CONSTITUTION

Approved May 2018

Version control

Version	Name	Amendment	Date
1	Andrea McCourt	First draft	21 May 2012
2	Lee Beresford/Cat de Jonge	Review	25 May 2012
3	Lee Beresford/Cat de Jonge	Review	31 May 2012
4	Kay Hughes	Finance input	6 June 2012
5	Andrea McCourt	Appendix C Standing Orders	18 June 2012
6	Constitution working group	Sections 6, 7 and 8	20 June 2012
7	Constitution working group	Organisational structure	21 June 2012
8	Managing Conflicts of Interest	Section 8 & 6.6.3	27 June 2012
9	Lee Beresford/Cat de Jonge	Review	6 August 20102
10	Lee Beresford/Cat de Jonge	Review following membership meeting	15 August 2012
11	Lee Beresford/Cat de Jonge	Update Terms of Reference	16 August 2012
12	Phil Earnshaw/Cat de Jonge	Update to Scheme of Delegation and Reservation	20 August 2012
13	Lee Beresford/Cat de Jonge	Update following final review	30 August 2012
14	Cat de Jonge/Gemma Gamble	Following discussions with Internal Audit	05 September 2012
15	Lee Beresford	Following LMC and member practice feedback	06 September 2012
16	Lee Beresford	Standing Orders at 2.2.2 (c)	14 September 2012
17	Cat de Jonge	Following CCE	19 September 2012
18 FINAL	Cat de Jonge		
19 FINAL 10.12.12	Gemma Gamble		10 December 2012
20 FINAL 07.03.13	Heather Wells	Terms of Reference changes following CCG Board meeting 7 March 2013	7 March 2013
21 FINAL 18.03.13	Heather Wells	Draft changes to Scheme of Delegation, Prime Financial Policies and Terms of Reference for Integrated Governance following Audit & Governance Group and Integrated Governance Committee 18 March 2013	18 March 2013
22 FINAL 16.04.13	Gemma Gamble	Updated lead commissioner GP names in appendix B as noted at the Governing body meeting of 16.04.13.	22 April 2013
23	Katherine Bryant	Updated to include an additional statement re whistleblowing (9.10)	31 May 2013

24 FINAL 15.08.13	Katherine Bryant	Amendments to the constitution and its appendix approved by NHS England.	15 August 2013
25	Katherine Bryant	Proposed removal of committee terms of reference as an appendix to the CCG. Updated website links throughout the constitution.	April 2014
26	Katherine Bryant	Amendments to the constitution and its appendix approved by NHS England.	25 July 2014
27	Katherine Bryant	Amendments to the constitution and appendix following a governance review and consultation of the members and the LMC	September – December 2014
28	Katherine Bryant	Amendments to the constitution and appendix approved by Chief Officer, Chair and Lay Member (Audit). Approved by the CCG's Members on 6th January 2015.	December 2014 - January 2015
29	Katherine Bryant	Amendments to the constitution and its appendix presented to NHS England for approval.	January 2015
30 FINAL 24.03.15	Katherine Bryant	Amendments to the constitution and its appendix approved by NHS England. Minor amendments to description of Conflicts of Interest Management Committee, retitled the Probity Committee.	March 2015
31	Ruth Unwin	Draft Amendments to the submitted to NHS England for approval	February 2018
32	Ruth Unwin	Amendments approved by NHS England. Section 8 amended to reflect NHSE feedback	May 2018

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FOREWORD

This constitution sets out the arrangements made by NHS Wakefield Clinical Commissioning Group to meet its responsibilities for commissioning care for the people for whom it is responsible. It describes the governing principles, rules and procedures that the group will establish to ensure probity and accountability in the day to day running of the clinical commissioning group; to ensure that decisions are taken in an open and transparent way and that the interests of patients and the public remain central to our goals.

The constitution includes:

- the name of the group;
- the membership of the group;
- the area of the group;
- the arrangements for the discharge of the group's functions and those of its Governing Body;
- the procedures to be followed by the group and its Governing Body in making decisions and securing transparency in its decision making;
- arrangements for discharging the group'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 group in certain aspects of those commissioning arrangements and the principles that underpin these.

The constitution applies to the following, all of whom are required to adhere to it as a condition of their appointment:

- the group's member practices;
- the group's employees;
- individuals working on behalf of the group;
- anyone who is a member of the group's Governing Body (including the Governing Body's audit and remuneration committees);
- anyone who is a member of any other committee(s) or sub-committees established by the group or its Governing Body.

Dr Phillip Earnshaw
Chair and Clinical Leader
NHS Wakefield Clinical Commissioning Group

1. INTRODUCTION AND COMMENCEMENT

1.1. Name

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

1.2. Statutory framework

1.2.1. Clinical commissioning groups are established under the Health and Social Care Act 2012 ("the 2012 Act") and The National Health Service (Clinical Commissioning Groups) Regulations 2012 (2012 No. 1631).[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 England is responsible for determining applications from Clinical Commissioning Groups for amendments to the Constitution and undertakes an annual assessment of each established group.[4] It has powers to intervene in a clinical commissioning group where it is satisfied that a group is failing or has failed to discharge any of its functions or that there is a significant risk that it will fail to do so.[5]

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.[6]

1.3. Status of this constitution

1.3.1. This original constitution was made between the members of NHS Wakefield Clinical Commissioning Group and has effect from 10th day of December 2012, when the NHS Commissioning Board (hereafter referred to as NHS England) established the group. [7] Amendments were approved by the Governing Body in March 2015 and January 2018.

1.3.2. The constitution is available to the public in the following way:

- published on the CCG website at: http://www.wakefieldccg.nhs.uk/resources/
- upon request for inspection at NHS Wakefield CCG's headquarters;

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

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

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

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

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

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

7 See section 14D of the 2006 Act, inserted by section 25 of the 2012 Act

- upon application by post, in writing to our headquarters at White Rose House, West Parade, Wakefield, WF1 1LT.

1.4. Amendment and variation of this constitution

1.4.1. This constitution can only be varied in two circumstances.[8]

a) where the group applies to NHS England NHS England (following approval of the changes by the CCG's Members in accordance with Standing Order 3) and that application is granted;
b) where in the circumstances set out in legislation the NHS England NHS England varies the CCG's constitution other than on application by the CCG.

2. AREA COVERED

2.1. The geographical area covered by NHS Wakefield Clinical Commissioning Group is coterminous with that of Wakefield Council.

3. MEMBERSHIP

3.1. Membership of the Clinical Commissioning Group

3.1.1. A list of current member practices in included in Appendix B of the constitution.

3.1.2 No practice shall become a member of the CCG unless they are a provider of primary medical services within the Wakefield district boundary, to a registered list of patients under a General Medical Services, Personal Medical Services or Alternative Provider Medical Services contract, and:

a) was a member (and included within Appendix B) at the date the CCG was authorized;

or

b) has completed an application for membership to the CCG, which has been agreed by the Governing Body ;

or

c) has submitted an application to NHS England NHS England and had its application approved.

