NHS CITY AND HACKNEY

CLINICAL COMMISSIONING GROUP

CONSTITUTION

VERSION 2.3

Version control

Version	Date	Author	Changes	Circulation
0.1	June	Paul	Amendments to standard format	Clare, Paul,
0.2	July	Paul	Incorporation of LMV versions, removal of unnecessary detail	Karl, Sue
0.3 & 0.4	26th July	Karl	After a review with Sue Assar, amendments made to some wording, format and order of detail	Clare/Paul to review prior to wider circulation – due to holiday this may go out to LMC and Greg Carns if no comments received by Monday 30.07.12
0.5	30th July	Matt	Formatting	Paul, Clare, LMC
0.6	August	Matt	Amendment to wording	Paul
0.7	29 August	Matt	New content following latest consultation	Paul, Karl, Clare
0.8	13 September	Matt	Consultation changes accepted, SFIs updated	CCG, external consultation & legal advice
0.8	17 September	Matt	Updated following Governing Body special session	
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.10	24 Sep. 12	Hempsons		Paul, Karl, Matt
.11	26 Sep. 12	Hempsons		Paul, Karl, Matt
.12	26 Sep. 12	Hempsons		Paul, Karl, Matt, Clare
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.15	08 Oct 12	Hempsons		Karl
.16	08 Oct 12	Karl		Paul and Clare
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.18	23.10.12 & 15 Nov 12	Karl	Changes to Finance structure and minor amendments	Karl
.19	20 Mch	Matt	formatting	Karl

Version	Date	Author	Changes	Circulation
.20	28 June	James & Karl	Constitutional change and formatting	Members' Forum NHSE Paul Haigh Clare Highton
.21	09 June 2014	Karl	Change to deputy chair relating to conflicts	Members' Forum NHSE Paul Haigh Clare Highton Philippa Lowe
.22	29 July 2014	Karl	Change regarding Remuneration TOR Kiv – associate lay member??	
.23	26/11/14	Karl	Amendments regarding associate lay members and additions of sub committees Amendments of reference to NCB and other changes. Closed practice removed.	Paul Haigh Philippa Lowe Members' Forum NHSE
.24	15/12/14	Karl	Amended version retaining appropriate additions made in preparations for Co-Commissioning but with the removal of specific primary care amendments. Additional changes are under review in respect to the changing responsibility of the contracts committee and Members' Forum for example and will be consulted on during September/October in time for the November window	Paul Haigh Philippa Lowe Members' Forum NHSE
1.0	16/09/2015	DAC Beachcroft LLP	Revised for compliance.	All
1.1	4/11/15	Karl Thompson, Paul Haigh	Reviewed for AC, Members' Forum, GB and NHSE consideration	Review process – AC, MF, GB, NHSE

Version	Date	Author	Changes	Circulation
1.2	20/11/2015	DAC Beachcroft	Review and amends for consistency post discussion with member representatives	Karl Thompson Fiona Sanders Deborah Colvin
1.3	6/4/16	Paul Haigh	Review and inclusion of LMC comments (Sarah Martyn)	
1.4	29/09/2016	DAC Beachcroft / Matthew Knell	Updated to take account of changes to Conflicts of Interest policy changes following revised NHSE guidance; Updated to cover role of third Lay Member; Updated to cover extension of terms of service for CCG Governing Body Members should need arise; Updated to cover GB succession arrangements.	
1.5	11/11/2016	Matt Hopkinson	Review and updates to Standing Orders Updates to Appendix H – Joint Arrangements	
1.6	29/11/2016	Matthew Knell	Added section 7.4 to Constitution and section 3 to the Scheme of Delegation to describe delegated commissioning of primary care governance, duties and functions.	NHSE in draft for Primary Care Commissioning application. DAC Beachcroft for legal advice.
1.7	26/01/2017	DAC Beachcroft / Matthew Knell	DAC Beachcroft comments and changes received. MK updated to take account of delegated primary care commissioning and integrated commissioning arrangements.	Members Forum for approval.
1.8	10/02/2017	Matthew Knell	Members Forum approval received, updated document to move Scheme of Delegation into standalone document and	Governing Body for approval

Version	Date	Author	Changes	Circulation
			prepare Constitution for Governing Body	
1.9	23/02/2017	Matthew Knell	Confirmation of the professional liability and indemnity of Governing Body members, in line with advice received from DAC Beachcroft, the CCG's solicitors added.	Governing Body & Members Forum for approval.
2.0	27/07/2017	Matthew Knell	Track changes accepted for publication post NHSE agreement	Publication on website
2.1	25/09/2017	Matthew Knell	Changes drafted to cover presidential Chair election	Internal advice, Members Forum and Governing Body
2.2	13/11/2017	Matthew Knell	NHSE agreed Constitutional changes	Public and published on website.
2.3	02/03/2018	Matthew Knell	Added changes to cover Managing Director role and changes to Nurse & Consultant term limits.	Agreed by Friday 23 February 2018 Governing Body, Thursday 1 March 2018 Members Forum and submitted to NHS England.

1 TABLE OF CONTENTS

2 FOREWORD

2.1.1 The Constitution sets out the arrangements made by NHS City and Hackney Clinical Commissioning Group (CCG) to meet our responsibilities for commissioning care for our patients and the principles we will operate by with our partners. It describes the governing principles, rules and procedures that we will establish to ensure probity and accountability in the day-to-day running of the CCG to ensure that decisions are made in an open and transparent way with the interests of our patients and clinicians central to our goals and ambitions.

3 INTRODUCTION

3.1 Name

3.1.1 The name of our Clinical Commissioning Group is NHS City and Hackney Clinical Commissioning Group (CCG).

3.2 Statutory Framework

3.2.1 Our CCG is established under the National Health Service Act 2006[1]. We are a statutory body which has the function of commissioning services for the purposes of the health service in England and are treated as an NHS body for the purposes of the 2006 Act[2]. The duties of our CCG are to commission certain health services set out in section 3 of the 2006 Act, as amended by section 13 of the Health and Social Care Act 2012, and the regulations made under that provision[3].

3.2.2 Our CCG will primarily be required to commission secondary care health services within the City of London and the London Borough of Hackney to:

a. All patients registered with members who are GP practices (as per section 5.1);
b. Individuals who are resident within the City of London and the London Borough of Hackney but not registered with members who are GP practices.

3.2.3 NHS England (NHSE), formally the NHS Commissioning Board (NCB) will undertake an annual assessment of the CCG[4]. It has powers to intervene where it is satisfied that the CCG is failing or has failed to discharge any of its functions or that there is a significant risk that it will do so[5].

3.2.4 We are a clinically led membership organisation made up of general practices. The members of our CCG (the Practices) are responsible for determining the governing arrangements for the CCG, which we are required to set out in this Constitution[6].

3.3 Status of this Constitution

3.3.1 This Constitution is made between the members of City and Hackney CCG and has effect from 1st day of April 2013 when the NCB established the CCG[7]. This Constitution is published on our website.

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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.

3.3.2 It is also available by post from NHS City and Hackney CCG, 3rd Floor, A Block, St Leonards Hospital, Nuttall Street, London N1 5LZ.

3.4 Amendment and Variation of this Constitution

3.4.1 This Constitution can only be varied in two circumstances[8]:

a. Where our members and the Governing Body apply to NHS England (following the process set out in paragraphs 3.4.2 to 3.4.6 below) and that application is granted;
b. Where, in the circumstances set out in legislation, NHS England varies our Constitution other than on application by our members.

3.4.2 Any Consortium representative, on behalf of their constituent members can call a meeting of the Members' Forum to discuss changes and amendments to this Constitution.

3.4.3 The CCG can also propose amendments to this Constitution and call a meeting of the Members' Forum to discuss the changes.

3.4.4 Constitutional amendments proposed by either a Consortium representative or the CCG must be agreed by a two thirds (⅔) majority vote of the total number of Practice Representatives at a meeting of the Members' Forum (i.e. not two thirds of those Practice Representatives present and voting, but two thirds of all Practice Representatives).

3.4.5 All proposed amendments to this Constitution also need to be confirmed by the Governing Body to be both lawful and in line with the CCGs statutory powers and responsibilities.

3.4.6 Amendments agreed by a vote of the Members' Forum in accordance with paragraph 3.4.4 and confirmed by the Governing Body shall be included in the Constitution and presented to NHS England for approval. Amendments to this Constitution can proceed to either the Governing Body for confirmation or to the Members' Forum for approval in either order, but both are required prior to submission to NHS England.

[8]See sections 14E and 14F of the 2006 Act, inserted by section 25 of the 2012 Act and any regulations issued.

4 AREA COVERED

4.1.1 The geographical area (the Area) covered by NHS City & Hackney CCG is:

a. The London Borough of Hackney;
b. The City of London Corporation.

5 MEMBERSHIP

5.1 Membership of the CCG

5.1.1 Appendix B of this Constitution lists the members of our CCG.

5.1.2 There are six Consortia (each a Consortium and together the Consortia) being South West Consortium, North West Consortium, North East Consortium, Rainbow & Sunshine Consortium, Well Consortium and Klear Consortium.

5.1.3 Each member shall belong to one of the CCG's six Consortia as shown in Appendix B.

5.2 Eligibility

5.2.1 A body which is a provider of primary care services (holding a General Medical Services (GMS), Personal Medical Services (PMS) or Alternative Personal Medical Services (APMS) Contract) in the locality may apply to become a Member of the CCG under the following conditions:

a. If the provider holds a contract for the provision of primary medical services;
b. It is a primary care services provider in City and Hackney;
c. It has duly submitted an application to NHS England for membership to City and Hackney CCG, such membership having been approved.

5.2.2 If an application is received from an eligible provider of primary care services as defined in 5.2.1, the Members' Forum will ask the Governing Body to apply to NHS England to amend the Constitution to admit the proposed new practice.

5.2.3 Each member shall nominate a Practice Representative to represent their Practice's views and act on behalf of the practice in matters relating to the CCG.

6 VISION, VALUES AND AIMS

6.1 What do we believe in?

6.1.1 We will transform the way services are delivered so that we can reduce health inequalities for our patients at the same time as improving quality and access, aspiring to provide the best healthcare to those living in the City of London and Hackney.

6.1.2 We want to ensure that our patients have easy access to a full range of services each of which delivers a consistently high standard of patient experience and clinical outcome.

6.1.3 We will adopt a whole person approach to what we commission, integrating NHS and social services where this makes clinical and financial sense and commit to commissioning and procuring services in a fair and ethical manner.

6.1.4 We will commission patient centred treatment and care that is grounded in dignity and mutual respect.

6.1.5 We will ensure that all our plans and decisions will benefit our patients and that all the work we engage in will really make a difference.

6.1.6 We will work together to protect and continue the strengths, ethos and values on which the NHS was founded.

6.1.7 We will work with our member practices, external partners and providers and our local communities to reduce health inequalities and improve quality for our patients.

6.1.8 We will play an active role in shaping, supporting and providing education both for members of our CCG and more widely for the NHS and the health and social care system.

6.1.9 We will make our decisions and conduct our business in an open and transparent fashion.

6.1.10 We will work to ensure clinicians and patients are motivated and inspired by what we do, and so will want to get involved and really influence our thinking.

6.1.11 We will work to ensure that patient choice is not restricted by the way we commission services and that the healthcare needs of different groups are considered equally and fairly.

6.1.12 We will ensure sustainability principles are embedded across our commissioned services thus preserving resources for future generations and ensuring public money is spent in the most effective and sustainable way possible.

6.1.13 We will play an active role in supporting and stimulating research and in ensuring that robust evidence from research is translated into clinical practice.

6.2 How will we do this?

6.2.1 By creating a strong and equal partnership between our patients, public and clinicians, working in an open and transparent manner.

6.2.2 By operating in an open and democratic manner, with GP consortia and other representative groups electing their representatives and involving all interested parties at all stages of our thinking and our decisions.

6.2.3 By committing to promoting and celebrating diversity and equality and to combatting racism, homophobia, sexism, discrimination against people with disabilities and similar behaviours and attitudes which undermine social cohesion and social justice.

6.2.4 By only commissioning services from providers who can demonstrate a commitment to their social responsibilities and to sustainability principles.

6.2.5 By working openly, transparently and extensively with our local providers to ensure we can stay in financial balance.

6.2.6 By debating and declaring conflicts of interest and anything that might be viewed as a conflict openly to ensure that we do not undermine the trust of our patients.

6.2.7 By committing to involving the public, patients and our members in our decisions, consulting and testing out our plans and ideas via our website, formal consultation, meetings and other appropriate routes.

6.2.8 By being receptive to all the feedback and views that we receive and explaining what we have done in response.

6.2.9 By publishing our Board papers and decisions in minutes on our website and documenting contract decisions in line with the Information Commissioner's Office Model Publication Scheme.

6.2.10 By being transparent in the decisions we make and how we make them, making as many decisions as possible in public and resisting being bound by conditions of commercial confidentiality.

6.2.11 By working with our Health and Wellbeing Boards (HWBs) and our patients, clinicians and partners to ensure that we collectively address the needs identified in both the Joint Strategic Needs Assessment (JSNA) and those raised by our patients, clinicians and partners.

6.2.12 By continually challenging our assumptions and initiatives through robust review of data, clinical evidence, best practice, research, clinical audit, patient and clinician views and experiences, patient and clinical outcomes, quality measures and benchmarked performance information.

6.2.13 By working with and always considering the needs of City and Hackneys unique communities and residents.

6.2.14 By working together with the public, patients, clinicians and local organisations, learning from and challenging each other and sharing ideas and best practice, promoting a culture of constructive challenge.

6.2.15 By promoting good governance and proper stewardship of public money in pursuing our goals and meeting our statutory responsibilities.

6.3 Principles of Good Governance

6.3.1 In accordance with section 14L (2) (b) of the 2006 Act[9], we will at all times observe generally accepted principles of good governance in the way we conduct our 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[10];
c. The standards of behaviour published by the Committee on Standards in Public Life (1995) known as the 'Nolan Principles'[11];
d. The seven key principles of the NHS Constitution[12];
e. The Equality Act 2010[13];
f. Establishing an inclusive and representative stakeholder community.

6.4 Accountability

6.4.1 We will demonstrate accountability to our members, local people, stakeholders and NHS England in a number of ways, including by:

a. Publishing our Constitution;
b. Appointing independent lay members and non GP clinicians to our Governing Body;
c. Holding meetings of our Governing Body in public on a monthly basis (except where we consider that it would not be in the public interest in relation to all or part of a meeting) that will be communicated well in advance of the meeting date not only through the CCG website and social media, but also via GP surgeries and the local press;
d. Production of an extensive website, detailing our role, ways of working, policies, performance information, tender, contract, procurement and service details as well as Governing Body and Sub Committee papers, consultations, decisions, local pathways, registers of interest, educational material and a Freedom of Information log and responses;
e. Disclosing on request all information that can lawfully be disclosed and flagging for inclusion on the website's Freedom of Information log;
f. Consulting our constituent practices, patients and the public, representative groups and local organisations and getting their ideas and input via our Consortia, representative groups, the Public and Patient Involvement Committee (PPIC), patient engagement activities of our

[9] Inserted by section 25 of the 2012 Act.
[10] 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.
[11] See Appendix F.
[12] See Appendix G.
[13] See http://www.legislation.gov.uk/ukpga/2010/15/contents.

practices, the monthly Clinical Commissioning Forum (CCF) and monthly newsletter;

g. Consulting on and publishing an annual commissioning plan developed with our practices and partners;
h. Complying with Local Authority health overview and scrutiny requirements;
i. Working with the Health and Wellbeing Boards;
j. Meeting at least annually in public in an annual general meeting (AGM) to publish and present our annual report;
k. Producing annual accounts in respect of each financial year which must be externally audited;
l. Having a published and clear complaints process;
m. Complying with the Freedom of Information Act 2000;
n. Exercising our patient and public engagement strategy available on our website;
o. Providing information to NHS England as required;
p. Calling a Members' Forum meeting.

6.4.2 The Governing Body of the CCG, supported by the Audit Committee will, throughout each year, have an ongoing role in reviewing our governance arrangements to ensure that we continue to reflect the principles of good governance and reflect on any lessons learnt from our operational experiences.

6.4.3 We recognise the role of the City and Hackney Local Medical Committee (LMC) in representing the professional interests of our GPs. We therefore are committed to maintaining a strong, open, effective and collaborative relationship with the LMC.

6.4.4 We will do this by:

a. Ensuring senior CCG representatives attend meetings of the City and Hackney LMC;
b. Keeping the LMC fully briefed on potential issues related to the delivery of services in practices as providers arising from the commissioning and activities of the CCG;
c. Sharing the Governing Body and Clinical Executive Committee papers with the LMC prior to each meeting and inviting a representative to attend;
d. Recognising that LMC representatives have the opportunity to raise issues at Consortia meetings and/or a Members' Forum meeting, as well as through the Chair, Accountable Officer and/or Managing Director;
e. Asking the LMC to oversee the GP election processes.

7 OUR FUNCTIONS AND GENERAL DUTIES

7.1 Functions

7.1.1 The functions that we are 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 CCGs'[14]. They relate to:

a. Commissioning certain health services (where NHS England is not under a duty to do so) that meet the reasonable needs of:
   - All people registered with member practices;
   - People who are usually resident within the area and are not registered with a member of any CCG.
b. Commissioning emergency care for anyone present in the CCGs area;
c. Paying its employees' and clinical leads 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 CCGs employees and clinical leads seconded to the CCG;
d. Determining the remuneration and travelling or other allowances of members of its Governing Body.

7.1.2 The CCG delegates to the Governing Body and its Committees the performance of its functions set out in clause 7.1.1.

7.1.3 In discharging its functions, the CCG and the Governing Body on its behalf will:

a. Act[15], when exercising our functions to commission health services, consistently with the discharge by the Secretary of State and the NHS England of their duty to promote a comprehensive health service[16] and with the objectives and requirements placed on the NHS England Board through the mandate[17] published by the Secretary of State before the start of each financial year by:
   - Delegating responsibility for exercising and ensuring compliance with this function to the Governing Body and its Sub Committees as laid out in the Standing Orders and in line with the vision, values and aims as laid out in section 6 of the Constitution.
b. Meet the public sector equality duty[18] by delegating responsibility for this function to the Governing Body to ensure the CCG operates with due regard to:
   - Elimination of unlawful discrimination, harassment and victimisation and other conduct prohibited by the 2010 Act;
   - Advancing equality of opportunity between people who share a protected characteristic and those who do not;
   - Fostering good relations between people who share a protected characteristic and those who do not.

