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FOREWORD

As the system of the NHS continues to evolve, our Clinical Commissioning Group (CCG) aims to keep patients at the heart of all we do. The core of our vision is to ensure the people of Newcastle and Gateshead get the best quality care and to make sure our priorities are driven by involvement of people and communities so that we better meet their needs.

This constitution sets out the arrangements made by NHS Newcastle Gateshead Clinical Commissioning Group, to meet its responsibilities including commissioning care for the people for whom it is responsible. It describes the governing principles, rules and procedures that the CCG will establish to ensure probity and accountability in the day to day running of the CCG; 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 CCG.

The constitution includes:

- the name of the CCG
- the membership of the CCG
- the area of the CCG
- the arrangements for the discharge of the CCG’s functions and those of its Governing Body
- the procedure to be followed by the CCG and its Governing Body in making decisions and securing transparency in its decision making
- arrangements for discharging the CCG’s duties in relation to registers of interests and managing conflicts of interests
- arrangements for securing the involvement of persons who are, or may be, provided with services commissioned by the CCG in certain aspects of those commissioning arrangements and the principles that underpin these

The Constitution applies to the following:

- the CCG’s member practices
- the CCG’s employees
- individuals working on behalf of the CCG and
- anyone who is a member of the CCG’s Governing Body (including the Governing Body, audit committee, remuneration committee, quality, safety and risk committee and the executive committee)
- anyone who is a member of any other committee(s) or sub-committees established by the CCG or its Governing Body

Dr Guy Pilkington
Chair, NHS Newcastle Gateshead Clinical Commissioning Group
INTRODUCTION AND COMMENCEMENT

1.1. Name

1.1.1. The name of this clinical commissioning Group is NHS Newcastle Gateshead Clinical Commissioning Group.

1.2. Statutory Framework

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

1.2.2. The NHS Commissioning Board is responsible for determining applications from prospective CCGs to be established as clinical commissioning groups⁴ and undertakes an annual assessment of each established CCG.⁵ It has powers to intervene in a clinical commissioning group where it is satisfied that a CCG is failing or has failed to discharge any of its functions or that there is a significant risk that it will fail to do so.⁶

1.2.3. Clinical commissioning groups are clinically led membership organisations made up of general practices. The members of the clinical commissioning group are responsible for determining the governing arrangements for their organisations, which they are required to set out in a constitution.⁷

1.3. Status of this Constitution

1.3.1. This constitution is made between the members of NHS Newcastle Gateshead Clinical Commissioning Group and has effect from the First of April 2015, when the NHS Commissioning Board established the CCG.⁸ The constitution is published on the CCG’s website at www.newcastlegatesheadccg.nhs.uk.

A copy of the Constitution is also available upon request for inspection at the CCG’s headquarters, upon application by post (NHS Newcastle Gateshead CCG, Riverside House, Goldcrest Way)

¹ See section 1I of the 2006 Act, inserted by section 10 of the 2012 Act
² See section 275 of the 2006 Act, as amended by paragraph 140(2)(c) of Schedule 4 of the 2012 Act
³ Duties of Clinical commissioning groups to commission certain health services are set out in section 3 of the 2006 Act, as amended by section 13 of the 2012 Act
⁴ See section 14C of the 2006 Act, inserted by section 25 of the 2012 Act
⁵ See section 14Z16 of the 2006 Act, inserted by section 26 of the 2012 Act
⁶ See sections 14Z21 and 14Z22 of the 2006 Act, inserted by section 26 of the 2012 Act
⁷ See in particular sections 14L, 14M, 14N and 14O of the 2006 Act, inserted by section 25 of the 2012 Act and Part 1 of Schedule 1A to the 2006 Act, inserted by Schedule 2 to the 2012 Act and any regulations issued
⁸ See section 14D of the 2006 Act, inserted by section 25 of the 2012 Act
1.4. Amendment and Variation of this Constitution

1.4.1 The member practices of the CCG and/or committees acting on their behalf may want to propose a variation to this constitution. Such proposals can be made at any time. Any proposal to vary the constitution will be considered by and will be subject to the approval of the member practices, as set out in the scheme of reservation and delegation.9

i. If a proposal to vary the constitution is approved by the member practices, application will be made to the NHS Commissioning Board.

ii. This constitution can only be varied in two circumstances.10

a) where the CCG applies to NHS England and that application is granted; or

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

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9 See scheme of reservation and delegation, appendix E to this constitution

10 See sections 14E and 14F of the 2006 Act, inserted by section 25 of the 2012 Act and any regulations issued
AREA COVERED

2.1 The geographical area covered by NHS Newcastle Gateshead Clinical Commissioning group is coterminous with the boundary of Newcastle City Council and Gateshead Council. The work of the CCG will be based on the two units of planning which are consistent with the two local authority footprints.
MEMBERSHIP

3.1 Membership of the Clinical Commissioning Group

3.1.1 The members of the CCG are listed in Appendix B.

3.1.2 Appendix B of the Constitution contains the list of practices that comprise the CCG, and has been signed by a representative of each Practice on behalf of the Practice confirming their agreement to the Constitution.

3.2 Eligibility

3.2.1 Providers of primary medical services to a registered list of patients under a General Medical Services, Personal Medical Services or Alternative Provider Medical Services contract, will be eligible to apply for membership of this CCG.\(^\text{11}\)

3.3 Member Engagement

3.3.1 The member practices of NHS Gateshead CCG, NHS Newcastle North and East CCG and NHS Newcastle West CCG were consulted on a proposed ‘Case for Change’ which would create a merged CCG and dissolve the three existing CCGs.

3.3.2 The proposal was accepted via a formal ballot of members in January 2014.

3.3.3 The creation of a merged, single CCG necessitated a review and revision to the high-level committee structure of the organisation. Whereas the three CCGs cited in 3.3.1 above each had a Practices Board, there was recognition that such a group would not be viable for a single CCG of 66 member practices.

3.3.4 Member representatives agreed a structure which includes the formation of a commissioning forum, which is outlined at 6.5.3 below.

MISSION, VISION AND VALUES

4.1 Mission

The CCG is committed to the principles of the NHS and as such the values that lie at the heart of the CCG’s work are consistent with those upheld by the NHS Constitution. These are:

i. **Commitment to Quality of Care:** We insist on quality and strive to get the basics right every time. We welcome feedback, learn from our mistakes and build on our successes.

ii. **Working together for patients:** We put patients first in everything we do. We put the needs of patients and communities before organisational boundaries.

\(^{11}\) See section 14A(4) of the 2006 Act, inserted by section 25 of the 2012. Regulations to be made
iii. **Compassion:** We respond with humanity and kindness to each person’s pain, distress, anxiety or need.

iv. **Improving Lives:** We strive to improve health and well-being and people’s experiences of the NHS.

v. **Respect & Dignity:** We value each person as an individual, respect their aspirations and commitments in life and seek to understand their priorities, needs, abilities and limits.

vi. **Everyone Counts:** We use our resources for the benefit of the whole community and recognise that we all have a part to play in making ourselves and our communities healthier.

### 4.2 Values

4.2.1 The values that lie at the heart of the CCG’s work are:
- Integrity
- Transparency
- Equity
- Humanity
- Consistency
- Accountability
- Responsibility
- Optimal Health Outcomes

4.2.2 The CCG aims to work within the following key characteristics at all times:
- Principle not rule based, underpinned by empirical evidence
- Professional, efficient and effective
- Supportive and inspirational
- Trustworthy
- Respectful in all our actions
- Patient, Community and partner focused
- Firm but flexible; realistic and pragmatic; confident & authoritative
- Learning and innovation friendly
- Courageous

4.2.3 The CCG will:
- Be a lean organisation retaining expert advice, co-producing health strategy with the Local Authorities and our population.
- Strive for excellence, through the setting of increasingly high standards
- Value People – public, patients, staff and stakeholders.
- Be professional
- Be honest, open and transparent
- Make the best use of available resources.
- Deliver system wide improvement in patient outcomes and cost effectiveness.
4.2.4 The CCG, leadership will:
- Behave in line with the Code of Conduct for NHS Managers/Nolan Principles.
- Acknowledge the voice of all CCG members.
- Corporately support any decisions made.
- Fulfil the requirements – and be managed against set criteria - of the roles they undertake.
- Engage or consult as required with the public and other stakeholders.

4.3 Vision/Aims

4.3.1 The CCG aims to be successful with our success being defined through innovation, public engagement, educational programmes, clinical leadership and delivery of health gain. We define health gain as the difference between our local morbidity and mortality rates and that expected given the socio-economic status of our population.

4.3.2 The CCG aims are:

i. To improve health and reduce health inequalities.

ii. To improve the quality of service we offer our patients.

iii. To improve equity of the services available.

iv. To improve the health and wellbeing outcomes achieved by our patients.

v. To embrace the principles of cost effectiveness and improve value for money, in order to ensure we deliver an overall balanced budget.

By retaining this focus, in the order shown, the CCG will ensure it does not make decisions simply to try and deliver efficiency at the detriment of the commissioned services.

The aims of working in this way are to ensure the CCG delivers optimal health outcomes, taking into account both quality and safety, and that public money is spent in a way which if efficient and effective will result in:

a) Improved effectiveness of prescribing & referrals.

b) Care delivered in the most appropriate setting: Right care, right time and right place.

c) Communities and patients are actively involved in commissioning and resource decisions.

d) An education programme for patients and carers to accept more control and responsibility.

e) Reform and co-ordination of community based services.

f) Reduced bureaucracy but improved flow of intelligent information.

g) Effective co-ordination with Public Health, Local Authority, Social and Voluntary care.

h) System-wide improvement in patient outcomes and cost-effectiveness.
The focus of the CCG will be to increase local clinical and stakeholder involvement in decisions about how services should be accessed, provided and designed for patients; moving towards commissioning with a health outcomes focus. In order to achieve this, the CCG will deliver complete pathways, which include a clear focus upon prevention. It is the role of the CCG, to manage transition to a service focused upon prevention rather than treatment. As part of that process, the CCG will support innovation and seize the opportunities that are available to improve the health and wellbeing of the population they serve.

4.3.3 The CCG will:

i. Care for people in a seamless way that is not restricted by either organisational or professional boundaries.

ii. Ensure commissioning is clinically led and driven by patient and carer involvement.

iii. Improve the quality of health services and ensure the people of Newcastle and Gateshead live longer, happier and healthier lives.

iv. Commissioning for quality is an integral part of the CCG’s vision and encompasses the three key components of quality: patient safety, clinical effectiveness and patient experience.

v. Embrace the principles of cost effectiveness and improving value for money, in order to ensure we deliver an overall balanced budget.

4.4 Principles of Good Governance

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

i. 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;

ii. The Good Governance Standard for Public Services (2004);

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

iv. the seven key principles of the NHS Constitution;

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12 Inserted by section 25 of the 2012 Act
13 The Good Governance Standard for Public Services, The Independent Commission on Good Governance in Public Services, Office of Public Management (OPM) and The Chartered Institute of Public Finance & Accountability (CIPFA), 2004
14 See Appendix F
v. the Equality Act 2010.\(^{16}\)


## 4.5 Accountability

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

i. publishing its constitution;

ii. appointing independent lay members and non GP clinicians to its governing body;

iii. holding meetings of its governing body in public (except where the CCG considers that it would not be in the public interest in relation to all or part of a meeting);

iv. publishing annually a commissioning plan;

v. complying with local authority health overview and scrutiny requirements;

vi. meeting annually in public to publish and present its annual report (which must be published);

vii. producing annual accounts in respect of each financial year which must be externally audited;

viii. having a published and clear complaints process;

ix. complying with the Freedom of Information Act 2000;

x. providing information to the NHS Commissioning Board as required;

xi. In addition to these statutory requirements, the CCG will demonstrate its accountability by:

a) ensuring all CCG decisions are made through a clear, rational and transparent prioritisation process, made in an open and transparent manner to ensure the CCG behaves with probity, abiding by the principles of good governance.

\(^{15}\) See Appendix G

4.5.2 The governing body of the CCG will throughout each year have an ongoing role in reviewing the CCG’s governance arrangements to ensure that the CCG continues to reflect the principles of good governance.

FUNCTIONS AND GENERAL DUTIES

5.1 Functions

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

i. commissioning certain health services (where the NHS Commissioning Board is not under a duty to do so) that meet the reasonable needs of:

a) all people registered with member GP practices, and
b) people who are usually resident within the area and are not registered with a member of any clinical commissioning group;

ii. commissioning emergency care for anyone present in the CCG’s area;

iii. 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 CCG’s employees;

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

5.1.2 In discharging its functions the CCG will:

i. act\textsuperscript{17}, 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 \textit{promote a comprehensive health service}\textsuperscript{18} and with the objectives and requirements placed on the NHS Commissioning Board through \textit{the mandate}\textsuperscript{19} published by the Secretary of State before the start of each financial year by:

a) delegating responsibility to the CCG’s governing body.
b) ensuring that this duty is discharged on behalf of the governing body by the CCG’s executive committee in accordance with their Terms of Reference.
c) developing an annual commissioning plan in accordance with the requirement of the Health and Social Care Act 2012.

\textsuperscript{17} See section 3(1F) of the 2006 Act, inserted by section 13 of the 2012 Act
\textsuperscript{18} See section 1 of the 2006 Act, as amended by section 1 of the 2012 Act
\textsuperscript{19} See section 13A of the 2006 Act, inserted by section 23 of the 2012 Act
d) requiring progress of delivery of the duty to be monitored through the CCG’s reporting mechanisms.

**ii. meet the public sector equality duty**{superscript 20} by:

a) delegating responsibility to the CCG’s governing body.
b) ensuring that this duty is discharged on behalf of the governing body by the CCG’s Quality, Safety and Risk Committee in accordance with their Terms of Reference.
c) using the Equality Delivery System, developing an annual equality, diversity and human rights strategy describing how the CCG will deliver duties both specific and general in line with the Equality Act 2010.
d) requiring progress of delivery of the duty to be monitored through the CCG’s reporting mechanisms.
e) publish, at least annually, sufficient information to demonstrate compliance with this duty across all their functions.

**iii.** work in partnership with Newcastle City Council and Gateshead Council to develop **joint strategic needs assessments**{superscript 21} and **joint health and wellbeing strategies**{superscript 22} by:

a) working in partnership with the Newcastle Wellbeing for Life Board and the Gateshead Health and Wellbeing Board. A CCG governing body member is a member of the Newcastle Wellbeing for Life Board and the Gateshead Health and Wellbeing Board and the minutes are received by the CCG governing body.

**5.2 General Duties** - in discharging its functions the CCG 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{superscript 23} by:

i. Ensuring that patients and the public are consulted with and involved in accordance with the relevant legislation. This will include publishing a strategy for communications and engagement.

ii. The following Statement of Principles will be adopted:

a) Create an organisational culture that encourages and enables involvement
b) Be inclusive and proactive in resolving barriers to effective involvement and participation.

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{superscript 20} See section 149 of the Equality Act 2010, as amended by paragraphs 184 and 186 of Schedule 5 of the 2012 Act

{superscript 21} See section 116 of the Local Government and Public Involvement in Health Act 2007, as amended by section 192 of the 2012 Act

{superscript 22} See section 116A of the Local Government and Public Involvement in Health Act 2007, as inserted by section 191 of the 2012 Act

{superscript 23} See section 14Z2 of the 2006 Act, inserted by section 26 of the 2012 Act

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c) Make clear the purpose of involvement and the extent to which people can expect their views to influence development of local health services.

d) Recognise the importance of providing feedback to people who have made their views known.

e) Work in partnership with other agencies to avoid duplication where possible when approaching the public.

f) Build upon best practice and be open to innovative and proven approaches from within and outwith the NHS.

g) Provide support and training to staff to equip them for this role.

iii. In delivering the Statement of Principle the CCG will:

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

b) Adapt engagement activities to meet the specific needs of the different patient CCGs and communities.

c) Publish information about health services on the CCG’s website and through other media.

d) Encourage and act on feedback.

e) Identify how the CCG will monitor and report its compliance against this statement of principles.

iv. the CCG will exercise this function by delegating responsibility to the CCG’s governing body:

a) by ensuring that this duty is discharged on behalf of the governing body by the Accountable Officer and the specific lead officer delegated by the Accountable Officer to oversee its discharge, having regard to any guidance or requirements published by the NHS Commissioning Board.

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\(^\text{24}\) by:

i. delegating responsibility to the CCG’s Governing Body.

ii. the CCG’s values reflecting the values set out in the NHS Constitution.

iii. all policies having regard to the NHS Constitution in their development.

iv. ensuring that all decisions made by the Governing Body are assessed for regard to the NHS Constitution.

v. promoting the NHS Constitution on the CCG’s website and internally with all staff.

\(^{24}\) See section 14P of the 2006 Act, inserted by section 26 of the 2012 Act and section 2 of the Health Act 2009 (as amended by 2012 Act)
vi. incorporating compliance with the NHS Constitution in all contracts with commissioned services.

vii. ensuring the CCG promotes the NHS Constitution, championing the interests of patients, using choice and information to empower people to improve services.