3.1.3 A member practice shall only be expelled from the CCG through the provision of relevant statute.

3.1.4 All members of the CCG will be recorded in the Register of Members (Appendix B). The Register of Members includes details of the practice name, address and details of the Lead Commissioner for each Member.

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

4. VISION, VALUES AND AIMS

4.1. Vision

4.1.1. The vision of NHS Wakefield Clinical Commissioning Group is as follows:

"We aspire to commission quality service that will improve our patients' experiences of care and their health outcomes. A key part of this will be to involve and listen to our patients, practices, partners and staff when redesigning services.

We believe that we will be successful if we work in a creative and empowering environment that is supportive and stimulates innovation. Our vision will forge effective joint solutions delivered in partnership across organisations that will be patient-centred."

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

4.2. Values

4.2.1. Good corporate governance arrangements are critical to achieving the group's objectives.

4.2.2. The values that lie at the heart of our work are:

a) putting patients at the heart of all commissioning decisions;
b) fostering strong partnerships between and within practices to enhance the commissioning of services for the whole health economy;
c) identifying and sharing good practice;
d) building health alliances with Wakefield Council, Public Health and other partners in the wider health economy;
e) encouraging public and patient participation to enhance service improvements;
f) commissioning high quality, safe services.

4.3. Aims

4.3.1. Our aims are:

a) strong communication in plain English;
b) honesty based on transparency;
c) abiding by our vision to be 'Locally Valued';
d) respecting opinions and valuing difference;
e) working collaboratively, both formally and informally;
f) managing dissent;
g) ownership of problems and opportunities at the practice level;
h) commitment to cost improvement and living within our means;
i) being bound by our decisions;
j) developing a sophisticated understanding of performance/quality in practice.

4.4. Principles of good governance

4.4.1. In accordance with section 14L (2) (b) of the 2006 Act,[9] the group will at all times observe "such generally accepted principles of good governance" in the way it conducts its business. These include:

a) the highest standards of propriety involving impartiality, integrity and objectivity in relation to the stewardship of public funds, the management of the organisation and the conduct of its business;
b) the Good Governance Standard for Public Services[10];
c) the standards of behaviour published by the Committee on Standards in Public Life (1995) known as the 'Nolan Principles'[11];
d) the seven key principles of the NHS Constitution[12];
e) the Equality Act 2010[13];
f) the Standards for Members of NHS Boards and Governing Bodies in England.

4.5. Accountability

4.5.1. NHS Wakefield CCG will demonstrate its accountability to its members, local people, stakeholders and NHS England in a number of ways, including by:

a) publishing its constitution;
b) appointing independent Lay Members and non-GP clinicians to its Governing Body;
c) holding Board meetings of its Governing Body in public (except where it would not be in the public interest in relation to all or part of a meeting)
d) publishing annually a commissioning plan;
e) engaging with the Local Medical Committee as local statutory representative of the medical profession;
f) complying with local authority health overview and scrutiny requirements;
g) meeting annually in public to publish and present its annual report;
h) producing annual accounts in respect of each financial year which must be externally audited;
i) having a published and clear complaints process;
j) complying with the Freedom of Information Act 2000;
k) providing information to NHS England as required.

4.5.2. In addition to these statutory requirements, the group will demonstrate its accountability by maintaining an effective membership model.

4.5.3. The Governing Body of the CCG will throughout each year have an ongoing role in reviewing the group's governance arrangements to ensure that the group continues to reflect the principles of good governance.

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[9] Inserted by section 25 of the 2012 Act

[10] *The Good Governance Standard for Public Services*, The Independent Commission on Good Governance in Public Services, Office of Public Management (OPM) and The Chartered Institute of Public Finance & Accountability (CIPFA), 2004

[11] See Appendix I

[12] See Appendix J

[13] See http://www.legislation.gov.uk/ukpga/2010/15/contents

5. FUNCTIONS AND GENERAL DUTIES

5.1. Functions

5.1.1. The functions that the group is responsible for exercising are largely set out in the 2006 Act, as amended by the 2012 Act. An outline of these appears in the Department of Health's *Functions of clinical commissioning groups:* published in March 2013. They relate to:

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

i. all people registered with member GP practices,
ii. people who are usually resident within the area and are not registered with a member of any clinical commissioning group.

b) commissioning emergency care for anyone present in the group's area;
c) determining the remuneration and travelling or other allowances of members of its Governing Body;
d) paying its employees' remuneration, fees and allowances in accordance with the determinations made by its Governing Body and determining any other terms and conditions of service of the group's employees.

5.1.2. In discharging its functions the group will:

a) act[14], when exercising its functions to commission health services, consistently with the discharge by the Secretary of State and NHS England of their duty to *promote a comprehensive health service*[15]*and* with the objectives and requirements placed on NHS England through *the mandate*[16] published by the Secretary of State before the start of each financial year by:

- delegating responsibility to its Governing Body and committees of the CCG;
- appointing a Chief Officer with lead responsibility to oversee its discharge;
- setting out its commissioning priorities and commissioning intentions in the commissioning plan;
- requiring progress of delivery of the duty to be monitored through the group's reporting mechanisms.

b) *meet the public sector equality duty*[17]by:

- delegating responsibility to its Governing Body, (or on their behalf a committee of the CCG), or a Chief Officer or member of the Governing Body with lead responsibility to oversee its discharge;

[14] See section 3(1F) of the 2006 Act, inserted by section 13 of the 2012 Act
[15] See section 1 of the 2006 Act, as amended by section 1 of the 2012 Act
[16] See section 13A of the 2006 Act, inserted by section 23 of the 2012 Act
[17] See section 149 of the Equality Act 2010, as amended by paragraphs 184 and 186 of Schedule 5 of the 2012 Act

- developing and publishing an Equality Strategy and objectives which sets out how the CCG intends to discharge this duty, reviewing them at least every four years;
- requiring progress of delivery of the duty to be monitored through the CCG's Integrated Governance Committee.

d) work in partnership with the local authority to develop *joint strategic needs assessments*[18] and *joint health and wellbeing strategies*[19]enacted through membership of the Wakefield Health and Wellbeing Board.

5.2. General duties

5.2.1. In discharging its functions the group will make arrangements to *secure public involvement* in the planning, development and consideration of proposals for changes and decisions affecting the operation of commissioning arrangements[20] through its communications and engagement plan by:

a) publishing and implementing a communications and engagement strategy and work plan;
b) putting governance arrangements in place to ensure the implementation and performance management of the strategy;
c) working in partnership with patients and the local community to secure the best care for them;
d) adapting engagement activities to meet the specific needs of the different patient groups.

