NHS Croydon Clinical Commissioning Group Constitution

NHS Commissioning Board Effective Date: [insert date]
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This constitution sets out Croydon Clinical Commissioning Group’s (CCG) responsibilities for commissioning care for its patients. It describes our governing principles, rules and procedures that Croydon CCG will establish to ensure probity and accountability in the day to day running of the clinical commissioning group; to ensure that decisions are taken in an open and transparent way and that the interests of patients and the public remain central to the goals of the group. It confirms: the group’s legal position, the group’s mission, values and aims, the group’s membership and the decisions reserved to the membership, how the membership relates to the group’s governing body, the group’s leaders, their roles and how they are selected and are expected to behave, the powers of the governing body, committees and individuals, the group’s meeting arrangements and the group’s prime financial policies

The constitution applies to all of the member practices; the group’s employees, individuals working on behalf of the group and to anyone who is a member of the group’s governing body (including the governing body’s integrated governance, audit and remuneration committees) and any other committee(s) established by the group or its governing body. Every member practice, employee or other person working on behalf of the group, or member of the governing body or any committees is responsible for knowing, complying with and for upholding the arrangements for the governance and operation of the group as described in this constitution.
1. Introduction and commencement

1.1 Name

1.1.1 The name of this clinical commissioning group is Croydon Clinical Commissioning Group (CCG).

1.2 Parties

1.2.1 The Primary Care Practices (the Council of “Members”) whose names, signatures and addresses are set out in Appendix 1 (the “Register of Members”) agree this Constitution.

1.3 Status of constitution

1.3.1 This constitution has immediate effect and will stand once authorisation is achieved, when the NHS Commissioning Board formally establishes the group. The constitution is published on the group’s website and is also available upon request at local practices or via email.

1.4 Statutory Framework

1.4.1 Clinical commissioning groups are established under the Health and Social Care Act 2012 (“the 2012 Act”). 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”). 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.

1.4.2 The NHS Commissioning Board is responsible for determining applications from prospective groups to be established as clinical commissioning groups and undertakes an annual assessment of each established group. 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.

1.4.3 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.

1.5 Amendment and Variation of this Constitution

1.5.1 Prior to authorisation, the constitution may only be amended in the following manner:

a) Formal proposals for amendment shall be sent to the Chair of Croydon CCG Board, who shall place them before the NHS Croydon CCG Board members for consideration at the earliest opportunity. The Board shall not consider the proposal unless members have received at least ten days clear notice of such proposals in advance of the next scheduled meeting;

b) amendments proposed by the Board shall be put to the next NHS Croydon member practice meeting for decision by vote;
c) a board member may invoke an extraordinary Board meeting to propose an amendment to the constitution at any time; and

d) a constituent Practice may invoke an extraordinary NHS Croydon Member Practice Member meeting to propose an amendment to the constitution if it is supported in writing by 6 Practices (20%).

e) where in the circumstances set out in legislation the NHS Commissioning Board varies the group’s constitution other than on application by the group.

1.5.2 Following authorisation, this constitution can only be varied in two circumstances:

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

b) where in the circumstances set out in legislation the NHS Commissioning Board varies the group’s constitution other than on application by the group.
2 Area covered

2.1 Area map
Area covered

NHS Croydon CCG covers the Unitary area of Croydon.
3  Membership

3.1  Membership of the Clinical Commissioning Group

3.1.1 The following practices comprise the members of NHS Croydon CCG

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<th>Address</th>
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<tr>
<td>Ashburton Park Medical Centre</td>
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<td>Parkway Health Centre (02 AT Medics)</td>
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<td>Brigstock Medical Centre</td>
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<td>Friends Road Medical Practice</td>
<td>St James’s Medical Centre</td>
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<td>Hartland Way Surgery</td>
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<td>The Whitehorse Practice</td>
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<td>The Woodcote Group Practice</td>
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<td>Leander Rd P.C. Centre</td>
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4. **Mission, values and aims**

### 4.1 Mission

“Working with the diverse population of Croydon we will use our resources wisely to transform and provide safe, sustainable and high quality services.”

The CCG’s mission has been restated as “our task” and is addressed to the population served:

**Our task is to:**

- drive delivery of quality through all that it does, facilitating engagement of all practice members and building strong partnerships with organisations outside Croydon while promoting and facilitating the involvement of patients and their carers;
- improve commissioning of services generally thereby improving the quality of primary and secondary care for local patients;
- where advantageous to patient care and/or more cost effective, identify opportunities to bring services out of hospital and closer to the patient’s home and also identify ways of managing patient flows through the system;
- share good practice and work constructively with local service providers and across neighbouring CCGs; and
- develop ways of involving and engaging patients and the public in commissioning decisions.

### 4.2 Values

- We will commission high quality, safe services for the patients of Croydon.
- We will prudently marshal our resources to maximum benefit of the population of Croydon.
- We will work collaboratively with our partners, colleagues and providers to transform the services for the people of Croydon.
- We will reduce health inequalities and unwarranted Clinical Variation.
- We will create a delivery culture where holding each other to account is the norm.

### 4.3 Aims

NHS Croydon CCG Board have agreed the following aims:

- improving by active involvement in commissioning the quality of care for patients, and offer member practices the platform to work together and learn by sharing best practice;
- planning and buying services that are high quality and provide the best health outcomes and experiences while achieving value for money for the people of Croydon;
• redesigning, developing and providing high-quality, cost-effective local services within primary care based on sound planning, common visions of members, and local and national priorities;
• ensuring all staff have the opportunity to attend appropriate training that will support delivery of services at the required level and providing hold training as a priority;
• retaining the core values of family practice in the process of modernisation;
• engaging patients and health care colleagues as early as possible in changes to services;
• establishing robust mechanisms through which to monitor the quality of services provided to patients;
• working collaboratively with other CCGs to achieve economies of scale and strategic change, where appropriate;
• contributing to NHS Croydon CCG’s long-term strategic commissioning intentions by way of active involvement in Clinical Commissioning and service redesign; and
• using the knowledge of the local patient population to identify needs and gaps in service and where appropriate offer expert clinical engagement for the benefit of commissioning health care scheme for our patients.

4.4 Principles of Good Governance

In accordance with section 14L(2)(b) of the 2006 Act, the group will at all times observe ‘such generally accepted principles of good governance in the way it conducts its business. These include:

• 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;
• The Good Governance Standard for Public Services;
• the standards of behaviour published by the Committee on Standards in Public Life (1995) known as the ‘Nolan Principles’;
• the seven key principles of the NHS Constitution;
• the Equality Act 2010; and
• the Standards for Members of NHS Boards and Governing Bodies in England (once published).

4.5 Accountability

The group will demonstrate its accountability to its members, local people, stakeholders and the NHS Commissioning Board in a number of ways, including by:

• publishing its constitution;
• appointing independent lay members and non GP clinicians to its governing body;
• holding meetings of its governing body in public (except where the group considers that it would not be in the public interest in relation to all or part of a meeting);
• publishing annually a commissioning plan;
• complying with local authority health overview and scrutiny requirements;
• meeting annually in public to publish and present its annual report and annual accounts;
• having a published and clear complaints process;
• complying with the Freedom of Information Act 2000; and
• providing information to the NHS Commissioning Board as required.
5. Functions and general duties

5.1 Functions

5.1.1 The functions that the group is responsible for exercising are set out in the 2006 Act, as amended by the 2012 Act. These are contained in the Department of Health’s Functions of clinical commissioning groups: a working document. In summary they are:

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

b) Commissioning emergency care for anyone present in the group’s area;

c) Determining the remuneration and travelling or other allowances of members of its governing body; and

d) 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.

5.1.2 In discharging its functions the group will:

a) Act, when exercising its functions to commission health services, consistently with the discharge by the Secretary of State and the NHS Commissioning Board of their duty to promote a comprehensive health service and with the objectives and requirements placed on the NHS Commissioning Board through the mandate published by the Secretary of State before the start of each financial year by:
   i. delegating responsibility to the elected NHS Croydon CCG Board; and
   ii. monitoring the progress made by NHS Croydon CCG Board through its performance reports, including those made by all sub-committees and working groups.

b) meet the public sector equality duty by working towards:
   i. better health outcomes for all;
   ii. improved patient access and experience;
   iii. empowered, engaged and included staff; and
   iv. inclusive leadership at all levels.

c) As per the Equality Act 2010, NHS Croydon CCG will, in the exercise of their functions, have due regard to the need to:
   i. eliminating unlawful discrimination harassment and victimisation and other conduct prohibited by the 2010 Act;
   ii. advancing equality of opportunity between people who share a protected characteristic and those who do not; and
   iii. fostering good relations between people who share a protected characteristic and those who do not.
Note – there are nine protected characteristics. These are defined as including age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex, sexual orientation and – for the elimination of discrimination element of the duty only – marriage and civil partnership.

d) NHS Croydon CCG will also work towards the recommendations within the Marmot Review, *Strategic review of health inequalities in England post 2010*.

Specifically:

i. the group commits to applying the broad principles of the Marmot review to its strategy, planning and commissioning process;

ii. the group commits to identifying ways of ensuring this happens through integrating these principles into its systems and processes;

iii. the group has developed a vision and will identify key outcome measures to ensure they remain on track; and

iv. the group will take into account the advice of the Public Health Team to determine their initial priorities and to establish the outcome measures.

The group will work with Croydon Borough Council and EDS support teams to strive to ensure these goals can be met.

e) In addition to meeting this general duty, NHS Croydon CCG will:

i. publish, at least annually, sufficient information to demonstrate compliance with this general duty across all their functions;

ii. by the end of April 2013, prepare and publish specific and measurable equality objectives, revising these at least every four years; and

iii. work in partnership with its local authority to develop *joint strategic needs assessments* and *joint health and wellbeing strategies* by: having the Chair of Croydon CCG Board sitting on the Health and Wellbeing Board; and ensuring targeted areas to support health care within the community is driven by discussion of need identified by the Health and Wellbeing Board.

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 by:

a) working in partnership with patients and the local community to secure the best care for them;

b) adapting engagement activities to meet the specific needs of the different patient groups and communities;

c) publishing information about health services on the group’s website and through other media;

d) encouraging and acting on feedback; and

e) identifying how the group will monitor and report its compliance against this statement of principles (i.e. the committee / mechanism to oversee this).
Where it is intended that services will change, NHS Croydon CCG will engage with the local authority health overview and scrutiny committee and, where formal consultation on changes is required, will follow the Cabinet Office’s *Code of Practice on Consultation*.

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** by:

a) ensuring the key principles of the NHS Constitution are at the heart of all group activities;
b) ensuring national as well as local initiatives drive commissioning within the region;
c) ensuring all group members are fully aware of the NHS Constitution and that it is available in every practice; and
d) reviewing all activity against the NHS Constitution to ensure probity.

5.2.3 **Act effectively, efficiently and economically** by:

a) working within the confines of the group budget;
b) ensuring value for money is at the heart of commissioning, while maintaining an effective and efficient health care service for the people of Croydon;
c) ensuring transparency in all group commissioning activity;
d) adhering to all statutory financial processes; and
e) working with the NCB and other Clinical Commissioning Groups to identify best practice and where relevant, achieve economies of scale.

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

a) adhering to the policies and principles set out in the Quality and Safeguarding Strategy and the Primary Care Quality and Performance Strategy;
b) collating and act upon feedback from within the group and from the local community to identify areas for further development;
c) identifying and share best practice amongst practices; and
d) regularly reporting and reviewing progress against agreed plans and publishing outcomes.

5.2.5 **Assist and support the NHS Commissioning Board in relation to the Board’s duty to improve the quality of primary medical services** by:

a) regularly meeting with NCB representatives to ensure commissioning processes, strategies and plans are being delivered effectively and in line with national guidance;
b) working closely with NCB on all national initiatives; and
c) informing NCB of any local issues that may benefit from national guidance or which may support other Clinical Commissioning Groups in their commissioning activities.

5.2.6 Have regard to the need to **reduce inequalities** by:

a) NHS Croydon CCG being fully committed to reducing inequalities according to local needs and national policy;

b) Regularly reviewing progress towards equality objectives, led by the Chair of the Board

c) Regular communication with NCB, Public Health and EDS support team to ensure NHS Croydon CCG reflects best practice and is maximising every opportunity to reduce inequality.

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

a) working closely with LINk and its successor organisation, Healthwatch, to ensure the voice of patients and the public is represented in all NHS Croydon CCG decisions;

b) ensuring patients, carers and their representatives are fully involved in relevant commissioning processes; and

d) ensuring practices have a direct link to the Board through the Clinical Forum of Member Practices to feedback ideas and concerns direct from the public or issues they identify themselves through their everyday interaction.

5.2.8 Act with a view to **enabling patients to make choices** by:

a) Ensuring patients are informed of options available to them when making decisions about current and future health care needs; and

b) Ensuring all GPs uphold defined NHS practice with regard to declaring any interest, financial or otherwise, they may have when making a referral.

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

a) ensuring that all workstreams and pathway reviews draw upon the wider knowledge and extensive experience of the wider group and other key stakeholders; and

b) where necessary, commissioning external support and expertise to drive initiatives and development where the specific experience required is not available within NHS Croydon CCG.

5.2.10 **Promote innovation** by:

a) supporting delivery of the QIPP challenge within financial resources by promoting innovation, identifying and sharing best practice in commissioning, clinical practice and service delivery from both internal and external sources;
b) encouraging development and innovation through pathways and work stream development; and

c) challenging embedded methods to ensure they remain the most effective and efficient means of delivery and approach.