5.2.3 **Act effectively, efficiently and economically**\(^{25}\) by:

i. delegating responsibility to the CCG’s governing body.

ii. ensuring that this duty is discharged on behalf of the governing body by the Accountable Officer in accordance with the responsibilities of the role, having regard to any guidance or requirements published by the NHS Commissioning Board.

iii. delegating responsibility to the governing body’s Audit Committee to provide assurance to the governing body with regard to its compliance with the duty and in accordance with the Committee’s Terms of Reference.

iv. delegating responsibility to The Executive Committee to assist in optimising the allocation and adequacy of the CCG’s resources in accordance with its Terms of reference.

v. requiring progress of delivery of the duty to be monitored through the CCG’s reporting mechanisms.

5.2.4 **Act with a view to securing continuous improvement to the quality of services**\(^{26}\) by:

i. delegating responsibility to the CCG’s governing body.

ii. ensuring that this duty is discharged on behalf of the governing body by the Accountable Officer and the specific lead officer delegated by the Accountable Officer to oversee its discharge, having regard to any guidance or requirements published by the NHS Commissioning Board.

iii. delegating responsibility to the governing body’s Quality, Safety and Risk Committee to assist the governing body in regard to discharge of the duty and in accordance with the Committee’s Terms of Reference.

iv. having a framework for securing continuous improvements in the quality of commissioned services and outcomes for patients with regard to clinical effectiveness, patient safety, risk, safeguarding and patient experience to contribute to improved patient outcomes across the NHS Outcomes Framework.

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

\(^{26}\) See section 14R of the 2006 Act, inserted by section 26 of the 2012 Act
v. requiring progress of delivery of the duty to be monitored through the CCG’s reporting mechanisms.

vi. Establishing a quality committee to provide assurance on the quality of services commissioned and promote a culture of continuous improvement and innovation with respect to patient safety, clinical effectiveness and patient experience.

vii. Working with Member Practices to ensure they implement and to follow pathways adopted by the CCG, as part of the continuous cycle of improvement, with the exception of where it can be justified that it is not clinically appropriate.

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\(^27\) by:

i. delegating authority the Governing Body.

ii. working collectively with member practices and all stakeholders to ensure best practice is implemented across the CCG, to continuously improve the quality of primary medical care services.

iii. ensuring all Member Practices within the CCG aspire to the delivery of the highest standards of excellence and professionalism in the provision of high-quality care that is safe, effective and focused on the patient experience.

iv. reinvesting realised efficiency gains (both cash and non-cash) in improved services for patients to improve quality, access and choice for patients, within prevention or interventions and Primary, Community and/or Secondary Care.

v. providing, where appropriate, high quality training to improve the skill sets within the CCG in order to improve existing services, and develop new services, for patients.

vi. delivering robust and sustainable decisions, based upon analysis of the clinical, provider and prescribing data within clinical practice (referrals, prescribing methods, disease management, patient interface etc.), which influence healthcare delivery, patient experience, and the quality of healthcare provided.

vii. working collectively with member practices and all stakeholders to ensure best practice is implemented across the CCG, to continuously improve the quality of primary medical care services.

viii. working with practices to drive up the quality of services available in primary care, while at the same time driving down the reliance on hospital services.

\(^{27}\) See section 14S of the 2006 Act, inserted by section 26 of the 2012 Act
doing this work practices improve the “make (doing the work in practice) and buy (referring on to an alternative provider)” decisions.

ix. ensuring all commissioning decisions are taken on the basis of quality, outcomes and value for money, working in partnership with the Practices, Local Authority and vitally the patients. Each stakeholder will have defined roles and responsibilities as part of the new working arrangements required under Clinical Commissioning.

5.2.6 Have regard to the need to reduce inequalities by:

i. delegating responsibility to the CCG’s Governing Body.

ii. ensuring that this duty is discharged on behalf of the Governing Body by the CCG’s executive committee in accordance with their Terms of Reference.

iii. ensuring that this duty is discharged on behalf of the Governing Body by the Accountable Officer and the specific lead officer delegated by the Accountable Officer to oversee its discharge.

iv. developing an annual commissioning plan in accordance with the requirement of the Health and Social Care Act 2012 which sets out the CCG’s role and plans in relation to reducing inequalities between patients in respect of their ability to benefit from health services.

v. through working with partners on the Wellbeing for Life Board and Health and Wellbeing Board to contribute to addressing the wider determinants of health in line with the priorities within the Newcastle Future Needs Assessment and the Joint Strategic Needs Assessment and to contribute to implementing the Wellbeing for Life strategy and Health and Wellbeing Strategy in relation to commissioning of health services.

vi. through the Directors of Public Health working into the CCG with regard to reducing inequalities.

vii. requiring progress of delivery of the duty to be monitored through the CCG’s reporting mechanisms.

viii. developing Governance and Commissioning Plans which are focused upon an ability to reduce health inequalities and maximise health outcomes for the population of the CCG, by working in partnership to commission health promotion and provision of appropriate care pathways, community, and all provider services.

ix. ensuring all service development proposals include an indication of the likelihood of reducing health inequalities.

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28 See section 14T of the 2006 Act, inserted by section 26 of the 2012 Act
5.2.7 **Promote the involvement of patients, their carers and representatives in decisions about their healthcare**\(^{29}\) by:

i. delegating responsibility to the CCG’s governing body.

ii. ensuring that this duty is discharged on behalf of the governing body by the Accountable Officer and the specific lead officer delegated by the Accountable Officer to oversee its discharge, having regard to any guidance or requirements published by the NHS Commissioning Board.

iii. ensuring that standards are contained within contracts with commissioned services requiring procedures to be in place in commissioned services to ensure patients, their carers and representatives are able to make informed decisions about their healthcare in line with the underlying policy for shared decision making “no decision about me without me”,

iv. requiring progress of delivery of the duty to be monitored through the CCG’s reporting mechanisms.

5.2.8 **Act with a view to enabling patients to make choices**\(^{30}\) by:

i. delegating responsibility to the CCG’s governing body.

ii. ensuring that this duty is discharged on behalf of the governing body by the Accountable Officer and the specific lead officer delegated by the Accountable Officer to oversee its discharge, having regard to any guidance or requirements published by the NHS Commissioning Board.

iii. embodying the requirements of patient choice within the CCG’s Access and Choice Policy and the CCG’s Communications and Engagement Strategy.

iv. requiring progress of delivery of the duty to be monitored through the CCG’s reporting mechanisms.

5.2.9 **Obtain appropriate advice**\(^{31}\) from persons who, taken together, have a broad range of professional expertise in healthcare and public health by:

i. Delegating responsibility to the governing body to ensure that it obtains appropriate advice in the exercise of its functions. This will be either:

   a) through individual members of the governing body.

   b) or those members in attendance at the governing body which will include the Director of Public Health or their designated representative.

   c) or where appropriate through invitation to individuals to attend as appropriate to provide advice on its functions.

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

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

\(^{31}\) See section 14W of the 2006 Act, inserted by section 26 of the 2012 Act
d) or by seeking advice through other external bodies such as a Clinical Senate, Public Health England, or other expert or independent organisation.

e) The CCG will also engage with the Local Medical Committee (LMC) with regard to their role as local statutory representatives of individual GPs and GP Practices.

ii. delegating responsibility within their Terms of Reference to the Chair of each Committee or subcommittee to ensure that they obtain appropriate advice in the exercise of its functions. This will be either through:

a) individual members of the Committee or sub-committee.

b) or those members in attendance at the Committee or subcommittee which may include the Director of Public Health or their designated representative.

c) or where appropriate, through invitation, to individuals to attend to provide advice on its functions.

d) or by seeking advice through other external bodies such as a Clinical Senate, Public Health England or other expert or independent organisation.

5.2.10 Promote innovation

i. delegating responsibility to the CCG’s governing body.

ii. ensuring that this duty is discharged on behalf of the governing body by the Accountable Officer and the specific lead officer delegated by the Accountable Officer to oversee its discharge, having regard to any guidance or requirements published by the NHS Commissioning Board.

iii. developing an annual commissioning plan which sets out innovative approaches to commissioning of services.

iv. seeking to develop an innovative operating model.

v. seeking out and adopting best practice, by supporting research and adopting and diffusing transformative, innovative ideas, products, services and clinical practice both within the CCG and within its commissioned services, which add value in relation to quality and productivity.

vi. developing a culture of continuous improvement and innovation with respect to patient safety, clinical effectiveness and patient experience.

5.2.11 Promote research and the use of research

i. delegating responsibility to the CCG’s governing body.
ii. ensuring that this duty is discharged on behalf of the governing body by the Accountable Officer and the specific lead officer delegated by the Accountable Officer to oversee its discharge, having regard to any guidance or requirements published by the NHS Commissioning Board.

iii. delegating responsibility to the governing body’s Quality, Safety and Risk Committee to assist the governing body in regard to oversight of research governance and in accordance with the CCG’s Terms of Reference.

iv. collaborating with key stakeholders such as Clinical Research Networks and academic institutions to establish evidence of best practice.

v. commissioning where appropriate independent research and evaluation as a means of developing or evaluating care pathways, evidence based practice and the translation of research evidence into clinical practice.

vi. requiring progress of delivery of the duty to be monitored through the CCG’s reporting mechanisms.

5.2.12 Have regard to the need to promote education and training\(^34\) for persons who are employed, or who are considering becoming employed, in an activity which involves or is connected with the provision of services as part of the health service in England so as to assist the Secretary of State for Health in the discharge of his related duty\(^35\) by:

i. delegating responsibility to the CCG’s governing body.

ii. ensuring that this duty is discharged on behalf of the governing body by the Accountable Officer and the specific lead officer delegated by the Accountable Officer to oversee its discharge, having regard to any guidance or requirements published by the NHS Commissioning Board.

iii. ensuring that the CCG engages with the Local Education and Training Board with a view to mutual alignment of the CCG’s Commissioning plan and local workforce, education and training plans.

iv. encouraging and supporting the continuous learning and development of its employees and member practices so that they are able to carry out their role confidently and effectively, achieve their individual potential and contribute fully to the objectives of the CCG.

v. requiring progress of delivery of the duty to be monitored through the CCG’s reporting mechanisms.

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

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\(^{34}\) See section 14Z of the 2006 Act, inserted by section 26 of the 2012 Act

\(^{35}\) See section 1F(1) of the 2006 Act, inserted by section 7 of the 2012 Act
services where the CCG considers that this would improve the quality of services or reduce inequalities\textsuperscript{36} by:

i. delegating responsibility to the CCG’s governing body.

ii. ensuring that this duty is discharged on behalf of the governing body by the CCG’s executive committee in accordance with their Terms of Reference.

iii. developing an annual commissioning plan in accordance with the requirement of the Health and Social Care Act 2012 which sets out the CCG’s role and plans in relation to promoting integration.

iv. working in partnership with others to take forward plans so that pathways of care are seamless and integrated within and across organisations, and seek to reduce inequalities in access and outcomes.

v. requiring progress of delivery of the duty to be monitored through the CCG’s reporting mechanisms.

vi. Working in partnership with NHS, Social Care and Public Health, and promoting joined up commissioning plans across the NHS, Social Care and Public Health. This includes;

   a) Support for joint commissioning and pooled budget arrangements.
   b) Promoting partnership working and integrated delivery of public services across the NHS, Social Care, Public Health and other services.

5.3 General Financial Duties
The CCG will perform its functions so as to:

5.3.1 *Ensure its expenditure does not exceed the aggregate of its allotments for the financial year*\textsuperscript{37} by

i. delegating responsibility to the CCG’s governing body.

ii. developing an annual commissioning plan (which incorporates the financial plan) in accordance with the requirement of the Health and Social Care Act 2012.

iii. ensuring that this duty is discharged on behalf of the governing body by the Chief Finance and Operating Officer in accordance with the responsibilities of the role.

iv. specifying Prime Financial Policies (at Appendix E) and detailed underpinning financial policies.

\textsuperscript{36} See section 14Z1 of the 2006 Act, inserted by section 26 of the 2012 Act

\textsuperscript{37} See section 223H(1) of the 2006 Act, inserted by section 27 of the 2012 Act
v. delegating responsibility to the governing body’s Audit Committee to assist the governing body in regard to discharge of the duty and in accordance with the Committee’s Terms of Reference.

vi. delegating responsibility to the executive committee to assist in optimising the allocation and adequacy of the CCG’s resources in accordance with its Terms of Reference.

vii. requiring progress of delivery of the duty to be monitored through the CCG’s reporting mechanisms.

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** \(^{38}\) by

i. delegating responsibility to the CCG’s governing body.

ii. developing an annual commissioning plan (which incorporates the financial plan) in accordance with the requirement of the Health and Social Care Act 2012.

iii. ensuring that this duty is discharged on behalf of the governing body by the Chief Finance and Operating Officer in accordance with the responsibilities of the role.

iv. specifying Prime Financial Policies (at Appendix E) and detailed underpinning financial policies.

v. delegating responsibility to the governing body’s Audit Committee to assist the governing body in regard to discharge of the duty and in accordance with the Committee’s Terms of Reference.

vi. delegating responsibility to the executive committee to assist in optimising the allocation and adequacy of the CCG’s resources in accordance with its Terms of Reference.

vii. requiring progress of delivery of the duty to be monitored through the CCG’s reporting mechanisms.

5.3.3 **Take account of any directions issued by the NHS Commissioning Board, in respect of specified types of resource use in a financial year, to ensure the CCG does not exceed an amount specified by the NHS Commissioning Board** \(^{39}\) by

i. delegating responsibility to the CCG’s governing body.

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\(^{38}\) See sections 223I(2) and 223I(3) of the 2006 Act, inserted by section 27 of the 2012 Act

\(^{39}\) See section 223J of the 2006 Act, inserted by section 27 of the 2012 Act
ii. developing an annual commissioning plan (which incorporates the financial plan) in accordance with the requirement of the Health and Social Care Act 2012.

iii. ensuring that this duty is discharged on behalf of the governing body by the Chief Finance and Operating Officer in accordance with the responsibilities of the role.

iv. delegating responsibility to the executive committee to assist in optimising the allocation and adequacy of the CCG’s resources in accordance with its terms of reference.

v. requiring progress of delivery of the duty to be monitored through the CCG’s reporting mechanisms.

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

i. delegating responsibility to the CCG’s governing body.

ii. ensuring that this duty is discharged on behalf of the governing body by the Accountable Officer and the specific lead officer delegated by the Accountable Officer to oversee its discharge the explanation to be published on the CCG’s website at www.newcastlegatesheadccg.nhs.uk, available upon request for inspection at the CCG’s headquarters, or upon application by post, Riverside House, Goldcrest Way, Newburn Riverside (Business Park), Newcastle upon Tyne. NE15 8NY, or by e-mail to ngccg.enquiries@nhs.net.

5.4 Other Relevant Regulations, Directions and Documents

5.4.1 The CCG will

i. comply with all relevant regulations;

ii. comply with directions issued by the Secretary of State for Health or the NHS Commissioning Board; and

iii. take account, as appropriate, of documents issued by the NHS Commissioning Board.

5.4.2 The CCG 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 CCG policies and procedures.

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40 See section 223K(7) of the 2006 Act, inserted by section 27 of the 2012 Act
DECISION MAKING: THE GOVERNING STRUCTURE

6.1 Authority to act

6.1.1 The clinical commissioning group is accountable for exercising its statutory functions. It may grant authority to act on its behalf to:

i. any of its members;

ii. its governing body;

iii. employees;

iv. a committee or sub-committee of the CCG.

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

i. the CCG’s scheme of reservation and delegation; and

ii. for committees, their terms of reference.

6.2 Scheme of Reservation and Delegation\(^{41}\)

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

i. those decisions that are reserved for the membership as a whole;

ii. those decisions that are the responsibilities of its governing body (and its committees), the CCG’s committees and sub-committees, individual members and employees.

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

6.3 General

6.3.1 In discharging functions of the CCG that have been delegated to its governing body (and its committees), committees, joint committees, sub-committees and individuals must:

i. comply with the CCG’s principles of good governance,\(^{42}\)

ii. operate in accordance with the CCG’s scheme of reservation and delegation,\(^{43}\)

\(^{41}\) See Appendix D

\(^{42}\) See section 4.4 on Principles of Good Governance above

\(^{43}\) See appendix D
iii. comply with the CCG’s standing orders,\textsuperscript{44}

iv. comply with the CCG’s arrangements for discharging its statutory duties,\textsuperscript{45}

v. where appropriate, ensure that member practices have had the opportunity to contribute to the CCG’s decision making process.

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

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

i. identify the roles and responsibilities of those clinical commissioning groups who are working together;

ii. identify any pooled budgets and how these will be managed and reported in annual accounts;

iii. specify under which clinical commissioning group’s scheme of reservation and delegation and supporting policies the collaborative working arrangements will operate;

iv. specify how the risks associated with the collaborative working arrangement will be managed between the respective parties;

v. identify how disputes will be resolved and the steps required to terminate the working arrangements;

vi. specify how decisions are communicated to the collaborative partners.