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*[21] by:

a) the delegation of responsibility from the CCG Governing Body to a member of the Governing Body with lead responsibility to oversee the discharge of this duty;
b) the development of a strategy/implementation plan which sets out how the CCG intends to discharge this duty;
c) the monitoring of progress against the delivery of this duty through the CCG's performance management and reporting mechanisms;
d) using plain language appropriate for all audiences;
e) being clear, open, honest, consistent and accountable;
f) delivering clear, accurate and consistent messages, linked to the CCG's vision and values;
g) encouraging and supporting communication and engagement based on good relationships;
h) ensuring planned, timely, targeted and proportionate communication and engagement;
i) providing a range of opportunities for people to engage with the organisation;
j) ensuring that the CCG's communications and engagement activity is equally

[18] See section 116 of the Local Government and Public Involvement in Health Act 2007, as amended by section 192 of the 2012 Act
[19] See section 116A of the Local Government and Public Involvement in Health Act 2007, as inserted by section 191 of the 2012 Act
[20] See section 14Z2 of the 2006 Act, inserted by section 26 of the 2012 Act
[21] See section 14P of the 2006 Act, inserted by section 26 of the 2012 Act and section 2 of the Health Act 2009 (as amended by 2012 Act)

accessible to all;

k) providing cost effective, high quality information – maximising resources;
l) ensuring that communication and engagement is everyone's responsibility and that skills will be shared and developed;
m) working in partnership with other agencies, stakeholders, patients, patient representatives and carers;
n) working with the local compact agreement for Wakefield

5.2.3. Act *effectively, efficiently and economically*[22] by:

a) specifying a financial control policy and process which set out how the group intends to discharge its duty;
b) the development and publication of a commissioning plan which set out the strategic objectives of the CCG;
c) the use of business intelligence to support evidence based commissioning;
d) the establishment of a transparent and robust business planning processes which is aligned to the financial plan;
e) monitoring and performance management through the Integrated Governance Committee of the CCG.

5.2.4. Act with a view to *securing continuous improvement to the quality of services*[23] by:

a) the Chief Officer taking the lead officer role for securing continuous improvement in quality;
b) establishing a Governing Body and Clinical Cabinet to advise the CCG;
c) the Integrated Governance Committee seeking assurance from providers, raising formal queries and referringissues to the CCG's Governing Body where there are significant concerns which may compromise quality and patient safety;
d) agreeing an annual programme of work developed with the Clinical Cabinet and in consultation with patients and the public that takes account of its commissioning priorities and is sufficiently flexible to respond to significant concerns should they arise.

5.2.5. Assist and support NHS England in relation to the Board's duty to *improve the quality of primary medical services*[24]by:

a) the production of a work plan which sets out the CCG's plans for the further development of a consistently high standard and effective primary medical care service;
b) ensuring that the outcomes from patient experience and involvement activity informs the development of primary medical services;
c) promoting the use of data and information tools to provide clinicians with the knowledge they need to identify and prioritise areas for quality improvement;
d) establishing a clear framework of accountability to manage poor performance and under achievement.

[22] See section 14Q of the 2006 Act, inserted by section 26 of the 2012 Act
[23] See section 14R of the 2006 Act, inserted by section 26 of the 2012 Act
[24] See section 14S of the 2006 Act, inserted by section 26 of the 2012 Act

5.2.6. Have regard to the need to *reduce inequalities*[25] by:

a) active membership of the Health and Wellbeing Board;
b) active engagement in the development of the Health and Wellbeing Strategy;
c) seeking to ensure that the commissioning plan reflects the health and wellbeing agenda and addresses inequalities;
d) appointment of a Lay Member who carries the responsibility for equality and diversity within the Governing Body.

5.2.7. *Promote the involvement of patients, their carers and representatives in decisions about their healthcare*[26] by:

a) the development and publication of communications and engagement strategies and associated work plans;
b) the establishment of a Clinical Cabinet with responsibility for the scrutiny of and monitoring the effectiveness of plans to promote involvement;
c) developing and evidencing effective engagement with groups with, or associated with, protected characteristics as set out in the Equality Act.

5.2.8. Act with a view to *enabling patients to make choices*[27]by:

a) seeking to ensure that patients for whom the CCG are responsible receive safe and timely treatment from the most appropriate providers;
b) monitoring provider performance to seek to ensure that all treatment is in line with policy and contractual requirements;
c) seeking to ensure that the health economy within Wakefield delivers the rights and pledges set out in the NHS Constitution in relation to access to services within maximum waiting times;
d) patients are able to choose which provider they are referred to by their GP;
e) ensuring patients can choose which hospital or other treatment setting they are seen in according to what matters most to them;
f) ensuring a choice of provider is available for most patients and in most circumstances. Exceptions include emergency and urgent services, cancer, maternity and mental health services.

5.2.9. *Obtain appropriate advice*[28]from persons who, taken together, have a broad range of professional expertise in healthcare and public health by:

a) working collaboratively with specialist regional clinical networks as they become established;
b) working collaboratively with the Yorkshire and Humber Clinical Senate;
c) the appointment of a secondary care clinician and registered nurse to the Governing Body of the CCG;
d) the appointment of the Director of Public Health to the Governing Body;
e) establishing formal communication with local medical committees;
f) establishing and supporting the development of local clinical networks and Federations of member practices;
g) working collaboratively with the third sector.

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25 See section 14T of the 2006 Act, inserted by section 26 of the 2012 Act
26 See section 14U of the 2006 Act, inserted by section 26 of the 2012 Act
27 See section 14V of the 2006 Act, inserted by section 26 of the 2012 Act
28 See section 14W of the 2006 Act, inserted by section 26 of the 2012 Act

5.2.10. *Promote innovation*[29] by:

a) the development of a commissioning plan and research and innovation strategy which reflects the CCG's approach to innovation;
b) delegating the oversight of innovation to the Clinical Cabinet;
c) developing relationships both within the CCG and with our health and social care partners in order to ensure that patients are at the centre of every system;
d) the creation of opportunities for the CCG's member practices, key stakeholders and patients, to be involved in the development of excellent healthcare.

5.2.11. *Promote research and the use of research*[30] by:

a) the delegation of responsibility to the Chief Officer;
b) the discharge of this responsibility through the Integrated Governance Committee;
c) working in partnership with the National Institute for Health Research;
d) working in partnership with Public Health to implement the research strategy.

5.2.12. Have regard to the need to *promote education and training*[31] 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[32] by:

a) Working with the local education and training boards;
b) Developing a CCG staff training and education programme.

