South West Lincolnshire
Clinical Commissioning Group

NHS SOUTH WEST LINCOLNSHIRE
CLINICAL COMMISSIONING GROUP

CONSTITUTION

Version: 4.0

NHS Commissioning Board Effective Date: 1 April 2013
(revised Constitution approved March 2015)

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CONTENTS

1. INTRODUCTION AND COMMENCEMENT

1.1. Name

1.1.1. The name of this Clinical Commissioning Group is NHS South West Lincolnshire Clinical Commissioning Group.

1.2 Statutory Framework

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

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

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

1.3 Status of this Constitution

1.3.1 This constitution is made between the members of NHS South West Lincolnshire Clinical Commissioning Group and has effect from 1st day of April 2013, when the NHS England established the group. The constitution is published on the group's website at wwwsouthwestlincolnshireccg.nhs.uk

1.4 Amendment and Variation of this Constitution

This constitution can only be varied in two circumstances.

a) where the group applies to NHS England and that application is granted;
b) where in the circumstances set out in legislation the NHS England varies the group's constitution other than on application by the group.

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

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

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

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

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

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

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

1.5. Additional Documents

1.5.1. This Constitution should be considered in conjunction with other NHS South West Lincolnshire CCG policies such as Standing Orders, Prime Financial Policies and Scheme of Reservation and Delegation, which do not form a part of the Constitution but are complementary to it. The policies will be reviewed at least annually and may be amended on the recommendation of the Governing Body with the approval of the Member's Council.

2. Geographical area

2.1.1. The geographical area covered by NHS South West Lincolnshire Clinical Commissioning Group is principally within the Boundary of Lincolnshire County Council but includes commissioning of services for patients currently registered with NHS Lincolnshire GP practices which lie within the borders of Leicestershire County Council. The three practices located within Leicestershire, or with surgeries within Leicestershire, have long established relationships with Lincolnshire health authorities and share similar demographics and patient flows to other NHS South West Lincolnshire practices. A map showing the geographical area and location of the CCG practices is at Appendix C.

3. MEMBERSHIP

3.1. Membership of the Clinical Commissioning Group

3.1.1. The following practices comprise the members of NHS South West Lincolnshire Clinical Commissioning Group. The Member Practices of the CCG are those who have agreed to abide by the terms and conditions of this Constitution.

Practice Code	Practice Name	Practice address
C82076	The Welby Practice, Bottesford	The Woll Surgery, Walford Close, Bottesford, NG13 0AN
C82123	Belvoir Vale Surgery, Bottesford	17A Walford Close, Bottesford, NG13 0AN
C83008	Swingbridge Surgery, Grantham	Swingbridge Road, Grantham, NG31 7XT
C83011	Millview Medical Centre, Heckington	1 Sleaford Road, Heckington, NG34 9QP
C83013	Ruskington Medical Practice, Ruskington	Brookside Close, Ruskington, NG34 9GQ
C83020	Ancaster & Caythorpe Surgery, Ancaster	12 Ermine Street, Ancaster, NG32 3PP
C83023	Sleaford Medical Group, Sleaford	47 Boston Road, Sleaford, NG34 7HD
C83024	The Glenside Country Practice, Castle Bytham	12B High Street, Castle Bytham, Grantham, NG33 4RZ
C83030	Billinghay Medical Practice, Billinghay	39 High Street, Billinghay, LN4 4AU
C83040	St Peters Hill Surgery, Grantham	15 St Peters Hill, Grantham, NG31 6QA
C83048	St Johns Medical Centre, Grantham	62 London Road, Grantham, NG31 6HR
C83053	The Surgery, Colsterworth	Back Lane, Colsterworth, Grantham, NG33 5NJ
C83067	The Medical Centre, Long Bennington	Drings Field, 10 Valley Lane, Long Bennington, NG23 5FR
C83075	Vine House Surgery, Grantham	Vine Street, Grantham, NG31 6RQ
C83080	The Harrowby Lane Surgery, Grantham	Harrowby Lane, Grantham, NG31 9NS
C83628	The Surgery, Woolsthorpe	Main Street, Woolsthorpe By Grantham, NG32 1LX
C83649	The Market Cross Surgery, Corby Glen	Bourne Road, Corby Glen, NG33 4BB
C83653	The Stackyard Surgery, Croxton Kerrial	1 The Stackyard, Croxton Kerrial, Grantham, NG32 1QS
Y01652	The New Springwells Practice, Billingborough	The Surgery, Springwells, Billingborough, NG34 0QQ

3.2. Eligibility

3.2.1. Providers of primary medical services to a registered list of patients under a General Medical Services, Personal Medical Services or Alternative Provider Medical Services contract, will be eligible to apply for membership of this group. Membership will terminate immediately if the practice ceases to be an eligible provider of primary medical services.

3.3. Application for Membership

3.3.1. Applications for membership from other practices meeting the eligibility should be forwarded to the Chair of NHS South West Lincolnshire CCG in the first instance. It is recommended that the practice has already sought advice from the NHS England who will be the final arbiter of the membership of CCGs.

3.3.2. The Members' Council of the CCG will consider all applications for membership on an equal basis, taking into account the views of relevant local authorities, the practice's ability to demonstrate that they have previous experience of engagement with the principles of clinically led commissioning, and that they are willing to abide by the constitution and rules of the NHS South West to Lincolnshire CCG. Each application will be taken to the CCG Members' Council for consideration.

3.3.3. The Clinical Commissioning Group will then apply to the NHS England to request changing the membership and constitution of the CCG.

3.4. Voluntary Withdrawal from the Clinical Commissioning Group

3.4.1. Any Member Practice may voluntarily leave NHS South West Lincolnshire CCG by writing formally to the Chair of the CCG to announce their decision. The member practice will also be required to inform the NHS England or organisation that is carrying out its functions as it will need to be a member of a clinical commissioning group if it is to remain a provider of primary medical services.

3.4.2. This notification must be given prior to 31st January in any given financial year, but Member Practices will not be permitted to leave the Clinical Commissioning Group until the end of the financial year in which notice is given. This would be on the 31st March following the formal notification of leaving.

3.4.3. Member practices who notify that they wish to leave the Clinical Commissioning Group will be subject to all Clinical Commissioning Group arrangements including use of savings and shared risk until the end of the financial year following their notice to leave.

3.4.4. In the interim period between a practice's giving notice and the actual date of leaving the CCG, that practice will not be permitted to vote in any decision making processes related to the business of the CCG.

3.4.5. If a practice leaves SWL CCG and then wishes to rejoin, it will go through the application process set out above as if it were a practice that had no previous relationship with the CCG.

3.4.6. The Clinical Commissioning Group will then seek approval from the NHS England to change the membership and constitution of the CCG.

3.5. Dispute resolution

3.5.1. Disputes may arise when a practice does not support the aims of the CCG Members' Council or is felt to be undermining the work or ethos of the CCG. Similarly a practice may have a dispute if it feels that the CCG is dictating to it outside the CCG's statutory remit or is making unreasonable demands of the practice. A member practice may be in dispute with the CCG where it is deemed to be that the practice is not engaging with or committed to the Clinical Commissioning Group, or if it engages in practises that raise concerns over its continued membership of the group or that relate to patient safety. It is anticipated that the Local Medical Committee may have an advisory role in the event of any dispute between the CCG and practice(s).