6.4 Committees of the CCG

The CCG will organise its committee structure to reflect the two units of planning which are consistent with the two local authority footprints, and will, therefore have an internal locality structure which will reflect a strong local focus on delivering healthcare and change. There will be a commissioning forum, made up predominantly of clinicians, whose role will be to influence the direction of commissioning and to arrange task and finish groups to manage specific projects, and an Executive Committee which will determine the strategic, planning and delivery processes of the CCG. The Governing Body will hold the overall accountability for the CCG and will provide assurance to the member practices.

A number of other statutory and non-statutory committees (see below) will provide the CCG with other supporting functions.

\textsuperscript{44} See appendix C

\textsuperscript{45} See chapter 5 above
6.4.1 The CCG shall have the authority to delegate any of its activities to a committee or sub-committee of the CCG. Such committee or sub-committee shall be made up of members or employees, and/or members of the governing body and any others approved by the CCG.

6.4.2 Committees will only be able to establish their own sub-committees, to assist them in discharging their respective responsibilities, if this responsibility has been delegated to them by the CCG or the committee they are accountable to. Terms of reference of such sub-committees are available on the CCG’s website.

6.4.3 The CCG may establish committee(s) with Gateshead Council and Newcastle City Council.

6.4.4 The CCG has established the following committees, the terms of reference of which are published separately and which are available on the CCG’s website.

6.5 The Governing Body

6.5.1 Functions - the governing body has the following functions conferred on it by sections 14L(2) and (3) of the 2006 Act, inserted by section 25 the 2012 Act, together with any other functions connected with its main functions as may be specified in regulations. The governing body has responsibility for:

i. ensuring that the CCG has appropriate arrangements in place to exercise its functions effectively, efficiently and economically and in accordance with the CCG’s principles of good governance (its main function);

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

iii. approving any functions of the CCG that are specified in regulations;

iv. functions as delegated by the CCG to the governing body as set out in paragraph 5.1.2 a) to c)

v. functions as delegated by the CCG to the governing body relating to the CCG’s General Duties as set out in paragraphs 5.2.1 and 5.2.13

vi. functions as delegated by the CCG to the governing body relating to the CCG’s General Financial Duties as set out in paragraphs 5.3.1 to 5.3.4

vii. the following functions as delegated by the CCG to the governing body:

46 See section 14L(3)(c) of the 2006 Act, as inserted by section 25 of the 2012 Act
47 See section 4.4 on Principles of Good Governance above
48 See section 14L(5) of the 2006 Act, inserted by section 25 of the 2012 Act
a) leading the setting of vision and strategy
b) approval of commissioning plans
c) monitoring performance against plans
d) providing assurance of strategic risk

6.5.2 **Composition of the Governing Body** - the governing body will be comprised of:

i. The Chair;

ii. The Assistant Clinical Chair;

iii. The Deputy Chair (Lay Member);

iv. Five further lay members;
   
   a) one to lead on audit, remuneration and conflict of interest matters,
   b) one to lead on financial and procurement matters
   c) three to lead on patient and public participation matters;

   (This provides a total of six lay members)

v. Four representatives of member practices;

vi. One Registered Nurse;

vii. One Secondary Care Specialist Doctor;

viii. The Accountable Officer;

ix. The Chief Finance and Operating Officer;

x. The Medical Director

xi. Director of Delivery and Transformation (Gateshead)

xii. Director of Delivery and Transformation (Newcastle)

xiii. Director of Quality development

6.5.3 **Committees of the Governing Body**

The governing body shall have the authority to delegate any of its activities to a committee or sub-committee of the CCG. Such committees or subcommittees shall be made up of members or employees, and/or members of the governing body and any others approved by the governing body, provided that they are members or employees of the CCG.

The governing body has appointed the following committees:
i. **Audit Committee**

The audit committee is a statutory committee which is accountable to the CCG’s governing body that provides the governing body with an independent and objective view of the CCG’s financial systems, financial information and compliance with laws, regulations and directions governing the CCG in so far as they relate to finance, and the CCG’s Assurance Framework. The governing body has approved and keeps under review the terms of reference for the audit committee, which includes information on the membership of the audit committee.

The Audit Committee will provide assurance to the governing body that the CCG is complying with its duty to exercise its functions effectively, efficiently and economically. In particular it will seek assurance on the effective use of the CCG’s resources to deliver its strategy and annual commissioning plan. It has authority to make decisions as set out within its Terms of Reference and the CCG’s scheme of delegation.

In addition, the CCG or the governing body has conferred or delegated the following functions, connected with the governing body’s main function, to its audit committee:

- Oversight and more detailed scrutiny of implementation of disinvestment programmes and QIPP delivery


ii. **Remuneration Committee**

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

In addition the CCG or the governing body has conferred or delegated the following functions, connected with the governing body’s main function, to its remuneration committee:

- **a)** Approving severance payments of the accountable officer, the chief finance and operating officer and of other staff.
- **b)** The Committee will also fulfil the role associated with that of a nominations committee to oversee and where relevant lead the process for governing body appointments, ensure the governing body has the balance of skills and expertise to discharge its duties and responsibilities and ensure succession planning for members of the governing body.

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49 See section 14L(2) of the 2006 Act, inserted by section 25 of the 2012 Act

iii. Quality, Safety and Risk Committee
The Quality, Safety and Risk Committee, which is accountable to the CCG’s governing body, will assist the governing body in its duty to secure continuous improvement in the quality of services, improve the quality of primary medical services and promote research and use of research. It will provide assurance to the governing body about the quality, safety and risks of the services being commissioned, and the overall risks to the organisation’s strategic and operational plans. The governing body has approved and keeps under review the terms of reference for the Quality, Safety and Risk Committee, which includes information on the membership of the Quality, Safety and Risk Committee. It has authority to make decisions as set out within its Terms of Reference and the CCG’s scheme of delegation.


iv. The Executive Committee
The Executive Committee is established as a committee of the governing body to support the CCG, its governing body and the accountable officer in the discharge of their functions. It will assist the governing body in its duties to promote a comprehensive health service, reduce inequalities and promote innovation.

The executive committee will work closely with, and provide support to, the commissioning forum in order to ensure that practices are informed appropriately of commissioning decisions, and are engaged in the commissioning process. The clinical representation will be sought from the two units of planning with appropriate balance across the CCG.

The committee is responsible for specific strategy and planning, and delivery processes relating to a number of core functions.

Strategy and Planning:

a) Preparing and recommending the strategy and annual commissioning plan prior to approval by the member practices and the management of its delivery by the governing body.

b) Formulating and implementing service change and development arising out of the strategy.

c) Preparing and recommending to the governing body the Organisational Development Plan and enabling strategies including the Communications and Engagement Strategy, and overseeing their delivery.
d) Developing CCG input to the Joint Health and Wellbeing Strategy (Gateshead) and the Newcastle Future Needs Assessment (Newcastle), with a view to reducing inequalities in health.

e) Establishing links and working arrangements with other CCGs, Provider Trusts, the Local Authority, other health care partners, the Area Team of NHS England and the clinical senate that would support the 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.

f) Ensuring that the views of patients and the public are properly reflected in the development and implementation of CCG policies and plans.

Delivery:

a) Delivering target outcomes and outputs set by the Secretary of State, NHS England, NICE, CQC and other national/regional authorised bodies and providing assurance to the governing body in this respect.

b) Ensuring the co-ordination and monitoring of the Group’s clinical work programme, in delivery of the Group’s annual commissioning plan.

c) Receiving reports on quality and patient safety and managing any associated clinical risks with appropriate mitigating action.

d) Managing the performance of the CCG against its financial and non-financial targets including QIPP.

e) Ensuring the control, co-ordination and monitoring within the organisation of risk and internal controls, reviewing the corporate risk register regularly.

f) Approving business cases and procurement contract awards in line with the CCG’s financial scheme of delegation and approved budgets

g) Leading the delivery of the CCG’s educational programme.

h) Preparing the CCG’s annual report for the audit committee to consider and approve and recommend to the governing body.

i) Approving the CCG’s operational policies and procedures.

j) Supporting the development of the business cycle of the CCG’s governing body and agenda setting for formal and informal meetings of the governing body.

Ensuring effective clinical engagement is a crucial element of the committee’s work and this will be facilitated through:

- Promoting the involvement of all member practices in the work of the CCG in securing improvements in commissioning of care and services.
• Providing support to the commissioning forum in order to ensure that practices are appropriately involved in, and informed of, commissioning issues and decisions, and are engaged in the commissioning process.

The committee has authority to make decisions as set out within its Terms of Reference and the CCG’s scheme of delegation;

a) functions as delegated by the CCG to the executive committee as set out in paragraph 5.1.2.

b) functions as delegated by the CCG to the executive committee relating to the CCG’s General Duties as set out in paragraphs 5.2.3 and 5.2.13.

c) functions as delegated by the CCG to the executive committee relating to the CCG’s General Financial Duties as set out in paragraphs 5.3.1 to 5.3.3.

The clinical representation will be sought from the two units of planning in equal measures to create a balance across the CCG.


v. Commissioning Forum

A commissioning forum will be established across the CCG, with each unit of planning establishing its own local fora. The commissioning fora will provide an approach to determining the development of care provision within the unit of planning footprints of both Newcastle and Gateshead. They will provide clinically-led direction on areas of commissioning for health care services and will be constituted of appointed practice representatives and other primary care representatives who will use the groups as vehicles for determining needs in relation to both patient services and practice development.

The remit of the commissioning forum will be to;

• Determine the development of clinical pathways based on the healthcare needs of the local population within their unit of planning i.e. Newcastle or Gateshead.

• Provide recommendations to the executive committee which will assist in the development of commissioning intentions.

• Ensure a constant process of engagement with the member practices, allowing for a greater involvement in the commissioning process.

• Ensure the provision of the clinical representation for the governing body.

• Establish, and be part of, task and finish groups who will undertake specific elements of work in relation to the development of clinical pathways.

• Undertake statutory responsibilities concerning the CCG as stated in the scheme of reservation and delegation (Appendix D).
As the commissioning forum will be constituted of member practice representatives, they will also be responsible for discharging certain statutory responsibilities, which are detailed in the scheme of reservation and delegation.

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


vi. **Primary Care Joint Committee**

The primary care joint committee of the CCG is a joint committee with NHS England established to support joint commissioning of primary medical services for the people of Newcastle and Gateshead. The committee is established as a committee of the governing body.

The role of the primary care joint committee shall be to carry out the functions relating to the commissioning of primary medical services under section 83 of the NHS Act (except those relating to individual GP performance management, which have been reserved to NHS England) and such CCG functions under sections 3 and 3A of the NHS Act as have been delegated to the joint committee.

The Governing Body has approved and keeps under review the terms of reference for the Primary Care Joint Committee, which includes information on the membership of the Committee. It has authority to make decisions as set out within its Terms of Reference and the CCG’s scheme of reservation and delegation.


6.6 **Member Practices**

In accordance with section 14Z15 of the Health and Social Care Act 2012, the member practices will meet at least once annually. This will include a meeting in public where the Annual Report and Accounts will be presented.

6.7 **Joint Commissioning Arrangements with other Clinical Commissioning Groups**

6.7.1 The clinical commissioning group (CCG) may wish to work together with other CCGs in the exercise of its commissioning functions.
6.7.2 The CCG may make arrangements with one or more CCG in respect of:

i. delegating any of the CCG’s commissioning functions to another CCG;

ii. exercising any of the commissioning functions of another CCG; or

iii. exercising jointly the commissioning functions of the CCG and another CCG

6.7.3 For the purposes of the arrangements described at paragraph (6.7.2), the CCG may:

i. make payments to another CCG;

ii. receive payments from another CCG;

iii. make the services of its employees or any other resources available to another CCG; or

iv. receive the services of the employees or the resources available to another CCG.

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

6.7.5 For the purposes of the arrangements described at paragraph (6.7.2) above, the CCG may establish and maintain a pooled fund made up of contributions by any of the CCGs working together pursuant to paragraph (6.7.2 ii) 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. Model wording for amendments to CCGs’ constitutions

6.7.6 Where the CCG makes arrangements with another CCG as described at paragraph (6.7.2) above, the CCG shall develop and agree with that CCG an agreement setting out the arrangements for joint working, including details of:

i. How the parties will work together to carry out their commissioning functions;

ii. The duties and responsibilities of the parties;

iii. How risk will be managed and apportioned between the parties;

iv. Financial arrangements, including, if applicable, payments towards a pooled fund and management of that fund;

v. Contributions from the parties, including details around assets, employees and equipment to be used under the joint working arrangements.

6.7.7 The liability of the CCG to carry out its functions will not be affected where the CCG enters into arrangements pursuant to paragraph (6.7.2) above.

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

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

6.7.10 The governing body of the CCG shall require, in all joint commissioning arrangements, which the lead clinician and lead manager of the lead CCG make a
quarterly written report to the governing body and hold at least annual engagement events to review aims, objectives, strategy and progress and publish an annual report on progress made against objectives.

6.7.11 Should a joint commissioning arrangement prove to be unsatisfactory the governing body of the CCG can decide to withdraw from the arrangement, but Model wording for amendments to CCGs’ constitutions has to give six months’ notice to partners, with new arrangements starting from the beginning of the next new financial year.

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

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

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

6.8.3 The arrangements referred to in paragraph (6.8.2) above may include other CCGs.

6.8.4 Where joint commissioning arrangements pursuant to (6.8.2) above are entered into, the parties may establish a joint committee to exercise the commissioning functions in question.

6.8.5 Arrangements made pursuant to (6.8.2) above may be on such terms and conditions (including terms as to payment) as may be agreed between NHS England and the CCG.

6.8.6 Where the CCG makes arrangements with NHS England (and another CCG if relevant) as described at paragraph (6.8.2) above, the CCG shall develop and agree with NHS England a framework setting out the arrangements for joint working, including details of:

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

6.8.7 The liability of the CCG to carry out its functions will not be affected where the CCG enters into arrangements pursuant to paragraph (6.8.2) above.

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

6.8.9 Only arrangements that are safe and in the interests of patients registered with member practices will be approved by the governing body.
6.8.10 The governing body of the CCG shall require, in all joint commissioning arrangements that the Commissioning Director of the CCG make a quarterly written report to the governing body and hold at least annual engagement events to review aims, objectives, strategy and progress and publish an annual report on progress made against objectives.

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

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

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

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

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

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

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

6.9.5 For the purposes of the arrangements described at paragraph (6.9.2) above, NHS England and the CCG may establish and maintain a pooled fund made up of contributions by the parties working together. Any such pooled fund may be used to make payments towards expenditure incurred in the discharge of any of the commissioning functions in respect of which the arrangements are made.

6.9.6 Where the CCG enters into arrangements with NHS England as described at paragraph (6.9.2) above, the parties will develop and agree a framework setting out the arrangements for joint working, including details of:

   i. How the parties will work together to carry out their commissioning functions;
   ii. The duties and responsibilities of the parties;
   iii. How risk will be managed and apportioned between the parties;
   iv. Financial arrangements, including payments towards a pooled fund and management of that fund;
   v. Contributions from the parties, including details around assets, employees and equipment to be used under the joint working arrangements.
6.9.7 The liability of NHS England to carry out its functions will not be affected where it and the CCG enter into arrangements pursuant to paragraph (6.9.2) above.

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

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

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

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

7.1 Governing Body Members

7.1.1 As members of the CCG’s governing body, selected clinical member representatives bring their unique understanding of the CCG’s member practices to the discussion and decision making of the governing body and have a more active role in the management and operation of the CCG.

7.1.2 Governing Body members will commit to listen to and work with Practices through an agreed programme of communication which may include annual meetings, visits and surveys.

7.1.3 Governing Body members will provide reasonable support to practices to enable them to participate in the work of the CCG, which may include access to information, peer support and appropriate education and training.

7.1.4 Governing Body members will take note of and act appropriately on conflicts of interest.

7.1.5 Governing Body members will adhere to the approved dispute resolution process.

7.2 All Members of the CCG’s Governing Body

7.2.1 Guidance on the roles of members of the CCG’s governing body is set out in a separate document.\(^{50}\)

7.3 Role of the Practice Representatives

7.3.1 Practice representatives represent their practice’s views and act on behalf of the practice in matters relating to the CCG. The role of each practice representative is to:

- i. attend general meetings of the member practices to represent their practice’s views.

- ii. endeavour to secure the effective participation of their practice in exercising of the CCG’s functions in a competent and confident manner.

- iii. ensure clinical commissioning business is on the agenda of the practice meeting.

- iv. support all staff to attend training or otherwise ensure education appropriate to their practice development plans and compliance with accredited pathways, protocols and policies.