5.2.13. Act with a view to *promoting integration* of *both* health services with other health services *and* health services with health-related and social care services where the group considers that this would improve the quality of services, reduce inequalities[33] and avoid the duplication of work by:

a) working collaboratively with Wakefield Council and other commissioner or provider partners on partnership Boards or Committees as appropriate and subject to the provisions of clause 6.5;
b) identifying opportunities for the development of an integrated health and social care commissioning plan as appropriate, in line with the strategic objectives of the CCG;
c) engaging Clinical Cabinet in providing strategic advice on service transformation

5.3. General financial duties – the group will perform its functions so as to:

5.3.1. *Ensure its expenditure does not exceed the aggregate of its allotments for the financial year*[34] by:

a) Delegating responsibility to its Chief Finance Officer for ensuring compliance with financial statutory obligations;

29 See section 14X of the 2006 Act, inserted by section 26 of the 2012 Act
30 See section 14Y of the 2006 Act, inserted by section 26 of the 2012 Act
31 See section 14Z of the 2006 Act, inserted by section 26 of the 2012 Act
32 See section 1F(1) of the 2006 Act, inserted by section 7 of the 2012 Act
33 See section 14Z1 of the 2006 Act, inserted by section 26 of the 2012 Act
34 See section 223H(1) of the 2006 Act, inserted by section 27 of the 2012 Act

b) Ensuring funding is drawn down from NHS England for approved expenditure only and in a way which provides value for money;
c) Ensuring that an adequate system of financial monitoring is in place to enable the group to fulfil its statutory responsibility not to exceed expenditure limits.

5.3.2. *Ensure its use of resources (both its capital resource use and revenue resource use) does not exceed the amount specified by NHS England for the financial year*[35] by

a) delegating responsibility to its Chief Finance Officer to oversee how this duty is discharged;
b) requiring progress of delivery of the duty to be monitored through its finance performance reporting mechanisms;
c) a report being submitted prior to start of each financial year showing both revenue and capital allocations received and the proposed distribution of resources.

5.3.3. *Take account of any directions issued by NHS England , in respect of specified types of resource use in a financial year, to ensure the group does not exceed an amount specified by NHS England* [36] by

a) delegating responsibility to its Chief Finance Officer to oversee how this duty is discharged;
b) requiring progress of delivery of the duty to be monitored through its performance reporting mechanisms;
c) determining whether specified resource must be treated as directed by NHS England and to which financial year they must be attributed.

5.3.4. *Publish an explanation of how the group spent any payment in respect of quality* made to it by the NHS England [37] by

a) delegating responsibility to its Chief Finance Officer to oversee how this duty is discharged;
b) requiring progress of delivery of the duty to be monitored through its performance reporting mechanisms
c) provision of principles against which payments may relate;
d) requiring progress on payment made against these principles through reporting mechanisms.

5.4. Other relevant Regulations, Directions and documents

5.4.1. The group will:

a) comply with all relevant regulations;
b) comply with directions issued by the Secretary of State for Health or NHS England ;
c) take account of documents issued by NHS England .

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

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35 See sections 223I(2) and 223I(3) of the 2006 Act, inserted by section 27 of the 2012 Act
36 See section 223J of the 2006 Act, inserted by section 27 of the 2012 Act
37 See section 223K(7) of the 2006 Act, inserted by section 27 of the 2012 Act

6. DECISION MAKING: THE GOVERNING STRUCTURE

6.1. Authority to act

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

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

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

a) the group's Scheme of Reservation and Delegation;
b) the terms of reference of its committees.

6.2. Scheme of Reservation and Delegation

6.2.1. The Scheme of Reservation and Delegation (Appendix D) sets out:

a) those decisions that are reserved for the membership as a whole;
b) those decisions that are reserved to the Governing Body as a whole the group's committees and sub-committees, individual members and employees, or to joint committees, as specified in their terms of reference.

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 group that have been delegated to its Governing Body and its committees, and individuals the CCG must:

a) comply with the group's principles of good governance;
b) operate in accordance with the group's Scheme of Reservation and Delegation;
c) comply with the group's Standing Orders;
d) comply with the group's arrangements for discharging its statutory duties;
e) where appropriate, ensure that member practices have had the opportunity to contribute to the group's decision making process through strong communication process and practice.

6.3.2. When discharging their delegated functions, groups, 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 arrangements must:

a) base all collaboration on a foundation of strong communication process and practice to ensure true collaboration and effective decision making from the outset;
b) identify the roles and responsibilities of those clinical commissioning groups who are working together;
c) identify any pooled budgets and how these will be managed and reported in annual accounts;
d) specify under which clinical commissioning group's Scheme of Reservation and Delegation and supporting policies the collaborative working arrangements will operate;
e) specify how the risks associated with the collaborative working arrangement will be managed between the respective parties;
f) identify how disputes will be resolved and the steps required to terminate the working arrangements;
g) specify how decisions are communicated to collaborative partners.

6.4. Joint arrangements

6.4.1 Joint commissioning arrangements with other Clinical Commissioning Groups

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

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

6.4.2.1 delegating any of the CCG's commissioning functions to another CCG;
6.4.2.2 exercising any of the commissioning functions of another CCG; or
6.4.2.3 exercising jointly the commissioning functions of the CCG and another CCG

6.4.1.3 For the purposes of the arrangements described at paragraph 6.5.1.2, the CCG may:
6.4.1.3.1 make payments to another CCG;
6.4.1.3.2 receive payments from another CCG;
6.4.1.3.3 make the services of its employees or any other resources available to another CCG; or
6.4.1.3.4 receive the services of the employees or the resources available to another CCG.

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

6.4.1.5 For the purposes of the arrangements described at paragraph 6.5.1.2 above, the CCG may establish and maintain a pooled fund made up of contributions by any of the CCGs working together pursuant to paragraph 6.5.1.2.3 above. Any such pooled fund may be used to make payments towards expenditure incurred in the discharge of any of the commissioning functions in respect of which the arrangements are made.

6.4.1.6 Where the CCG makes arrangements with another CCG as described at paragraph 6.4.1.2 above, the CCG shall develop and agree with that CCG an agreement setting out the arrangements for joint working, including details of:

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

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

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

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

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

6.4.1.10 The Governing Body of the CCG shall require, in all joint commissioning arrangements, that the lead clinician and lead manager of the lead CCG make a regular 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.

6.4.1.11 Should a joint commissioning arrangement prove to be unsatisfactory the Governing Body of the CCG can decide to withdraw from the arrangement, but has to give a minimum of six months' notice to partners.

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

6.4.2.1 Subject to approval by the Governing Body, the CCG may wish to work together with NHS England in the exercise of its commissioning functions.

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

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

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

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

6.4.2.6 Where the CCG makes arrangements with NHS England (and another CCG if relevant) as described at paragraph 6.5.2.2 above, the CCG shall develop and agree with NHS England a framework setting out the arrangements for joint working, including details of:

- How the parties will work together to carry out their commissioning functions;
- The duties and responsibilities of the parties;
- How risk will be managed and apportioned between the parties;
- Financial arrangements, including, if applicable, payments towards a pooled fund and management of that fund;

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

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

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

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

6.4.2.10 The Governing Body of the CCG shall require, in all joint commissioning arrangements that the Chief Officer of the CCG make a regular 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.