5.2.11 *Promote research and the use of research* by:

a) Managing the knowledge base and delivering high quality knowledge services that promote innovation in healthcare, and support the application of research evidence to address priorities;

b) ensuring leading research is shared regularly with the Clinical Forum for Member Practices; and

c) where funding allows, encouraging research within the group to enhance delivery and provide a better health care service for the people of Croydon, sharing outcomes nationally.

5.2.12 Have regard to the need to *promote education and training* 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 services in England so as to assist the Secretary of State for Health in the discharged of his related duty by:

a) ensuring all NHS Croydon CCG staff complete all relevant mandatory education and training;

b) supporting and monitoring appropriate professional development for all NHS Croydon CCG staff and commissioned personnel; and

c) promoting education and training through all contacts with external providers.

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 by:

a) fostering strong working relationships between health partners and social care within NHS Croydon.

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 allocations for the financial year*

a) A monthly finance report will be presented to NHS Croydon CCG Board by the Chief Financial Officer. The finance report will include a forecast of yearend financial position along with a commentary on the position, risk, and management action needed to ensure financial balance.

b) For governance purposes, NHS Croydon CCG Integrated Governance and Audit Committee will provide assurance as a Finance Sub Committee.

c) The Finance Sub Committee will receive detailed performance reports for delegated budgets, to include QIPP delivery. The purpose of the Finance Sub Committee review is to consider the performance reports to determine:
i. if the forecast is within financial balance and will meet the delegated Revenue Resource Limit (RRL) of NHS Croydon CCG.
ii. that the forecast is reasonable and gives early warning of adverse trends.
iii. if financial balance is not forecast then review recovery action.
iv. having assessed risk, determine appropriate reporting to NHS Croydon CCG Board.

d) The Finance report to the Board will also include a Balance Sheet report that will follow the same principles as above to ensure NHS Croydon CCG meets its delegated Capital Resource Limit (CRL).

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 Commissioning Board for the financial year**

a) In year monitoring of the RRL will be delivered through NHS Croydon CCG Finance Sub Committee as outlined in 5.3.1 above.

5.3.3 **Take account of any directions issued by the NHS Commissioning Board**, in respect of specified types of resource in a financial year, to ensure the CCGT does not exceed an amount specified by the NHS Commissioning Board;

a) The NHS South West London Cluster manage the Revenue Resource Limit relating to NHS Croydon CCG delegated budgets. Directions from the NHS Commissioning Board relating to specified use of resources would normally be supported by a specific revenue allocation. NHS Croydon CCG will receive reports on RRL’s from the Cluster and have systems of control that will ensure specific allocations are spent for the purpose intended.

b) NHS Croydon CCG will monitor the RRL taken from the Department of Health exposition book, plus known adjustments advised by the DOH. In the shadow period until the PCT budget is fully disaggregated the PCT Cluster, will advise NHS Croydon CCG of its share of the PCT RRL. NHS Croydon CCG will delegate the monitoring of the RRL to the Chief Financial Officer, the CFO will produce a financial report to NHS Croydon CCG that will include assurance on specific allocations. In addition NHS Croydon CCG may delegate the responsibility for more detailed monitoring of allocations to the Finance Sub Committee.

5.3.4 **Publish an explanation of how the group spent any payment in respect of quality** made to it by the NHS Commissioning Board by

a) delegating responsibility to its Chief Financial Officer to oversee the expenditure;

b) agreeing appropriate Clinical Quality Incentive Schemes (CQUINs) with Providers and monitoring the delivery of these schemes through clinical quality review groups; and

c) embedding quality payments in contracts.
5.4 Other Relevant Regulations, Directions and Guidance

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 Commissioning Board; and
   c) have regard to guidance issued by the NHS Commissioning Board.

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 CCG is a clinically led membership organisation and is accountable for exercising the statutory functions of the CCG. It grants authority to act on its behalf to:

a) a Council of Members, which comprises a representative appointed by each Member;
b) the Governing Body;
c) employees, and;
d) committees of the Governing Body, namely a remuneration committee and an integrated governance and audit, which has a finance sub-committee.

6.1.2 The Members will exercise their constitutional rights and fulfill their statutory responsibilities in respect of the CCG through a Council of Members. Each Member shall appoint a Member Representative to the Council of Members.

6.1.3 The CCG will, acting through the Council of Members, establish its Governing Body (the “Governing Body”) which shall fulfill its statutory responsibilities and such other functions as are delegated to it by the CCG, which shall include the powers and authority to lead the CCG and to set its strategic direction.

6.1.4 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.

6.1.5 The election process for the Council of Members is as set out in 2.3 of the Standing orders, Appendix 3.

6.2 Scheme of Reservation and Delegation

6.2.1 The group’s scheme of reservation and delegation (appendix x) sets out:

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

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

6.3.1 In discharging their delegated responsibilities the Board (and its committees), and any other committees established by the group and individuals must:

a) Comply with the group's principles of good governance;
b) Operate in accordance with the group's scheme of reservation and delegation;
c) Comply with the group's standing orders;
d) Comply with the group's arrangements for discharging its statutory duties; and
e) Where appropriate, ensure that member practices have had the opportunity to contribute to the group's decision making process.

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

6.4 Committees of the group

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

6.5 The Governing Body

6.5.1 Functions – NHS Croydon CCG Board (the governing body) has the functions conferred on it by sections 14L(2) and (3) of the 2006 Act, inserted by section 25 the 2012 Act, together with any conferred by regulations made and any other functions connected with its main functions as may be specified in regulations. The governing body may also have functions delegated to it by NHS Croydon CCG. It has responsibility for:

a) ensuring that the group has appropriate arrangements in place to exercise its functions effectively, efficiently and economically and in accordance with the groups principles of good governance (its main function);
b) determining the remuneration, fees and other allowances payable to employees or other persons providing services to the group and the allowances payable under any pension scheme it may establish under paragraph 11(4) of Schedule 1A of the 2006 Act, inserted by Schedule 2 of the 2012 Act;
c) approving any functions of the group that are specified in regulations;
d) any additional functions as described in the Board's Terms of Reference
e) ensuring that the register of interest is reviewed regularly, and updated as necessary; and
f) ensuring that all conflicts of interest or potential conflicts of interest are declared.

6.5.2 Composition of the NHS Croydon Clinical Commissioning Group Board - the Board shall not have less than twelve members and comprises:

a) the Chair (elected GP Board member);
b) Assistant Clinical Chair (elected GP Board member)
c) 2 GP’s co-opted from the Clinical Leadership Group
d) The Accountable Officer (salaried appointment)
e) a minimum of two lay members:
   i. the Lay Vice Chair, leading on audit, remuneration and conflict of interest matters
   ii. one to lead on patient and public participation matters
f) one registered nurse (appointment)
g) one secondary care specialist doctor (appointment)
h) Chief Financial Officer (salaried appointment)
i) Croydon PEC Chair (this role may be held by one of the above members or be a separate appointment)

The 4 elected GPs and the 2 GPs co-opted from the Clinical Leadership Group will each have a portfolio of responsibility and are supported directly in this by members of the Clinical Leadership Group.

In attendance (no voting rights)

a) Communications officer (while still available)
b) Director of Public Health
c) Representative from Croydon Borough Council

**Their method of appointment**, terms of office and roles are as set out in 2.4 of the Standing Orders Appendix 3.

6.6 Committees of the Board

6.6.1 The Governing Body shall also establish an:

**Integrated Governance & Audit Committee** (which shall be chaired by one of the Governing Body’s lay members), which shall have a **Finance Sub Committee** and a **Remuneration Committee**. The functions and remit of these committees will be set out in their terms of reference and roles as in Annex x. The Governing Body shall establish other Committees as necessary.

6.6.2 The Governing Body shall appoint an **Operational Management Group (Senior Management Team)** to manage the day to day operations of the CCG.

6.6.3 The process of appointment of and arrangements for conducting committees and sub committees are set out in Section 4 of the Standing Orders, Appendix 3.

You have a process for electing your clinical leaders but in relation to governance their positioning is unclear. Essentially they are a group of clinical leaders elected to support a set of clinical leadership functions. So they can be aligned to the governing body, sub committees or other working groups to provide clinical leadership and focus, but they do not exist as a separate entity or have a role in reporting directly to the Board. The member practices are elected to the council of members that elect the Governing Body. The functions of clinical leaders are described in the constitution and standing orders and indeed your membership relating to sub committees/working groups.

Your member practice meetings are part of the governing structure as the member practice clinical forum and will replace clinical leadership group on the structure reporting to the Board.
7 Roles and responsibilities

7.1 Practice Clinical Leads

7.1.1 Practice Clinical Leads represent their practice’s views and act on behalf of the practice in matters relating to the group. Practice Clinical Leads will be selected by the member practice.

7.1.2 The role of the practice clinical lead is to ensure that their practice engages with clinically-led commissioning by:
   a) participating in the regular meetings of the Clinical Forum of Member Practices - to enable discussions with and between member practices to discuss priorities for commissioning, review progress of commissioning programmes and contribute to service redesign;
   b) engaging with local communities through their practice Patient Participation Group to gather feedback on the quality of commissioned services and identify potential areas for improvement; and
   c) participating in the regular neighbourhood quality and performance team meetings to identify and spread best practice.

7.2 Clinical Leaders

7.2.1 Elected Clinical Leaders have a more active role in the management and operation of the group. As members of the group’s Board, they bring their unique understanding of the group’s member practices to the discussion and decision making of the Board. The role of the Clinical Leaders includes:
   a) developing a new culture that ensures the voice of the member practices is heard and the interests of patients and the community remain at the heart of discussions and decisions;
   b) ensuring the Board and the wider group act in the best interests with regard to the health of the local population at all times;
   c) developing the vision and strategy for improving and delivering the health care of the population of NHS Croydon in consultation with patients, the public, health and wellbeing Governing Body and other key local Stakeholders;
   d) securing, through effective commissioning and within available resource allocation, a range of safe and effective community, secondary and specialised services (as determined by national definition) which offer quality and value for money;
   e) ensuring the group acts with a view that health services are provided in a way which promotes the NHS Constitution, that it is there to improve our health and wellbeing, supporting us to keep mentally and physically well, to get better when we are ill and when we cannot fully recover, to stay as well as we can to the end of our lives;
   f) ensuring that measures of quality outcomes, cost, efficiency and patient experience are established, and monitor and ensure remedial action;
   g) ensuring the group meets its responsibilities in safeguarding children and vulnerable adults;
   h) working closely with Croydon Borough Council to ensure integrated commissioning of health and social care;
   i) maintaining a current and good understanding of the national and regional perspective and future strategy for the NHS and related areas of Health and Social Care;
j) bringing a clinical leaders perspective to discussions and decision-making;

k) taking a key role and champion the design and implementation of quality, innovation, productivity and prevention (QIPP) schemes for Croydon;

l) promoting effective patient and local community involvement and act with a view to enabling patients to make choices in respect of their care, adopting innovative approaches to engagement, and actively participate in Health and Wellbeing Governing Body meetings and activities and key stakeholder groups;

m) ensuring the Board is responsive to the views of local people and promotes self-care and shared decision-making in all aspects of its business; and

n) that good governance remains central at all times.

7.3 All Members of the Group’s Governing Body

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

7.4 The Chair of the Governing Body

7.4.1 In addition to the responsibilities held by the elected clinical leads, the Chair of the governing body is also responsible for:

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

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

c) attending and chair formal and informal meetings of the Board;

d) providing supportive, developmental and challenging leadership to the full Board and to the group;

e) acting as the principal spokesperson for the group across the health economy, attending the Cluster Board, Croydon Health and Wellbeing Board and key meetings with other stakeholders;

f) securing agreed results as set out in NHS Croydon CCG Strategic and Operational Plans, ensuring that the Group discharges both its healthcare and financial responsibilities, keeping expenditure within the delegated revenue resource limit;

g) ensuring transparency of decision-making and proper constitutional and good governance arrangements in accordance with the Nolan principles of public life, and ensure the Board is familiar with these requirements;

h) ensuring local adherence to agreed pathways and commissioning policies;

i) leading an effective outcome orientated NHS Croydon CCG Governing Body, agreeing personal objectives and work programmes with each Member of the Board and ensuring it remains continuously able to discharge its duties and responsibilities;
j) establishing agreed portfolios of work to deliver the Group’s vision and ensure each member of the Board takes responsibility for an agreed portfolio;
k) meeting regularly with the Chief Officer (the Chief Executive of the Cluster Board) to review progress on deliverables and strategic planning and support them in discharging the responsibilities of the organisation;
l) holding regular appraisal meetings with Board members;
m) ensuring that public and patients’ views are heard and their expectations understood and, as far as possible, met;
n) ensuring that the organisation is able to account to its local patients, stakeholders and the NHS Commissioning Board;
o) establishing arrangements for the continuing governance of the Board when the chair is not available; and
p) ensuring, through the appropriate support, information and evidence, the governing body is able to discharge its duties.

7.4.2 As the Chair of the governing body is also the lead clinician of the group they will have the respect of the group’s member practices and will also have the following responsibilities:
a) lead the group ensuring it is able to discharge its functions; and
b) be the senior clinical voice of the group in interactions with stakeholders including the NHS Commissioning Board.

7.5 The GP Vice Chair of the Governing Body

7.5.1 The GP Vice Chair of the governing body deputises for the chair as the lead clinician of the governing body where the chair has a conflict of interest or is otherwise unable to act.
Working closely with the Chair of the governing body the GP Vice Chair:
- chairs the Clinical Forum of Member Practices
- takes the lead on engaging with the LMC
Further details of the GP Vice Chair Roles and Responsibilities can be found on our website xxxx

7.6 The Lay Vice Chair of the Governing Body

7.6.1 The Lay Vice Chair of the governing body deputises for the chair of the governing body when both the Chair and the GP Vice Chair have a conflict of interest or are otherwise unable to act.