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14 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_134570.

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.

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

c. Work in partnership with Local Authorities to develop joint strategic needs assessments[19] and joint health and wellbeing strategies[20] by:
    - Membership of the City of London Corporation and London Borough of Hackney Health and Wellbeing Boards.

7.2 General Duties

7.2.1 We are responsible for making arrangements to:

a. Secure public involvement in the planning, development and consideration of proposals for changes and decisions affecting the operation of commissioning arrangements[21]. These duties are delegated to our Governing Body who will abide by the following principles:
    - Working in partnership with patients, carers and the local community to secure the best care for them;
    - Adapting engagement activities to meet the specific needs of different patient groups and communities;
    - Publishing information about health services on the CCGs website and through other media;
    - Encouraging and acting on feedback;
    - Developing a Communications and Patient Public Involvement strategy that expands on these principles, details how we will implement them and how we will monitor and report compliance.

7.2.2 The CCG will fulfil the following general duties by delegating responsibility for exercising and ensuring compliance to the Governing Body and its Sub Committees as laid out in the Standing Orders and in line with the vision, values and aims as laid out in section 6 of the Constitution:

a. 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[22];
b. Act effectively, efficiently and economically[23];
c. Act with a view to securing continuous improvement to the quality of services[24];
d. Assist and support NHS England as the responsible commissioner, in relation to the Governing Body's duty to improve the quality of primary medical services and specialist commissioning, working in collaboration with the HWBBs[25];
e. Have regard to the need to reduce inequalities[26];
f. Promote the involvement of patients, their carers and representatives in decisions about their healthcare[27];

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[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 14Z2 of the 2006 Act, inserted by section 26 of the 2012 Act.
[22] 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).
[23] See section 14Q of the 2006 Act, inserted by section 26 of the 2012 Act.
[24] See section 14R of the 2006 Act, inserted by section 26 of the 2012 Act.
[25] See section 14S of the 2006 Act, inserted by section 26 of the 2012 Act.
[26] See section 14T of the 2006 Act, inserted by section 26 of the 2012 Act.
[27] See section 14U of the 2006 Act, inserted by section 26 of the 2012 Act.

g. Act with a view to enabling patients to make choices[28];
h. Obtain appropriate advice from persons who, taken together, have a broad range of professional expertise in healthcare and public health[29];
i. Promote innovation[30];
j. Promote research and the use of research[31];
k. Have regard to the need to promote education and training[32] for persons who are employed, or who are considering becoming employed, in an activity which involves or is connected with the provision of services as part of the health service in England so as to assist the Secretary of State for Health in the discharge of their related duty[33];
l. Act with a view to promoting integration of both health services and social care services where the CCG considers that this would improve the quality of services or reduce inequalities[34].

7.3 General Financial Duties

7.3.1 The CCG will fulfil the following financial duties by delegating responsibility for exercising and ensuring compliance to the Governing Body and its Sub Committees as laid out in the Standing Orders and in line with the vision, values and aims as laid out in section 6 of the Constitution:

a. Ensure its expenditure does not exceed the aggregate of its allocations for the financial year[35];
b. Ensure its use of resources (both its capital resource use and revenue resource use) does not exceed the amount specified by NHS England for the financial year[36];
c. Take account of any directions issued by NHS England, in respect of specified types of resource use in a financial year, to ensure the CCG does not exceed an amount specified by NHS England [37];
d. Publish an explanation of how the CCG spent any payment in respect of quality made to it by NHS England [38].

7.4 Other Relevant Regulations, Directions and Documents

7.4.1 The CCG will:

a. Comply with all relevant regulations;
b. Comply with directions issued by the Secretary of State for Health or NHS England;
c. Take account, as appropriate, of documents issued by NHS England;
d. Develop, consult on 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 (SORD) and other relevant CCG policies and procedures.

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[28] See section 14V of the 2006 Act, inserted by section 26 of the 2012 Act.
[29] See section 14W of the 2006 Act, inserted by section 26 of the 2012 Act.
[30] See section 14X of the 2006 Act, inserted by section 26 of the 2012 Act.
[31] See section 14Y of the 2006 Act, inserted by section 26 of the 2012 Act.
[32] See section 14Z of the 2006 Act, inserted by section 26 of the 2012 Act.
[33] See section 1F(1) of the 2006 Act, inserted by section 7 of the 2012 Act.
[34] See section 14Z1 of the 2006 Act, inserted by section 26 of the 2012 Act.
[35] See section 223H(1) of the 2006 Act, inserted by section 27 of the 2012 Act.
[36] See sections 223I(2) and 223I(3) of the 2006 Act, inserted by section 27 of the 2012 Act.
[37] See section 223J of the 2006 Act, inserted by section 27 of the 2012 Act.
[38] See section 223K(7) of the 2006 Act, inserted by section 27 of the 2012 Act.

8 DECISION MAKING AND OUR GOVERNING STRUCTURE

8.1 Authority to act

8.1.1 The CCG is accountable for exercising the statutory functions of the CCG. It may grant authority to act on its behalf to:

a. Any of its members;
b. Its Governing Body and its Committees;
c. Employees;
d. A Committee or Sub-Committee of the CCG.

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

a. The CCG's scheme of reservation and delegation (SORD);
b. For Committees, their duly approved terms of reference.

8.2 Scheme of Reservation and Delegation[39]

8.2.1 Our SORD is detailed in appendix D (available in a separate document) and sets out:

a. Those decisions that are reserved for the membership as a whole;
b. Those decisions that are the responsibilities of our Governing Body (and its Committees), the CCGs Committees and sub-committees, individual members and employees.

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

8.3 General

8.3.1 In discharging the functions of the CCG that have been delegated to its Governing Body (and its Committees), all individual committee members are expected to:

a. Comply with the CCGs principles of good governance[40] and Conflicts of Interest policy;
b. Operate in accordance with our scheme of reservation and delegation[41];
c. Comply with our standing orders[42];
d. Comply with our arrangements for discharging our statutory duties[43];
e. Where appropriate, ensure that member practices have had the opportunity to contribute to our decision making process.

8.3.2 When discharging their delegated functions, Committees and individuals must also operate in accordance with the approved terms of reference.

8.3.3 Where delegated responsibilities are being discharged collaboratively, the joint (collaborative) arrangements must:

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[39] See Appendix D.
[40] See section 6.3.
[41] See appendix D.
[42] See appendix C.
[43] See section 7.2.

a. Identify the roles and responsibilities of those CCGs who are working together;
b. Identify any pooled budgets and how these will be managed and reported in annual accounts;
c. Specify under which CCGs scheme of reservation and delegation and supporting policies the collaborative working arrangements will operate;
d. Specify how the risks associated with the collaborative working arrangement will be managed between the respective parties;
e. Identify how disputes will be resolved and the steps required to terminate the working arrangements;
f. Specify how decisions are communicated to the collaborative partners.

8.4 Joint commissioning arrangements with other Clinical Commissioning Groups

8.4.1 The Clinical Commissioning Group (CCG) may wish to work together with other CCGs in the exercise of its commissioning functions.

8.4.2 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;
c. Exercising jointly the commissioning functions of the CCG and another CCG.

8.4.3 For the purposes of the arrangements described at paragraph 8.4.2, 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;
d. Receive the services of the employees or the resources available to another CCG.

8.4.4 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.

8.4.5 For the purposes of the arrangements described at paragraph 8.4.2 above, the CCG may establish and maintain a pooled fund made up of contributions by any of the CCGs working together pursuant to paragraph 8.4.2 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.

8.4.6 Where the CCG makes arrangements with another CCG as described at paragraph 8.4.2 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.

8.4.7 The liability of the CCG to carry out its functions will not be affected where the CCG enters into arrangements pursuant to paragraph 8.4.2 above.

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

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

8.4.10 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 and hold at least annual engagement events to review aims, objectives, strategy and progress and publish an annual report on progress made against objectives.

8.4.11 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.

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

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

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

8.5.3 The arrangements referred to in paragraph 8.5.2 above may include other CCGs.

8.5.4 Where joint commissioning arrangements pursuant to 8.5.2 above are entered into, the parties may establish a joint Committee to exercise the commissioning functions in question.

8.5.5 Arrangements made pursuant to 8.5.2 above may be on such terms and conditions (including terms as to payment) as may be agreed between NHS England and the CCG.

8.5.6 Where the CCG makes arrangements with NHS England (and another CCG if relevant), as described at paragraph 8.5.2 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.

8.5.7 The liability of the CCG to carry out its functions will not be affected where the CCG enters into arrangements pursuant to paragraph 8.5.2 above.

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

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

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

8.5.11 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.

8.6 Joint and delegated commissioning arrangements with NHS England for the exercise of NHS England's functions

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

8.6.2 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.

8.6.3 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. Where arrangements are made for the CCG to exercise functions delegated from NHS England, a Committee of the CCG will be established to exercise the functions in question.

8.6.4 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.

8.6.5 For the purposes of the arrangements described at paragraph 8.6.2, 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.

8.6.6 Where the CCG enters into arrangements with NHS England as described at paragraph 8.6.2, 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.

8.6.7 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 8.6.2.

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

8.6.9 Only arrangements that are safe and in the interests of patients registered with member practices will be approved by the Local GP Provider Contracts Committee (LGPPCC).

8.6.10 The Governing Body of the CCG shall require, in all joint or delegated commissioning arrangements that the Accountable Officer and/or Managing Director of the CCG make a quarterly written report to the Governing Body and hold at least annual engagement events to review aims, objectives, strategy and progress and publish an annual report on progress made against objectives.

8.6.11 Should a joint or delegated 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.

8.7 Consortia

8.7.1 The CCG has six members' Consortia as listed in appendix B of this Constitution.

8.7.2 Application to join or change Consortium is made in writing by the lead Practice GP to the Lead of the Consortium they wish to join.

8.7.3 The Consortium members consider the application collectively and agree their decision which is communicated to the applying Practice and to the CCG within four weeks of the receipt of the application.

8.7.4 New Consortium membership is ratified by the Members' Forum.

8.8 Consortia Leads

8.8.1 Each Consortium has a Lead that must be a GP and as such:

a. Be either an active partner, a sessional GP or locum of a Member;
b. Shall not be eligible if they are, or subsequently are retired from the Member, suspended by either the General Medical Council (GMC), NHS England or any successor body;
c. If the individual is a sessional GP, they shall not be eligible in the event that they are suspended from their employment or subject to grievance or disciplinary proceedings;
d. For those individuals (including those stated at (c) above) who are not party to direct contractual arrangements for the provision of primary medical services, they must be on the NHS England Performers List;
e. The Chair and Vice Chair of the Local Medical Committee (LMC) cannot be a Consortium representative and consequently cannot be a Governing Body member or Clinical Executive Committee member.

8.8.2 The constituent members of each Consortium decide how to appoint their Consortia Lead and Deputy.

8.8.3 The Consortium members choose, by a simple majority, to:

a. Have a Lead and a Deputy or a job share Lead;
b. Elect or appoint their Lead(s);
c. Election and/or selection process for the Leads;
d. Constituency - i.e. who can stand - for each position.

8.8.4 Consortia should inform the LMC and Governing Body of their election/selection process.

8.8.5 A Consortium Lead is required to notify the Governing Body of their election providing evidence that the process detailed in 8.8.3 and the criteria in 8.8.1 of this Constitution have been followed.

8.8.6 Each Consortium Lead has a term of office of 2 years.

8.8.7 Three months' notice should be given on resigning from the role of Consortium Lead.

8.8.8 If at least 51% of a Consortium's members express that they no longer have confidence in their Consortium Lead, they can commence a new selection/election process at any time during their term of office.

8.8.9 The Consortia Leads feed in the views of their constituent Members to inform the CCG's decision making, policies and processes and provide an update on Consortia issues at the monthly Clinical Executive Committee meeting.

8.8.10 Any Consortium representative can request, in writing to the CCG Chair that an item is discussed and addressed at the next meeting of the Governing Body.

8.9 Committees of the CCG

8.9.1 The CCG may, from time to time, appoint such Committees as it considers appropriate. The role and functions of such Committees shall be set out in authorised terms of reference.

8.9.2 The CCG shall have a committee called the Members' Forum which shall comprise all of the Practice Representatives at any one time. Resolutions of the Members' Forum shall be agreed by a two thirds (⅔) majority vote of the total number of Practice Representatives (i.e. not two thirds of those Practice Representatives present and voting, but two thirds of all Practice Representatives).

8.9.3 Resolutions passed by such a vote of the Members' Forum shall be implemented by the Governing Body once the content of the resolution has been confirmed by the Governing Body to be both lawful and in line with the CCGs statutory powers and responsibilities.

8.10 The CCG Governing Body

8.10.1 The Governing Body shall not have less than ten members and shall comprise:

a. Three GP members, one of whom will be the Chair of the Governing Body;
b. At least three Lay Members, including:
    - One to lead on financial management, governance, conflicts of interest, audit and remuneration;
    - One with knowledge of the geographical area covered by the CCG, to lead on patient and public involvement and conflict of interest matters;
    - One to lead on other matters as required.
c. Additional Lay Members and Associate Lay Members may be appointed to provide additional independent lay representation as agreed by the Governing Body;
    - Associate lay members may be appointed to provide additional lay perspective and management of conflicts for committees or sub committees;
    - Associate Lay Members are non-voting Members of the Governing Body;
d. One registered nurse;
e. One secondary care specialist doctor;
f. The Accountable Officer;
g. The Chief Finance Officer;
h. The Managing Director:
    - The Managing Director is a non-voting Member of the Governing Body, able to exercise the Accountable Officer's vote in their absence;
i. Other attendees as invited, including Health Watch representatives from the City of London and London Borough of Hackney, the Local Authority Director of Public Health and the Local Medical Council representative, to provide advice and support, not as formal members of the Governing Body;

8.10.2 Three months notice should be given on resigning from any Governing Body post.

8.10.3 Any member of the Governing Body, including the Chair but excluding the Accountable Officer, Chief Finance Officer and Managing Director may be removed by a majority vote of no confidence by the Governing Body requiring at least two thirds (⅔) of the total number of members of the Governing Body (i.e. not two thirds of those Governing Body members present and voting, but two thirds of all Governing Body members).

8.10.4 When any member of the Governing Body is removed in accordance with section 8.10.3, or ceases to hold a position on the Governing Body at the end of their term of office under section 8.10.8, any other positions held by the individual on any other Committee or group of the CCG shall automatically be terminated.

8.10.5 Any member of the Governing Body (whether executive, non-executive or otherwise) who has acted honestly and in good faith, will not have to meet out of his or her own personal resources any civil liability which is incurred in the execution of his or her CCG functions, save where the person has acted recklessly.

8.10.6 All appointments to Governing Body roles are to be served consecutively, with any role only able to be filled by one individual at a time. Any election or appointment to a role cannot commence until any predecessor's appointment has ended.

8.10.7 Selecting the GPs for the Governing Body:

a. Each of the Consortia Leads is eligible to be one of the three GP members of the Governing Body;
b. Two of the GP positions on the Governing Body are selected to and filled by Consortia Leads, the process for which is covered in this section, while the CCG Chair is subject to an open election process set out in section 8.10.8;
c. The following procedure is subject to the process defined at 2.2 in Appendix C, which is to be adopted in the event of one or more unplanned vacancies for GP members of the Governing Body;
d. A Consortium Lead who applies to be a GP member of the Governing Body shall be assessed in accordance with an assessment process to be recommended by the Remuneration Committee and approved by the Members Forum;
e. The Consortia Leads shall decide by a simple majority the process by which they are selected to be GP members of the Governing Body, one as the Clinical Vice Chair, providing clinical leadership in the absence of the Chair of the Governing Body and the Chair of the Clinical Executive Committee. The other GP decided through this process will take up the role of Governing Body GP;
f. If the Consortia Leads cannot decide by a simple majority the process by which they are selected to be GP members of the Governing Body, they may decide that a ballot is required. If this is the case, then the Consortia Leads should decide who should vote (i.e. just the Consortia Leads or the wider GP membership);
g. Any election process involving the wider GP membership will need to be ratified by a majority vote of the Members' Forum;
h. The Governing Body will decide if the Consortium Lead has satisfactorily completed the assessment such that he or she is a suitable person to be one of the GP members of the Governing Body and that they are in accordance with paragraphs 8.8.1 and 8.15.1;

i. A Consortium Lead's appointment or election as a GP member of the Governing Body will be subject to ratification by a majority vote of the Members' Forum.

8.10.8 Selecting the Chair of the Governing Body:

a. The following procedure is subject to the process defined at 2.2 in Appendix C, which is to be adopted in the event of one or more unplanned vacancies for GP members of the Governing Body;
b. The CCG Chair is the Chair of the Governing Body and the position is elected to through an election process that is open to any candidate meeting the following criteria:
    - Working as a partnered or salaried GP with a CCG Member Practice in the CCG area for a minimum period of two years;
    - Be a suitable person to be a GP member of the Governing Body in accordance with paragraphs 8.8.1 and 8.15.1;
    - Meet the requirements of section 8.10.9 with regards to their term of service with the CCG;
    - Any candidate requires the written support of two sponsors, each of which must also be partnered or salaried GPs working with CCG Member Practices for a minimum period of two years.
c. The CCG will make an application process available, that includes a job role, person specification and require applications in writing to be returned within a specified time frame;
d. The CCG will arrange for candidate applications to be assessed and shortlisted by a panel in a consistent and fair manner against a framework agreed by the CCGs Remuneration Committee. The panel will be made up of the current CCG Chair, CCG Governing Body Lay Member, Consortia Lead GP that is not standing for the Chair role and the Chair of the Health and Wellbeing Board;
e. The CCG will host an event, chaired by the current CCG Chair and with a panel made up of the successfully shortlisted candidates. This event will:
    - Be advertised at least 14 days in advance of the event taking place, with all CCG Member Practices invited;
    - Be open to all staff working in CCG Member Practices;
    - Require questions for the panel to be submitted to the CCG 5 days in advance of the event.
f. The same questions will be posed to each candidate on the panel and the same amount of time allocated to each candidate to answer each question;
g. The final questions posed to the panel will be decided on by the current CCG Chair;
h. Each GP working as a partnered or salaried GP with a CCG Member Practice in the CCG area for a minimum period of two years will be allocated one vote;
i. The CCG will make a secure, electronic voting system available for a minimum period of one week. Details of how to access this system will be communicated to eligible GPs;
j. The CCGs Head of Membership Engagement or Head of Corporate Services will act as the returning officer;
k. Any issues with the election process can be raised with the returning officer, who will conduct an investigation with the involvement of the current CCG Chair and CCG Lay Member for Governance and keep the Members' Forum updated on their findings;

l. The returning officer will report the results of the open election process to the CCGs Member Practices within 2 days of the voting system closing, barring any issues with the process;
m. The successful candidate for CCG Chair will require appointment by a majority vote of the members of the Governing Body and ratification by a quorate vote of the Members' Forum;
n. If the successful candidate for CCG Chair is currently serving as a Consortia Lead GP, any duties that would be fulfilled by the Consortia Lead that may pose a conflict of interest should be dealt with in a fashion to be agreed by their Consortia;
o. Once the Chair has been agreed and takes up the role, that GP will need to relinquish any post as lead for a Consortia and the relevant Consortium chooses another GP representative for the Clinical Executive Committee;
p. The Deputy Chair of the Governing Body shall be one of the members of the Governing Body who is a Lay Member and shall be appointed by majority vote of the Governing Body.

