NHS BLACKPOOL
CLINICAL COMMISSIONING GROUP

CONSTITUTION

NHS Commissioning Board Effective Date:
5 December 2012

Revised July 2013 – Approved by NHS England August 2013
Revised May 2014 – Approved by NHS England July 2014
Revised January 2015 – Approved by NHS England March 2015
## CONTENTS

<table>
<thead>
<tr>
<th>Part</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Foreword</strong></td>
<td>3</td>
</tr>
<tr>
<td>1</td>
<td><strong>Introduction and Commencement</strong></td>
<td></td>
</tr>
<tr>
<td>1.1</td>
<td>Name</td>
<td>4</td>
</tr>
<tr>
<td>1.2</td>
<td>Statutory Framework</td>
<td>4</td>
</tr>
<tr>
<td>1.3</td>
<td>Status of this Constitution</td>
<td>4</td>
</tr>
<tr>
<td>1.4</td>
<td>Amendment and Variation of this Constitution</td>
<td>4</td>
</tr>
<tr>
<td>2</td>
<td><strong>Area Covered</strong></td>
<td>5</td>
</tr>
<tr>
<td>3</td>
<td><strong>Membership</strong></td>
<td>6</td>
</tr>
<tr>
<td>3.1</td>
<td>Membership of the Clinical Commissioning Group</td>
<td>6</td>
</tr>
<tr>
<td>3.2</td>
<td>Eligibility</td>
<td>6</td>
</tr>
<tr>
<td>4</td>
<td><strong>Mission, Values and Aims</strong></td>
<td>7</td>
</tr>
<tr>
<td>4.1</td>
<td>Mission</td>
<td>7</td>
</tr>
<tr>
<td>4.2</td>
<td>Values</td>
<td>7</td>
</tr>
<tr>
<td>4.3</td>
<td>Aims</td>
<td>7</td>
</tr>
<tr>
<td>4.4</td>
<td>Principles of Good Governance</td>
<td>8</td>
</tr>
<tr>
<td>4.5</td>
<td>Accountability</td>
<td>8</td>
</tr>
<tr>
<td>5</td>
<td><strong>Functions and General Duties</strong></td>
<td>9</td>
</tr>
<tr>
<td>5.1</td>
<td>Functions</td>
<td>9</td>
</tr>
<tr>
<td>5.2</td>
<td>General Duties</td>
<td>10</td>
</tr>
<tr>
<td>5.3</td>
<td>Compliance with General Duties</td>
<td>11</td>
</tr>
<tr>
<td>5.4</td>
<td>Public Involvement</td>
<td>11</td>
</tr>
<tr>
<td>5.5</td>
<td>General Financial Duties</td>
<td>12</td>
</tr>
<tr>
<td>5.6</td>
<td>Compliance with General Financial Duties</td>
<td>12</td>
</tr>
<tr>
<td>5.7</td>
<td>Other Relevant Regulations, Directions and Documents</td>
<td>12</td>
</tr>
<tr>
<td>6</td>
<td><strong>Decision Making: The Governing Structure</strong></td>
<td>13</td>
</tr>
<tr>
<td>6.1</td>
<td>Authority to Act</td>
<td>13</td>
</tr>
<tr>
<td>6.2</td>
<td>Scheme of Reservation and Delegation</td>
<td>13</td>
</tr>
<tr>
<td>6.3</td>
<td>General</td>
<td>13</td>
</tr>
<tr>
<td>6.4</td>
<td>Committees of the Group</td>
<td>14</td>
</tr>
<tr>
<td>6.4A</td>
<td>Members’ Council</td>
<td>14</td>
</tr>
<tr>
<td>6.5</td>
<td>Joint Arrangements</td>
<td>15</td>
</tr>
<tr>
<td>6.6</td>
<td>The Governing Body</td>
<td>19</td>
</tr>
<tr>
<td>6.6.5</td>
<td>Committees of the Governing Body</td>
<td>20</td>
</tr>
<tr>
<td>6.6.5a</td>
<td>Audit Committee</td>
<td>20</td>
</tr>
<tr>
<td>6.6.5b</td>
<td>Remuneration Committee</td>
<td>21</td>
</tr>
<tr>
<td>6.6.5c</td>
<td>Finance and Performance Committee</td>
<td>21</td>
</tr>
<tr>
<td>6.6.5d</td>
<td>Quality and Engagement Committee</td>
<td>22</td>
</tr>
<tr>
<td>6.6.5e</td>
<td>Patient and Public Involvement Forum</td>
<td>23</td>
</tr>
<tr>
<td>6.6.5f</td>
<td>Primary Care Commissioning Committee</td>
<td>23</td>
</tr>
</tbody>
</table>
### 7 Roles and Responsibilities

<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.1</td>
<td>Practice Representatives</td>
<td>24</td>
</tr>
<tr>
<td>7.2</td>
<td>All Members of the Group's Governing Body</td>
<td>24</td>
</tr>
<tr>
<td>7.3</td>
<td>The Chair of the Governing Body</td>
<td>24</td>
</tr>
<tr>
<td>7.4</td>
<td>The Deputy Chair of the Governing Body</td>
<td>25</td>
</tr>
<tr>
<td>7.5</td>
<td>Role of the Accountable Officer</td>
<td>25</td>
</tr>
<tr>
<td>7.6</td>
<td>Role of the Chief Finance Officer</td>
<td>26</td>
</tr>
<tr>
<td>7.7</td>
<td>Role of the Chief Operating Officer</td>
<td>26</td>
</tr>
<tr>
<td>7.8</td>
<td>Role of the Chief Nurse</td>
<td>27</td>
</tr>
<tr>
<td>7.9</td>
<td>Role of the Secondary Care Doctor</td>
<td>27</td>
</tr>
<tr>
<td>7.10</td>
<td>Role of the Lay Member – Governance</td>
<td>28</td>
</tr>
<tr>
<td>7.11</td>
<td>Role of the Lay Member – Patient and Public Involvement</td>
<td>29</td>
</tr>
<tr>
<td>7.12</td>
<td>Role of the Lay Member – Health Inequalities</td>
<td>29</td>
</tr>
<tr>
<td>7.13</td>
<td>Role of the Director of Public Health</td>
<td>30</td>
</tr>
<tr>
<td>7.14</td>
<td>Joint Appointments with Other Organisations</td>
<td>30</td>
</tr>
</tbody>
</table>

### 8 Standards of Business Conduct and Managing Conflicts of Interest

<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.1</td>
<td>Standards of Business Conduct</td>
<td>30</td>
</tr>
<tr>
<td>8.2</td>
<td>Conflicts of Interest</td>
<td>30</td>
</tr>
<tr>
<td>8.3</td>
<td>Declaring and Registering Interests</td>
<td>32</td>
</tr>
<tr>
<td>8.4</td>
<td>Managing Conflicts of Interest: General</td>
<td>33</td>
</tr>
<tr>
<td>8.5</td>
<td>Managing Conflicts of Interest: Contractors and People Who Provide Services to the Group</td>
<td>34</td>
</tr>
<tr>
<td>8.6</td>
<td>Transparency in Procuring Services</td>
<td>36</td>
</tr>
</tbody>
</table>

### 9 The Group as Employer

<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>10.1</td>
<td>General</td>
<td>38</td>
</tr>
</tbody>
</table>

### 10 Transparency, Ways of Working and Standing Orders

<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>10.2</td>
<td>Standing Orders</td>
<td>39</td>
</tr>
</tbody>
</table>

### Appendix

<table>
<thead>
<tr>
<th>Appendix</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Definitions of Key Descriptions used in this Constitution</td>
<td>40</td>
</tr>
<tr>
<td>B</td>
<td>List of Member Practices</td>
<td>42</td>
</tr>
<tr>
<td>C</td>
<td>Standing Orders</td>
<td>43</td>
</tr>
<tr>
<td>D</td>
<td>Scheme of Reservation and Delegation</td>
<td>56</td>
</tr>
<tr>
<td>E</td>
<td>Prime Financial Policies</td>
<td>66</td>
</tr>
<tr>
<td>F</td>
<td>The Nolan Principles</td>
<td>76</td>
</tr>
<tr>
<td>G</td>
<td>NHS Constitution - The Seven Key Principles</td>
<td>77</td>
</tr>
<tr>
<td>H</td>
<td>Standards for Members of NHS Boards and Clinical Commissioning Group Governing Bodies in England</td>
<td>78</td>
</tr>
<tr>
<td>J</td>
<td>Procurement Template</td>
<td>82</td>
</tr>
</tbody>
</table>
FOREWORD

NHS Blackpool Clinical Commissioning Group (the Group) is a membership organisation consisting of GP practices in Blackpool.

The Group is coterminous with Blackpool Council and will advance the partnership working arrangements with the local authority to ensure that the needs of the population of Blackpool are better understood to inform the commissioning strategies and reduce health inequalities.

The Group is the successor body of the former Blackpool PCT. It has developed from GP leaders as part of clinical leadership Groups within previous practice based commissioning and Blackpool PCT clinical groups. Blackpool PCT, as a commissioning organisation, had a history of clinical leadership. The Group will build upon the principles of clinically led commissioning, continuous improvement in the quality of care, and empowerment and engagement of patients, public and carers.

The Group aims to;

• Improve the health outcomes of the population and reduce health inequalities

• Work to ensure that commissioned services are responsive to patient needs, and that patients and the public are involved and integral to the work of the Group

• Continuously improve quality and outcomes of services and strive for excellence

• Commission all services for the population within the financial allocation of the Group.
1. INTRODUCTION AND COMMENCEMENT

1.1. Name

1.1.1. The name of this Clinical Commissioning Group is NHS Blackpool Clinical Commissioning Group (the Group).

1.2. Statutory Framework

1.2.1. The Group is established under the Health and Social Care Act 2012 (“the 2012 Act”).

It is a statutory body which has the function of commissioning services for the purposes of the health service in England and is an NHS body for the purposes of the National Health Service Act 2006 (“the 2006 Act”).

The duties of the Group 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.

1.2.2. The NHS Commissioning Board shall undertake an annual assessment of the Group.

It has powers to intervene in the Group if it is satisfied that it is failing or has failed to discharge any of its functions or that there is a significant risk that it will fail to do so.

1.2.3. The Group is a clinically led membership organisation made up of general practices. The members of the Group are responsible for determining its governing arrangements, which are set out in this Constitution.

1.3. Status of this Constitution

1.3.1. This Constitution is made between the members of the Group and has effect from 5th December 2012, when the NHS Commissioning Board established the Group. The Constitution shall be published on the Group’s website.

1.4. Amendment and Variation of this Constitution

1.4.1. This Constitution can only be varied in two circumstances.

a) where the Group applies to the NHS Commissioning Board and that application is granted;

b) where in the circumstances set out in legislation the NHS Commissioning Board varies the Group’s Constitution other than on application by the Group.

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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 14Z16 of the 2006 Act, inserted by section 26 of the 2012 Act
5 See sections 14Z21 and 14Z22 of the 2006 Act, inserted by section 26 of the 2012 Act
6 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
7 See section 14D of the 2006 Act, inserted by section 25 of the 2012 Act
8 See sections 14E and 14F of the 2006 Act, inserted by section 25 of the 2012 Act and any regulations issued
2. AREA COVERED

2.1. The geographical area covered by NHS Blackpool Clinical Commissioning Group is fully coterminous with the area of Blackpool Council. The Lower-layer Super Output Areas are shown in the map below.
3. **MEMBERSHIP**

3.1. **Membership of the Clinical Commissioning Group**

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

<table>
<thead>
<tr>
<th>Practice Name</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abbey Dale Medical Centre</td>
<td>50 Common Edge Road, Blackpool. FY4 5AU</td>
</tr>
<tr>
<td>Adelaide Street Family Practice</td>
<td>118 Adelaide Street, Blackpool. FY1 4LN</td>
</tr>
<tr>
<td>Arnold Medical Centre</td>
<td>204 St Annes Road, Blackpool. FY4 2EF</td>
</tr>
<tr>
<td>Ashfield Medical Centre</td>
<td>Moor Park Health and Leisure Centre, Bristol Avenue, Bispham, Blackpool. FY2 0JG</td>
</tr>
<tr>
<td>Bloomfield Medical Centre</td>
<td>118-120 Bloomfield Road, Blackpool. FY1 6JW</td>
</tr>
<tr>
<td>Cleveleys Group Practice</td>
<td>Kelso Avenue, Cleveleys, Blackpool. FY5 3LF</td>
</tr>
<tr>
<td>Crescent Surgery Cleveleys</td>
<td>Cleveleys Health Centre, Kelso Avenue, Cleveleys, Blackpool. FY5 3LF</td>
</tr>
<tr>
<td>Elizabeth Street Surgery</td>
<td>61 Elizabeth Street, Blackpool. FY1 3JG</td>
</tr>
<tr>
<td>Glenroyd Medical Centre</td>
<td>Moor Park Health and Leisure Centre, Bristol Avenue, Blackpool. FY2 0JG</td>
</tr>
<tr>
<td>Gorton Street Practice</td>
<td>Gorton Street, Blackpool. FY1 3JW</td>
</tr>
<tr>
<td>Grange Park Health Centre</td>
<td>Dinmore Avenue, Grange Park, Blackpool. FY3 7RW</td>
</tr>
<tr>
<td>Harrowside Medical Centre</td>
<td>72 Harrowside, Blackpool. FY4 1LR</td>
</tr>
<tr>
<td>Highfield Surgery</td>
<td>South Shore Primary Care Centre, Lytham Road, Blackpool. FY4 1TJ</td>
</tr>
<tr>
<td>Layton Medical Centre</td>
<td>200 Kingscote Drive, Blackpool. FY3 7EN</td>
</tr>
<tr>
<td>Marton Medical Practice</td>
<td>Whitegate Health Centre, Whitegate Drive, Blackpool. FY3 9ES</td>
</tr>
<tr>
<td>Newton Drive Health Centre</td>
<td>Newton Drive, Blackpool. FY3 8NX</td>
</tr>
<tr>
<td>North Shore Surgery</td>
<td>Moor Park Health and Leisure Centre, Bristol Avenue, Bispham, Blackpool. FY2 0JG</td>
</tr>
<tr>
<td>South King Street Medical Centre</td>
<td>25 South King Street, Blackpool. FY1 4NF</td>
</tr>
<tr>
<td>Stonyhill Medical Practice</td>
<td>South Shore Primary Care Centre, Lytham Road, Blackpool. FY4 1TJ</td>
</tr>
<tr>
<td>St Paul's Medical Centre</td>
<td>Dickson Road, North Shore, Blackpool. FY1 2HH</td>
</tr>
<tr>
<td>Vicarage Lane Surgery</td>
<td>189 Vicarage Lane, Marton, Blackpool. FY4 4NG</td>
</tr>
<tr>
<td>Waterloo Medical Centre</td>
<td>178 Waterloo Road, Blackpool. FY4 3AD</td>
</tr>
</tbody>
</table>

3.1.2. Appendix B of this Constitution contains the list of practices, together with the signatures of the practice representatives confirming their agreement to this Constitution.

3.2. **Eligibility**

3.2.1. A provider of primary medical services to a registered list of patients under a General Medical Services, Personal Medical Services or Alternative Provider Medical Service Contract, will be eligible to apply for membership of this Group\(^9\) provided that.