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\(^{50}\)Clinical commissioning group governing body members: Role outlines, attributes and skills October 2012
v. take a balanced view of the clinical and management agenda;

vi. contribute to and support the CCG as appropriate in delivering the clinical objectives which will in turn ensure that the CCG is a robust organisation.

vii. support their practice to meet the objectives and assist in the development and delivery of the CCG’s commissioning plans.

viii. support their practice to share lessons learned and adopt good practice as agreed by the CCG.

ix. commit to work collaboratively within the CCG.

x. declare any conflicts of interests of the individual and of other individuals within their GP Practice which may affect the integrity of the CCG’s decision making process.

7.4 Other GP and Primary Care Health Professionals

7.4.1 In addition to the practice representatives identified in section 7.1 above, the CCG will identify other GPs / primary care health professionals from member practices to either support the work of the CCG and / or represent the CCG rather than represent their own individual practices. These GPs and primary care health professional undertake the following roles on behalf of the CCG:

7.4.2 The role of the members will include leading on a portfolio of agreed responsibilities across areas including:

i. Finance.

ii. Contracting (acute/community/mental health).

iii. Quality, Innovation, Productivity and Prevention (QIPP).

iv. Communications/engagement/Patient and Public Involvement.

v. Lead on pathway developments and service redesign.

vi. Provide the link between the clinical leadership and assigned locality to support implementation of strategic plans.

7.5 The Chair of the Governing Body

7.5.1 The chair of the governing body is responsible for:

i. leading the governing body, ensuring it remains continuously able to discharge its duties and responsibilities as set out in this constitution;
ii. building and developing the CCG’s governing body and its individual members;

iii. ensuring that the CCG has proper constitutional and governance arrangements in place;

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

v. supporting the accountable officer in discharging the responsibilities of the organisation;

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

vii. leading and influencing to achieve clinical and organisational change to enable the CCG to deliver its commissioning responsibilities;

viii. overseeing governance and particularly ensuring that the governing body and the wider CCG behaves with the utmost transparency and responsiveness at all times;

ix. ensuring that public and patients’ views are heard and their expectations understood and, where appropriate as far as possible, met;

x. ensuring that the organisation is able to account to its local patients, stakeholders and the NHS Commissioning Board;

xi. ensuring that the CCG builds and maintains effective relationships, particularly with the individuals involved in overview and scrutiny from Newcastle City Council and Gateshead Council.

7.5.2 Where the chair of the governing body is also the senior clinical voice of the CCG they will take the lead in interactions with stakeholders, including the NHS Commissioning Board.

7.6 The Assistant Clinical Chair

7.6.1 The assistant clinical chair shall support the chair of the Governing Body in delivering his/her responsibilities as set out at paragraph 7.5.1 above.

7.6.2 The assistant clinical chair shall preside at meetings of the Governing Body where the chair is absent (save where the chair is absent on the grounds of a declared conflict of interest, in which case the deputy chair shall preside).
7.7 The Deputy Chair of the Governing Body

7.7.1 The deputy chair of the governing body shall preside at meetings of the governing body where the chair of the governing body has a declared conflict of interest (whether he/she is absent from the meeting or not) or where both the chair and the assistant clinical chair are otherwise absent from a meeting of the governing body. Where the role of Chair is fulfilled by a health care professional, the role of Deputy Chair will be fulfilled by one of the Lay Members.

7.8 Role of the Accountable Officer

7.8.1 The accountable officer of the CCG is a member of the governing body.

7.8.2 This role of accountable officer has been summarised in a national document\(^51\) as:

- i. being responsible for ensuring that the CCG fulfils its duties to exercise its functions effectively, efficiently and economically thus ensuring improvement in the quality of services and the health of the local population whilst maintaining value for money;

- ii. 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.

- iii. working closely with the chair of the governing body, the accountable officer will ensure that proper constitutional, governance and development arrangements are put in place to assure the members (through the governing body) of the organisation's ongoing capability and capacity to meet its duties and responsibilities. This will include arrangements for the ongoing developments of its members and staff.

- iv. the accountable officer will also exercise the functions as delegated by the CCG to the accountable officer as set out in paragraph 5.1.2 i.- iii.

- v. exercise the functions as delegated by the CCG to the accountable officer relating to the CCG's General Duties as set out in paragraphs 5.2.1 and 5.2.13

- vi. ensure that the registers of interest are reviewed regularly, and updated as necessary.

7.8.3 In addition to the accountable officer’s general duties, where the accountable officer is also the senior clinical voice of the CCG they will take the lead in interactions with stakeholders, including the NHS Commissioning Board.

\(^{51}\) See the latest version of the NHS Commissioning Board Authority's Clinical commissioning group governing body members: Role outlines, attributes and skills
7.9 Role of the Chief Finance and Operating Officer

7.9.1 The chief finance and operating officer is a member of the governing body and is responsible for providing financial advice to the CCG and for supervising financial control and accounting systems.

7.9.2 This role of chief finance and operating officer has been summarised in a national document as:

i. being the governing body’s professional expert on finance and ensuring, through robust systems and processes, the regularity and propriety of expenditure is fully discharged;

ii. making appropriate arrangements to support, monitor and report on the CCG’s finances;

iii. overseeing robust audit and governance arrangements leading to propriety in the use of the CCG’s resources;

iv. being able to advise the governing body on the effective, efficient and economic use of the CCG’s allocation to remain within that allocation and deliver required financial targets and duties; and

v. producing the financial statements for audit and publication in accordance with the statutory requirements to demonstrate effective stewardship of public money and accountability to the NHS Commissioning Board;

vi. the chief finance and operating officer will also exercise the functions as delegated by the CCG to the chief finance and operating officer relating to the CCG’s General Financial Duties as set out in paragraphs 5.3.1 to 5.3.4;

vii. undertake the role of the Senior Information Risk Owner (SIRO).

7.10 Role of the Lay Members

7.10.1 Five Lay Members, in addition to the Deputy Chair, will be appointed to the governing body.

i. One lay member will have a lead role in overseeing key elements of financial management and audit and will:

   a) assess and confirm that appropriate systems of internal control and assurance are in place for all aspects of governance, including financial and risk management;

   b) understand the role of audit in wider accountability frameworks;

52 See the latest version of the NHS Commissioning Board Authority's Clinical commissioning group governing body members: Role outlines, attributes and skills
c) understand the resource allocations devolved to NHS bodies and a general knowledge of the accounting regime within which a CCG will operate;

d) chair meetings effectively;

e) give an independent view on possible internal conflicts of interest;

f) engage with financial management and reporting in the organisation and associated assurances.

ii. One lay member will have a lead role in overseeing financial matters and will:

a) give an independent view on the financial activities of the CCG;

b) give an independent view on procurement matters;

c) act as deputy chair to the audit committee.

iii. Three lay members will have lead roles in championing patient and public involvement and will:

a) give an independent view on possible internal conflicts of interest;

b) understand the local arrangements for listening and responding to the voices of patients, carers and patient organisations;

c) understand the role of effective involvement and engagement techniques, and how these can be applied in practice;

d) use their knowledge of the local community to enable them to express informed views about the discharge of the CCG’s functions so that they are able to act as a champion for patient and public involvement;

e) be competent to chair meetings.

7.11 Role of the Secondary Care Doctor

7.11.1 A secondary care doctor will be a member of the governing body and will:

i. understanding of how care is delivered in a secondary care setting;

ii. be competent, confident and willing to give an independent strategic clinical view on all aspects of CCG business;

iii. work as a leader across more than one clinical discipline and/or specialty, providing a high level of collaborative working;
iv. take a balanced view of the clinical and management agenda, and draw on an in-depth understanding of secondary care to add value;

v. contribute a generic view from the perspective of a secondary care doctor whilst putting aside specific issues relating to their own clinical practice or their employing organisation’s circumstances;

vi. understand how secondary care providers work within the health system to bring appropriate insight to discussions regarding service re-design, clinical pathways and system reform.

7.12 Role of the Registered Nurse

7.12.1 A registered nurse will be a member of the governing body and will:

i. give an independent strategic clinical view on all aspects of CCG business;

ii. work as a leader across more than one clinical discipline and/or specialty, providing a high level of collaborative working;

iii. take a balanced view of the clinical and management agenda and draw on their specialist skills to add value;

iv. contribute a generic view from the perspective of a registered nurse whilst putting aside specific issues relating to their own clinical practice or employing organisation’s circumstances;

v. provide detailed insights from nursing and perspectives into discussions regarding service re-design, clinical pathways and system reform.

7.13 Role of the Medical Director

7.13.1 A general practitioner acting as medical director will be a member of the governing body and will:

i. undertake the role of accountable officer for professional performance for independent contractors and performers;

ii. undertake the role of Caldicott Guardian;

iii. undertake the role of the Controlled Drugs Accountable Officer;

iv. support the revalidation for independent contractors and performers;

v. support Professional Performance Review Panels and Professional Performance Case Panels;

vi. provide advice and input to the CCG governing body as required, in line with statutory and regulatory requirements;
vii. establish and ensure on-going implementation of a robust annual appraisal/performance review system for all clinical professional staff employed in the CCG;

viii. lead in the investigation of clinical complaints, to provide advice, leadership and guidance as necessary, relevant to independent contractors and performers;

ix. communicate with Chairs, Accountable Officer, and the governing body regarding issues of professional performance;

x. ensure that lessons learnt from the investigation of clinical incidents and complaints are appropriately shared within the health system;

xi. lead effective communication with medical and other professional colleagues;

xii. act as the key communications link in relation to professional clinical matters for independent contractors and performers;

xiii. lead the recruitment and retention of senior clinical staff;

xiv. advise and support the senior management teams in handling matters of professional performance/discipline;

xv. advise in the development of clinical workforce planning issues;

xvi. advise and ensure consistency of clinical process and policy relating to the NHS Commissioning Board.
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 CCG and members of the governing body (and its committees) will at all times comply with this constitution and be aware of their responsibilities as outlined in it. They should act in good faith and in the interests of the CCG and should follow the Seven Principles of Public Life, set out by the Committee on Standards in Public Life (the Nolan Principles). The Nolan Principles are incorporated into this constitution at Appendix F.

They must comply with the CCG’s policy on business conduct, including the requirements set out in the policy for managing conflicts of interest. This policy will be available on the CCG’s website at www.newcastlegatesheadccg.nhs.uk. It will also be available upon request for inspection at the CCG’s headquarters, upon application by post (NHS Newcastle Gateshead CCG, Riverside House, Goldcrest Way, Newburn Riverside (Business Park), Newcastle upon Tyne. NE15 8NY or by e-mail [ngccg.enquiries@nhs.net].

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

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 CCG will make arrangements to manage conflicts and potential conflicts of interest to ensure that decisions made by the CCG will be taken and seen to be taken without any possibility of the influence of external or private interest.

8.2.2 Where an individual, i.e. an employee, CCG member, member of the governing body, or a member of a committee or a sub-committee of the CCG 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 CCG considering an action or decision in relation to that interest, that must be considered as a potential conflict, and is subject to the provisions of this constitution.

8.2.3 A conflict of interest will include:

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

ii. 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;
iii. a non-pecuniary interest: where an individual holds a non-remunerative or non-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);

iv. 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);

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

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

8.3 Declaring and Registering Interests

8.3.1 The CCG will maintain one or more registers of the interests of:

i. the members of the CCG;
   a) the members of its governing body;
   b) the members of its committees or sub-committees and the committees or sub-committees of its governing body; and
   c) its employees (Bands 7 and above).

The registers will be published on the CCG’s website at www.newcastlegatesheadccg.nhs.uk. They will also be available upon request for inspection at the CCG’s headquarters, upon application by post (NHS Newcastle Gateshead CCG, Riverside House, Goldcrest Way, Newburn Riverside (Business Park), Newcastle upon Tyne. NE15 8NY or by e-mail [ngccg.enquiries@nhs.net].

8.3.2 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 CCG, 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.

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

8.3.4 The Accountable Officer will ensure that the registers of interest are reviewed regularly, and updated as necessary.
8.4 Managing Conflicts of Interest: general

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

8.4.2 The Accountable Officer 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 CCG’s decision making processes.

8.4.3 Arrangements for the management of conflicts of interest are to be determined by the Accountable Officer 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. The arrangements will confirm the following:

i. when an individual should withdraw from a specified activity, on a temporary or permanent basis;

ii. monitoring of the specified activity undertaken by the individual, either by a line manager, colleague or other designated individual.

8.4.4 Where an interest has been declared, either in writing or by oral declaration, the declarer will ensure that before participating in any activity connected with the CCG’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 Accountable Officer.

8.4.5 Where an individual member, employee or person providing services to the CCG is aware of an interest which:

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

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

iii. The chair of the meeting will then determine how this should be managed and inform the member of their decision. Where no arrangements have been confirmed, the chair of the meeting may require the individual to withdraw from the meeting or part of it. The individual will then comply with these arrangements, which must be recorded in the minutes of the meeting.

8.4.6 Where the chair of any meeting of the CCG, including committees, sub-committees, or the governing body and the governing body’s committees and sub-committees,
has a personal interest, previously declared or otherwise, in relation to the scheduled or likely business of the meeting, they must make a declaration and the deputy chair will act as chair for the relevant part of the meeting.

i. Where arrangements have been confirmed for the management of the conflict of interests or potential conflicts of interests in relation to the chair, the meeting must ensure these are followed.

ii. Where no arrangements have been confirmed, the deputy chair may require the chair to withdraw from the meeting or part of it. Where there is no deputy chair, the members of the meeting will select one.

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

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

8.4.9 In making this decision the chair will consider whether the meeting is quorate, in accordance with the number and balance of membership set out in the CCG’s standing orders.

i. 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.

ii. Where a quorum cannot be convened from the membership of the meeting, owing to the arrangements for managing conflicts of interest or potential conflicts of interests, the chair of the meeting shall consult with the Accountable Officer on the action to be taken.

These arrangements must be recorded in the minutes.

8.4.10 This may include:

i. requiring another of the CCG’s committees or sub-committees, the CCG’s governing body or the governing body’s committees or sub-committees (as appropriate) which can be quorate to progress the item of business, or if this is not possible,

ii. inviting on a temporary basis one or more of the following to make up the quorum (where these are permitted members of the governing body or committee / sub-committee in question) so that the CCG can progress the item of business:

   a) a member of the CCG who is an individual;
   b) an individual appointed by a member to act on its behalf in the dealings between it and the CCG;
c) a member of a relevant Health and Wellbeing Board;
d) a member of a governing body of another clinical commissioning group.

These arrangements must be recorded in the minutes.

8.4.11 In any transaction undertaken in support of the CCG’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 Accountable Officer of the transaction.

8.4.12 The Accountable Officer will take such steps as deemed appropriate, and request information deemed appropriate from individuals, to ensure that all conflicts of interest and potential conflicts of interest are declared.

8.5 Managing Conflicts of Interest: contractors and people who provide services to the CCG

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

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

8.6 Managing Conflicts of interest: where GP practices are potential providers of clinical commissioning group-commissioned services

8.6.1 The CCG’s Standards of Business Conduct and Declarations of Interest policy sets out the factors it will assure itself upon when commissioning services from GP practices, including provider consortia or organisations in which GPs have a financial interest.

8.6.2 Where decisions are being made on such matters either at the governing body or at a committee or subcommittee of the CCG, GP practice members who have declared a specific interest in the matter, or all GP practice members at the meeting (where it is likely that all or most practices would wish to be qualified providers for a service under AQP) will be excluded from relevant parts of the meeting. Alternatively if deemed appropriate by the Chair of the meeting (or Deputy Chair if the meeting if the Chair of the meeting has declared an interest in the matter ) they may join in the discussions, but not take part in the decision making itself and would normally be asked to leave the room until a decision has been made. In such circumstances the
quorum arrangements for the governing body as set out in Standing Orders will apply. Wherever possible conflicts of interest will not be managed by exclusion.

8.6.3 If the governing body considers it prudent in a particular circumstance, to seek additional scrutiny for assurance purposes on such a decision they may refer the matter to the CCG’s own Audit Committee for additional scrutiny, or alternatively may invite an individual(s) from another CCG to review the proposal or alternatively they may invite the Health and Wellbeing Board to review the proposal; this will take place prior to a final decision on the matter by the CCG’s own governing body or one of its committees as relevant.

8.7 Transparency in Procuring Services

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

8.7.2 Overall day to day responsibility for procurement rests with the CCG. In undertaking this role the CCG is supported by expert technical and managerial support from the procurement team in North of England Commissioning Support (NECS).

8.7.3 The Procurement service provides the CCG with a range of procurement activities that enable the acquisition of high quality healthcare provision efficiently and effectively. The service will provide capacity and capability to assess and analyse healthcare markets in order to inform market or contract interventions. NECS procurement service systems and processes will ensure sound governance arrangements are in place to support the statutory obligations of the CCG.

8.7.4 The CCG will have systems in place to assure itself that NECS business processes are robust and enable the CCG to meet their duties in relation to procurement.