8.10.9 Duration of Appointments to the Governing Body:

a. All appointments to the Governing Body and Clinical Executive Committee are for a 2 year term of service, excepting the Accountable Officer, Chief Finance Officer and Managing Director, who are employed by the CCG on a permanent contract basis;
b. Each term of service or extension must be agreed by the Governing Body and Members Forum;
c. After serving a term of 2 years all GP positions are subject to re-election under the process described in 8.8 and 8.10. GP Members (excepting Chairs / Vice Chairs as detailed in 8.10.8f) can be re-elected to serve a further term of 2 years and in addition have the flexibility of a 1 year extension as detailed in 8.10.8e;
d. Lay Member appointments to the Governing Body and Clinical Executive Committee can be offered a further 2 year term of service after their first term of office expires. A total of two consecutive terms of 2 years, with the flexibility of a 1 year extension as detailed in 8.10.8f can be served, subject to agreement by both the Governing Body and Members' Forum;
e. Nurse and Consultant appointments to the Governing Body can be offered a further 2 year term of service after their first term of office expires. Two consecutive terms of two years each, with the flexibility of a 1 year extension as detailed in 8.10.8f can be served, subject to agreement by both the Governing Body and Members' Forum;
f. A fair and transparent recruitment process for the Nurse and Consultant roles will be undertaken when needed, or after four years. If this process is unable to secure suitable candidates to join the Governing Body, the Governing Body and Members Forum can agree a further two year term of service for these appointments. This process can be repeated as needed and any extension (as detailed in 8.10.8f) can be sought after any term of service;
g. An additional 1 year extension to the term of each position (excepting the Accountable Officer, Chief Finance Officer and Managing Director, who are employed on a permanent contract basis and the Chair / Vice Chair) may be agreed, following the normal process of agreement from the Governing Body and Members' Forum, in order to allow for a staggered replacement of members;

h. Chair / Vice Chair appointees may serve a maximum of three consecutive 2 year terms. No Chair / Vice Chair shall serve for a period of more than 3 (2 year) terms without a break of at least 2 years.

8.11 Lay Members

8.11.1 The Lay Members (as listed in 8.10.1b) of this Constitution are subject to the following appointment process:

a. The following procedure is subject to the process defined at 2.2 in Appendix C, which is to be adopted in the event of one or more unplanned vacancies for Lay Members of the Governing Body;
b. They will be recruited following national advert, shortlisting and interview as recommended by the Remuneration Committee and approved by the Members' Forum;
c. Following ratification by a majority vote of the Members' Forum, they will be appointed for a two year period;
d. They may be removed by a vote of no-confidence by the Governing Body requiring at least two thirds of votes available.

8.11.2 Associate Lay Members attending the Governing Body will not be voting members unless they are asked to cover for an absent voting Lay Member and will be subject to the same appointment process as Lay Members. In addition, Associate Lay Members:

a. May be invited to attend the Board on a regular basis in order to provide additional lay input;
b. May be invited to attend or chair Committees, Sub Committees or other meetings of the CCG;
c. When covering for a voting Lay Member, will not be able to undertake the role of the PPI / Governance Lay Member if they are being asked to stand in as Chair of the Governing Body in the event of a conflict as highlighted in the Conflicts of Interest section 10.2 and the Standing Orders, appendix C.

8.12 Nurse Member

8.12.1 The independent nurse member of the Governing Body must have at least 5 years of post qualification experience and will be recruited following national advert, shortlisting and interview as recommended by the Remuneration Committee and approved by the Members' Forum.

8.12.2 Subject to ratification by a majority vote of the Members' Forum, they will be appointed for a two year period.

8.12.3 Subject to the exceptions stated in clause 8.12.4, the independent nurse member cannot:

a. Be an employee or member (including shareholder) of or a partner in a provider of primary care medical services, or a provider with whom the CCG has made commissioning arrangements;
b. Cannot work for more than 50% of their time for a non NHS organisation.

8.12.4 The exceptions are where the CCG has made an arrangement with a provider, subsequent to a patient exercising choice, and where the CCG has made an

arrangement with a provider in special circumstances to meet the specific needs of a patient (for example, where there is a very limited choice of provider for a highly specialised service). This is especially in relation to this particular role and does not preclude practice nurses from being members of the Governing Body in other capacities.

8.12.5 The independent nurse member may be removed by, in addition to that covered in 8.10.3:

a. If they are not registered with the Nursing and Midwifery Council under the Nursing and Midwifery Order 2001;
b. Are no-longer practising for another reason.

8.12.6 The following procedure is subject to the process defined at 2.2 in Appendix C, which is to be adopted in the event of an unplanned vacancy for the Nurse Member of the Governing Body.

8.12.7 They may be removed by a vote of no confidence by the Governing Body requiring at least two thirds of votes available.

8.13 Hospital Consultant

8.13.1 The following procedure is subject to the process defined at 2.2 in Appendix C, which is to be adopted in the event of an unplanned vacancy for the Hospital Consultant member of the Governing Body.

8.13.2 The Hospital Consultant member of the Governing Body must have at least 5 years experience as a consultant and will be recruited following national advert, short listing and interview as recommended by the Remuneration Committee and approved by the members Forum.

8.13.3 Subject to ratification by a majority vote of the Members' Forum, they will be appointed for a two year period.

8.13.4 Whilst the individual may well no longer practise medicine, they will need to demonstrate that they still have a relevant understanding of care in the secondary setting.

8.13.5 The Hospital Consultant member:

a. Cannot be an employee or member (including shareholder) of, or a partner in a provider of primary medical services, or a provider with whom the CCG has made commissioning arrangements;
b. Cannot work for more than 50% of their time for a non NHS organisation.

8.13.6 The exceptions are where the CCG has made an arrangement with a provider, subsequent to a patient exercising choice, and where the CCG has made an arrangement with a provider in special circumstances to meet the specific needs of a patient (for example, where there is a very limited choice of provider for a highly specialised service).

8.13.7 The Hospital Consultant member may be removed by, in addition to that covered in 8.10.3:

a. If they lose their license to practice;

b. Are no-longer practicing for another reason.

8.13.8 They may be removed by a vote of no confidence by the Governing Body requiring at least two thirds of votes available.

8.14 Joint appointments

8.14.1 Where the office of a Governing Body member is shared jointly by more than one person:

a. Either or both of those persons may attend or take part in meetings of the Governing Body;
b. If both are present at a meeting they should cast one vote if they agree;
c. In the case of disagreements no vote should be cast;
d. The presence of either or both of those persons should count as the presence of one person for the purposes of the quorum laid out in section 3.7 in Appendix C.

8.15 Disqualification of members of the Governing Body

8.15.1 Members of the Governing Body shall vacate their offices in the following circumstances:

a. If a receiving order is made against them or they make any arrangement with their creditors;
b. If in the opinion of the Governing Body (having taken appropriate professional advice in cases where it is deemed necessary) they become or are deemed to have developed mental or physical illness which prohibits or inhibits their ability to undertake their role;
c. If they should for a period of five (5) consecutive meetings of the Governing Body have been absent and the Governing Body exercises its discretion in deciding that they should vacate their office;
d. If they should be convicted of a criminal offence whereby the sentence imposed shall be for a minimum of six (6) months imprisonment (whether such sentence is held to be suspended or conditional). The Governing Body shall take into account the circumstances of the offence in relation to the individual before exercising its discretion in deciding that they should vacate their office;
e. If they should have behaved in a manner or exhibited conduct which in the opinion of the Governing Body has or is likely to be detrimental to the honour and interest of the Governing Body or the CCG as a whole and is likely to bring the Governing Body and/or the CCG into disrepute. This includes but is not limited to dishonesty, misrepresentation (either knowingly or fraudulently), defamation of any member of the Governing Body (being slander or libel), abuse of position, non-declaration of a conflict of interest of which the member should be reasonably aware, seeking to lead or manipulate a decision of the Governing Body in a manner that would ultimately be in favour of that member whether financially or otherwise;
f. Where the Governing Body decides that the relevant member of the Governing Body is unable to discharge their duties as a member of the Governing Body on an ongoing basis as a result of a declaration of any conflict of interest;

g. Where they no longer meets the relevant criteria for inclusion as part of the Governing Body as specified in The National Health Service (Clinical Commissioning Groups) Regulations 2012 (as amended) (SI 2012/1631).

8.15.2 In addition to the above, the CCG Governing Body GP positions (including Chair and Vice Chair) shall be subject to a vote of no confidence, if at least two thirds of all Practice Representatives (i.e. not simply those Practices that are present and voting) resolve that they do not have the skills, abilities and competencies to fulfil the duties of their role or any other reasonable reason relating to their appointment. In order for this to take effect, the Practices must take a formal vote at the Members' Forum as outlined in section 4, Appendix C.

8.15.3 Other Governing Body members that are appointed to their positions, (Lay, Nurse and Consultant roles), can also be subject to a vote of no confidence, if at least two thirds of all Practice Representatives (i.e. not simply those Practices that are present and voting) resolve that they do not have the skills, abilities and competencies to fulfil the duties of their role or any other reasonable reason relating to their appointment. In order for this to take effect, the Practices must take a formal vote at the Members' Forum as outlined in section 4, Appendix C.

8.15.4 Where Practices undertake a vote of no confidence at the Members' Forum, save for in exceptional circumstances, the informal and formal routes for disputes and disagreements between the Practices and the Governing Body set out in this Constitution (see 8.16) should be utilised. In all cases, where a Governing Body member has been disqualified or removed, or vacates their position, the provisions relating to the reconstitution of the Governing Body membership as detailed in Appendix C shall apply.

8.15.5 The Accountable Officer and Chief Finance Officer can also be subjected to a vote of no confidence, if at least two thirds of all Practice Representatives (i.e. not simply those Practices that are present and voting) resolve that they do not have the skills, abilities and competencies to fulfil the duties of their role or any other reasonable reason relating to their appointment. In order for this to take effect, the Practices must take a formal vote at the Members' Forum as outlined in section 4, Appendix C. As these positions are employed by the CCG on a permanent contract basis, the route for discussion and resolution of the expression of no confidence will be through the measures set out in their contracts of employment and through discussions with the CCG Chair.

8.16 Escalation of Concerns to NHS England

8.16.1 A Practice ceases to be a Practice of the CCG where that Practice no longer satisfies the criteria of membership as set out in section 5.

8.16.2 The CCG is committed to engaging its Practices in all strategic proposals and developments using the Clinical Commissioning Forum and Consortia for consultation and feedback. However, we will, from time to time, have differing preferred opinions on how best to proceed in any given matter. As a membership organisation with significant responsibility and public accountability, we recognise the validity of every opinion and, so as to ensure that we accept the validity of opinions and preferences, we will stringently test our decisions against established standards.

8.16.3 Where a Practice disputes or disagrees with the decisions or actions of the CCG, the Practice wherever possible will be encouraged to discuss this through their Consortium informally with their Consortium Lead. This can then be raised at the Clinical Executive Committee or Clinical Commissioning Forum to allow other Practices and Governing Body members the opportunity to comment. They also have the opportunity to raise a question at the Governing Body. If necessary, it may be helpful to hold a Members' Forum to discuss the matter in more detail, where the Governing Body should take all reasonable steps to ensure appropriate attendance is available to support the discussion. If the matter cannot be resolved the member shall be entitled to invoke a three stage dispute resolution process which will involve:

a. Stage 1 - An informal process where each party involves the LMC in either an advisory or mediation role to facilitate an informal dialogue between parties. The informal process must have been exhausted before either party is able to escalate the dispute to Stage 2;
b. Stage 2 - A local formal process where either party remains dissatisfied with the outcome of stage 1, they have the right to request a Formal Local Dispute Resolution, in writing to the Accountable Officer, Chair and/or Managing Director of the CCG. Other than in cases, which in the opinion of the Accountable Officer, Chair and/or Managing Director, and following consultation with the LMC, are considered to be frivolous or vexatious, a Local Dispute Resolution Panel (LDRP) shall be convened to hear the dispute and make a determination within an agreed timeframe. Members of the LDRP will comprise, but not be limited to, the following members. The Panel will agree its own Chairman:
    - A clinical member of the Governing Body of another CCG;
    - A Health and Wellbeing Board representative;
    - A LMC representative;
    - Panel Secretary/Minute taker (non-voting).
c. Stage 3 - This stage will involve an appeal to NHS England.

8.16.4 The Practice shall give written notice to NHS England and the Governing Body as soon as practicable in the event of any of the circumstances which may give rise to a proposed termination of membership, together with a formal request to NHS England that the Practice's membership of the CCG is terminated.

8.16.5 If the formal request is approved and accepted by NHS England, the Governing Body and other Practices shall agree to remove the Practice from the CCG and list of Practices at Appendix B.

8.16.6 Any Practice, if served with a notice of termination of membership shall have the right of appeal against that decision by application to NHS England.

8.16.7 The decision of NHS England on consultation with the CCG, the Local Medical Committee and any other relevant party shall be final.

8.16.8 If a Practice chooses to leave the CCG of their own volition, an application would need to be made to NHS England in order to vary this Constitution. NHS England will then make a decision as to whether permission shall be granted for the Practice to be assigned to another CCG, or to remain within NHS City and Hackney CCG.

8.17 Committees of the Governing Body

8.17.1 The Governing Body has established the following Committees for the discharge of the role, duties, and functions as set out in the duly approved Terms of Reference:

a. Audit Committee - which is accountable to the CCGs Governing Body, provides the Governing Body with an independent and objective view of the CCGs financial systems, mitigation of major risks to delivery, financial information and compliance with laws, regulations and directions governing the CCG in so far as they relate to finance and governance. The Governing Body shall approve and keep under review the terms of reference for the Audit Committee, which including information on the membership of the Committee;

b. Remuneration Committee - which is accountable to the CCGs Governing Body makes recommendations to the Governing Body on determinations about the remuneration, fees and other allowances for employees and for people who provide services to the CCG and on determinations about allowances under any pension scheme that the CCG may establish as an alternative to the NHS pension scheme. The Governing Body shall approve and keep under review the terms of reference for the Remuneration Committee, including information on the membership of the Committee.

8.17.2 The Governing Body may appoint such other committees as it considers may be appropriate including:

a. Clinical Executive Committee (CEC) - which is accountable to the CCGs Governing Body, the Governing Body has approved and keeps under review the terms of reference for the Clinical Executive which includes information on the membership of the Executive Committee[44]. The CEC has the following role on behalf of the Governing Body:
   - Development and implementation of the CCGs clinical strategy, Commissioning Strategic Plan (CSP) and Quality, Innovation, Productivity and Prevention (QIPP) targets;
   - Ensuring the effective discharge of the functions of the CCG;
   - Oversee the work of the CCGs Programme Boards which are responsible for development and delivery of the annual CSP;
   - Ensuring effective consultation and discussion with member practices about the CCGs clinical plans.

b. Finance and Performance Committee (FPC) - which is accountable to the CCGs Governing Body. The Governing Body has approved and keeps under review the terms of reference for the FPC which includes information on the membership of the Committee. The FPC has the following role:
   - To receive the monthly finance, activity and KPI reports produced by the Commissioning Support Unit (CSU);
   - To receive a monthly report on progress with implementation of the Quality, Innovation, Productivity and Prevention (QIPP) plans;
   - To agree responsibilities and implement action plans and reporting arrangements for variances or areas of performance identified;

- The CCGs CFO will ensure that remedial actions plans are reported to the Governing Body as part of the performance reporting arrangements and that progress is monitored.

c. Patient and Public Involvement (PPI) Committee – which is accountable to the CCGs Governing Body. The Governing Body has approved and keeps under review the terms of reference for the PPI Committee which includes information on the membership of the PPI Committee. The PPI Committee has the following role:
   - To develop and deliver the CCGs engagement plans;
   - To oversee and coordinate the various sources of patient, carer and public views and issues on the services which the CCG commissions and ensure that the CCG has a comprehensive understanding of these;
   - To make recommendations to the Governing Body, Programme Boards and Clinical Executive Committee on changes to our commissioning plans to address these issues satisfactorily;
   - To ensure that learning from complaints takes place and is reflected in our commissioning plans to ensure that the complaints management service received from the CSU is robust and meets the specification;
   - To ensure that we communicate back to our patients and public on what we have done about the issues they have raised.

d. Prioritisation & Investment Committee (PIC) - which is accountable to the CCGs Governing Body. The Governing Body has approved and keeps under review the terms of reference for the PIC which includes information on the membership of the PIC Sub Committee. The PIC Committee has the following role:
   - To recommend to the CCG Board all proposals for use of recurrent and non-recurrent investment;
   - To receive advice from the Accountable Officer, Managing Director and Chief Finance Officer on resources available and the CCG Chair on Clinical ambitions and strategy;
   - To assess bids, score and prioritise against the agreed prioritisation framework;
   - Proposals received in the form of Project Initiation Documents (PIDs) will be assessed to ensure value for money, impact on patients and outcomes and to ensure they are in line with the CCG clinical and financial strategy;
   - To consider service specifications, key performance indicators, metrics and the proposed contractual arrangements;
   - To recommend investment to the CCG Board.

e. Local GP Providers Contracts Committee (LGPPCC) - which is accountable to the CCGs Governing Body. The Governing Body has approved and keeps under review the terms of reference for the LGPPCC which includes information on the membership of the LGPPCC Sub Committee. The LGPPCC Committee has the following role:
   - To review service specifications for new investment in primary care providers (either directly or via the City and Hackney GP Confederation). In doing so they will ensure these have no conflicts and represent value for money;
   - Review the contracting route for the proposals;
   - In respect of procurement activities, review proposals from Programme Boards around process, documentation (including service

specifications and evaluation criteria) and membership to help assure conflicts have been mitigated in order for them to make recommendations to the Board;
    - To review procurement process after completion and ensure process was followed and endorse the recommendation to award a contract;
    - Take advice from the CCG Audit Committee and follow any framework they suggest for initiatives and/or procurement;
    - Consider all proposals for entering into contracts with practices i.e. renewal of existing service specifications and contracts and the proposed contractual arrangements;
    - In respect to contracting arrangement for renewal or new contracts, the Committee will also be required to review and assess any incorporated key performance indicators (KPIs) and the basis on which contractual payments would be made and provider performance assessed;
    - Consider any supporting legal advice obtained in respect to contracting matters and may request specific advise taken where the Committee feels this would help their recommendations;
    - The Governing Body requires the Committee to review requests for payments to be made under any GP contracts that have been entered into by the CCG. The Contracts Committee review whether the control processes have been followed in practice and make recommendation for payment to be supported by the Governing Body.

f. The Prioritisation & Investment Committee and Local GP Provider Contracts Committee (Primary Care Committee) will meet in public, except where it would not be in the public interest in relation to all or part of a meeting. This disclaimer will only be used in instances of commercial confidentiality or sensitive discussions and when we receive legal advice forcing a closed session of the Governing Body. The Committee meeting dates will be communicated well in advance of the meeting date and the arrangements for public attendance clear and transparent.