3.5.2. In the first instance attempts at reconciliation will be made within the CCG, with the help of the Governing Body and/or Local Medical Committee. External assistance may be sought from other local CCGs or other local and national support networks. Assistance may also be sought from the NHS England. Where there are significant concerns over patient safety, the Accountable Officer and Chair will raise this with the NHSCB or CQC as appropriate.

3.5.3. The practice will be informed of any concerns as soon as sufficient data is available to the Accountable Officer and Chair to formulate this into a report and to highlight to the Members' Council. Where the issue relates to practice performance or patient safety, the Members' Council will be asked to consider referral of the case to the NHSCB or CQC as appropriate.

3.5.4. The practice will have a period of six months during which it must demonstrate engagement with addressing any issues.

3.5.5. If it is deemed by the Accountable Officer and Chair that despite all efforts by the CCG to engage the practice or work with the practice to improve on the above concerns is being unsuccessful, the practice will be informed that the Members' Council will be asked to consider application of sanctions against the practice. These may include not awarding all or part of any quality payment made to the CCG for distribution to member practices, referral to the NHSCB or CQC where there are concerns over the practice's contractual performance or patient safety, or to the NHSCB to consider other actions.

3.5.6. The practice will be asked to provide a written report in response to the Accountable Officer's report to be considered by the Members' Council and may have LMC representation at the meeting. A decision will be made on the basis of an 80% majority of all member practices present at the meeting. The practice under review may vote in this exercise.

3.5.7. In normal circumstances the matter could be considered at the next available routine meeting of the Member's Council. In exceptional circumstances the Accountable Officer and Chair may call an extraordinary meeting of the Members' Council with 14 days' notice.

3.5.8. Any decision of the Members' Forum will be communicated with the practice within 10 working days of the decision.

4. MISSION AND VALUES

4.1. Mission

4.1.1. The mission of NHS South West Lincolnshire Clinical Commissioning Group is to be a CCG for the whole community, striving for the continued improvement in health and wellbeing for all residents in our locality.

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

4.2. Values

4.2.1. In South West Lincolnshire CCG we believe that high quality services need to be accessible to the whole community. Our clinicians are well placed to lead the development of commissioning and quality improvement in the locality – but we can only do this by close working with councils, local people, allied health professionals and care providers to design the very best services. We intend to maximise input and engagement in improving the quality of local health services.

We believe that:

a) Patient safety is paramount;
b) We need to be realistic in our expectations and accept that our resources will never allow us to provide everything for everyone all of the time. We will be open and transparent about the difficult decisions we will have to make and always strive to do the most good for the benefit of our population;
c) Services should be local where viable and safe, centralised and accessible where necessary;
d) Patients should be at the heart of their health care;
e) We will work in an open, honest and transparent manner, always seeking a win:win situation;
f) Integration between primary, community and secondary care services and social care services is critical to the success of health provision;
g) Services start at home and our carers are an important part of this;

4.2.2. Good corporate governance arrangements are critical to achieving the group's objectives and financial sustainability.

5. FUNCTIONS AND GENERAL DUTIES

5.1. Functions

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

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

b) commissioning emergency care for anyone present in the group's area;

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

d) determining the remuneration and travelling or other allowances of members of its governing body.

5.1.2. In discharging its functions the group will:

a) act[8], when exercising its 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***[9] *and* with the objectives and requirements placed on the NHS England through *the mandate*[10] published by the Secretary of State before the start of each financial year by:

   i) Delegating the activities needed for promotion of a comprehensive health service including commissioning to the Members' Council who will work with the Executive, Quality and Patient Experience and Audit Committees to ensure provision of high quality care and health promotion and protection in accordance with the needs of the population, and the resources available

   ii) Delegating to the Members' Council, Executive Committee and other standing Committees the authority to make appropriate arrangements to ensure efficient and effective provision of health care. These will include seeking advice from Public Health and consulting with the Health and Well Being Board and other groups representing the interests of patients and the population; working in collaboration with other CCGs to share the work involved in commissioning and negotiating with current and potential providers; and the policy and procedural framework that will support such arrangements

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8 See section 3(1F) of the 2006 Act, inserted by section 13 of the 2012 Act

9 See section 1 of the 2006 Act, as amended by section 1 of the 2012 Act

10 See section 13A of the 2006 Act, inserted by section 23 of the 2012 Act

iii) Ensuring that information on the process of providing comprehensive healthcare is given on a regular basis to the Member Practices who are in turn are expected to contribute to the process

iv) Delegating to the Executive Committee and Governing Body the authority to prepare the annual operating budgets and commissioning plan for formal sign off by the Member's council.

v) Considering what arrangements may be needed for meeting the various duties imposed on authorised CCGs as described in the Health and Social Care Act 2012, such as the duties to promote patient involvement and choice, to obtain appropriate advice, to promote the NHS Constitution etc.

vi) Planning which powers as described in the Health and Social Care Act 2012 should be exercised by the group once it is established, for instance in relation to joint arrangements with other CCGs, or the joint exercise of functions with local Health and Wellbeing Boards.

b) ***meet the public sector equality duty***[11] by:

i) Delegating the activities needed to meet the requirements of the Public Sector Equality Duty to the Governing Body who will work with the Standing Committees and any other sub-committees that may be found to be necessary: subject to annual review by the members council.

ii) Ensuring that progress on delivery of these duties will be published at least annually in the Annual Report and at other times as may be necessary and expedient.

iii) Ensuring that all the policies and practices carried out in NHS South West Lincolnshire CCG or on behalf of the CCG have made informed decisions based on equality analysis and assessment of impact that has identified if there are any effects on people, specifically those with protected characteristics within our community who may use our services or on the people we employ in line with the Equality Act 2010.

iv) Ensuring its plans demonstrate its aims of:

- Eliminating unlawful discrimination, harassment and victimisation and any other conduct prohibited by the Act;
- Advancing equality of opportunity between people who share a protected characteristic and people who do not share it;
- Fostering good relations between people who share a protected characteristic and people who do not share it;
- Ensuring that all the requirements of the Equality Act to set "specific, measurable equality objectives" including preparing and publishing specific and measureable equality objectives, revising these at least every four years; and,
- Publishing "relevant and proportionate" information on an annual basis, to present to the Members 'Council, and Governing Body and to demonstrate the steps being taken to comply with these requirements.

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

The nine protected characteristics covered by the Equality Duty are:

Age
Pregnancy and maternity
Disability
Sex (gender)
Gender reassignment
Sexual orientation
Marriage and civil partnership (but only in respect of eliminating unlawful discrimination)
Race – this includes ethnic or national origins, colour or nationality
Religion or belief - this includes lack of belief

c) work in partnership with its local authorities (Lincolnshire County Council, North and South Kesteven District Councils) to develop *joint strategic needs assessments*[12] and *joint health and wellbeing strategies*[13] by:

i) Participating in and contributing to the work of the Health and Well Being Boards of Lincolnshire County Council, North and South Kesteven District Councils by attendance at meetings, and the receiving and production of reports;

ii) Considering the recommendations of the Health and Well Being Boards when drawing up its Annual Commissioning Plan;

iii) Consulting with the Health and Well Being Boards when drawing up the Annual Commissioning Plan;

iv) Considering in conjunction with local authorities any opportunities to develop Section 75 agreements where such agreements show potential to improve delivery of healthcare; and,

v) Being prepared to give information and answer questions from the Health and Well Being Board and Health Scrutiny Committee on matters relating to the group's vision, mission and goals and its performance in relation to achieving those goals.