7.7 Role of the Chief Officer

7.7.1 The Chief Officer of the group is a member of the governing body.
7.7.2 This role of Chief Officer has been summarised by the NHS Commissioning Board Authority in its document Clinical commissioning group governing body members: Roles outlines, attributes and skills as:
a) being responsible for ensuring that the clinical commissioning group fulfils its duties to exercise its functions effectively, efficiently and economically thus ensuring improvement in the quality of services and the health of the local population whilst maintaining value for money;
b) at all times ensuring that the regularity and propriety of expenditure is discharged, and that arrangements are put in place to ensure that good practice (as identified through such agencies as the Audit Commission and the National
Audit Office) is embodied and that safeguarding of funds is ensured through effective financial and management systems; and c) working closely with the Chair of the governing body, the Chief Officer will ensure that proper constitutional, governance and development arrangements are put in place to assure the members (through the governing body) of the organisation’s ongoing capability and capacity to meet its duties and responsibilities.

7.8 Role of the Chief Financial Officer

7.8.1 The Chief Financial Officer is a member of the governing body. The Chief Financial Officer is responsible for the financial strategy, financial management and financial governance of the group. Specific responsibilities associated with this role include:

a) being the governing body’s professional expert on finance and ensure through robust systems and processes the regularity and propriety of expenditure is fully discharged;

b) making appropriate arrangements to support, monitor and report on the clinical commissioning group’s finances;

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

d) being able to advise the governing body on the effective, efficient and economic use of its 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 statutory requirements to demonstrate effective stewardship of public money and accountability to the NHS Commissioning Board.
8 Standards of Business Conduct and managing conflicts of interest

8.1 Standards of Business Conduct

8.1.1 Employees, members, committee and sub-committee members of the group and members of the governing body (and its committees) will at all times comply with this constitution and be aware of their responsibilities as outlined in it. They should act in good faith and in the interests of the group and should follow the Seven Principles of Public Life, set out by the Committee on Standards in Public Life (the Nolan Principles). The Nolan Principles are incorporated into this constitution at Appendix 8.

8.1.2 They must comply with the group’s policy on business conduct, including the requirements set out in the policy for managing conflicts of interest.

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

8.2 Conflicts of Interest

8.2.1 As required by section 14O of the 2006 Act, as inserted by section 25 of the 2012 Act, the clinical commissioning group will make arrangements to manage conflicts and potential conflicts of interest 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.

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

8.2.3 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.

8.2.4 If in doubt, the individual concerned should assume that a potential conflict of interests exists.
8.3 Declaring and Registering Interests

8.3.1 The group will maintain one or more registers of the interests of:
   a) the members of the group;
   b) the members of its governing body;
   c) the members of its committees or sub-committees and the committees or sub-committees of its governing body; and
   d) its employees.

8.3.2 The registers will be published on the group’s website at xxxx

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

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

8.3.5 The governing body will ensure that the register of interest is reviewed regularly, and updated as necessary.

8.3.6 The lay member of the governing body, with particular responsibility for governance, will make themselves available to provide advice to any individual who believes they have, or may have, a conflict of interest.

8.3.7 The governing body will take such steps as it deems appropriate, and request information it deems appropriate from individuals, to ensure that all conflicts of interest and potential conflicts of interest are declared.

8.4 Managing Conflicts of Interest: general

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

8.4.2 The governing body will ensure that for every interest declared, either in writing or by oral declaration, arrangements are in place to manage the conflict of interests or potential conflict of interests, to ensure the integrity of the group’s decision making processes. Arrangements for the governing body are set out below.

8.4.3 Arrangements for the management of conflicts of interest are to be determined by the governing body and will include the requirement to put in writing to the relevant individual arrangements for managing the conflict of interests or potential conflicts of interests, within a week of declaration.

8.4.4 The arrangements will confirm the following:
   a) when an individual should withdraw from specified activity, on a temporary or permanent basis;
   b) monitoring of the specified activity undertaken by the individual, either by a line manager, colleague or other designated individual.
8.4.5 In any meeting where an individual is aware of an interest, previously declared or otherwise, in relation to the scheduled or likely business of the meeting, the individual concerned will bring this to the attention of the chair, together with details of arrangements which have been confirmed by the governing body for the management of the conflict of interests or potential conflict of interests. Where no arrangements have been confirmed, the chair may require the individual to withdraw from the meeting or part of it.

8.4.6 Where the chair of any meeting of the group, including committees, sub-committees, or the governing body, 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 lay vice chair will act as chair for the relevant part of the meeting. Where arrangements have been confirmed with the governing body 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 lay vice chair may require the chair to withdraw from the meeting or part of it. Where there is no lay vice chair, the members of the meeting will select one.

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

8.4.8 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. The individual must also inform either their line manager (in the case of employees), or the governing body, of the transaction.

8.5 Managing Conflicts of Interest: governing body

8.5.1 Individual members of the governing body will comply with the arrangements determined by the governing body for managing conflicts or potential conflicts of interest.

8.5.2 Where a governing body member is aware of an interest which has not been declared, either in the register or orally to the governing body, they will declare this at the start of the meeting. The governing body will then determine how this should be managed and inform the member of their decision. The member will then comply with these arrangements, which must be recorded in the minutes of the meeting.

8.5.3 Where more than 50% of the members of the governing body, or 3 out of the 6 portfolio holding elected GPs, are required to withdraw from a meeting or part of it, owing to the arrangements agreed by the governing body for the management of conflicts of interests or potential conflicts of interests, the remaining chair will determine whether or not the discussion can proceed.

8.5.4 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 governing body, owing to the arrangements for managing conflicts of interest or potential conflicts of interests, the chair may invite on a temporary basis one or
more of the following to make up the quorum so that the group can progress the item of business:
  a) a member of the clinical commissioning group who is an individual;
  b) an individual appointed by a member to act on its behalf in the dealings between it and the clinical commissioning group;
  c) a member of a relevant Health and Wellbeing Board; and/or
  d) a member of a governing body of another clinical commissioning group.

8.5.5 These arrangements must be recorded in the minutes. NHS

8.6 Managing Conflicts of Interest: contractors

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

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

8.7 Transparency in Procuring Services

8.7.1 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.

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

8.7.3 Copies of this Procurement Strategy will be available on the group’s web site
9 The group as employer

- The group recognises that its most valuable asset is its people. It will seek to enhance their skills and experience and is committed to their development in all ways relevant to the work of the group.
- The group will seek to set an example of best practice as an employer and is committed to offering all staff equality of opportunity. It will ensure that its employment practices are designed to promote diversity and to treat all individuals equally.
- The group will ensure that it employs suitably qualified and experienced staff who will discharge their responsibilities in accordance with the high standards expected of staff employed by the group. All staff will be made aware of this constitution, the commissioning strategy and the relevant internal management and control systems which relate to their field of work.
- The group will maintain and publish policies and procedures (as appropriate) on the recruitment and remuneration of staff to ensure it can recruit, retain and develop staff of an appropriate calibre. The group will also maintain and publish policies on all aspects of human resources management, including grievance and disciplinary matters.
- The group will ensure that its rules for recruitment and management of staff provide for the appointment and advancement on merit on the basis of equal opportunity for all applicants and staff.
- The group will ensure that employees’ behaviour reflects the values, aims and principles set out above.
- The group will ensure that it complies with all aspects of employment law.
- The group will ensure that its employees have access to such expert advice and training opportunities as they may require in order to exercise their responsibilities effectively.
- The group will adopt a Code of Conduct for staff and will maintain and promote effective ‘whistleblowing’ procedures to ensure that concerned staff have means through which their concerns can be voiced.
- Copies of this Code of Conduct, together with the other policies will be available on the group website.
10 Working with other Clinical Commissioning Groups

10.1 Arrangements

10.1.1 The CCG may work together with other Clinical Commissioning Groups in the exercise of its commissioning functions.

10.1.2 The CCG may make arrangements with one or more Clinical Commissioning Groups in respect of:
   (a) Delegating any of the CCGs Commissioning Functions to another Clinical Commissioning Group
   (b) Exercising any of the Commissioning Functions of another Clinical Commissioning Group; or
   (c) Exercising jointly the Commissioning Functions of the CCG and another Clinical Commissioning Group

10.1.3 The collaborative commissioning Memorandum of Understanding is set out in Appendix x

10.2 Payment

10.2.1 For the purposes of the arrangements described at paragraph 10.1.2, the CCG may:
   (a) Make payments to another Clinical Commissioning Group
   (b) Receive payments from another Clinical Commissioning Group; or
   (c) Make the services of its employees or any other resources available to another Clinical Commissioning Group; or
   (d) Receive the services of its employees or any other resources available from another Clinical Commissioning Group

10.2.2 For the purpose of the arrangements described at paragraph 10.1.2, the CCG may establish and maintain a pooled fund made of contributions by any of the CCGs working together pursuant to paragraph 10.1.2 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.
11 Transparency, ways of working and standing orders

11.1 General

11.1.1 All communications issued by the group, including the commissioning plan, annual report, notices of procurements, public consultations, reports, governing body meeting dates, times, venues, and papers will be published on the group's website at xxx

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

11.2 Standing Orders

11.2.1 This constitution is also informed by a number of documents which provide further details on how the group will operate. They are the group's:

a) Standing orders (Appendix 3) – which sets out the arrangements for meetings and the appointment processes to elect the group's representatives and appoint to the group's committees, including the governing body;

b) Scheme of reservation and delegation (Appendix 4) – which sets out those decisions that are reserved for the membership as a whole and those decisions that are the responsibilities of its governing body, its committees and sub-committees, individual members and employees;

c) Prime financial policies (Appendix 7) – which sets out the arrangements for managing the group's financial affairs

11.2.2 Further documentation, such as Job Descriptions, Committee Terms of Reference and specific frameworks and policies, can be found on NHS Croydon Commissioning CCG's website, xxxxxxxx
### Appendix 1  Definitions of key descriptions used in this constitution

<table>
<thead>
<tr>
<th>Description</th>
<th>Definition</th>
</tr>
</thead>
</table>
| **Chief officer**                                | An individual, as defined under paragraph 12 of Schedule 1A of the 2006 Act (as inserted by Schedule 2 of the 2012 Act), appointed by the NHS Commissioning Board, with responsibility for ensuring the group:  
  - complies with its obligations under:  
    - sections 14Q and 14R of the 2006 Act (as inserted by section 26 of the 2012 Act),  
    - sections 223H to 223J of the 2006 Act (as inserted by section 27 of the 2012 Act),  
    - paragraphs 17 to 19 of Schedule 1A of the NHS Act 2006 (as inserted by Schedule 2 of the 2012 Act), and  
    - any other provision of the 2006 Act (as amended by the 2012 Act) specified in a document published by the Board for that purpose;  
  - exercises its functions in a way which provides good value for money. |
| **Area**                                         | The geographical area that the group has responsibility for, as defined in Chapter 2 of this constitution                                                                                                   |
| **Chair of the governing body**                  | The individual appointed by the group to act as chair of the governing body                                                                                                                               |
| **Chief Financial Officer**                      | The qualified accountant employed by the group with responsibility for financial strategy, financial management and financial governance                                                                    |
| **Clinical commissioning group**                 | A body corporate established by the NHS Commissioning Board in accordance with Chapter A2 of Part 2 of the 2006 Act (as inserted by section 10 of the 2012 Act)                                                |
| **Committee**                                    | A committee or sub-committee created and appointed by:  
  - the membership of the group  
  - a committee / sub-committee created by a committee created / appointed by the membership of the group  
  - a committee / sub-committee created / |

**2006 Act**  National Health Service Act 2006  
**2012 Act**  Health and Social Care Act 2012 (this Act amends the 2006 Act)
<table>
<thead>
<tr>
<th><strong>Financial year</strong></th>
<th>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.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Group</strong></td>
<td>NHS Croydon CCG, whose constitution this is.</td>
</tr>
<tr>
<td><strong>Governing body</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Governing body member</strong></td>
<td>Any member appointed to the governing body of the group.</td>
</tr>
<tr>
<td><strong>Lay member</strong></td>
<td>A lay member of the governing body, appointed by the group. A lay member is an individual who is not a member of the group or a healthcare professional or as otherwise defined in regulations.</td>
</tr>
<tr>
<td><strong>Member</strong></td>
<td>A provider of primary medical services to a registered patient list, who is a member of this group (see tables in Chapter 3 and Appendix 2).</td>
</tr>
</tbody>
</table>
## Appendix 2 List of member practices