3.2.2.1 The Provider is located within the area of Blackpool Council.

3.2.2.2 The Governing Body approves the application.

See section 14A(4) of the 2006 Act, inserted by section 25 of the 2012 Regulations to be made.
4. MISSION, VALUES AND AIDS

4.1. Mission

4.1.1. The mission of NHS Blackpool Clinical Commissioning Group is to improve the health of the people of Blackpool and reduce health inequalities through strong, clinically led, commissioning of high quality healthcare services that are modern, truly patient centred and in the most appropriate setting.

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

4.2. Values

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

4.2.2. The values that lie at the heart of the Group’s work are to:

   a) uphold the values, rights and principles as set out within the NHS Constitution (see appendix G).
   b) ensure we listen and respond to the needs of our patients, service users, carers and the local community and that they are the centre of everything that we do.
   c) work effectively with all partners including staff, patients, service users, carers, other services and agencies to ensure the best possible outcomes.
   d) commission high quality healthcare which is focused on outcomes for individuals and wider community.
   e) continuously develop effective services building on best practice and delivering innovation and improvement.
   f) operate at all times in an open and transparent manner with effective risk management.
   g) work effectively in partnership with all stakeholders to integrate services where appropriate and ensure the best outcomes for patients.
   h) operate such that no conflict of interest affects the relationship between the GP as commissioner of services and being the patient’s advocate, and acting in the patient’s best interest at all times.
   i) to abide by principles of good governance set out or referred to in Clause 4.4 of this Constitution.
   j) involve local people and service users in the Group’s service planning and development processes.
   k) commit in the Group’s decision-making, and service planning and development processes to openness and transparency.

4.3. Aims

4.3.1. The Group’s aims are to:

   a) improve the health outcomes of the population and reducing health inequalities.
b) work to ensure that commissioned services are responsive to patient needs, and that patients and the public are involved and integral to the work of the CCG.

c) work to secure the continuous improvement of outcomes and quality of commissioned services and strive for excellence.

d) operate within its financial allocation and that it delivers financial balance.

4.4. Principles of Good Governance

4.4.1. In accordance with section 14L(2)(b) of the 2006 Act, 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;

c) the standards of behaviour published by the Committee on Standards in Public Life (1995) known as the ‘Nolan Principles’;

d) the seven key principles of the NHS Constitution;

e) the Equality Act 2010.

f) Standards for members of NHS boards and Clinical Commissioning Group governing bodies in England (incorporated into this Constitution at Appendix H)

4.5. Accountability

4.5.1. The Group will demonstrate its accountability to its members, local people, stakeholders and the NHS Commissioning Board 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 the NHS Commissioning Board as required.

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10 Inserted by section 25 of the 2012 Act

11 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

12 See Appendix F

13 See Appendix G

k) holding a number of events each year with local people and organisations to explain the progress and work of the Group

4.5.2. In addition to these statutory requirements, the Group will demonstrate its accountability by publishing principal commissioning and operational policies on its website.

4.5.3. 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.

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 (Gateway reference 17005, published 12 June 2012). They relate to:

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

b) commissioning emergency care for anyone present in the Group’s area;

c) paying its employees’ remuneration, fees and allowances in accordance with the determinations made by its Governing Body and determining any other terms and conditions of service of the Group’s employees;

d) determining the remuneration and travelling or other allowances of members of its Governing Body.

5.1.2. In discharging its functions the Group will:

a) act\(^\text{15}\), when exercising its functions to commission health services, consistently with the discharge by the Secretary of State and the NHS Commissioning Board of their duty to promote a comprehensive health service\(^\text{16}\) and with the objectives and requirements placed on the NHS Commissioning Board through the mandate\(^\text{17}\) published by the Secretary of State before the start of each financial year by:

   i) Delegating decision making authority to the Governing Body.
   ii) Complying with the terms of this Constitution, standing orders and scheme of delegation and reservation, the Governing Body will discharge all of its functions supported via a range of committees detailed within the Group’s organisational structure to include

\(^{15}\) See section 3(1F) of the 2006 Act, inserted by section 13 of the 2012 Act

\(^{16}\) See section 1 of the 2006 Act, as amended by section 1 of the 2012 Act

\(^{17}\) See section 13A of the 2006 Act, inserted by section 23 of the 2012 Act
a) Finance and Performance Committee - The committee will comply with its agreed terms of reference.
b) Quality and Engagement Committee - The committee will comply with its agreed terms of reference.
c) Audit Committee - The committee will comply with its agreed terms of reference.
d) Remuneration Committee - The committee will comply with its agreed terms of reference.
e) Primary Care Commissioning Committee - The committee will comply with its agreed terms of reference.

b) meet the public sector equality duty\(^{18}\) by:
   i) Publishing, at least annually, sufficient information to demonstrate compliance with this general duty across all functions.
   ii) Publishing specific measurable equality objectives.
   iii) Act in accordance with the Group’s equality strategy following the guidance of the Equality Delivery System for the NHS.

c) work in partnership with Blackpool Council to develop joint strategic needs assessments\(^{19}\) and joint health and wellbeing strategies\(^{20}\) by:
   i) Providing clinical membership and Group representation on the Blackpool Council Health and Well-being Board
   ii) Having provision for Blackpool Council’s Director of Public Health to be a voting member of the Governing Body

5.2. General Duties. In discharging its functions the Group will comply with its general duties to:

5.2.1. 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\(^{21}\)

5.2.2. Act effectively, efficiently and economically\(^{22}\)

5.2.3. Act with a view to securing continuous improvement to the quality of services\(^{23}\)

5.2.4. Assist and support the NHS Commissioning Board in relation to the Board’s duty to improve the quality of primary medical services\(^{24}\)

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\(^{18}\) See section 149 of the Equality Act 2010, as amended by paragraphs 184 and 186 of Schedule 5 of the 2012 Act
\(^{19}\) See section 116 of the Local Government and Public Involvement in Health Act 2007, as amended by section 192 of the 2012 Act
\(^{20}\) See section 116A of the Local Government and Public Involvement in Health Act 2007, as inserted by section 191 of the 2012 Act
\(^{21}\) 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)
\(^{22}\) See section 14Q of the 2006 Act, inserted by section 26 of the 2012 Act
\(^{23}\) See section 14R of the 2006 Act, inserted by section 26 of the 2012 Act
5.2.5. Promote the involvement of patients, their carers and representatives in decisions about their healthcare\(^\text{25}\)

5.2.6. Act with a view to enabling patients to make choices\(^\text{26}\)

5.2.7. Obtain appropriate advice\(^\text{27}\)

5.2.8. Have regard to the need to reduce inequalities\(^\text{28}\)

5.2.9. Promote innovation\(^\text{29}\)

5.2.10. Promote research and the use of research\(^\text{30}\)

5.2.11. 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\(^\text{31}\)

5.3. **Compliance with General Duties.** The Group will comply with its general duties by:

5.3.1. delegating responsibility for them to the Governing Body

5.3.2. discharging them in accordance with a policy that the Governing Body will adopt, keep under review and update for the Group

5.3.3. monitoring delivery of the duties through the Group’s reporting mechanisms.

5.4. **Public Involvement.** The Group will make arrangements to secure public involvement in the planning, development and consideration of proposals for changes and decisions affecting the operation of commissioning arrangements\(^\text{32}\) by:

a) Working in line with the Group’s engagement strategy

b) Working in partnership with patients, the local community, and as wide as possible cross-section of the people who use or may use the services provided to secure the best care

c) Adapting engagement activities to meet the specific needs of the different patient groups and communities

d) Publishing information about health services on its website, through other media, and in a variety of ways tailored to the needs of the local community

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\(^{24}\) See section 14S of the 2006 Act, inserted by section 26 of the 2012 Act

\(^{25}\) See section 14U of the 2006 Act, inserted by section 26 of the 2012 Act

\(^{26}\) See section 14V of the 2006 Act, inserted by section 26 of the 2012 Act

\(^{27}\) See section 14W of the 2006 Act, inserted by section 26 of the 2012 Act

\(^{28}\) See section 14T of the 2006 Act, inserted by section 26 of the 2012 Act

\(^{29}\) See section 14X of the 2006 Act, inserted by section 26 of the 2012 Act

\(^{30}\) See section 14Y of the 2006 Act, inserted by section 26 of the 2012 Act

\(^{31}\) See section 14Z1 of the 2006 Act, inserted by section 26 of the 2012 Act

\(^{32}\) See section 14Z2 of the 2006 Act, inserted by section 26 of the 2012 Act
e) Encouraging and acting on feedback
f) Having a lay member with a role to oversee public involvement
g) Having the Quality and Engagement Committee to oversee and give assurance of compliance

5.5. **General Financial Duties.** The Group will perform its functions so as to comply with its general financial duties to:

5.5.1. Ensure its expenditure does not exceed the aggregate of its allotments for the financial year\(^{33}\)

5.5.2. Ensure its use of resources (both its capital resource use and revenue resource use) does not exceed the amount specified by the NHS Commissioning Board for the financial year\(^{34}\)

5.5.3. Take account of any directions issued by the NHS Commissioning Board, in respect of specified types of resource use in a financial year, to ensure the Group does not exceed an amount specified by the NHS Commissioning Board\(^{35}\)

5.5.4. Publish an explanation of how the Group spent any payment in respect of quality made to it by the NHS Commissioning Board\(^{36}\)

5.6. **The Group will comply with its general financial duties by:**

5.6.1. delegating responsibility for them to the Governing Body

5.6.2. discharging them in accordance with a policy that the Governing Body will adopt, keep under review and update for the Group

5.6.3. monitoring delivery of the duties through the Group’s reporting mechanisms.

5.7. **Other Relevant Regulations, Directions and Documents**

5.7.1. The Group will

   a) comply with all relevant regulations;
   b) comply with directions issued by the Secretary of State for Health or the NHS Commissioning Board; and
   c) take account, as appropriate, of documents issued by the NHS Commissioning Board.

5.7.2. 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.

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\(^{33}\) See section 223H(1) of the 2006 Act, inserted by section 27 of the 2012 Act

\(^{34}\) See sections 223I(2) and 223I(3) of the 2006 Act, inserted by section 27 of the 2012 Act

\(^{35}\) See section 223J of the 2006 Act, inserted by section 27 of the 2012 Act

\(^{36}\) See section 223K(7) of the 2006 Act, inserted by section 27 of the 2012 Act
6. DECISION MAKING: THE GOVERNING STRUCTURE

6.1. Authority to act

6.1.1. The Group is accountable for exercising its statutory functions. 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) this Constitution;
b) the Group’s scheme of reservation and delegation; and

c) for committees, their terms of reference.

6.2. Scheme of Reservation and Delegation

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

a) those decisions that are reserved for the membership as a whole;
b) those decisions that are the responsibilities of its Governing Body (and its committees), the Group’s committees and sub-committees, individual members and employees.

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

6.3. General

6.3.1. In discharging functions of the Group that have been delegated to them, the Governing Body (and its committees including any sub- or joint committees) and any Committees of the Group (including any sub- or joint committees) must:

a) comply with the Group’s principles of good governance,\(^{38}\)
b) operate in accordance with the Group’s scheme of reservation and delegation,\(^{39}\)
c) comply with the Group’s standing orders.\(^{40}\)

\(^{37}\) See Appendix D
\(^{38}\) See section 4.4 on Principles of Good Governance above
\(^{39}\) See appendix D
\(^{40}\) See appendix C
d) comply with the Group’s arrangements for discharging its statutory duties, 

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

6.3.2. When a committee (including any sub- or joint committee) discharges delegated functions, it must also operate in accordance with its approved terms of reference.

6.4. Committees of the Group

6.4.1. The Group:

a) must on its establishment appoint a committee to be known as the Members’ Council, and

b) may on or at any time after its establishment appoint such other committees as it considers may be appropriate.

6.4.2. Committees will be able to establish their own sub-committees to assist them in discharging their respective responsibilities, but only if the power to do so has been delegated to them by the Group or the committee they are accountable to.

6.4A Members’ Council

6.4A.1 The members of the Members’ Council shall be the Group’s Practice Representatives.

6.4A.2 Subject to the provisions of the 2006 Act, the Members’ Council shall perform such functions of the Group which have been delegated to it by this Constitution and such further functions of the Group which have not otherwise been delegated to the Governing Body or another committee or an individual under this Constitution.

6.4A.3 The Members’ Council shall regulate their proceedings in accordance with the terms of reference that they will adopt at their first meeting and may thereafter amend at any subsequent meeting.

6.4A.4 The Members’ Council may appoint sub-committees consisting wholly or partly of Practice Representatives or wholly of persons who are not Practice Representatives.

6.4A.5 The Members’ Council shall first meet as soon as reasonably practicable after the Group’s authorisation and thereafter must meet at least once in each financial year of the Group.

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See chapter 5 above
6.5 Joint Arrangements

6.5.1 Joint commissioning arrangements with other Clinical Commissioning Groups

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

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

a. delegating any of the CCG’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 CCG and another CCG

6.5.1.3 For the purposes of the arrangements described at paragraph 6.5.1.2, the CCG 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.

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

6.5.1.5 For the purposes of the arrangements described at paragraph 6.5.1.2 above, the CCG may establish and maintain a pooled fund made up of contributions by any of the CCGs working together pursuant to paragraph 6.5.1.2.c above. Any such pooled fund may be used to make payments towards expenditure incurred in the discharge of any of the commissioning functions in respect of which the arrangements are made.

6.5.1.6 Where the CCG makes arrangements with another CCG as described at paragraph 6.5.1.2 above, the CCG 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.

6.5.1.7 The liability of the CCG to carry out its functions will not be affected where the CCG enters into arrangements pursuant to paragraph 6.5.1.2 above.

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

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

6.5.1.10 The Governing Body of the CCG shall require, in all joint commissioning arrangements, that the lead clinician and lead manager of the lead CCG make a quarterly written report to the Governing Body; hold at least annually an engagement event to review aims, objectives, strategy and progress; and publish an annual report on progress made against objectives.

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

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

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

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

6.5.2.3 The arrangements referred to in paragraph 6.5.2.2 above may include other CCGs.

6.5.2.4 Where joint commissioning arrangements pursuant to 6.5.2.2 above are entered into, the parties may establish a joint committee to exercise the commissioning functions in question.

6.5.2.5 Arrangements made pursuant to 6.5.2.2 above may be on such terms and conditions (including terms as to payment) as may be agreed between NHS England and the CCG.

6.5.2.6 Where the CCG makes arrangements with NHS England (and another CCG if relevant) as described at paragraph 6.5.2.2 above, the CCG 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.

6.5.2.7 The liability of the CCG to carry out its functions will not be affected where the CCG enters into arrangements pursuant to paragraph 6.5.2.2 above.

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

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

6.5.2.10 The Governing Body of the CCG shall require, in all joint commissioning arrangements that the lead clinician and lead manager of the CCG make a quarterly written report to the Governing Body; hold at least annually an engagement event to review aims, objectives, strategy and progress; and publish an annual report on progress made against objectives.

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

6.5.3 Joint commissioning arrangements with NHS England for the exercise of NHS England’s functions

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

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

6.5.3.4 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.

6.5.3.5 For the purposes of the arrangements described at paragraph 6.5.3.2 above, NHS England and the CCG may establish and maintain a pooled fund made up of contributions by the parties working together. Any such pooled fund may be used to make payments towards expenditure incurred in the discharge of any of the commissioning functions in respect of which the arrangements are made.

