflicts of interest are to be determined by the lay member identified at 8.3.5 and will include the requirement to put in writing to the relevant individual arrangements for managing the actual or potential conflict within a week of declaration. The arrangements will confirm the following:

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

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

8.4.4. Where an interest has been declared, either in writing or by oral declaration, the declarer will ensure that before participating in any activity connected with the group's exercise of its commissioning functions, they have received confirmation of the arrangements to manage the conflict of interest or potential conflict of interest from the ~~lay member identified at 8.3.5~~Conflict of Interest Guardian.

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

a) has not been declared, either in the register or orally, they will declare this at the start of the meeting;

b) has previously been declared, in relation to the scheduled or likely business of the meeting, the individual concerned will bring this to the attention of the chair of the meeting, together with details of arrangements which have been confirmed for the management of the actual or potential conflict of interest(s);

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

which must be recorded in the minutes of the meeting. The Chair's determination in relation to action to be taken in relation to a conflict arising, shall be final.

8.4.6. Where the chair of any meeting of the group, including committees, sub-committees, or the governing body and the governing body's committees and sub-committees, has a personal interest, previously declared or otherwise, in relation to the scheduled or likely business of the meeting, they must make a declaration and the deputy chair will act as chair for the relevant part of the meeting. Where arrangements have been confirmed for the management of the actual or potential conflict of interest in relation to the chair, the meeting must ensure these are followed. Where no arrangements have been confirmed, the deputy chair may require the chair to withdraw from the meeting or part of it. Where there is no deputy chair, the members of the meeting will select one.

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

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

8.4.9. In making this decision the chair will consider whether the meeting is quorate, in accordance with the number and balance of membership set out in the group's Standing Orders. Where the meeting is not quorate, owing to the absence of certain members, the discussion will be deferred until such time as a quorum can be convened. Where a quorum could never be convened from the membership of the meeting, owing to the arrangements for managing actual or potential conflicts of interest, the chair of the meeting will consult with the lay member identified at 8.3.5 on the action to be taken.

8.4.10. This action might include:

a) referring the matter to the group's governing body, its committees or sub-committees , which can be quorate to progress the item of business even if all the elected members and/or other members have to be excluded from voting (Standing Order 3.6.2);

b) inviting, on a temporary basis, one or more of the following to make up the quorum, i.e. those who do not have a conflict of interest, to attend the relevant part of the governing body's meeting to provide additional scrutiny to the matter and advice to those members of the governing body who can vote on it:

i) a practice representative; and/or
ii) an individual appointed by a member to act on his/her behalf in the dealing between it and the group
iii) a member of a relevant Health and Wellbeing Board;

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

These arrangements must be recorded in the relevant minutes.

8.4.11. In any transaction undertaken in support of the clinical commissioning group's exercise of its commissioning functions (including conversations between two or more individuals, e-mails, correspondence and other communications), individuals must ensure, where they are aware of an interest, that they conform to the arrangements confirmed for the management of that interest. Where an individual has not had confirmation of arrangements for managing the interest, they must declare their interest at the earliest possible opportunity in the course of that transaction, and declare that interest as soon as possible thereafter. The individual must also inform either their line manager (in the case of employees), or the lay member identified at 8.3.5 of the transaction.

8.4.12. The ~~lay member identified at 8.3.5~~Conflict of Interest Guardian will take such steps as deemed appropriate, and request information deemed appropriate from individuals, to ensure that all actual and potential conflicts of interest are declared and recorded.

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

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

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

8.6. Transparency in Procuring Services

8.6.1. The group recognises the importance in making decisions about the services it procures in a way that does not call into question the motives behind the procurement decision that has been made. The group will procure services in a manner that is open, transparent, non-discriminatory and fair to all potential providers, using special designated procedures when GPs or their practices are potential providers or have an interest therein.

8.6.2. The group will publish a Procurement Strategy approved by its governing body which will ensure that:

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

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

8.6.3. Copies of this Procurement Strategy will be available on the group's website at www.wolverhamptonccg.nhs.uk, available for inspection at the group's offices, and either by post or email, on request.

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, approved by the Remuneration Committee, 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 will adopt a Code of Conduct for staff and will maintain and promote effective 'whistleblowing' procedures to ensure that concerned employees 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 group press release, 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, will be available on the group's website at www.wolverhamptonccg.nhs.uk, available for inspection at the group's offices, and either by post or email, on request.

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. This will be available on the group's website at www.wolverhamptonccg.nhs.uk, available for inspection at the group's offices, and either by post or email, on request

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 at www.wolverhamptonccg.nhs.uk.

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

10.2. Standing Orders etc

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

a) *Standing Orders* (Appendix E)**,** which set out the arrangements for meetings and the appointment processes to elect the group's representatives and appoint to the group's committees, governing body and its committees;

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

c) *Prime financial policies* (Appendix G), which set out the arrangements for managing the group's financial affairs.

APPENDIX A
DEFINITIONS OF KEY DESCRIPTIONS USED IN THIS CONSTITUTION

2006 Act	National Health Service Act 2006
2012 Act	Health and Social Care Act 2012 (this Act amends the 2006 Act)
Accountable Officer	an individual, as defined under paragraph 12 of Schedule 1A of the 2006 Act (as inserted by Schedule 2 of the 2012 Act), appointed by the NHS Commissioning Board, with responsibility for ensuring the group complies with its obligations under: • sections 14Q and 14R of the 2006 Act (as inserted by section 26 of the 2012 Act), • sections 223H to 223J of the 2006 Act (as inserted by section 27 of the 2012 Act), • paragraphs 17 to 19 of Schedule 1A of the NHS Act 2006 (as inserted by Schedule 2 of the 2012 Act), and • any other provision of the 2006 Act (as amended by the 2012 Act) specified in a document published by the Board for that purpose; and exercises its functions in a way which provides good value for money.
Area	the geographical area that the group has responsibility for, as defined in Chapter 2 of this constitution
Chair of the governing body	the individual appointed by the group to act as chair of the governing body
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 the NHS Commissioning Board in accordance with Chapter A2 of Part 2 of the 2006 Act (as inserted by section 10 of the 2012 Act)
Committee	a committee or sub-committee created and appointed by: • the membership of the group • a committee/sub-committee created/appointed by a committee created/appointed by the membership of the group • the governing body or one of its committees
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 Wolverhampton Clinical Commissioning Group, whose constitution this is
Governing body	the body appointed under section 14L of the NHS Act 2006 (as inserted by section 25 of the 2012 Act), with the main function of ensuring that a clinical commissioning group has made appropriate arrangements for ensuring that it complies with: • its obligations under section 14Q under the NHS Act 2006 (as inserted by section 26 of the 2012 Act), and • such generally accepted principles of good governance as are relevant to it.
Governing body member	any member elected or appointed to the governing body of the group

Healthcare professional	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
Lay member	a lay member of the governing body, appointed by the group. A lay member is an individual who is not a member of the group or a healthcare professional or as otherwise defined in regulations
Locality Board Chairs	the individuals to be appointed by the locality boards to act as chairs of their respective localities
Member	a provider of primary medical services to a registered patient list, who is a member of this group (see tables in Chapter 3 and Appendix B)
Practice representatives	an individual appointed by a practice (who is a member of the group) to act on its behalf in the dealings between it and the group, under regulations made under section 89 or 94 of the 2006 Act (as amended by section 28 of the 2012 Act) or directions under section 98A of the 2006 Act (as inserted by section 49 of the 2012 Act)
Registers of interests	registers a group is required to maintain and make publicly available under section 14O of the 2006 Act of the interests of: • the members of the group; • the members of its governing body; • the members of its committees or sub-committees and committees or sub-committees of its governing body; and • its employees.
Regulations	Any regulations issued by the Secretary of State under the 2006 Act,2012 Act or any other relevant legislation that determine the duties, powers or conduct of a clinical commissioning group