<table>
<thead>
<tr>
<th>Practice</th>
<th>Address</th>
<th>Neighbourhood</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addiscombe Surgery</td>
<td>Parkside Group Practice</td>
<td>Signature</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Date</td>
</tr>
<tr>
<td>Ashburton Park Medical Centre</td>
<td>Parkway Health Centre (01 Baskaran)</td>
<td>Signature</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Date</td>
</tr>
<tr>
<td>Auckland Surgery</td>
<td>Parkway Health Centre (02 Medics)</td>
<td>Signature</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Date</td>
</tr>
<tr>
<td>Birdhurst Medical Practice</td>
<td>Parkway Health Centre (03 Salerno)</td>
<td>Signature</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Date</td>
</tr>
<tr>
<td>Bramley Avenue Surgery</td>
<td>Portland Medical Centre</td>
<td>Signature</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Date</td>
</tr>
<tr>
<td>Brigstock Family Practice</td>
<td>Purley Medical Practice</td>
<td>Signature</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Date</td>
</tr>
<tr>
<td>Brigstock Medical Centre</td>
<td>Queenhill Medical Practice</td>
<td>Signature</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Date</td>
</tr>
<tr>
<td>Broughton Corner Medical Centre</td>
<td>Selhurst Medical Centre</td>
<td>Signature</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Date</td>
</tr>
<tr>
<td>Coulson Medical Practice</td>
<td>Selsdon Park Medical Practice</td>
<td>Signature</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Date</td>
</tr>
<tr>
<td>Downland Surgery</td>
<td>Shirley Medical Centre</td>
<td>Signature</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Date</td>
</tr>
<tr>
<td>East Croydon Medical Centre</td>
<td>South Croydon Medical Centre</td>
<td>Signature</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Date</td>
</tr>
<tr>
<td>Edridge Road Community Health Centre</td>
<td>South Norwood Hill Medical Centre</td>
<td>Signature</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Date</td>
</tr>
<tr>
<td>Practice</td>
<td>Address</td>
<td>Neighbourhood</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>-------------------------------------------------</td>
<td>---------------</td>
</tr>
<tr>
<td>Eversley Medical Centre</td>
<td>South Norwood Medical Centre</td>
<td>Signature</td>
</tr>
<tr>
<td>Fairview Medical Practice</td>
<td>South Norwood Medical Practice</td>
<td>Date</td>
</tr>
<tr>
<td>Farley Road Surgery</td>
<td>South Way Surgery</td>
<td>Signature</td>
</tr>
<tr>
<td>Fieldway Medical Centre</td>
<td>Spring Park Medical Practice</td>
<td>Date</td>
</tr>
<tr>
<td>Friends Road Medical Practice</td>
<td>St James’s Medical Centre</td>
<td>Signature</td>
</tr>
<tr>
<td>Greenside Medical Practice</td>
<td>Stovell House Surgery</td>
<td>Date</td>
</tr>
<tr>
<td>Hartland Way Surgery</td>
<td>The Haling Park Practice</td>
<td>Signature</td>
</tr>
<tr>
<td>Headley Drive Surgery (AT Medics)</td>
<td>The Moorings Medical Practice</td>
<td>Date</td>
</tr>
<tr>
<td>Heathfield Surgery</td>
<td>The Whitehorse Practice</td>
<td>Signature</td>
</tr>
<tr>
<td>Keston House Medical Practice</td>
<td>The Woodcote Group Practice</td>
<td>Date</td>
</tr>
<tr>
<td>Leander Rd P.C. Centre</td>
<td>Thornton Heath Health Centre</td>
<td>Signature</td>
</tr>
<tr>
<td>Linden Lodge Medical Practice</td>
<td>Thornton Road Surgery (AT Medics)</td>
<td>Date</td>
</tr>
<tr>
<td>Mersham Medical Centre</td>
<td>Upper Norwood GP Practice</td>
<td>Signature</td>
</tr>
<tr>
<td>Practice</td>
<td>Address</td>
<td>Neighbourhood</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>--------------------------</td>
<td>---------------</td>
</tr>
<tr>
<td>Mitchley Avenue Surgery</td>
<td>Valley Park Surgery</td>
<td></td>
</tr>
<tr>
<td>Morland Road Surgery</td>
<td>Violet Lane Medical Practice</td>
<td></td>
</tr>
<tr>
<td>Norbury Medical Practice</td>
<td>Woodside Group Practice</td>
<td></td>
</tr>
<tr>
<td>North Croydon Medical Centre</td>
<td>Woodside Health Centre Barber</td>
<td></td>
</tr>
<tr>
<td>Old Coulsdon Medical Practice</td>
<td>Woodside Health Centre Noronha</td>
<td></td>
</tr>
<tr>
<td>Parchmore Medical Centre</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix 3 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 Croydon Clinical Commissioning Group so that group can fulfil its obligations, as set out largely in the 2006 Act, as amended by the 2012 Act and related regulations. They are effective from the date the group is established.

1.1.2. The standing orders, together with the group’s scheme of reservation and delegation and the group’s prime financial policies, provide a procedural framework within which the group discharges its business. They set out:

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

b) the appointment of member practice representatives;

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

d) the process to delegate powers,

e) the framework around declaration of interests and standards of conduct.

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

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

1.2.1. The 2006 Act (as amended by the 2012 Act) provides the group with powers to delegate the group’s functions and those of the governing body to certain bodies (such as committees) and certain persons. The group has decided

---

1 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.
that certain decisions may only be exercised by the group in formal session. These decisions and also those delegated are contained in the group’s scheme of reservation and delegation.

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

2.1. Composition of membership

2.1.1. Chapter 3 of the group’s constitution provides details of the membership of the group (also see Appendix 2).

2.1.2. Chapter 6 of the group’s constitution provides details of the governing structure used in the group’s decision-making processes, whilst Chapter 7 of the constitution outlines certain key roles and responsibilities within the Council of Members and its governing body, including the role of practice representatives (section 7.1 of the constitution).

2.2. Key Roles

2.2.1. Paragraph 6.5.2 of the group’s constitution sets out the composition of the group’s governing body whilst Chapter 7 of the group’s constitution identifies certain key roles and responsibilities within the Council of Members and its governing body. These standing orders set out how the group appoints individuals to these key roles.

2.2.2. The roles and responsibilities of each of these key roles are further defined in NHS Commissioning Board guidance.

2.3. COUNCIL OF MEMBERS

2.3.1. The roles of chair and vice chair of the Council of Members are subject to the following appointment process:

a) **Nominations** – by Members.
b) **Eligibility** – all GP Principals and salaried doctors working in Member practices who are on the Performers’ List and locums on the Performers’ List where a Member is prepared to endorse and take responsibility for them as acting in compliance with the Constitution and the Inter Practice agreement.
c) **Appointment process** – by secret ballot of representatives.
d) **Term of office** - to be elected annually.
e) **Eligibility for reappointment** - Eligible for re-election annually, but with a maximum period of tenure of 3 years unless a formal change to this stipulation is agreed by the Council of Members.
f) **Grounds for removal from office** - Upon a vote of 75% or more of the Council of Members, in which case a 3 months’ notice period shall be given. In the event of suspension from the Performers’ list or by the GMC or in the event of proven gross misconduct, suspension shall be immediate. The Member shall have the right to involve the LMC in any discussions and decisions relating to this issue.
g) **Notice period** - Three months.
2.4. GOVERNING BODY

2.4.1. The roles of the Governing Body are subject to the following appointment process:

CHAIR AND DEPUTY CHAIR

2.4.2. The roles of the Chair and Deputy Chair of the Governing Body, as listed in paragraphs [7.4 and 7.5] of the Constitution, is subject to the following appointment process:

a) **Nominations** – An invitation will be made to Governing Body members to apply for the posts of Chair and Vice Chair who have been considered eligible for these roles during the selection process.

b) **Eligibility** – the role of the Chair of the Governing Body may be filled by any member of the Governing Body. If the Chair is a GP or other healthcare professional, the Deputy Chair should be a lay member who would take the Chair’s role for discussions and decisions involving conflict of interest for the Chair.

c) **Appointment process** - In the event of more than one candidate arising for either post, a secret ballot of the remaining voting members of the Governing Body will be held. In the event of equal numbers of votes being cast, the decision will be referred to the Council of Members. Thereafter the nominated candidate will proceed to the national assessment process.

d) **Term of office** - 3 years.

e) **Eligibility for reappointment** - The Chair and Vice Chair will be eligible for reappointment if they remain a member of the Governing Body.

f) **Grounds for removal from office** - Where the Chair or Vice Chair is a GP, upon a vote of 75% or more of the Council of Members, in which case a 3 months’ notice period shall be given. In the event of suspension from the Performers’ list or by the GMC or in the event of proven gross misconduct, suspension shall be immediate. The Member shall have the right to involve the LMC in any discussions and decisions relating to this issue.

g) **Notice period** - 3 months.

2.4.3. Where the Chair is a GP, the remaining GPs on the Governing Body shall elect a Deputy Chair – Clinical, who will deputise for the Chair when the Chair is not available or where the Chair declares a conflict of interest and where clinical leadership is required. The Deputy Chair – Clinical may assume the role of Interim Chair if the Chair is not available for an extended period to ensure clinical leadership of the group is maintained.

REPRESENTATIVES OF MEMBER PRACTICES
2.4.4. Representatives of member practices are subject to the following appointment process, which may be undertaken by an external body such as the LMC at the request of the electorate:

a) **Eligibility** - All GPs who are on the Performers List at the time of the nomination and who are principals or sessional GPs. Where GPs operate as long term locums and are on the Performers List, they will be eligible if endorsed by a named Member practice in which they work.

b) **Nominations** - The body conducting the election will write to all the eligible electorate of which it is aware as stated above seeking nominations. If it is subsequently discovered that the current list of eligible members is incomplete as a result of the body receiving incomplete information it shall not invalidate this process or any other element of the process described herein.

c) **Appointment process**

1) **Selection:**
   - The purpose of selection is to identify the pool of potential candidates that have an acceptable level of knowledge, skill and experience to stand for election. The Job Description and Person Specification for the role will be used to make that assessment.
   - Purpose is to create a pool of candidates with the capability, potential and willingness to create capacity (i.e. time) to fulfil the role.
   - Assessment will be made by a panel made up of senior managers from the CCG, external assessors with in-depth understanding of the clinical leadership role in commissioning and governance processes and an external GP leader with no local conflicts of interest
   - Assessment will be made on the basis of the person specification taking into account both the written application and interview
   - Candidates will be asked to complete an application form and attend an interview
   - The application form will seek evidence of the candidate's knowledge, skills and experience using the person specification as the benchmark
   - Candidates will also be asked to identify their priority areas for development
   - Candidates will be asked to confirm their ability to fulfil the stated time commitment
   - Candidates will be asked if they are willing to be considered for election as Chair of the Governing Body
   - All candidates will be given the opportunity before interview to complete a 360 degree feedback process on their leadership capability, identifying strengths and development needs
   - The assessment panel will decide whether an individual can be put forward for election
2) **Election process:**

- All GPs that are successful in the selection process may then put themselves forward for election.
- Where six or fewer GPs are nominated, appointment shall be automatic. Where seven or more are nominated, an election shall be undertaken.
- The electorate is as described in Appendix [x].
- Candidates will be given 2 weeks for a ‘hustings period’ when they can promote themselves to the electorate.
- The LMC will manage the election process which shall be by secret ballot.

d) **Term of office** - To be 2 or 3 years as agreed by the CoM to ensure continuity.

e) **Eligibility for reappointment** - Automatic for a second term, by agreement with the Council thereafter.

f) **Grounds for removal from office** - Upon a vote of 75% of the Council of Members requesting the removal of an elected GP member, the electorate shall be polled both on removal of the member and for a replacement in which case a 3 months’ notice period shall be given. In the event of suspension from the Performers’ list or by the GMC or in the event of proven gross misconduct, suspension shall be immediate. The member shall have the right to involve the LMC in any discussions and decisions relating to this issue.

g) **Notice period** - Three months.

2.5. **LAY MEMBERS**

2.5.1. The roles of the [two] lay members on the Governing Body is subject to the following appointment process:

a) **Nominations** – advertisement and application.

b) **Eligibility** – according to national guidance in place at the time of recruitment.

c) **Appointment process** - selection against job description and person specification.

d) **Term of office** - To be 2 or 3 years as agreed by the CoM to ensure continuity.

e) **Eligibility for reappointment** – post to be advertised before end of term of office. The post holder is eligible for reappointment.

f) **Grounds for removal from office** – non performance against agreed objectives as assessed by Chair and Accountable Officer.
Recommendation of Chair and Accountable Officer requires approval by Council of Members.

g) **Notice period** – 3 months.

REGISTERED NURSE

2.5.2. The role of the registered nurse on the Governing Body is subject to the following appointment process:

a) **Nominations** – advertisement and application.

b) **Eligibility** – according to national guidance in place at the time of recruitment.

c) **Appointment process** - selection against job description and person specification.

d) **Term of office** - To be 2 or 3 years as agreed by the CoM to ensure continuity.

e) **Eligibility for reappointment** – post to be advertised before end of term of office. The post holder is eligible for reappointment.

f) **Grounds for removal from office** – non performance against agreed objectives as assessed by Chair and Accountable Officer. Recommendation of Chair and Accountable Officer requires approval by Council of Members.

g) **Notice period** – 3 months.

SECONDARY CARE SPECIALIST DOCTOR

2.5.3. The role of the Secondary Care Specialist Doctor on the Governing Body is subject to the following appointment process.

a) **Nominations** – advertisement and application.

b) **Eligibility** – according to national guidance in place at the time of recruitment.

c) **Appointment process** - selection against job description and person specification.

d) **Term of office** - To be 2 or 3 years as agreed by the CoM to ensure continuity.

e) **Eligibility for reappointment** – post to be advertised before end of term of office. The post holder is eligible for reappointment.

f) **Grounds for removal from office** – non performance against agreed objectives as assessed by Chair and Accountable Officer.
Recommendation of Chair and Accountable Officer requires approval by Council of Members.

g) Notice period – 3 months.

THE ACCOUNTABLE OFFICER

2.5.4. The Accountable Officer, as listed in paragraph [7.6] of the Constitution, is subject to the following appointment process:

a) Nominations – advertisement and application.

b) Eligibility – according to national guidance in place at the time of recruitment.

c) Appointment process - selection against job description and person specification.

d) Term of office – substantive appointment.

e) Eligibility for reappointment – does not apply.

f) Grounds for removal from office – CCG employment policies and procedures apply.

g) Notice period – 3 months.