6.5.3.6 Where the CCG enters into arrangements with NHS England as described at paragraph 6.5.3.2 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.

6.5.3.7 The liability of NHS England to carry out its functions will not be affected where it and the CCG enter into arrangements pursuant to paragraph 6.5.3.2 above.

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

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

6.5.3.10 The Governing Body of the CCG shall require, in all joint commissioning arrangements that the lead clinician and lead manager of the CCG make a quarterly written report to the Governing Body; hold at least annually an engagement event to review aims, objectives, strategy and progress; and publish an annual report on progress made against objectives.

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

6.5.4 Joint committee arrangements with local authorities

6.5.4.1 The CCG may establish joint committees with one or more local authorities as it considers appropriate

6.6. The Governing Body

6.6.1. 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. The Governing Body has responsibility for:

a) ensuring that the Group has appropriate arrangements in place to exercise its functions effectively, efficiently and economically and in accordance with the Groups principles of good governance (its main function);

b) determining the remuneration, fees and other allowances payable to employees or other persons providing services to the Group and the allowances payable under any pension scheme it may establish under paragraph 11(4) of Schedule 1A of the 2006 Act, inserted by Schedule 2 of the 2012 Act;

c) approving any functions of the Group that are specified in regulations;

d) planning; setting the vision, strategy and operational plans;

e) approving commissioning plans;

f) monitoring performance against plans;

g) providing assurance of strategic risk;

h) commissioning health services areas; community health services, maternity services, elective hospital services, urgent and emergency services including accident and emergency, ambulance and out of hours, older people’s services, children’s services, including those with complex healthcare needs, rehabilitation services, wheelchair services, mental health services, learning disability services and continuing healthcare.

6.6.2. Composition of the Governing Body - the Governing Body shall not have less than 15 members and comprises of:

a) the Chair;

b) 7 GP representatives of member practices;

c) Up to 4 lay members:

i) one to lead on audit, remuneration and conflict of interest matters

ii) one to lead on patient and public participation matters

iii) one to be appointed Chair of the Governing Body

iv) one to lead on health inequalities

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

43 See section 4.4 on Principles of Good Governance above

44 See section 14L(5) of the 2006 Act, inserted by section 25 of the 2012 Act
d) 1 registered nurse;
e) 1 secondary care specialist doctor;
f) the Accountable Officer;
g) the Chief Finance Officer;
h) the Director of Public Health of Blackpool Council.
i) Chief Operating Officer

6.6.3. A Governing Body member’s post may be held by two individuals on a shared basis (save that the positions of registered nurse and secondary care specialist doctor cannot be shared between the two professions) but where such an arrangement is in force the two individuals may only exercise one vote between them at any meeting of the Governing Body.

6.6.4. The Governing Body shall comply with Standing Orders covering the proceedings and business of its meetings. The proceedings shall not, however, be invalidated by any vacancy of its membership, or defect in the calling of the meeting or a Governing Body member’s appointment.

6.6.5. Committees of the Governing Body - the Governing Body shall appoint the following committees and sub-committees:

a) Audit Committee

The key duties of the Audit Committee are governance, risk management and internal control. The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the CCG’s activities that support the achievement of the CCG’s objectives. In particular, the Committee will review the adequacy and effectiveness of:

- All risk and control related disclosure statements, together with any appropriate independent assurances, prior to endorsement by the CCG
- The underlying assurance processes that indicate the degree of the achievement of CCG objectives, the effectiveness of the management of principal risks and the appropriateness of the disclosure statements
- The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certification
- The policies and procedures for all work related to fraud and corruption
- All procedures and their operation in relation to conflicts of interest

The Audit Committee will meet not less than three times per year. The Lay Member on the Governing Body with a lead role in overseeing key elements of governance will chair the Audit Committee. The membership will include all other Lay Members excluding the Chair of the CCG. Officers in attendance at the invitation of the Chair will include: Chief Finance Officer; Internal Auditors; External Auditors; Local Anti-Fraud Specialist.
Appendix D of this Constitution details the decisions delegated to the Audit Committee.

The Governing Body has approved and keeps under review the terms of reference for the Audit Committee. Further information relating to the Committee can be found on the CCG’s website at:
http://blackpoolccg.nhs.uk/about-blackpool-ccg/who-we-are/our-committees/

b) Remuneration Committee

The Remuneration Committee shall determine the pay and remuneration of employees of the CCG. The Committee shall determine the remuneration and conditions of service, and review the performance of the Accountable Officer and other very senior team members, and determine annual salary awards if appropriate.

The Remuneration Committee will meet not less than once per year. The membership will comprise all of the CCG’s Lay Members, one of whom will be the Chairman of this Committee.

Appendix D of this Constitution details the decisions delegated to the Remuneration Committee.

The Governing Body has approved and keeps under review the terms of reference for the Remuneration Committee. Further information relating to the Committee can be found on the CCG's website at:
http://blackpoolccg.nhs.uk/about-blackpool-ccg/who-we-are/our-committees/

c) Finance and Performance Committee

The aims of the Finance and Performance Committee are to:
- Oversee the performance of the CCG in delivering the targets and objectives included in the local commissioning plan, ensuring the effective and efficient use of resources whilst delivering financial balance
- Assure that the commissioning portfolio delivers against national, regional and local contracted performance metrics and outcomes
- Consider and review high level financial issues and risks, and ensure corrective plans are in place where variation from plan requires action
- Ensure the CCG meets its financial duties and objectives
- Ensure the CCG complies with all information governance requirements

Meetings will be held monthly. The membership will comprise two lay members, one of whom is the Committee Chair; Chief Clinical Officer; three GP Clinical Elected Members; Chief Operating Officer; Chief Finance Officer. Other officers may be required to attend on an ad hoc basis.
Appendix D of this Constitution details the decisions delegated to the Finance and Performance Committee.

The Governing Body has approved and keeps under review the terms of reference for the Finance and Performance Committee. Further information relating to the Committee can be found on the CCG’s website at: http://blackpoolccg.nhs.uk/about-blackpool-ccg/who-we-are/our-committees/

d) Quality and Engagement Committee

The key aims of the Quality and Engagement Committee are to:

- Provide strategic overview of patient and public involvement and engagement in commissioning processes and decisions
- Oversee the development, implementation and monitoring of strategies which meet the requirements of the NHS Constitution and secure patient and public engagement
- Review the implementation and monitor progress on the Quality Strategy; Medicines Management Strategy; Public and Patient Engagement Strategy; Equality and Inclusion Strategy; Risk Management Strategy
- Secure continuous improvements in the quality of services for patients and in outcomes, with particular regard to clinical effectiveness, safety and patient experience, monitoring and reviewing quality performance
- Have regard to the need to reduce inequalities between patients with respect to their ability to access health services and the outcomes achieved for them
- Co-operate with the local authority and other partner organisations to improve the wellbeing of children
- Meet safeguarding duties including having regard to the need to safeguard and promote the welfare of children and adults
- Promote the involvement of individual patients and their carers and representatives in decisions relating to their care and treatment

Meetings will be held every two months. The membership will comprise two lay members, one of whom is the Committee Chair; Chief Clinical Officer; four GP Clinical Elected Members; Chief Operating Officer; Chief Nurse; Chief Finance Officer; Medicines Optimisation Lead. Other officers may be required to attend on an ad hoc basis.

Appendix D of this Constitution details the decisions delegated to the Quality and Engagement Committee.
The Governing Body has approved and keeps under review the terms of reference for the Quality and Engagement Committee. Further information relating to the Committee can be found on the CCG’s website at: http://blackpoolccg.nhs.uk/about-blackpool-ccg/who-we-are/our-committees/

e) Patient and Public Involvement Forum

The Patient and Public Involvement Forum is accountable to the Quality and Engagement Committee. The key aims of the Patient and Public Involvement Forum are to:

- Ensure the CCG fulfils its statutory responsibilities to:
  - Make arrangements to involve and consult patients and the public in service planning and operation, and in the development of proposals for change
  - Involve and engage people in line with the Equality Act 2010
  - Work in partnership with relevant bodies such as the Health and Wellbeing Board and Health Watch, and engage with different groups and communities
  - Ensure effective mechanisms are in place to capture the voice of practice populations

Meetings will be held every four to six weeks. The Lay Member on the Governing Body with a lead role in overseeing key elements of patient and public involvement will chair the Forum. The membership will include the Chief Nurse; a GP representative; an Equality and Inclusion Representative; a local authority representative; a Health Watch representative; a Council for Voluntary Services representative. Other officers may be required to attend on an ad hoc basis.

Appendix D of this Constitution details the decisions delegated to the Patient and Public Involvement Forum.

The Quality and Engagement Committee has approved and keeps under review the terms of reference of the Patient and Public Involvement Forum. Further information relating to the

Forum can be found on the CCG’s website at: http://blackpoolccg.nhs.uk/about-blackpool-ccg/who-we-are/our-committees/

f) Primary Care Commissioning Committee

NHS England has delegated to the CCG the authority to exercise certain specified primary care commissioning functions. The Primary Care Commissioning Committee has responsibility for the management of these delegated functions and the exercise of the delegated powers in accordance with the agreement entered into between NHS England and the CCG. The Committee will make decisions on the review, planning and procurement of primary care services, under delegated authority to the CCG from NHS England.
Meetings will be held every two months, and will be held in public. The membership will comprise all of the CCG’s Lay Members, one of whom will be Chairman of this Committee; Chief Clinical Officer; two GP Clinical Elected Members; Chief Operating Officer; Chief Finance Officer; Chief Nurse. A local authority representative and Health Watch representative will be invited to attend. Other officers may be required to attend on an ad hoc basis.

Appendix D of this Constitution details the decisions delegated to the Primary Care Commissioning Committee.

The Governing Body has approved and keeps under review the terms of reference for the Primary Care Commissioning Committee. Further information relating to the Committee can be found on the CCG’s website at: http://blackpoolccg.nhs.uk/about-blackpool-ccg/who-we-are/our-committees/

7. ROLES AND RESPONSIBILITIES

7.1. Practice Representatives

7.1.1. Each member of the Group shall appoint a practice representative and notify the Accountable Officer in writing the name of its practice representative for the time being.

7.1.2. Practice representatives represent their practice’s views and act on behalf of the practice in matters relating to the Group.

7.1.3. The role of each practice representative is to:
   a) be a member of the Members’ Council, and
   b) act on behalf of the member 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)

7.2. All Members of the Group’s Governing Body


7.3. The Chair of the Governing Body

7.3.1. The Chair of the Governing Body will be appointed from the lay members of the Governing Body and is responsible for:

   a) leading the Governing Body, ensuring it remains continuously able to discharge its duties and responsibilities as set out in this Constitution;
   b) building and developing the Group’s Governing Body and its individual members;
c) ensuring that the Group has proper constitutional and governance arrangements in place;
d) ensuring that, through the appropriate support, information and evidence, the Governing Body is able to discharge its duties;
e) supporting the accountable officer in discharging the responsibilities of the organisation
f) contributing to building a shared vision of the aims, values and culture of the organisation
g) leading and influencing to achieve clinical and organisational change to enable the Group to deliver its commissioning responsibilities;
h) overseeing governance and particularly ensuring that the Governing Body and 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 the NHS Commissioning Board;
k) ensuring that the Group builds and maintains effective relationships, particularly with the individuals involved in overview and scrutiny from the relevant local authority.

7.4. The Deputy Chair of the Governing Body

7.4.1. The deputy Chair of the Governing Body shall deputise for the Chair of the Governing Body where he or she has a conflict of interest or is otherwise unable to act.

7.5. Role of the Accountable Officer

7.5.1. The Accountable Officer of the Group is a member of the Governing Body.

7.5.2. This role of Accountable Officer has been summarised in the NHS Commissioning Board’s guidance *Clinical commissioning Group governing body members: Role outlines, attributes and skills* (April 2012) as:

a) being responsible for ensuring that the clinical commissioning Group fulfils its duties to exercise its functions effectively, efficiently and economically thus ensuring improvement in the quality of services and the health of the local population whilst maintaining value for money;
b) at all times ensuring that the regularity and propriety of expenditure is discharged, and that arrangements are put in place to ensure that good practice (as identified through such agencies as the Audit Commission and the National Audit Office) 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.

7.5.3. In addition to the Accountable Officer’s general duties, where the Accountable Officer is also the senior clinical voice of the Group they will take the lead in interactions with stakeholders, including the NHS Commissioning Board.

7.6. Role of the Chief Finance Officer

7.6.1. The Chief Finance Officer is a member of the Governing Body and is responsible for providing financial advice to the Group and for supervising financial control and accounting systems.

7.6.2. This role of Chief Finance Officer has been summarised in a national document\(^{45}\) as:

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 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 the NHS Commissioning Board;

7.7. Role of the Chief Operating Officer

7.7.1. The Chief Operating Officer is a member of the Governing Body and is responsible for the executive managerial leadership for the establishment and operation of the Group.

7.7.2. The role of the Chief Operating Officer has been summarised in the NHS Commissioning Board’s guidance *Clinical commissioning Group governing body members: Role outlines, attributes and skills* (April 2012)\(^{46}\) as:

a) contributing to the senior leadership of the Group;
b) providing effective operational management across the organisation;
c) supporting the Chair of the Governing Body and other Governing Body members to ensure that the Governing Body remains properly constituted and delivers its functions as required by the Health and Social Care Bill;
d) ensuring that services commissioned by the Group are effectively performance managed and quality assured;

\(^{45}\) *Clinical commissioning Group governing body members: Role outlines, attributes and skills*. NHS Commissioning Board Authority April 2012

\(^{46}\) *Clinical commissioning Group governing body members: Role outlines, attributes and skills*. NHS Commissioning Board Authority April 2012
e) facilitating constructive relationships with and between member practices
f) ensuring that high quality, effective commissioning support services are in place
g) developing and maintaining collaborative and partnerships that will further the objectives of the Group
h) ensuring the Group implements appropriate mechanisms to communicate effectively with its external stakeholders
i) developing a capable and confident workforce with a positive culture that continually develops.

7.8. Role of the Chief Nurse

7.8.1. The chief nurse is a member of the Governing Body and is responsible for bringing a broader view, from their perspective as a registered nurse, on health and care issues to underpin the work of the Group especially the contribution of nursing to patient care.

7.8.2. The role of chief nurse has been summarised in the NHS Commissioning Board’s guidance Clinical commissioning Group governing body members: Role outlines, attributes and skills (April 2012)\(^{47}\) as:

a) being a registered nurse who has developed a high level of professional expertise and knowledge;
b) being competent, confident and willing to give an independent strategic clinical view on all aspects of Group business;
c) being highly regarded as a clinical leader, probably across more than one clinical discipline and/or specialty – demonstrably able to think beyond their own professional viewpoint;
d) being able to take a balanced view of the clinical and management agenda and draw on their specialist skills to add value;
e) being able to contribute a generic view from the perspective of a registered nurse whilst putting aside specific issues relating to their own clinical practice or employing organisation’s circumstances;
f) being able to bring detailed insights from nursing and perspectives into discussions regarding service re-design, clinical pathways and system reform; and
g) being the designated role responsible for safeguarding.

7.9. Role of the Secondary Care Doctor

7.9.1. The secondary care doctor is a member of the Governing Body and will bring a broad view on health and care issues to underpin the work of the Group. In particular, they will bring to the Governing Body an understanding of patient care in the secondary care setting.

