NHS WOLVERHAMPTON
CLINICAL COMMISSIONING GROUP

CONSTITUTION

Version: [8]

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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]

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11 Inserted by section 25 of the 2012 Act

12 *The Good Governance Standard for Public Services*, The Independent Commission on Good Governance in Public Services, Office of Public Management (OPM) and The Chartered Institute of Public Finance & Accountability (CIPFA), 2004

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.

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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.

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

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

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;

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

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

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

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

f) thus delivering the *Statement of Principles* below;
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;

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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;

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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.

6.5.12. The CCG has established a Joint Commissioning Committee with NHS Dudley, NHS Sandwell and West Birmingham and NHS Walsall CCGs to exercise the functions set out in the Committee's Terms of Reference and in line with the CCG's Scheme of Reservation and Delegation. The Terms of Reference are appended to (but are not part of) this Constitution.

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 15 members:

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

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

b) Six other GPs, who shall be their practices representatives, elected by member practices to ensure that groupings of primary care in Wolverhampton are represented in proportion with the patient list of practices within each group at the point the election takes place. Clinical leads for Finance and Performance, Commissioning and Contracting and Quality and Safety will be appointed from amongst these GPs;

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, 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.

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

f) one secondary care specialist doctor;

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

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

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

j) the group's Director of Operations

k) 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 *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, 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[48]. In addition the group or the governing body has conferred upon or delegated the following functions, connected with the governing body's main function[49], 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[50];
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[51]. 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

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

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;

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[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 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[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 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);

52 See Appendix H3 Terms of Reference of the Quality and Safety Committee

53 See Appendix H4 Terms of Reference of the Finance and Performance Committee

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;
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[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 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).

(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.

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;

54 See Appendix H5 Terms of Reference of the Commissioning Committee

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.

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[55]. 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;

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

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

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

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

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

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

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

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

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

k) ensuring that the group builds and maintains effective relationships, particularly with the individuals involved in overview and scrutiny from 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[56] and this is reflected in (a) to (c) below:

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

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

b) at all times ensuring that the regularity and propriety of expenditure is discharged and that arrangements are put in place to ensure that good practice (as identified 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[57] 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;

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

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.

7.8. Joint Appointments with other Organisations

7.8.1. The Group's Chief Finance Officer is a joint appointment with NHS Walsall CCG.

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.[58] This policy 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.

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) **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) **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

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

which might result in the closure of a busy clinic next door to an individual's house);;

8.2.4. If in doubt, the individual concerned should assume that a potential conflict of interest exists and notify the 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 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 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 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 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
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)
Practice Groupings	groups of practices who are working together to develop new community and primary care services in response to the Five Year Forward View. This includes the Primary Care Home, Vertical Integration and Medical Chambers groupings.
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 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
Dr H Leung & Partner Lea Road Medical Practice	35 Lea Road, Pennfields Wolverhampton, WV3 0LS

Practice Name	Address
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)[59]

[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)[60]

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