8.7.5 The executive committee of the CCG will remain directly responsible for:

- Approving a procurement route;
- Signing off specification and evaluation criteria;
- Signing off decisions on which providers will be invited to tender;
- Making final decisions on the selection of the provider.
THE CCG AS EMPLOYER

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

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

9.3 The CCG 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 CCG will also maintain and publish policies on all aspects of human resources management, including grievance and disciplinary matters.

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

9.5 The CCG will ensure that employees' behaviour reflects the values, aims and principles set out above.

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

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

9.8 Staff within the CCG will adopt relevant NHS Codes of Conduct for Senior Managers and all other staff and will maintain and promote effective 'whistle blowing' procedures to ensure that concerned staff have means through which their concerns can be voiced.

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

9.9 Copies of all policies and procedures outlined in this chapter will be available on the CCG’s website at www.newcastlegatesheadccg.nhs.uk. It will also be available upon request for inspection at the CCG’s headquarters, upon application by post (NHS Newcastle Gateshead CCG, Riverside House, Goldcrest Way, Newburn Riverside
(Business Park), Newcastle upon Tyne. NE15 8NY) or by e-mail [ngccg.enquiries@nhs.net].
TRANSPARENCY, WAYS OF WORKING AND STANDING ORDERS

10.1 General

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

10.1.2 Key communications issued by the CCG, including the notices of procurements, public consultations, governing body meeting dates, times, venues, and certain papers will be published on the CCG’s website at www.newcastlegatesheadccg.nhs.uk.

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

10.2 Standing Orders

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

i. **Standing orders (Appendix C)** – which sets out the arrangements for meetings and the appointment processes to appoint the CCG’s representatives and appoint to the CCG’s committees, including the governing body;

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

iii. **Prime financial policies (Appendix E)** – which sets out the arrangements for managing the CCG’s financial affairs.

iv. **Disputes Resolution Process (Appendix F)** - which sets out the arrangements for managing disputes between practice(s) and the CCG.
## APPENDIX A: DEFINITIONS OF KEY DESCRIPTIONS USED IN THIS CONSTITUTION

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<thead>
<tr>
<th><strong>2006 Act</strong></th>
<th>National Health Service Act 2006</th>
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<tr>
<td><strong>2012 Act</strong></td>
<td>Health and Social Care Act 2012 (this Act amends the 2006 Act)</td>
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</tbody>
</table>
| **Accountable officer** | an individual, as defined under paragraph 12 of Schedule 1A of the 2006 Act (as inserted by Schedule 2 of the 2012 Act), appointed by the NHS Commissioning Board, with responsibility for ensuring the CCG:  
- complies with its obligations under:  
  - sections 14Q and 14R of the 2006 Act (as inserted by section 26 of the 2012 Act),  
  - sections 223H to 223J of the 2006 Act (as inserted by section 27 of the 2012 Act),  
  - paragraphs 17 to 19 of Schedule 1A of the NHS Act 2006 (as inserted by Schedule 2 of the 2012 Act), 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 CCG has responsibility for, as defined in Chapter 2 of this constitution |
| **Chair of the governing body** | the individual appointed by the CCG to act as chair of the governing body |
| **Chief finance and operating officer** | the qualified accountant employed by the CCG 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 CCG  
- a committee / sub-committee created by a committee created / appointed by the membership of the CCG  
- a committee / sub-committee created / appointed by the governing body |
| **Financial year** | this usually runs from 1 April to 31 March, but under paragraph 17 of Schedule 1A of the 2006 Act (inserted by Schedule 2 of the 2012 Act), it can for the purposes of audit and accounts run from when a Clinical commissioning group is established until the following 31 March |
| **CCG** | NHS Gateshead Clinical Commissioning Group, whose constitution this is |
| **Executive Committee** | A sub-committee of the governing body responsible for development and implementation of commissioning strategy, monitoring and delivery of delegated duties, operational, financial, contractual and clinical performance. |
| **Governing body** | the body appointed under section 14L of the NHS Act 2006 (as inserted by section 25 of the 2012 Act), with the main function of ensuring that a Clinical commissioning group has made appropriate arrangements for ensuring that it complies with:  
- its obligations under section 14Q under the NHS Act 2006 (as inserted by section 26 of the 2012 Act), and |
- such generally accepted principles of good governance as are relevant to it.

<table>
<thead>
<tr>
<th><strong>Governing body member</strong></th>
<th>any member appointed to the governing body of the CCG</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gateshead Health &amp; Wellbeing Board</strong></td>
<td>A local authority board which brings together local commissioners of health and social care, elected representatives and representatives of HealthWatch to agree an integrated way of improving local health and wellbeing.</td>
</tr>
<tr>
<td><strong>Lay member</strong></td>
<td>A lay member of the governing body, appointed by the CCG. A lay member is an individual who is not a member of the CCG or a healthcare professional (i.e. an individual who is a member of a profession regulated by a body mentioned in section 25(3) of the National Health Service Reform and Health Care Professions Act 2002) or as otherwise defined in regulations</td>
</tr>
<tr>
<td><strong>Local Medical Committee</strong></td>
<td>statutory bodies which are in place to represent the interests of all local GPs and their teams</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 CCG (see tables in Chapter 3 and Appendix B)</td>
</tr>
<tr>
<td><strong>Newcastle Wellbeing For Life Board</strong></td>
<td>A local authority board which brings together local commissioners of health and social care, elected representatives and representatives of HealthWatch to agree an integrated way of improving local health and wellbeing.</td>
</tr>
<tr>
<td><strong>Practice representatives</strong></td>
<td>an individual appointed by a practice (who is a member of the CCG) to act on its behalf in the dealings between it and the CCG, under regulations made under section 89 or 94 of the 2006 Act (as amended by section 28 of the 2012 Act) or directions under section 98A of the 2006 Act (as inserted by section 49 of the 2012 Act)</td>
</tr>
</tbody>
</table>
| **Registers of interests** | registers a CCG is required to maintain and make publicly available under section 140 of the 2006 Act (as inserted by section 25 of the 2012 Act), of the interests of:  
  - the members of the CCG;  
  - the members of its governing body;  
  - the members of its committees or sub-committees and committees or sub-committees of its governing body; and  
  - its employees. |
# APPENDIX B - LIST OF MEMBER PRACTICES

<table>
<thead>
<tr>
<th>Practice Name</th>
<th>Address</th>
<th>Practice Representative’s Signature &amp; Date Signed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fell Tower Medical Centre</td>
<td>575 Durham Road, Low Fell, Gateshead, NE9 5EY</td>
<td></td>
</tr>
<tr>
<td>Bensham Family Practice</td>
<td>Sidney Grove, Bensham, NE8 2XB</td>
<td></td>
</tr>
<tr>
<td>The Medical Centre (Rowlands Gill)</td>
<td>The Grove, Rowlands Gill, NE39 1PW</td>
<td></td>
</tr>
<tr>
<td>Longrigg Medical Centre</td>
<td>Leam Lane Estate, Felling, NE10 8PH</td>
<td></td>
</tr>
<tr>
<td>Oxford Terrace &amp; Rawling Road Medical Group</td>
<td>1 Oxford Terrace, Gateshead, NE8 1RQ</td>
<td></td>
</tr>
<tr>
<td>Glenpark Medical Centre</td>
<td>61 Ravensworth Road, Dunston, NE119AD</td>
<td></td>
</tr>
<tr>
<td>Fell Cottage Surgery</td>
<td>123 Kells Lane, Low Fell, NE9 5XY</td>
<td></td>
</tr>
<tr>
<td>Birtley Medical Group</td>
<td>Durham Road, Birtley, DH3 2QT</td>
<td></td>
</tr>
<tr>
<td>Crowhall Medical Centre</td>
<td>Felling Health Centre, Stephenson Terrace, Felling, NE10 9QG</td>
<td></td>
</tr>
<tr>
<td>Chainbridge Medical Partnership</td>
<td>The Precinct, Blaydon, NE215BT</td>
<td></td>
</tr>
<tr>
<td>St. Albans Medical Group</td>
<td>Felling Health Centre, Stephenson Tce., Felling, NE109QG</td>
<td></td>
</tr>
<tr>
<td>Metro Interchange Surgery</td>
<td>Unit 5B, New Century House, Jackson Street, Gateshead, NE8 1HR</td>
<td></td>
</tr>
<tr>
<td>Millennium Family Practice</td>
<td>Trinity Health Centre, Trinity Square, Gateshead, NE8 1AD</td>
<td></td>
</tr>
<tr>
<td>Crawcrook Surgery</td>
<td>Pattinson Drive, Crawcrook, NE40 4US</td>
<td></td>
</tr>
<tr>
<td>Wrekenton Medical Group ( incorporating The Croft and High Street Practices)</td>
<td>Springwell Road, Wrekenton , NE9 7AD</td>
<td></td>
</tr>
<tr>
<td>Bewick Road Surgery</td>
<td>10 Bewick Road, Gateshead, NE8 4DP</td>
<td></td>
</tr>
<tr>
<td>Oldwell Surgery</td>
<td>10 Front Street, Winlaton, NE21 4RD</td>
<td></td>
</tr>
<tr>
<td>Central Gateshead Medical Group</td>
<td>Gateshead Health Centre, Prince Consort Road, NE8 1NB</td>
<td></td>
</tr>
<tr>
<td>Whickham Health Centre</td>
<td>Rectory Lane, Whickham, NE16 4PD</td>
<td></td>
</tr>
<tr>
<td>Second Street Surgery</td>
<td>Second Street, Bensham, NE8 2UR</td>
<td></td>
</tr>
<tr>
<td>Teams Medical Practice</td>
<td>Watson Street, Teams, NE8 2PQ</td>
<td></td>
</tr>
<tr>
<td>Practice Name</td>
<td>Address</td>
<td></td>
</tr>
<tr>
<td>---------------------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Primary Health Care Centre</td>
<td>1A South Road, Chopwell, NE17 7BU</td>
<td></td>
</tr>
<tr>
<td>Beacon View Medical Centre</td>
<td>Beacon Lough Road, Gateshead, NE9 6YS</td>
<td></td>
</tr>
<tr>
<td>Ryton Surgery</td>
<td>7 Elvaston Road, Ryton, NE40 3NT</td>
<td></td>
</tr>
<tr>
<td>108 Rawling Road</td>
<td>108 Rawling Road, Bensham, NE8 4QR</td>
<td></td>
</tr>
<tr>
<td>Pelaw Medical Centre</td>
<td>7-8 Croxdale Terrace, Pelaw, NE10 0RR</td>
<td></td>
</tr>
<tr>
<td>Bridges Medical Centre</td>
<td>Trinity Health Centre, Trinity Square, Gateshead, NE8 1AD</td>
<td></td>
</tr>
<tr>
<td>Hollyhurst</td>
<td>8 Front Street, Winlaton, NE21 4RD</td>
<td></td>
</tr>
<tr>
<td>Sunniside Surgery</td>
<td>8 Dewhurst Terrace, Sunniside, NE16 5LP</td>
<td></td>
</tr>
<tr>
<td>Grange Road</td>
<td>Grange Road, Ryton, NE40 3LT</td>
<td></td>
</tr>
<tr>
<td>Blaydon GP Practice &amp; Minor Injuries / illness unit</td>
<td>Shibdon Road, Blaydon, NE21 5NW</td>
<td></td>
</tr>
<tr>
<td>Avenue Medical Practice</td>
<td>5 Osborne Avenue, Jesmond, Newcastle upon Tyne, NE2 1JQ</td>
<td></td>
</tr>
<tr>
<td>Benfield Park Medical Group (formerly 37a Heaton Road)</td>
<td>Benfield Road, Newcastle upon Tyne, NE6 4QD</td>
<td></td>
</tr>
<tr>
<td>Biddlestone Health Group</td>
<td>Biddlestone Road, Newcastle Upon Tyne, NE6 5SL</td>
<td></td>
</tr>
<tr>
<td>Brunton Park Health Centre</td>
<td>Princes Road, Brunton Park, Newcastle upon Tyne, NE3 5NF.</td>
<td></td>
</tr>
<tr>
<td>Falcon Medical Group</td>
<td>Molineux Street NHS Centre, Molineux Street, Byker, Newcastle upon Tyne, NE6 1SG</td>
<td></td>
</tr>
<tr>
<td>Gosforth Memorial Medical Centre</td>
<td>Church Road, Gosforth, Newcastle upon Tyne, NE3 1TX</td>
<td></td>
</tr>
<tr>
<td>Heaton Road Surgery</td>
<td>17 - 19 Heaton Road, Newcastle Upon Tyne, NE3 1TX</td>
<td></td>
</tr>
<tr>
<td>Holly Medical Group</td>
<td>17 Osborne Road, Jesmond, NE2 2AH</td>
<td></td>
</tr>
<tr>
<td>Newcastle Medical Centre</td>
<td>Hotspur Way, Eldon Square, Newcastle upon Tyne, NE1 7XE</td>
<td></td>
</tr>
<tr>
<td>Park Medical Group</td>
<td>Fawdon Park Road, Fawdon, Newcastle upon Tyne, NE3 2PE</td>
<td></td>
</tr>
<tr>
<td>Practice Name</td>
<td>Address</td>
<td>Practice Representative’s Signature&amp; Date Signed</td>
</tr>
<tr>
<td>--------------------------------------------------------</td>
<td>---------------------------------------------------</td>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td>Regent Medical Centre (formerly Elmfield Health Group)</td>
<td>Ridley House, Henry Street Gosforth, NE3 1DQ</td>
<td></td>
</tr>
<tr>
<td>Saville Medical Group</td>
<td>7 Saville Place, Newcastle upon Tyne, NE1 8DQ</td>
<td></td>
</tr>
<tr>
<td>St Anthony’s Health Centre</td>
<td>Saint Anthony’s Road, Newcastle Upon Tyne, NE6 2NN</td>
<td></td>
</tr>
<tr>
<td>The Grove Medical Group</td>
<td>1 The Grove, Gosforth. Newcastle, NE3 1NU</td>
<td></td>
</tr>
<tr>
<td>The Surgery</td>
<td>200 Osborne Road Newcastle, NE2 3LD</td>
<td></td>
</tr>
<tr>
<td>Thornfield Medical Group</td>
<td>Molineux Street NHS Centre Molineux Street, Byker, Newcastle upon Tyne, NE6 1SG</td>
<td></td>
</tr>
<tr>
<td>Walker Medical Group</td>
<td>Walker Centre, Church Walk Newcastle upon Tyne, NE6 3BS</td>
<td></td>
</tr>
<tr>
<td>Betts Avenue Medical Centre</td>
<td>2 Betts Avenue, Benwell, Newcastle-upon-Tyne, NE15 6TQ</td>
<td></td>
</tr>
<tr>
<td>Broadway Medical Centre</td>
<td>164 Great North Road, Newcastle-upon-Tyne, NE3 5JP</td>
<td></td>
</tr>
<tr>
<td>Cruddas Park Surgery</td>
<td>178 Westmorland Road, Newcastle upon Tyne, NE4 7JT</td>
<td></td>
</tr>
<tr>
<td>Denton Turret Medical Centre</td>
<td>10 Kenley Road, Slatyford, Newcastle upon Tyne, NE5 2UY</td>
<td></td>
</tr>
<tr>
<td>Denton Park Medical Group</td>
<td>Denton Park Health Centre, West Denton Way, Newcastle Upon Tyne, NE5 2QW</td>
<td></td>
</tr>
<tr>
<td>Dilston Medical Centre</td>
<td>23 Dilston Road, Newcastle Upon Tyne, NE4 5AB</td>
<td></td>
</tr>
<tr>
<td>Fenham Hall Medical Group</td>
<td>Fenham Hall Drive, Newcastle upon Tyne, NE4 9XD</td>
<td></td>
</tr>
<tr>
<td>Grainger Medical Group incorporating Scotswood GP Practice</td>
<td>Elswick Health Centre, Meldon Street, Elswick, Newcastle upon Tyne, NE4 6SH</td>
<td></td>
</tr>
<tr>
<td>Holmside Medical Group</td>
<td>142 Armstrong Road, Benwell, Newcastle Upon Tyne, NE4 8QB</td>
<td></td>
</tr>
<tr>
<td>Newburn Surgery</td>
<td>4 Newburn Road, Newburn, Newcastle upon Tyne, NE15 8LX</td>
<td></td>
</tr>
<tr>
<td>Parkway Medical Group</td>
<td>Chapel House Primary Care Centre, Hillhead Parkway Newcastle upon Tyne, NE5 1LJ</td>
<td></td>
</tr>
<tr>
<td>Ponteland Road Health Centre</td>
<td>169 Ponteland Road, Newcastle upon Tyne, NE5 3AE</td>
<td></td>
</tr>
<tr>
<td>Prospect Medical Group</td>
<td>501 Westgate Road, Newcastle upon Tyne, NE4 8AY</td>
<td></td>
</tr>
<tr>
<td>Practice Name</td>
<td>Address</td>
<td>Practice Representative’s Signature&amp; Date Signed</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>----------------------------------------------------------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>Roseworth Surgery</td>
<td>27-29 Roseworth Avenue, Gosforth, Newcastle upon Tyne, NE3 1NB</td>
<td></td>
</tr>
<tr>
<td>Throckley Primary Care</td>
<td>Throckley Primary Care Centre, Tillmouth Park Road, Newcastle upon Tyne, NE15 9PA</td>
<td></td>
</tr>
<tr>
<td>West Road medical Centre</td>
<td>170 West Road, Newcastle upon Tyne, NE4 9QB</td>
<td></td>
</tr>
<tr>
<td>Westerhope Medical Group</td>
<td>377 Stamfordham Road, Newcastle upon Tyne, NE5 2LH</td>
<td></td>
</tr>
</tbody>
</table>

**APPENDIX C – STANDING ORDERS**
1 STATUTORY FRAMEWORK AND STATUS

1.1 Introduction

1.1.1 These standing orders have been drawn up to regulate the proceedings of the CCG so that the CCG 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 CCG is established.