8.17.3 The Audit Committee may include individuals who are not members of the Governing Body.

8.17.4 Other Committees of the Governing Body may include individuals who are not members of the Governing Body but are:

a. Members, officers or Governing Body members of the Group or another Clinical Commissioning Group;
b. Partners or employees of Members of the Group or another Clinical Commissioning Group.

8.17.5 Committees of the Governing Body will only be able to establish their own sub-committees, to assist them in discharging their respective responsibilities, if this responsibility has been delegated to them by the Governing Body or the Committee they are accountable to.

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

8.18 Membership of the Clinical Executive Committee

8.18.1 In addition to the 6 Consortia leads, the other members of the Clinical Executive Committee (CEC) are:

a. A representative of the Members' Practice Managers (the Practice Managers' representative);
b. A representative of the Members' Practice Nurses (the Practice Nurses' representative);
c. The CCG's Lay Member with an interest in PPI;
d. The Accountable Officer (AO);
e. Managing Director;
f. The Chief Finance Officer(CFO);
g. The Chair of the Governing Body.

8.18.2 A representative of Commissioning Support Unit (CSU) may be invited to attend to provide advice and support, but not as a formal member of the Committee.

8.18.3 In addition, the CCG Clinical Chairs of the Programme Boards and LMC Chair will receive papers for the Committee and be invited to attend to provide advice and support, but not as formal members of the Committee.

8.18.4 The CCG Lay Member for PPI, Accountable Officer, CFO and Managing Director are members of the CEC in an ex-officio capacity.

8.18.5 The Practice Managers and Nurses from members listed in Appendix B can decide how to appoint their respective representatives onto the CEC. They can choose, by a simple majority:

a. To elect or appoint their lead(s);
b. The election and/or selection process for the leads;
c. Eligibility criteria for each position.

8.18.6 Subject to ratification by a majority vote of the Members' Forum, the Governing Body will appoint them for a two year period.

8.18.7 If at least 51% of Practice Managers or Nurses express that they no longer have confidence in their respective representative in a meeting, they can commence a new selection/election process at any time during their term of office.

8.18.8 The GP elected as Clinical Vice Chair of the Governing Body becomes the Chair of the Clinical Executive Committee. The deputy or job share for that GP's Consortia role then joins the Clinical Executive Committee to represent that Consortium.

9 ROLES AND RESPONSIBILITIES

9.1 Member Practices and Practice Representatives

9.1.1 Practices are the foundation of NHS City and Hackney CCG. Consistent and regular involvement of Practices with the CCG will enable CCG to act in a manner that is in the best interests of the CCG as a whole.

9.1.2 The CCG has developed a Clinical Commissioning and Engagement contract which sets out how member practices can engage with the CCG and support its commissioning responsibilities. The contract will be reviewed on an annual basis by the Clinical Executive Committee and Governing Body. A tracker has been developed for practices and Consortium leads to use to enable them to monitor their performance against the contract requirements.

9.1.3 Practice Representatives represent their Member's views and act on their behalf in matters relating to the CCG. The role of each Practice Representative, recognising that they may change for different meetings throughout the year, is to:

a. Ensure effective two way communications with the CCG;
b. Ensure they communicate with their practice to enable them to give a representative view when proving feedback to CCG engagement and consultation;
c. Engage in Consortia, Clinical Commissioning Forum (CCF) and other activities;
d. Ensure democracy and input to CCG decisions;
e. Attend the Members' Forum.

9.2 Clinical Commissioning Forum

9.2.1 The CCG will use the monthly Clinical Commissioning Forum, which is open to all GPs working for a City and Hackney practice, as well as Consortia meetings, to consult and engage all Member Practices to debate our clinical plans, for early involvement from practices in shaping our plans, service models and strategies and for testing out ideas.

9.3 Consortia

9.3.1 Each Consortium plays a key role in providing a peer support network for constituent practices, for communication and input to CCG plans, thinking and decisions.

9.4 Consortium Lead

9.4.1 The role of the elected Consortium lead is to undertake the following on behalf of the CCG:

a. Support the work of the Consortia;
b. Represent the Consortium rather than represent their own individual practices;
c. Hold and Chair regular Consortium meetings;

d. Ensure Consortia Practices are kept updated on current CCG issues and priorities and that there is an understanding from all Practices of the Consortia view on commissioning matters;
e. Ensure effective two way communications with constituent Practices, representing their views at CCG meetings;
f. Provide input to the CCGs clinical plans and represent the Consortium via membership of the Clinical Executive Committee (CEC).

9.5 Members' Forum

9.5.1 The role of the Members' Forum is to:

a. Consider and agree any changes to the Constitution (such changes to be effected subject to the approval of NHS England) as laid out in 3.4 including changes in membership of the CCG;
b. Confirm the appointments process for Governing Body members;
c. Ratify all appointments to the CCG that hold a Governing Body membership;
d. Review any decisions by the Governing Body where a challenge is raised by a Practice (Consortium leads may request a meeting of the Members' Forum to discuss any appropriate matter as defined by the terms of reference of the Members' Forum);
e. The role of the Members' Forum is further covered in the CCGs Standing Orders under section 16.

9.6 All Members of the CCGs' Governing Body

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

9.7 The Chair

9.7.1 The Chair of the Governing Body, in conjunction with the Governing Body is responsible for:

a. Leading the Governing Body, ensuring it remains continuously able to discharge its duties and responsibilities as set out in this Constitution;
b. Providing clinical leadership;
c. Taking account of the views of member practices when making decisions;
d. Building and developing the Governing Body and its individual members;
e. Ensuring that the CCG has proper constitutional and governance arrangements in place;
f. Ensuring that, through the appropriate support, information and evidence, the Governing Body is able to discharge its duties;
g. Supporting the Accountable Officer and Managing Director in discharging the responsibilities of the organisation;
h. Contributing to building a shared vision of the aims, values and culture of the organisation;
i. Leading and influencing to achieve clinical and organisational change to enable the CCG to deliver its commissioning responsibilities;

j. Overseeing governance and particularly ensuring that the Governing Body and the wider CCG behaves with the utmost transparency and responsiveness at all times;
k. Ensuring that public and patients' views are heard and their expectations understood and, where appropriate as far as possible, met;
l. Ensuring that the organisation is able to account to its local patients, stakeholders and NHS England;
m. Ensuring that the CCG builds and maintains effective relationships, particularly with the individuals involved in overview and scrutiny from the relevant Local Authorities.

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

9.8 The Deputy Chair

9.8.1 The Deputy Chair of the Governing Body deputises for the Chair of the Governing Body where he or she has a conflict of interest or is otherwise unable to act.

9.8.2 The Deputy Chair is the Lay Member for Patient and Public Involvement and matters of conflict of interest as per 8.10.1.

9.9 The Accountable Officer

9.9.1 The Accountable Officer is subject to an appointment process by interview and other requirement as may be set out in guidelines, regulation or the CCG's HR policy and varied from time to time.

9.9.2 The Accountable Officer may be removed in line with their contract of employment.

9.9.3 The Accountable Officer:

a. Is responsible for ensuring that the CCG 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. Will at all times ensure 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. By working closely with the Chair of the Governing Body, 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 development of its members and staff.

9.10 Managing Director

9.10.1 The Managing Director is subject to an appointment process of interview and other requirement as may be set out in guidelines, regulation or the CCGs HR policy and varied from time to time.

9.10.2 The Managing Director may be removed in line with their contract of employment.

9.10.3 The Managing Director is a non-voting member of the Governing Body to enable them to deputise for the Accountable Officer in their absence for local CCG matters and is able to cast the Accountable Officers vote in decision making bodies and Committees of the CCG when the Accountable Officer is not present.

9.10.4 The Managing Director supports the Accountable Officer in the discharge of their full duties and responsibilities with respect to the CCG. The Accountable Officer remains responsible for how those duties are discharged or votes exercised if they have not been specifically delegated to the Managing Director.

9.10.5 The Managing Director is charged with ensuring that the day to day operation of the CCG and its activities at the local level are carried out in line with the Accountable Officers directions.

9.10.6 The Managing Director has decision making powers of their own with respect to the local operation of the CCG. These powers are described in the CCGs Scheme of Reservation and Delegation, Standing Orders and Prime Financial Policy.

9.11 Chief Finance Officer

9.11.1 The Chief Finance Officer is subject to an appointment process of interview and other requirement as may be set out in guidelines, regulation or the CCGs HR policy and varied from time to time.

9.11.2 The Chief Finance Officer may be removed in line with their contract of employment.

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

9.11.4 This Chief Finance Officer is responsible for:

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 the CCGs finances;
c. Overseeing robust audit and governance arrangements leading to propriety in the use of the CCGs resources;
d. Being able to advise the Governing Body on the effective, efficient and economic use of the CCGs allocation to remain within that allocation and deliver required financial targets and duties;
e. Producing the financial statements for audit and publication in accordance with the statutory requirements to demonstrate effective stewardship of public money and accountability to NHS England.

9.12 The Role of the Governing Body

9.12.1 The functions of the Governing Body shall include:

a. Ensuring that the CCG has appropriate arrangements in place to exercise its functions effectively, efficiently and economically and in accordance with the CCGs principles of good governance[45] (its main function);
b. Ensuring effective engagement of member practices, patients and the public in consultation and decision making;
c. Ensure that all providers of primary medical services in the locality are members of the CCG, and shall keep up to date registers of the same;
d. Determining the remuneration, fees and other allowances payable to employees or other persons providing services to the CCG 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;
e. Approving any functions of the CCG that are specified in regulations[46];
f. Monitoring the clinical quality and safety of all commissioned services through regular reports produced by CSU;
g. Assuring decision making arrangements;
h. Oversight of the arrangements for dealing with conflicts of interest;
i. Leading the setting out of our vision and strategy and ensuring that these are followed;
j. Approving commissioning plans and strategies on behalf of the CCG;
k. Facilitating the delivery and implementation of any guidance or standards issued by any relevant regulatory body including, but not limited to, the Care Quality Commission (CQC) or any successor bodies or their authorised assignees;
l. Ensuring that there are robust plans and responsibilities assigned to manage staff engagement, external relationships and communications;
m. Approving the annual budget;
n. Monitoring performance against the plan and budget;
o. Supporting a variety of diverse approaches to commissioning, particularly for practices to work proactively to improve efficiency and value;
p. Encouraging innovation by enabling and supporting practices and clinicians in creating change;
q. Working with all local stakeholders to achieve delivery of the targets, policies and standards;
r. Working collaboratively to deliver the outcomes and milestones set out in any Local Delivery Plan;
s. Exercising and/or delegating functions which have not otherwise been expressly delegated under the Constitution;
t. Complying with all relevant procurement law and policy and adhering to the obligations placed on the governing Board and CCG with regard to all providers applying the following principles of:
    - Transparency and openness;
    - Support, assistance and training so as to permit compliance with procurement law, competition law and any relevant policies;
    - Application of guidance within the 'procurement guide for commissioners of NHS funded services' and the 'principles and rules for co-operation and competition';
    - Equality of treatment.
u. Providing assurance of strategic risks.

9.12.2 The Governing Body shall:

a. Ensure that all decisions made in relation to commissioning are fully recorded and auditable;
b. Be engaged in the day to day management and application of commissioning and related activity in the locality and shall operate in good faith using all due skill and diligence;
c. Provide reports of all activity including financial activity at all meetings. The reports shall be available to all governing body members prior to the governing body meetings and form part of the main agenda;
d. Ensure that all the CCGs policies and procedures with regard to the involvement and consultation of patients and practices and other relevant bodies are fully complied with at all times;
e. Fairly and equitably advertise any specific salaried posts;
f. Adhere to any other obligations as set out in statute, regulation and/or direction;
g. Implement all processes required to comply with any regulation, direction or internal governance where relevant;
h. Keep an up-to-date list of all committees, sub-committees and joint working arrangements;
i. Agree a set of standing orders (set out in appendix C) which shall dictate processes by which the CCG shall operate, including but not limited to any election process, quorum and frequency of elections.

9.13 Joint arrangements with other Organisations

9.13.1 The CCG may enter into joint arrangements with other CCGs including the joint arrangements detailed in Appendix H.

9.13.2 The CCG may establish joint committees with one or more local authorities in accordance with the requirements of section 75 of the NHS Act 2006 and regulations made under that section, as it considers may be appropriate.

9.13.3 The CCG may make joint appointments including joint appointments with other CCGs. Any such joint appointments will be supported by a memorandum of understanding between the organisations that are party to these joint appointments, outlining:

a. Who will be the statutory employer of the individual(s) working across organisations;
b. Confirmation that the statutory employer's policies will apply in all matters concerning the employment of the individual;
c. The arrangements for funding, including funding for any temporary or acting arrangements in the event of absence, funding of redundancy costs and funding for training and development etc;
d. The arrangements for approval of annual and special leave of the individual;
e. The arrangements for performance appraisal;
f. How disciplinary matters will be handled;
g. Risk sharing arrangements in respect of liability issues or redundancy / dismissal costs.

9.13.4 Where a Joint Appointment is made, the appointee may choose a named deputy in each of the CCGs, normally the Managing Director. The named deputy must be agreed by the Chair of the Governing Body.

10 STANDARDS OF BUSINESS CONDUCT AND MANAGING CONFLICTS OF INTEREST

10.1 Standards of Business Conduct

10.1.1 Employees, members, Committee and Sub-Committee members of the CCG and members of the Governing Body (and its Committees) will at all times comply with this Constitution and be aware of their responsibilities as outlined in it. They should act in good faith, in the interests of the CCG and should follow the seven principles of public life, set out by the Committee on Standards in Public Life (the Nolan Principles). The Nolan Principles are incorporated into this Constitution at Appendix F.

10.1.2 They must comply with the CCGs policy on business conduct, including the requirements set out in the Conflicts of Interest Policy. This policy will be available on the CCGs website.

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

10.2 Conflicts of Interest

10.2.1 In accordance with section 14O of the 2006 Act, as inserted by section 25 of the 2012 Act, and NHS England's "Managing Conflicts of Interest: Revised Statutory Guidance for CCGs" (from time to time updated), the CCG will make arrangements to manage conflicts and potential conflicts of interest, to ensure that decisions made by the CCG will be taken and seen to be taken without any possibility of the influence of external or private interest. These arrangements shall be set out in the CCGs Conflicts of Interest policy.

10.2.2 Conflicts and potential conflicts of interest include:

a. Financial interests;
b. Non-financial professional interests (where an individual might increase their professional reputation or status or promote their professional career as a result of a commissioning decision);
c. Non-financial personal interests (where an individual might benefit personally in ways which are not directly linked to their professional career);
d. Indirect interests (where an individual has a close association with an individual who has an interest which falls into one of the above categories).

10.2.3 The Head of Corporate Services shall have responsibility for the day-to-day management of conflicts of interest at the CCG.

10.2.4 The Head of Corporate Services shall report to the CCG's Conflicts of Interest Guardian, a role which shall be undertaken by CCG Audit Committee Chair. To ensure this position is not compromised, the Chair of the Audit Committee should not also hold the position of Chair of the Local GP Provider Contracts Committee

or any Primary Care Commissioning related Committee. The Conflict of Interest Guardian's responsibilities are to:

a. Act as a conduit for GP practice staff, members of the public and healthcare professionals who have any concerns with regards to conflicts of interest;
b. Be a safe point of contact for employees or workers of the CCG to raise any concerns in relation to this policy;
c. Support the rigorous application of conflict of interest principles and policies;
d. Provide independent advice and judgment where there is any doubt about how to apply conflicts of interest policies and principles in an individual situation;
e. Provide advice on minimising the risks of conflicts of interest.
f.

10.2.5 Any Member of the CCG, member of the Governing Body, member of any Sub-Committee or employee must declare any conflict or potential conflict of interest that the person has in relation to a decision to be made in the exercise of the commissioning functions of the group, in accordance with the Conflicts of Interest policy, as soon as practicable after the person becomes aware of the conflict or potential conflict and, in any event, within 28 days.

10.2.6 Further details of our responsibilities and details of how conflicts of interest are identified, declared, recorded, communicated and acted on are contained in the conflicts of interest policy document.