CHIEF FINANCE OFFICER

2.5.5. The Chief Finance Officer, as listed in paragraph [7.7] of the Constitution, is subject to the following appointment process:

a) Nominations – advertisement and application.

b) Eligibility – according to national guidance in place at the time of recruitment.

c) Appointment process - selection against job description and person specification.

d) Term of office – substantive appointment.

e) Eligibility for reappointment – does not apply.

f) Grounds for removal from office – CCG employment policies and procedures apply. If the post is shared with another CCG then that CCG’s employment policies and procedures will also apply.

g) Notice period – 3 months.

2.6. OTHER INDIVIDUALS
3. MEETINGS OF THE CLINICAL COMMISSIONING GROUP

3.1. Calling meetings

COUNCIL OF MEMBERS

3.1.1. Meetings of the Council of Members shall be held at least every [six months] at such times and places as the Council of Members may determine. In addition, special general meetings may be requested by the Council of Members, the Governing Body or on a written request by [50%] of Members.

3.1.2. A notice period of fourteen days shall be given for a special general meeting. Unless the Chair agrees to shorter time periods, the same constraints shall apply as for an ordinary meeting.

3.1.3. The Council of Members shall hold an annual general meeting in public (the “Annual General Meeting”). The matters to be considered at the Annual General Meeting shall be set out in the notice calling it, but shall include:

3.1.3.1. Consideration (and if appropriate) approval of the group’s annual report, accounts, operating plan and commissioning strategy;

3.1.3.2. Consideration of a report describing all patient and public engagement activity, including public consultations undertaken by the group and the findings and actions taken by the group as a result, and;

3.1.3.3. Election of members of the Governing Body when vacancies arise.

GOVERNING BODY

3.1.4. The Governing Body shall meet monthly.

OTHER MEETINGS

3.1.5. For all other of the group’s Committees and sub-committees, including the Governing Body’s committees and sub-committees, the details of how meetings are called are set out in the appropriate terms of reference.

3.2. Agenda, supporting papers and business to be transacted

3.2.1. Items of business to be transacted for inclusion on the agenda of a meeting need to be notified to the Chair at least 10 working days (i.e. excluding weekends and bank holidays) before the meeting takes place. Supporting papers for such items need to be submitted at least [6] working days before the meeting.
takes place. The agenda and supporting papers will be circulated to all members of a meeting at least [3] working days before the date the meeting will take place.

3.2.2. Agendas and certain papers for the group’s meetings – including details about meeting dates, times and venues - will be published on the group’s website at www.[insert group’s website].

3.3. **Petitions**

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

3.4. **Chair of a meeting**

3.4.1. At any meeting of the council of members or its governing body or of a committee or sub-committee, the chair of the group, governing body, committee or sub-committee, if any and if present, shall preside. If the chair is absent from the meeting, the deputy chair, if any and if present, shall preside. The deputy chair cannot assume the Chair’s vote.

3.4.2. If the chair is absent temporarily on the grounds of a declared conflict of interest the deputy chair, 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 council of members, governing body, committee or sub-committee respectively shall be chosen by the members present, or by a majority of them, and shall preside.

3.5. **Chair’s ruling**

3.5.1. The decision of the chair of the governing body on questions of order, relevancy and regularity and their interpretation of the constitution, standing orders, scheme of reservation and delegation and prime financial policies at the meeting, shall be final.

3.6. **Quorum**

**Council of Members**

3.6.1. [50%] of Members Representatives (or their proxies) shall constitute a quorum.

**Governing Body**

3.6.2. [One third] of the voting members are in attendance, of which the majority are clinicians. It shall also include [one] Lay Member and either the Accountable Officer or Chief Finance Officer. The only decision the governing body may take if its meeting is not quorate is to request a meeting of the council of members.

3.6.3. Votes are not transferable. An officer in attendance for a Member of the Governing Body but without formal acting up status may not count towards the quorum.
3.6.4. The quorum for the governing body shall only include members of the governing body.

Conflicts of Interest

3.6.5. For the policy and procedure for declaring and managing conflicts of interest refer to Annex 6.

3.6.6. 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 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 item.

Other Committees

3.6.7. For all other of the group’s committees and sub-committees, including the governing body’s committees and sub-committees, the details of the quorum for these meetings and status of representatives are set out in the appropriate terms of reference

3.7. Decision making

3.7.1. Chapter 6 of the group’s constitution, together with the scheme of reservation and delegation, sets out the governing structure for the exercise of the group’s statutory functions. Generally it is expected that 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:

Council of Members

3.7.2. A [60%] majority of the GP electorate is necessary to pass a resolution or confirm a decision. In the event of no overall majority, the Chair shall have the casting vote.

3.7.3. If there are dissenting views, the secretary shall record in the minutes the names of all those present at the meeting. Should a vote be taken the outcome of the vote, and any dissenting views, must also be recorded in the minutes of the meeting. The minutes of each meeting will be formally signed off by the chair of the meeting. The minutes of all meetings and parts of meetings held in public shall be published on the group’s website.

Governing Body

3.7.4. A simple majority is required to make a decision. Should this not be possible then a vote of all members of the Governing Body will be required, with each member having one vote and in the case of equality of votes, the chair shall have a casting vote.

3.7.5. Should a vote be taken the outcome of the vote, and any dissenting views, must be recorded in the minutes of the meeting.

Other Committees
3.7.6. For all other of the group’s committees and sub-committees, including the governing body's committees and sub-committee, the details of the voting arrangements are set out in the appropriate terms of reference.

3.8. Emergency powers and urgent decisions

3.8.1. In an emergency, where a decision must be made by the council of members or governing body before its next meeting, the powers and duties of the group or governing body may be exercised by the Chair (Emergency Action).

3.8.2. For this purpose “emergency” means circumstances in which:-

(a) the group will be unable to discharge its statutory functions or be exposed to a significant level of risk if urgent action is not taken; or

(b) urgent action must be taken to prevent loss, damage or significant disadvantage to the group;

and, for the avoidance of doubt, a matter is not an emergency solely because it has been omitted from inclusion in the agenda for a meeting of the council of members, governing body or any committee or sub-committee on a particular occasion.

3.8.3. Before taking any Emergency Action, the chair must consult the Accountable Officer and a Lay Member.

3.8.4. The Emergency Action must be ratified at the next meeting of the Governing Body.

3.8.5. The Emergency Action functions of the Chair and Accountable Officer may be exercised by such other persons as the Chair and Accountable Officer may respectively nominate in writing.

3.9. Suspension of Standing Orders

3.9.1. Except where it would contravene any statutory provision or any direction made by the Secretary of State for Health or the NHS Commissioning Board, any part of these standing orders may be suspended at any meeting, provided [75%] group members are in agreement.

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

3.9.3. A separate record of matters discussed during the suspension shall be kept. These records shall be made available to the governing body’s audit committee for review of the reasonableness of the decision to suspend standing orders.

3.10. Record of Attendance and Quoracy
3.10.1. The names of all members of the meeting present at the meeting shall be recorded in the minutes of the group's 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.

3.10.2. Quoracy also needs to be established and recorded for each meeting where decisions are to be taken.

3.11. Minutes

3.11.1. The secretary shall keep minutes of each meeting.

3.11.2. At each meeting, the minutes of the preceding meeting shall be confirmed (or confirmed as amended) and be signed by the Chair as a true record of that meeting.

3.11.3. The signed minutes of a meeting shall, unless the contrary is proved, be conclusive proof of the proceedings of that meeting.

3.12. Admission of public and the press

3.12.1. The public and representatives of the press may attend all public meetings of the Governing Body and are invited to ask questions of the Governing Body at the designated time on the agenda, in relation to matters on the agenda and at the discretion of the Chair. The public shall be required 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', (Section 1 (2), Public Bodies (Admission to Meetings) Act 1960).

3.12.2. Information and discussion of a confidential nature includes:

(a) information relating to a patient, unless it can be anonymised;
(b) information relating to an employee or office holder, former employee or applicant for any post or office;
(c) the terms of, or expenditure under, a tender or contract for the purchase or supply of goods or services or the acquisition or disposal of property;
(d) negotiations or consultation concerning labour relations between the group and its employees;
(d) any issue relating to legal proceedings which are being contemplated or instituted by or against the group;
(e) action being taken to prevent or detect crime or to prosecute offenders;
(f) the source of information given to the group in confidence; or
(g) any other matter which, in the opinion of the Chair, is confidential or the public disclosure of which would prejudice the effective discharge of the group's functions.

3.12.3. Where a meeting is held in private, the relevant reason from the list above must be given. Guidance should be sought from the group’s Freedom of
Information Lead to ensure correct procedure is followed on matters to be included in the exclusion.

3.13. **Conduct of meetings**

3.13.1. The order of business at a meeting shall follow that set out in the agenda unless it is varied by the Chair with the consent of the meeting.

3.13.2. A member may only initiate a debate or move a motion on a matter which is not on the agenda with the consent of the meeting.

3.13.3. All motions must relate to matters that are within or related to the functions of the group.

3.13.4. Members shall be respectful of each other and not make derogatory personal references or use offensive expressions or improper language to any other member or any employee of the group.

3.13.5. A member must speak to the subject under discussion. The Chair may call attention to any irrelevance, repetition, unbecoming language or other improper conduct on the part of a member and, where the member persists in that conduct, may direct that member to cease speaking.

3.13.6. The secretary or any other person advising on the business before a meeting (including advising the Chair on issues of order) may attend and, with the consent of the Chair, speak at that meeting.

3.13.7. A ruling by the Chair on any question of order, whether or not provided for by the Standing Orders, shall be final and shall not be open to debate.


3.14.1. 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 Board to complete its business without the presence of the public’. Section 1(8) Public Bodies (Admissions to Meetings) Act 1960.

4. **APPOINTMENT OF COMMITTEES AND SUB-COMMITTEES**

4.1. **Appointment of committees and sub-committees**

4.1.1. The Council of Members may appoint committees and sub-committees of the Governing Body, subject to any regulations made by the Secretary of State\(^2\). Where such committees and sub-committees are appointed they are included in Chapter 6 of the group’s constitution.

4.1.2. Other than where there are statutory requirements, such as in relation to the governing body’s audit committee or remuneration committee, the council of members 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 council of members.

\(^2\) See section 14N of the 2006 Act, inserted by section 25 of the 2012 Act
4.1.3. The provisions of these standing orders shall apply where relevant to the operation of the governing body and the governing body’s committees and sub-committees unless stated otherwise in the committee or sub-committee’s terms of reference.

4.2. Terms of Reference

4.2.1. Terms of reference shall have effect as if incorporated into the constitution and shall be added to this document as an appendix.

4.3. Delegation of Powers by Committees to Sub-committees

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

4.4. Approval of Appointments to Committees and Sub-Committees

4.4.1. The council of members shall approve the appointments to each of the committees and sub-committees which it has formally constituted. The council of members shall agree such travelling or other allowances as it considers appropriate.

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

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

6. USE OF SEAL AND AUTHORISATION OF DOCUMENTS

6.1. Clinical Commissioning Group’s seal

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

   a) the accountable officer;

   b) the chair of the governing body;

   c) the chief finance officer;

6.2. Execution of a document by signature

6.2.1. The following individuals are authorised to execute a document on behalf of the group by their signature.
a) the accountable officer  
b) the chair of the governing body  
c) the chief finance officer

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

7.1. Policy statements: general principles

7.1.1. The group will from time to time agree and approve policy statements / procedures which will apply to all or specific groups of staff employed by NHS Croydon Clinical Commissioning Group. The decisions to approve such policies and procedures will be recorded in an appropriate group minute and will be deemed where appropriate to be an integral part of the group’s standing orders.
Appendix 4 Scheme of reservation & delegation

1. **Schedule of Matters Reserved to the CCG and Scheme of Delegation**

   1.1 The arrangements made by the CCG as set out in this scheme of reservation and delegation of decisions will have effect as if incorporated in the Constitution.

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

2. **Functions reserved to the Members**

   2.1 The following are reserved for the Members:

   - Amending the inter-practice agreement;
   - Request permission of the NHS Commissioning Board to amend the Constitution;
   - Request to the NHSCB for a statutorily permissible change to the Geography of the CCG;
   - Request to the NHSCB for a statutorily permissible change to the name of the CCG;
   - Proposing de-selection of members of the Governing Body;
   - Merger with another Clinical Commissioning Group where statutorily permissible.