1.1.2 The standing orders, together with the CCG’s scheme of reservation and delegation\(^{53}\) and the CCG’s prime financial policies\(^{54}\), provide a procedural framework within which the CCG discharges its business. They set out:

i. the arrangements for conducting the business of the CCG;

ii. the appointment of member practice representatives;

iii. the procedure to be followed at meetings of the CCG, the governing body and any committees or sub-committees of the CCG or the governing body;

iv. the process to delegate powers,

v. the 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\(^{55}\) 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 CCG’s constitution. CCG members, employees, members of the governing body, members of the governing body’s committees and sub-committees, members of the CCG’s committees and sub-committees and persons working on behalf of the CCG should be aware of the existence of these documents and, where necessary, be familiar with their detailed provisions. Failure to comply with the standing orders, scheme of reservation and delegation and prime financial policies may be regarded as a disciplinary matter that could result in dismissal.

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

1.2.1 The 2006 Act (as amended by the 2012 Act) provides the CCG with powers to delegate the CCG’s functions and those of the governing body to certain bodies (such as committees) and certain persons. The CCG has decided that certain decisions may only be exercised by the CCG in formal session. These decisions and

\(^{53}\) See Appendix D

\(^{54}\) See Appendix E

\(^{55}\) Under some legislative provisions the CCG is obliged to have regard to particular guidance but under other circumstances guidance is issued as best practice guidance.
also those delegated are contained in the CCG’s scheme of reservation and delegation (see Appendix D).

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 CCG’s constitution provides details of the membership of the CCG (also see Appendix B).

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

2.2 Key Roles

2.2.1 Paragraph 6.6.2 of the CCG’s constitution sets out the composition of the CCG’s governing body and Chapter 7 of the CCG’s constitution identifies certain key roles and responsibilities within the CCG and its governing body. These standing orders set out how the CCG appoints individuals to these key roles.

2.2.2 Disqualification criteria will apply to members of the governing body as in section 14, Tables 1 to 8

2.2.3 As a member of the CCG’s governing body, each appointed individual will share responsibility as part of the team to ensure that the CCG exercises its functions effectively, efficiently, economically, with good governance and in accordance with the terms of this constitution, as agreed by its members. Each member is there to bring their unique perspective, informed by their expertise and experience. This will support decisions made by the governing body as a whole and will help ensure that:

i. the governing body and the wider CCG act in the best interests of the health of the communities served at all times, with the interests of patients and communities at the heart of discussions and decisions;

ii. the CCG listens and is responsive to the views of local people, promotes self-care and shared decision-making in all aspects of its business;

iii. the voice of member practices is heard and listened to;

iv. the CCG commissions the highest quality services and secures the best possible patient outcomes, within its resource allocation, and maintains a consistent focus on accessibility, safety, quality, integration and innovation;

v. the CCG, when exercising its functions, acts with a view to improve health and wellbeing, supporting people to keep mentally and physically well, to get better when they are ill and, when they cannot fully recover, to stay as well as they can to the end of their lives;
vi. the CCG is responsive to the views of local people and promotes self-care and shared decision-making in all aspects of its business;

vii. the CCG, when exercising its functions, acts to secure that health services are provided in a way which stays true to the founding principles of the NHS as set out in the NHS Constitution;

viii. the CCG’s decisions are taken with regard to securing the best use of public money; and

ix. the CCG operates on the basis of good governance embodied in the Nolan Principles on standards in public life.

2.2.4 Each member of the governing body needs to demonstrate the following attributes and competencies:

i. a commitment to tackling health inequalities, promoting continuous improvements in service quality and in providing value for money.

ii. a commitment to clinical commissioning, the CCG and to the wider interests of the health services;

iii. be committed to ensuring that the Governing Body remains “in tune” with the member practices;

iv. bring a sound understanding of the NHS principles and values as set out in the NHS Constitution;

v. demonstrate a commitment to upholding the Nolan Principles of Public Life along with an ability to reflect them in his/her leadership role and the culture of the CCG;

vi. be committed to ensuring that the CCG’s values diversity and promotes equality in all aspects of its business; and

vii. bring to the governing body, the following leadership qualities:

a) **creating the vision** - effective leadership involves contributing to the creation of a compelling vision for the future and communicating this within and across organisations;

b) **working with others** - effective leadership requires individuals to work with others in teams and networks to commission continually improving services;

c) **being close to patients** - this is about truly engaging and involving patients and communities;

d) **intellectual capacity and application** - able to think conceptually in order to plan flexibly for the longer term and being continually alert to finding ways to improve;
2.2.5 The members of the governing body, as listed in paragraph 6.5.2 of the CCG’s constitution, are subject to the appointment processes as set out in tables 1 - 8, below.

i. The roles and responsibilities of each of these key roles are set out in Chapter 7 of the CCG’s constitution.

2.3 Appointment process for Governing Body Members

Table 1

<table>
<thead>
<tr>
<th>Chair of Governing Body / Assistant Clinical Chair</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Applications</strong></td>
</tr>
<tr>
<td><strong>Eligibility</strong></td>
</tr>
<tr>
<td><strong>Appointment Process</strong></td>
</tr>
<tr>
<td><strong>Term of Office</strong></td>
</tr>
<tr>
<td><strong>Eligibility for reappointment</strong></td>
</tr>
<tr>
<td><strong>Grounds for removal from office</strong></td>
</tr>
<tr>
<td><strong>Notice period</strong></td>
</tr>
</tbody>
</table>
removed from office or choosing to resign. In the event of the successful applicant wishing to resign, they should give a minimum of 90 days’ notice, in writing, addressed to the Accountable Officer of the CCG.

Table 2

<table>
<thead>
<tr>
<th>Assistant Clinical Chair / Chair of Governing Body</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Applications</strong></td>
</tr>
<tr>
<td><strong>Eligibility</strong></td>
</tr>
<tr>
<td><strong>Appointment Process</strong></td>
</tr>
<tr>
<td><strong>Term of Office</strong> (see paragraph 2.4 below)</td>
</tr>
<tr>
<td><strong>Eligibility for reappointment</strong></td>
</tr>
<tr>
<td><strong>Grounds for removal from office</strong></td>
</tr>
<tr>
<td><strong>Notice period</strong></td>
</tr>
</tbody>
</table>
### Table 3

<table>
<thead>
<tr>
<th>Clinical Primary Care Representative Members of Governing Body</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Applications</strong></td>
</tr>
<tr>
<td><strong>Eligibility</strong></td>
</tr>
<tr>
<td><strong>Appointment Process</strong></td>
</tr>
<tr>
<td><strong>Term of Office</strong></td>
</tr>
<tr>
<td><strong>Eligibility for reappointment</strong></td>
</tr>
<tr>
<td><strong>Grounds for removal from office</strong></td>
</tr>
<tr>
<td><strong>Notice period</strong></td>
</tr>
</tbody>
</table>
### Table 4

<table>
<thead>
<tr>
<th>Lay Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applications</td>
</tr>
<tr>
<td>Eligibility</td>
</tr>
<tr>
<td>Appointment Process</td>
</tr>
<tr>
<td>Term of Office</td>
</tr>
<tr>
<td>Eligibility for reappointment</td>
</tr>
<tr>
<td>Grounds for removal from office</td>
</tr>
<tr>
<td>Notice period</td>
</tr>
</tbody>
</table>

### Table 5

<table>
<thead>
<tr>
<th>Accountable Officer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applications</td>
</tr>
<tr>
<td>Eligibility</td>
</tr>
<tr>
<td>Appointment Process</td>
</tr>
<tr>
<td>Term of Office</td>
</tr>
<tr>
<td>Eligibility for reappointment</td>
</tr>
<tr>
<td>Grounds for removal from office</td>
</tr>
</tbody>
</table>
removal from office | the governing body where that person, during the term of office, fulfils the disqualification criteria set out in The National Health Service (Clinical Commissioning Groups) Regulations 2012.
---|---
Notice period | In the event of the Accountable Officer wishing to resign, they should give a minimum of 180 days’ notice, in writing, addressed to the NHS Commissioning Board.

Table 6

**Chief Finance and Operating Officer**

<table>
<thead>
<tr>
<th>Applications</th>
<th>Recruitment via open advert. Application on the basis of a person specification and job description.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eligibility</td>
<td>Applicants must meet the requirements for the governing body membership as set out in The National Health Service (Clinical commissioning groups) Regulations 2012. Applicants must hold a qualification of one of the individual Consultative Committee of Accountancy Bodies (CCAB) or Chartered Institute of Management Accountants (CIMA).</td>
</tr>
<tr>
<td>Appointment Process</td>
<td>Appointment by a process to be determined by the Remuneration Committee (acting in its role as an Appointments Committee). The appointment process to include assessment and interview of the candidate(s) against agreed competency criteria by a suitably qualified panel.</td>
</tr>
<tr>
<td>Term of Office</td>
<td>Tenure specified by NHS Commissioning Board in line with terms and conditions.</td>
</tr>
<tr>
<td>Eligibility for reappointment</td>
<td>Not applicable as this post will be held by an employee.</td>
</tr>
<tr>
<td>Grounds for removal from office</td>
<td>The Chief Finance and Operating Officer shall cease to be eligible to be a member of the governing body where that person, during the term of office, fulfils the disqualification criteria set out in The National Health Service (Clinical Commissioning Groups) Regulations 2012.</td>
</tr>
<tr>
<td>Notice period</td>
<td>In the event of the Chief Finance and Operating Officer wishing to resign, they should give a minimum of 180 days’ notice, in writing, addressed to the NHS Commissioning Board.</td>
</tr>
</tbody>
</table>

Table 7

**Medical Director**

<table>
<thead>
<tr>
<th>Applications</th>
<th>Recruitment via open advert. Application on the basis of a person specification and job description.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eligibility</td>
<td>Applicants must not be disqualified from membership under Clinical Commissioning Group regulations. Applicants must be a clinician with current or recent experience in a member practice of NHS Newcastle Gateshead CCG, irrespective of contractual status.</td>
</tr>
<tr>
<td>Appointment Process</td>
<td>Appointment by a process to be determined by the Remuneration Committee (acting in its role as an Appointments Committee). The appointment process to include assessment and interview of the candidate(s) against agreed competency criteria by a suitably qualified panel.</td>
</tr>
</tbody>
</table>
### Term of Office
Minimum of three years and maximum of four to ensure no more than 50% of governing body is replaced in a period of twelve months. Not applicable if this post is held by an employee.

### Eligibility for reappointment
Eligibility criteria must continue to be met by the incumbent. Not applicable if this post is held by an employee.

### Grounds for removal from office
The Medical Director shall cease to be eligible to be a member of the governing body where that person, during the term of office, fulfils the disqualification criteria set out in The National Health Service (Clinical Commissioning Groups) Regulations 2012 or is no longer registered with the General Medical Council. The removal from office would be dealt with in line with employment policies and procedures.

### Notice period
Not applicable as this post will be held by an employee.

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**Table 8**

<table>
<thead>
<tr>
<th>Executive Director of Nursing, Patient Safety and Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Applications</strong></td>
</tr>
<tr>
<td><strong>Eligibility</strong></td>
</tr>
<tr>
<td><strong>Appointment Process</strong></td>
</tr>
<tr>
<td><strong>Term of Office</strong></td>
</tr>
<tr>
<td><strong>Eligibility for reappointment</strong></td>
</tr>
<tr>
<td><strong>Grounds for removal from office</strong></td>
</tr>
<tr>
<td><strong>Notice period</strong></td>
</tr>
</tbody>
</table>
### Table 9

<table>
<thead>
<tr>
<th><strong>Secondary Care Specialist Doctor</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Applications</strong></td>
</tr>
<tr>
<td><strong>Eligibility</strong></td>
</tr>
<tr>
<td><strong>Appointment Process</strong></td>
</tr>
<tr>
<td><strong>Term of Office</strong></td>
</tr>
<tr>
<td><strong>Eligibility for reappointment</strong></td>
</tr>
<tr>
<td><strong>Grounds for removal from office</strong></td>
</tr>
<tr>
<td><strong>Notice period</strong></td>
</tr>
</tbody>
</table>

### Table 10

<table>
<thead>
<tr>
<th><strong>Non-Clinical Primary Care Representative Members of Governing Body</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Applications</strong></td>
</tr>
<tr>
<td><strong>Eligibility</strong></td>
</tr>
<tr>
<td><strong>Appointment Process</strong></td>
</tr>
<tr>
<td><strong>Term of Office</strong></td>
</tr>
<tr>
<td>Eligibility for reappointment</td>
</tr>
<tr>
<td>Grounds for removal from office</td>
</tr>
<tr>
<td>Notice period</td>
</tr>
</tbody>
</table>

2.4 The chair of the Governing Body and the assistant clinical chair

2.4.1 The individuals who are appointed to the positions of chair of the governing body and assistant clinical chair shall rotate between the two positions on an annual basis throughout the term of their appointment as members of the CCG's governing body.

2.4.2 The individuals holding the positions of chair of the governing body and the assistant clinical chair shall work together in order to ensure a smooth handover of responsibilities from one to the other every twelve months and minimise any disruption to the work of the governing body. The deputy chair of the governing body shall assist the individuals holding the positions of chair and assistant clinical chair to affect a smooth handover.

2.4.3 The individuals appointed to the positions of chair of the governing body and assistant clinical chair recognise that (between them) they need to provide:

   i. strong leadership for the governing body; and

   ii. a consistent policy direction for the CCG.

On each annual rotation, the individual assuming the role of the chair of the governing body shall therefore maintain the policy direction put in place by his / her predecessor (except where law or guidance dictates otherwise).

2.5 Removal of the Chair

2.5.1 The Chair of the Governing Body may be removed from office by a vote at a Commissioning Forum Meeting or other ordinary meeting of the membership if he or she:

   i. Fails to meet 2012 Regulations for Governing Body membership;
i. Breaches the Nolan principles;

iii. Becomes disqualified from office including no longer fulfilling the requirements of the role as set out in the CCG regulations or no longer meeting the general requirements for Governing Body members as set out in the CCG regulations;

iv. Does not attend the majority of meetings of the CCG, the Governing Body and/or the Executive Committee each year;

v. Fails to disclose a pecuniary interest regarding matters under discussion within the organisation;

vi. No longer enjoys the confidence of the CCG.

vii. Causes significant reputation damage to the group
3. MEETINGS OF THE GOVERNING BODY

The following procedures will apply to meetings of the governing body and will apply in principle to all committees and sub committees of the CCG and the governing body. The specific procedures of committees and sub-committees will be set out in their individual Terms of Reference.

3.1 Calling meetings

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

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 of the meeting at least 15 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 9 working days before the meeting takes place. The agenda and supporting papers will usually be circulated to all members of a meeting 5 working days before the date the meeting will take place and not less than 3 clear working days before the meeting, save in an emergency or in exceptional circumstances.

3.2.2 The agenda will be agreed between by the Chair and the accountable officer

3.2.3 Agendas and certain papers for the CCG’s governing body – including details about meeting dates, times and venues - will be published on the CCG's website at www.newcastlegatesheadccg.nhs.uk.

3.3 Petitions

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

3.4 Chair of a meeting

3.4.1 At any meeting of the CCG’s governing body the chair of the governing body if any and if present, shall preside. If the chair is absent from the meeting, the assistant clinical chair, if any and if present, shall preside (save where the chair is absent on the grounds of a declared conflict of interest, in which case the deputy chair shall preside). If both the chair and the assistant clinical chair are absent from a meeting, the deputy chair shall preside.

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 governing body 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

3.6.1 No business shall be transacted at the meeting unless at least one-third of the whole number of the Chair and members are present, including at least one independent member (from amongst two lay members and the secondary care specialist doctor) and one Primary Care Representative member and either the accountable officer or the chief finance and operating officer are present.