6.4.2.11 Should a joint commissioning arrangement prove to be unsatisfactory the Governing Body of the CCG can decide to withdraw from the arrangement, but has to give minimum of six months' notice to partners.

6.4.3 Joint commissioning arrangements with NHS England for the exercise of NHS England's functions

6.4.3.1 Subject to approval by the Governing Body, the CCG may wish to work with NHS England and, where applicable, other CCGs, to exercise specified NHS England functions.

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

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

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

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

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

6.4.3.6 Where the CCG enters into arrangements with NHS England as described at paragraph 6.5.3.2 above, the parties will develop and agree a framework setting out the arrangements for joint working, including details of:

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

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

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

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

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

6.4.3.10 The Governing Body of the CCG shall require, in all joint commissioning arrangements that the Chief Officer of the CCG make a regular 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.

6.4.3.11 Should a joint commissioning arrangement prove to be unsatisfactory the Governing Body of the CCG can decide to withdraw from the arrangement, but has to give minimum of six months' notice to partners.

6.4.4 Joint Committee(s) with Wakefield Council

6.4.4.1 Subject to approval by the Governing Body, the group may make arrangements for joint committees in respect of designated functions as defined in an agreement under section 75 of the 2006 Act with Wakefield Council.

6.4.4.2 Where the CCG enters into arrangements with Wakefield Council as described at paragraph 6.5.4.1 above, the parties will develop and agree a framework setting out the arrangements for joint working, including details of:

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

6.4.4.3 Arrangements made between the CCG and Wakefield Council may be on such terms and conditions as may be agreed between the parties and approved by the CCG's Governing Body.

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 or in

this constitution.[38]The Governing Body has responsibility for:

a) ensuring that the group has appropriate arrangements in place to exercise its functions effectively, efficiently and economically and in accordance with the groups principles of good governance[39] (its main function);
b) determining the remuneration, fees and other allowances payable to employees or other persons providing services to the group and the allowances payable under any pension scheme it may establish under paragraph 11(4) of Schedule 1A of the 2006 Act, inserted by Schedule 2 of the 2012 Act;
c) approving any functions of the group that are specified in regulations;[40]
d) identify any budget allocated to its committees including any management of the same;
e) setting out how reports shall be submitted to the Governing Body including frequency of submission;
f) having a robust procedure to manage and resolve any disputes and any termination procedures with regard to the dissolution of the relevant committee;
g) reviewing registers of interest on a regular basis.

6.5.2. *Composition of the Governing body* - the Governing Body shall have no less than five clinical representatives who have been elected by member practices. The voting members of the Governing Body will be:

a) the Clinical Chair ,a General Practitioner elected by the Members;
b) the Assistant Clinical Leader, a General Practitioner elected by the Members;
c) up to three General Practitioners elected Members (these are in addition to the Chair and Assistant Clinical Leader listed above);
d) three Lay Members:
    i. Deputy Chair;
    ii. Audit - lead on audit, remuneration and conflict of interest matters;
    iii. PPI - lead on patient and public participation matters;
e) one independent registered nurse;
f) one independent secondary care specialist doctor;
g) the Chief Officer;
h) the Chief Finance Officer;
i) the Chief Operating Officer
j) Executive Nursethe Director of Public Health;
k) the Local Authority Executive representative;

6.5.3. *Committees of the Governing Body* - the Governing Body is required to have in place the following committees:

a) Audit Committee – the Audit Committee is accountable to the Governing Body and supports the CCG by critically reviewing governance and assurance processes on which the Governing Body places reliance. These assurances will include a risk management system and a performance management system underpinned by an 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

38 See section 14L(3)(c) of the 2006 Act, as inserted by section 25 of the 2012 Act
39 See section 4.4 on Principles of Good Governance above
40 See section 14L(5) of the 2006 Act, inserted by section 25 of the 2012 Act

Committee. Terms of reference can be seen at [New link needed]

The Governing Body's Audit Committee approves any changes to the provision or delivery of assurance services to the group.

b) Remuneration Committee– the Remuneration Committee is accountable to the Governing Body and determines remuneration, fees and other allowances for employees and for people who provide services to the group and makes determinations about allowances under any pension scheme that the group may establish as an alternative to the NHS pension scheme.

To avoid potential conflicts of interest the CCG has set up Remuneration Committee of independent Lay Members to make recommendations to the Governing Body, within agreed terms of reference, on the CCG's framework of executive remuneration and its costs; and to determine on their behalf specific remuneration packages for each of the executive officers, including pension rights and any compensation payments.

The Remuneration Committee should consist exclusively of Lay Members who are independent of management and free from any business or other relationships which would materially interfere with the exercise of their independent judgement. The members of the Remuneration Committee should be listed each year in the Governing Body's remuneration report.

The Governing Body itself should determine the remuneration of Lay Members, including members of the Remuneration Committee, within the limits set in national guidance. The Remuneration Committee should consult the Chair and Chief Officer about their proposals relating to the remuneration of other executive officers and have access to professional advice inside and outside the CCG.

The Governing Body should report each year on remuneration. The report should form part of, or be annexed to, the annual report and accounts. It should be the main vehicle through which the CCG reports on executive officer's remuneration.

The Governing Body has approved and keeps under review the terms of reference for the remuneration committee (available at www.wakefieldccg.nhs.uk/fileadmin/site_setup/contentUploads/Corporate_documents/Terms_of_Reference_Combined_May_2018 which includes information on the membership of the Remuneration Committee.

6.5.3.1 Other committees

The Governing Body is authorised to establish other committees to support it in the discharge of functions that have been delegated by the CCG to the Governing Body. The committees and their responsibilities are set out in Appendix H.

7. ROLES AND RESPONSIBILITIES OF MEMBERS OF THE GOVERNING BODY

7.1. All members of the Governing Body

7.1.1. Guidance on the roles of members of the group's Governing Body is set out in a separate document[41]. In summary, each member of the Governing Body should share responsibility as part of a team to ensure that the group exercises its functions effectively, efficiently and economically, with good governance and in accordance with the terms of this constitution. Each brings their unique perspective, informed by their expertise and experience.