7.9.2. The role of secondary care doctor has been summarised in the NHS Commissioning Board’s guidance Clinical commissioning Group governing body members: Role outlines, attributes and skills (April 2012)\(^{48}\) as:

\(^{47}\) Clinical commissioning Group governing body members: Role outlines, attributes and skills. NHS Commissioning Board Authority April 2012

NHS Blackpool Clinical Commissioning Group’s Constitution - 27 -
Approved by NHS England – June 2015
a) being a doctor who is, or has been, a secondary care specialist, who has a high level of understanding of how care is delivered in a secondary care setting;
b) being competent, confident and willing to give an independent strategic clinical view on all aspects of Group business;
c) being highly regarded as a clinical leader, preferably with experience working as a leader across more than one clinical discipline and/or specialty with a track record of collaborative working;
d) being able to take a balanced view of the clinical and management agenda, and draw on their in depth understanding of secondary care to add value;
e) being able to contribute a generic view from the perspective of a secondary care doctor whilst putting aside specific issues relating to their own clinical practice or their employing organisation’s circumstances; and
f) being able to provide an understanding of how secondary care providers work within the health system to bring appropriate insight to discussions regarding service redesign, clinical pathways and system reform.

7.10. Role of the Lay Member – with a lead role in overseeing key elements of governance

7.10.1. The lay member will bring specific expertise and experience to the work of the Governing Body. Their focus will be strategic and impartial, providing an external view of the work of the Group that is removed from the day to day running of the organisation. Their role will be to oversee key elements of governance including audit, remuneration and managing conflicts of interest.

7.10.2. The role of lay member has been summarised in the NHS Commissioning Board’s guidance Clinical commissioning Group governing body members: Role outlines, attributes and skills (April 2012) as:

a) having the skills, knowledge and experience to assess and confirm that appropriate systems of internal control and assurance are in place for all aspects of governance, including financial and risk management;
b) having an understanding of the role of audit in wider accountability frameworks;
c) having an understanding of the resource allocations devolved to NHS bodies and a general knowledge of the accounting regime within which the Group will operate;
d) having the ability to chair meetings effectively;
e) being able to give an independent view on possible internal conflicts of interest; and
f) having recent and relevant financial and audit experience is essential – sufficient to enable them to competently engage with financial management and reporting in the organisation and associated assurances.
7.11. **Role of the Lay Member – with a lead role in championing patient and public involvement**

7.11.1. The lay member will bring specific expertise and experience, as well as their knowledge as a member of the local community to the work of the Group. Their focus will be strategic and impartial, providing an external view of the work of the Group that is removed from the day to day running of the organisation. As one of the lay members, they may be asked to fulfil the role of Deputy Chair or Chair of the Governing Body, if appropriate. The role will ensure that; public and patients’ view are heard and their expectations understood and met as appropriate, the Group builds and maintains effective relationship with Local Healthwatch and draws ion existing patient and public engagement and involvement expertise; and ensure the Group has appropriate arrangements in place to secure public and patient involvement and responds in an effective and timely way to feedback and recommendations from patients, carers and the public.

7.11.2. The role of a lay member in championing patient and public involvement has been summarised in the NHS Commissioning Board’s guidance *Clinical commissioning Group governing body members: Role outlines, attributes and skills* (April 2012)\(^50\) as:

a) being able to give an independent view on possible conflicts of interest
b) having demonstrable understanding of the local arrangements for listening and responding to the voices of patients, carers and patient organisations;

c) having a track record of successfully involving patients carers and the public in the work of a public sector organisation;

d) having an understanding of effective involvement and engagement techniques, and how these can be applied in practice;

e) living within the local community or be able to demonstrate how they are otherwise able to bring that perspective to the Governing Body; and

f) being competent to chair meetings.

7.12. **Role of the Lay Member – with a lead role for health inequalities**

7.12.1. The lay member will bring specific expertise and experience to the work of the Governing Body. Their focus will be to ensure the work of the Group aims to address the issues of health inequalities.

7.12.2. The role of lay member responsible for health inequalities can be summarised as:

a) being able to give an independent view on possible conflicts of interest
b) having demonstrable understanding of the local health inequalities agenda.

c) ensuring that the strategic work of the Group addresses health inequalities.

d) living within the local community or be able to demonstrate how they are otherwise able to bring that perspective to the Governing Body; and

e) being competent to chair meetings.

\(^50\) *Clinical commissioning Group governing body members: Role outlines, attributes and skills*. NHS Commissioning Board Authority April 2012
7.13. Role of the Director of Public Health

7.13.1. The Director of Public Health for Blackpool Council is a member of the Governing Body and is responsible for bringing a public health perspective on health and care issues to underpin the work of the Group especially the contribution of ensuring the commissioning plans deliver improvements to health and wellbeing and address health inequalities.

7.14. Joint Appointments with other Organisations

7.14.1. The Group may have joint appointments with other organisations.

7.14.2. Joint appointments shall be supported by a memorandum of understanding between the organisations who are party to them.

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 follow the Seven Principles of Public Life, set out by the Committee on Standards in Public Life (the Nolan Principles), incorporated into this Constitution at Appendix F. They should act in accordance with the Standards for members of NHS boards and Clinical Commissioning Group governing bodies in England, set out by the Professional Standards Authority, incorporated into this Constitution at Appendix H. They must comply with this Managing Conflicts of Interest Policy set out here in the Group’s Constitution.

8.2 Conflicts of Interest

8.2.1 Effective handling of conflicts of interest is crucial for the maintenance of public trust in the commissioning system. In managing conflicts of interest, the Group will adhere to NHS England’s Managing Conflicts Of Interest: Statutory Guidance for CCGs. This guidance has been issued as statutory guidance under sections 14O and 14Z8 of the NHS Act 2006 (as amended by the Health and Social Care Act 2012). The Act sets out requirements for CCGs to make arrangements for managing conflicts of interest and potential conflicts of interest to ensure they do not affect, or appear to affect, the integrity of the CCG’s decision-making processes. The Group’s Audit Committee Chair and Accountable Officer will be required to verify to NHS England that the CCG has complied with this statutory guidance, and this will form part of an annual certification and CCG assurance.
8.2.2 A conflict of interest occurs where an individual’s ability to exercise judgement, or act in a role, is or could be impaired or otherwise influenced by his or her involvement in another role or relationship. The individual does not need to exploit his or her position or obtain an actual benefit, financial or otherwise, for a conflict of interest to occur.

8.2.3 Conflict of interests include:

- Direct financial interests – where an individual may financially benefit from the consequences of a commissioning decision

- Indirect financial interest – for example, payment to a spouse; or where an individual is a partner, member, or shareholder in an organisation that will benefit financially from the consequences of a commissioning decision

- Non-financial interest – for example, where an individual may enjoy a qualitative benefit from the consequence of a commissioning decision such as a positive effect on an individual’s reputation

- Conflicts of loyalty - for example, where an organisation of which the individual is a member or with which they have an affiliation benefits from the consequence of a commissioning decision

- Conflicts from personal or professional relationships with others – for example, where the role or interest of a family member, friend or acquaintance may influence an individual’s judgement or actions, or could be perceived to do so

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

8.2.5 The Group therefore requires its members and employees to follow the policy included here in the Constitution, and the NHS England Statutory Guidance on Managing Conflicts Of Interest. The Group’s policy is that if its members and employees are in any doubt about whether there is a potential conflict of interest, the Group requires the potential conflict of interest to be declared. Members and employees must recognise that:

- A perception of wrongdoing, impaired judgement or undue influence can be as detrimental as any of them actually occurring
• It is better to assume the existence of a conflict of interest and manage it appropriately rather than ignore it

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

8.3 Principles for managing conflicts of interest

8.3.1 In managing conflicts of interest, the Group will use the principles developed by NHS Clinical Commissioners, the Royal College of General Practitioners, the British Medical Association, and NHS England as follows:

• Doing business appropriately - if commissioners get their needs assessments, consultation mechanisms, commissioning strategies and procurement procedures right from the outset, then conflicts of interest become much easier to identify, avoid and/or manage, because the rationale for all decision-making will be clear and transparent and should withstand scrutiny

• Being proactive, not reactive - commissioners should seek to identify and minimise the risk of conflicts of interest at the earliest possible opportunity, for instance by: considering potential conflicts of interest when electing or selecting individuals to join the governing body or other decision-making bodies; ensuring individuals receive proper induction and training so that they understand their obligations to declare conflicts of interest. They should establish and maintain registers of interests, and agree in advance how a range of possible situations and scenarios will be handled, rather than waiting until they arise

• Assuming that individuals will seek to act ethically and professionally, but may not always be sensitive to all conflicts of interest - rules should assume people will volunteer information about conflicts and, where necessary, exclude themselves from decision-making, but there should also be prompts and checks to reinforce this

• Being balanced and proportionate - rules should be clear and robust but not overly prescriptive or restrictive. They should ensure that decision-making is transparent and fair, but not constrain people by making it overly complex or cumbersome

• Openness - ensuring early engagement with patients, the public, clinicians and other stakeholders, including local Health Watch and Health and Wellbeing Boards, in relation to proposed commissioning plans

• Responsiveness and best practice - ensuring that commissioning intentions are based on local health needs and reflect evidence of best practice – securing ‘buy in’ from local stakeholders to the clinical case for change
• Transparency - Documenting clearly the approach taken at every stage in the commissioning cycle so that a clear audit trail is evident

• Securing expert advice - ensuring that plans take into account advice from appropriate health and social care professionals, e.g. through clinical senates and networks, and draw on commissioning support, for instance around formal consultations and for procurement processes

• Engaging with providers - early engagement with both incumbent and potential new providers over potential changes to the services commissioned for a local population

• Creating clear and transparent commissioning specifications that reflect the depth of engagement and set out the basis on which any contract will be awarded

• Following proper procurement processes and legal arrangements, including even-handed approaches to providers

• Ensuring sound record-keeping, including up to date registers of interests

• A clear, recognised and easily enacted system for dispute resolution

8.4 Maintaining a register of interests

8.4.1 The Group will maintain a register of interests to include: the members of the group, members of its governing body, members of its committees or sub-committees of its governing body, and its employees. The Group will publish this register on the Group’s website.

8.4.2 Individuals must declare any conflict or potential conflict (using the Group’s Declaration of interests for members/employees form) in relation to a decision to be made by the group as soon as they become aware of it, and in any event within 28 days of becoming aware of it. The Group will record the interest in the register as soon as they become aware of it.

8.4.3 Individuals must ensure that, when they declare interests, this includes the interests of all relevant individuals within their own organisations (e.g. partners in a GP practice), who have a relationship with the Group and who would potentially be in a position to benefit from the Group’s decisions.

8.4.4 When entering an interest on its register of interests, the Group must ensure that it includes sufficient information about the nature of the interest and the details of those holding the interest.
8.4.5 The Group will ensure that, as a matter of course, declarations of interest are made and regularly confirmed or updated. This includes the following circumstances:

- On appointment - applicants for any appointment to the Group or its governing body will be asked to declare any relevant interests. When an appointment is made, a formal declaration of interests will be made and recorded.

- At meetings - all attendees will be asked to declare any interest they have in any agenda item before it is discussed or as soon as it becomes apparent. Even if an interest is declared in the register of interests, it will be declared in meetings where matters relating to that interest are discussed. Declarations of interest will be recorded in minutes of meetings.

- Quarterly – the Group will check on a quarterly basis that the register of interests is accurate and up to date.

- On changing role or responsibility - where an individual changes role or responsibility within the Group or its governing body, any change to the individual’s interests will be declared.

- On any other change of circumstances - wherever an individual’s circumstances change in a way that affects the individual’s interests (e.g. where an individual takes on a new role outside the Group or sets up a new business or relationship), a further declaration will be made to reflect the change in circumstances. This could involve a conflict of interest ceasing to exist or a new one materialising

8.4.6 If an individual fails to comply with this policy for managing conflicts of interest as set out here in section 8 of the Group’s Constitution, the individual will be subject to the Group’s Disciplinary Policy.

8.5 Register of procurement decisions, procurements and designing service requirements

8.5.1 The Group will maintain a register of procurement decisions taken, including the details of the decision; who was involved in making the decision (e.g. governing body or committee members and others with decision-making responsibility); and a summary of any conflicts of interest in relation to the decision and how this was managed by the CCG. The register will form part of the CCG’s annual accounts and will be signed off by external auditors.

8.5.2 The Group recognises the importance of managing any conflicts or potential conflicts of interest that may arise in relation to procurement. The Procurement, Patient Choice and Competition Regulations place requirements
on commissioners to ensure that they adhere to good practice in relation to procurement, do not engage in anti-competitive behaviour that is against the interest of patients, and protect the right of patients to make choices about their healthcare. The regulations set out that commissioners must manage conflicts and potential conflicts of interests when awarding a contract by prohibiting the award of a contract where the integrity of the award has been, or appears to have been, affected by a conflict; and keep appropriate records of how they have managed any conflicts in individual cases.

8.5.3 An area in which conflicts could arise is where the Group commissions (or continues to commission by contract extension) healthcare services, including GP services, in which a member of the Group has a financial or other interest. This may arise in the context of co-commissioning of primary care. The Group will use the factors set out in the procurement template (incorporated into this Constitution as Appendix J) when drawing up plans to commission services where this potentially is the case. Bidders, potential contractors, and potential service providers must declare any conflict or potential conflict using the Group’s declaration of interests for bidders/contractors form.

8.5.4 The Group will engage where appropriate, relevant providers, especially clinicians, in confirming that the design of service specifications will meet patient need. Such engagement must be done transparently and fairly. However, conflicts of interest may occur if the Group engages selectively with only certain providers (be they incumbent or potential new providers) in developing a service specification for a contract for which they may later bid. The Group will seek, as far as possible, to specify the outcomes that they wish to see delivered through a new service, rather than the process by which these outcomes are to be achieved. As well as supporting innovation, this helps prevent bias towards particular providers in the specification of services. Such engagement should follow the three main principles of procurement law, namely equal treatment, non-discrimination and transparency. This includes:

- Ensuring that the same information is given to all
- Advertise that a service design/re-design exercise is taking place widely and invite comments from any potential providers and other interested parties (ensuring a record is kept of all interactions)
- As the service design develops, engage with a wide range of providers on an ongoing basis to seek comments on the proposed design, e.g. via the Group’s website or via workshops with interested parties
- Use engagement to help shape the requirement to meet patient need but take care not to gear the requirement in favour of any particular provider(s)
• If appropriate, engage the advice of an independent clinical adviser on the design of the service

• Be transparent about procedures

• Ensure at all stages that potential providers are aware of how the service will be commissioned

• Maintain commercial confidentiality of information received from providers

8.5.5 The Group will manage conflicts of interest on an ongoing basis as part of the regular monitoring of a contract that has been awarded to a provider in which an individual commissioner has a vested interest.

8.5.6 The Group will ensure that details of all contracts, including the contract value, are published on the Group’s website as soon as contracts are agreed. Where the Group decides to commission services through Any Qualified Provider (AQP), the Group will publish on the website the type of services being commissioned and the agreed price for each service. The Group will ensure that such details are also set out in the annual report. Where services are commissioned through an AQP approach, the Group will ensure that there is information publicly available about those providers who qualify to provide the service.