3.6.2 A member may, if the Chair agrees in advance of the meeting and in exceptional circumstances, participate in the meeting by way of tele-conferencing. In the exceptional circumstances of:

i. the chair participating by tele-conference, the assistant clinical chair will preside at the meeting;

ii. the chair and the assistant clinical chair participating by tele-conference, the deputy chair will preside at the meeting.

3.6.3 Representatives of members will count towards the quorum where the representative either has formal acting up status or has been agreed with the Chair as the member’s representative in advance of the meeting.

3.6.4 If the quorum is lost due to a member or members being disqualified from taking part in a vote or discussion due to a declared interest the chair of the meeting will determine the action to be taken in accordance with the Constitution. Where a conflict of interest exists for GP practice members present at the meeting and they are unable to take part in decision making the quorum for transaction of that business will be a minimum of at least one lay member and either the Accountable Officer or Chief Finance Officer and at least one other member of the Board.

3.6.5 For all other of the CCG’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 CCG’s constitution, together with the scheme of reservation and delegation, sets out the governing structure for the exercise of the CCG’s statutory functions. Generally it is expected that at the CCG’s governing body’s meetings decisions will be reached by consensus. Should this not be possible then a vote of members will be required, the process for which is set out below:

i. Eligibility – members of the governing body will be eligible to vote on the basis of one member one vote. Representatives of governing body members
will be eligible to vote where the representative either has formal acting up
status or has been agreed with the Chair as the member’s representative in
advance of the meeting

ii. **Form of vote** – at the discretion of the chair any question put to a vote shall
be by oral expression or by a show hands, unless the Chair directs otherwise,
or it is proposed, seconded and carried that a vote be taken by paper ballot.

iii. **Majority necessary to confirm a decision** – the decision will be determined
by the majority of the votes cast by members present;

iv. **Casting vote** – in the case of an equal vote, the person presiding (i.e. the
Chair of the meeting) will have a second, and casting vote

v. **Dissenting views** - members taking a dissenting view but losing a vote may
have their dissent recorded in the minutes

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

3.7.3 For all other of the CCG’s committees and sub-committees, including the governing
body’s committees and sub-committee, the details of the process for holding a vote
are set out in the appropriate terms of reference.

3.8 **Emergency powers and urgent decisions**

3.8.1 The powers which are reserved to the governing body within the scheme of
delegation may in emergency or for an urgent decision be exercised by the Chair
and the Accountable Officer after having consulted with at least two other members
which will include one of the Lay members. The exercise of such powers by the
Chair and the Accountable Officer shall be reported to the next formal meeting of the
governing body in public session for formal ratification. If the exercise of the function
relates to a matter which is not in the public interest to be disclosed under SO
paragraph 3.12 the exercise of the powers will be reported in private to the governing
body.

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 at least two- thirds of
the 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

3.10.1 The names of all members of the meeting present at the meeting shall be recorded in the minutes of the CCG’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. The names of all Practice Representatives and the name of the Member practice they represent shall be recorded.

3.11 Minutes

3.11.1 The minutes of the proceedings of a meeting shall be drawn up by the nominated support and submitted for agreement at the next ensuing meeting where they will be confirmed as a true record of the meeting by the Chair and others present at the meeting for which the minutes have been presented.

3.11.2 The minutes of the governing body will be made available to the public on the CCG’s website at www.newcastlegatesheadccg.nhs.uk and to members on the CCG’s intranet for members. Minutes of the meetings/parts of meetings from which members of the public are excluded will not be made public.

3.12 Admission of public and the press

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

i. The public and representatives of the press may attend all meetings of the governing body, but shall be required to withdraw upon the governing body as follows:

a) 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*, paragraph 8(3) of schedule 1A of the 2006 Act, as amended by the 2012 Act.

b) Guidance should be sought from the CCG’s Freedom of Information Lead to ensure correct procedure is followed on matters to be included in the exclusion.

General disturbances

The Chair (or Deputy Chair if one has been appointed) 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 the governing body’s business shall be conducted without interruption and disruption and, without prejudice to the power to exclude on grounds of the confidential nature of the business to be transacted, the public will be required to withdraw upon the governing body resolving as follows:
That in the interests of public order the meeting adjourn for (the period to be specified) to enable the governing body to complete its business without the presence of the public' (paragraph 8(3) of schedule 1A of the 2006 Act, as amended by the 2012 Act).

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

i. Matters to be dealt with by the governing body following the exclusion of representatives of the press, and other members of the public, as provided in (i) and (ii) above, shall be confidential to the members of the governing body.

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

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

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

**Observers at CCG meetings**

i. The CCG or its governing body will decide what arrangements and terms and conditions it feels are appropriate to offer in extending an invitation to observers to attend and address any of the CCG’s meetings and may change, alter or vary these terms and conditions as it deems fit.
4. APPOINTMENT OF COMMITTEES AND SUB-COMMITTEES

4.1 Appointment of committees and sub-committees

4.1.1 The CCG may appoint committees and sub-committees of the CCG, subject to any regulations made by the Secretary of State\(^\text{56}\), and make provision for the appointment of committees and sub-committees of its governing body. Where such committees and sub-committees of the CCG, or committees and sub-committees of its governing body, are appointed they are included in Chapter 6 of the CCG’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 CCG shall determine the membership and terms of reference of committees and sub-committees and shall, if it requires, receive and consider reports of such committees at the next appropriate meeting of the CCG.

4.1.3 The provisions of these standing orders shall apply where relevant to the operation of the governing body, the governing body’s committees and sub-committee and all committees and sub-committees unless stated otherwise in the committee or sub-committee’s terms of reference.

4.2 Terms of Reference

4.2.1 Terms of reference shall be published separately and will form part of the CCG’s governance framework. Such Terms of Reference will be available on the CCG’s website.

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 CCG.

4.4 Approval of Appointments to Committees and Sub-Committees

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

\(^{56}\) See section 14N of the 2006 Act, inserted by section 25 of the 2012 Act
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 CCG 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 CCG may have a seal for executing documents where necessary. The following individuals or officers are authorised to authenticate its use by their signature:

- i. the accountable officer;
- ii. the chair of the governing body;
- iii. the chief finance and operating officer;
- iv. senior managers duly authorised by the accountable 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 CCG by their signature.

- i. the accountable officer
- ii. the chair of the governing body
- iii. the chief finance officer
- iv. senior managers duly authorised by the accountable officer

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

7.1 Policy statements: general principles

7.1.1 The CCG will from time to time agree and approve policy statements / procedures which will apply to all or specific CCGs of staff employed by the CCG. The decisions to approve such policies and procedures will be recorded in an appropriate CCG minute and will be deemed where appropriate to be an integral part of the CCG’s standing orders.
APPENDIX D - NHS NEWCASTLE GATESHEAD CLINICAL COMMISSIONING GROUP: FUNCTIONS, DUTIES AND SCHEME OF RESERVATION AND DELEGATION

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

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

   ii. The Clinical commissioning group remains accountable for all of its functions, including those that it has delegated.

Functions and General Duties of the CCG

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

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

   ii. commissioning emergency care for anyone present in the CCG’s area

   iii. 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 CCG’s employees;

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

Specifically, in discharging its functions the CCG will:

   i. 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\(^{57}\) and with the objectives and requirements placed on the NHS Commissioning Board through the mandate\(^{58}\) published by the Secretary of State before the start of each financial year;

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\(^{57}\) See section 1 of the 2006 Act, as amended by section 1 of the 2012 Act

\(^{58}\) See section 13A of the 2006 Act, inserted by section 23 of the 2012 Act
ii. meet the public sector equality duty\textsuperscript{59}

iii. work in partnership with its local authority[ies] to develop joint strategic needs assessments\textsuperscript{60} and joint health and wellbeing strategies\textsuperscript{61};

iv. make arrangements to secure public involvement in the planning, development and consideration of proposals for changes and decisions affecting the operation of commissioning arrangements\textsuperscript{62};

v. 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\textsuperscript{63};

vi. act effectively, efficiently and economically\textsuperscript{64};

vii. act with a view to securing continuous improvement to the quality of services\textsuperscript{65};

viii. assist and support the NHS Commissioning Board in relation to the Board’s duty to improve the quality of primary medical services\textsuperscript{66};

ix. have regard to the need to reduce inequalities\textsuperscript{67};

x. Promote the involvement of patients, their carers and representatives in decisions about their healthcare\textsuperscript{68};

xi. act with a view to enabling patients to make choices\textsuperscript{69};

xii. Obtain appropriate advice\textsuperscript{70} from persons who, taken together, have a broad range of professional expertise in healthcare and public health;

xiii. Promote innovation\textsuperscript{71};

\textsuperscript{59} See section 149 of the Equality Act 2010, as amended by paragraphs 184 and 186 of Schedule 5 of the 2012 Act

\textsuperscript{60} See section 116 of the Local Government and Public Involvement in Health Act 2007, as amended by section 192 of the 2012 Act

\textsuperscript{61} See section 116A of the Local Government and Public Involvement in Health Act 2007, as inserted by section 191 of the 2012 Act

\textsuperscript{62} See section 14Z2 of the 2006 Act, inserted by section 26 of the 2012 Act

\textsuperscript{63} See section 14P of the 2006 Act, inserted by section 26 of the 2012 Act and section 2 of the Health Act 2009 (as amended by 2012 Act)

\textsuperscript{64} See section 14Q of the 2006 Act, inserted by section 26 of the 2012 Act

\textsuperscript{65} See section 14R of the 2006 Act, inserted by section 26 of the 2012 Act

\textsuperscript{66} See section 14S of the 2006 Act, inserted by section 26 of the 2012 Act

\textsuperscript{67} See section 14T of the 2006 Act, inserted by section 26 of the 2012 Act

\textsuperscript{68} See section 14U of the 2006 Act, inserted by section 26 of the 2012 Act

\textsuperscript{69} See section 14V of the 2006 Act, inserted by section 26 of the 2012 Act

\textsuperscript{70} See section 14W of the 2006 Act, inserted by section 26 of the 2012 Act

\textsuperscript{71} See section 14X of the 2006 Act, inserted by section 26 of the 2012 Act
xiv. Promote research and the use of research\textsuperscript{72};

xv. have regard to the need to promote education and training\textsuperscript{73} for persons who are employed, or who are considering becoming employed, in an activity which involves or is connected with the provision of services as part of the health service in England so as to assist the Secretary of State for Health in the discharge of his related duty\textsuperscript{74};

xvi. 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 CCG considers that this would improve the quality of services or reduce inequalities\textsuperscript{75}.

The CCG’s General Financial Duties

i. Ensure its expenditure does not exceed the aggregate of its allotments for the financial year\textsuperscript{76};

ii. 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\textsuperscript{77};

iii. Take account of any directions issued by the NHS Commissioning Board, in respect of specified types of resource use in a financial year, to ensure the CCG does not exceed an amount specified by the NHS Commissioning Board\textsuperscript{78};

iv. Publish an explanation of how the CCG spent any payment in respect of quality made to it by the NHS Commissioning Board\textsuperscript{79}.

Functions of the CCG’s Governing Body

The governing body has the following functions conferred on it by sections 14L(2) and (3) of the 2006 Act, inserted by section 25 the 2012 Act, together with any other functions connected with its main functions as may be specified in regulations and in the constitution\textsuperscript{80}. The governing body has responsibility for:

\textsuperscript{72} See section14Y of the 2006 Act, inserted by section 26 of the 2012 Act
\textsuperscript{73} See section14Z of the 2006 Act, inserted by section 26 of the 2012 Act
\textsuperscript{74} See section 14F(1) of the 2006 Act, inserted by section 7 of the 2012 Act
\textsuperscript{75} See section 14Z1 of the 2006 Act, inserted by section 26 of the 2012 Act
\textsuperscript{76} See section 223H(1) of the 2006 Act, inserted by section 27 of the 2012 Act
\textsuperscript{77} See sections 223I(2) and 223I(3) of the 2006 Act, inserted by section 27 of the 2012 Act
\textsuperscript{78} See section 223J of the 2006 Act, inserted by section 27 of the 2012 Act
\textsuperscript{79} See section 223K(7) of the 2006 Act, inserted by section 27 of the 2012 Act
\textsuperscript{80} See section 14L(3)(c) of the 2006 Act, as inserted by section 25 of the 2012 Act
i. ensuring that the CCG has appropriate arrangements in place to exercise its functions effectively, efficiently and economically and in accordance with the CCGs principles of good governance\(^{81}\) (its main function);

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

iii. approving any functions of the CCG that are specified in regulations\(^ {82}\).

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

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

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

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\(^{81}\) See section 4.4 on Principles of Good Governance above

\(^{82}\) See section 14L(5) of the 2006 Act, inserted by section 25 of the 2012 Act
<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>Delegated to a Committee or Sub-Committee</th>
<th>Delegated to Accountable Officer</th>
<th>Delegated to Chief Finance and Operating Officer</th>
<th>Delegated to others</th>
</tr>
</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>☑</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</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>☑</td>
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<tr>
<td>REGULATION AND CONTROL</td>
<td>Approve Constitution</td>
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<tr>
<td>REGULATION AND CONTROL</td>
<td>Exercise or delegation of those functions of the CCG which have not been retained as reserved by the CCG, delegated to the governing body or other committee or sub-committee or specified member or employee</td>
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<tr>
<td>REGULATION AND CONTROL</td>
<td>Prepare for review by the governing body the CCG’s overarching scheme of reservation and delegation, which sets out those decisions of the CCG reserved to the membership and those</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>Delegated to a Committee or Sub-Committee</td>
<td>Delegated to Accountable Officer</td>
<td>Delegated to Chief Finance and Operating Officer</td>
<td>Delegated to others</td>
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<td></td>
<td>delegated to the governing body’s committees and sub-committees, its members or employees and sets out those decisions of the governing body reserved to the governing body and those delegated to the governing body’s committees and sub-committees, members of the governing body, and an individual who is a member of the CCG but not the governing body or a specified person for inclusion in the CCG’s constitution.</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>✓</td>
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<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>
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<td></td>
<td></td>
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<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>
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<td>Delegated to Chief Finance and Operating Officer</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></td>
<td></td>
<td>✓</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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<td>✓</td>
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<tr>
<td>REGULATION AND CONTROL</td>
<td>Approve Prime financial policies</td>
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<tr>
<td>REGULATION AND CONTROL</td>
<td>Approve detailed financial policies.</td>
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<tr>
<td>REGULATION AND CONTROL</td>
<td>Approval of policies not specified elsewhere in this scheme of delegation</td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
<td>Quality, Safety and Risk Committee</td>
<td></td>
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<tr>
<td>REGULATION AND CONTROL</td>
<td>Approve arrangements for managing exceptional funding requests.</td>
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<td></td>
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<td>✓</td>
</tr>
<tr>
<td>REGULATION AND CONTROL</td>
<td>Approve exceptional funding requests (within financial delegated limits).</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Individual members appointed to make decisions on behalf of the CCG</td>
<td></td>
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<tr>
<td>REGULATION AND CONTROL</td>
<td>Set out who can execute a</td>
<td>✓</td>
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<td>✓</td>
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<tr>
<td>Policy Area</td>
<td>Decision</td>
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<tr>
<td>CONTROL</td>
<td>document by signature / use of the seal</td>
<td>In approving Standing Orders</td>
<td></td>
<td></td>
<td>To authorise specific senior managers to execute a document by signature / use of the seal</td>
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<tr>
<td>PRACTICE MEMBER REPRESENTATIVES</td>
<td>Approve the arrangements for 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</td>
<td>Approve 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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<tr>
<td>PRACTICE MEMBER REPRESENTATIVES</td>
<td>Approve the appointment of governing body members</td>
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<tr>
<td>PRACTICE MEMBER REPRESENTATIVES</td>
<td>Approve arrangements for identifying the CCG's proposed accountable officer.</td>
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<td>STRATEGY AND PLANNING</td>
<td>Agree the vision, values and overall strategic direction of the</td>
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<td>Policy Area</td>
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<td>STRATEGY AND PLANNING</td>
<td>Approval of the CCG’s operating structure.</td>
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<td>STRATEGY AND PLANNING</td>
<td>Approval of the CCG’s commissioning plan.</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. As proposed by the CFO in accordance with the prime financial policies</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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<tr>
<td>ANNUAL REPORTS AND ACCOUNTS</td>
<td>Approval of the CCG’s annual report and annual accounts.</td>
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<tr>
<td>ANNUAL REPORTS AND ACCOUNTS</td>
<td>Approval of the arrangements for discharging the CCG’s statutory financial duties.</td>
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<td>In approving Constitution</td>
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<tr>
<td>HUMAN RESOURCES</td>
<td>Approve the arrangements for determining the terms and conditions, remuneration and</td>
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<td>In approving Terms of</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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<td></td>
<td>travelling or other allowances for governing body members, including pensions and gratuities.</td>
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<td>reference of Remuneration Committee</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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<td>✓</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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<td>✓</td>
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<tr>
<td>HUMAN RESOURCES</td>
<td>Determine pensions, remuneration, fees and allowances payable to employees and to other persons</td>
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<td>✓</td>
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<tr>
<td>Policy Area</td>
<td>Decision</td>
<td>Reserved to Membership</td>
<td>Reserved or delegated to Governing Body</td>
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<td>providing 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>✓ Remuneration Committee</td>
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<tr>
<td>HUMAN RESOURCES</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>
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<tr>
<td>HUMAN RESOURCES</td>
<td>Review disciplinary arrangements where the accountable officer is an employee or member of another CCG</td>
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<td>✓</td>
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<tr>
<td>HUMAN RESOURCES</td>
<td>Approval of the arrangements for discharging the CCG’s statutory duties as an employer.</td>
<td>✓</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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<td>✓</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>
<td></td>
<td>✓</td>
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<td>✓ Oversight and Scrutiny to</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>
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<td>improvement in quality and patient outcomes.</td>
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<td></td>
<td>Quality, Safety and Risk Committee</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>✓</td>
<td></td>
<td>✓ Oversight and Scrutiny to Quality, Safety and Risk Committee</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>
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<td></td>
<td>✓</td>
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<tr>
<td>OPERATIONAL AND RISK MANAGEMENT</td>
<td>Approve an operational scheme of delegation that sets out who has responsibility for operational decisions within the CCG.</td>
<td></td>
<td>✓</td>
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<tr>
<td>OPERATIONAL AND RISK MANAGEMENT</td>
<td>Approve the appointment of internal auditors, as proposed by the CFO and note the appointment of External Auditors</td>
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<tr>
<td>OPERATIONAL AND RISK MANAGEMENT</td>
<td>Approve the CCG’s counter fraud and security management arrangements.</td>
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<tr>
<td>OPERATIONAL AND RISK MANAGEMENT</td>
<td>Approval of the CCG’s risk management arrangements.</td>
<td>✓</td>
<td></td>
<td>Through approval Risk Management Strategy</td>
<td></td>
<td>Determination, and Oversight and scrutiny by</td>
<td></td>
</tr>
<tr>
<td>Policy Area</td>
<td>Decision</td>
<td>Reserved to the Membership</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 Clinical commissioning groups or pooled budget arrangements under section 75 of the NHS Act 2006).</td>
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<tr>
<td>OPERATIONAL AND RISK MANAGEMENT</td>
<td>Approval of a comprehensive system of internal control, including budgetary control, that underpins the effective, efficient and economic operation of the CCG.</td>
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<tr>
<td>OPERATIONAL AND RISK MANAGEMENT</td>
<td>Approve arrangements for action on litigation against or on behalf of the CCG.</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>
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</tbody>
</table>