7.2. The Chair of the Governing Body and Clinical Leader

7.2.1. The Chair of the Governing Body is the Clinical Leader and is responsible for:

a) leading the Governing Body, ensuring it remains continuously able to discharge its duties and responsibilities as set out in this constitution;
b) building and developing the group's Governing Body and its individual members;
c) ensuring that the group has proper constitutional and governance arrangements in place;
d) ensuring strong communication processes and practices are in place to facilitate effective communication with the membership;
e) ensuring that, through the appropriate support, information and evidence, the Governing Body is able to discharge its duties;
f) supporting the Chief Officer in discharging the responsibilities of the organisation;
g) contributing to building a shared vision of the aims, values and culture of the organisation;
h) leading and influencing to achieve clinical and organisational change to enable the group to deliver its commissioning responsibilities;
i) overseeing governance and particularly ensuring that the Governing Body and the wider group behaves with the utmost transparency and responsiveness at all times;
j) ensuring that public and patients' views are heard and their expectations understood and, where appropriate as far as possible, met;
k) ensuring that the organisation is able to account to its local patients, stakeholders and the NHS England ;
l) ensure mechanisms exists by which practices can appeal decisions or raise grievances with the CCG;
m) ensuring that the group builds and maintains effective relationships, particularly with the individuals involved in overview and scrutiny from the local authority.

7.2.2. Where the chair of the Governing Body is also the senior clinical voice of the group they will take the lead in interactions with stakeholders, including NHS England .

7.2.3 The Chair and Clinical Leader will be a General Practitioner and will be appointed in accordance with section 2 of the Standing Orders.

7.3. Lay Member - Deputy Chair of the Governing Body

7.3.1. The Lay Member - Deputy Chair of the Governing Body will be a Lay Member and deputises for the Chair of the Governing Body where the Chair has a conflict of interest

[41] *https://www.england.nhs.uk/publication/clinical-commissioning-group-governing-body-members-role-outlines-attributes-and-skills/*

or is otherwise unable to act. Where the Deputy Chair may also be conflicted, one of the other Lay Members will act in their stead.

7.3.2. The Lay Member - Deputy Chair of the Governing Body will be appointed in accordance with section 2 of the Standing Orders.

7.3.3 The role of Lay Member – Deputy Chair of the Governing Body is to:

a) bring specific expertise and experience to the work of the Governing Body.
b) bring a strategic and impartial focus, providing an external view of the work of the CCG that is removed from the day-to-day running of the organisation.
c) oversee key elements of governance including remuneration.
d) serve as Chair of the Integrated Governance Committee and Remuneration Committee.
e) undertake a lead role in ensuring that the Governing Body and the wider CCG behaves with the utmost probity at all times

7.4. Role of the Chief Officer

7.4.1. The Chief Officer of the group is a member of the Governing Body.

The Chief Officer is the Accountable Officer and will be appointed in accordance with national guidance and regulations.

7.4.3. This role of Chief Officer is summarised in NHS England's governing body members role outlines, attributes and skills:

> The accountable officer is responsible for ensuring that the CCG fulfils its duties to exercise its functions effectively, efficiently and economically thus ensuring improvement in the quality of services and the health of the local population whilst maintaining value for money.
>
> The accountable officer will, at all times, ensure that the regularity and propriety of expenditure is discharged, and that arrangements are put in place to ensure that good practice (as identified through such agencies as the Audit Commission and the National Audit Office) is embodied and that safeguarding of funds is ensured through effective financial and management systems.
>
> The accountable officer, working closely with the Chair of the governing body, 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 development of its members and staff.

7.5. Role of the Chief Finance Officer

7.5.1. The Chief Finance Officer is a member of the Governing Body and is responsible for providing financial advice to the clinical commissioning group and for supervising financial control and accounting systems.

7.5.2. The Chief Finance Officer will be appointed in accordance with national guidance and regulations.

7.5.3. This role of Chief Finance Officer has been summarised in a national document[42] as:

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

7.6 Role of Chief Operating Officer

7.6.1 The Chief Operating Officer is a member of the Governing Body and is responsible for:

- Securing strategic alignment of acute commissioning across North Kirklees, Wakefield, Mid Yorkshire and the wider Yorkshire and Humber footprint in the delivery of a robust sustainability and transformational plan.
- Supporting the Accountable Officers of NHS North Kirklees CCG and NHS Wakefield CCG in the delivery of the key strategic objectives including accountability for key Director deliverables.
- Leading the development and delivery of a planned care transformation programme across North Kirklees and Wakefield building on the current prioritisation and sustainability agenda.
- Creating a single approach to commissioning business across the Mid Yorkshire footprint which eliminates duplication, strengthens commissioning and delivers robust and real value e.g. through QIPP and with a focus on quality, safety and driving efficiencies.
- Working with organisational leads for place-based commissioning to ensure translation into strategic operating plans for delivering the interdependent changes in community and primary care services.
- Act as Deputy Accountable Officer for the CCG.

7.7 Role of General Practitioners

7.7.1 In addition to the general responsibilities of all Governing Body members the General Practitioners elected by the Members will have an active role in the management and operation of the CCG. As members of the Governing Body, they bring their unique understanding as clinicians to bear on the decision making of the Governing Body. Furthermore they will bring the unique understanding of those Members to the discussion and decision making of the Governing Body.

42 See the latest version of NHS England's *Clinical commissioning group governing body members: Role outlines, attributes and skills*

7.7.2 The General Practitioners elected by the Members will be appointed in accordance with section 2 of the Standing Orders.

7.7.3 This role of General Practitioners elected by the Members has been summarised in a national document[43] as:

a) have the confidence of the Members of the CCG,
b) understand the issues Members face and what is important to them;
a. bring an unbiased strategic clinical view on all aspects of CCG business;
c) bring a balanced view of the clinical and management agenda, drawing on their specialist skills to add value;
d) contribute a generic view from the perspective of Members in the CCG, whilst putting aside specific issues relating to their own practice circumstances.

7.7.4 One of the elected General Practitioners will be appointed as Assistant Clinical Leader to support the Clinical Leader in the discharge of his/her responsibilities

7.8 Role of the Independent Registered Nurse

7.8.1 In addition to the general responsibilities of all Governing Body members, the independent registered nurse as a non-elected clinical member of the Governing Body is responsible for bringing a broader view as an independent registered nurse on health and social care issues to underpin the work of the CCG, especially the contribution of nursing knowledge for improvements in patient care.

7.8.2 The Independent Registered Nurse will be appointed in accordance with section 2 of the Standing Orders.

7.8.3 The role of Independent Registered Nurse has been summarised in a national document[44] as:

a) bring a high level of professional expertise and knowledge to the work of the Governing Body.
b) bring an independent strategic clinical view on all aspects of CCG business that is removed from the day-to-day running of the organisation.
c) take a balanced view of the clinical and management agenda and draw on their specialist skills to add value;
d) 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; and
e) bring detailed insights from nursing and perspectives into discussions regarding service re-design, clinical pathways and system reform.

7.9 Role of the Independent Secondary Care Specialist Doctor

7.9.1 In addition to the general responsibilities of all Governing Body members, the Independent Secondary Care Specialist Doctor, as a non-elected clinical member of the Governing Body, will bring a broader view, on health and care issues to underpin the

43 See the latest version of NHS England’s *Clinical commissioning group governing body members: Role outlines, attributes and skills*

44 See the latest version of NHS England’s *Clinical commissioning group governing body members: Role outlines, attributes and skills*

work of the CCG. In particular, they will bring to the Governing Body an understanding of patient care in the secondary care setting.