8.6 Governance and decision-making

8.6.1 The Group’s Audit Committee will regularly review governance structures and arrangements for managing conflicts of interest and potential conflicts of interests to ensure that they do not, and do not appear to, affect the integrity of the Group’s decision-making, and that they reflect current statutory guidance. This review will include consideration of the following:

• The make-up of the Governing Body and committee structures (including the approach for decision-making in delegated commissioning of primary care)

• Whether there are sufficient management and internal controls to detect breaches of the Group’s conflicts of interest policy detailed here in the Group’s Constitution, including appropriate external oversight and adequate provision for whistleblowing

• How any non-compliance with these arrangements relating to conflicts of interest will be managed (including how this will be addressed when it relates to contracts already entered into). As well as actions to address non-compliance, the Group will review any lessons to be learned from such cases, e.g., by the Group’s Audit Committee conducting an incident review
• Reviewing and revising approaches to the Group’s register of interests, together with the introduction of a record of decisions

• Whether any training or other programmes are required to assist with compliance

8.6.2 The Group will consider whether conflicts of interest should exclude individuals from being appointed to the Governing Body or to a committee or sub-committee of the Group or Governing Body. The Group will assess the materiality of the interest, in particular whether the individual (or a family member or business partner) could benefit from any decision the Governing Body might make. If it is related to an area of business significant enough that the individual would be unable to make a full and proper contribution to the Governing Body, that individual should not become a member of the Governing Body. Any individual who has a material interest in an organisation which provides, or is likely to provide, substantial services to the Group (either as a provider of healthcare or commissioning support services) should not be a member of the Governing Body if the nature of their interest is such that they are likely to need to exclude themselves from decision-making on so regular a basis that it significantly limits their ability to effectively operate as a Governing Body member.

8.6.3 Where certain members of a decision-making body (be it the Governing Body, its committees or sub-committees, or a committee or sub-committee of the Group) have a material interest, they should either be excluded from relevant parts of meetings, or join in the discussion but not participate in the decision-making itself (i.e. not have a vote). The chair of the meeting has responsibility for deciding whether there is a conflict of interest and the appropriate course of corresponding action. All decisions, and details of how any conflict of interest issue has been managed, will be recorded in the minutes of the meeting and published in the register. In the event that the chair of a meeting is conflicted, the deputy-chair of that decision-making body must take the chair’s role for discussions and decision-making of that relevant part of the meeting.

8.6.4 Where more than 50% of the members attending a Governing Body or committee are prevented from taking a decision because of conflicted interests, the chair or deputy-chair will determine whether the discussion can proceed or whether it should be deferred. Decisions could still be made by the remaining members of the Governing Body or committee if the meeting remains quorate. If the meeting is not quorate, the Group’s Chair, Accountable Officer, and Audit Committee Chair will decide how the decision should be taken, or whether the decision will be deferred until such time that a quorum can be convened.
8.6.5 Procurement decisions relating to the commissioning of primary medical services will be made by the Primary Care Commissioning Committee. The membership of this committee is constituted so as to ensure that the majority is held by lay and executive members. The chair and vice-chair will always be lay members of the committee. A standing invitation is made to the Group’s local HealthWatch and Health and Wellbeing Board to appoint representatives to attend, including, for items where the public is excluded from a particular item or meeting for reasons of confidentiality. These two representatives do not form part of the voting membership of the committee. Meetings of this committee, including the decision-making and the deliberations leading up to the decision, should be held in public unless the Group has decided it is appropriate to exclude the public. These arrangements for primary medical care decision making do not preclude GP participation in strategic discussions on primary care issues, subject to appropriate management of conflicts of interest. They apply to decision-making on procurement issues and the deliberations leading up to the decision.

9. THE GROUP AS EMPLOYER

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

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

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

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

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

9.6. The Group will ensure that employees’ behaviour reflects the values, aims and principles set out above.
9.7. The Group will ensure that it complies with all aspects of employment law.

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

9.9. The Group recognises and confirms that nothing in or referred to in this constitution (including in relation to the issue of any press release or other public statement or disclosure) will prevent or inhibit the making of any protected disclosure (as defined in the Employment Rights Act 1996, as amended by the Public Interest Disclosure Act 1998) by any member of the group, any member of its governing body, any member of any of its committees or sub-committees or the committees or sub-committees of its governing body, or any employee of the group or of any of its members, nor will it affect the rights of any worker (as defined in that Act) under that Act.

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

10. TRANSPARENCY, WAYS OF WORKING AND STANDING ORDERS

10.1. General

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

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

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

10.2. Standing Orders

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

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

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

c) **Prime financial policies (Appendix E)** – which sets out the arrangements for managing the Group’s financial affairs.
## APPENDIX A - DEFINITIONS OF KEY DESCRIPTIONS USED IN THIS CONSTITUTION

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
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<tbody>
<tr>
<td><strong>2006 Act</strong></td>
<td>National Health Service Act 2006</td>
</tr>
<tr>
<td><strong>2012 Act</strong></td>
<td>Health and Social Care Act 2012 (this Act amends the 2006 Act)</td>
</tr>
</tbody>
</table>
| **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:  
    o sections 14Q and 14R of the 2006 Act (as inserted by section 26 of the 2012 Act),  
    o sections 223H to 223J of the 2006 Act (as inserted by section 27 of the 2012 Act),  
    o paragraphs 17 to 19 of Schedule 1A of the NHS Act 2006 (as inserted by Schedule 2 of the 2012 Act), and  
    o any other provision of the 2006 Act (as amended by the 2012 Act) specified in a document published by the Board for that purpose;  
  • exercises its functions in a way which provides good value for money. |
| **Area**                                  | the geographical area that the Group has responsibility for, as defined in Chapter 2 of this Constitution                                                                                                  |
| **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 by a committee created / appointed by the membership of the Group  
  • a committee / sub-committee created / appointed by the Governing Body |
| **Financial year**                        | this usually runs from 1 April to 31 March, but under paragraph 17 of Schedule 1A of the 2006 Act (inserted by Schedule 2 of the 2012 Act), it can for the purposes of audit and accounts run from when a clinical commissioning Group is established until the following 31 March |
| **Group**                                 | NHS Blackpool Clinical Commissioning Group, whose Constitution this is                                                                                                                                     |
| **Governing body**                        | the body appointed under section 14L of the NHS Act 2006 (as inserted by section 25 of the 2012 Act), with the main function of ensuring that a clinical commissioning Group has made appropriate arrangements for ensuring that it complies with:  
  • its obligations under section 14Q under the NHS Act 2006 (as inserted by section 26 of the 2012 Act), and  
  • such generally accepted principles of good governance as are relevant to it. |
| **Governing body member**                 | any member appointed to the Governing Body of the Group                                                                                                                                                   |
| **Lay member** | a lay member of the Governing Body, appointed by the Group. A lay member is an individual who is not a member of the Group or a healthcare professional (i.e. an individual who is a member of a profession regulated by a body mentioned in section 25(3) of the National Health Service Reform and Health Care Professions Act 2002) or as otherwise defined in regulations |
| **Member** | a provider of primary medical services to a registered patient list, who is a member of this Group (see tables in Chapter 3 and Appendix B) |
| **Practice representatives** | an individual appointed by a practice (who is a member of the Group) to act on its behalf in the dealings between it and the Group, under regulations made under section 89 or 94 of the 2006 Act (as amended by section 28 of the 2012 Act) or directions under section 98A of the 2006 Act (as inserted by section 49 of the 2012 Act) |
| **Registers of interests** | registers a Group is required to maintain and make publicly available under section 14O of the 2006 Act (as inserted by section 25 of the 2012 Act), of the interests of: • the members of the Group; • the members of its Governing Body; • the members of its committees or sub-committees and committees or sub-committees of its Governing Body; and • its employees. |
### APPENDIX B - LIST OF MEMBER PRACTICES

<table>
<thead>
<tr>
<th>Practice Name</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abbey Dale Medical Centre</td>
<td>50 Common Edge Road, Blackpool. FY4 5AU</td>
</tr>
<tr>
<td>Adelaide Street Family Practice</td>
<td>118 Adelaide Street, Blackpool. FY1 4LN</td>
</tr>
<tr>
<td>Arnold Medical Centre</td>
<td>204 St Annes Road, Blackpool. FY4 2EF</td>
</tr>
<tr>
<td>Ashfield Road Medical Centre</td>
<td>70-72 Ashfield Road, Bispham, Blackpool. FY2 0DJ</td>
</tr>
<tr>
<td>Bloomfield Medical Centre</td>
<td>118 - 120 Bloomfield Road, Blackpool. FY1 6JW</td>
</tr>
<tr>
<td>Cleveleys Group Practice</td>
<td>Kelso Avenue, Cleveleys, Blackpool. FY5 3LF</td>
</tr>
<tr>
<td>Crescent Surgery Cleveleys</td>
<td>Cleveleys Health Centre, Kelso Avenue, Cleveleys, Blackpool. FY5 3LF</td>
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<tr>
<td>Elizabeth Street Surgery</td>
<td>61 Elizabeth Street, Blackpool. FY1 3JG</td>
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<tr>
<td>Glenroyd Medical Centre</td>
<td>Moor Park Health and Leisure Centre, Bristol Avenue, Blackpool. FY2 0JG</td>
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<tr>
<td>Gorton Street Practice</td>
<td>Gorton Street, Blackpool. FY1 3JW</td>
</tr>
<tr>
<td>Grange Park Health Centre</td>
<td>Dinmore Avenue, Grange Park, Blackpool, FY3 7RW</td>
</tr>
<tr>
<td>Harrowside Medical Centre</td>
<td>72 Harrowside, Blackpool. FY4 1LR</td>
</tr>
<tr>
<td>Highfield Surgery</td>
<td>South Shore Primary Care Centre, Lytham Road, Blackpool. FY4 1TJ</td>
</tr>
<tr>
<td>Layton Medical Centre</td>
<td>200 Kingscote Drive, Blackpool. FY3 7EN</td>
</tr>
<tr>
<td>Marton Medical Practice</td>
<td>Whitegate Health Centre, Whitegate Drive, Blackpool. FY3 9ES</td>
</tr>
<tr>
<td>Newton Drive Health Centre</td>
<td>Newton Drive, Blackpool. FY3 8NX</td>
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<tr>
<td>North Shore Surgery</td>
<td>Moor Park Health and Leisure Centre, Bristol Avenue, Blackpool. FY2 0JG</td>
</tr>
<tr>
<td>South King Street Medical Centre</td>
<td>25 South King Street, Blackpool. FY1 4NF</td>
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<tr>
<td>Stonyhill Medical Practice</td>
<td>South Shore Primary Care Centre, Lytham Road, Blackpool. FY4 1TJ</td>
</tr>
<tr>
<td>St Paul’s Medical Centre</td>
<td>Dickson Road, North Shore, Blackpool. FY1 2HH</td>
</tr>
<tr>
<td>Vicarage Lane Surgery</td>
<td>189 Vicarage Lane, Marton, Blackpool. FY4 4NG</td>
</tr>
<tr>
<td>Waterloo Medical Centre</td>
<td>178 Waterloo Road, Blackpool. FY4 3AD</td>
</tr>
</tbody>
</table>
APPENDIX C – STANDING ORDERS OF THE GOVERNING BODY

1. STATUTORY FRAMEWORK AND STATUS

1.1.1 Introduction

1.1.2 These Standing Orders (SOs) have been drawn up to regulate the proceedings of the Governing Body of NHS Blackpool Clinical Commissioning Group (the Group) so that it can fulfil the Group's obligations, as set out in the National Health Services Act 2006, as amended by the Health and Social Care Act 2012 (the Act) and related regulations. They are effective from the date the Group is established.

1.1.3 The standing orders, together with the Group's scheme of reservation and delegation and prime financial policies, provide a procedural framework within which the Governing Body discharges the Group's business on its behalf. They set out the arrangements for conducting the Group's business, procedure at meetings of the Group, governing body and any committees or sub-committees, delegation of powers, declaration of interests and standards of conduct. These arrangements must comply, where applicable, with requirements set out in the 2012 Act and related regulations.

1.1.4 The standing orders, scheme of reservation and delegation, and prime financial policies have effect as if incorporated into the Group's constitution. Group members, employees, members of the governing body, committee and sub-committee members and persons working on behalf of the Group should be aware of the existence of these documents and, where necessary, be familiar with their detailed provisions.

1.2 Schedule of matters reserved to the Group and Scheme of Delegation

1.2.1 The National Health Service Act 2006 (the 2006 Act) as amended by the Health and Social Care Act 2012 (the 2012 Act) gives the Group powers to delegate its functions and those of the Governing Body to certain bodies (such as committees) and persons. The Group may decide that certain decisions may only be exercised by the Group’ members. These decisions and also those delegated are contained in the Group’s Scheme of Reservation and Delegation.

1.2.2 The Group will comply with the 2006 Act and related regulations which set out provisions as to:

   • Qualification and disqualification for membership and appointment of chairs of governing bodies of their audit and remuneration committees;
   • How governing body members are to be appointed;
   • Eligibility for reappointment.

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

2.1 Composition of Membership

2.1.1 Chapter 3 of the Group's Constitution provides details of the membership (also see Appendix B).

2.1.2 Chapter 6 of the Group's Constitution provides details of the governing structure used in the Group's decision making process, whilst chapter 7 of the Constitution outlines certain key roles and responsibilities within the Group and its Governing Body, including the role of nominated practice representatives.
2.2 **Key Roles**

2.2.1 Paragraph 6.6.2 of the Group’s Constitution sets out the composition of the Group’s Governing Body whilst chapter 7 of the Group’s Constitution identifies certain key roles and responsibilities within the Group and its Governing Body. These standing orders set out how the Group appoints individuals to these key roles.

2.2.2 **The Chair**, as listed in paragraph 6.6.2 of the Group’s Constitution, is subject to the following appointment process:

   a) **Nominations.**
   The Group will appoint up to 4 Lay Members following a defined selection process. Lay Members appointed will be asked if they wish to be considered for the position of Chair, and if so, will be nominated for selection.

   b) **Eligibility.**
   The Chair must be an appointed Lay Member of the Group’s Governing Body. The Chair must be able to demonstrate that they meet the requirements as defined by the NHS Commissioning Board\(^5\)

   c) **Appointment Process.**
   Nomination of Lay Members who wish to be considered for the post of Chair are required to attend the NHS Commissioning Board national assessment centre, and receive positive confirmation of meeting the requirement for appointment.

   Interview with a panel from the Group’s Governing Body to confirm Lay Member matches the required skills, qualities and competencies for the role.

   Governing Body interview panel recommend to the Governing Body for appointment/non appointment.

   d) **Term of Office.**
   Length of tenure shall be three years.

   e) **Eligibility for reappointment.**
   The Chair will able to apply for re-appointment at the end of their term.

   f) **In the event of the Group receiving no suitable applications for the role of Accountable Officer from individuals holding a substantive clinical post**
   In this event, the amendment detailed in Appendix C, section 2.2.4 point e) will apply to the appointment of the Chair of the Group

2.2.3 **Deputy Chair**, one of the Governing Body roles as listed in paragraph 6.6.2 of the Group’s Constitution, will have the role of Deputy Chair.

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\(^5\) Clinical commissioning Group governing body members: Role outlines, attributes and skills. NHS Commissioning Board Authority April 2012
a) **Nominations.**
By application from the GP clinical elected members

b) **Eligibility.**
The deputy chair shall be appointed from the GP clinically elected members

c) **Appointment Process.**
Interview with a panel consisting of the Chair and Accountable Officer of the CCG.

d) **Term of Office.**
Length of tenure shall be three years

e) **Eligibility for reappointment.**
The deputy chair will be able to apply for re-appointment at the end of their term.