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

5.2.1. Make arrangements to secure public involvement in the planning, development and consideration of proposals for changes and decisions affecting the operation of commissioning arrangements[14] by:

a) Ensuring effective involvement of key partners in the development of strategy relating to the wider health economy and the clinical networks across the region.

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

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

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

b) Having regard to the need to reduce inequalities in access to healthcare and outcomes, promote patient and carer involvement in decisions about them and enable patients to make choices with respect to aspects of their healthcare.

c) The CCG will follow a Statement of Principles in implementing these arrangements. These principles include:-

i) Working in partnership with patients and the local community to secure the best care for the population.

ii) Listening to our patients and communities to ensure that they are involved informed and empowered.

iii) Adapting engagement activities to meet the specific needs of the different patients groups and communities.

iv) Publishing information about health services on the website and by making the information available in other formats.

v) Encouraging and acting on feedback and handling complaints in accordance with the CCG's complaint handling policy.

vi) Engaging with the Lincolnshire Health Overview and Scrutiny Committees and where necessary formally consulting with stakeholders and the public on proposals when there is need to change services.

vii) Identifying how the group will monitor and report its compliance against the Statement of Principles.

5.2.2. ***Promote awareness of, and act with a view to securing that health services are provided in a way that promotes awareness of, and have regard to the NHS Constitution***[15] by:

a) Delegating responsibility to the Governing Body to consider what arrangements will be needed to discharge this duty and monitor compliance with the NHS Constitution.

b) Acting with a view to promoting the NHS Constitution in the exercise of its functions.

5.2.3. Act ***effectively, efficiently and economically***[16] by:

a) Delegating oversight of this function to the Audit Committee of the Governing Body.

b) Ensuring the delivery of QIPP initiatives

c) Ensuring that expenditure and use of resources do not exceed the limits set.

d) Supporting the achievement of national and local targets.

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15 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)

16 See section 14Q of the 2006 Act, inserted by section 26 of the 2012 Act

e) Taking into regard the need to reduce inequalities in access to healthcare and outcomes, promote patient and carer involvement in decisions about them and the need to enable patients to make informed choices with respect to aspects of their healthcare.

f) Ensuring appropriate plans are in place to deal with relevant unexpected events that might affect the delegated responsibilities of the group.

g) Promoting innovation and having regard to the need to promote research in the exercise of functions.

h) Reviewing the performance monitoring framework for care commissioned by the group on a regular basis and responding to recommendations made by the Audit Committee.

i) Receiving regular performance reports from the Chief Finance Officer.

5.2.4. Act with a view to ***securing continuous improvement to the quality of services***[17] by:

a) Identifying, determining and monitoring through the Quality and Patient Experience Committee of the Governing Body, appropriate quality performance indicators for care commissioned by SWLCCG. This Committee will make regular reports and recommendations to the Governing Body and will assess and monitor the clinical effectiveness and quality standards achieved by providers from whom NHS South West Lincolnshire CCG commissions services as well as seeking patients', carers' and the public's views within the area served by the group;

b) Appointing a Clinical Governance Lead who will hold lead responsibility within the group for working with its commissioned providers to ensure that commissioned services are planned and monitored to deliver continuous improvement in the quality of services;

c) Exercising its functions with a view to securing continuous improvements in the quality of services and in outcomes for patients, with particular regard to clinical effectiveness, safety and patient experience; and,

d) Ensuring that South West Lincolnshire CCG as a team and as individuals has the right mind-set to drive the changes that will deliver the highest quality and greatest productivity.

5.2.5. Assist and support the NHS England in relation to the Board's duty to ***improve the quality of primary medical services***[18] by:

a) Giving responsibility to the Clinical Governance Lead and Quality and Patient Experience Committee to support the improvement in the quality of primary medical services

17 See section 14R of the 2006 Act, inserted by section 26 of the 2012 Act

18 See section 14S of the 2006 Act, inserted by section 26 of the 2012 Act

b) Producing evidence of benchmarking on primary medical care outcome indicators across member practices when this is required.

c) Being committed to openness and the sharing of data/information

d) Communicating effectively to all Member Practices on matters relating to quality improvements

e) Working with other agencies in developing its plans (including the Health & Wellbeing Strategy" and the Communication and Engagement and Information Strategies)

f) Working collaboratively with other agencies when appropriate to address variation, make service improvements, and develop shared models of commissioning support.

5.2.6. Have regard to the need to ***reduce inequalities***[19] by:

a) Working in conjunction with upper tier and lower tier local authorities and, specifically the Lincolnshire Joint health and Wellbeing Board and the Lincolnshire County Council Public Health Directorate to understand the population profile and identify population health needs including health inequalities;

b) Developing commissioning plans to reduce health inequalities based on the health needs of the population;

c) Implementing Annual Plans based on the CCG Equality and Diversity Strategy incorporating Equality Delivery System 2012-2014

The Quality and Patient Experience Committee will hold delegated responsibility for overseeing the implementation of the Equality and Diversity Strategy, incorporating the Equality Delivery System reporting on progress to the Governing Body and reporting formally annually to the Members Council

5.2.7. ***Promote the involvement of patients, their carers and representatives in decisions about their healthcare***[20] by:

a) Delegating to the Quality and Patient Experience Committee the responsibility of leading the development, overseeing the implementation and ensuring the monitoring of the group's Communication and Engagement Strategy

b) Engaging appropriately with patients and the public in developing, considering and making decisions on any proposals that would have a significant impact on service delivery or the range of health services available including undertaking formal public consultations in line with statute and the Communications and Engagement Strategy

c) Acting with a view to promoting the NHS Constitution in the exercise of its functions.

19 See section 14T of the 2006 Act, inserted by section 26 of the 2012 Act

20 See section 14U of the 2006 Act, inserted by section 26 of the 2012 Act

d) Contributing to the Joint Strategic Needs Assessment (JSNA) and the Joint Health and Wellbeing Strategy led by the Health and Wellbeing Board and having regard to the JSNA and Joint Strategy in exercising any relevant functions.

e) Always taking into account the need to reduce inequalities in access to healthcare and outcomes, to promote patient and carer involvement in decisions about them and to enable patients to make choices with respect to aspects of their healthcare

5.2.8. Act with a view to ***enabling patients to make choices***[21] by:

a) Considering what arrangements may be needed for meeting the various duties imposed on authorised CCGs, such as the duties to promote patient involvement and choice, to obtain appropriate advice and to promote the NHS Constitution etc.;

b) Taking regard of the need to reduce inequalities in access to healthcare and outcomes, promote patient and carer involvement in decisions about them and enable patients to make choices with respect to aspects of their healthcare.