APPENDIX B - LIST OF MEMBER PRACTICES

Practice Name	Address
Dr S Agrawal Tudor Medical Practice	1 Tudor Road , Heath Town Wolverhampton, WV10 0LT
Dr S Asghar Caerleon Surgery	Dover Street Bilston Wolverhampton WV14 6AL
Dr D Bagary Low Hill Medical Centre	191 First Avenue, Low Hill Wolverhampton, WV10 9SX
Dr R Bilas & A Thomas	75 Griffiths Drive, Ashmore Park, Wednesfield, WV11 2JN
Dr D Bush Penn Surgery	2a Coalway Road, Penn Wolverhampton, WV3 7LR
Dr U Chelliah Showell Park	Fifth Avenue Wolverhampton WV10 9ST
~~Dr A Christopher~~ ~~Heath Town Medical Centre~~	~~Chervil Rise, Heath Town~~ ~~Wolverhampton, WV10 0HP~~
Dr S Cowen & Partners The Surgery	119 Coalway Road, Penn Wolverhampton, WV3 7NA
Dr D DeRosa & Dr A Williams Warstones Health Centre	Pinfold Grove, Warstones Wolverhampton, WV4 4PS
Dr G Dhillon Ashfield Surgery	39 Ashfield Road, Fordhouses Wolverhampton, WV10 6QX
Dr J Fowler	470 Stafford Road Wolverhampton, WV10 6AR
Dr George & Partner Ashmore Park Health Centre	Griffiths Drive, Ashmore Park Wednesfield, WV11 2LH
Dr Hibbs & Partners Ettingshall Medical Centre	Herbert Street, Ettingshall Wolverhampton WV14 0NF
Dr Hibbs & Partners Parkfields Medical Practice	255 Parkfield Road, Parkfields Wolverhampton WV4 6EG
Intrahealth (Dr V Rai) Bilston Urban Village Medical Centre	Bankfield Road, Bilston Wolverhampton WV14 0EE
Intrahealth Pennfields Medical Centre	Upper Zoar Street, Pennfields Wolverhampton WV3 0JH
Dr Jackson & Partners Tettenhall Medical Practice	Lower Street Tettenhall Wolverhampton WV6 9LL
Dr J Kainth All Saints Surgery	17 Cartwright Street, All Saints Wolverhampton WV2 3BT
Dr M Kainth Primrose Lane Health Centre	Primrose Lane, Low Hill Wolverhampton WV10 8RN
Dr S Kanchan	1 Shale Street, Bilston Wolverhampton WV14 0HF
Dr M Kehler Keats Grove Surgery	7 Keats Grove, The Scotlands Wolverhampton WV10 8LY
Dr A Khan Duncan Street Primary Care Centre	Duncan Street, Blakenhall Wolverhampton WV2 3AN
Dr R Kharwadkar	68 Marsh Lane, Fordhouses Wolverhampton, WV10 6RU
Dr K Krishan Mayfields Medical Centre	272 Willenhall Road Wolverhampton, WV1 2GZ
Dr C Lal Bradley Medical Centre	83-84 Hall Green Street, Bradley Wolverhampton, WV14 8TH

Practice Name	Address
Dr H Leung & Partner Lea Road Medical Practice	35 Lea Road, Pennfields Wolverhampton, WV3 0LS
Dr Libberton	60 Cannock Road Wednesfield WV10 8PJ
Dr G Mahay Poplars Medical Practice	Third Avenue, Low Hill Wolverhampton WV10 9PG
Dr S Mittal Probert Road Surgery	Probert Road, Oxley Wolverhampton, WV10 6UF
Dr J Morgans & Partners	81 Prestwood Road West Wednesfield, WV11 1HT
Dr N Mudigonda Bilston Health Centre	Prouds Lane, Bilston Wolverhampton, WV14 6PW
Drs K Ahmed, V Pahwa & V Rai Bilston Health Centre	130a Park Street South, Goldthorn Hill Wolverhampton WV2 3JF
Dr J Parkes Alfred Squire Road Health Centre	Alfred Squire Road Wednesfield W11 1XU
Dr U Passi & Handa Leicester Street Medical Centre	Leicester Street, Whitmore Reans, Wolverhampton WV6 0PS
Dr G Pickavance & Partners The Newbridge Surgery	255 Tettenhall Road Wolverhampton WV6 0DE
Dr S Ravindran & Majid East Park Medical Centre	Jonesfield Crescent, East Park Wolverhampton WV1 2LW
Dr H Richardson & Partners Thornley Street Surgery	40 Thornley Street Wolverhampton WV1 1JP
Dr A Saini & Partner	62-64 Church Street, Bilston Wolverhampton WV14 0AX
Dr A Sharma & Partner Bilston Health Centre	Prouds Lane, Bilston Wolverhampton, WV14 6PW
Dr S Suryani The Surgery	Hill Street, Bradley, Wolverhampton WV148SB
Dr S Taylor & Cam	80 Tettenhall Road, Tettenhall Wolverhampton, WV1 4TF
Dr P Venkataramanan & Partner Grove Medical Centre	175 Steelhouse Lane Wolverhampton WV2 2AU
Dr Vij & Partners Whitmore Reans Health Centre	Lowe Street, Whitmore Reans Wolverhampton WV6 0QL
Dr Wagstaff & Partners Castlecorft Medical Practice,	Castlecroft Avenue Wolverhampton WV3 8JN
Dr White & Partners Penn Manor Medical Centre	Manor Road, Penn Wolverhampton WV4 5PY
Dr Whitehouse	199 Tettenhall Road Wolverhampton WV6 0DD

APPENDIX C - NOLAN PRINCIPLES

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

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

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

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

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

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

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

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

Source: *The First Report of the Committee on Standards in Public Life* (1995)[60]

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

APPENDIX D – NHS CONSTITUTION

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

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

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

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

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

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

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

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

Source: *The NHS Constitution: The NHS belongs to us all* (March 2012)[61]

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

NHS WOLVERHAMPTON
CLINICAL COMMISSIONING GROUP

CONSTITUTION APPENDIX E

STANDING ORDERS

Version: [6]

CONTENTS

1. STATUTORY FRAMEWORK AND STATUS

1.1. Introduction

1.1.1. These Standing Orders have been drawn up to regulate the proceedings of the NHS Wolverhampton Clinical Commissioning Group so that it 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 and are deemed to be part of its constitution, as noted at paragraph 10.2 thereof.

1.1.2. The Standing Orders, together with the group's Scheme of Reservation and Delegation and the group's Prime Financial Policies, provide a procedural framework within which the group discharges its business. They set out:

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

b) the appointment of member practice representatives;

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

d) the process to delegate powers,

e) the protocol for declaration of interests and standards of conduct.

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

1.1.3. Group members, employees, members of the governing body, members of the governing body's committees and sub-committees, members of the group's committees and sub-committees and persons working on behalf of the group should be aware that these three documents are part of the group's constitution and, where necessary, be familiar with their detailed provisions. Failure to comply with them may be regarded as a disciplinary matter that could result in dismissal.

1.2. Schedule of matters reserved to the clinical commissioning group and the Scheme of Reservation and Delegation

1.2.1. The 2006 Act (as amended by the 2012 Act) provides the group with powers to delegate the group's functions and those of the governing body to certain bodies (such as committees) and certain persons. The group has decided that certain decisions may only be exercised by the group in formal session. These decisions and also those delegated are contained in the group's Scheme of Reservation and Delegation.

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

2.1. **Composition of membership**

2.1.1. Part 3 and Appendix B of the group's constitution provide details of the membership of the group.

2.1.2. Part 6 of the group's constitution provides details of the governing structure used in the group's decision-making processes, whilst Part 7 of the constitution outlines certain key roles and responsibilities within the group and its governing body, including the role of practice representatives at paragraph 7.1.

2.2. Key Roles and Appointment Processes

2.2.1. Paragraph 6.9.2 of the group's constitution sets out the composition of the group's governing body whilst Part 7 of the group's constitution identifies certain key roles and responsibilities within the group and its governing body. These Standing Orders set out how the group appoints individuals to these key positions using best practice and with reference to the national guidance on roles, attributes and skills.

2.2.2. The chair of the governing body, see 6.9.2(a) and 7.4 of the constitution, is subject to the following:

a) **Nominations** – before the first meeting of the governing body and as determined by (d) below thereafter, an eligible individual may put themselves forward for election to this position by notifying the Accountable Officer and each of the other elected members at least 48 hours before the relevant meeting;

b) **Eligibility** – any of the elected members unless disqualified by virtue of (e) below;

c) **Appointment process** – election, by elected members only, in a secret ballot of the governing body on the basis of one vote per person with voters who know they will be absent allowed to submit their vote to the meeting in writing;

d) **Term of office** – three years

e) **Eligibility for reappointment** – no individual will serve more than two consecutive terms of office;

f) **Grounds for removal from office** – no longer being a member of the governing body or a failure to perform to the required standard;

g) **Notice period** – three months to be served in writing to the Accountable Officer.

2.2.3. The deputy chair of the governing body, see 7.5 of the constitution, will be the lay member selected for their knowledge of Wolverhampton (constitution 6.9.2 (c) (ii)). The governing body's chair is to be an elected member and if, in addition the chair is a health professional, and Regulations (SI 2012/1631) require that the deputy chair's position to be held by a lay member.

2.2.4. The existing GP members of the governing body seeking re-election and prospective members seeking membership, (see 6.9.2(b) of the constitution), will be subject to the following criteria and process :

a) **Nominations** – any eligible GP can put themselves forward for election to the governing body and this must be done in the format, to the named individual(s) and by the date/time specified in the rules for that election;

b) **Eligibility** – any GP working in any member practice(s) (other than on a locum basis) on the date specified by the rules for the election, unless disqualified by virtue of regulations or (e) below, subject to paragraph 8.3.6 of the constitution;

c) **Appointment process** – election by secret ballot, overseen by the Local Medical Committee, of all eligible GPs, as defined at (b) above, with each GP's vote allocated a weight based on the list size of their practice(s) (0.1 per complete 100 patients) and then allocated pro rata according to the number of sessions per week that they work, both as recorded by the group on dates specified by the rules for the election;

d) **Term of office** – three years subject to 2.2.2 (f) (notice period) below ;

e) **Eligibility for reappointment** – no individual will serve more than two consecutive terms of office;

f) **Grounds for removal from office** – no longer being eligible as defined at (b) above, failure to perform to the required standard or any proven misconduct that would in the case of an employee of the group, result in their dismissal;

g) **Notice period** – three months to be served in writing to the Chair;

h) **By-elections** – if any of the eight places fall vacant, there will be a by-election to fill the vacancy for the remainder of that term. If the number of places does not fall below seven but a vacancy arises, the governing body will decide whether there shall be an election to fill that vacancy. The winner of that election will be deemed to have served one term of office which shall be discounted for the purposes of (e) above only if their time in office is over eighteen months.