3. The CCG delegate all of its functions at paragraph 2.1 of this scheme of reservation and delegation to the Council of Members

4. **Functions delegated to the Governing Body**

   4.1 All other functions are delegated to the Governing Body.

5. **Functions delegated to the committees and sub-committees of the Governing Body**

   The Governing Body delegates the following functions to the following committees:-
<table>
<thead>
<tr>
<th>Policy Area</th>
<th>Decision</th>
<th>Reserved to the Membership</th>
<th>Reserved or delegated to Governing Body</th>
<th>Accountable Officer</th>
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</thead>
<tbody>
<tr>
<td>REGULATION AND CONTROL</td>
<td>Determine the arrangements by which the members of the CCG approve those decisions that are reserved for the membership.</td>
<td>x</td>
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</tr>
<tr>
<td>REGULATION AND CONTROL</td>
<td>Consideration and approval of applications to the NHS Commissioning Board on any matter concerning changes to the CCG’s constitution, including terms of reference for the CCG’s Governing Body, its committees, membership of committees, the overarching scheme of reservation and delegated powers, arrangements for taking urgent decisions, standing orders and prime financial policies.</td>
<td>x</td>
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</tr>
<tr>
<td>REGULATION AND CONTROL</td>
<td>Exercise or delegation of those functions of the CCG which have not been retained as reserved to the Membership via the Council of Members, delegated to the Governing Body or other committee or sub-committee</td>
<td></td>
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<tr>
<td>Policy Area</td>
<td>Decision</td>
<td>Reserved to the Membership</td>
<td>Reserved or delegated to Governing Body</td>
<td>Accountable Officer</td>
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<tr>
<td>REGULATION AND CONTROL</td>
<td>Prepare the CCG’s overarching scheme of reservation and delegation, which sets out those decisions of the CCG reserved to the membership and those delegated to the:</td>
<td></td>
<td>x</td>
<td>Chief Finance Officer</td>
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<td>o CCG’s Governing Body</td>
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<td>o committee(s) and sub-committee(s) of the CCG, or</td>
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<td>o its members or employees</td>
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<td></td>
<td>and sets out those decisions of the Governing Body reserved to the Governing Body and those delegated to the:</td>
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<td></td>
<td>o Governing Body’s committees and sub-committees,</td>
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<td>o members of the Governing Body,</td>
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<td>o an individual who is member of the CCG but not the Governing Body or a specified person for</td>
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<td>Policy Area</td>
<td>Decision</td>
<td>Reserved to the Membership</td>
<td>Reserved or delegated to Governing Body</td>
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<tr>
<td>REGULATION AND CONTROL</td>
<td>Approval of the CCG’s overarching scheme of reservation and delegation.</td>
<td>x</td>
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</tr>
<tr>
<td>REGULATION AND CONTROL</td>
<td>Prepare the CCG’s operational scheme of delegation, which sets out those key operational decisions delegated to individual employees of the CCG, not for inclusion in the CCG’s constitution.</td>
<td>x</td>
<td></td>
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<tr>
<td>REGULATION AND CONTROL</td>
<td>Approval of the CCG’s operational scheme of delegation that underpins the CCG’s ‘overarching scheme of reservation and delegation’ as set out in its constitution.</td>
<td>x</td>
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<tr>
<td>REGULATION AND CONTROL</td>
<td>Prepare detailed financial policies that underpin the CCG’s prime financial policies.</td>
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<tr>
<td>REGULATION AND CONTROL</td>
<td>Approve detailed financial policies.</td>
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<td>REGULATION AND CONTROL</td>
<td>Approve arrangements for managing exceptional funding</td>
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<td>Policy Area</td>
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<td>Reserved to the Membership</td>
<td>Reserved or delegated to Governing Body</td>
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<tr>
<td>REGULATION AND CONTROL</td>
<td>Set out who can execute a document by signature / use of the seal</td>
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<td>x</td>
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<tr>
<td>PRACTICE MEMBER REPRESENTATIVES AND MEMBERS OF THE GOVERNING BODY</td>
<td>Approve the arrangements for: o identifying practice members to represent practices in matters concerning the work of the CCG; and appointing clinical leaders to represent the CCG’s membership on the CCG’s Governing Body, for example through election (if desired).</td>
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<tr>
<td>PRACTICE MEMBER REPRESENTATIVES AND MEMBERS OF THE GOVERNING BODY</td>
<td>Approve the appointment of Governing Body members, the process for recruiting and removing non-elected members to the Governing Body (subject to any regulatory requirements) and succession planning.</td>
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<td>x</td>
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<tr>
<td>PRACTICE MEMBER REPRESENTATIVES</td>
<td>Approve arrangements for identifying</td>
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<td>Policy Area</td>
<td>Decision</td>
<td>Reserved to the Membership</td>
<td>Reserved or delegated to Governing Body</td>
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<tr>
<td>IVES AND MEMBERS OF THE GOVERNING BODY</td>
<td>the CCG’s proposed Accountable Officer.</td>
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<tr>
<td>STRATEGY AND PLANNING</td>
<td>Agree the vision, values and overall strategic direction of the CCG.</td>
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<tr>
<td>STRATEGY AND PLANNING</td>
<td>Approval of the CCG’s operating structure.</td>
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<tr>
<td>STRATEGY AND PLANNING</td>
<td>Approval of the CCG’s commissioning plan.</td>
<td></td>
<td>x</td>
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<tr>
<td>STRATEGY AND PLANNING</td>
<td>Approval of the CCG’s corporate budgets that meet the financial duties as set out in section 5.3 of the main body of the constitution</td>
<td>x</td>
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<tr>
<td>STRATEGY AND PLANNING</td>
<td>Approval of variations to the approved budget where variation would have a significant impact on the overall approved levels of income and expenditure or the CCG’s ability to achieve its agreed strategic aims.</td>
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<td>x</td>
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<tr>
<td>ANNUAL REPORTS AND ACCOUNTS</td>
<td>Approval of the CCG’s annual report and annual accounts.</td>
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<td>x</td>
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<tr>
<td>ANNUAL REPORTS AND ACCOUNTS</td>
<td>Approval of the arrangements for discharging the CCG’s</td>
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<td>Policy Area</td>
<td>Decision</td>
<td>Reserved to the Membership</td>
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<td>statutory financial duties.</td>
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<tr>
<td>HUMAN RESOURCES</td>
<td>Approve the terms and conditions, remuneration and travelling or other allowances for Governing Body members, including pensions and gratuities.</td>
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<tr>
<td>HUMAN RESOURCES</td>
<td>Approve terms and conditions of employment for all employees of the CCG including, pensions, remuneration, fees and travelling or other allowances payable to employees and to other persons providing services to the CCG.</td>
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<tr>
<td>HUMAN RESOURCES</td>
<td>Approve any other terms and conditions of services for the CCG’s employees.</td>
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<tr>
<td>HUMAN RESOURCES</td>
<td>Determine the terms and conditions of employment for all employees of the CCG</td>
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<tr>
<td>HUMAN RESOURCES</td>
<td>Determine pensions, remuneration, fees and allowances payable to employees and to other persons providing</td>
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<td>Policy Area</td>
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<td>services to the CCG.</td>
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<tr>
<td>HUMAN RESOURCES</td>
<td>Recommend pensions, remuneration, fees and allowances payable to employees and to other persons providing services to the CCG.</td>
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<td></td>
<td>Approve disciplinary arrangements for employees, including the Accountable Officer (where he/she is an employee or member of the CCG) and for other persons working on behalf of the CCG.</td>
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<td></td>
<td>Approval of the arrangements for discharging the CCG’s statutory duties as an employer.</td>
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<tr>
<td>HUMAN RESOURCES</td>
<td>Approve human resources policies for employees and for other persons working on behalf of the CCG</td>
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<tr>
<td>QUALITY AND SAFETY</td>
<td>Approve arrangements, including supporting policies, to minimise clinical risk, maximise patient safety and to secure continuous</td>
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<td>Policy Area</td>
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<td>Reserved to the Membership</td>
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<tr>
<td>QUALITY AND SAFETY</td>
<td>Approve arrangements for supporting the NHS Commissioning Board in discharging its responsibilities in relation to securing continuous improvement in the quality of general medical services.</td>
<td></td>
<td>x</td>
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</tr>
<tr>
<td>OPERATIONAL AND RISK MANAGEMENT</td>
<td>Prepare and recommend an operational scheme of delegation that sets out who has responsibility for operational decisions within the CCG.</td>
<td></td>
<td>x</td>
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<tr>
<td>OPERATIONAL AND RISK MANAGEMENT</td>
<td>Approve the CCG’s counter fraud and security management arrangements</td>
<td></td>
<td>x</td>
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<tr>
<td>OPERATIONAL AND RISK MANAGEMENT</td>
<td>Approval of the CCG’s risk management arrangements.</td>
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<td>x</td>
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<tr>
<td>OPERATIONAL AND RISK MANAGEMENT</td>
<td>Approve arrangements for risk sharing and or risk pooling with other organisations (for example arrangements for pooled funds with other CCGs)</td>
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<tr>
<td>Policy Area</td>
<td>Decision</td>
<td>Reserved to the Membership</td>
<td>Reserved or delegated to Governing Body</td>
<td>Accountable Officer</td>
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<td>or pooled budget arrangements under section 75 of the NHS Act 2006).</td>
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<td>x</td>
</tr>
<tr>
<td>OPERATIONAL AND RISK MANAGEMENT</td>
<td>Approval of a comprehensive system of internal control, including budgetary control, that underpin the effective, efficient and economic operation of the CCG.</td>
<td></td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>OPERATIONAL AND RISK MANAGEMENT</td>
<td>Approve proposals for action on litigation and claims handling against or on behalf of the CCG.</td>
<td>x</td>
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<tr>
<td>OPERATIONAL AND RISK MANAGEMENT</td>
<td>Approve the CCG’s arrangements for business continuity and emergency planning.</td>
<td>x</td>
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<tr>
<td>OPERATIONAL AND RISK MANAGEMENT</td>
<td>Approve the CCG’s arrangements for handling complaints.</td>
<td>x</td>
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<tr>
<td>INFORMATION GOVERNANCE</td>
<td>Approval of the arrangements for ensuring appropriate and safekeeping and confidentiality of records and for the storage, management and transfer of information and data.</td>
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<tr>
<td>TENDERING</td>
<td>Approval of the</td>
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<tr>
<td>Policy Area</td>
<td>Decision</td>
<td>Reserved to the Membership</td>
<td>Reserved or delegated to Governing Body</td>
<td>Accountable Officer</td>
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<tr>
<td>AND CONTRACTING</td>
<td>CCG’s contracts for any commissioning support.</td>
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<tr>
<td>TENDERING AND CONTRACTING</td>
<td>Approval of the CCG’s contracts for corporate support (for example finance provision)</td>
<td></td>
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<tr>
<td>PARTNERSHIP WORKING</td>
<td>Approve decisions delegated to joint committees established under section 75 of the 2006 Act.</td>
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<tr>
<td>COMMISSIONING AND CONTRACTING FOR CLINICAL SERVICES</td>
<td>Approval of the arrangements for discharging the CCG’s statutory duties associated with its commissioning functions, including but not limited to promoting the involvement of each patient, patient choice, reducing inequalities, improvement in the quality of services, obtaining appropriate advice and public engagement and consultation.</td>
<td></td>
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<tr>
<td>COMMISSIONING AND CONTRACTING FOR CLINICAL SERVICES</td>
<td>Approve arrangements for co-ordinating the commissioning of services with other CCGs and or with the local authority(ies), where</td>
<td></td>
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</tr>
<tr>
<td>Policy Area</td>
<td>Decision</td>
<td>Reserved to the Membership</td>
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<tr>
<td>COMMUNICATIONS/INFORMATION GOVERNANCE</td>
<td>Approving arrangements for handling Freedom of Information requests. Determining arrangements for handling Freedom of Information requests. Approving a comprehensive Publication Scheme for the CCG</td>
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Appendix 5 Conflicts of interest policy

This policy sets out how NHS Croydon CCG will manage conflicts of interest arising from the operation of the clinical commissioning group’s council of members and governing body.

1. Why we have a policy

The council of members and governing body of [name of NHS clinical commissioning group] have ultimate responsibility for all actions carried out by staff and committees throughout the clinical commissioning group’s activities. This responsibility includes the stewardship of significant public resources and the commissioning and provision of healthcare to the community. The council of members and governing body is therefore determined to ensure the organisation inspires confidence and trust amongst its patients, staff, partners, funders and suppliers by demonstrating integrity and avoiding any potential or real situations of undue bias or influence in the decision-making of the clinical commissioning group.

This conflict of interest policy respects the seven principles of public life promulgated by the Nolan Committee. The seven principles are:

- selflessness
- integrity
- objectivity
- accountability
- openness
- honesty
- leadership.

The council of members and governing body have a legal obligation to act in the best interests of [name of the NHS clinical commissioning group], and in accordance with the clinical commissioning group’s constitution and terms of establishment created by the NHS Commissioning Board, and to avoid situations where there may be a potential conflict of interest.

Conflicts of interest may arise where an individual’s personal interests, or a connected person’s interests and/or loyalties conflict with those of the clinical commissioning group. Such conflicts may create problems such as inhibiting free discussion which could:

- result in decisions or actions that are not in the interests of the clinical commissioning group and the public it was established to serve
- risk the impression that the clinical commissioning group has acted improperly.

It is not possible, or desirable, to define all instances in which an interest may be a real or perceived conflict. It is for each individual to exercise their judgement in deciding whether to register any interests that may be construed as a conflict. Individuals can seek guidance from the group secretariat, but may decide to declare when in doubt.

The aim of this policy is to protect both the organisation and the individuals involved from any appearance of impropriety and demonstrate transparency to the public and other interested parties.

2. General Medical Council guidance
The General Medical Council (GMC) provides the following general guidance:

- you may wish to note on the patient’s record when an unavoidable conflict of interest arises; and
- if you have a financial interest in an institution and are working under an NHS employers’ policy you should satisfy yourself, or seek other assurance from your employing or contracting body, that systems are in place to ensure transparency and to avoid, or minimise the effects of, conflicts interest. You must follow the procedures governing the schemes.

The GMC also states:

“You must be honest in financial and commercial dealings with employers, insurers and other organisations or individuals. In particular before taking part in discussions about buying or selling goods or services, you must declare any relevant financial or commercial interest that you or your family might have in the transaction.”

Additionally, the GMC’s guidance on managing conflicts of interest states:

If you have financial or commercial interests in organisations providing healthcare or in pharmaceutical or other biomedical companies, these interests must not affect the way you prescribe for, treat or refer patients”.