10.3 Interests and gifts

10.3.1 Interests and gifts will be recorded on the register of interests and register of gifts and hospitality, which will be maintained by the Head of Corporate Services. The register will be accessible by the public and inspection of the register of Board members interests will be encouraged, as appropriate. Further information is available in the CCGs Conflicts of Interest policy.

10.4 Managing Conflicts of Interest: contractors and service providers

10.4.1 Anyone seeking information in relation to procurement, or participating in a procurement, or otherwise engaging with the CCG in relation to the potential provision of services or facilities to the CCG, will be required to make a declaration of any relevant conflict / potential conflict of interest compliant with the CCGs policy.

10.4.2 Anyone contracted to provide services or facilities directly to the CCG will be subject to the same provisions of this Constitution in relation to managing conflicts of interests. This requirement will be set out in the contract for their services.

10.4.3 The CCG shall maintain a register of procurement decisions taken, either for the procurement of a new service or any extension or material variation of a current contract. The register will record details of the decision and a summary of the conflicts of interest for those involved in each procurement decision. The register will be considered by the decision-making body as part of its deliberations in

accordance with the CCG policy on Conflicts of Interest and will be published on the CCG website to ensure transparency in line with section 6.

10.5 Transparency in Procuring Services

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

10.5.2 The CCG will publish a procurement strategy approved by its Governing Body which will ensure that:

a. All relevant clinicians (not just members of the CCG) and potential providers, together with local members of the public, are engaged in the decision-making processes used to procure services;
b. Service redesign and procurement processes are conducted in an open, transparent, non-discriminatory and fair way.

10.5.3 The CCG will conduct procurement activities compliant and in line with the following principles, expanded on in the Procurement Strategy:

a. We will, consistently with our obligations under, inter alia, the Public Contracts Regulations 2006, Public Contracts Regulations 2015, NHS (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013 and applicable Community law, ascertain whether it is necessary, desirable or appropriate to invite competition when purchasing in order to ensure it will incur only budgeted, approved and necessary spending;
b. We will seek value for money for all goods and services by reference to the optimum combination of whole life cost and quality;
c. We shall ensure that, subject to the threshold provisions of the Public Contracts Regulations 2015 (as applicable), 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 or NHS England);
    - For the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens) for disposals.
d. We will, in relation to each purchasing decision concerning health care and social services:
    - Consider the extent to which the Public Contract Regulations 2006, Public Contracts Regulations 2015 and NHS (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013 (as may be applicable) require any form of competition and consider the most appropriate process and procedure for awarding the relevant contract or contracts;
    - In that regard give consideration to whether the use of a framework agreement, including the use of approved lists, is the most appropriate means of appointing providers.
e. We shall, wherever possible and where it is consistent with legal requirements, ensure that contractual provisions, procurement

procedures and selection and award criteria are designed to ensure that contractors and providers are:

- Good employers who comply with all relevant employment legislation, including the Public Interest Disclosure Act 1998;
- Maintain acceptable standards of health and safety and comply fully with all legal obligations;
- Meet all tax and national insurance obligations;
- Meet all equal opportunities legislation;
- Reputable in their standards of business conduct;
- Respect the environment and take appropriate steps to ensure that they minimise their environmental impact;
- Can evidence a track record of providing high quality services and meeting the above points on a consistent basis.

f. We will, in each procurement and consistently with the relevant law, exclude companies which have been convicted of offences, or whose director(s) or any other person or company who has powers of representation, decision or control of the company has or have been convicted of offences in the conduct of their business or committed an act of grave professional misconduct in the conduct of their business, such as breaches of employment, equal opportunities or environmental legislation. However, any corrective/remedial action taken by the company in response to such an offence should also be taken into account in determining its suitability as a bidder;

g. We will, in each procurement (insofar as possible, in compliance with all relevant EU and international law), ensure that contractual provisions, procurement procedures and selection and award criteria prohibit or restrict contractors' use of offshore jurisdictions and/or improper tax avoidance schemes or arrangements and/or exclude companies which use such jurisdictions and/or such schemes or arrangements;

h. We may only negotiate contracts on behalf of the CCG, and the CCG 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:

- The CCGs standing orders;
- The Public Contracts Regulation 2006, Public Contracts Regulations 2015, NHS (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013, any successor legislation and any other applicable law;

i. Take into account as appropriate any applicable NHS England or the Monitor guidance that does not conflict with 10.5.3a above.

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

10.5.4 Copies of the Procurement Strategy will be available on the CCGs website along with details of all contracts awarded.

11 THE CCG AS EMPLOYER

11.1 General

11.1.1 The CCG 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 CCG.

11.1.2 The CCG 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.

11.1.3 The Governing Body shall be permitted to employ or engage the services of any individual if it reasonably believes that the employment or engagement of such an individual shall be of benefit to the CCG as a whole.

11.1.4 In the event of such employment or engagement, the Remuneration Committee shall reasonably decide and agree the remuneration with such an individual or organisation on a case by case basis.

11.1.5 The Remuneration Committee shall be permitted to reasonably decide the remuneration payable in respect of the duties undertaken by the Accountable Officer, staff on VSM, Governing Body members and all clinicians providing services and clinical leadership to the CCG.

11.1.6 The CCG 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 CCG. 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.

11.1.7 The CCG will ensure that it complies with all aspects of employment law.

11.1.8 The CCG 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.

11.1.9 The CCG 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.

11.1.10 Copies of this Code of Conduct, together with the other policies and procedures outlined in this section, will be available on the CCGs website.

12 TRANSPARENCY, WAYS OF WORKING AND STANDING ORDERS

12.1 General

12.1.1 The CCG will publish this Constitution and its policies and strategies (including communications and public patient engagement strategy), detailing any changes or updates to the document on our website.

12.1.2 The CCG will publish annually a commissioning plan and a report, including accounts which will be externally audited, presenting the CCGs annual report to one of its public meetings.

12.1.3 Key communications issued by the CCG will be published on our website, including:

a. Conflicts of Interest policy;
b. Register of interests and register of gifts and hospitality;
c. Tenders and notices of procurements;
d. Contract details;
e. Service details;
f. Policies, strategies and ways of working, including the CCG's complaints process, communications strategy and public and patient engagement strategy;
g. Performance and financial information;
h. Public consultations;
i. Governing Board meeting dates, times and venues;
j. Governing Body papers and decisions and those of Sub Committees;A Freedom of Information log, including responses to all requests;
k. Any Committees held any public, meeting dates, times and venues.

12.1.4 The Governing Body will meet in public on a monthly basis, except where it would not be in the public interest in relation to all or part of a meeting. This disclaimer will only be used in instances of commercial confidentiality or sensitive discussions and when we receive legal advice forcing a closed session of the Governing Body. The Governing Body meeting dates will be communicated well in advance of the meeting date and the arrangements for public attendance clear and transparent.

12.1.5 The CCG will appoint independent Lay Members and non GP clinicians to the Governing Body and will actively seek to have patient views and opinions represented at all levels of decision making within the CCG (where clinically appropriate).

12.1.6 We will disclose all information that can lawfully be disclosed and make any requests that were not previously available on our website accessible to all in the Freedom of Information log.

12.1.7 We may use other means of communication, including circulating information by post, or making information available in venues or services accessible to the public to include local GP surgeries and local press and by working with our local authority communications teams.

12.1.8 We will consult widely, openly and routinely, actively seeking to involve our constituent practices, patients and the public, local authorities, local representative CCGs and other organisations. We will use our monthly Clinical Commissioning Forum, Consortia meetings and newsletter for all consultations and seek to find the most appropriate ways of working with all interested parties to gather information and views, including, but not limited to:

a. Public meetings and forums, whether hosted by the CCG or via CCG attendance at other organisations' meetings;
b. Public notices, not only on our website, but in local GP surgeries, local press and distributed via local authority communications routes that can provide valuable in-roads into the areas diverse communities.

12.1.9 We will work closely with, and provide information to, local authorities and NHS England, including the Health and Wellbeing Boards and complying with the requirements of Health Scrutiny and Overview Committees.

12.2 Standing Orders

12.2.1 This Constitution is also informed by a number of documents which provide further details on how we will operate. They are our:

a. Standing Orders (appendix C) - which sets out the arrangements for meetings and the appointment processes to elect our representatives and appoint to the CCGs 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 CCGs Governing Body, the Governing Body's Committees and Sub Committees, the CCGs Committees and Sub Committees, individual members and employees;
c. Prime Financial Policies (appendix E) - which sets out the arrangements for managing our financial affairs.

APPENDIX A - DEFINITIONS OF KEY DESCRIPTIONS USED IN THIS CONSTITUTION

2006 Act	National Health Service Act 2006
2012 Act	Health and Social Care Act 2012 (this Act amends the 2006 Act)
Accountable Officer	An individual, as defined under paragraph 12 of Schedule 1A of the 2006 Act (as inserted by Schedule 2 of the 2012 Act), appointed by the NHS Commissioning Board, with responsibility for ensuring the CCG complies with its obligations under: • Sections 14Q and 14R of the 2006 Act (as inserted by section 26 of the 2012 Act); • Sections 223H to 223J of the 2006 Act (as inserted by section 27 of the 2012 Act); • Paragraphs 17 to 19 of Schedule 1A of the NHS Act 2006 (as inserted by Schedule 2 of the 2012 Act); • Any other provision of the 2006 Act (as amended by the 2012 Act) specified in a document published by the Governing Body for that purpose; • Exercises its functions in a way which provides good value for money.
Area	The geographical area that the CCG has responsibility for, as defined in section 4 of this Constitution.
Chair of the Governing Body	The individual appointed by the CCG to act as Chair of the Governing Body.
Chief finance officer	The qualified accountant employed by the CCG with responsibility for financial strategy, financial management and financial governance.
Clinical commissioning forum	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 CCG 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); • Such generally accepted principles of good governance as are relevant to it.
Clinical Commissioning Group (CCG)	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 CCG; • A committee / sub-committee created by a committee created / appointed by the membership of the CCG; • A committee / sub-committee created / appointed by the Governing Body.

Conflict of Interest Guardian	a position held by the chair of the Audit Committee, whose responsibilities as Conflict of Interest Guardian are set out in the Conflict of Interest Policy
Consortia	Means the Consortia described in paragraph 5.1.2 of this Constitution and “Consortium” shall be interpreted accordingly.
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 CCG is established until the following 31 March.
Governing Body	Any member appointed to the Governing Body of the CCG.
Interim Governing Body Member	An individual voted temporarily to a position on the Governing Body (in accordance with Appendix C) for the period during which a position is vacant; between a previous member's notice period expiring and a new individual being appointed..
Lay member	Any member of the Governing Body, appointed by the CCG. A lay member is an individual who is not a member of the CCG 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.
Managing Director	The Managing Director provides local senior management support to the Accountable Officer and Chair in ensuring that the CCG exercises its functions effectively, efficiently and economically. The Managing Director is responsible for the development and implementation of effective management systems to enable CCG leaders, together with the wider membership, to deliver the CCG’s business and strategic objectives.
Member	A provider of primary medical services to a registered patient list, who is a member of this CCG (see section 5 and Appendix B).
Practice	A provider of primary medical services to a registered patient list, who is a members of this CCG (see section 5 and Appendix B).
Practice representatives	An individual appointed by a practice (who is a member of the CCG) to act on its behalf in the dealings between it and the CCG, 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).

Register of interests	Registers a CCG 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 CCG; • The members of its Governing Body; • The members of its committees or sub-committees and committees or sub-committees of its Governing Body; • Its employees.

APPENDIX B – MEMBER AND CONSORTIUM PRACTICES

Practice Name	Address	GP Lead
South West Consortium		Dr G Marlow/ Dr P Kelland
DeBeauvoir Practice	30 Hertford Road, London, N1 5QT	Dr G Marlowe
Hoxton Surgery	12 Rushton Street, London, N1 5DR	Dr Jenny Darkwah
The Lawson Practice	85 Nuttall Street, London, N1 5HZ	Dr D Colvin
Neaman Practice	15 Half Moon Court, London, EC1A 7HF	Dr D Vasserman
Queensbridge Group Practice	24 Holly Street, London, E8 3XP	Dr G Kelvin
Shoreditch Park Surgery	10 Rushton Street, London, N1 5DR	Dr P Kelland
North West Consortium		Dr M Rickets
Barton House Health Centre	233 Albion Road, London, N16 9JT	Dr M Bench
Cedar Practice	John Scott Health Centre, Green Lanes, London, N4 2NU	Dr D Shier
Heron Practice	John Scott Health Centre, Green Lanes, London N4 2NU	Dr M Krishnamurthy
Statham Grove Surgery	Statham Grove, Stoke Newington, London, N16 9DP	Dr James Melia
Cranwich Road Spitzer and Partners	62 Cranwich Road, London, N16 5JF	Dr J Spitzer
Springfield Medical Centre	19-21 Oldhill Street, London, N16 6LU	Dr Kirsten Brown
North East Consortium		Dr N Katiyar
Elm Practice	1a Fountayne Road, London, N16 7EA	Dr Denyse Hosein
Barretts Grove Surgery	6 Barretts Grove, London, N16 8AR	Dr M Gangola
Nightingale Practice	10 Kenninghall Road, London, E5 8BY	Dr J Brown
Stamford Hill Group practice	2 Egerton Road, London, N16 6UA	Dr C Marks
Somerford Grove Practice	Somerford Grove, Stoke Newington, London, N16 7UA	Dr D Keene
The Allerton Rd Surgery	34a Allerton Road, Stoke Newington, London, N16 5UF	Dr L Jayapal
R&S Consortium		Dr A Pathan
Gadhvi Practice	1a Fountayne Road, London, N16 7EA	Dr A H Pathan

Rosewood Practice	1a Fountayne Road, London, N16 7EA	Dr Nada Hadid
Athena Medical Centre	21 Atherden Road, London, E5 0QP	Dr A Okoreaffia
Clapton Surgery	Theydon Road HC, 14 Urban Hive, Theydon Road,	Dr Sarwat Sharif
Southgate Road Medical Centre and Whiston Road	101-103 Southgate Road, London, N1 3JS	Dr R P Tahalani
Sandringham Practice	1 Madinah Road, London, E8 1PG	Dr Edward Waller
Beechwood Medical Centre	86-86a Dalston Lane, London, E8 3AH	Dr I Nathans
Well Consortium		Dr M Cahill / Dr K Wenaden
Well Street Surgery	28 Shore Road, London, E9 7TA	Dr J Heyman
Elsdale Street Surgery	28 Elsdale Street, London, E9 6QY	Dr H Charles
London Fields Medical Centre	38-44 Broadway Market, London, E8 4QJ	Dr M Cahill
Lower Clapton Health Centre	36 Lower Clapton Road, London, E5 OPD	Dr C Highton
Wick Health Centre	200 Wick Road, London, E9 5AN	Dr J Osen
Trowbridge Practice	18 Merriam Av, London, E9 5NE	Dr T Radwan
Sorsby Health Centre	3 Mandeville Street, London, E5 0DH	Dr N Brewer
Green House Health Centre	19 Tudor Road, Hackney, London, E9 7SN	Dr M Choudhry
Klear Consortium		Dr H Patel
Latimer Health Centre	4 Homerton Terrace, London, E9 6RT	Dr Haren Patel
Kingsmead Health Centre	4 Kingsmead Way, London, E9 9QG	Dr Gorur Anantha
Richmond Road Medical Centre	136 Richmond Road, London, E8 3HN	Dr Suresh Tibrewal
Riverside Surgery, Theydon Road Health	14 Urban Hive, Theydon Road, E5 9BQ	Dr Rajiv Goel
Tollgate Health Care Centre	57 Stamford Hill, London, N16 5SR	Dr Suresh Pandya
Abney House Medical Centre	2 Defoe Road, London, N16 0EP	Dr Haluk Salih
Brooke Road Surgery	40 Brooke Road, London, N16 7LR	Dr N S Ramanathan
The Lea Surgery	Alfred Heath Centre, 186 Homerton High St, London, E9 6AG	Dr Ajay Goel

Healey Medical Centre	200 Upper Clapton Road, London, E5 9DH	Dr Manjeet Duggal
The Dalston Practice	1B Madinah Road, London, E8 1PG	Dr Suresh Kawale

APPENDIX C – STANDING ORDERS

1 STATUTORY FRAMEWORK AND STATUS

1.1 Introduction

1.1.1 These standing orders have been drawn up to regulate the proceedings of the NHS City & Hackney Clinical Commissioning CCG so that we can fulfil our obligations, as set out largely in the 2006 Act, as amended by the 2012 Act and related regulations. They are effective from the date the CCG is established.

1.1.2 The standing orders, together with the CCGs scheme of reservation and delegation[47] and the CCGs prime financial policies[48], provide a procedural framework within which the CCG discharges its business. They set out:

a. The arrangements for conducting the business of the CCG;
b. The appointment of member practice representatives;
c. The procedure to be followed at meetings of the CCG, the Governing Body and any Committees or Sub Committees of the CCG or the Governing Body;
d. The process to delegate powers,
e. The declaration of interests and standards of conduct.

1.1.3 These arrangements must comply, and be consistent where applicable, with requirements set out in the 2006 Act (as amended by the 2012 Act) and related regulations and take account as appropriate[49] of any relevant guidance.

1.1.4 The standing orders, scheme of reservation and delegation and prime financial policies have effect as if incorporated into the CCGs Constitution. CCG members, employees, members of the Governing Body, members of the Governing Body's Committees and Sub Committees, and persons working on behalf of the CCG should be aware of the existence of these documents and, where necessary, be familiar with their detailed provisions. Failure to comply with the standing orders, scheme of reservation and delegation and prime financial policies may be regarded as a disciplinary matter that could result in dismissal.

1.2 Schedule of matters reserved to the CCG and the scheme of reservation and delegation

1.2.1 The 2006 Act (as amended by the 2012 Act) provides the CCG with powers to delegate the CCGs functions and those of the Governing Body to certain bodies (such as Committees) and certain persons. The CCG has decided that certain decisions may only be exercised by the Members' Forum. These decisions and also those delegated are contained in the CCGs scheme of reservation and delegation (see Appendix D).

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[47] See Appendix D.
[48] See Appendix E.
[49] Under some legislative provisions the group is obliged to have regard to particular guidance but under other circumstances guidance is issued as best practice guidance.