2.2.5. The practice representatives, see 7.1 of the constitution, are subject to the following:

a) **Nominations** – any eligible GP or other primary care health professional can put themselves forward for selection as the practice representative;

b) **Eligibility** – any GP or other primary care health professional working in the member practice other than on a locum basis only;

c) **Appointment process** – selection by the practice using a voting procedure including all of its eligible GPs and primary care health professionals and which has been documented and lodged with the group's Accountable Officer, who will then be notified in writing as to who each representative is;

d) **Term of office** – three years subject to f) (removal from office) and g) (notice period);

e) **Eligibility for reappointment** – no individual will serve more than three consecutive terms of office;

f) **Grounds for removal from office** – no longer being eligible as defined at (b) above or failure to perform to the required standard;

g) **Notice period** – one month to be served in writing to the Accountable Officer.

2.2.6. The lay members, see 6.9.2 (c) and (d) of the constitution, are subject to the following:

a) **Nominations** – persons who meet the requirements of and are not disqualified by regulations, will be invited to apply for these positions;

b) **Eligibility** – further qualifying criteria for each of the positions will be clearly set out and only applicants who meet those criteria will be considered, subject to paragraph 8.3.6 of the constitution;

c) **Appointment process** – eligible applicants will be shortlisted and selected by interview using further criteria designed to identify the candidate best suited to each position;

d) **Term of office** – five years, with the first term starting on the effective date of the group's constitution;

e) **Eligibility for reappointment** – no individual will serve more than two terms of office

f) **Grounds for removal from office** – no longer being eligible as defined at (b) above, failure to perform to the required standard or any proven misconduct that would in the case of an employee of the group result in their dismissal;

g) **Notice period** – one month to be served in writing to the chair.

2.2.7. The registered nurse, see 6.6.2 (~~d~~e) of the constitution, is subject to the following:

a) **Nominations** – membership of the governing body will rest with the individual appointed as the group's Executive Nurse and applications will be sought by advertising that position;

b) **Eligibility –** a registered nurse who will not, once appointed, also be employed in general practice or by any organisation from which the group secures any significant volume of provision, is not otherwise disqualified by regulations and who meets the specific criteria identified for the position, subject to paragraph 8.3.6 of the constitution;

c) **Appointment process** – eligible applicants will be shortlisted and selected by interview using further criteria designed to identify the candidate best suited to the position;

d) Terms relating to tenure in post, including cessation provisions will be determined by the post-holder's contract of employment with the group.

2.2.8. The secondary care specialist doctor, see 6.9.2 (~~e~~f) of the constitution, is subject to the following:

a) **Nominations** – applications will be sought by advertising the position;

b) **Eligibility** – a doctor who is/has been a secondary care specialist with a high level of understanding of how care is delivered in a secondary care setting, who is not employed in a member practice or any organisation from which the group secures any significant volume of provision, is not otherwise disqualified by regulations and who meets the specific criteria identified for the position, subject to paragraph 8.3.6 of the constitution;

c) **Appointment process** – eligible applicants will be shortlisted and selected by interview using further criteria designed to identify the candidate best suited to the position;

d) **Term of office** – five years, with the first term starting on the effective date of the group's constitution;

e) **Eligibility for reappointment** – no individual will serve more than two terms of office;

f) **Grounds for removal from office** – no longer being eligible as defined at (b) above, failure to perform to the required standard or any proven misconduct that would in the case of an employee of the group result in their dismissal;

g) **Notice period** – one month to be served in writing to the Chair.

2.2.9. The Accountable Officer, see 6.9.2(~~f~~g) and 7.6 of the constitution is subject to the following:

a) **Nominations** – membership of the governing body will rest with the individual appointed as the group's Chief Officer and applications will be sought by advertising that position;

b) **Eligibility** – the qualifying criteria for the position will be clearly set out and only applicants who meet those criteria and are not disqualified by regulations will be considered, subject to paragraph 8.3.6 of the constitution;

c) **Appointment process** – eligible applicants will be shortlisted and selected by interview using further criteria designed to identify the candidate best suited to the position. The appointment will then be formally confirmed by the NHS Commissioning Board;

d) Terms relating to tenure in post, including cessation provisions will be determined by the post-holder's contract of employment with the group.

2.2.10. The Chief Finance Officer, see 6.9.2(~~g~~h) and 7.7 of the constitution is subject to the following:

a) **Nominations** – applications for post as employee of the group;

b) **Eligibility** – holder of recognised accountancy qualification with current membership of the relevant professional body who meets the other specified criteria identified for the position and is not disqualified by regulations, subject to paragraph 8.3.6 of the constitution;

c) **Appointment process** – eligible applicants will be shortlisted and selected by interview using further criteria designed to identify the candidate best suited to the position;

d) Terms relating to tenure in post, including cessation provisions will be determined by the post-holder's contract of employment with the group.
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2.2.11. The Group's Director of Strategy and Transformation, see 6.9.2(h) is subject to the following;

a) **Nominations** – applications for post as employee of the group;

b) **Eligibility** – the qualifying criteria for the position will be clearly set out and only applicants who meet those criteria and are not disqualified by regulations will be considered, subject to paragraph 8.3.6 of the constitution;

c) **Appointment process –** eligible applicants will be shortlisted and selected by interview using further criteria designed to identify the candidate best suited to the position;

d) Terms relating to tenure in post, including cessation provisions will be determined by the post-holder's contract of employment with the group.

2.2.12. The practice manager representative, see 6.9.2(ii) of the constitution is subject to the following:

a) **Nominations** – applications will be sought by advertising the position;

b) **Eligibility** – anyone who is/has been a GP practice manager with a high level of understanding of that role, who meets the other specified criteria identified for the position and is not disqualified by regulations, subject to paragraph 8.3.6 of the constitution;

c) **Appointment process** – eligible applicants will be shortlisted and selected by interview using further criteria designed to identify the candidate best suited to the position;

d) **Term of office** – five years, with the first term starting on the effective date of the group's constitution;

e) **Eligibility for reappointment** – no individual will serve more than two consecutive terms of office ;

f) **Grounds for removal from office** – no longer being eligible as defined at (b) above, failure to perform to the required standard or any proven misconduct that would in the case of an employee of the group result in their dismissal;

g) **Notice period** – one month's to be served in writing to the chair.

3. MEETINGS OF THE CLINICAL COMMISSIONING GROUP

3.1. Calling meetings

3.1.1. Ordinary meetings of the group will be held quarterly with at least one month's notice given to all members via an e-mail to their practice representative. The details of the date, time and venue of these meetings will be publicised on the group's website www.wolverhamptonccg.nhs.uk.

3.1.2. An extraordinary meeting of the group will be held if deemed necessary by the governing body or if requested in writing to the chair of the governing body by at least ten practice representatives. At least one week's notice will be given to all members via an e-mail to their practice representative. Unless otherwise determined by the governing body or the chair thereof, because of the nature of

the business of the meeting, the details of the date, time and venue of such meetings will be publicised on the group's website www.wolverhamptonccg.nhs.uk.

3.1.3. The governing body will schedule its meetings in advance and hold at least six such meetings in each financial year. Details of meeting dates, times and venues will be published on the group's website www.wolverhamptonccg.nhs.uk and no meeting will be rescheduled without at least one week's notice of the re-arranged date.

3.1.4. Committees of the group or the governing body and any sub-committees thereof will hold meetings as specified in their terms of reference.

3.2. Agenda, supporting papers and business to be transacted

3.2.1. Items of business to be transacted for inclusion on the agenda of a meeting of the group or the governing body need to be notified to the chair of the governing body at least ten working days (excluding weekends and bank holidays) before the meeting takes place. Supporting papers for such items need to be submitted such that the agenda and supporting papers will be circulated to all members of a meeting at least five working days before the date the meeting will take place. Addition of further agenda items or acceptance by the meeting of supporting papers after these deadlines will be at the discretion of the chair of the governing body or other person chairing the meeting as appropriate.

3.2.2. Agendas and certain papers for meetings of the group and its governing body will be published on the group's website www.wolverhamptonccg.nhs.uk.

3.3. Petitions

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

3.4. Chair of a meeting

3.4.1. At any meeting of the group or its governing body, the chair of the governing body will preside. At any meeting of a committee or sub-committee, its chair as defined in its terms of reference will preside. If the designated chair is absent from any meeting, the designated deputy chair, if any and if present, shall preside. Otherwise a member of the forum will be chosen by the members present, or by a majority of them, and 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, will preside for the relevant business of the meeting. If both the chair and deputy chair are absent or disqualified from participating, a member of the forum who is able to participate will be chosen by the members present, or by a majority of them, and will preside.