2.2.4 The **Accountable Officer** as listed in paragraph 6.6.2 of the Group’s Constitution, is subject to the following appointment process:

a) **Nominations**
By application

b) **Eligibility**
Applicants must hold a substantive clinical post. On appointment, this clinical post must be in a Blackpool CCG Member Practice.

c) **Appointment process**
Applicants will be interviewed by a panel comprised of representatives of the GP Clinical Elected Members of the Governing Body, the Chairman of the Governing Body, and an external individual capable of providing an expert opinion on the candidate’s ability to undertake the role. This panel will then nominate an applicant to NHS England, and the applicant must receive positive confirmation that they meet the requirements for appointment as detailed by NHS England. The Chief Executive of NHS England is legally responsible for confirming AO status on the successful applicant.

d) **Term of office**
Employed role, and shall therefore be for as long as they hold the post within the Group.

e) **In the event of the Group receiving no suitable applications from individuals holding a substantive clinical post**
In this event, the Group’s Governing Body will pass a resolution to invite applications from non-clinicians for the post of Chief Officer of the Group, and to undertake the role of Accountable Officer of the Group. The appointment process detailed in point c) above will still apply, and the term of office detailed in point d) will still apply.
In this event, the following amendment will apply to the appointment of the Chair of the Group as detailed in Appendix C, section 2.2.2:

The Chair as listed in paragraph 6.6.2 of the Group’s Constitution, is subject to the following appointment process:

i) Nominations

By application from the GP Clinical Elected Members of the Governing Body

ii) Eligibility

The Chair shall be appointed from the GP Clinical Elected Members of the Governing Body

iii) Appointment process

Applicants will be interviewed by a panel comprised of representatives of the GP Clinical Elected Members of the Governing Body. This panel will then nominate an applicant to NHS England, and the applicant must receive positive confirmation that they meet the requirements for appointment as detailed by NHS England.

iv) Term of office

Length of tenure shall be three years

v) Eligibility for reappointment

The Chair will be entitled to stand for re-election as a Clinical Elected Member, and if re-elected, apply for re-appointment as Chair

2.2.5 Chief Finance Officer as listed in paragraph 6.6.2 of the Group’s Constitution, is subject to the following appointment process:

a) Nominations.

By application.

b) Eligibility.

Any person who meets the person specification, which incorporates the national requirements for the role, and does not have any material conflict of interest.

c) Appointment Process.

Vacancies will be advertised in either local, regional or national media or respective professional publications.

Interview with a panel consisting of three individuals from the Group, and one external individual capable of providing an expert opinion on the candidate’s ability to undertake the role, and recommended by the NHS Commissioning Board.

Interview panel recommend to Governing Body the appointment/non-appointment of the Chief Finance Officer.

d) Term of Office.

Employed role, and shall therefore be for as long as they hold post within the Group.
2.2.6 **Chief Operating Officer** as listed in paragraph 6.6.2 of the Group’s Constitution, is subject to the following appointment process:

a) **Nominations.**
By application.

b) **Eligibility.**
The Accountable Officer shall be appointed from the GP Clinically Elected members.

c) **Appointment Process.**
Vacancies will be advertised in either local, regional or national media or respective professional publications.

Interview with a panel consisting of three individuals from the Group, and one external individual capable of providing an expert opinion on the candidate’s ability to undertake the role.

Interview panel recommend to Governing Body the appointment/non-appointment.

d) **Term of Office.**
Employed role, and shall therefore be for as long as they hold post within the Group.

2.2.7 **Chief Nurse** as listed in paragraph 6.6.2 of the Group’s Constitution, is subject to the following appointment process:

a) **Nominations.**
By application.

b) **Eligibility.**
Any person who meets the person specification, which incorporates the national requirements for the role, and does not have any material conflict of interest. The Chief Nurse will be a registered nurse.

c) **Appointment Process.**
Vacancies will be advertised in either local, regional or national media or respective professional publications.

Interview with a panel consisting of three individuals from the Group, and one external individual capable of providing an expert opinion on the candidate’s ability to undertake the role and recommended by the NHS Commissioning Board.

Interview panel recommend to Governing Body the appointment/non-appointment of the Chief Nurse.

d) **Term of Office.**
Employed role, and shall therefore be for as long as they hold post within the Group.
2.2.8 **Secondary Care Doctor** as listed in paragraph 6.6.2 of the Group’s Constitution, is subject to the following appointment process:

**a) Nominations.**  
By application

**b) Eligibility.**  
Any person who meets the person specification, which incorporates the national requirements for the role, and does not have any material conflict of interest.

**c) Appointment Process.**  
Advertisement in local media; short-listing process to national guidance; interview with a panel consisting of the Chair, Deputy Chair, and Accountable Officer of the CCG; interview panel recommend to Governing Body the appointment/non appointment.

**d) Term of Office.**  
Length of tenure shall be three years

**e) Eligibility for reappointment.**  
The Secondary Care Doctor will be able to apply for re-appointment at the end of their term.

2.2.9 **GP Clinical Elected Members** as listed in paragraph 6.6.2 of the Group’s Constitution, is subject to the following appointment process:

**a) Nominations.**  
Nominations will be submitted to the Local Medical Committee (LMC) who will oversee the election process.

**b) Eligibility.**  
All GPs in Blackpool holding a substantive clinical post in a member practice and meet the nationally defined skills and competencies\(^{52}\) are eligible.

**c) Appointment Process.**  
Working in partnership, nominations will be submitted to the LMC. Where nominations exceed positions on the Governing Body, elections will be held.

Voting eligibility will be any GP on the Blackpool performer list and providing the majority of service within member practices.

The Governing Body will be informed by the LMC of the outcome of the elections.

**d) Term of Office.**  
Length of tenure shall be three years

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\(^{52}\) *Clinical commissioning Group governing body members: Role outlines, attributes and skills.* NHS Commissioning Board Authority April 2012
e) Eligibility for reappointment.
Elected GP members will be entitled to stand for re-election for consecutive terms.

2.2.10 Lay Members as listed in paragraph 6.6.2 of the Group’s Constitution, is subject to
the following appointment process:

a) Nominations.
By application.

b) Eligibility.
Any person who meets the person specification, which incorporates the national
requirements for the role, is not an excluded person as defined nationally, and does
not have any material conflict of interest. Lay Members should be local residents, or
have close links with the local community.

c) Appointment Process.
Advertisement in local media.

Short listing process to national guidance for Groups.

Interview with a panel consisting of members of the Governing Body, including at
least two GPs, and one external individual capable of providing an expert opinion on
the candidate’s ability to undertake the role.

Interview panel recommend to Governing Body the appointment/non-appointment of
the Lay Member.

d) Term of Office
Length of tenure shall be three years

e) Eligibility for reappointment.
The lay members will be able to apply for re-appointment at the end of their term.

2.3 Disputes with member practices

2.3.1 The Group will agree a local dispute resolution process, supported by a decision
making panel. The process will set out how to raise a dispute, the right of appeal
and the escalation to the NHS Commissioning Board.

3. MEETINGS OF THE GOVERNING BODY

3.1 Meetings

3.1.1 The Governing Body will meet at least four times per year in public

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

3.1.3 One-third or more members of the Governing Body may requisition a meeting of it by
putting their request in writing to the Chair.
3.2 Notice of Meetings and the Business to be transacted

(1) Before each meeting of the Governing Body, a written notice specifying the business proposed to be transacted shall be sent to every member of the Governing Body and every member practice of the Group at least six clear days before the meeting.

(2) No business shall be transacted at the meeting other than that specified on the agenda, or emergency motions allowed under Standing Order 3.8.

(3) Before each public meeting of the Governing Body a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed on the Group’s website at least three clear days before the meeting.

3.3 Agenda and Supporting Papers

3.3.1 The Chair of the Governing Body will draw up the agenda with the Accountable Officer.

3.3.2 The Governing Body may determine that, at its meetings, certain matters shall appear on every agenda and shall be addressed prior to any other business being conducted.

3.3.3 A Practice Representative desiring a matter to be included on an agenda shall make his/her request in writing to the Chair at least 15 clear days before the meeting. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than 15 days before a meeting may be included on the agenda at the discretion of the Chair.

3.3.4 The Agenda will be sent to Practice Representatives six days before the meeting and supporting papers, whenever possible, shall accompany the agenda, but will certainly be despatched no later than three clear days before the meeting, save in emergency.

3.3.5 Subject to the agreement of the Chair, a Practice Representative may give written notice of an emergency motion after the issue of the notice of meeting and agenda, up to one hour before the time fixed for the meeting. The notice shall state the grounds of urgency. If in order, it shall be declared to the Governing Body at the commencement of the business of the meeting as an additional item included in the agenda. The Chair’s decision to include the item shall be final.

3.3 Petitions

3.3.1 Where a petition has been received by the Group the Chair shall include the petition as an item for the agenda of the next meeting of the Governing Body.

3.4 Chair of meeting

3.4.1 At any meeting of the Governing Body, the Chair, if present, shall preside. If the Chair is absent from the meeting, the nominated Deputy Chair if present, shall preside.
3.4.2 If the Chair is absent temporarily on the grounds of a declared conflict of interest the nominated Deputy Chair, if present, shall preside. If both are absent, a member chosen by the members present, or by a majority of them, shall preside.

3.5 Chair’s ruling

3.5.1 The decision of the Chair of the meeting on questions of order, relevancy and regularity and their interpretation of the Constitution, Standing Orders, Scheme of Reservation and Delegation and Prime Financial Policies at the meeting, shall be final.

3.6 Quorum

3.6.1 Meetings of the Governing Body

The quorum for the Governing Body shall be no less than half of the core membership and include at least one lay member and a minimum of two clinicians.

3.7 Decision making – all member practices

3.7.1 Commissioning decision making is delegated to the Governing Body as set out in the Constitution and the scheme of delegation.

3.7.2 Matters reserved to the Group will decided at a meeting of the Members Council.

3.8 Decision making – Governing Body

3.8.1 Governing Body decisions will be reached by consensus. Should a consensus not be reached, than a vote of members will be required.

3.8.2 Only members of the Governing Body will be permitted to vote. In the event of a tied vote the Chair will hold a second and casting vote.

3.9 Disagreement with a decision

In exceptional circumstances, there may be disagreement within the membership of the Group with a decision that has been made. In such circumstances those members taking a dissenting view may have their dissent recorded in the minutes.

3.10 Emergency powers and urgent decisions

The functions delegated to the Governing Body may in emergency or for an urgent decision be exercised by the Accountable Officer and the Chair of the Governing Body after having consulted at least two other members of the Governing Body. The exercise of such powers by the Accountable Officer and the Chair of the Governing Body shall be reported to the next formal meeting of the Governing Body in public session for formal ratification.

3.11 Suspension of Standing Orders

3.11.1 Except where it would contravene any statutory provision or any direction made by the Secretary of State for Health or the NHS Commissioning Board, any part of these
standing orders may be suspended at any meeting of the Governing Body, provided one third of the Governing Body members are in agreement.

3.11.2 A decision to suspend Standing Orders together with the reasons for doing so shall be recorded in the minutes of the Governing Body meeting.

3.11.3 A separate record of matters discussed during the suspension shall be kept. These records shall be made available to the Audit Committee for review of the reasonableness of the decision to suspend Standing Orders.

3.12 Application for variation and amendment of Standing Orders

3.12.1 This constitution can only be varied in two circumstances:

   a) where the Group formally applies to the NHS Commissioning Board and that application is granted;
   b) where in the circumstances set out in legislation the NHS Commissioning Board varies the Group’s constitution other than on application by the Group.

3.12.2 Any variation of the Constitution will be communicated to all members via the Group website with two weeks’ notice.

3.12.3 Standing Orders will be reviewed at least annually

3.13 Record of Attendance

The names of all members present at the meeting shall be recorded in the minutes of the Group meeting.

3.14 Minutes

The minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next meeting where they shall be signed by the person presiding at it as a true record.

No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate.

Minutes shall be made available to members and the public via the Group website.

3.15 Admission of the public and press

3.15.1 Admission and exclusion on grounds of confidentiality of business to be transacted

All meetings of the Group Governing Body will be open to the membership of the Group.

The Group will agree and publicise criteria for exclusion of business from the public part of any meeting.
The public and representatives of the press may attend all meetings of the Group or its Governing Body held in public, and should only be required to withdraw from these meetings where any information being shared is exempt from publication under the agreed criteria.

The public and representatives of the press shall be required to withdraw upon a resolution as follows:
'that representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest', Section 1 (2), Public Bodies (Admission to Meetings) Act 1960

3.15.2 Business proposed to be transacted when the press and public have been excluded from a meeting

Matters to be dealt with by the Group or its Governing Body following the exclusion of representatives of the press, and other members of the public, as provided above, shall be confidential to the members of the Group.

Members of the Group and Officers or any employee of the Group in attendance shall not reveal or disclose the contents of papers marked 'In Confidence' or minutes headed 'Items Taken in Private' outside of the meeting, without the express permission of the Governing Body. This prohibition shall apply equally to the content of any discussion during the Governing Body meeting which may take place on such reports or papers.

Minutes will be taken during this part of a meeting and will be marked confidential.

3.16 Vacancies and defective process

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

4. APPOINTMENT OF COMMITTEES AND SUB-COMMITTEES

4.1 Appointment of committees and sub-committees

4.1.1 Subject to any directions given by the NHS Commissioning Board, the Group may appoint committees and sub-committees of the Group and make provision for the appointment of committees and sub-committees of its Governing Body.

4.1.2 Other than where there are statutory requirements, such as in relation to the Audit Committee and Remuneration Committee of the Governing Body, the Group shall determine the membership and terms of reference of committees and sub-committees and shall, if it requires, receive and consider reports of such committees at the next appropriate meeting of the Group Governing Body.

4.1.3 The provisions of these Standing Orders shall apply where relevant to the operation of the Governing Body, all committees and sub-committees unless stated otherwise in the committee or sub committee’s Terms of Reference.
4.2 Terms of Reference

4.2.1 Terms of reference shall have effect as if incorporated into the Standing Orders.

4.3 Delegation of powers by committees to sub-committees

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

4.4 Approval of Appointments to Committees and Sub-Committees

4.4.1 The Group shall approve the appointments to each of the committees and sub-committees which it has formally constituted including those of the Governing Body. Where the Group determines that persons, who are neither members nor employees, shall be appointed to a committee or sub-committee the terms of such appointment shall be within the powers of the Group. The Group shall define the powers of such appointees and shall agree such travelling or other allowances as it considers appropriate.

5. DUTY TO REPORT NON-COMPLIANCE WITH STANDING ORDERS AND PRIME FINANCIAL POLICIES

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

6. USE OF SEAL AND AUTHORISATION OF DOCUMENTS

6.1 Group Seal

6.1.1 The Group shall have a seal for executing documents where necessary. The following individuals or officers are authorised to authenticate its use by their signature, or their named deputy:

- The Accountable Officer
- The Chairman of the Governing Body
- The Chief Finance Officer
- The Chief Operating Officer
- Elected GP Governing Body Members

6.1.2 An entry of every sealing shall be made and numbered consecutively in a book provided for that purpose, and shall be signed by the persons who shall have approved and authorised the document and those who attested the seal.