2 THE CCG: COMPOSITION OF MEMBERSHIP, KEY ROLES AND APPOINTMENT PROCESS

2.1 Composition of membership

2.1.1 Section 5 of the CCG's Constitution provides details of the membership of the CCG (also see Appendix B).

2.1.2 Sections 8 and 9 of the CCGs Constitution provide details of the governing structure used in the CCGs decision-making processes, whilst section 9 of the Constitution outlines certain key roles and responsibilities within the CCG and its Governing Body, including the role of Practice Representatives (section 9.1 of the Constitution).

2.2 Reconstitution of the Governing Body

2.2.1 The CCG has in place and will maintain robust arrangements through which the organisation is governed but it is recognised that there could be circumstances which lead to one or more vacancies on the Governing Body and which thereby put at risk the governance of the CCG.

2.2.2 The CCG has in place succession planning arrangements such that no vacancies should arise when Governing Body members reach the end of their terms of office or when notice is given of a member's intention to resign. The arrangements in this section are intended to address unplanned vacancies, which could arise when Governing Body members resign without giving notice or are required to stand down from their roles in accordance with the Constitution.

2.2.3 The CCG recognises that NHS England has statutory powers to ensure the continued good governance of the CCG in such circumstances but the following provisions aim to ensure that the CCG can implement swift arrangements to ensure that the CCG complies with its obligations.

2.2.4 The following provisions, which are cross-referenced to others within the Constitution where necessary, provide procedures to address individual vacancies on the Governing Body but also circumstances in which the number and/or type of vacancies is such that no quorum can be achieved for meetings of the Governing Body.

2.2.5 The Head of Corporate Services and other CCG officers will provide support to ensure that the procedures are implemented swiftly but robustly and in compliance with the Constitution and any other relevant requirements (including any from NHS England).

2.2.6 Chair:

a. Where there is an unplanned vacancy for the Chair, the Clinical Vice Chair shall, subject to meeting the eligibility criteria in the Constitution, take up the role of Interim Chair with immediate effect until a permanent successor is appointed in accordance with the Constitution. It shall not be necessary for the Members' Forum to approve the interim appointment of the Clinical Vice Chair as Interim Chair but the Members' Forum shall be

informed about the vacancy and the appointment of the Interim Chair. The appointment shall be confirmed in writing by the Accountable Officer, Managing Director or another senior officer of the CCG, such confirmation to include a copy of the role description;

b. If the Clinical Vice Chair is unavailable or is ineligible under the Constitution one of the GP members of the Governing Body shall be appointed by the Governing Body and ratified by the Members' Forum (in accordance with the Constitution) to become Interim Chair. If no quorum can be achieved for the Governing Body, the Members' Forum shall (in accordance with the Constitution) appoint one of the GP members of the Governing Body to become Interim Chair. The appointment shall be arranged swiftly and in any event within seven days of the Chair role becoming vacant. The appointment shall be confirmed in writing by the Accountable Officer, Managing Director or another senior officer of the CCG, such confirmation to include a copy of the role description;
c. If neither of the GP members of the Governing Body is available or wishes to be appointed as Interim Chair, the election of a GP to become Chair shall be arranged in accordance with the process laid out in section 8.10.7 of the Constitution. Any election process required shall be completed as swiftly as possible but in any event within 21 days of the Chair role becoming vacant. The Accountable Officer, Managing Director or another senior officer of the CCG shall confirm to the elected GP their role as Chair, such confirmation to include a copy of the role description;
d. In the event that no Interim Chair is appointed it will not be possible to achieve a quorum for the Governing Body and the arrangements described in 2.4 below will apply.

2.2.7 GP Members:

a. Where there is an unplanned vacancy for a GP member of the Governing Body, the remaining Consortia Leads shall elect a successor GP member (or members) of the Governing Body, in accordance with the process set out in section 8.10.6 of the Constitution. The GP who has left office on the Governing Body shall not be eligible to stand in this election but is able to vote in the election, if they retain their Consortia Lead role;
b. This unplanned vacancy process may also necessitate undertaking an election or selection process to secure a new Consortia Lead (or Leads) to represent a Consortium at the CEC. See section 8.8 in the Constitution;
c. In the event that two (or more, including the CCG Chair) of the GP Member roles are vacant it will not be possible to achieve a quorum for the Governing Body so the arrangements described in 2.4 below will apply.

2.2.8 Accountable Officer:

a. The Accountable Officer is an employee of the CCG. They may resign or may be removed from their role as a member of the Governing Body, any such action being in accordance with their contract of employment and the relevant policies of the CCG and NHS England;
b. Where there is an unplanned vacancy for the Accountable Officer, the Chief Financial Officer shall, subject to their eligibility under the Constitution, take up the role of Interim Accountable Officer until a permanent successor is appointed in accordance with the Constitution.

The appointment of an Interim Accountable Officer shall be subject to approval by the Member's Forum and NHS England and, subject to that approval, shall be confirmed in writing by the CCG Chair or a senior officer of the CCG (with a copy of the role description);

c. If the Chief Financial Officer is unavailable or does not wish to be appointed as Interim Accountable Officer, another of the executives of the CCG shall be so appointed, subject to meeting the eligibility criteria in the Constitution. The selection and appointment process shall led by the Chair. In the absence of the Chair the process shall be led by the Interim Chair or, if that role is also vacant, by a representative of the Members' Forum;
d. A process to recruit and select a permanent successor for the Accountable Officer shall be commenced immediately upon the role becoming vacant.

2.2.9 Chief Finance Officer:

a. The Chief Finance Officer is an employee of the CCG. They may resign or may be removed from their role as a member of the Governing Body, any such action being in accordance with their contract of employment and the relevant policies of the CCG and NHS England;
b. Where there is an unplanned vacancy for the Chief Finance Officer, a senior finance manager shall, subject to their eligibility under the Constitution, take up the role of Interim Chief Finance Officer until a permanent successor is appointed in accordance with the Constitution. The process shall be led by the Accountable Officer or, if that role is vacant, by the Chair. If no Chair is in office, the Interim Chair shall lead the process or if that role is vacant a representative of the Members' Forum shall do so. The appointment shall be confirmed in writing by the CCG Chair or a senior officer of the CCG (with a copy of the role description);
c. A process to recruit and select a permanent successor for the Chief Finance Officer shall commence immediately upon the role becoming vacant.

2.2.10 Lay Member:

a. Where there is an unplanned vacancy for a Lay Member, an Associate Lay Member shall take up the role of Interim Lay Member with immediate effect until a permanent successor is appointed in accordance with the Constitution. It shall not be necessary for the Members' Forum to approve the interim appointment of the Associate Lay Member as Interim Lay Member but the Members' Forum shall be informed about the vacancy and the appointment of the Interim Lay Member. The appointment shall be confirmed in writing by the Accountable Officer, Managing Director or another senior officer of the CCG, such confirmation to include a copy of the role description and to state that the Interim Lay Member will count in the quorum for, and have a vote on matters discussed at, Governing Body meetings;
b. If no Associate Lay Member is available or wishes to be appointed as Interim Lay Member, a process to recruit and select a Lay Member shall be commenced immediately upon the role becoming vacant. The process shall be led by the Chair. In the absence of the Chair the process shall be

led by the Interim Chair or, if that role is also vacant, by a representative of the Members' Forum;

c. In the event that both Lay Members roles are vacant it will not be possible to achieve a quorum for the Governing Body so the arrangements described in 2.4 below will apply.

2.2.11 Nurse:

a. The CCG has no deputy for the Nurse role on the Governing Body so where there is an unplanned vacancy a process to recruit and select a Nurse shall commence immediately upon the role becoming vacant. The process shall be led by the Chair. In the absence of the Chair the process shall be led by the Interim Chair or, if that role is also vacant, by a representative of the Members' Forum;

b. Subject to there being one third of the members present the Nurse role is not required to achieve a quorum for Governing Body meetings.

2.2.12 Secondary Care Consultant:

a. The CCG has no deputy for the Secondary Care Consultant role on the Governing Body so where there is an unplanned vacancy a process to recruit and select a Secondary Care Consultant shall commence immediately upon the role becoming vacant. The process shall be led by the Chair. In the absence of the Chair the process shall be led by the Interim Chair or, if that role is also vacant, by a representative of the Members' Forum;

b. Subject to there being one third of the members present the Secondary Care Consultant role is not required to achieve a quorum for Governing Body meetings.

2.3 Governing Body Quorum and Emergency Powers

2.3.1 The quorum for the Governing Body is defined in paragraph 3.7 of Appendix C (Standing Orders) to the Constitution as: one third of the total number of the Chair and members of the Governing Body, to include at least two GP members, one Lay Member and one Executive Officer, ie. either the Accountable Officer, Managing Director (if exercising the Accountable Officer's vote as laid out in section 6.6 of the Constitution) or the Chief Finance Officer.

2.3.2 The Governing Body should be quorate for all meetings and all decisions. The three month notice period for all Governing Body members is intended to allow time for recruitment or election to any posts made vacant.

2.4 Role of NHS England

2.4.1 It will not be possible to use the emergency powers outlined in 2.3 if the failure to achieve a quorum results from there being no Lay Member in office, or if either the Chair or Accountable Officer role is vacant. In these circumstances it will not be possible for the Governing Body to function so the CCG will discuss the circumstances with NHS England and will act in accordance with any directions issued or other arrangements made such that the CCG's responsibilities can be discharged until such time as the Governing Body can be reconstituted.

3 MEETINGS OF THE GOVERNING BODY

3.1 Calling meetings

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

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

3.1.3 One-third or more members of the Governing Body may requisition a meeting in writing. If the Chair refuses, or fails, to call a meeting within seven days of a requisition being presented, the members signing the requisition may forthwith call a meeting.

3.1.4 Before each meeting of the Governing Body a written notice specifying the business proposed to be transacted shall be delivered to every member, or sent by post to the usual place of residence of each member, so as to be available to members at least three clear days before the meeting. The notice shall be signed by the Chair or by the Company Secretary. Want of service of such a notice on any member shall not affect the validity of a meeting.

3.1.5 A member desiring a matter to be included on an agenda shall make his/her request in writing to the Chair at least fifteen 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 fifteen days before a meeting may be included on the agenda at the discretion of the Chair.

3.1.6 Any Consortia representative can request, in writing to the CCG Chair, with at least fifteen clear days before the meeting that an item is discussed and addressed at the next Governing Body. 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.

3.1.7 Before each meeting of the Governing Body a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed at the principal office at least three clear days before the meeting, (required by the Public Bodies (Admission to Meetings) Act 1960 Section 1 (4) (a)).

3.2 Agenda, supporting papers and business to be transacted

3.2.1 Items of business to be transacted for inclusion on the agenda need to be notified to the Accountable Officer and/or Managing Director at least fifteen clear days before the meeting takes place.

3.2.2 Supporting papers for such items need to be submitted at least 10 working days before the meeting takes place.

3.2.3 The agenda and supporting papers will be sent to members five working days before the meeting, whenever possible, but will certainly be despatched no later than three clear working days before the meeting, save in emergency. The Governing Body may determine that certain matters shall appear on every agenda

for a meeting and shall be addressed prior to any other business being conducted. (Such matters may be identified within these Standing Orders or, following subsequent resolution, shall be listed in an Appendix to the Standing Orders).

3.2.4 Agenda and certain papers for the CCGs Governing Body – including details about meeting dates, times and venues – will be published on the CCGs website and distributed to key partner organisations, including the LMC.

3.2.5 Copies of Board papers and other key documents will be made available on request for inspection at the CCG principal office or by email on request.

3.3 Petitions

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

3.4 Conflicts of Interest

3.4.1 Members are required to declare any new interest immediately on becoming aware of its existence and in any event at the start of the next meeting after they were aware of it. A standing item shall be included on each meeting agenda for this purpose

3.4.2 Members are required to review and update their registered declarations of interest on a six-monthly basis, including a "nil" return where there are either no conflicts to declare, or a "no change" return where there is no change.

3.5 Chair of a meeting

3.5.1 At any meeting of the CCG or its Governing Body or of a Committee or Sub Committee, the Chair of the CCGs, Governing Body, Committee or Sub-Committee, if any and if present, shall preside. If the Chair is absent from the meeting, the Clinical Vice Chair, if any, or nominated Chair shall preside.

3.5.2 If the Chair is absent temporarily on the grounds of a declared conflict of interest the Lay Member for PPI and conflicts of interest, if present, shall preside. If both the Chair and Deputy Chair are absent, or are disqualified from participating, or there is neither a Chair or deputy a member of the CCG, Governing Body committee or sub-committee respectively shall be chosen by the members present, or by a majority of them, and shall preside.

3.6 Chair's ruling

3.6.1 The decision of the Chair of the Governing Body, in conjunction with the Lay Members for governance and patient and public involvement 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, except in cases of Members' Forum intervention.

3.7 Quorum

3.7.1 No business shall be transacted at a meeting unless at least one-third of the whole number of the Chair and members (including at least two GPs, one lay member and one Executive Officer) is present.

3.7.2 An Executive in attendance for an Executive Director (Executive Member) but without formal acting up status may not count towards the quorum.

3.7.3 If the Chair or member has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of a declaration of a conflict of interest (see section 3.4 of the Standing Orders) that person shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

3.7.4 For all of the CCGs Committees and Sub Committees, including the Governing Body's Committees and Sub Committees, the details of the quorum for these meetings and status of representatives are set out in the appropriate terms of reference.

3.7.5 An exception to the arrangements set out in 3.7.1 to 3.7.4 above is where the Governing Body is discussing and deciding on commissioning services from GP providers, (including where we are commissioning services from the local GP Confederation or the GP Social Enterprise that provide GP Out of Hours service). In this situation, the GP Governing Body members must recuse themselves from the Governing Body and decisions made by a quorum of 1 Lay Member, 1 clinician and 1 Executive Officer. These specific decisions cannot be challenged by the Members' Forum.

3.7.6 A template has been developed for use when commissioning services from GP practices, provider Consortia or organisations where GPs have a financial interest and this must be completed in order to satisfy the requirement to give assurance to the Contracts Committee.

3.8 Decision making

3.8.1 Section 8 of the CCGs Constitution, together with the scheme of reservation and delegation, sets out the governing structure for the exercise of the CCGs statutory functions. Generally it is expected that at the CCGs meetings decisions will be reached by consensus. Should this not be possible then a vote of members will be required, the process for which is set out below:

3.8.2 Eligibility - the list below outlines all voting members of the Governing Body:

a. Elected GPs;
b. 3 Lay members;
c. Additional lay members as recruited;
d. Nurse member;
e. Hospital consultant;
f. Accountable Officer;

g. Chief Finance Officer;
h. Managing Director (when exercising the Accountable Officer's vote in their absence).

3.8.3 A manager who has been formally appointed to act up for a non GP or Lay Executive Member during a period of incapacity or temporarily to fill an Executive Director vacancy shall be entitled to exercise the voting rights of the Executive Member.

3.8.4 A manager attending the Governing Body meeting to represent a non GP or Lay Member during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the Executive Member. An Executive's status when attending a meeting shall be recorded in the minutes.

3.8.5 The Managing Director is a non-voting member of the Governing Body, able to cast the Accountable Officers vote in the Governing Body and other decision making bodies and Committees of the CCG when the Accountable Officer is not present. The Accountable Officer remains responsible for how that vote is exercised.

3.8.6 In no other circumstances may an absent member vote by proxy. Absence is defined as being absent at the time of the vote.

3.8.7 Where the post of a voting member is jointly held by more than one individual, they shall be considered to have only a single vote, regardless of whether both are in attendance.

3.9 Majority necessary to confirm a decision

3.9.1 At least one-third of the Governing Body membership is required in order to make a formal board decision.

3.10 Casting vote

3.10.1 In the case of an equal vote, the Chair of the meeting shall have a second, and casting vote.

3.11 Dissenting views

3.11.1 Dissenting views will be recorded in the minutes of the meeting.

3.11.2 Should a vote be taken then the outcome of the vote and dissenting views must be recorded in the minutes.

3.11.3 For all other of the CCGs Committees and Sub Committees, including the Governing Body's Committees, the details of the process for holding a vote are set out in the appropriate terms of reference.

3.12 Emergency powers and urgent decisions

3.12.1 In an emergency or if an urgent decision is required, the Accountable Officer and the Chair, after having consulted at least one Lay Member and one Governing

Body GP, can make a decision on behalf of the Governing Body. The exercise of such powers by the Accountable Officer and Chair shall be reported to the next formal meeting of the Governing Body for formal ratification.

3.12.2 Emergency meetings may be called in accordance with 3.1.2 and 3.1.3.

3.12.3 In the case of a meeting called by members in default of the Chair calling the meeting, the notice shall be signed by those members.

3.12.4 No business shall be transacted at the meeting other than that specified on the agenda.

3.13 Suspension of Standing Orders

3.13.1 Except where it would contravene any statutory provision or any direction made by the Secretary of State for Health or NHS England, any part of these standing orders may be suspended at any meeting, providing at least one third of the CCG members are in agreement.

3.13.2 A decision to suspend the standing orders together with the reasons for doing so shall be recorded in the minutes of the meeting.

3.13.3 A separate record of matters discussed during the suspension shall be kept. These records shall be made available to the Governing Body's Audit Committee for review of the reasonableness of the decision to suspend the standing orders.

3.14 Record of Attendance

3.14.1 The names of all members of the meeting present at the meeting shall be recorded in the minutes of the CCGs meetings. The names of all members of the Governing Body present shall be recorded in the minutes of the Governing Body meetings. The names of all members of the Governing Body's Committees / Sub Committees present shall be recorded in the minutes of the respective Governing Body Committee / Sub Committee meetings.

3.15 Minutes

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

3.15.2 Free discussion shall take place upon the minutes, for example upon their accuracy or where the Chair wishes to draw the Governing Body's attention. Minutes shall be circulated in a timely manner after Board meeting, in advance of the following months meeting at the latest.

3.15.3 Where providing a record of a public meeting the minutes shall be made available to the public as required by Code of Practice on Openness in the NHS and published on the CCGs website.

3.16 Admission of public and the press

3.16.1 Admission and exclusion on grounds of confidentiality of business to be transacted. The public and representatives of the press may attend all meetings of the Governing Body and are invited to ask questions of the Governing Body at the designated time on the agenda, but shall be asked to withdraw upon the Governing Body resolving 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'.