3.5. Chair's ruling

3.5.1. The decision of the chair of the meeting 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. Meetings of the group will be quorate if more than 50% of the practices in the group are represented by their practice representative or any substitute notified in writing to the Accountable Officer at least 24 hours before the meeting was scheduled to start. If enough members are disqualified from taking part in a vote due to a declared interest that the meeting ceases to be quorate for that item of business, no such vote will be taken and the item and/or the remainder of the meeting (if it cannot be quorate thereafter) shall be adjourned and the business remaining on the agenda dealt with on a date to be agreed.

3.6.2. Meetings of the governing body will be quorate if more than 50% of the members as defined by paragraph 6.9.2 of the constitution, including at least ~~four~~ half of the ~~eight~~ elected members, are present or represented by an individual as notified to the chair more than 24 hours before the meeting was scheduled to start. If the reason for the meeting not being quorate is that all or some of the elected members and the practice manager are disqualified from taking part in a vote due to a declared interest, in line with the group's arrangements for managing conflicts of interest, the meeting will be quorate provided that more than 50% of the other members of the Governing Body are present. ~~those members may, subject to the chair's discretion, take part in a discussion of the relevant item of business but will not be allowed to vote upon it~~. The chair of the meeting for that item of business will ensure that the requirements of the constitution at 8.4.9 and 8.4.10 have been met.

3.6.3. For all other of the group's committees and sub-committees, including the governing body's committees and sub-committees, the details of the quorum for these meetings and status of representatives are set out in the appropriate terms of reference and are governed by the constitution at 8.4.8 to 8.4.10 if declared interests reduce the membership for any item of business.

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 meetings of the group and the governing body, decisions will be reached by consensus. Should this not be possible then a vote of members will be required, the processes for which are set out below.

3.7.2. In the event of a vote being necessary at a meeting of the group:

a) **Eligibility** – practice representatives, or any substitute notified in writing to the Accountable Officer at least 24 hours before the meeting was scheduled to start, will be able to cast one vote on behalf of their practice.

b) **Majority necessary to confirm a decision** - a simple majority of the members present and voting at the meeting;

c) **Casting vote** - the chair of the meeting will have a casting vote in the unlikely event of no overall majority being established.

3.7.3. In the event of a vote (other than those described at 2.2 above) being necessary at a meeting of the governing body:

a) **Eligibility** – members of the governing body as defined by paragraph 6.9.2 of the constitution will be able to cast one vote but others in attendance at the meeting will not. Any member who cannot attend the meeting and wishes their vote to be cast by a representative must have notified the Chair of the identity of that individual more than 24 hours before the meeting was scheduled to start;

b) **Majority necessary to confirm a decision** – a simple majority

c) **Casting vote** - the chair of the meeting will have a casting vote in the event of no overall majority being established.

3.7.4. If a vote is taken the outcome of the vote and any dissenting views must be recorded in the minutes of the meeting.

3.7.5. For all other of the group's committees and sub-committees, including the governing body's committees and sub-committees, any vote will be decided at a quorate meeting by a simple majority, as set out in the respective terms of reference, with the chair of the meeting having a casting vote if necessary.

3.8. Emergency powers and urgent decisions

3.8.1. Those powers that the group has reserved to itself (see SO 1.2) may, in an emergency or unforeseen circumstances, be exercised by the Chair of the governing body and the Accountable Officer after consultation with at least two practice representatives and the Chief Finance Officer if the group will, or is likely to, incur any excessive or unnecessary expenditure as a result of them not utilising the emergency powers, suffer exposure to a risk outside the group's stated risk appetite (including but not limited to prospective reputational damage) or other matter which, in the opinion of the Chair, requires an urgent decision to be taken prior to the next meeting of the group. The exercise of such powers will be reported to all practice representatives and subsequently ratified (or not as the case may be) and recorded at the next meeting of the group.

3.8.2. Those powers that the group has delegated to the governing body may in an emergency or the need for an urgent decision be exercised by the Chair of the governing body and the Accountable Officer after consultation with at least two

other elected members of the governing body and the Chief Finance Officer if the group will, or is likely to, incur any excessive or unnecessary expenditure as a result of them not utilising the emergency powers, suffer exposure to a risk outside the group's stated risk appetite (including but not limited to prospective reputational damage) or other matter which, in the opinion of the Chair, requires an urgent decision to be taken prior to the next meeting of the governing body The exercise of such powers will be reported to all members of the governing body as defined by paragraph 6.9.2 of the constitution and subsequently ratified (or not as the case may be) and recorded at the next meeting of the governing body. An urgent decision is one that needs to be taken before the next meeting of the governing body in order to ensure that the group meets it statutory, regulatory, governance and contractual obligations.

~~3.8.2.~~3.8.3. The provisions of paragraphs 3.8.1 and 3.8.2 shall apply (suitably modified) to the any committees established by the group and the governing body.

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3.9. Suspension of Standing Orders

3.9.1. Except where it would contravene any statutory provision or any direction made by the Secretary of State for Health or NHS England, any part of these Standing Orders may be suspended at any meeting, provided a simple majority plus one of the voting members of that meeting 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 Governance Committee for review of the reasonableness of the decision to suspend Standing Orders.

3.10. Records of Attendance

3.10.1. The names of all voting members (or their representatives) present at any meeting of the group, its governing body and any committee/sub-committee must be recorded in the minutes of that meeting together with the names of any attendees at such meetings.

3.11. Minutes

3.11.1. It will be the responsibility of the person chairing any meeting to ensure that an individual has been identified to take and draft the minutes of that meeting. The-chair of that meeting will confirm the accuracy of those minutes before they are presented to the next meeting of that forum for formal approval and be signed off by the person chairing that subsequent meeting.

3.11.2. Minutes of meetings of the group and its governing body will be among the papers published on the group's website www.wolverhamptonccg.nhs.uk.

3.12. Those invited to attend and admission of public and the press

3.12.1. Employees of and providers of relevant services to the group and other representatives of any organisations with which it jointly commissions or from whom it commissions healthcare services will be invited to attend meetings of the governing body whenever the transaction of its business will be made more efficient and effective by their presence.

3.12.2. In addition, representatives of the following will be invited to attend and contribute from their perspective, to all meetings of the governing body as observers, declaring any interests as appropriate:

- the Local Medical Committee, as statutory representatives of the GP profession;
- Wolverhampton City Council, as key commissioning partners and host of the local Public Health function;
- Wolverhampton Health and Wellbeing Board, through which the group and the Council will develop joint strategic needs assessments and joint strategies;
- local HealthWatch to represent patients/carers.

3.12.3. The public and representatives of the press may attend all meetings of the group and its governing body unless it is necessary to ask them and those invited to attend as observers, to withdraw under: (a) Section 1(2) of the Public Bodies (Admission to Meetings) Act 1960 because of the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest; (b) Section 1(8) of that Act in the interests of public order.

3.12.4. Members and employees of the group who remain at a meeting whilst confidential business is discussed will treat the relevant papers, discussion and minutes as absolutely confidential d and not to be disclosed outside of the group without express written permission to do so from the Chair or Deputy Chair of the governing body, the Accountable Officer or the Chair of the Audit and Governance Committee.

3.12.5. No member of the public or representative of the press will record or transmit a meeting of the group or its governing body without express permission from the chair of the meeting.

4. APPOINTMENT OF COMMITTEES AND SUB-COMMITTEES

4.1. Appointment of committees and sub-committees

4.1.1. The group may appoint committees and sub-committees of the group, subject to any regulations made by the Secretary of State, and make provision for the appointment of committees and sub-committees of its governing body. Where such committees and sub-committees of the group or the governing body are appointed they are included in Chapter 6 of the group's constitution.

4.1.2. Other than where there are statutory requirements, such as in relation to the governing body's Audit and Governance and Remuneration committees, the

group shall determine the membership and terms of reference of committees and sub-committees and shall, if it requires, receive and consider reports of such committees at the next appropriate meeting of the group.

4.1.3. The provisions of these Standing Orders shall apply where relevant to the operation of the governing body, the governing body's committees and sub-committees and all committees and sub-committees unless stated otherwise in the committee's or sub-committee's terms of reference.

4.2. Terms of Reference

4.2.1. Terms of reference shall have effect as if incorporated into the constitution and shall be appended to it.

4.3. Delegation of Powers by Committees to Sub-committees

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

4.4. Approval of Appointments to Committees and Sub-Committees

4.4.1. The group shall approve the appointments to each of the committees and sub-committees which it has formally constituted including those of the governing body. The Remuneration Committee will agree such travelling or other allowances for the members of such forums, as it considers appropriate.

5. DUTY TO REPORT NON-COMPLIANCE WITH STANDING ORDERS

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

6. USE OF SEAL AND AUTHORISATION OF DOCUMENTS

6.1. Clinical Commissioning Group's seal

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

a) the Accountable Officer;

b) the Chair of the governing body;

c) the Chief Finance Officer;

6.1.2 A register of sealings will be maintained by the Corporate Operations Manager

6.2. Execution of a document by signature

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

a) the Accountable Officer

b) the Chair of the governing body

c) the Chief Finance Officer

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

7.1. Policy statements: general principles

7.1.1. The group will from time to time agree and approve policy statements and procedures which will apply to all or specific groups of staff employed by NHS Wolverhampton Clinical Commissioning Group. The decisions to approve such policies and procedures will be recorded in an appropriate group or governing body minute, will be deemed where appropriate to be an integral part of the group's standing orders and will indicate as appropriate, those for which non-compliance may be regarded as a disciplinary matter that could result in dismissal.