6.1.3 Use of Seal – General guide
- All contracts for the purchase/lease of land and/or building
• All contracts for capital works exceeding £100,000
• All lease agreements where the annual lease charge exceeds £10,000 per annum and the period of the lease exceeds beyond five years
• Any other lease agreement where the total payable under the lease exceeds £100,000
• Any contract or agreement with organisations other than NHS or other government bodies including local authorities where the annual costs exceed or are expected to exceed £500,000

6.2 Execution of a document by signature

6.2.1 The following individuals or their named deputy are authorised to execute a document on behalf of the Group by their signature.

The Accountable Officer
The Chairman of the Governing Body
The Chief Finance Officer
The Chief Operating Officer
Elected GP Governing Body Members

7. OVERLAP WITH OTHER GROUP POLICY STATEMENTS/PROCEDURES AND REGULATIONS

7.1 Policy statements: general principles

7.1.1 The Group will from time to time agree and approve Policy statements/ procedures which will apply to all or specific groups of staff employed by NHS Calderdale Clinical Commissioning Group. The decisions to approve such policies and procedures will be recorded in an appropriate Group minute and will be deemed where appropriate to be an integral part of the Group’s Standing Orders.
APPENDIX D – SCHEME OF RESERVATION AND DELEGATION

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

1.1. The arrangements made by the Group as set out in this scheme of reservation and delegation of decisions shall have effect as if incorporated in the Group’s Constitution.

1.2. The Group remains accountable for all of its functions, including those that it has delegated.
<table>
<thead>
<tr>
<th>Decision</th>
<th>Reserved to the Membership Council</th>
<th>Reserved or Delegated to Governing Body</th>
<th>Audit Committee</th>
<th>Remuneration Committee</th>
<th>Finance and Performance Committee</th>
<th>Quality and Engagement Committee</th>
<th>Primary Care Commissioning Committee</th>
<th>Accountable Officer</th>
<th>Chief Finance Officer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Determine the arrangements by which the members of the group approve those decisions that are reserved for the membership.</td>
<td>✓</td>
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<td>Consideration and approval of applications to the NHS Commissioning Board on any matter concerning changes to the group’s constitution, including terms of reference for the group’s governing body, its committees, membership of committees, the overarching scheme of reservation and delegated powers, arrangements for taking urgent decisions, standing orders and prime financial policies.</td>
<td>✓</td>
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<tr>
<td>Exercise or delegation of those functions of the clinical commissioning group which have not been retained as reserved by the group, delegated to the governing body or other committee or sub-committee or [specified] member or employee</td>
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<td></td>
<td></td>
<td>✓</td>
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<td>Prepare the group’s overarching scheme of reservation and delegation, which sets out those decisions of the group reserved to the membership and those delegated to the</td>
<td></td>
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<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Decision</td>
<td>Reserved to the Membership Council</td>
<td>Reserved or Delegated to Governing Body</td>
<td>Audit Committee</td>
<td>Remuneration Committee</td>
<td>Finance and Performance Committee</td>
<td>Quality and Engagement Committee</td>
<td>Primary Care Commissioning Committee</td>
<td>Accountable Officer</td>
<td>Chief Finance Officer</td>
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<td>• committees and sub-committees of the group, or</td>
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<td>• its members or employees and sets out those decisions of the governing body reserved to the governing body and those delegated to the governing body’s committees and sub-committees, members of the governing body, an individual who is member of the group but not the governing body or a specified person For inclusion in the group’s constitution.</td>
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<td>Approval of the group’s overarching scheme of reservation and delegation</td>
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<td>Prepare the group’s operational scheme of delegation, which sets out those key operational decisions delegated to individual employees of the clinical commissioning group, not for inclusion in the group’s constitution.</td>
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<td>Approval of the group’s operational scheme of delegation that underpins the group’s ‘overarching scheme of reservation and delegation’ as set out in its constitution.</td>
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<td>Prepare detailed financial policies that underpin the clinical commissioning group’s prime financial policies</td>
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<td>Approve arrangements for managing exceptional funding requests</td>
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<td><strong>PRACTICE MEMBER REPRESENTATIVES AND MEMBERS OF THE GOVERNING BODY</strong></td>
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<td>Approve the arrangements for • identifying practice members to represent practices in matters concerning the work of the group; and • appointing clinical leaders to represent the group’s membership on the group’s governing body, for example through election (if desired).</td>
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<td>Approve the appointment of governing body members, the process for recruiting and removing non-elected members to the governing body (subject to any regulatory requirements) and succession planning</td>
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<td>Approve arrangements for identifying the group’s proposed accountable officer.</td>
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NHS Blackpool Clinical Commissioning Group’s Constitution
Approved by NHS England – June 2015
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<td><strong>STRATEGY AND PLANNING</strong></td>
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<td>Agree the vision, values and overall strategic direction of the group</td>
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<td>Approval of the group’s operating structure</td>
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<td>Approval of the group’s commissioning plan. Approval of the group’s corporate budgets that meet the financial duties as set out in section 5.3 of the main body of the constitution</td>
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<td>Approval of variations to the approved budget where variation would have a significant impact on the overall approved levels of income and expenditure or the group’s ability to achieve its agreed strategic aims.</td>
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<td><strong>ANNUAL REPORT AND ACCOUNTS</strong></td>
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<td>Approval of the group’s annual report and annual accounts</td>
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<td>Approval of the arrangements for discharging the group’s statutory financial duties.</td>
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<td><strong>HUMAN RESOURCES</strong></td>
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<td>Approve the terms and conditions, remuneration and travelling or other allowances for governing body members, including pensions and gratuities</td>
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<td>Approve terms and conditions of employment for all employees of the group including, pensions, remuneration, fees and travelling or other allowances payable to employees and to other persons providing services to the group.</td>
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<td>Approve any other terms and conditions of services for the group’s employees</td>
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<td>Determine the terms and conditions of employment for all employees of the group.</td>
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<td>Determine pensions, remuneration, fees and allowances payable to employees and to other persons providing services to the group.</td>
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<td>Recommend pensions, remuneration, fees and allowances payable to employees and to other persons providing services to the group.</td>
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<td>Approve disciplinary arrangements for employees, including the accountable officer (where he/she is an employee or member of the clinical commissioning group) and for other persons working on behalf of the group.</td>
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<td>Review disciplinary arrangements where the accountable officer is an employee or member of another clinical commissioning group</td>
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<td>Approval of the arrangements for discharging the group’s statutory duties as an employer.</td>
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<td>Approve human resources policies for employees and for other persons working on behalf of the group</td>
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<td>Approve arrangements, including supporting policies, to minimise clinical risk, maximise patient safety and to secure continuous improvement in quality and patient outcomes</td>
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<td>Approve arrangements for supporting the NHS Commissioning Board in discharging its responsibilities in relation to securing continuous improvement in the quality of general medical services</td>
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<td>Approve the group’s counter fraud and security management arrangements.</td>
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<td>Approval of the group’s risk management arrangements</td>
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<td>Approve arrangements for risk sharing and or risk pooling with other organisations (for example arrangements for pooled funds)</td>
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<td>with other clinical commissioning groups or pooled budget arrangements under section 75 of the NHS Act 2006).</td>
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<td>Approval of a comprehensive system of internal control, including budgetary control, that underpin the effective, efficient and economic operation of the group</td>
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<td>Approve proposals for action on litigation against or on behalf of the clinical commissioning group.</td>
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<td>Approve the group’s arrangements for business continuity and emergency planning</td>
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**INFORMATION GOVERNANCE**

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<td>Approve the group’s arrangements for handling complaints</td>
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<td>Approval of the arrangements for ensuring appropriate and safekeeping and confidentiality of records and for the storage, management and transfer of information and data</td>
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**TENDERING AND CONTRACTING**

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<tr>
<td>Approval of the group’s contracts for any commissioning support.</td>
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<td>Approval of the group’s contracts for corporate support (subject to value)</td>
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### PARTNERSHIP WORKING

Approve decisions that individual members or employees of the Group participating in joint arrangements on behalf of the Group can make. Such delegated decisions must be consistent with this scheme of reservation and delegation, and with the Group’s scheme of delegation detailing limits of delegated authority of employees.

Ratify, decisions delegated to joint committees established under section 75 of the 2006 Act.

### COMMISSIONING AND CONTRACTING FOR CLINICAL SERVICES

Approval of the arrangements for discharging the group’s statutory duties associated with its commissioning functions, including but not limited to promoting the involvement of each patient, patient choice, reducing inequalities, improvement in the quality of services, obtaining appropriate advice and public engagement and consultation.
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<th>Decision</th>
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<tr>
<td>Approve arrangements for co-ordinating the commissioning of services with other groups and or with the local authority(ies), where appropriate.</td>
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<td>Approve arrangements for the review, planning, and procurement of primary care services – delegated to the Primary Care Commissioning Committee</td>
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<td>Approving arrangements for handling Freedom of Information requests</td>
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<td>Determining arrangements for handling Freedom of Information requests.</td>
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APPENDIX E – PRIME FINANCIAL POLICIES

1. INTRODUCTION

1.1. General

1.1.1. These prime financial policies and supporting detailed financial policies shall have effect as if incorporated into the Group’s Constitution.

1.1.2. The prime financial policies are part of the Group’s control environment for managing the organisation’s financial affairs. They contribute to good corporate governance, internal control and managing risks. They enable sound administration, lessen the risk of irregularities and support commissioning and delivery of effective, efficient and economical services. They also help the Accountable Officer and Chief Finance Officer to effectively perform their responsibilities. They should be used in conjunction with the scheme of reservation and delegation found at Appendix D.

1.1.3. In support of these prime financial policies, the Group has prepared more detailed policies, approved by the Accountable Officer, known as detailed financial policies. The Group refers to these prime and detailed financial policies together as the clinical commissioning Group’s financial policies.

1.1.4. These prime financial policies identify the financial responsibilities which apply to everyone working for the Group and its constituent organisations. They do not provide detailed procedural advice and should be read in conjunction with the detailed financial policies. The Accountable Officer is responsible for approving all detailed financial policies.

1.1.5. A list of the Group’s detailed financial policies will be published and maintained on the Group’s website.

1.1.6. Should any difficulties arise regarding the interpretation or application of any of the prime financial policies then the advice of the Chief Finance Officer must be sought before acting. The user of these prime financial policies should also be familiar with and comply with the provisions of the Group’s Constitution, standing orders and scheme of reservation and delegation.

1.1.7. Failure to comply with prime financial policies and standing orders can in certain circumstances be regarded as a disciplinary matter that could result in dismissal.

1.2. Overriding Prime Financial Policies

1.2.1. If for any reason these prime financial policies are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next formal meeting of the Governing Body’s audit committee for referring action or ratification. All of the Group’s members and employees have a duty to disclose any non-compliance with these prime financial policies to the chief finance officer as soon as possible.
1.3. **Responsibilities and delegation**

1.3.1. The roles and responsibilities of Group’s members, employees, members of the Governing Body, members of the Governing Body’s committees and sub-committees, members of the Group’s committee and sub-committee (if any) and persons working on behalf of the Group are set out in chapters 6 and 7 of this Constitution.

1.3.2. The financial decisions delegated by members of the Group are set out in the Group’s scheme of reservation and delegation (see Appendix D).

1.4. **Contractors and their employees**

1.4.1. Any contractor or employee of a contractor who is empowered by the Group to commit the Group to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Accountable Officer to ensure that such persons are made aware of this.

1.5. **Amendment of Prime Financial Policies**

1.5.1. To ensure that these prime financial policies remain up-to-date and relevant, the chief finance officer will review them at least annually. Following consultation with the Accountable Officer and scrutiny by the Governing Body’s audit committee, the chief finance officer will recommend amendments, as fitting, to the Governing Body for approval. As these prime financial policies are an integral part of the Group’s Constitution, any amendment will not come into force until the Group applies to the NHS Commissioning Board and that application is granted.

2. **INTERNAL CONTROL**

**POLICY** – the Group will put in place a suitable control environment and effective internal controls that provide reasonable assurance of effective and efficient operations, financial stewardship, probity and compliance with laws and policies

2.1. The Governing Body is required to establish an audit committee with terms of reference agreed by the Governing Body (see paragraph 6.6.3(a) of the Group’s Constitution for further information).

2.2. The Accountable Officer has overall responsibility for the Group’s systems of internal control.

2.3. The Chief Finance Officer will ensure that:

   a) financial policies are considered for review and update annually.
   b) a system is in place for proper checking and reporting of all breaches of financial policies; and
   c) a proper procedure is in place for regular checking of the adequacy and effectiveness of the control environment.
3. **AUDIT**

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

3.1. In line with the terms of reference for the Governing Body’s Audit Committee, the person appointed by the Group to be responsible for internal audit and the Audit Commission appointed external auditor will have direct and unrestricted access to audit committee members and the chair of the Governing Body, accountable officer and chief finance officer for any significant issues arising from audit work that management cannot resolve, and for all cases of fraud or serious irregularity.

3.2. The person appointed by the Group to be responsible for internal audit and the external auditor will have access to the Audit Committee and the Accountable Officer to review audit issues as appropriate. All Audit Committee members, the chair of the Governing Body and the Accountable Officer will have direct and unrestricted access to the head of internal audit and external auditors.

3.3. The Chief Finance Officer will ensure that:

a) the Group has a professional and technically competent internal audit function; and
b) the Governing Body’s Audit Committee approves any changes to the provision or delivery of assurance services to the Group.

4. **FRAUD AND CORRUPTION**

4.1. The Group shall require all staff to always act honestly and with integrity to safeguard the public resources they are responsible for. The Group will not tolerate any fraud perpetrated against it and will actively chase any loss suffered.

4.2. The Governing Body’s audit committee will satisfy itself that the Group has adequate arrangements in place for countering fraud and shall review the outcomes of counter fraud work. It shall also approve the counter fraud work programme.

4.3. The Governing Body’s audit committee will ensure that the Group has arrangements in place to work effectively with NHS Protect.
5. EXPENDITURE CONTROL

5.1. The Group is required by statutory provisions\textsuperscript{53} to ensure that its expenditure does not exceed the aggregate of allotments from the NHS Commissioning Board and any other sums it has received and is legally allowed to spend.

5.2. The Accountable Officer has overall executive responsibility for ensuring that the Group complies with certain of its statutory obligations, including its financial and accounting obligations, and that it exercises its functions effectively, efficiently and economically and in a way which provides good value for money.

5.3. The Chief Finance Officer will:

a) provide reports in the form required by the NHS Commissioning Board;

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

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

6. ALLOTMENTS\textsuperscript{54}

6.1. The Group’s Chief Finance Officer will:

a) periodically review the basis and assumptions used by the NHS Commissioning Board for distributing allotments and ensure that these are reasonable and realistic and secure the Group’s entitlement to funds;

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

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

7. COMMISSIONING STRATEGY, BUDGETS, BUDGETARY CONTROL AND MONITORING

\begin{quote}
\textbf{POLICY} – the Group will produce and publish an annual commissioning plan\textsuperscript{55} that explains how it proposes to discharge its financial duties. The Group will support this with comprehensive medium term financial plans and annual budgets
\end{quote}

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

\textsuperscript{53} See section 223H of the 2006 Act, inserted by section 27 of the 2012 Act

\textsuperscript{54} See section 223(G) of the 2006 Act, inserted by section 27 of the 2012 Act.