3.16.2 General disturbances. The Chair or the person presiding over the meeting shall give such directions as he/she thinks fit with regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that business shall be conducted without interruption and disruption and, without prejudice to the power to exclude on grounds of the confidential nature of the business to be transacted, the public will be required to withdraw upon the Governing Body resolving as follows: `That in the interests of public order the meeting adjourn for (the period to be specified) to enable the Governing Body to complete its business without the presence of the public'.

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

a. Matters to be dealt with by the Governing Body following the exclusion of representatives of the press, and other members of the public, as provided in 3.16.1 and 3.16.2 above on grounds of the confidential nature of the business to be transacted, shall be confidential to the members of the Governing Body.
b. Members and Executives or any employee in attendance shall not reveal or disclose the contents of papers marked 'In Confidence' or minutes headed 'Items Taken in Private' outside of NHS City & Hackney CCG, without the express permission of the NHS City & Hackney CCG 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.

3.17 Use of Mechanical or Electrical Equipment for Recording or Transmission of Meetings

3.17.1 Nothing in these Standing Orders shall be construed as permitting the introduction by the public, or press representatives, of recording, transmitting, video or similar apparatus into meetings of the Governing Body or Committee thereof. Such permission shall be granted only upon resolution of the Governing Body.

3.18 Observers at meetings

3.18.1 The Governing Body will decide what arrangements and terms and conditions it feels are appropriate to offer in extending an invitation to observers to attend and address any of the Governing Body's meetings and may change, alter or vary these terms and conditions as it deems fit.

4 MEETINGS OF THE MEMBERS' FORUM

4.1 Calling and Notice of General Meetings

4.1.1 A Consortium lead may call a General Meeting of the Members' Forum at any time by giving notice in accordance with this section 4 of the Standing Orders.

4.1.2 Every notice calling a General Meeting must specify the location, date and time of the meeting and the general nature of the business to be transacted. Any resolution to be passed must be set out in full. The location must be publicly accessible premises within the Group's Area.

4.1.3 The Consortium lead who calls a General Meeting must give at least 15 clear days' written notice before the date of it to all Practice Representatives and all members of the Governing Body.

4.1.4 On the calling of a General Meeting the Chair shall forthwith arrange to give notice of it at the offices of the Group and on the Group's website.

4.2 Agenda and Papers for General Meetings

4.2.1 The Chair shall arrange for the agenda and papers to be prepared for a General meeting.

4.2.2 The agenda and any papers for a General Meeting must be circulated at least 5 clear days prior to the General Meeting to each Practice Representative and each member of the Governing Body.

4.2.3 Any papers relating to items that are to be discussed in private at a General Meeting shall not be made public.

4.3 Attendance and Speaking at General Meetings

4.3.1 The Chair may make whatever arrangements he or she considers appropriate to enable those attending a General Meeting to listen and contribute including to exercise their rights to speak or vote.

4.3.2 Any Partner or salaried GP of a Member and any member of the Governing Body may attend and speak at a General Meeting.

4.3.3 Other attendees may ask questions by invitation of the Chair.

4.3.4 The accidental omission to give notice of a meeting to, or the non-receipt of notice of a meeting, agenda or papers by, any person entitled to receive notice shall not invalidate proceedings at that meeting.

4.4 Quorum

4.4.1 No business shall be transacted at a General Meeting if the persons attending do not constitute a quorum.

4.4.2 A quorum for a General Meeting shall be two thirds (2/3) of all Practice Representatives (or their proxies).

4.5 Chairing of General Meetings

4.5.1 The Chair of the Governing Body shall chair General Meetings if present. If not present the Deputy Chair shall chair the General Meeting if present.

4.5.2 If the Chair and Deputy Chair are not present or are not present within 10 minutes of the time at which a General Meeting was due to start the Practice Representatives present at the meeting shall on a majority vote appoint one of them to chair the meeting.

4.5.3 If the persons attending a General Meeting within half an hour of the time at which the meeting was due to start do not constitute a quorum, or if during a meeting a quorum ceases to be present, the Chair of the meeting must adjourn it.

4.5.4 The Chair of a quorate General Meeting may adjourn it if:

a. The meeting consents to an adjournment;
b. It appears to the Chair of the meeting that an adjournment is necessary to ensure that the business of the meeting is conducted in an orderly manner.

4.5.5 The Chair of a General Meeting must adjourn it if directed to do so by Practice Representatives holding a simple majority of the nominated voting rights allocated to the Practice Representatives present at the meeting.

4.5.6 When adjourning a General Meeting, the Chair of the meeting must:

a. Either specify the time and place to which it is adjourned or state that it is to continue at a time and place to be fixed by the Governing Body
b. Have regard to any directions as to the time and place of any adjournment which have been given by the meeting.
a. If the continuation of an adjourned meeting is to take place more than 14 days after it was adjourned, the Chair must give at least 14 clear days notice of it to the same persons to whom notice of a General Meeting is required to be given, containing the same information which such notice is required to contain.

4.5.7 At an adjourned General Meeting only that business which formed the business to be transacted at the original meeting can be transacted.

4.6 Decision Making at General Meetings

4.6.1 All matters requiring a decision at a General Meeting shall be decided by a vote of the Practice Representative who shall each have one vote. A vote shall be carried only if at least two thirds (2/3) of the total number of Practice Representatives (or their proxies) vote in favour of it (i.e. not two thirds of those Practice Representatives present and voting, but two thirds of all Practice Representatives).

4.6.2 Only the Practice Representatives (or their proxies) shall be eligible to vote at a General Meeting save that in the case of an equality of votes, the Chair of the meeting shall be entitled to a casting vote.

4.6.3 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.

4.7 Errors and Disputes

4.7.1 No objection may be raised to the qualification of any person voting at a General Meeting except at the meeting or adjourned meeting at which the vote objected to is tendered, and every vote allowed at the meeting is valid.

4.7.2 Any such objection must be referred to the Chair of the meeting whose decision is final.

4.8 Content of Proxy Notices

4.8.1 Proxies may only validly be appointed by a notice in writing (a “proxy notice”) which:

a. States the name and address of the Practice Representative appointing the proxy;
b. Identifies the person appointed to be that Practice Representative’s proxy and the General Meeting in relation to which that person is appointed;
c. Is signed by or on behalf of the Practice Representative appointing the proxy, or is authenticated by the relevant Member;
d. Is delivered to the Governing Body in accordance with the Constitution and any instructions contained in the notice of the General Meeting to which they relate.

4.8.2 The Governing Body may require proxy notices to be delivered in a particular form, and may specify different forms for different purposes.

4.8.3 Proxy notices may specify how the proxy appointed under them is to vote (or that the proxy is to abstain from voting) on one or more resolutions.

4.8.4 Unless a proxy notice indicates otherwise, it must be treated as:

a. Allowing the person appointed under it as a proxy discretion as to how to vote on any ancillary or procedural resolutions put to the meeting;
b. Appointing that person as a proxy in relation to any adjournment of the General Meeting to which it relates as well as the meeting itself.

4.8.5 An appointment under a proxy notice may be revoked by delivering to the Governing Body a notice in writing given by or on behalf of the Practice Representative by whom or on whose behalf the proxy notice was given.

4.8.6 A notice revoking a proxy appointment only takes effect if it is delivered before the start of the meeting or adjourned meeting to which it relates.

4.8.7 If a proxy notice is not executed by the Practice Representative appointing the proxy, it must be accompanied by written evidence of the authority of the person who executed it to execute it on the relevant Member's behalf.

5 ANNUAL GENERAL MEETING

5.1 Calling the Annual General Meeting

5.1.1 The Governing Body shall call and hold an Annual General Meeting (AGM) of the CCG:

a. Once in each year provided that not more than 15 months shall elapse between the date of one Annual General Meeting and that of the next;
b. On a Business Day;
c. At such a time and place as the Governing Body shall determine no later than September 30th of any year and in publicly accessible premises within the CCGs Area.

5.1.2 The matters to be discussed at the AGM shall be set out in the notice, and shall include the consideration and, if thought fit, approval of:

a. The CCG accounts;
b. The CCG Annual Report;
c. The CCG Report on Public Involvement;
d. The CCG Annual Plan;
e. The transaction of any other business included in the notice convening the meeting;
f. Any matters reserved to the Members' Forum;
g. The appointment or approval of appointment of members to the Governing Body, where applicable.

5.1.3 The AGM shall be open to the public.

5.1.4 Notice of the AGM will be published at least 15 clear days prior to the meeting.

5.1.5 Standing Orders 4.3 to 4.8 will apply to an Annual General Meeting.

5.2 MINUTES

5.2.1 Minutes of a General Meeting and the Annual General Meeting will be drawn up and signed by the Chair.

5.2.2 The names of all practices leads and their practices present at the meeting shall be recorded in the minutes of a General Meeting.

5.2.3 Minutes of the Annual General Meeting and (except insofar as it is held in private) a General Meeting shall be a public document that will be circulated to all Members and to all members of the Governing Body and published on the CCG website within 3 days of the meeting having taken place.

6 APPOINTMENT OF COMMITTEES AND SUB-COMMITTEES

6.1 Appointment of Committees

6.1.1 In addition to the Members' Forum, and subject to any regulations made by the Secretary of State[50], the CCG may appoint other Committees and Sub Committees of the CCG and the Governing Body may appoint Committees and Sub Committees of the Governing Body.

6.1.2 Other than where there are statutory requirements, such as in relation to the Governing Body's Audit Committee or Remuneration Committee, the CCG 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 CCG.

6.1.3 The provisions of these standing orders shall apply where relevant to the operation of the Governing Body, the Governing Body's Committees and Sub Committee and all Committees and Sub Committees unless stated otherwise in the Committee or Sub Committee's terms of reference.

6.2 Delegation of Power by Committees to Sub-Committees

6.2.1 Where Committees are authorised to establish Sub Committees they may not delegate executive powers to the Sub Committee unless expressly authorised by the CCG or the Governing Body on its behalf.

6.3 Approval of Appointments to Committees and Sub-Committees

6.3.1 The CCG or the Governing Body on its behalf shall approve the appointments to each of the Committees and Sub Committees which it has formally constituted including those the Governing Body. The CCG shall agree such travelling or other allowances as it considers appropriate.

[50] See section 14N of the 2006 Act, inserted by section 25 of the 2012 Act.

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

7.1.1 If for any reason these standing orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the Governing Body and Audit Committee for action or ratification. All members of the CCG and staff have a duty to disclose any non-compliance with these standing orders to the Accountable Officer and/or Managing Director as soon as possible.

8 USE OF SEAL AND AUTHORISATION OF DOCUMENTS

8.1 CCG seal

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

a. The Accountable Officer;
b. The Chief Finance Officer.

8.1.2 The use of the seal shall be reported to the Governing Body by the Secretary (Head of Corporate Services).

9 OVERLAP WITH OTHER CCG POLICY STATEMENTS / PROCEDURES AND REGULATIONS

9.1 Policy statements: general principles

9.1.1 The CCG will from time to time agree and approve policy statements / procedures which will apply to all or specific groups of staff employed by NHS City & Hackney CCG. The decisions to approve such policies and procedures will be recorded in an appropriate CCG minute and will be deemed where appropriate to be an integral part of the CCGs standing orders.

APPENDIX D – SCHEME OF RESERVATION & DELEGATION

10 SCHEDULE OF MATTERS RESERVED TO THE CCG AND SCHEME OF DELEGATION

10.1.1 The arrangements made by the CCG are set out in the scheme of reservation and delegation, available as a separate standalone document. That document sets out how decisions shall have effect as if incorporated in the CCGs Constitution.

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

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 in the Constitution.

1.1.2 The Prime Financial Policies are part of the CCGs 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, Managing Director and Chief Finance Officer to effectively perform their responsibilities. They should be used in conjunction with the Scheme of Reservation and Delegation adopted by the CCG.

1.1.3 In support of these Prime Financial Policies, there are more detailed policies, approved by the Accountable Officer and Chief Finance Officer (CFO), known as Detailed Financial Policies. The Prime and Detailed Financial Policies are referred together as the CCGs Financial Policies.

1.1.4 These Prime Financial Policies identify the financial responsibilities which apply to everyone working for the CCG 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 and Chief Finance Officer are responsible for preparing all Detailed Financial Policies which will be approved in accordance with the CCGs Scheme of Reservation and Delegation.

1.1.5 Should any difficulties arise regarding the interpretation or application of any of the Prime Financial Policies then the advice of the Accountable Officer, Managing Director and/or 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 CCGs Constitution, Standing Orders and Scheme of Reservation and Delegation.

1.1.6 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.

2 OVERRIDING PRIME FINANCIAL POLICIES

2.1 General

2.1.1 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 Audit Committee for referring action or ratification. All members of the CCG and staff have a duty to disclose any non-compliance with these Prime Financial Policies to the Chief Finance Officer as soon as possible.

2.2 Responsibilities and Delegation

2.2.1 The roles and responsibilities of Members of the CCG, the Governing Body, its Committees and Sub-Committees are set out in the main body of the CCG constitution and the CCGs Scheme of Reservation and Delegation.

2.3 Delegated Financial Decisions

2.3.1 The financial decisions delegated by Members of the CCG are set out in the CCGs Scheme of Reservation and Delegation.

2.4 Contractors and their Employees

2.4.1 Any contractor or employee of a contractor who is empowered by the CCG to commit the CCG to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Accountable Officer, Chief Finance Officer and Managing Director to ensure that such persons are made aware of this.

2.5 Amendment of Prime Financial Policies

2.5.1 To ensure that these policies remain up-to-date and relevant, the Chief Finance Officer will review them annually. Following consultation with the Accountable Officer and scrutiny by the Audit Committee, the Chief Finance Officer will recommend amendments, as fitting, to the appropriate body as set out in the Scheme of Reservation and Delegation.

3 INTERNAL CONTROL

3.1 General

3.1.1 The CCG 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.

3.1.2 The Governing Body will set up an Audit Committee with terms of reference agreed by the Governing Body.

3.1.3 The Accountable Officer has overall responsibility for the CCGs systems of internal control.

3.1.4 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;
c. A proper procedure is in place for regular checking of the adequacy and effectiveness of the control environment.

4 AUDIT

4.1 General

4.1.1 The CCG will keep an effective and independent internal audit function and fully comply with the requirements of external audit and other statutory reviews.

4.1.2 In line with the Audit Committee Terms of Reference, the Head of Internal Audit and the CCGs appointed external auditor will have direct and unrestricted access to Audit Committee members and the CCGs Chair, Accountable Officer, Chief Finance Officer and Managing Director for any significant issues arising from audit work that management cannot resolve, and for all cases of fraud or serious irregularity.

4.1.3 The Head of internal Audit and external auditor will have access to the Audit Committee, Accountable Officer, Chief Finance Officer and Managing Director to review audit issues as appropriate. All Audit Committee Members, the Chair of the CCG, Accountable Officer, Chief Finance Officer and Managing Director will have direct and unrestricted access to the Head of Internal Audit and external auditors.

4.1.4 The Chief Finance Officer will ensure that:

a. The CCG has a professional and technically competent internal audit function;
b. The Audit Committee approves any changes to the provision or delivery of assurance services to the CCG.

5 FRAUD AND CORRUPTION

5.1 General

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

5.1.2 The Audit Committee will satisfy itself that the CCG 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 previously reviewed by and agreed with the CFO.

6 EXPENDITURE CONTROL

6.1 General

6.1.1 The CCG is required by statutory provisions to ensure that its expenditure does not exceed the aggregate of allocations from NHS England and any other sums it has received and is legally allowed to spend. The Accountable Officer has overall executive responsibility for ensuring that the CCG 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.

6.1.2 The Chief Finance Officer will: provide reports in the form required by NHS England; ensure money drawn from NHS England is required for approved expenditure only is drawn down only at the time of need and follows best practice; be responsible for ensuring that an adequate system of monitoring financial performance is in place to enable the CCG to fulfil its statutory responsibility not to exceed its expenditure limits, as set by direction of NHS England.

7 ALLOCATIONS

7.1 General

7.1.1 The Chief Finance Officer of the CCG will:

a. Periodically review the basis and assumptions used by the NHS Commissioning Board for distributing allocations of funds to CCGs and ensure that these are reasonable and realistic and secure the CCGs full entitlement to funds;
b. Prior to the start of each financial year submit to the CCG Governing Body for approval a report showing the total allocations received and their proposed distribution including any sums to be held in reserve;
c. Regularly update the CCG Governing Body on significant changes to the initial allocation and the uses of such funds.

8 COMMISSIONING STRATEGY, BUDGETS, BUDGETARY CONTROL AND MONITORING

8.1 General

8.1.1 The CCG will produce and publish an annual commissioning plan that explains how it proposes to discharge its financial duties. The plan will be supported by comprehensive medium term financial plans and annual budgets.

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

8.1.3 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 under the terms of the Scheme of Reservation & Delegation.

8.1.4 The Chief Finance Officer shall monitor financial performance against budget and plan, periodically review them, and report to the Governing Body. This report shall include explanations for significant variances or anticipated risks.

8.1.5 The Accountable Officer is responsible for ensuring that information relating to the CCGs accounts or to its income or expenditure, or its use of resources is provided to NHS England as requested.

8.1.6 The Chief Finance Officer shall approve all virements which have not been reserved for decision by the Governing Body.

8.1.7 Non-recurrent funds must not be used to support any activity of a recurrent nature.

8.1.8 All permanent appointments must be approved by the Accountable Officer, Chief Finance Officer or Managing Director.

8.1.9 The Accountable Officer is responsible for identifying cost improvements and savings plans in accordance with the requirements identified in the annual financial plan.

9 ANNUAL ACCOUNTS AND REPORTS

9.1 General

9.1.1 The Chief Finance Officer will ensure the CCG:

a. Prepares a timetable for producing the annual report and accounts and agrees it with external auditors and the Governing Body;
b. Prepares the accounts according to the timetable approved by the Governing Body;
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;
e. Publishes the external auditor's management letter on the CCGs internet site.

10 ACCOUNTING SYSTEMS

10.1 General

10.1.1 The CCG will ensure it has in place an accounting system that creates management and financial accounts.

10.1.2 The CFO will ensure the CCG has suitable financial and other software to enable it to comply with these policies and any consolidation requirements of the NHS Commissioning Board.