NHS WOLVERHAMPTON
CLINICAL COMMISSIONING GROUP

CONSTITUTION APPENDIX F

SCHEME OF RESERVATION AND DELEGATION

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

1.1. The decision-making arrangements made by the group as set out in this Scheme of Reservation and Delegation of decisions shall have effect as if incorporated in the group's constitution.

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

1.3. The table below indicates which decisions have been reserved to the group membership and these decisions can only be taken at a quorate meeting of the group itself, as described in the constitution and Standing Orders, or under 3.8.1 of Standing Orders in emergency or unforeseen circumstances.

1.4. Other decisions have been delegated to the governing body and these must be taken at a quorate meeting of that body, as described in the constitution and Standing Orders, or under 3.8.2 of Standing Orders in emergency or unforeseen circumstances.

1.5. Decisions delegated to the Accountable Officer or the Chief Finance Officer must be taken by the relevant individual or someone with express, written authority to do so on their behalf.

1.6. Decisions delegated to committees or sub-committees must be taken at a quorate meeting of that body, as described in the constitution, Standing Orders and the relevant terms of reference

Decision	Reserved to the Membership	Reserved or delegated to Governing Body	Accountable Officer	Other Officer	Committee
Approval of applications to ~~the NHS Commissioning Board~~ NHS England on any matter concerning changes to the group's constitution	✓				
Approval of the group's detailed scheme of delegation, setting out the key operational decisions delegated to individual employees of the group (and not deemed to be part of the constitution)		✓			
Approval of the delegation of powers to the group's joint committee with Wolverhampton City Council	✓				
Approval of the delegation of powers to representatives of the group under any joint or collaborative arrangements with other clinical commissioning groups		✓			
Approval of proposed changes to the Prime Financial Policies		✓			
Approval of the group's detailed financial policies (not deemed to be part of the constitution) and overall banking arrangements					**Finance and Performance**
Determination of detailed arrangements, consistent with its prime and detailed financial policies, under which the group will meet its general financial duties				**Chief Finance**	
Approval of the group's operating structure		✓			
Approval of the group's commissioning strategy, plans and policies, together with any arrangements for consultation thereon, and its procurement strategy		✓			

Decision	Reserved to the Membership	Reserved or delegated to Governing Body	Accountable Officer	Other Officer	Committee
Approval of the group's budgets and any variations thereto which are significant enough to impact on the group's ability to meet its statutory duties and/or agreed strategic aims		✓			
Approval to award any contract of a higher value than that specified in Prime Financial Policy 13.3		✓			
Approval of budget variations not significant enough to impact on the group's ability to meet its statutory duties and/or agreed strategic aims					**Finance and Performance**
Approval of the group's annual report and annual accounts		✓			
Approval of terms and conditions, remuneration, fees and allowances for governing body members, including any pensions					**Remuneration**
Approval of arrangements by the group to form or participate in forming a company and invest in and/or provide loans and guarantees and make other financial provision to the company In addition, the governing body will consider recommendations to vary the Prime Financial Policies made to it by the AGC		✓			
Approval of terms and conditions, remuneration, fees, allowances and pensions payable to all employees and others providing services					**Remuneration**
Approval of grants and loans to voluntary organisations		✓			

Decision	Reserved to the Membership	Reserved or delegated to Governing Body	Accountable Officer	Other Officer	Committee
Approval of human resources policies for employees and others working on behalf of the group, through which the group will discharge its statutory duties as an employer					**Remuneration**
Determination of arrangements for ensuring that the group meets the public sector equality duty and reduces inequalities in both access and outcomes			✓		
Determination of arrangements for securing public involvement, , promoting both awareness and use of the NHS Constitution, obtaining appropriate advice and promoting integration of services			✓		
Determination of arrangements for securing continuous improvement to the quality of commissioned services				**Executive Nurse**	
Determination of arrangements for supporting NHS England as regards improving the quality of primary medical services including quality and safety			✓		
Determination of arrangements for promoting the involvement of patients, their carers and representatives in decisions about their healthcare				**Executive Nurse**	
Determination of arrangements for enabling patients to make choices				**Executive Nurse**	
Determination of arrangements for promoting innovation, research, education and training				**Executive Nurse**	
Approval of policies for risk management including assurance, information governance, business continuity, emergency planning, security and complaints handling					**Quality and Safety**
Approval of action plans to address risks to the		✓			

Decision	Reserved to the Membership	Reserved or delegated to Governing Body	Accountable Officer	Other Officer	Committee
achievement of strategic objectives or acceptance of the risk as currently assessed					
Determination of arrangements for internal audit and counter fraud services				**Chief Finance**	
Approval of internal audit and counter fraud plans and other arrangement for/sources of assurance through an integrated governance framework					**Audit and Governance**
Determination of arrangements for external audit services		✓			
Approval of business cases relating to new investments, new service developments or service increases within the overall operating plan or budgetary financial limit					**Commissioning**

NHS WOLVERHAMPTON CLINICAL COMMISSIONING GROUP

CONSTITUTION APPENDIX G

PRIME FINANCIAL POLICIES

Version: [6]

CONTENTS

1. INTRODUCTION

1.1. General

1.1.1. These Prime Financial Policies shall have effect as if incorporated into the group's constitution as noted at paragraph 10.2 thereof.

1.1.2. The Prime Financial Policies are part of the group's control environment for managing the organisation's financial affairs. They contribute to good corporate governance, internal control and management of 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 duties and responsibilities and identify the financial responsibilities applying to everyone working for the group and its constituent organisations. They are used in conjunction with the Standing Orders and Scheme of Reservation and Delegation.

1.1.3. In support of these Prime Financial Policies, the group has prepared detailed financial policies that provide day-to-day procedural guidance. These are not part of the constitution and any changes to them will be approved by the Finance and Performance Committee. A list of the group's detailed financial policies is published and maintained on the group's website at www.wolverhamptonccg.nhs.uk. The group refers to these prime and detailed financial policies together as the group's financial policies.

1.1.4. These prime financial policies identify the financial responsibilities which apply to everyone working for the group and its constituent organisations. They do not provide detailed procedural advice and should be read in conjunction with the detailed financial policies. The Finance and Performance Committee is responsible for approving all detailed financial policies. Should any difficulties arise regarding the interpretation or application of any of these policies then the advice of the Chief Finance Officer must be sought before acting. The user of these prime financial policies should also be familiar with and comply with the provisions of the group's constitution, standing orders and scheme of reservation and delegation ~~and reservation~~. Failure to comply with them may be regarded as a disciplinary matter that could result in dismissal.

1.2. Overriding Prime Financial Policies

1.2.1. If for any reason these prime financial policies are not complied with, full details of the non-compliance, any justification for and the circumstances around it will be reported to the next formal meeting of the Audit and Governance Committee for referring action or ratification. All of the group's members and employees have a duty to disclose any such non-compliance to the Chief Finance Officer as soon as possible.

1.3. Responsibilities and delegation

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

1.3.2. The financial decisions delegated by members of the group are set out in the group's Scheme of Reservation and Delegation or the detailed scheme of delegation as appropriate.

1.4. Contractors and their employees

1.4.1. Any contractor or employee of a contractor who is empowered by the group to commit the group to expenditure or who is authorised to obtain income will be covered by these instructions. It is the responsibility of the Chief Finance Officer to ensure that such persons are made aware of this and that contractual terms ensure the contractor and their employees comply with the same standards of governance and financial probity as would apply to any employee.

1.5. Amendment of Prime Financial Policies

1.5.1. To ensure that these Policies remain up-to-date and relevant, the Chief Finance Officer will review them at least annually. Following consultation with the Accountable Officer, review by the Finance and Performance Committee and scrutiny by the Audit and Governance Committee on behalf of the governing body, the Chief Finance Officer will recommend appropriate amendments to the governing body for approval. As an integral part of the constitution, any such amendment will not come into force until the group applies to the NHS England and that application is granted.

2. INTERNAL CONTROL

2.1. The Accountable Officer has overall responsibility for ensuring that the group has 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.

2.2. The governing body has established an Audit and Governance Committee with terms of reference agreed by the governing body (see paragraph 6.9.5(a) of the constitution for further information).

2.3. The Chief Finance Officer will ensure that:

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

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

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

3. AUDIT

3.1. The group will ensure that it has an effective and independent internal audit function and fully complies with Public Sector Internal Audit Standards and any other statutory reviews.

3.2. The Head of Internal Audit and the group's external auditor will have direct and unrestricted access to members of the Audit and Governance Committee, 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.

3.3. All members of the Audit and Governance Committee, the Chair of the governing body, the Accountable Officer and the Chief Finance Officer will have direct and unrestricted access to the Head of Internal Audit and external auditors.

~~a)~~

~~3.3. The Chief Finance Officer will ensure that :~~

~~a) the group has a professional and technically competent internal audit function that is compliant with the Public Sector Internal Audit Standards; and~~

~~b)~~3.4. the Audit and Governance Committee approves any changes to the provision or delivery of assurance services to the group.