5.2.9. ***Obtain appropriate advice***[22] from persons who, taken together, have a broad range of professional expertise in healthcare and public health by:

a) Considering what arrangements may be needed for meeting the various duties imposed on authorised CCGs, such as the duties to promote patient involvement and choice, to obtain appropriate advice, to promote the NHS Constitution etc.

b) Ensuring that the group obtains appropriate advice from a wide range of health professionals as laid down in its Communication and Engagement Strategy

c) Taking appropriate steps to follow best practice and learn from other CCGs and organisations involved in commissioning

5.2.10. ***Promote innovation***[23] by:

a) Having plans in place or under development to –

i) Specify local priority areas in line with the current NHS Operating Framework for the NHS in England;

ii) Consider how local flexibilities in the use of tariff might be used to incentivise innovation;

iii) Take steps to ensure strong leadership and accountability for innovation within the CCG;

iv) Facilitate partnerships with public and private sector organisations and patient networks and organisations to enable local innovation and its diffusion;

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21 See section 14V of the 2006 Act, inserted by section 26 of the 2012 Act

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

23 See section 14X of the 2006 Act, inserted by section 26 of the 2012 Act

v) Be an active partner in the local Academic Health Science Network once established

5.2.11. ***Promote research and the use of research***[24] by:

a) Delivering the statutory duties with respect to research, as an individual organisation or as part of a collaborative with neighbouring CCG's.

b) Ensuring that when appropriate, providers have processes in place to facilitate recruitment of patients into research studies.

c) Considering the need for commissioners to have in place a process to meet the treatment costs of research for patients who are taking part in research funded by Government and research charity partner organisations.

d) Ensuring the best available research evidence is used when commissioning services.

e) Ensuring that the responsibility for research and the use of research evidence is clear at a level equivalent to Governing Body level with operational responsibility delegated as appropriate.

f) Proactively engaging with local partners who promote and support research, including the local NIHR Clinical Research Networks and the emerging Academic Health Science Networks.

5.2.12. Have regard to the need to ***promote education and training***[25] for persons who are employed, or who are considering becoming employed, in an activity which involves or is connected with the provision of services as part of the health service in England so as to assist the Secretary of State for Health in the discharge of his related duty[26] by:

a) Consulting with the governing bodies of Local Education & Training Boards (LETBs) in the group's area as commissioning plans are developed, to ensure workforce development can rapidly respond to innovation and changes in the way services are delivered.

b) Working in partnership with the governing bodies of LETBs in the group's area to ensure that plans for the commissioning and quality assurance of education and training are responsive to service commissioning priorities.

c) Promoting compliance with the terms of the NHS standard contract to ensure that all providers of NHS services from whom the CCG commissions services are members of a LETB and therefore represented on the governing body of a LETB, and support the governing bodies of LETBs in the CCG in carrying out its education and training functions.

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24 See section 14Y of the 2006 Act, inserted by section 26 of the 2012 Act

25 See section 14Z of the 2006 Act, inserted by section 26 of the 2012 Act

26 See section 1F(1) of the 2006 Act, inserted by section 7 of the 2012 Act

5.2.13. Act with a view to ***promoting integration*** of *both* health services with other health services *and* health services with health-related and social care services where the group considers that this would improve the quality of services or reduce inequalities[27] by:

a) Working with the Health and Well Being Boards of relevant Local Authorities to develop the Joint Strategic Needs Assessment and Joint Strategic Plan.

b) Encouraging co-operation and integration at all levels in the local health economy and building relationships with other commissioners, keeping patient and public views and interest foremost.

c) Discussing and determining decisions around lead commissioning arrangements and federation arrangements with the Lincolnshire CCG Leaders Council (or equivalent body) and reporting these decisions to Practice Members as part of the Annual Report

d) Developing strong arrangements for joint commissioning with local authorities to commission services where integration of health and social care is in the best interests of the patient and the public: including Upper Tier authority membership of the Governing Body and Executive Committees.

e) Devoting resources to promoting integration.

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

5.3.1. ***Ensure its expenditure does not exceed the aggregate of its allotments for the financial year***[28] by

a) Formulating the financial strategy.

b) Delegating responsibility to the Chief Finance Officer (CFO) to prepare an annual financial plan for consideration and approval by the Members' Council. This to be scrutinised by the Governing Body who will be required to recommend the final version to the Members' Council.

c) Requiring the submission and approval of budgets within approved allocations/available resources.

d) Defining specific responsibilities placed on Officers and employees as specified in the Scheme of Delegation.

e) Retaining certain powers and decision making authority to be exercised by the Members' Council, Governing Body and Executive Committee. Further powers have been delegated to the Committees described in this document. All other powers shall be exercised by the Member Practices collectively.

f) Setting out a formal financial regime and governance framework in the form of Prime Financial Policies.

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27 See section 14Z1 of the 2006 Act, inserted by section 26 of the 2012 Act

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

g) Delegating responsibility to the CFO for documenting and implementing appropriate financial procedures to be followed by all CCG Officers and staff.

h) Reporting financial performance and forecast outturn projections on a monthly basis to the Governing Body who shall receive and consider the content of such reports and any remedial action required.

i) Providing, so far as practically possible, a contingency reserve in each financial year to facilitate the mitigation of financial risks that present in-year.

5.3.2. ***Ensure its use of resources*** *(both its capital resource use and revenue resource use)* ***does not exceed the amount specified by the NHS England for the financial year***[29] by

a) Delegating authority to the Accountable Officer and Chief Financial Officer to agree a specific annual 'control total' with the NHS England, in the context of known risks in each financial year.

b) Complying with the provisions of 5.3.1 above.

5.3.3. ***Take account of any directions issued by the NHS England, in respect of specified types of resource use in a financial year, to ensure the group does not exceed an amount specified by the NHS England*** [30] by

a) Establishing discrete budgets in accordance with directions issued by the NHS England, in respect of specified types of resource use in a financial year.

b) Complying with the provisions of 5.3.1 above.

5.3.4. ***Publish an explanation of how the group spent any payment in respect of quality*** made to it by the NHS England[31] by

a) publishing an annual report detailing financial allocations, budgets and spending including how the group has spent any payments in respect of quality received form the NHS England.

5.4. Other Relevant Regulations, Directions and Documents

5.4.1. The group will

a) comply with all relevant regulations;

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

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

29 See sections 223I(2) and 223I(3) of the 2006 Act, inserted by section 27 of the 2012 Act

30 See section 223J of the 2006 Act, inserted by section 27 of the 2012 Act

31 See section 223K(7) of the 2006 Act, inserted by section 27 of the 2012 Act

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

6. DECISION MAKING: THE GOVERNING STRUCTURE

6.1. Authority to act

6.1.1. The Members' Council of the clinical commissioning group is the representative body of the CCG member practices and is accountable to the CCG for delivering the statutory functions of the group. It may grant authority to act on its behalf to:

a) any of its members;
b) its governing body;
c) employees; or
d) a committee or sub-committee of the group.

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

a) the group's scheme of reservation and delegation; and
b) for committees, their terms of reference.