7.9.2. The Independent Secondary Care Specialist Doctor will be appointed in accordance with section 2 of the Standing Orders.

7.9.3 The role of Independent Secondary Care Specialist Doctor has been summarised in a national document[45] as:

a) bring has a high level of understanding of how care is delivered in a secondary care setting;
b) bring an independent strategic clinical view on all aspects of CCG business that is removed from the day-to-day running of the organisation.
c) take a balanced view of the clinical and management agenda and draw on their in depth understanding of secondary care to add value;
d) 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;
e) provide an understanding of how secondary care providers work within the health system to bring appropriate insight to discussions regarding service re-design, clinical pathways and system reform.

7.10 Role of the Lay Member (Audit)

7.10.1 In addition to the general responsibilities of all Governing Body members the Lay Member (Audit) is a member of the Governing Body and is the lead on audit, remuneration and conflict of interest matters.

7.10.2 The Lay Member (Audit) will be appointed in accordance with section 2 of the Standing Orders.

7.10.3This role of Lay Member (Audit) has been summarised in a national document[46] as:

a) bring specific expertise and experience to the work of the Governing Body.
b) bring a strategic and impartial focus, providing an external view of the work of the CCG that is removed from the day-to-day running of the organisation
c) to oversee key elements of governance including audit, remuneration and managing conflicts of interest.
d) serve as Chair of the Audit Committee.
e) undertake a lead role in ensuring that the Governing Body and the wider CCG behaves with the utmost probity at all times
f) ensure that appropriate and effective whistle blowing and anti-fraud systems are in place.

45 See the latest version of NHS England's *Clinical commissioning group governing body members: Role outlines, attributes and skills*

46 See the latest version of the NHS Commissioning Board Authority's *Clinical commissioning group governing body members: Role outlines, attributes and skills*

7.11 Role of the Lay Member (patient and public participation)

7.11.1 In addition to the general responsibilities of all Governing Body members the Lay Member (patient and public participation) is a member of the Governing Body and is the lead on patient and public participation matters.

7.11.2 The Lay Member (patient and public participation) will be appointed in accordance with section 2 of the Standing Orders.

7.11.3 The role of Lay Member (patient and public participation) has been summarised in a national document[47] as:

a) bring specific expertise and experience, as well as their knowledge as a member of the local community, to the work of the Governing Body.
b) bring a strategic and impartial focus, providing an external view of the work of the CCG that is removed from the day-to-day running of the organisation.
c) help to ensure that, in all aspects of the CCG's business, the public voice of the local population is heard and that opportunities are created and protected for patient and public empowerment in the work of the CCG.
d) ensure that public and patients' views are heard and their expectations understood and met as appropriate.
e) ensure the CCG builds and maintains an effective relationship with Local Healthwatch and draws on existing patient and public engagement and involvement expertise.
f) ensure that the CCG has appropriate arrangements in place to secure public and patient involvement and responds in an effective and timely way to feedback and recommendations from patients, carers and the public.

7.12 Role of the Executive Nurse

7.12.1 In addition to the general responsibilities of all Governing Body members, the Executive Nurse will lead and spread innovation and continuous improvement for good quality, clinically effective and efficient services.

7.12.2 The Executive Nurse will be appointed in accordance with section 2 of the Standing Orders.

7.13 Role of the Director of Public Health

7.13.1 The Director of Public Health will bring leadership, expertise and advice on a range of issues in particular the joint strategic needs assessment and associated health and wellbeing strategies for Wakefield district.

7.13.2 The role of Director of Public Health has been summarised in a national document[48] as:

a) provide expert, objective advice on health matters,

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47 See the latest version of the NHS Commissioning Board Authority's *Clinical commissioning group governing body members: Role outlines, attributes and skills*

48 See the latest version of the Department of Health publication *Directors of Public Health in Local Government; Roles, responsibilities and context.*

b) provide leadership, expertise and advice on a range of issues, from outbreaks of disease and emergency preparedness through to improving local, people's health and concerns around access to health services,
c) know how to improve the population's health by understanding the factors that determine health and ill health, how to change behaviour and promote both health and wellbeing in ways that reduce inequalities in health,
d) ensure effective and tested plans are in place for the wider health sector to protect the local population from risks to public health,
e) work with wider civil society to engage local partners in fostering improved health and wellbeing.

7.13.3 The Director of Public Health will be appointed in accordance with section 2 of the Standing Orders.

7.14 Role of the Local Authority Executive

7.14.1 The Local Authority Executive will bring leadership, expertise and advice on a range of issues in particular the integration of person-centred social care services and health services; delivering an integrated whole systems approach to support communities.

7.14.2 The Local Authority Executive will be appointed in accordance with section 2 of the Standing Orders.

7.15 Joint appointments with other organisations

7.15.1. The Group has the following joint appointment(s) with other organisation(s):

a) The Chief Operating Officer of Wakefield CCG and North Kirklees is a joint appointment

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

8. STANDARDS OF BUSINESS CONDUCT AND MANAGING CONFLICTS OF INTEREST

8.1. Standards of Business Conduct

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

8.1.2. They must comply with the Group's policy on standards of business conduct and declaration of interest, including the requirements set out in the policy for managing conflicts of interest. This policy will be available on the Group's website at http://www.ccg.nhs.uk/ and will be made available on request.

8.1.3. Individuals contracted to work on behalf of the Group or otherwise providing services or

facilities to the Group will be made aware of their obligation with regard to declaring conflicts or potential conflicts of interest. This requirement will be written into their contract for services and is also outlined in the Group's Standards of Business Conduct and Declaration of Interest policy.

8.2. Conflicts of Interest

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

8.2.2. Where an individual, i.e. an employee, member of the CCG's Governing Body, member of its committee or sub-committee Group Member i.e. GP partners (or where the practice is a company, each director) and any individual directly involved with the business or decision-making of the CCG, has an interest, or becomes aware of an interest which could lead to a conflict of interests in the event of the Group considering an action or decision in relation to that interest, that must be considered as a potential conflict, and is subject to the provisions of this constitution and the Standards of Business Conduct and Conflicts of Interest policy.

8.2.3. 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 Group will maintain one or more registers of the interests of those individuals listed in the CCG'S Standards of Business Conduct and Conflicts of Interest Policy.

8.3.2. As a minimum, CCGs should publish the registers of Conflicts of interest and gifts and hospitality of decision making staff at least annually in a prominent place on the Group's website at www. ccg.nhs.uk/ and make them available at their headquarters upon request.