~~3.4.~~3.5. In line with the requirements of the Local Audit and Accountability Act 2014, the Group will appoint an Auditor Panel. In line with the requirement of the Act and subsequent regulations, the Panel will oversee and advise on the maintenance of an independent relationship between the group and its external auditor, and on the auditor's selection and appointment.

4. COUNTERING FRAUD AND CORRUPTION

4.1. The group has a zero tolerance approach to any lack of honesty, integrity or probity by employees or anyone with whom it does business in order to safeguard the public resources that they are responsible for. The group will not tolerate any fraud perpetrated against it and will actively chase any loss suffered. Any suspected fraud will be investigated professionally with commensurate sanctions applied if fraud is proven. The group will seek to recover any financial loss suffered provided that it is cost effective to do so.

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4.2. The Audit and Governance Committee will satisfy itself that the group has adequate arrangements in place for countering fraud, approve the counter fraud work plan and review the outcomes of counter fraud work.

4.3. The Audit and Governance Committee will ensure that the group has suitable arrangements in place to work effectively with NHS Protect.

5. EXPENDITURE CONTROL

5.1. The group is required by statutory provisions[1] 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.

5.3. The Chief Finance Officer will:

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

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

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

6. ALLOTMENTS[2]

6.1. The Chief Finance Officer will:

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

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

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

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

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

7. COMMISSIONING STRATEGY, BUDGETS, BUDGETARY CONTROL AND MONITORING

7.1. The Accountable Officer will annually compile and submit to the governing body for approval a commissioning plan that explains how it proposes to discharge its financial duties and which takes into account financial targets, forecast limits of available resources and the results of consultation carried out in accordance with the arrangements approved by the governing body[3]. The governing body will support this with comprehensive medium term plans and annual budget.

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

7.3. The Chief Finance Officer will monitor financial performance against the budgets and commissioning plan, periodically review them and prepare reports explaining significant variances based on any significant departures from agreed financial plans or budgets, for the Finance and Performance Committee and the governing body as required.

7.4. The approval of the governing body will be required for any changes to budgets significant enough to impact on the group's ability to meet its statutory duties and/or agreed strategic aims. Other changes will be approved by the Finance and Performance Committee.

7.5. The Accountable Officer has overall responsibility for ensuring that information relating to the group's accounts, its income or expenditure or its use of resources is provided to NHS England as requested.

8. ANNUAL ACCOUNTS AND REPORTS

8.1. 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.

8.2. The Chief Finance Officer will ensure that the group:

a) prepares a timetable for producing the annual report and accounts and agrees it with external auditors and the Finance and Performance Committee;

b) adheres to that timetable in preparing accounts in accordance with all statutory obligations[4], relevant accounting standards and accounting best practice in the form and content at the time required by NHS England;

[3] See section 14Z13 of the 2006 Act, inserted by section 26 of the 2012 Act

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

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

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

publishes the external auditor's management letter on the group's website at www. www.wolverhamptonccg.nhs.uk. Alternatively, on request, a copy will be posted or sent by email to any enquirer who may wish to receive this.

9. INFORMATION TECHNOLOGY

9.1. The group will ensure the accuracy and security of its computerised financial data.

9.2. The Chief Finance Officer is responsible for the accuracy and security of the group's computerised financial data and will:

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

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

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

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

9.3. In addition, the Chief Finance Officer will 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

10.1. The Chief Finance Officer will ensure:

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

b) that contracts for computer services for accounting applications with another health organisation or any other agency clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage as well as ensuring the rights of access for audit purposes.

10.2. Where another health organisation or any other agency provides any accounting service to the group, the Chief Finance Officer will periodically seek assurances that adequate controls are in operation in line with the relevant auditing standards.

11. BANK ACCOUNTS

11.1. The Chief Finance Officer will:

a) review the banking arrangements of the group at regular intervals to ensure they are in accordance with Secretary of State directions[5], best practice and represent best value for money;

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

c) prepare detailed instructions on the operation of bank accounts such that the group maintains sufficient liquidity to meet its current commitments .

11.2. The Finance and Performance Committee will approve the overall banking arrangements.

12. INCOME, CHARGES, SECURITY, GRANTS, LOANS AND INVESTMENTS

12.1. The Chief Financial Officer is responsible for:

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

b) ensuring that the group maximises its potential to raise additional income but only to the extent that this does not interfere with the performance of the group or its functions[6];

c) approving and regularly reviewing the level of all fees and charges other than those determined by ~~the NHS Commissioning Board~~ NHS England or

5 See section 223H(3) of the NHS Act 2006, inserted by section 27 of the 2012 Act
6 See section 14Z5 of the 2006 Act, inserted by section 26 of the 2012 Act.

by statute with independent professional advice on matters of valuation taken as necessary;

d) establishing and maintaining systems and procedures for the secure handling of cash or other negotiable instruments and ensuring the safe receipt of funds by electronic transfer;

e) developing effective arrangements for exercising the group's powers to:

i) make grants and loans to voluntary organisations which provide or arrange for the provision of similar services to those in respect of which CCGs have functions[7] with any such payments to be approved by the governing body;

ii) form or participate in forming a company and invest in and/or provide loans and guarantees and make other financial provision to the company, but only for the purpose of improving the physical and mental health of, and the prevention, diagnosis and treatment of illness in, the people for whom the CCG has responsibility. Any such arrangements will require the approval of the governing body.

13. TENDERING AND CONTRACTING

13.1. The group will ensure that competitive tenders, or quotes as appropriate, are invited for the supply of all goods and services or disposals of group assets when the nature of the expenditure/income and the likely value are such that competition is required by the group's detailed financial policies.

13.2. The Chief Finance Officer will ensure that any businesses/individuals invited to tender (or quote) and to whom any contract is be awarded have been subject to the checking and vetting procedures defined by the group's detailed financial policies.

13.3. The award of any contract will be approved as determined by the group's detailed financial policies and detailed scheme of delegation and documents will be signed on behalf of the group in accordance with Standing Order 6.

13.4. The group may only enter into contracts within the statutory framework set up by the 2006 Act, as amended by the 2012 & 2015 Acts. Such contracts will:

a) be consistent with the group's Standing Orders;

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

[7] See section 14Z6 of the 2006 Act, inserted by section 26 of the 2012 Act.

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

13.5. In all contracts entered into, the group will endeavour to obtain best value for money. The Accountable Officer has nominated the Chief Finance Officer to oversee and manage each contract on behalf of the group.

14. COMMISSIONING

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

14.2. The group will enter into healthcare contracts in order to deliver its commissioning plans. This contracting activity will be subject to Prime Financial Policy 13 above, including the aspects relating to competition when the group chooses or is required to adopt a competitive approach to selecting its healthcare providers.

14.3. The group will maintain a register of procurement decisions that have been taken that will specify the decision, who was involved in making the decision and how any conflicts of interest that arose were dealt with.

14.4. The Accountable Officer will establish arrangements to ensure that regular reports are provided to the Finance and Performance Committee and governing body detailing actual and forecast expenditure and activity for each healthcare contract above the value specified in detailed Financial Policies, with similar reports presented to the Finance and Performance Committee for all healthcare contracts below that value.

14.5. The Chief Finance Officer will maintain a system of financial monitoring to ensure the effective accounting of expenditure under healthcare contracts. This will provide a suitable audit trail for all payments made under these contracts whilst maintaining patient confidentiality.

15. RISK MANAGEMENT, ASSURANCE AND INSURANCE

15.1. The group has arrangements in place such that the identification, analysis, evaluation and treatment of its risks are carried out in a systematic and consistent manner.

15.2. The group recognises that some level of risk is unavoidable in everything it seeks to do. The risk management policy approved by the Quality and Safety

Committee describes its risk management philosophy, risk appetite and assigns the relevant responsibilities.

15.3. Any risk to the achievement of the group's strategic objectives are recorded and quantified in the group's Assurance Framework, for which the governing body is be responsible. The Framework describes the controls in place to manage these risks and the sources of assurance provided to the governing body that those controls are in place and effective. Action plans to address any risks or the decision to accept risks as assessed, are scrutinised by the Audit and Governance Committee which reports to the governing body.

15.4. Other risks are recorded and quantified in the group's Risk Register, for which the Quality and Safety Committee is responsible. The Register is populated by reference to incidents, complaints and contract non-compliances as well as management assessments of inherent risk. Action plans to address high-scoring risks, as required by the risk management policy, are endorsed by the Quality and Safety Committee so that the necessary actions can be approved in line with the relevant part of the group's constitution.

15.5. The Governing Body receives regular integrated assurance reports from both the Audit and Governance and Quality and Safety Committees on their work, which provide assurance on risk management arrangements and an opportunity to escalate any issues that arise. In addition, the Governing Body considers the Board Assurance Framework on a Quarterly basis to highlight and address any issues with the effectiveness of internal controls and the Risk Management arrangements and Assurance framework are subject to annual review and evaluation by Internal Audit.

15.6. The Chief Finance Officer shall decide if the CCG will insure through the risk pooling schemes administered by the NHS Litigation Authority or self insure for some or all of the risks covered by the risk pooling schemes. If the Chief Finance Officer decides not to use the risk pooling schemes for any of the risk areas (clinical, property and employers / third party liability) covered by the scheme this decision shall be reviewed annually by the Governing Body.