11 BANK ACCOUNTS

11.1 General

11.1.1 The Chief Finance Officer will review the banking arrangements of the CCG at regular intervals to ensure they reflect any Secretary of State directions, best practice and represent best value for money.

11.1.2 The Chief Finance Officer will manage the CCGs banking arrangements and advise the CCG on the provision of banking services and operation of accounts.

11.1.3 The Accountable Officer shall approve the banking arrangements.

11.1.4 The Chief Finance Officer will prepare detailed instructions on the operation of bank accounts.

11.1.5 The CCG will keep enough liquidity to meet its current commitments.

12 INCOME, FEES AND CHARGES AND SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS.

12.1 General

12.1.1 The CCG will operate a sound system for prompt recording, invoicing and collection of all monies due.

12.1.2 The CCG will seek to maximise its potential to raise additional income only to the extent that it does not conflict with its overall aims and objectives as set out in its Constitution.

12.1.3 The CCG will ensure its power to make grants and loans is used to discharge its functions effectively.

12.1.4 The Chief Finance Officer is responsible for developing effective arrangements for making grants or loans

12.1.5 The Chief Finance Officer is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, and collection and coding of all monies due.

12.1.6 The Chief Finance Officer will establish and maintain systems and procedures for the secure handling of all cash and other negotiable instruments.

12.1.7 The Chief Finance Officer is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the NHS Commissioning Board or by statute.

13 TENDERING AND CONTRACTING PROCEDURE

13.1 General

13.1.1 The CCG will ensure compliance with all legal and statutory requirements for competition within all purchasing and that only budgeted, approved and necessary spending is incurred.

13.1.2 The CCG will seek value for money for all goods and services.

13.1.3 The CCG shall ensure that competitive tenders are invited for:

a. The supply of goods, materials and manufactured articles;
b. The rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the DH);
c. The purchase or disposal of fixed assets.

13.1.4 The Governing Body may only negotiate contracts on behalf of the CCG, and the CCG enter into contracts, within the statutory framework set up under the Health and Social Care Bill 2012. These contracts shall comply with:

a. The CCGs Standing Orders;
b. The Public Contracts Regulation 2006, any successor legislation and any other applicable law; and any applicable Commissioning Board or Monitor instruction that is legally enforceable.

13.1.5 The Accountable Officer or Managing Director shall nominate an officer who shall oversee and manage each contract on behalf of the CCG including those being managed by a third party on behalf of the CCG

13.1.6 The Accountable Officer shall put in place effective systems to ensure the CCG is compliant with the requirements of the Bribery Act 2010.

13.1.7 The Governing Body shall agree limits whereby tendering may be waived or circumstances under which tendering may not be applied. All waivers should be reported to the Audit Committee.

13.1.8 The Chief Finance Officer shall establish formal procedures for tendering which shall be made available to all staff involved in tendering activities.

14 COMMISSIONING

14.1 General

14.1.1 Working in partnership with relevant national and local stakeholders, the CCG will commission certain health services to meet the reasonable requirements of the persons for whom it has responsibility within the resource allocated.

14.1.2 The CCG will coordinate its work with the NHS Commissioning Board, local NHS Trusts, other CCGs, NHS Trusts and Foundation Trusts, the local authority, including through Health & Wellbeing Boards, users, carers and the voluntary sector to develop its commissioning plans.

14.1.3 The Accountable Officer, Chief Finance Officer and/or Managing Director 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 SLA and ensure the Governing Body are made aware of any significant variations to the annual plan.

14.1.4 Where the CCG makes arrangements for the provision of services by non-NHS providers it is the Accountable Officer and/or Managing Director who is responsible for ensuring that the agreements put in place have due regard to the quality and cost-effectiveness of services provided. Before making any agreement with non-NHS providers, the CCG should explore fully the scope to make maximum cost-effective use of NHS facilities.

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

15 RISK MANAGEMENT AND INSURANCE

15.1 General

15.1.1 The CCG will put arrangements in place for evaluation and management of its risks.

15.1.2 The Accountable Officer and/or Managing Director will ensure effective arrangements are put in place to identify, assess, record, manage and mitigate risks.

15.1.3 The CCG will ensure arrangements for reporting risks to the Governing Body.

16 NON-PAY EXPENDITURE

16.1 General

16.1.1 The Accountable Officer 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 within any overall CCG Scheme of Reservation and Delegation.

16.1.2 The Accountable Officer and/or Managing Director shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

16.1.3 The Chief Finance Officer will:

a. Advise the Accountable Officer, Managing Director and Governing Body on the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in the CCGs 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.

16.1.4 The CCG will ensure it has in place arrangements to seek to obtain the best value for money goods and services received.

17 CAPITAL INVESTMENT, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

17.1 General

17.1.1 Within the statutory powers of the CCG for acquisition, disposal and holding of assets, the Accountable Officer:

a. Shall 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. Is 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 that the revenue consequences, including capital charges, are affordable within the CCGs projected allocations and medium term financial plan.

17.1.2 The CCG shall maintain an asset register recording fixed assets. The Accountable Officer is responsible for the maintenance of registers of assets, taking account of the advice of the Chief Finance Officer and Managing Director 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.

17.1.3 The Accountable Officer and/or Chief Finance Officer is responsible for establishing and maintaining effective arrangements with NHS Property Co. or its successor bodies.

18 AUDIT COMMITTEE

18.1 General

18.1.1 In accordance with Standing Orders the Governing Body shall formally establish an Audit Committee, with clearly defined terms of reference and following guidance from the NHS Audit Committee Handbook to perform the following reviews:

a. Reviewing the establishment and maintenance of an effective system of governance, risk management and internal control, across the whole of the CCGs activities;
b. Ensuring there is an effective internal audit function established by management, that meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Accountable Officer, Chief Finance Officer, Managing Director and Governing Body;

c. Reviewing the work and findings of the appointed external auditor and considering the implications of and management's responses to their work;
d. Reviewing the findings of other significant assurance functions, both internal and external to the organisation, and considering the implications for the governance of the CCG;
e. Reviewing the systems for financial reporting to the Governing Body, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Governing Body;
f. Reviewing financial and information systems and monitoring the integrity of the financial statements and reviewing significant financial reporting judgments;
g. Monitoring compliance with Standing Orders and Standing Financial Instructions;
h. Reviewing schedules of losses and compensations and making recommendations to the Governing Body;
i. Reviewing schedules of aged debtors and creditors balances over 6 months;
j. Review the annual report and financial statements prior to submission to the Governing Body focusing particularly on:
k. The wording in the Statement of Internal Control and other relevant disclosures;
l. Changes in, and compliance with, accounting policies and practices;
m. Unadjusted mis-statements in the financial statements;
n. Major judgmental areas;
o. Significant adjustments resulting from audit.
p. Reviewing the annual financial statements and recommend their approval to the Governing Body;
q. Reviewing the external auditor's report on the financial statements and the annual management letter;
r. Reviewing any incident of fraud or corruption or possible breach of ethical standards, conflicts of interest or legal or statutory requirements that could have a significant impact on the CCGs financial accounts or reputation;
s. Reviewing any objectives and effectiveness of the internal audit services including its working relationship with external auditors;
t. Reviewing major findings from internal and external audit reports and ensure appropriate action is taken;
u. Investigating any matter within its terms of reference, having the right of access to any information relating to the particular matter under investigation;
v. Reviewing waivers to Standing Orders;
w. Reviewing templates completed where GP practices are potential providers of CCG-commissioned services in order to gain assurance that a robust process has been followed.

19 CHIEF FINANCE OFFICER

19.1 General

19.1.1 The Chief Finance Officer is responsible for:

a. Ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective Internal Audit function;
b. Ensuring that the Internal Audit function meets the NHS mandatory audit standards and provides sufficient independent and objective assurance to the Audit Committee, Governing Body, Accountable Officer and Managing Director;
c. Deciding at what stage to involve the police in cases of misappropriation and other irregularities not involving fraud or corruption;
d. Ensuring that an annual Internal Audit report is prepared for the consideration of the Audit Committee.

19.1.2 The Chief Finance Officer or designated internal or external auditor is entitled without necessarily giving prior notice to require and receive:

a. Access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;
b. Explanations concerning any matter under investigation.

20 ROLE OF INTERNAL AUDIT

20.1 General

20.1.1 Internal Audit is an independent and objective appraisal service within an organisation which provide:

a. An independent and objective opinion to the Accountable Officer, Chief Finance Officer, Managing Director, the Governing Body, and the Audit Committee on the degree to which risk management, control and governance, support the achievement of the organisation's agreed objectives;
b. An independent and objective service to help improve the organisation's risk management, control and governance arrangements.

20.1.2 Internal Audit will review, appraise and report upon policies, procedures and operations in place to;

a. Identify, assess and manage the risks to achieving the organisation's objectives;
b. Ensure the economical, effective and efficient use of resources;
c. Ensure compliance with established policies procedures, laws and regulations;
d. Safeguard the organisation's assets and interests from losses of all kinds, including those arising from fraud, irregularity or corruption;
e. Ensure the integrity and reliability of information, accounts and data, including internal and external reporting and accountability processes.

20.1.3 The Head of Internal Audit will provide to the Audit Committee:

a. A risk-based plan of internal audit work, agreed with management;
b. Regular updates on the progress against plan;
c. Reports of management's progress on the implementation of action agreed as a result of internal audit findings;

d. An annual opinion, based upon and limited to the work performed, on the overall adequacy and effectiveness of the organisation's risk management, control and governance processes (i.e. the organisation's system of internal control);
e. Additional reports as requested by the Audit Committee.

20.1.4 Whenever any matter arises which involves, or is thought to concern any suspected irregularity the Chief Finance Officer must be notified immediately.

20.1.5 The Head of Internal Audit will normally attend Audit Committee meetings and has a right of access to all Audit Committee members, the Chair, Accountable Officer, Chief Finance Officer and Managing Director.

20.1.6 The Head of Internal Audit reports to the Audit Committee and is managed by the Chief Finance Officer.

20.1.7 The appointment and termination of the Head of Internal Audit and/or the Internal Audit Service must be approved by the Audit Committee.

21 EXTERNAL AUDIT

21.1 General

21.1.1 The External Auditor is appointed to the CCG.

21.1.2 The Audit Committee must ensure a cost-efficient service. If there are any problems relating to the service provided by the External Auditor, then this should be raised with the External Auditor.

22 FRAUD AND CORRUPTION

22.1 General

22.1.1 In line with their responsibilities, the Accountable Officer, Managing Director and Chief Finance Officer shall monitor and ensure compliance with Directions issued by the Secretary of State for Health on fraud and corruption.

22.1.2 The CCG shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist (LCFS) as specified by the NHS Counter Fraud and Corruption Manual, and guidance.

22.1.3 The LCFS shall report to the Chief Finance Officer.

22.1.4 The LCFS will provide a written report, at least annually to the Audit Committee, on counter fraud work. The LCFS will be entitled to attend any Audit Committee meetings and have a right of access to all Audit Committee members and to the Chair, Accountable Officer, Chief Finance Officer and Managing Director of the NHS body.

22.1.5 The LCFS will undertake as specified by the Accountable Officer, Chief Finance Officer or Managing Director, proactive work to detect cases of fraud and corruption.

23 SHARED SERVICE ARRANGEMENTS

23.1 General

23.1.1 The Accountable Officer, Chief Finance Officer and/or Managing Director shall ensure that any commissioning, financial or other activity which is performed by a Shared Service Organisation shall have in place a service level agreement to cover the functions being performed.

24 INFORMATION TECHNOLOGY

24.1 General

24.1.1 Any computerised systems established or operated by the CCG must comply with all legal requirements. The Chief Finance Officer will ensure that contracts for computer services for financial applications with another health organisation or 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 and shall periodically seek assurances that adequate controls are in operation.

25 PAYROLL

25.1 General

25.1.1 The CCG will put arrangements in place for an effective payroll service. The CFO will ensure that the payroll service meets NHS requirements, is supported by a service level agreement or contract which ensures compliance with requirements for tax and deductions, data security and provides assurance on internal controls and audit.

26 TRUST FUNDS AND TRUSTEES

26.1 General

26.1.1 The Chief Finance Officer shall oversee the setting up of trust funds and 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

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

1. **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.
2. **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.
3. **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.
4. **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.
5. **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.
6. **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.
7. **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)[51]

[51] 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)[52]

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

APPENDIX H – JOINT ARRANGEMENTS

The CCG may enter into joint arrangements with other CCGs including the following:

Name of joint arrangement	Name(s) of the CCGs this arrangement is with
Delegated coordinating commissioner for London PCTs/CCGs - Homerton University Hospital Foundation Trust	All London CCGs with delegated authority for acute commissioning (or their host PCTs) acting as coordinating commissioner/associates to the contract.
Delegated coordinating commissioner for ELC PCTs/CCGs – University College London Hospitals Foundation Trust	Associates to the contract: Tower Hamlets CCG Newham CCG
Delegated coordinating commissioner for London PCTs/CCGs – East London Foundation Trust	All London CCGs with delegated authority for acute commissioning (or their host PCTs) acting as coordinating commissioner/associates to the contract.
Associate commissioner – Barts Health	All London CCGs with delegated authority for acute commissioning (or their host PCTs) acting as coordinating commissioner/associates to the contract.
Associate commissioner – Newham University Hospital NHS Trust	All London CCGs with delegated authority for acute commissioning (or their host PCTs) acting as coordinating commissioner/associates to the contract.
Associate commissioner – Great Ormond Street Hospital NHS Trust	All London CCGs with delegated authority for acute commissioning (or their host PCTs) acting as coordinating commissioner/associates to the contract.
Associate commissioner – North West London Hospitals NHS Trust	All London CCGs with delegated authority for acute commissioning (or their host PCTs) acting as coordinating commissioner/associates to the contract.
Associate commissioner – Imperial College Healthcare NHS Trust	All London CCGs with delegated authority for acute commissioning (or their host PCTs) acting as coordinating commissioner/associates to the contract.
Associate commissioner – North Middlesex NHS Trust	All London CCGs with delegated authority for acute commissioning (or their host PCTs) acting as coordinating commissioner/associates to the contract.
Associate commissioner – Whittington NHS Trust	All London CCGs with delegated authority for acute commissioning (or their host PCTs) acting as coordinating commissioner/associates to the contract.
Associate commissioner – Royal Free	All London CCGs with delegated authority for acute commissioning (or their host PCTs) acting as coordinating commissioner/associates to the contract.

Associate commissioner – Royal National Orthopaedic Hospital NHS Trust	All London CCGs with delegated authority for acute commissioning (or their host PCTs) acting as coordinating commissioner/associates to the contract.
Associate commissioner – Whipps Cross University Hospital	All London CCGs with delegated authority for acute commissioning (or their host PCTs) acting as coordinating commissioner/associates to the contract.
Associate commissioner – Barking Havering and Redbridge University NHS Trust	All London CCGs with delegated authority for acute commissioning (or their host PCTs) acting as coordinating commissioner/associates to the contract.
Associate commissioner – St Georges Hospital NHS Trust	All London CCGs with delegated authority for acute commissioning (or their host PCTs) acting as coordinating commissioner/associates to the contract.
Associate commissioner – Royal Brompton and Harefield Foundation Trust	All London CCGs with delegated authority for acute commissioning (or their host PCTs) acting as coordinating commissioner/associates to the contract.
Associate commissioner – Royal Marsden Foundation Trust	All London CCGs with delegated authority for acute commissioning (or their host PCTs) acting as coordinating commissioner/associates to the contract.
Associate commissioner – Moorfields Foundation Trust	All London CCGs with delegated authority for acute commissioning (or their host PCTs) acting as coordinating commissioner/associates to the contract.
Associate commissioner – Guys and St Thomas' Foundation Trust	All London CCGs with delegated authority for acute commissioning (or their host PCTs) acting as coordinating commissioner/associates to the contract.
Associate commissioner – Chelsea & Westminster Foundation Trust	All London CCGs with delegated authority for acute commissioning (or their host PCTs) acting as coordinating commissioner/associates to the contract.
Associate commissioner – Kings College Foundation Trust	All London CCGs with delegated authority for acute commissioning (or their host PCTs) acting as coordinating commissioner/associates to the contract.
Associate commissioner – Barnet Enfield and Haringey Mental Health Trust	All London CCGs with delegated authority for acute commissioning (or their host PCTs) acting as coordinating commissioner/associates to the contract.
Associate commissioner – North East London Foundation Trust	All London CCGs with delegated authority for acute commissioning (or their host PCTs) acting as coordinating commissioner/associates to the contract.
Associate commissioner – Camden & Islington Foundation Trust	All London CCGs with delegated authority for acute commissioning (or their host PCTs) acting as coordinating commissioner/associates to the contract.

Associate commissioner – BMI Healthcare Limited	All London CCGs with delegated authority for acute commissioning (or their host PCTs) acting as coordinating commissioner/associates to the contract.
Associate commissioner – InHealth Limited	All London CCGs with delegated authority for acute commissioning (or their host PCTs) acting as coordinating commissioner/associates to the contract.
Associate commissioner – London Ambulance Service	All London CCGs with delegated authority for acute commissioning (or their host PCTs) acting as coordinating commissioner/associates to the contract.
Associate commissioner – St Georges NHS Trust Community Services (Community and Prosthetics) NB. Recent information from the DH suggests that Prosthetics will move to the NHSCB	Surrey, Berkshire (East and West), Hampshire, West Sussex and all London CCGs with delegated authority for commissioning (or their host PCTs) as coordinating commissioner/associates to the contract.

The group may establish joint committees with one or more local authorities as it considers may be appropriate including the following:

Name of joint arrangement	Name(s) of the local authority(ies) this joint committee with
Section 75 Executive Committee	London Borough of Hackney
Section 75 Executive Committee	London Borough of Hackney
Section 75 for Joint Care (Reablement)	London Borough of Hackney
Section 75 for LD	London Borough of Hackney
Section 256 for Carers	London Borough of Hackney
Section 256 for DOL	London Borough of Hackney
Section 256 for Dementia Services	London Borough of Hackney
Section 256 for DeafPlus	London Borough of Hackney
Section 256 for Dementia Community Memory Services	London Borough of Hackney
Section 256 – Physical Disabilities	London Borough of Hackney