- Approval of underpinning Risk Management policies
- (Determination and Oversight and scrutiny by Quality, Safety and Risk)
<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>Delegated to a Committee or Sub-Committee</th>
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<th>Delegated to Chief Finance and Operating Officer</th>
<th>Delegated to others</th>
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<tbody>
<tr>
<td><strong>OPERATIONAL AND RISK MANAGEMENT</strong></td>
<td>Approve the CCG’s arrangements for handling complaints.</td>
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<tr>
<td><strong>INFORMATION GOVERNANCE</strong></td>
<td>Approval of the arrangements for Information Governance, 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><strong>TENDERING AND CONTRACTING</strong></td>
<td>Approval of the CCG’s contracts for any commissioning support.</td>
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<tr>
<td><strong>TENDERING AND CONTRACTING</strong></td>
<td>Approval of the CCG’s contracts for corporate support (for example finance provision).</td>
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<tr>
<td><strong>PARTNERSHIP WORKING</strong></td>
<td>Approve decisions that individual members or employees of the CCG participating in joint arrangements on behalf of the CCG can make. Such delegated decisions must be disclosed in this scheme of reservation and delegation.</td>
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<tr>
<td><strong>PARTNERSHIP</strong></td>
<td>Decisions in accordance with the</td>
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<td>Policy Area</td>
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<td>WORKING</td>
<td>ToR of the ONE Partnership Forum including approval of HR policies</td>
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<tr>
<td>PARTNERSHIP WORKING</td>
<td>Decisions on high cost cancer drugs in line with ToR of the North East Cancer Drugs Approval CCG and in line with the financial scheme of delegation</td>
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<td></td>
<td>Insert the individuals delegated by the CCG to make decisions at NECDAG</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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<td>✓</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>
<td></td>
<td>✓</td>
<td>✓</td>
<td>Exercise of the Functions discharged on behalf of the Membership where named in section 5 of the Constitution</td>
<td></td>
</tr>
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<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>Delegated to a Committee or Sub-Committee</th>
<th>Delegated to Accountable Officer</th>
<th>Delegated to Chief Finance and Operating Officer</th>
<th>Delegated to others</th>
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<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 appropriate</td>
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<tr>
<td>COMMISSIONING AND CONTRACTING FOR CLINICAL SERVICES</td>
<td>Approve actions in relation to the co-commissioning of primary care services in partnership with NHS England</td>
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<td>Joint Committee (Section 6.9 of the Constitution)</td>
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<td>COMMUNICATIONS</td>
<td>Approving arrangements for handling Freedom of Information requests.</td>
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<td>Quality, Safety and Risk Committee</td>
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<td>COMMUNICATIONS</td>
<td>Determining arrangements for handling Freedom of Information requests.</td>
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<td></td>
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APPENDIX E – PRIME FINANCIAL POLICIES

1. INTRODUCTION

1.1 General

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

1.1.2 The prime financial policies are part of the CCG’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 and operating 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 CCG has prepared more detailed policies, approved by the chief finance officer, known as detailed financial policies. The CCG refers to these prime and detailed financial policies together as the CCG’s financial policies.

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

1.1.5 A list of the CCG’s detailed financial policies will be published and maintained on the CCG’s website at www.newcastlegatesheadccg.nhs.uk.

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 CCG’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 CCG’s members and employees have a duty to disclose any non-compliance with these prime financial policies to the chief finance and operating officer as soon as possible.
1.3 Responsibilities and delegation

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

1.3.2 The financial decisions delegated by members of the CCG are set out in the CCG’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 CCG to commit the CCG to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the accountable officer 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 and operating 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 CCG’s constitution, any amendment will not come into force until the CCG applies to the NHS Commissioning Board and that application is granted.

2. INTERNAL CONTROL

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 CCG’s constitution for further information).

2.2 The accountable officer has overall responsibility for the CCG’s systems of internal control.

2.3 The chief finance and operating officer will ensure that:

   i. financial policies are considered for review and update annually;

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

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

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

3.2 The person appointed by the CCG 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 and operating officer will ensure that:

   i. the CCG has a professional and technically competent internal audit function; and

   ii. the governing body’s audit committee approves any changes to the provision or delivery of assurance services to the CCG.

4. **FRAUD AND CORRUPTION**

4.1 The governing body’s audit committee will satisfy itself that the CCG has adequate arrangements in place for countering fraud and shall review the outcomes of counter fraud work. It shall also approve the counter fraud work programme.

4.2 The governing body’s audit committee will ensure that the CCG has arrangements in place to work effectively with NHS Protect.

5. **EXPENDITURE CONTROL**

5.1 The CCG is required by statutory provisions\(^{83}\) 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 CCG complies with certain of its statutory obligations, including its financial and accounting obligations, and that it exercises its functions effectively, efficiently and economically and in a way which provides good value for money.

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\(^{83}\) See section 223H of the 2006 Act, inserted by section 27 of the 2012 Act
5.3 The chief finance officer will:

i. provide reports in the form required by the NHS Commissioning Board;

ii. 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;

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

6. ALLOTMENTS

6.1 The CCG’s chief finance and operating officer will:

i. 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 CCG’s entitlement to funds;

ii. 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

iii. 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

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 financial 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.

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84 See section 223(G) of the 2006 Act, inserted by section 27 of the 2012 Act.
7.4 The accountable officer is responsible for ensuring that information relating to the CCG’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 [insert name] will approve consultation arrangements for the CCG’s commissioning plan.\(^{85}\)

8. **ANNUAL ACCOUNTS AND REPORTS**

8.1 The chief finance and operating officer will ensure the CCG:

   i. prepares a timetable for producing the annual report and accounts and agrees it with external auditors and the governing body;

   ii. prepares the accounts according to the timetable approved by the governing body;

   iii. complies with statutory requirements and relevant directions for the publication of annual report;

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

   v. publishes the external auditor’s management letter on the CCG’s website at www.newcastlegatesheadccg.nhs.uk.

9. **INFORMATION TECHNOLOGY**

9.1 The chief finance officer is responsible for the accuracy and security of the CCG’s computerised financial data and shall:

   i. devise and implement any necessary procedures to ensure adequate (reasonable) protection of the CCG'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;

   ii. 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;

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

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

\(^{85}\) See section 14Z13 of the 2006 Act, inserted by section 26 of the 2012 Act
9.2 In addition the chief finance and operating 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

10.1 The chief finance and operating officer will ensure:

i. the CCG has suitable financial and other software to enable it to comply with these policies and any consolidation requirements of the NHS Commissioning Board;

ii. 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 and operating officer shall periodically seek assurances that adequate controls are in operation.

BANK ACCOUNTS

11.1 The chief finance and operating officer will:

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

ii. manage the CCG's banking arrangements and advise the CCG on the provision of banking services and operation of accounts;

iii. prepare detailed instructions on the operation of bank accounts.

11.2 The governing body's audit committee shall approve the banking arrangements.

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

12.1 The Chief Financial Officer is responsible for:

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

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86 See section 223H(3) of the NHS Act 2006, inserted by section 27 of the 2012 Act
ii. establishing and maintaining systems and procedures for the secure handling of cash and other negotiable instruments;

iii. 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;

iv. for developing effective arrangements for making grants or loans.

TENDERING AND CONTRACTING PROCEDURE

13.1 The CCG shall ensure that the firms / individuals invited to tender (and where appropriate, quote) are identified from those that are suitably approved, for example through a framework agreement. Where in the opinion of the chief finance and operating officer it is desirable to seek tenders from other firms, the reason shall be recorded in writing to the accountable officer or the CCG’s governing body.

13.2 The governing body may only negotiate contracts on behalf of the CCG, and the CCG may only enter into contracts, within the statutory framework set up by the 2006 Act, as amended by the 2012 Act. Such contracts shall comply with:

i. the CCG’s standing orders;

ii. the Public Contracts Regulation 2006, any successor legislation and any other applicable law; and

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

13.3 In all contracts entered into, the CCG 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 CCG.

COMMISSIONING

14.1 The CCG 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 governing body detailing actual and forecast expenditure and activity for each contract.

14.3 The chief finance and operating 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.

**RISK MANAGEMENT AND INSURANCE**

15.1 The Accountable Officer will ensure that the CCG has a programme of risk management in place, in accordance with current guidance on risk management and risk assurance.

15.2 The risk management programme will include:

   i. A risk management strategy, approved by the Board;
   
   ii. A process for identifying and quantifying risks and potential liabilities;
   
   iii. Engendering in staff a positive attitude towards the identification and management of risk
   
   iv. Management processes to ensure significant risks are addressed, including effective systems of internal control and clear decision making about acceptable levels of risk
   
   v. Contingency plans to offset the impact of adverse events
   
   vi. Audit arrangements, including internal audit and external audit
   
   vii. A clear indication of which risks shall be insured, through national or other schemes as appropriate
   
   viii. Arrangements to review the risk management strategy and associated policies and procedures

15.3 These arrangements for risk management will assist in providing the basis for the effectiveness of internal control in the Annual Governance Statement, which the accountable officer is required to make at each year end.

**PAYROLL**

16.1 The chief finance and operating officer will ensure that the payroll service selected:

   i. is supported by appropriate (i.e. contracted) terms and conditions;
   
   ii. has adequate internal controls and audit review processes;
   
   iii. has suitable arrangements for the collection of payroll deductions and payment of these to appropriate bodies.

16.2 In addition the chief finance and operating officer shall set out comprehensive procedures for the effective processing of payroll
NON-PAY EXPENDITURE

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

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

17.3 The chief finance and operating officer will:

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

ii. be responsible for the prompt payment of all properly authorised accounts and claims;

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

CAPITAL INVESTMENT, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

18.1 The accountable officer will

i. 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;

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

iii. 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;

iv. be responsible for the maintenance of registers of assets, taking account of the advice of the chief finance and operating 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 and operating officer will prepare detailed procedures for the disposals of assets.
RETENTION OF RECORDS

19.1 The Accountable Officer shall:

i. 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;

ii. ensure that arrangements are in place for effective responses to Freedom of Information requests;

iii. publish and maintain a Freedom of Information Publication Scheme.

20 TRUST FUNDS AND TRUSTEES

20.1 The chief finance and operating officer shall ensure that each trust fund which the CCG is responsible for managing is managed appropriately with regard to its purpose and to its requirements.
APPENDIX F - DISPUTES RESOLUTION PROCESS

1 Context

It may arise that there is a dispute between a Practice and the CCG or vice versa, or between practices within the CCG. If there is a serious disagreement between parties that cannot be resolved through normal channels of communication, this dispute resolution process will apply.

Such a dispute may arise over a number of issues, which could include but is not limited to:

1. budget setting methodology and/or budget allocation
2. incentive scheme assessments
3. referral management processes
4. prescribing practice
5. achievement of objectives set by the CCG
6. eligibility for any Quality Premium

Where the dispute is by the CCG with a practice or practices, the CCG will offer help, support, encouragement, training and education at every stage, where any of these are identified by the practice(s) as being required.

Inter-Practice Disputes
In cases where the dispute is between Practices and it is an issue which warrants formal dispute resolution, then the same processes and timescales will apply.

Principles of dispute resolution
In resolving the dispute, all parties will undertake to adopt the principles of;

- **Transparency** - including clear communication, engagement of relevant stakeholders and enforcing declarations of interest
- **Objectivity** – including analysis and decision making on objective information and criteria and the maintenance of an audit trail
- **Non-discriminatory** – adopting a fair and respectful approach throughout.
- **Proportionality** – only using the formal disputes process on matters of material importance and only using resources proportionate to the significance of the dispute

1.1 Stages of the disputes process

Stage 1: The Informal Process
Informal resolution between the Practices and/or the CCG shall be attempted through a formal meeting involving a nominated member of the Executive and a nominated member of the Practice / Practices. Each party will be invited to involve the LMC in either an advisory or mediation role.

It is a requirement that this informal procedure must have been exhausted before either party is able to escalate the dispute to Stage 2.

If the dispute is not resolved through this informal process, the dispute will move to stage two.
Stage 2: The Formal Local Process
In cases where either party remains dissatisfied with the outcome of Stage 1, then they have the right to request Formal Local Dispute Resolution in writing, including the grounds for the request, to the Accountable Officer of the CCG.

In consultation with the Local Medical Committee the Accountable Officer will consider the request and determine that it is neither frivolous nor vexatious and is appropriate to proceed through the disputes resolution process. If it is relevant then the Accountable Officer will convene a Local Disputes Resolution Panel (LDRP) to hear the dispute and make a determination.

Members of the LDRP
The Panel will consist of:
- A lay member of the CCG’s governing body
- A member of the Governing Body of another CCG.
- A GP conciliator (from a Panel to be established by the LMC)
- An LMC Representative from a different part of the LMC area.
- A Panel Secretary (non-voting)
The lay member of the CCG will act as the panel Chair. The Chair has the responsibility to ensure that the panel obtains appropriate advice.

The Hearing
The hearing will be held within twenty working days of the request being lodged. A minimum of seven working days’ notice will be given to all participants.

Documentation
All relevant documentation will be requested from both parties and copies will be provided to all parties and panel members at least five days prior to the hearing.

Procedures at the LDRP Hearing
- The discussion of the Panel will remain confidential. The Panel Secretary will keep a record of the hearing.
- The Appellant will be asked to present their case. Members of the Panel will be given the opportunity to ask any questions relevant to the case.
- The Respondent will be asked to present their response. Members of the Panel will be given the opportunity to ask any questions relevant to the case.
- The Appellant and the Respondent will then withdraw. The Panel will deliberate and reach a decision on the case based, if necessary, on a majority of the voting Panel Members.
- The Panel Chair will notify both parties of the decision, including any recommendations, in writing within seven days of the hearing.

It is a requirement that this formal local process must have been exhausted before either party is able to escalate the dispute to Stage 3.

If the dispute is not resolved through this formal process, the dispute will move to stage three.
Stage 3: **Referral to the NHS Commissioning Board**

In cases where either party remains wholly dissatisfied with the outcome of Stage 2, then they have the right to request that the NHS Commissioning Board formally considers the case.

The NHS Commissioning Board will decide what process is followed from there on.
APPENDIX G - NOLAN PRINCIPLES

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

   i. **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.

   ii. **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.

   iii. **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.

   iv. **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.

   v. **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.

   vi. **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.

   vii. **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)*[^87]

APPENDIX H – 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 CCGs or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population.

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

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

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

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

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

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

Source: *The NHS Constitution: The NHS belongs to us all* (March 2012)\(^8\)

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