16. PAYROLL

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

a) is supported by appropriate contractual terms and conditions;

b) has adequate internal controls and audit review processes, as required by Prime Financial Policy 10;

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

16.2. In addition the Chief Finance Officer will set out comprehensive procedures for the group's effective submission of payroll data to the service provider and the receipt and use of output from them.

17. NON-PAY EXPENDITURE

17.1. The governing body will approve the level of non-pay expenditure on an annual basis (Prime Financial Policy 7.2) and the Accountable Officer will determine the level of delegation to budget managers through the detailed scheme of delegation.

17.2. The Chief Finance Officer will set out procurement procedures consistent with Prime Financial Policy 13 and covering the seeking of professional advice regarding the supply of goods and services.

17.3. The Chief Finance Officer will:

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

b) be responsible for a system of verification, recording and payment of all amounts payable;

c) ensure compliance with Prime Financial Policies 10 and 13 as relevant.

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

18.1. The Accountable Officer will

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

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

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

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

18.2. The Chief Finance Officer will prepare detailed procedures consistent with Prime Financial Policy 13 for disposals of the group's assets.

19. INFORMATION GOVERNANCE AND RETENTION OF RECORDS

19.1. The Accountable Officer will act as the group's Caldicott Guardian and:

a) be responsible for ensuring that the group retains or destroys all records in accordance with NHS Code of Practice: Records Management 2006 and other relevant notified guidance;

b) publish and maintain a Freedom of Information Publication Scheme and ensure that arrangements are in place for effective responses to Freedom of Information requests as required by the relevant legislation;

c) be responsible for ensuring that the group maintains compliance with all other relevant legislation including the Data Protection Act 1998 (as amended).

19.2 The Chief Finance Officer will act as the group's Senior Information Risk Owner.

19.3 Information governance policies to facilitate the above will be approved by the Quality and Safety Committee and the group will use the NHS Information Governance Toolkit in order to assess its performance in this area.

20. TRUST FUNDS

20.1. The Chief Finance Officer will ensure that the group does not hold any funds on trust, charitable or otherwise.

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NHS Wolverhampton
Clinical Commissioning Group
Constitution Appendix H4

Governing Body's
Finance and Performance Committee
Terms of Reference

1. Introduction

The Finance and Performance Committee (FPC) is established in accordance with paragraph 6.9.3(d) of NHS Wolverhampton City Clinical Commissioning Group's constitution, Standing Orders and Scheme of Reservation and Delegation. These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the FPC and shall have effect as if incorporated into the constitution and standing orders.

The FPC will evaluate its own performance and terms of reference annually. Any resulting changes to the terms of reference and/or concerns in relation to the performance evaluation will be received and considered for approval by the governing body, or the group if they relate to the membership of the committee (Standing Order 4.4), before becoming part of an application for variation to be approved by the group and submitted to NHS England (constitution 1.4). The terms of reference will be published on the group's website (www.wolverhamptonccg.nhs.uk) and available by post or email, if requested.

2. Membership

The Chair of the FPC will be ~~a~~ the lay member of the governing body for finance and performance.

The number of members of FPC shall be at least 5.

In the event of the Chair of the FPC being unable to attend all or part of a meeting, the members of FPC will nominate a replacement from within the membership to deputise for that meeting.

The other members of the FPC will be appointed by the group to include other members of the governing body including the Chief Finance Officer and employees of the group including at least one representative of the Commissioning function save that, subject to the qualifying proviso below, members of FPC need not be members of the governing body

No individual who could not be a member of the group's governing body by virtue of sections (4) to (10) of Schedule 5 of the 2012 Regulations (SI 2012/1631) will be eligible to be a non-governing body member of the group's FPC

3. In attendance

Employees of and providers of relevant services to the group and representatives of any organisations with which it jointly commissions or from whom it commissions healthcare services may be invited to attend when the FPC is discussing areas that are the responsibility of that person.

4. Secretary

A named individual (or his/her nominee) shall be responsible for supporting the Chair in the management of the FPC's business and for drawing members' attention to best practice, national guidance and other relevant documents as appropriate.

5. Quorum

A meeting of the FPC will be quorate provided that three members are present of whom at least one is a member of the governing body (the Chief Finance Officer not being counted as a member of the governing body for this purpose), the Chief Finance Officer or his/her authorised deputy and one other FPC member.

6. Voting

Should a vote need to be taken, only the members of FPC shall be allowed to vote. In the event of a tied vote, the Chair shall have a second and casting vote.

7. Frequency and notice of meetings

The FPC will meet at least eight times per annum with meeting dates scheduled in advance for at least 12 months, save in an emergency when the Chair of FPC may call a meeting of his/her volition or at the request of a member(s) with the Chair's consent.. No unscheduled or rescheduled meetings will take place without members usually having at least ten days of the date and in an emergency, standing order 3.8 (Emergency Powers and Urgent Decisions) shall apply. The agenda and supporting papers will be circulated to all members at least five working days before the date the meeting will take place unless a shorter time period for circulation of papers is necessary due to a meeting being re-scheduled at short notice..

8. Remit and responsibilities of the committee

The FPC is accountable to the governing body and its remit is to provide the governing body with assurance on issues related to the finances, including financial health, of the group and the achievement of performance objectives and targets. It will deliver this remit in the context of the group's priorities, as they emerge and develop, and the risks associated with achieving them.

The specific duties delegated to or conferred on the FPC by the group of its governing body are:

- to support the Chief Finance Officer in the delivery of the general financial duties (constitution 5.3.1 – 5.3.3);
- to report to the governing body on areas of concern regarding financial and performance issues;
- to receive reports from the group's representative on the Wolverhampton Health and Wellbeing Board with regard to development of the joint assessments and strategies and delivery of the latter (constitution 5.1.2(c)(ii));
- to monitor the group's delivery of the duty to act effectively, efficiently and economically (constitution 5.2.3);
- to monitor the group's delivery of the duty to have regard to the need to reduce inequalities (constitution 5.2.6);
- review the Chief Finance Officer's proposals for any changes to the Prime Financial Policies prior to scrutiny of them by the Audit and Governance Committee (PFP 1.5.1)
- approval of detailed financial policies (PFP 1.1.3);
- to consider reports from the Chief Finance Officer regarding significant variances from budgeted performance (PFP 7.3) and approve any changes to budgets not significant enough to require approval by the governing body (PFP 7.4);

- to consider reports from management regarding significant variances from non-financial performance targets;
- agree the Chief Finance Officer's timetable for producing the annual accounts and report (PFP 8.1(a));
- approve the group's overall banking arrangements (PFP 11.2);
- receive reports detailing actual and forecast expenditure and activity for all healthcare contracts (PFP14.3).

It will deliver these duties by developing and delivering annual work programmes giving appropriate focus to the following:

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- receive and consider detailed monthly monitoring reports and year-end forecast of performance against financial and performance targets;
- review plans for and delivery of initiatives under QIPP and any subsequent programme of that nature;
- to make recommendations as necessary to the governing body on the remedial actions to be taken with regard to finance and performance issues and risks, including in-year changes to budgets; and
- to report annually to the governing body in relation to how FPC has discharged its duties.

9. Relationship with the governing body

For the next meeting of the governing body following each meeting of the FPC, the Chair of the committee will provide a written summary of the key matters covered by the meeting.

The minutes of each meeting of the FPC, as agreed at the subsequent meeting, will be presented to the next meeting of the governing body for information.

The Chair of the FPC will report by exception to the next meeting of the governing body any significant financial or performance issues brought to the Chair's attention other than at a meeting of the Committee.

10. Policy and best practice

In seeking to apply best practice in the decision- making process, the QSC has full authority to commission any reports, surveys or other information that it deems necessary to assist it in fulfilling its obligations.

NHS Wolverhampton
Clinical Commissioning Group
Constitution Appendix H6

The ~~NHS England and Wolverhampton CCG~~ Primary Care ~~Joint~~ Commissioning Committee Terms of Reference

1. Introduction

1.1 Simon Stevens, the Chief Executive of NHS England, announced on 1 May 2014 that NHS England was inviting Clinical Commissioning Groups (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 and CCGs would delegate the exercise of certain specified primary care commissioning functions to a CCG~~would jointly commission primary medical services~~.

1.2 In accordance with its statutory powers under section 13Z of the National Health Service Act 2006 (as amended), NHS England has delegated the exercise of the functions specified in Schedule 2 to these Terms of Reference to Wolverhampton CCG. The delegation is set out in Schedule 1.

~~1.2~~1.3 The CCG has established the ~~NHS England and~~ Wolverhampton CCG Primary Care ~~joint c~~Commissioning ~~c~~Committee ("the Committee"). The Committee will function as ~~a~~ a corporate decision-making body for the management of the delegated functions and the exercise of these delegated powers ~~is a joint committee with the primary purpose of jointly~~ for commissioning primary medical services for the people of Wolverhampton.

2. Statutory Framework

2.1 ~~2.1~~ NHS England has delegated authority to the CCG to exercise the commissioning functions set out in Schedule 2 in accordance with Section 13Z of The National Health Service Act 2006 (as amended) ("NHS Act") ~~provides, at section 13Z, that NHS England's functions may be exercised jointly with a CCG,~~

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~~and that functions exercised jointly in accordance with that section may be exercised by a joint committee of NHS England and the CCG~~.