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

8.3.4 All persons referred to in paragraph 45 of the Managing conflicts of interest: revised statutory guidance for CCG's must declare any interests. Declarations should be made as soon as reasonably practicable and by law within 28 days after the interest arises. This could include interests an individual is pursuing.

8.3.5 The CCG ensures that, as a matter of course, declarations of interest are made and confirmed or updated at least annually. All persons required to, must declare any interests as soon as reasonable practicable and by law within 28 days after the interest arises.

8.3.6 Interests (including gifts and hospitality) of decision making staff should remain on the public register for a minimum of six months. In addition the CCG must retain a record of historic interests and offers/receipt of gifts and hospitality for a minimum of 6 years after the date on which it expired. The CCG's published register of interests should state that

historic interests are retained by the CCG for the specified timeframe and details of whom to contact to submit a request for this information.

8.4 Managing Conflicts of Interest: general

8.4.1 Individual members of the Governing Body, committees or sub-committees, the committees or sub-committees of its Governing Body, Group Member i.e. GP partners (or where the practice is a company, each director) and any individual directly involved with the business or decision-making of the CCG, and employees will comply with the arrangements determined by the Group 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 Group's decision making processes.

8.4.3 The CCG manages conflicts of interest of members, employees and contractors in line with statutory guidance, as outlined in its Standards of Business Conduct and Conflicts of Interest Policy available on its website. http://www. ccg.nhs.uk/

8.5 Transparency in Procuring Services

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

8.5.2 The Group will publish a Procurement Strategy approved by its Governing Body which will ensure that:

8.5.3 All relevant clinicians (not just members of the Group) and potential providers, together with local members of the public are engaged in the decision-making processes used to procure services.

8.5.4 Service redesign and procurement processes are conducted in an open, transparent, non-discriminatory and fair way.

8.5.5 Copies of this Procurement Strategy will be available on the Group's website at www. ccg.nhs.uk/ and will be made available on request.

9. THE GROUP AS EMPLOYER

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

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

9.3. The group will ensure that it employs suitably qualified and experienced staff who will discharge their responsibilities in accordance with the high standards expected of staff employed by the group. All staff will be made aware of this constitution, the

commissioning strategy and the relevant internal management and control systems which relate to their field of work.

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

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

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

9.7. The group will ensure that it complies with all aspects of employment law.

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

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

9.11. Copies of this Code of Conduct, together with the other policies and procedures outlined in this section, will be available on the CCG website at http://www.wakefieldccg.nhs.uk/resources/ as set out in 1.3.2.

10. TRANSPARENCY, WAYS OF WORKING AND STANDING ORDERS

10.1. General

10.1.1. The group will publish annually a commissioning plan, an annual report and accounts.

10.1.2 The group will present the group's annual report and accounts to a public at an Annual General Meeting.

10.1.3 The group will hold an annual meeting for the Members; the Annual Members Meeting. Further details about the arrangements for the Annual Members Meeting can be found at Standing Order 3.3.

10.1.3 Key communications issued by the group, including the notices of procurements, public consultations, Governing Body meeting dates, times, venues, and certain papers will be

published on the group's website at http://www.wakefieldccg.nhs.uk/resources/ as set out in 1.3.2.

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

10.2. Standing Orders

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

a) *Standing Orders (Appendix C)* – which sets out the arrangements for meetings and the appointment processes to elect the Group's representatives and appoint to the group's committees, including the Governing Body;
b) *Scheme of Reservation and Delegation (Appendix D)* – which sets out those decisions that are reserved for the membership as a whole and those decisions that are the responsibilities of the group's Governing Body, the Governing Body's committees and sub-committees, the group's committees and sub-committees, individual members and employees;
c) *Prime financial policies (Appendix E)* – which set out the arrangements for managing the group's financial affairs.

APPENDIX A

DEFINITIONS OF KEY DESCRIPTIONS USED IN THIS CONSTITUTION

2006 Act	National Health Service Act 2006.
2012 Act	Health and Social Care Act 2012 (this Act amends the 2006 Act).
Chief Officer	an individual, as defined under paragraph 12 of Schedule 1A of the 2006 Act (as inserted by Schedule 2 of the 2012 Act), appointed by the NHS England , with responsibility for ensuring the group: • complies with its obligations under: o sections 14Q and 14R of the 2006 Act (as inserted by section 26 of the 2012 Act), o sections 223H to 223J of the 2006 Act (as inserted by section 27 of the 2012 Act), o paragraphs 17 to 19 of Schedule 1A of the NHS Act 2006 (as inserted by Schedule 2 of the 2012 Act), and o any other provision of the 2006 Act (as amended by the 2012 Act) specified in a document published by the Board for that purpose; • exercises its functions in a way which provides good value for money.
Area	the geographical area that the group has responsibility for, as defined in Section 2 of this constitution.
Chair of the Governing Body	the individual appointed by the group to act as Chair of the Governing Body.
Chief Finance Officer	the qualified accountant employed by the group with responsibility for financial strategy, financial management and financial governance.
Clinical commissioning group	a body corporate established by NHS England in accordance with Chapter A2 of Part 2 of the 2006 Act (as inserted by section 10 of the 2012 Act).
Committee	a committee or sub-committee created and appointed by: • the membership of the group; • a committee / sub-committee created by a committee created / appointed by the membership of the group; • a committee / sub-committee created / appointed by the Governing Body.
Financial year	this usually runs from 1 April to 31 March, but under paragraph 17 of Schedule 1A of the 2006 Act (inserted by Schedule 2 of the 2012 Act), it can for the purposes of audit and accounts run from when a clinical commissioning group is established until the following 31 March.

Group	NHS Wakefield Clinical Commissioning Group, whose constitution this is.
Governing Body	the body appointed under section 14L of the NHS Act 2006 (as inserted by section 25 of the 2012 Act), with the main function of ensuring that a clinical commissioning group has made appropriate arrangements for ensuring that it complies with: • its obligations under section 14Q under the NHS Act 2006 (as inserted by section 26 of the 2012 Act), • such generally accepted principles of good governance as are relevant to it.
Governing Body member	any member appointed to the Governing Body of the group.
Lay Member	a Lay Member of the Governing Body, appointed by the group. A Lay Member is an individual who is not a member of the group or a healthcare professional (i.e. an individual who is a member of a profession regulated by a body mentioned in section 25(3) of the National Health Service Reform and Health Care Professions Act 2002) or as otherwise defined in regulations.
Member	provider of primary medical services within the Wakefield district boundary, to a registered list of patients under a General Medical Services, Personal Medical Services or Alternative Provider Medical Services contract, as defined in clause 3 of this Constitution.
Registers of interests	registers a group is required to maintain and make publicly available under section 14O of the 2006 Act (as inserted by section 25 of the 2012 Act), of the interests of: • the members of the group; • the members of its Governing Body; • the members of its committees or sub-committees and committees or sub-committees of its Governing Body; • its employees with decision making responsibilities.