\textsuperscript{55} See section 14Z11 of the 2006 Act, inserted by section 26 of the 2012 Act.
7.2. Prior to the start of the financial year the chief finance officer will, on behalf of the accountable officer, prepare and submit budgets for approval by the Governing Body.

7.3. The Chief Financial Officer shall monitor financial performance against budget and plan, periodically review them, and report to the Finance and Performance Committee. This report should include explanations for variances. These variances must be based on any significant departures from agreed financial plans or budgets.

7.4. The Accountable Officer is responsible for ensuring that information relating to the Group’s accounts or to its income or expenditure, or its use of resources is provided to the NHS Commissioning Board as requested.

7.5. The Governing Body will approve consultation arrangements for the Group’s commissioning plan.

8. ANNUAL ACCOUNTS AND REPORTS

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

8.1. The Chief Finance Officer will ensure the Group:

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

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

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

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

e) publishes the external auditor’s management letter on the Group’s website.

9. INFORMATION TECHNOLOGY

POLICY – the Group will ensure the accuracy and security of the Group’s computerised financial data.

9.1. The Chief Finance Officer is responsible for the accuracy and security of the Group’s computerised financial data and shall:

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

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56 See section 14Z13 of the 2006 Act, inserted by section 26 of the 2012 Act
57 See paragraph 17 of Schedule 1A of the 2006 Act, as inserted by Schedule 2 of the 2012 Act.
b) ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;

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

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

9.2. In addition the Chief Finance Officer shall ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy must be obtained from them prior to implementation.

10. ACCOUNTING SYSTEMS

POLICY – the Group will run an accounting system that creates management and financial accounts

10.1. The Chief Finance Officer will ensure:

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

b) that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

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

11. BANK ACCOUNTS

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

11.1. The Chief Finance Officer will:

a) review the banking arrangements of the Group at regular intervals to ensure they are in accordance with Secretary of State directions\(^{58}\), best practice and represent best value for money;

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

c) prepare detailed instructions on the operation of bank accounts.

11.2. The Governing Body shall approve the banking arrangements.

\(^{58}\) See section 223H(3) of the NHS Act 2006, inserted by section 27 of the 2012 Act
12. INCOME, FEES AND CHARGES AND SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS.

**POLICY** – the Group will
- operate a sound system for prompt recording, invoicing and collection of all monies due
- seek to maximise its potential to raise additional income only to the extent that it does not interfere with the performance of the Group or its functions\(^{59}\)
- ensure its power to make grants and loans is used to discharge its functions effectively\(^{60}\)

12.1. The Chief Financial Officer is responsible for:

a) designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, and collection and coding of all monies due;
b) establishing and maintaining systems and procedures for the secure handling of cash and other negotiable instruments;
c) approving and regularly reviewing the level of all fees and charges other than those determined by the NHS Commissioning Board or by statute. Independent professional advice on matters of valuation shall be taken as necessary;
d) for developing effective arrangements for making grants or loans.

13. TENDERING AND CONTRACTING PROCEDURE

**POLICY** – the Group:
- will ensure proper competition that is legally compliant within all purchasing to ensure we incur only budgeted, approved and necessary spending
- will seek value for money for all goods and services
- shall ensure that competitive tenders are invited for
  - the supply of goods, materials and manufactured articles;
  - the rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the Department of Health); and
  - for the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens) for disposals

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

\(^{59}\) See section 14Z5 of the 2006 Act, inserted by section 26 of the 2012 Act.
\(^{60}\) See section 14Z6 of the 2006 Act, inserted by section 26 of the 2012 Act.
13.2. The Governing Body may only negotiate contracts on behalf of the Group, and the Group may only enter into contracts, within the statutory framework set up by the 2006 Act, as amended by the 2012 Act. Such contracts shall comply with:

a) the Group’s standing orders;
b) the Public Contracts Regulation 2006, any successor legislation and any other applicable law; and
c) take into account as appropriate any applicable NHS Commissioning Board or the Independent Regulator of NHS Foundation Trusts (Monitor) guidance that does not conflict with (b) above.

13.3. In all contracts entered into, the Group shall endeavour to obtain best value for money. The Accountable Officer shall nominate an individual who shall oversee and manage each contract on behalf of the Group.

14. COMMISSIONING

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

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

14.2. The Accountable Officer will establish arrangements to ensure that regular reports are provided to the Finance and Performance Committee detailing actual and forecast expenditure and activity for each contract.

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

15. RISK MANAGEMENT AND INSURANCE

POLICY – the Group will put arrangements in place for evaluation and management of its risks

15.1. The Group’s Chief Finance Officer will ensure that the Group has a robust and effective risk management policy, which has been approved by the Group’s Governing Body. This will include:

a) a procedure for identifying and quantifying risks and potential liabilities throughout the Group
b) suitable management procedure to mitigate all significant risk and potential liabilities
c) arrangements to review risk management procedures periodically.
15.2. The Group’s Chief Finance Officer will report to the Governing Body’s Audit Committee at least biannually on key risks and procedures for managing them.

15.3. The Governing Body’s Audit Committee must approve any significant changes to insurance arrangements that increase the risk to the Group.

16. PAYROLL

**POLICY** – the Group will put arrangements in place for an effective payroll service

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

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

b) has adequate internal controls and audit review processes;

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

16.2. In addition the chief finance office shall set out comprehensive procedures for the effective processing of payroll

17. NON-PAY EXPENDITURE

**POLICY** – the Group will seek to obtain the best value for money goods and services received

17.1. The Governing Body will approve the level of non-pay expenditure on an annual basis and the accountable officer will determine the level of delegation to budget managers

17.2. The Accountable Officer shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

17.3. The Chief Finance Officer will:

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

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

c) be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable.
18. CAPITAL INVESTMENT, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

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

18.1. The Accountable Officer will

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

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

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

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

18.2. The Chief Finance Officer will prepare detailed procedures for the disposals of assets.

19. RETENTION OF RECORDS

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

19.1. The Accountable Officer shall:

a) be responsible for maintaining all records required to be retained in accordance with NHS Code of Practice Records Management 2006 and other relevant notified guidance;

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

c) publish and maintain a Freedom of Information Publication Scheme.

20. TRUST FUNDS AND TRUSTEES

**POLICY** – the Group will put arrangements in place to provide for the appointment of trustees if the Group holds property on trust

20.1. The Chief Finance Officer shall ensure that each trust fund which the Group is responsible for managing is managed appropriately with regard to its purpose and to its requirements.
APPENDIX F - NOLAN PRINCIPLES

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

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

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

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

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

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

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

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

Source: *The First Report of the Committee on Standards in Public Life (1995)* \(^{61}\)

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\(^{61}\) Available at http://www.public-standards.gov.uk/
APPENDIX G – NHS CONSTITUTION

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

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

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

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

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

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

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

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

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

Standards for members of NHS boards and Clinical Commissioning Group governing bodies in England

November 2013

All members of NHS boards and CCG governing bodies should understand and be committed to the practice of good governance and to the legal and regulatory frameworks in which they operate. As individuals they must understand both the extent and limitations of their personal responsibilities.

To justify the trust placed in me by patients, service users, and the public, I will abide by these Standards at all times when at the service of the NHS.

I understand that care, compassion and respect for others are central to quality in healthcare; and that the purpose of the NHS is to improve the health and well-being of patients and service users, supporting them to keep mentally and physically well, to get better when they are ill and, when they cannot fully recover, to stay as well as they can to the end of their lives.

I understand that I must act in the interests of patients, service users, and the community I serve, and that I must uphold the law and be fair and honest in all my dealings.

Professional Standards Authority
167-197 Buckingham Palace Road, London SW1W 9SP
Telephone: 020 7389 8030  Email: info@professionalstandards.org.uk
Web: www.professionalstandards.org.uk
© Professional Standards Authority, Version 2.0, November 2013
Personal behaviour

1. As a Member¹ I commit to:
   * The values of the NHS Constitution
   * Promoting equality
   * Promoting human rights
   * in the treatment of patients and service users, their families and carers, the community, colleagues and staff, and in the design and delivery of services for which I am responsible.

2. I will apply the following values in my work and relationships with others:
   * **Responsibility**: I will be fully accountable for my work and the decisions that I make, for the work and decisions of the board², including delegated responsibilities, and for the staff and services for which I am responsible.
   * **Honesty**: I will act with honesty in all my actions, transactions, communications, behaviours and decision-making, and will resolve any conflicts arising from personal, professional or financial interests that could influence or be thought to influence my decisions as a board member.
   * **Openness**: I will be open about the reasoning, reasons, and processes underpinning my actions, transactions, communications, behaviours, and decision-making and about any conflicts of interest.
   * **Respect**: I will treat patients and service users, their families and carers, the community, colleagues and staff with dignity and respect at all times.
   * **Professionalism**: I will take responsibility for ensuring that I have the relevant knowledge and skills to perform as a board member and that I reflect on and identify any gaps in my knowledge and skills, and will participate constructively in appraisal of myself and others. I will adhere to any professional or other codes by which I am bound.
   * **Leadership**: I will lead by example in upholding and promoting these Standards, and use them to create a culture in which their values can be adopted by all.
   * **Integrity**: I will act consistently and fairly by applying these values in all my actions, transactions, communications, behaviours, and decision-making, and always raise concerns if I see harmful behaviour or misconduct by others.

¹ The term ‘Member’ is used throughout this document to refer to members of NHS boards and CCG governing bodies in England.
² The term ‘board’ is used throughout this document to refer collectively to NHS boards and CCG governing bodies in England.
Technical competence

3. As a Member, for myself, my organisation, and the NHS, I will seek:
   Excellence in clinical care, patient safety, patient experience, and the accessibility of services
   To make sound decisions individually and collectively
   Long term financial stability and the best value for the benefit of patients, service users, and the community.

4. I will do this by:
   - Always putting the safety of patients and service users, the quality of care, and patient experience first, and enabling colleagues to do the same
   - Demonstrating the skills, competencies, and judgement necessary to fulfil my role, and engaging in training, learning, and continuing professional development
   - Having a clear understanding of the business and financial aspects of my organisation’s work and of the business, financial, and legal contexts in which it operates
   - Making the best use of my expertise and that of my colleagues while working within the limits of my competence and knowledge
   - Understanding my role and powers, the legal, regulatory, and accountability frameworks and guidance within which I operate, and the boundaries between the executive and the non-executive
   - Working collaboratively and constructively with others, contributing to discussions, challenging decisions, and raising concerns effectively
   - Publicly upholding all decisions taken by the board under due process for as long as I am a member of the board
   - Thinking strategically and developmentally
   - Confidently and competently using data and other forms of intelligence, including patient complaints and feedback, to improve the quality of care
   - Understanding the health needs of the population I serve
   - Reflecting on personal, board, and organisational performance, and on how my behaviour affects those around me; and supporting colleagues to do the same
   - Looking for the impact of decisions on the services we and others provide, on the people who use them, and on staff
   - Listening to patients and service users, their families and carers, the community, colleagues, and staff, and making sure people are involved in decisions that affect them
   - Communicating clearly, consistently and honestly with patients and service users, their families and carers, the community, colleagues, and staff, and ensuring that messages have been understood.
Business practices

5. As a Member, for myself and my organisation, I will seek:
   To ensure my organisation is fit to serve its patients and service users, and the community
   To be fair, transparent, measured, and thorough in decision-making and in the management of public money
   To be ready to be held publicly to account for my organisation’s decisions and for its use of public money.

6. I will do this by:
   • Declaring any personal, professional, or financial interests and ensuring that they do not interfere with my actions, transactions, communications, behaviours, or decision-making, and removing myself from decision-making when they might be perceived to do so
   • Taking responsibility for ensuring that any harmful behaviour, misconduct, or systems weaknesses are addressed and learnt from, and taking action to raise any such concerns that I identify
   • Ensuring that effective incident reporting, disclosure, complaints, and whistleblowing procedures are in place and in use
   • Condemning any practices that could inhibit or prohibit the reporting of concerns by members of the public, staff, or board members about standards of care or conduct
   • Ensuring that staff provide high quality care in a listening, supportive, learning environment
   • Ensuring that patients and service users and their families have clear and accessible information about the choices available to them so that they can make their own decisions
   • Respecting patients’ rights to consent, privacy and confidentiality, and access to information, while enabling the legitimate sharing of information between care teams and professionals for the purposes of a patient’s direct care
   • Being open about the evidence, reasoning, and reasons behind decisions about budget, resource, and contract allocation
   • Seeking assurance that my organisation’s financial, operational, and risk management frameworks are sound, effective, and properly used, and that the values in these Standards are put into action in the design and delivery of services
   • Ensuring that my organisation’s contractual and commercial relationships are honest, legal, regularly monitored, and compliant with best practice in the management of public money
   • Working in partnership and co-operating with local and national bodies to support the delivery of safe, high quality care
   • Ensuring that my organisation’s dealings are made public, unless there is a justifiable and properly documented reason for not doing so.
APPENDIX J – PROCUREMENT TEMPLATE

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

Service:

<table>
<thead>
<tr>
<th>Question</th>
<th>Comment/Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. How does the proposal deliver good or improved outcomes and value for money – what are the estimated costs and the estimated benefits? How does it reflect the CCG’s proposed commissioning priorities? How does it comply with the CCG’s commissioning obligations?</td>
<td></td>
</tr>
<tr>
<td>2. How have you involved the public in the decision to commission this service?</td>
<td></td>
</tr>
<tr>
<td>3. What range of health professionals have been involved in designing the proposed service?</td>
<td></td>
</tr>
<tr>
<td>4. What range of potential providers have been involved in considering the proposals?</td>
<td></td>
</tr>
<tr>
<td>5. How have you involved your Health and Wellbeing Board? How does the proposal support the priorities in the relevant joint health and wellbeing strategy (or strategies)?</td>
<td></td>
</tr>
<tr>
<td>6. What are the proposals for monitoring the quality of the service?</td>
<td></td>
</tr>
<tr>
<td>7. Have all conflicts and potential conflicts of interests been appropriately declared and entered in registers which are publicly available? Have you recorded how you have managed any conflict or potential conflict?</td>
<td></td>
</tr>
<tr>
<td>8. Why have you chosen this procurement route?</td>
<td></td>
</tr>
<tr>
<td>9. What additional external involvement will there be in scrutinising the proposed decisions?</td>
<td></td>
</tr>
<tr>
<td>10. How will the CCG make its final commissioning decision in ways that preserve the integrity of the decision-making process and award of any contract?</td>
<td></td>
</tr>
</tbody>
</table>

Additional question when qualifying a provider on a list or framework or pre selection for tender (including but not limited to any qualified provider) or direct award (for services where national tariffs do not apply)

11. How have you determined a fair price for the service?

Additional question when qualifying a provider on a list or framework or pre selection for tender (including but not limited to any qualified provider) where GP practices are likely to be qualified providers

12. How will you ensure that patients are aware of the full range of qualified providers from whom they can choose?

Additional questions for proposed direct awards to GP providers

13. What steps have been taken to demonstrate that the services to which the contract relates are capable of being provided by only one provider?

14. In what ways does the proposed service go above and beyond what GP practices should be expected to provide under the GP contract?

15. What assurances will there be that a GP practice is providing high-quality services under the GP contract before it has the opportunity to provide any new services?