6.2. Scheme of Reservation and Delegation

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

a) those decisions that are reserved for the membership as a whole;
b) those decisions that are delegated to the Members' Council;
c) those decisions that are the responsibilities of its governing body (and its committees), the group's committees and sub-committees, individual members and employees.

6.2.2. The Members' Council of the clinical commissioning group remains accountable to the CCG membership for all of its functions, including those that it has delegated.

6.3. Committees of the group

6.3.1. The following committees have been established by the group:

a) Members' Council;
b) Executive Committee (accountable to the Member's Council);
c) Quality and Patient Experience Committee (accountable to the Governing Body);
d) Remuneration committee (accountable to the Governing Body);
e) Audit Committee (accountable to the Governing Body).

6.3.2. Committees will only be able to establish their own sub-committees, to assist them in discharging their respective responsibilities, if this responsibility has been delegated to them by the group or the committee to which they are accountable.

6.4. Joint Arrangements

6.4.1. The group has entered into joint arrangements with the following clinical commissioning groups:

a) NHS East Lincolnshire CCG
b) NHS Lincolnshire West CCG
c) NHS South Lincolnshire CCG

6.4.2. The scope and terms of these joint arrangements are set out annually in a federation agreement. These joint arrangements are overseen collaboratively by the Lincolnshire CCG Council.

6.4.3. The group has joint committees with Lincolnshire County Council.

a) Joint Commissioning Board for Learning Disabilities (on behalf of the Lincolnshire CCGs and represented by the Accountable Officer);
b) CAMHS Partnership Board (on behalf of the Lincolnshire CCGs and represented by the Accountable Officer);

6.5 Joint commissioning arrangements with other CCGs

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

6.5.2 The CCG may make arrangements with one or more CCG in respect of:
6.5.2.1 Delegating any of the CCG's commissioning functions to another CCG;
6.5.2.2 Exercising any of the commissioning functions of another CCG; or
6.5.2.3 Exercising jointly the commissioning functions of the CCG and another CCG

6.5.3 For the purposes of the arrangements described at paragraph [6.5.2], the CCG may:
6.5.3.1 Make payments to another CCG;
6.5.3.2 Receive payments from another CCG;
6.5.3.3 Make the services of its employees or any other resources available to another CCG; or
6.5.3.4 Receive the services of the employees or the resources available to another CCG.

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

6.5.5 For the purposes of the arrangements described at paragraph [6.5.2] above, the CCG may establish and maintain a pooled fund made up of contributions by any of the CCGs working together pursuant to paragraph 6.5.2.3 above. Any such pooled fund may be used to make payments towards expenditure incurred in the discharge of any of the commissioning functions in respect of which the arrangements are made.

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

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

6.5.7 The liability of the CCG to carry out its functions will not be affected where the CCG enters into arrangements pursuant to paragraph [6.5.1] above.

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

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

6.5.10 The Governing Body of the 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.

6.5.11 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.

6.6 Joint commissioning arrangements with NHS England for CCG functions

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

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

6.6.3 The arrangements referred to in paragraph [6.6.2] above may include other CCGs.

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

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

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

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

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

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

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

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

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

6.7 Joint commissioning arrangements with NHS England for NHS England functions

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

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

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

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

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

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

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

- How the parties will work together to carry out their commissioning functions;
- The duties and responsibilities of the parties;

- How risk will be managed and apportioned between the parties;
- Financial arrangements, including payments towards a pooled fund and management of that fund;
- Contributions from the parties, including details around assets, employees and equipment to be used under the joint working arrangements.

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

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

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

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

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

6.8 The Members' Council of the Clinical Commissioning Group

6.8.1 The Members' Council which is accountable to the CCG membership for the performance of the CCG, is responsible for the following functions:

a) Key roles
   i) Setting strategic priorities and direction taking into account a range of issues such as national and local priorities, the commissioning outcomes framework, the Joint Strategic Needs Assessment, Health and Wellbeing Board Strategy, financial and quality issues;
   ii) Production of Local Operating Plan;
   iii) Production and maintenance of the CCG constitution;
   iv) Oversight and monitoring of clinical quality in all providers to ensure continued improvement of quality, safety and effectiveness;
   v) Providing assistance and support to the NHS England in ensuring the quality of primary care services.

b) Other functions
   i) Ensuring clinical engagement and drive at the centre of all CCG activity;
   ii) Supporting and encouraging individual clinicians and practices in participating in clinical commissioning at a variety of levels;
   iii) Overseeing CCG clinical governance;
   iv) Supporting external relationships, particularly with NHSCB and local stakeholders;

6.8.2 Membership

a) Members

i) GP Chair (who will be directly elected by the membership);

ii) A Practice Representative from each member practice who will be a clinician nominated by the practice (the vice-chair of the Members' Council will be elected from amongst this group by the committee. This role is separate to the Vice Chair of the CCG Governing Body);

b) Other invitees without voting rights

i) Any primary health care providers who are not major contract holders with the CCG who may be approved by the voting members. These will be individuals or organisations who have responsibility for the provision of health care to individuals in the CCG area who are not registered with a member practice, but who are not in themselves eligible to be full members of the CCG by nature of their contractual arrangements for health provision. This may include local military care providers*.

ii) CCG Accountable Officer*;

iii) CCG Chief Finance Officer*;

iv) CCG Public Health Consultant*; and

v) CCG Corporate secretary*.

*In attendance

6.8.3 ***Operation*** - The Members' Council will meet four times a year in private and will act in accordance with its Terms of Reference approved by the CCG member practices. The terms of reference will also define the voting mechanism to be used by the members' Council in reaching its decisions.

a) The Members' Council will be quorate when there are at least 12 practice representatives present, including the Chair or Vice Chair. Practice representatives will usually be GPs, however, in exceptional circumstances, an alternative representative may attend the meeting. The representatives will have the ability to vote on behalf of the practice, and will count towards the quorum of the meeting.

b) Its agenda and minutes will be noted by the Governing Body;

c) The Members' Council will organise an Annual General Meeting which shall be open to all members of the Clinical Commissioning Group and other General Practitioners on the local performers' list. At this meeting the CCG Annual Report and Accounts will be presented.

6.9 The Governing Body

6.9.1 ***Functions*** **- The governing body has responsibility for:**

a) ensuring that the group has appropriate arrangements in place to exercise its functions effectively, efficiently and economically and in accordance with the groups principles of good governance;

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

c) Approving CCG strategic and annual operating plans;

d) Monitoring quality, safety, and progress against CCG plans and priorities;

e) Monitoring CCG risk and compliance with national and local safeguarding policies;

f) Assessing any commissioning plans or proposals that may involve a conflict of interest for CCG members;

g) Ensuring that national and local commissioning priorities are considered in any decisions made by any of the CCG committees or sub-committees;

h) Approving any functions of the group that are specified in regulations; and

i) Any other functions included in the CCG scheme of delegation.

j) Production of the CCG Annual Report and Accounts for submission to NHS England.