2.2 Section 13Z of the NHS Act further provides that arrangements made under that section may be on such terms and conditions (including terms as to payment) as may be agreed between NHS England and the CCG.

2.3 Arrangements made under section 13Z do not affect the liability of NHS England for the exercise of any of its functions. However, the CCG acknowledges that in exercising its functions (including those delegated to it), it must comply with the statutory duties set out in Chapter A2 of the NHS Act and including:

a) Management of conflicts of interest (section 14O);
b) Duty to promote the NHS Constitution (section 14P);
c) Duty to exercise its functions effectively, efficiently and economically (section 14Q);
d) Duty as to improvement in quality of services (section 14R);
e) Duty in relation to quality of primary medical services (section 14S);
f) Duties as to reducing inequalities (section 14T);
g) Duty to promote the involvement of each patient (section 14U);
h) Duty as to patient choice (section 14V);
i) Duty as to promoting integration (section 14Z1);
j) Public involvement and consultation (section 14Z2).

2.4 The CCG will also need to specifically, in respect of the delegated functions from NHS England, exercise those functions 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).

2.5 The Committee is established as a committee of the Governing Body of the CCG in accordance with Schedule 1A of the NHS Act.

2.6 The members acknowledge that the Committee is subject to any directions made by NHS England or by the Secretary of State.

3. Role of the ~~Joint~~ Committee

3.1 ~~3.1~~ The ~~role of the Joint~~ 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 Wolverhampton, under delegated authority from NHS England.

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3.2 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.

3.3 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 except those relating to individual GP performance management, which have been reserved to NHS England. This includes the following activities:

- 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).

3.~~2~~4 The Committee will also be responsible for maintaining an overview of the CCG's other activities in relation to the delegated functions related to Primary Care and ensuring ~~for the delivery of~~ that they are aligned with the CCG's Primary Care strategy. These activities~~,~~ include~~ing:~~:-

- ~~Developing and infrastructure that prioritises choice, community development and neighbourhood development to promoting the right care at the right time in the right place~~
- ~~Developing strategies to support self care and improved information about services~~
- ~~Improved access to community and primary care facing services~~
- ~~Enhanced clinical leadership that ensures GPs are at the centre of a neighbourhood approach.~~
- ~~Improved care coordination, particularly for individuals with complex, life limiting conditions or at risk of hospital admission~~
- ~~Delivery of integrated primary care models than span primary and secondary care using population-based local incentive schemes etc.~~
- ~~Ensuring wider patient and key stakeholder engagement in the development of future primary care development plans.~~
- ~~Improvements in the quality and performance of primary medical services~~

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- ~~Managing the budget for Primary Care Medical Services~~Planning for sustainable primary medical care services in Wolverhampton;
- Reviewing primary medical care services in Dudley with the aim of further improving the care provided to patients
- Co-ordinating the approach to the commissioning of primary care services generally;
- Managing the budget for commissioning of primary medical care services in Wolverhampton.

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

4. Geographical coverage

4.1 The ~~Joint~~ Committee will comprise the ~~NHS England West Midlands Sub-Region (The Sub-Regional Team) and the NHS~~ Wolverhampton CCG (The CCG). It will undertake the function of jointly commissioning primary medical services for Wolverhampton.

5. Membership

5.1 The Membership of the ~~Joint~~ Committee shall consist of:-

- The Deputy Chair of the CCG's Governing Body
- The CCG Governing Body Lay Member for Finance and Performance
- Two Executive Members of the CCG's Governing Body (currently the Director of Strategy and Transformation and the Executive Director of Nursing and Quality)
- ~~One elected GP Member of the CCG's Governing Body~~
- ~~Three representatives from the Sub-Regional Team (One from each of the Medical, Finance and Primary Care Directorates)~~The Three GPs elected to the CCG Governing Body as Locality Leads (Non-Voting)
- Two Patient Representatives

5.2 The Chair of the Joint Committee shall be the Deputy Chair of the CCG's Governing Body

5.3 The Vice Chair of the Joint Committee shall be the CCG Governing Body Lay Member for Finance and Performance. ~~one of the representatives from the Sub-Regional Team.~~

5.4 Any member of the committee may nominate a substitute to attend a meeting on their behalf, provided that they notify the Chair 24 hours before the meeting.

6. Invited Attendees

6.1 Both a representative of Healthwatch Wolverhampton and a representative of the Wolverhampton Health and Wellbeing Board (who must represent Wolverhampton City Council on the Board) shall be invited to attend meetings of the Committee as a non-voting observer.

6.2 The observers shall be invited to provide assurance that the provisions for managing conflicts of interest are being correctly applied and shall be entitled to attend private sessions of the Joint Committee.

6.3 The Joint Committee may also call additional experts to attend meetings on an ad hoc basis to inform discussions.

7. Meetings and Voting

7.1 The ~~Joint~~ Committee ~~shall adopt~~will operate in line with~~-~~ the CCG's Standing Orders~~ of the CCG insofar as they relate to the:~~

- ~~Notice of meetings;~~
- ~~Handling of meetings;~~
- ~~Agendas;~~
- ~~Circulation of papers; and~~
- ~~Conflicts of interest~~

~~7.2~~ and Policy for Declaring and Managing Interests. The agenda and supporting papers will be circulated to all members at least five working days before the date the meeting will take place unless a shorter time period for circulation of papers is necessary due to a meeting being re-scheduled at short notice.

7.3 Decisions of the ~~Joint~~ Committee should be reached by consensus where possible. Where this is not possible, a vote will be taken with a simple majority of the votes cast being required to reach a decision ~~unless the decision relates to a statutory function of NHS England outlined in Paragraph 3.1. When the Joint Committee exercises these functions, the votes of the Sub-Regional team representatives shall be weighted so that, when cast together, they shall be sufficient to give the sub-regional team a casting vote. (E.g. If all 4 of the CCG's representatives are present and voting, the sub-regional team's representatives votes will be weighted so that they total 5, etc.).~~ with the Chair having a second and casting vote in the event of a tie.

N.B. In line with national statutory guidance, the GP representatives on the Committee shall not be entitled to vote.

7.3 Meetings of the Joint Committee shall be held in public, unless the ~~Joint~~ Committee resolves to exclude the public from either 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.

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7.4 Members of the Joint Committee have a collective responsibility for the operation of the Joint 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.

7.5 Members of the Joint Committee shall respect confidentiality requirements as set out in the Standing Orders referred to above unless separate confidentiality requirements are set out for the joint committee in which event these shall be observed.

8. Quorum

8.1 Meetings of the ~~Joint~~ Committee shall be quorate when over 50% of its members, including ~~there is at least one lay or executive representative of the CCG and two representatives of the Sub-Regional team present and the~~the Chair or Vice Chair and at least one Executive Governing Body member is present and ~~-~~overall make up of those present is such that there is a majority of non-clinical members.

9. Frequency of Meetings

9.1 The ~~Joint~~ Committee shall agree a regular programme of meetings each year. In addition, the Chair may call additional meetings if they are required in line with the provisions for notice of meetings set out above.

10. Secretary

10.1 A named individual (or his/her nominee) shall be responsible for supporting the Chair in the management of the Joint Committee's business and for drawing members' attention to best practice, national guidance and other relevant documents as appropriate.

10.2 The Secretary will circulate the minutes and action notes of the committee with 3 working days of the meeting to all members and present the minutes and action notes to ~~the Sub-Regional Team~~NHS West Midlands and the governing body of the CCG.

10.3 The Secretary will also provide an executive summary report which will presented to ~~the Sub-Regional team~~ NHS West Midlands and the governing body of the CCG each month for information.

11. Accountability of the Committee

11.1 The Committee will be directly accountable for the commitment of the resources / budget delegated to the CCG by NHS England for the purpose of commissioning primary care medical services. This includes accountability for determining appropriate arrangements for the assessment and procurement of primary care medical services, and ensuring that the CCG's responsibilities for consulting with its GP members and the public are properly accounted for as part of the established commissioning arrangements.

11.2 For the avoidance of doubt, the CCG's Scheme of Reservation & Delegation, Standing Orders and Prime Financial Policies will prevail in the event of any conflict between these terms of reference and the aforementioned documents.

11.3 The Committee is accountable to the governing body to ensure that it is effectively discharging its functions.

12. Procurement of Agreed Services

12.1 The procurement arrangements will be set out in the delegation agreement (Schedule 1 and 2 to this Terms of Reference between NHS Wolverhampton CCG and NHS England.

~~11.~~13. Decisions

~~11.1~~13.1 The ~~Joint~~ Committee will make decisions within the bounds of its remit set out in paragraph 3 above. The decisions of the Joint Committee shall be binding on NHS England and NHS Wolverhampton CCG and will be published by both parties.

~~12.~~14. Review of Terms of Reference

~~12.1~~14.1 These terms of reference will be formally reviewed by the ~~sub-regional team and the CCG~~ Committee in April of each year, following the year in which the ~~joint~~ committee is created and any recommendations for changes will be made to the Governing Body~~, and may be amended by mutual agreement between both parties at any time to reflect changes in circumstances which may arise.~~.

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