3. What conflicts does this policy cover?

The council of members and governing body members should declare an interest in the following circumstances:

a) Direct financial interests.
   The most easily recognisable form of conflict of interest arises when a board member obtains, or is perceived to obtain, a direct financial benefit over and above the agreed remuneration and terms of service package agreed by the remuneration committee. Examples include:
   - the award of a contract to a company or other business with which a board member is involved
   - the sale of assets at below market value to a governing body member
   - awarding a contract for provision of health services to a GP practice, in which partners are members of the council of members or governing body.

b) Indirect financial interests
   This arises when a close relative of a governing body member benefits from the decisions of the group. Council of members or governing body members will benefit indirectly if their financial affairs are bound with those of the relative in question through the legal concept of “joint purse”, as would be the case if the relative were the spouse, partner, dependent child of the governing body member, or directly connected in some other way. For example, the council of members or governing body member being involved in a decision to award a contract to an organisation where the member’s spouse is a director.

c) Non-financial or personal interests
   These occur where board members receive no financial benefit, but are influenced by external factors.
For instance:
- to gain some other intangible benefit or kudos;
- awarding contracts to friends or personal business contacts.

d) **Conflicts of loyalty**
Council of members or governing body members may have competing loyalties between the clinical commissioning group to which they owe a primary duty and some other person or entity, including their GP practice, and patients.

Council of members or governing body members should also avoid using knowledge gained in other roles to influence decisions so as to acquire a competitive advantage over other service providers.

4. **The declaration of interests**

Accordingly, we require council of members and governing body members to declare any relevant and material interests, and any gifts or hospitality offered and received in connection with their role in the clinical commissioning group.

Interests that may impact on the work of the governing body and should be declared include:
- Roles and responsibilities held within member practices.
- Membership of a Partnership (whether salaried or profit sharing) seeking to enter into any contacts with [name of NHS clinical commissioning group] and which relate to the functions exercised by the group.
- Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the group.
- Directorships, including non-executive Directorship held in private or public limited companies seeking to enter into contracts with [name of NHS clinical commissioning group] and which relate to the functions exercised by the group.
- Material Shareholdings of companies in the field of health and social care seeking to enter into contracts with the [name of NHS clinical commissioning group] and which relate to the functions exercised by the group.
- Positions of authority in an organisation (e.g. charity or voluntary organisation) in the field of health and social care.
- Any interest that they are (if registered with the General Medical Council) would be required to declare in accordance with paragraph 55 of the GMC’s publication Management for Doctors or any successor guide.
- Any interest that they (if they are registered with the Nursing and Midwifery Council) would be to declare in accordance with paragraph 7 of the NMC’s publication Code of Professional Conduct or any successor Code.
- Any interest which does or might constitute a conflict of interest in relation to the specification for or award of any contract to provide goods or services to [name of NHS clinical commissioning group] and which relate to the functions exercised by the group.
- Any research funding or grants that may be received by the individual or any organisation that they have an interest or role in.
- Any role or relationship which the public could perceive would impair or otherwise influence the individual’s judgement or actions in their role within the group.

5. **Recording Interests**
All council of members and governing body members are required to 1) declare interests following their appointment; 2) update the declaration at least annually and 3) declare their interests in relation to any items on the agenda at the start of each council of members and governing body or committee meeting.

A declaration of interests form is provided for this purpose (Annex A) listing the types of interest you should declare. To be effective, the declaration of interests form must be completed prior to appointment, then updated at least annually and when any material changes occur.

If you are not sure what to declare, or whether/when your declaration needs to be updated, please err on the side of caution. If you would like to discuss this issue, please contact the CCG secretariat for confidential guidance.

Interests and gifts will be recorded on the clinical commissioning group’s register of interests and register of gifts and hospitality, which will be maintained by the group secretariat on behalf of the Accountable Officer. The register will be accessible by the public and inspection of the register of members' interests will be encouraged, as appropriate. Furthermore, council of members or governing body members should not use confidential information acquired in the pursuit of their role to benefit themselves or another connected person.

A section detailing your responsibilities regarding declaring interests at meetings is provided later in this document.

6. Changes of Interests

Where an individual changes role or responsibility within the group any change to the individual’s interest should be declared.

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

7. Data protection

The information provided will be processed in accordance with data protection principles as set out in the Data Protection Act 1998. Data will be processed only to ensure that the council of members and governing body members act in the best interests of the group and the public and patients the group was established to serve. The information provided will not be used for any other purpose, unless otherwise stated within statutory legislation. Signing the declaration form will also signify that you consent to your data being processed for the purposes set out in this policy.

8. Declaring Interests at Meetings

Where the conflict is material to the discussion of the council of members or governing body, that member shall withdraw from discussions pertaining to that agenda item, taking account of the steps in the decision making process (e.g. presentation, questions, deliberations and decision). The conflict and the action will be recorded in the minutes of the meeting and the register of interests updated accordingly.
It is the responsibility of the CCG secretariat to monitor quorum and advise the chair accordingly to ensure it is maintained throughout the discussion and decision of the agenda item. Should the withdrawal of the conflicted director result in the loss of quorum, the item cannot be decided upon at that meeting.

9. Waiver

Where permitted under the clinical commissioning group’s constitution or the conditions of its establishment, the council of members or governing body has the power to waive restrictions on any clinical professional governing body member participating in council of members or governing body business, where to authorise such a conflict would be in the interests of the clinical commissioning group. The application of a waiver can, therefore, be used in the following situations:

- a member of the council of members or governing body is a clinical professional providing healthcare services to the clinical commissioning group that do not exceed the average for other practices and NHS entities commissioned to provide services by the clinical commissioning group; or
- where the council of members or governing body member has a pecuniary interest arising out of the delivery of some professional service on behalf of the clinical commissioning group, and the conflict has been adjudged by the chair and the governance lay member not to bestow any greater pecuniary benefit to other professionals in a similar relationship with the clinical commissioning group.

Where the chair and the governance lay member have approved the use of the waiver, the chair must have discussed it with the Accountable Officer before the meeting. In such circumstances where the waiver is used, the council of members or governing body member:

- must disclose his/her interest as soon as practicable at the start of the meeting
- may participate in the discussion of the matter under consideration; but
- must not vote on the subject under discussion.

The minutes of the meeting will formally record that the waiver has been used, and that this policy and the governing document provisions have been observed in managing that authorised conflict. Where a member has withdrawn from the meeting for a particular item, the group secretariat will ensure that the minutes for that member do not contain such information that may compound the potential conflict, but do not unnecessarily disadvantage the member in their performance of their functions and legal responsibilities.

10. Decisions taken where a council of members or governing body member has an interest

3 Adapted from the NHS Model Standing Orders, Reservation and Delegation Of Powers and Standing Financial Instructions, Department of Health, 2006. It is currently unclear as to whether clinical commissioning groups will be able to implement a similar approach once they become statutory bodies, independent of the primary care trust cluster. This guidance note will be updated accordingly in line with future guidance from the Department of Health or NHS Commissioning Governing body.
In the event of the council of members or governing body having to decide upon a question in which a council of members or governing body member has an interest, all decisions will be made by vote, with a [simple majority] [two thirds majority] required. A quorum must be present for the discussion and decision; interested parties will not be counted when deciding whether the meeting meets quorum. Interested council of members or governing body members must not vote on matters affecting their own interests, even where the use of the waiver has been approved by the chairman and used.

All decisions under a conflict of interest will be recorded by [the CCG secretariat] and reported in the minutes of the meeting. The report will record:

- the nature and extent of the conflict
- an outline of the discussion
- the actions taken to manage the conflict
- use of the waiver and reasons for its implementation.

Where a council of members or governing body member benefits from the decision, this will be reported in the annual report and accounts, as a matter of best practice.

All payments or benefits in kind to council of members or governing body members will be reported in the clinical commissioning group’s accounts and annual report, with amounts for each member listed for the year in question.

Independent external mediation will be used where conflicts cannot be resolved through the usual procedures.

11. Breaches of this policy

Breaches of the policy may result in the council of members or governing body member being removed from office in line with the clinical commissioning group’s constitution.

12. Declaration of Interests in relation to procurement

Where a relevant and material interest or position of influence exists in the context of the specification for, or award of, a contract the member will be expected to:

- Declare the interest;
- Ensure that the interest is recorded in the register;
- Withdraw from all discussion on the specification or award;
- Not have a vote in relation to the specification or award.

Members will be expected to declare any interest early in any procurement process if they are to be a potential bidder in that process. Failure to do this could result in the procurement process being declared invalid and possible suspension of the relevant member from the group.

Potential conflicts will vary to some degree depending on the way in which a service is being commissioned, for example:

- Where a group is commissioning a service through Competitive Tender (i.e. seeking to identify the best provider or set of providers for a service) a conflict of interest may arise where GP practices or other providers in which group members have an interest are amongst those bidding.
- Where the group is commissioning a service through Any Qualified Provider a conflict could arise where one or more GP practices (or other providers in which
group members have an interest) are amongst the qualified providers from whom patients can choose. Guidance within the GMC’s core guidance Good Medical Practice (2006) and reiterated in its document Conflicts of Interest (2008) indicates, in such cases, that:

- “You must act in your patients best interests when making referrals and when providing or arranging treatment of care. You must not ask for or accept any inducement, gift or hospitality which may affect or be seen to affect the way you prescribe, treat or refer patients. You must not offer such inducements to colleagues.
- if you have financial or commercial interest in organisations providing healthcare or in pharmaceutical or other biomedical companies, these interests must not affect the way you prescribe for, treat or refer patients.
- if you have a financial or commercial interest in an organisation to which you plan to refer a patient for treatment or investigation, you must also tell the patient about your interest. When treating NHS patients you must also tell the healthcare provider.”
Appendix 6 Declaration of interest form

This form is required to be completed in accordance with the Constitution.

Notes:

- Within 28 days of a relevant event, members need to register their financial and other interests.
- If any assistance is required to complete this form please contact the CCG Secretariat.
- The signed hard copy of the completed form should be sent to the CCG Secretariat.
- Any changes to interests declared must also be registered within 28 days of the relevant event by completing and submitting a new declaration form.
- The register will be published in the Annual Report.
- Members and employees completing this declaration form must provide sufficient detail of each interest so that a member of the public would be able to understand clearly the sort of financial or other interest the member has and the circumstances in which a conflict of interest with the business or running of the group might arise.
- If in doubt as to whether a conflict of interest could arise, a declaration of the interest should be made.

Interests that must be declared:

1. Roles and responsibilities held within member practices
2. Directorships, including non-executive directorships, held in private companies or PLCs;
3. Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the group
4. Material Shareholdings of companies in the field of health and social care;
5. Positions of authority in an organisation (e.g. charity or voluntary organisation) in the field of health and social care.
6. Any connection with a voluntary or other organisation contracting for NHS Services;
7. Research/funding grants that may be received by the individual or any organisation they have an interest or role in;
8. Any other role or relationship which the public could perceive would impair or otherwise influence the individual's judgement or actions in their role with the group.

Whether such interests are those of the individual themself, a family member, any other relationship or other acquaintance of the individual.
### DECLARATION:

<table>
<thead>
<tr>
<th>Type of Interest</th>
<th>Details</th>
<th>Personal interest or that of a family member, close friend or other acquaintance?</th>
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<tbody>
<tr>
<td>Roles and Responsibilities held within member practices</td>
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<tr>
<td>Directorships, including non-executive directorships, held in private companies or PLCs</td>
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<td>Ownedships or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the CCG</td>
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<tr>
<td>Shareholdings (more than 5%) of companies in the field of health and social care</td>
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<tr>
<td>Positions of authority in an organisation (e.g. charity or voluntary organisation) in the field of health and social care</td>
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<tr>
<td>Any connection with a voluntary or other organisation contracting for NHS services</td>
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</tr>
<tr>
<td>Research funding/ grants that may be received by the individual or any organisation they have an interest or role in.</td>
<td></td>
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<tr>
<td>Any other role or relationship which the public could perceive would impair or otherwise influence the individual's judgement or actions in their role within the CCG</td>
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I have read and understood the group policy on conflicts of interest and agree to abide by it. I understand that it is against the law to accept inducements or rewards or to corruptly show favour or disfavour in an official capacity. To the best of my knowledge and belief, the above information is complete and correct. I undertake to update as necessary the information provided and to review the accuracy of the information.
provided regularly and no longer than annually. I give my consent for the information to be used for the purposes described in the CCG Constitution and published accordingly.

Signed: …………………………………………………………………………………………………… Date: ……………………

……………………………..
Appendix 7 Prime Financial Policies

1. INTRODUCTION

1.1. General

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

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

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

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

1.1.5. A list of the group’s detailed financial policies will be published and maintained on the group’s website at www.[insert group’s website].

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

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

1.2. Overriding Prime Financial Policies

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

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

1.3.2. The financial decisions delegated by members of the group are set out in the group’s Scheme of Reservation and Delegation (see Appendix D).

1.4. Contractors and their employees

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

1.5. Amendment of Prime Financial Policies

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

2. INTERNAL CONTROL

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

2.1. The Governing Body is required to establish an Audit Committee with terms of reference agreed by the Governing Body (see paragraph 6.6.3(a) of the group’s constitution for further information).

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

2.3. The Chief Finance Officer will ensure that:

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

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

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

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

3.1. In line with the terms of reference for the Governing Body’s Audit Committee, the person appointed by the group to be responsible for internal audit and the Audit Commission appointed external auditor will have direct and unrestricted access to Audit Committee members and the Chair of the Governing Body, Accountable Officer, Chief Finance Officer and Local Counter Fraud Specialist (where relevant) for any significant issues arising from audit work that management cannot resolve, and for all cases of fraud or serious irregularity.

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

3.3. The Chief Finance Officer will ensure that:

   a) the group has a professional and technically competent internal audit function; and

   b) the Governing Body’s Audit Committee approves any changes to the provision or delivery of assurance services to the group.

4. **FRAUD, CORRUPTION AND BRIBERY**

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

4.1. The Governing Body’s Audit Committee will satisfy itself that the group has adequate arrangements in place for countering fraud and shall review the outcomes of counter fraud and anti-bribery work. It shall also approve the counter fraud work programme.