6.9.2 **Composition of the Governing Body** - the Governing Body comprises of:

a) **Voting Members**

- CCG GP Chair
- Executive Committee GP Chair
- Lay member, Governance (also Chair of the Audit Committee and Vice Chair of the Governing Body)
- Lay member, Patient and Public Involvement)
- Lay member nominee from local HealthWatch
- Registered nurse (CCG Executive lead for Quality and Patient Experience)
- Secondary Care specialist (CCG lead for research, education and training)
- Chief Officer
- Chief Finance Officer
- Senior commissioning representative from local Authority

b) **Attendees by invitation (non voting)**

- Representative from North Kesteven District Council (to be an employee not a member of the council)
- Representative from South Kesteven District Council (to be an employee not a member of the council)
- CCG Public Health consultant
- Other attendees may be invited on a regular basis or as required for specific purposes

6.9.3 ***Operation*** - The governing body will usually meet monthly in public. It may meet in private where necessary and where it is in the public interest to do so, in accordance with the Standing Orders of the CCG.

6.9.4 The Governing Body will be quorate when at least 6 members are present, including at least 2 GP members, 2 lay members and either the Accountable Officer or the Chief Finance Officer. Its agenda and minutes will be available on the CCG website.

If required to vote, the Governing Body will adopt a “one member, one vote” system, with the GP Chair of the Governing Body holding the casting vote. The GP Chair will have the authority to ask any member to leave where they consider there to be a material conflict of interest.

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

a) **Audit Committee** – the audit committee, which is accountable to the group's governing body, provides the governing body with an independent and objective view of the group's financial systems, financial information and compliance with laws, regulations and directions governing the group in so far as they relate to finance. The audit committee may include members who are not members of the governing body. The governing body has approved and keeps under review the terms of reference for the audit committee, which includes information on the membership of the audit committee.

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

c) **CCG Quality and Patient Experience Committee** – The *'Quality and Patient Experience Committee'* will report to the Governing Body, which will approve its terms of reference, and its minutes will be considered by the Executive Committee. Its role is to enable delivery and performance management of providers in relation to all aspects of quality and safeguarding including:

- The monitoring and assurance of quality in all commissioned services;
- The monitoring and assurance of quality in primary care services;
- The monitoring and assurance of quality in NHS commissioned care homes;
- Monitoring provider workforces to ensure safe delivery of commissioned care;
- Improving patient experience across all commissioned services;
- Ensuring that all commissioning decisions are Quality Impact Assessed and risks are identified and managed;
- The management of all reported Serious Incidents in line with approved SI policy;
- Assurance that providers effectively discharge safeguarding duties;
- Statutory responsibilities for safeguarding and public protection boards namely Local Safeguarding Children Board; Local Safeguarding Adults Board; Multi Agency Public Protection Arrangements;
- The management of safeguarding related assessments and investigations including serious case reviews; child death review; serious incident/safeguarding investigations into service failures; domestic homicide review – health reports etc;
- Monitoring of adherence to Mental Capacity Act statutory requirements to include oversight of Deprivation of Liberty Safeguards
- Providing patient safety reports to the Governing Body and Executive Committee and to external local and national reporting systems

6.10 The Executive Committee

6.10.1 The Executive Committee is accountable to the Member's Council for the following functions:

a) Key roles
   i) To oversee the day to day operational business of the CCG;
   ii) To review and prioritise all business cases and project initiatives utilising the CCG Project Framework;
   iii) To oversee and monitor delivery against CCG priorities and operating plan;
   iv) To oversee the development and implementation of appropriate frameworks which ensure the CCG achieves continuous quality improvement;
   v) To oversee the advancement of joint commissioning towards an increased integration with social care commissioning;
   vi) To review and discuss the implications and implementation of key policy documentation issued by the NHS England, the Department of Health and other statutory authorities for recommendation to the Member's Council regarding the potential impact on plans and services commissioned by the CCG;
   vii) To develop and promote an organisation wide culture which enables clinicians, managers and staff from all backgrounds to work both in partnership and individually to effectively deliver safe and sound services;
   viii) Exercising any other delegated functions on behalf of the Members' Council;

b) Other functions
   i) Direct resources and responsibility on a day to day basis to deal with operational issues, implement objectives and operating plan, and achieve local and national targets;
   ii) To monitor contracts and oversee QIPP negotiations on a day to day basis in partnership with the Commissioning Support Unit (CSU).

6.10.2 Members
   i) CCG Chair
   ii) 6 GPs elected by the CCG membership (one will be elected as the Executive Committee chair/CCG Vice Chair)
   iii) 2 non GP practice representatives
   iv) CCG Accountable Officer
   v) CCG Chief Finance Officer
   vi) CCG Public Health Consultant
   vii) CCG Head of Business Delivery
   viii) CCG Senior Nurse
   ix) Other officers or members in attendance as required

6.10.3 ***Operation*** - The Executive Committee will meet monthly in private.

a) The Executive Committee will be quorate when at least 50 % of its membership is present, to include at least 4 elected CCG members.
b) Its agenda and minutes will be considered by the Governing Body.

7. KEY ROLES AND RESPONSIBILITIES

7.1. The Chair of the Governing Body

7.1.1. The Chair of the Governing Body must be a General Practitioner (Partner or Salaried) whose practice is a member of the CCG.

7.1.2. The Chair of the Governing Body will be elected by the Members' Council for a term of three years. All candidates will be subject to a formal interview process by the Executive Committee prior to going forward for election. Only candidates approved as meeting the key competencies of the role will be approved by the Executive Committee to stand for election. The process will be carried out in accordance with the CCG Human Resources Policy.

7.1.3. The Chair of the Governing Body will be subject to approval and ratification by NHS England and all appointments remain subject to approval by the NHS England Area Team Director in line with the guidance current at the time of the appointment.

7.1.4. The Chair of the Governing Body will be the formal clinical leader of the CCG in line with NHS England guidance.

7.1.5. The position of the CCG Chair is a senior clinical management position.

7.1.6. Where there is a need for a deputy for the Chair of the Governing Body on clinical matters, ie a role as deputy clinical leader, this will role will be fulfilled by the Chair of the Executive Committee.

7.1.7. Where there is an unexpected or planned absence of the Chair of the Governing Body, the Chair of the Executive Committee will become the Acting Chair for a period not to exceed six months.

7.1.8. The Chair of the Governing Body is responsible for:

a) leading the Governing Body, ensuring it remains continuously able to discharge its duties and responsibilities as set out in this constitution;
b) building and developing the group's governing body and its individual members;
c) ensuring that the Clinical Commissioning Group has proper constitutional and governance arrangements in place;
d) ensuring that the Chair and Accountable Officer perform their statutory duties in accordance with this Constitution
e) ensuring that, through the appropriate support, information and evidence, the governing body is able to discharge its duties;
f) supporting the accountable officer in discharging the responsibilities of the organisation;
g) contributing to building a shared vision of the aims, values and culture of the organisation;
h) overseeing governance and particularly ensuring that the governing body and the wider group behaves with the utmost transparency and responsiveness at all times;
i) ensuring that public and patients' views are heard and their expectations understood and, where appropriate as far as possible, met;
j) ensuring that the organisation is able to account to its local patients, stakeholders and NHS England;

k) ensuring that the group builds and maintains effective relationships, particularly with the individuals involved in overview and scrutiny from the relevant local authorities.

7.2. The Vice Chair of the Governing Body

7.2.1. The Lay Member for Governance and Chair of the Audit Committee will be the Vice Chair of the Governing Body, Chairing any meeting where there is identified to be a conflict of interest, the CCG Chair is otherwise unable to act or not present at the meeting.

7.3. The Accountable Officer

7.3.1. The Accountable Officer of the group is responsible for ensuring that the clinical commissioning group fulfils its duties to exercise its functions effectively, efficiently and economically thus ensuring improvement in the quality of services and the health of the local population whilst maintaining value for money. The accountable officer will be a member of the Members' Council and the Governing Body.

7.3.2. The roles of accountable officer are:

a) To ensure that the CCG complies with its
   i) duty to exercise its functions effectively, efficiently and economically;
   ii) duty to exercise its functions with a view to securing continuous improvement in the quality of services provided to individuals for, or in connection with, the prevention, diagnosis or treatment of illness;
   iii) financial obligations, including information requests;
   iv) obligations relating to accounting and auditing; and
   v) duty to provide information to the NHS England, following requests from Secretary of State.
b) To ensure that the CCG performs its functions in a way which provides good value for money at all times ensuring that the regularity and propriety of expenditure is discharged, and that arrangements are put in place to ensure that good practice is embodied and that safeguarding of funds is ensured through effective financial and management systems.
c) To work closely with the chair of the CCG to develop and deliver the CCGs strategic and operational aims.
d) To work closely with the chair of the governing body to ensure that proper constitutional, governance and development arrangements are put in place to assure the members (through the governing body) of the organisation's ongoing capability and capacity to meet its duties and responsibilities. This will include arrangements for the ongoing developments of its members and staff.
e) To work with and represent the clinical commissioning group in dealings with other clinical commissioning groups and local authorities to secure continual improvement in joint working and integrated commissioning.
f) To be the senior administrative office responsible for the general running of the clinical commissioning group.

7.4. Chief Finance Officer

7.4.1. The Chie Finance Officer is a member of the Governing Body and is responsible for providing financial advice to the Clinical Commissioning Group and for supervising financial control and accounting systems

7.4.2. The roles of Chief Finance Officer are:

a) being the Governing Body's professional expert on finance and ensuring, through robust systems and processes, the regularity and propriety of expenditure is fully discharged;
b) making appropriate arrangements to support, monitor on the group's finances;
c) overseeing robust audit and governance arrangements leading to propriety in the use of the group's resources;
d) being able to advise the Governing Body on the effective, efficient and economic use of the group's allocation to remain within that allocation and deliver required financial targets and duties; and
e) producing the financial statements for audit and publication in accordance with the statutory requirements to demonstrate effective stewardship of public money and accountability to NHS England;

7.5. The CCG Senior Nurse

7.5.1. The CCG Senior Nurse is a member of the CCG Governing Body. The roles of the Senior Nurse are to:

a) Be responsible for monitoring quality of primary care and all contracts held by the CCG, ensuring compliance and continual improvement;
b) To chair the CCG Quality and Performance Committee;
c) Provide a nursing perspective to decisions made by the CCG and to advice the Members' Council, Executive Committee and Governing Body on nursing matters;

7.6. Practice Representatives

7.6.1. Practice representatives are clinicians nominated represent their practice's views and act on behalf of the practice in matters relating to the group. Each practice representative will be a member of the Members' Council.

7.7. Joint Appointments with other Organisations

7.7.1. The group has the following joint appointment with other organisations:

a) CCG Corporate Secretary appointed jointly with NHS South Lincolnshire CCG.

7.7.2. All these joint appointments are supported by a memorandum of understanding between the organisations who are party to these joint appointments.

8. ELECTIONS AND APPOINTMENT PROCESSES

8.1. Elected members and officers of the CCG

8.1.1. The following positions will be directly elected by the CCG membership:
a) CCG Chair
b) GP members of Executive Committee (6 – to be two from each of the Grantham town practices, Grantham rural practices and Sleaford area practices)
c) Non GP practice members of Executive Committee (2)

8.1.2. Elected members will be held to account by the membership of the CCG through the Members' Council.

8.1.3. Where positions are subject to election by member practices, the following principles will apply:
a) Each practice will be entitled to a number of points proportional to its practice list size at the previous 31 March and should use these to ensure effective participation of all GPs within the practice. It may decide to include other doctors such as those who regularly work as locum GPs or are GP registrars in the practice;
b) Elections will be organised under the auspices of the Local Medical Committee;
c) Any GP who is on the local performers' list will be eligible to stand for election if not otherwise barred from holding any public office or position on the governing body;
d) Individuals elected to these positions will serve a period of three years;
e) No more than 50% of the elected positions will change in any six month period.

8.1.4. Individuals in elected posts may leave their position early if:
a) They provide three months' written notice to the CCG Chair of their intention to do so; or
b) A vote of no confidence is passed by at least 50% of the Members' Council. In the event of a vote against the chair of the CCG, this individual will be ineligible to vote.
c) The individual is a GP who is removed from the local performers' list;
d) The individual becomes ineligible to hold public office or to meet the criteria for membership of the governing body.

8.2. Appointments to the CCG

8.2.1. The following positions will be appointed by the CCG:
a) Accountable Officer;
b) Chief Finance Officer;
c) Chair of the Governing Body
d) CCG Senior Nurse
e) Lay Members on the Governing Body
f) Secondary Care specialist on the Governing Body

8.2.2. Where positions are made by appointment, the following principles will apply:
a) All appointment to be made in accordance with CCG Human resources and recruitment policies
b) Appointments will be made with support from Commissioning Support provider Human Resources team;

c) Best practice in appointment processes and procedures will be applied in line with the agree policies and the advice from the Commissioning Support service Human resources team.
d) Individuals appointed as Chair, Lay Members or secondary care specialist on the Governing Body will serve a period of three years;
e) No more than 50% of the positions on the Governing Body will be planned to change in any six month period.

8.2.3. Individuals in appointed posts may leave their position early if:

a) A vote of no confidence must be passed by at least 50% of the Members' Council. In the event of a vote of no confidence in the chair or another post holder of the CCG, then the chair will be ineligible to vote.
b) The individual becomes ineligible to hold public office or to meet the criteria for membership of the governing body.
c) Severance arrangements for postholders will be in accordance with CCG policy and the individual contracts of the postholders.

9. STANDARDS OF BUSINESS CONDUCT AND MANAGING CONFLICTS OF INTEREST

9.1. Standards of Business Conduct

9.1.1. Employees, members, committee and sub-committee members of the group and members of the governing body (and its committees) will at all times comply with this constitution and be aware of their responsibilities as outlined in it. They should act in good faith and in the interests of the group and should follow the *Seven Principles of Public Life*; set out by the Committee on Standards in Public Life (the Nolan Principles) The Nolan Principles are incorporated into this constitution at Appendix B.

9.1.2. They must comply with the group's policy on business conduct which will form part of Standing Orders, including the requirements set out in the policy for managing conflicts of interest.