4.2. The Governing Body’s Audit Committee will ensure that the group has arrangements in place to work effectively with NHS Protect.

4.3. The Bribery Act 2010, which repealed existing corruption legislation, has introduced the offences of offering and receiving a bribe. It also places specific responsibility on organisations to have sufficient and adequate procedures in place to prevent bribery and corruption taking place. Under the Bribery Act 2010, Bribery is defined as “Inducement for an action which is illegal, unethical or a breach of trust. Inducements can take the form of gifts, loans, rewards or other privileges”. Corruption is broadly defined as “the offering or acceptance of inducements, gifts, favours, payment or benefit-in-
kind which may influence the action of any person. Corruption does not always result in a loss. The corrupt person may not benefit directly from their deeds; however, they may be unreasonably using their position to give some advantage to another”. To demonstrate that the organisation has sufficient and adequate procedures in place and to demonstrate openness and transparency, all staff are required to comply with the requirements of the Prime Financial Policies. For more detailed information, please see the Anti-Bribery policy.

5. EXPENDITURE CONTROL

5.1. The group is required by statutory provisions⁴ to ensure that its expenditure does not exceed the aggregate of allotments from the NHS Commissioning Board and any other sums it has received and is legally allowed to spend.

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

5.3. The Chief Finance Officer will:

   a) provide reports in the form required by the NHS Commissioning Board;
   
   b) ensure money drawn from the NHS Commissioning Board is required for approved expenditure only is drawn down only at the time of need and follows best practice;
   
   c) be responsible for ensuring that an adequate system of monitoring financial performance is in place to enable the group to fulfil its statutory responsibility not to exceed its expenditure limits, as set by direction of the NHS Commissioning Board.

6. ALLOTMENTS⁵

6.1. The group’s Chief Finance Officer will:

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

7. COMMISSIONING STRATEGY, BUDGETS, BUDGETARY CONTROL AND MONITORING

⁴ See section 223H of the 2006 Act, inserted by section 27 of the 2012 Act
⁵ See section 223(G) of the 2006 Act, inserted by section 27 of the 2012 Act.
POLICY – the group will produce and publish an annual commissioning plan\(^6\) that explains how it proposes to discharge its financial duties. The group will support this with comprehensive medium term financial plans and annual budgets.

7.1. 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.

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

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

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

7.5. The Governing Body will approve consultation arrangements for the group’s commissioning plan\(^7\).

8. ANNUAL ACCOUNTS AND REPORTS

POLICY – the group will produce and submit to the NHS Commissioning Board accounts and reports in accordance with all statutory obligations\(^8\), relevant accounting standards and accounting best practice in the form and content and at the time required by the NHS Commissioning Board.

8.1. The Chief Finance Officer will ensure the group:

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

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

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

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

e) publishes the external auditor’s management letter on the group’s website at www.[insert group’s website].

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\(^7\) See section 14Z13 of the 2006 Act, inserted by section 26 of the 2012 Act.

\(^8\) See paragraph 17 of Schedule 1A of the 2006 Act, as inserted by Schedule 2 of the 2012 Act.
9. INFORMATION TECHNOLOGY

**POLICY** – the group will ensure the accuracy and security of the group’s computerised financial data

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

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

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

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

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

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

10. ACCOUNTING SYSTEMS

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

10.1. The Chief Finance Officer will ensure:

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

   b) that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.
10.2. Where another health organisation or any other agency provides a computer service for financial applications, the Chief Finance Officer shall periodically seek assurances that adequate controls are in operation.

11. BANK ACCOUNTS

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

11.1. The Chief Finance Officer will:

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

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

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

11.2. The Audit Committee shall approve the banking arrangements.

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

**POLICY** – the group will

- operate a sound system for prompt recording, invoicing and collection of all monies due
- seek to maximise its potential to raise additional income only to the extent that it does not interfere with the performance of the group or its functions
- ensure its power to make grants and loans is used to discharge its functions effectively

12.1. The Chief Financial Officer is responsible for:

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

   b) establishing and maintaining systems and procedures for the secure handling of cash and other negotiable instruments;

   c) approving and regularly reviewing the level of all fees and charges other than those determined by the NHS Commissioning Board or by statute. Independent professional advice on matters of valuation shall be taken as necessary;

   d) for developing effective arrangements for making grants or loans.

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9 See section 223H(3) of the NHS Act 2006, inserted by section 27 of the 2012 Act
10 See section 14Z5 of the 2006 Act, inserted by section 26 of the 2012 Act.
13. TENDERING AND CONTRACTING PROCEDURE

POLICY – the group:

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

13.1. The Chief Finance Officer may only negotiate contracts on behalf of the group, and the group may only enter into contracts, within the statutory framework set up by the 2006 Act, as amended by the 2012 Act. Such contracts shall comply with:

a) the group’s standing orders;

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

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

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

13.3. The group should also follow the detailed procedures set out in Annex A and as set out in the detailed procurement guide.

14. COMMISSIONING

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

14.1. The group will coordinate its work with the NHS Commissioning Board, other clinical commissioning groups, local providers of services, local authority(ies), including through Health & Wellbeing Boards, patients and their carers and the voluntary sector and others as appropriate to develop robust commissioning plans.
14.2. The Accountable Officer will establish arrangements to ensure that regular reports are provided to the [Audit/Finance] Committee detailing actual and forecast expenditure and activity for each contract.

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

15. **RISK MANAGEMENT AND INSURANCE**

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

15.1. The Governing Body will agree the assurance framework and risk management strategy.

15.2. The assurance framework will be developed by:

   a) The Governing Body agreeing the principal objectives at strategic level with involvement of the Management Team and Council of Members.
   b) Identifying the risks to the achievement of these objectives and recording these within the Assurance Framework;
   c) Identifying the key controls intended to manage these risks
   d) Evaluating the assurances available to cover these objectives and risks together with any gaps;
   e) Putting in place action plans are to address any gaps that have been identified; and
   f) Monitoring the implementation of the action plans

15.3. This work will be supported and coordinated by the [Head of Governance and Business Support – or equivalent]

15.4. The Accountable Officer has an overall responsibility for risk management

15.5. The [Integrated Governance Committee or equivalent] will oversee the management of the assurance framework ensuring that it meets the needs of the CCG in being able to identify and reduce risk:

15.6. a) Reviewing the framework and making recommendations for action within the organisation to improve controls, seek assurances and reduce risk;
   b) Reporting progress to reduce risk against identified outcomes six monthly to the Governing Body.

15.7. The risk register will be reviewed monthly by the Management Team

16. **PAYROLL**

| POLICY – the group will put arrangements in place for an effective payroll service |

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

   a) is supported by appropriate (i.e. contracted) terms and conditions;
b) has adequate internal controls and audit review processes;

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

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

17. NON-PAY EXPENDITURE

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

17.1. The Finance Committee will approve the level of non-pay expenditure on an annual basis and the Accountable Officer will determine the level of delegation to budget managers.

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

17.3. The Chief Finance Officer will:

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

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

c) be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable.

17.4. Joint Finance Arrangements with Local Authorities and Voluntary Bodies

The governing body may confirm contracts to purchase from a voluntary organisation or a local authority using its powers under Section 256 of the NHS Act 2006. The Board may confirm contracts to transfer money from the NHS to the voluntary sector or the health related functions of local authorities where such a transfer is to fund services to improve the health of the local population more effectively than equivalent expenditure on NHS services, using its powers under Section 256 of the NHS Act 2006, as amended by section 29 of the Health Act 1999.

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

POLICY – the group will put arrangements in place to manage capital investment, maintain an asset register recording fixed assets and put in place polices to secure the safe storage of the group's fixed assets

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

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

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

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

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

19. DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

19.1. Disposals and Condemnations

19.1.1. Procedures

The Chief Finance Officer must prepare detailed procedures for the disposal of assets including condemnations, and ensure that these are notified to managers.

a) When it is decided to dispose of a group asset, the Head of Department or authorised deputy will determine and advise the Chief Finance Officer of the estimated market value of the item, taking account of professional advice where appropriate. The disposal of any asset with a book value or estimated market value greater than £50,000 shall require prior approval of the governing body.

19.1.2. All unserviceable articles shall be:

b) condemned or otherwise disposed of by an employee authorised for that purpose by the Chief Finance Officer;

c) recorded by the Condemning Officer in a form approved by the Chief Finance Officer which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Chief Finance Officer.

19.1.3. The Condemning Officer shall satisfy himself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Chief Finance Officer who will take the appropriate action.

19.2. Losses and Special Payments

19.3.1. Procedures
The Chief Finance Officer must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments by way of a “Condemning and Disposal Policy”.

19.3.2. Any employee or officer discovering or suspecting a loss of any kind must either immediately inform their Head of Department, who must immediately inform the Accountable Officer and the Chief Finance Officer or inform an officer charged with responsibility for responding to concerns involving loss. This officer will then appropriately inform the Chief Finance Officer and/or Accountable Officer. Where a criminal offence is suspected, the Chief Finance Officer must immediately inform the police if theft or arson is involved. In cases of fraud, corruption and bribery or of anomalies which may indicate fraud, corruption or bribery, the Chief Finance Officer must inform the relevant Local Counter Fraud Specialist (LCFS) who will then notify NHS Protect in accordance with Secretary of State for Health’s Directions.

19.3. Suspected fraud

The Chief Finance Officer must notify NHS Protect and the External Auditor of all frauds.

19.3.3. For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the Chief Finance Officer must immediately notify:

a) the Governing body,
b) the External Auditor, and
c) the Local Security Management Specialist

19.3.4. Within limits delegated to it by the Department of Health, the Board shall approve the writing-off of losses.

19.3.5. The Chief Finance Officer shall specify to the shared service provider to take any necessary steps to safeguard the group’s interests in bankruptcies and company liquidations.

19.3.6. For any loss, the Chief Finance Officer should consider whether any insurance claim can be made.

19.3.7. The Chief Finance Officer shall maintain a Losses and Special Payments Register in which write-off action is recorded.

19.3.8. No special payments exceeding delegated limits shall be made without the prior approval of the Department of Health.

19.3.9. All losses and special payments must be reported to the Audit Committee at every meeting.

19.3.10. No payment(s) exceeding delegated limits determined by the governing body shall be made without the prior approval of the Chief Finance Officer. This requirement will also be specified to the Shared Service provider in the Service Level Agreement.
20. RETENTION OF RECORDS

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

20.1. The Accountable Officer shall:

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

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

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

21. TRUST FUNDS AND TRUSTEES

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

21.1. The Chief Finance Officer shall ensure that each trust fund which the group is responsible for managing is managed appropriately with regard to its purpose and to its requirements.
Appendix 8: 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)*
9 Collaborative commissioning MOU

Memorandum of Understanding

Purpose of document

This memorandum of understanding (M.O.U) and lays out the framework for relationships, roles and responsibilities between South West London Clinical Commissioning Groups (SWL CCGs) including Croydon CCG, Kingston CCG, Merton CCG, Richmond CCG, Sutton CCG and Wandsworth CCG. The SWL CCGs have identified a number of areas where they wish to collaborate to support effective clinical commissioning to improve quality, outcomes and value for money for their residents.

Context

Clinical leaders have agreed to a model for commissioning support that;

- Ensures commissioning resources are predominantly locally based, for example each CCG will retain local lead commissioners for both acute and non-acute commissioning as well as support to develop local CCG strategy, QIPP and service re-design work

- A common set of commissioning support functions purchased from South London Commissioning Support Services (SL CSS)

- Identified a small set of areas where CCGs wish to collaborate, i.e. bring together, co-ordinate and align existing resources to support clinical commissioning.

The diagram below summarises the model for commissioning support. This M.O.U. should be read alongside the South West London Framework for collaboration, which describes how the model for commissioning support will work in practice in greater detail.

The document is structured to include the following:

1. General commitments

2. Acute Commissioning

3. Mental Health

4. Out of hospital

5. Continuing Health care

6. Strategy contingency fund

Full copy of the MOU is available via the website at xxxxxx
Appendix 10  Member practice accountability agreement

1. Statement of Intent between Practices

The vision of the NHS Croydon CCG is to work together as member practices in a consortium arrangement, to provide and to commission patient centred services which focus on patients’ well being as well as their health needs. As a member of the NHS Croydon CCG, all practices within the group sign up to the following:

a) Nominate a Lead within each practice to liaise and meet with the CCG and Network group as required
b) Members agree to the Network Terms of Reference
c) One of the elected Clinical Leadership Group will chair the Network group meetings, attend Clinical Commissioning related meetings, liaise with other Network groups within Croydon and report back to NHS Croydon CCG as appropriate
d) Decisions on the operation of NHS Croydon CCG will be made on a majority vote of the Executive Board. In cases where there is a split decision, the chair shall have the casting vote.
e) Each group member is held to account for the assigned key role to support NHS Croydon CCG
f) Share referral data and prescribing data electronically
g) Support analysis of patient pathways within the local health system with a view to improving services in a cost effective manner, sensitive to the implications for existing services
h) Share specialist skills within the CCG
i) Share resources available for Network, in a manner agreed by NHS Croydon CCG
j) Support performance management framework in terms of activity, finance and quality
k) Maintain a willingness to appreciate that Clinical Commissioning is a shared agenda between practices
l) Each practice will operate within their budget and there should be financial balance across the Network group. For the Network group to work with each practice to ensure that where there is an overspend, there is a coherent strategy for recovery
m) Practices will normally be expected to introduce and implement all primary care pathways supported by NHS Croydon CCG.
Appendix 11  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.
Appendix 12  Terms of reference

All T of R now need to be checked against the standing orders for wording and accuracy. Once we have agreed the final structure we can then embed in the standing orders.