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

9.2. Conflicts of Interest

9.2.1. As required by section 14O of the 2006 Act, as inserted by section 25 of the 2012 Act, the clinical commissioning group will make arrangements to manage conflicts and potential conflicts of interest to ensure that decisions made by the group will be taken and seen to be taken without any possibility of the influence of external or private interest.

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9.2.2. In addition, in accordance with its statutory powers under section 13Z of the National Health Service Act 2006 (as amended), NHS England has delegated the exercise of the primary care co-commissioning functions. As such the clinical commissioning group will make arrangements to manage conflicts within this area.

9.2.3. Where an individual, i.e. an employee, group member, member of the governing body, or a member of a committee or a sub-committee of the group or its governing body has an interest, or becomes aware of an interest which could lead to a conflict of interests in the event of the group considering an action or decision in relation to that interest, that must be considered as a potential conflict, and is subject to the provisions of this constitution.

9.2.4. A conflict of interest will include:

a) a direct pecuniary interest: where an individual may financially benefit from the consequences of a commissioning decision (for example, as a provider of services);

b) an indirect pecuniary interest: for example, where an individual is a partner, member or shareholder in an organisation that will benefit financially from the consequences of a commissioning decision;

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

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

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

9.2.5. If in doubt, the individual concerned should assume that a potential conflict of interest exists.

9.3. Declaring and Registering Interests

9.3.1. The group will maintain one or more registers of the interests of:

a) the members of the group;

b) the members of its Governing Body;

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

d) its employees.

9.3.2. The registers will be published on the group's website at www.southwestlincolnshireccg.nhs.uk.

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

9.3.4. Where an individual is unable to provide a declaration in writing, for example, if a conflict becomes apparent in the course of a meeting, they will make an oral declaration before witnesses which will be recorded in the minutes of the meeting.

9.3.5. The CCG Corporate Secretary will ensure that all Registers of Interests are reviewed regularly, and updated as necessary.

9.4. Managing Conflicts of Interest: general

9.4.1. The Governing Body, with a non GP member majority, will have a central role in managing potential conflicts of interest and advising on appropriate action when there is deemed to be a potential or actual conflict of interest. The Chair of the Governing Body is responsible for overseeing matters of actual or potential conflict of interest in the CCG.

9.4.2. Individual members of the group, the governing body, committees or sub-committees, the committees or sub-committees of its governing body and employees will comply with the arrangements determined by the group for managing conflicts or potential conflicts of interest.

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

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

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

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

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

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

9.4.7. In making this decision the chair will consider whether the meeting is quorate, in accordance with the number and balance of membership set out in the group's standing orders. Where the meeting is not quorate, owing to the absence of certain members, the discussion will be deferred until such time as a quorum can be convened. Where a quorum cannot be convened from the membership of the meeting, owing to the arrangements for managing conflicts of interest or potential conflicts of interests, the chair of the meeting shall consult with the Chair of the Governing Body on the action to be taken.

9.4.8. In any transaction undertaken in support of the Clinical Commissioning Group's exercise of its commissioning functions (including conversations between two or more individuals, e-mails, correspondence and other communications), individuals must ensure, where they are aware of an interest, that they conform to the arrangements confirmed for the management of that interest. Where an individual has not had confirmation of arrangements for managing the interest, they must

declare their interest at the earliest possible opportunity in the course of that transaction, and declare that interest as soon as possible thereafter.

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

9.4.10. Anyone contracted to provide services or facilities directly to the clinical commissioning group or in a position to do so 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.

9.5. Transparency in Procuring Services

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

9.5.2. The group will publish a Procurement Strategy approved by its Governing Body which will ensure that:

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

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

10. OPENNESS, TRANSPARENCY AND DUTY OF CANDOUR: CONSTITUTIONAL STATEMENT

'The Clinical Commissioning Group recognises and confirms that nothing in or referred to in this Constitution (including in relation to the issue of any press release or other public statements 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 or any of its committees, or sub-committees or the committees of sub-committees of its Governing Body, or any employee of the group or any of its members, nor will it affect the rights of any worker (as defined in the Act) under that Act'.

11.

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 England, with responsibility for ensuring the group:
	• complies with its obligations under:
	  ○ sections 14Q and 14R of the 2006 Act (as inserted by section 26 of the 2012 Act),
	  ○ sections 223H to 223J of the 2006 Act (as inserted by section 27 of the 2012 Act),
	  ○ paragraphs 17 to 19 of Schedule 1A of the NHS Act 2006 (as inserted by Schedule 2 of the 2012 Act), and
	  ○ any other provision of the 2006 Act (as amended by the 2012 Act) specified in a document published by the Board for that purpose;
	• exercises its functions in a way which provides good value for money.

Area	the geographical area that the group has responsibility for, as defined in Chapter 2 of this constitution
Chair of the clinical commissioning group	The clinical leader of the CCG who is a senior GP elected by the CCG member practices
Chair of the governing body	the individual appointed by the group to act as chair of the governing body
Chief finance officer	the qualified accountant employed by the group with responsibility for financial strategy, financial management and financial governance
Clinical commissioning group	a body corporate established by the NHS England in accordance with Chapter A2 of Part 2 of the 2006 Act (as inserted by section 10 of the 2012 Act)
Executive Committee	a committee created and appointed by the membership of the group charged with overseeing operational aspects of the CCG and project delivery.
Financial year	this usually runs from 1 April to 31 March, but under paragraph 17 of Schedule 1A of the 2006 Act (inserted by Schedule 2 of the 2012 Act), it can for the purposes of audit and accounts run from when a clinical commissioning group is established until the following 31 March
Group	NHS South West Lincolnshire Clinical Commissioning Group, whose constitution this is
Governing body	the body appointed under section 14L of the NHS Act 2006 (as

	inserted by section 25 of the 2012 Act), with the main function of ensuring that a clinical commissioning group has made appropriate arrangements for ensuring that it complies with: • its obligations under section 14Q under the NHS Act 2006 (as inserted by section 26 of the 2012 Act), and • such generally accepted principles of good governance as are relevant to it.
Governing body member	any member appointed to the governing body of the group
Lay member	a lay member of the governing body, appointed by the group. A lay member is an individual who is not a member of the group or a healthcare professional (i.e. an individual who is a member of a profession regulated by a body mentioned in section 25(3) of the National Health Service Reform and Health Care Professions Act 2002) or as otherwise defined in regulations
Member	a provider of primary medical services to a registered patient list, who is a member of this group
Practice representatives	an individual appointed by a practice (who is a member of the group) to act on its behalf in the dealings between it and the group, under regulations made under section 89 or 94 of the 2006 Act (as amended by section 28 of the 2012 Act) or directions under section 98A of the 2006 Act (as inserted by section 49 of the 2012 Act)
Registers of interests	registers a group is required to maintain and make publicly available under section 14O of the 2006 Act (as inserted by section 25 of the 2012 Act), of the interests of: • the members of the group; • the members of its governing body; • the members of its committees or sub-committees and committees or sub-committees of its governing body; and • its employees.

APPENDIX B - NOLAN PRINCIPLES

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

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

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

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

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

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

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

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

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

APPENDIX C – MAP OF NHS SOUTH WEST LINCOLNSHIRE CCG AREA