NHS HULL
CLINICAL COMMISSIONING GROUP

CONSTITUTION

Version: 3.3
NHS England Effective Date: January 2015
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FOREWORD

NHS Hull Clinical Commissioning Group (CCG) comprises a membership of 57 GP practices and at the heart of the success of the CCG is the tenet that the whole is genuinely greater than the sum of its constituent parts. As members, they will use their local knowledge and unique insight into the communities of Kingston upon Hull to design and implement changes that deliver our vision of Creating a Healthier Hull.

The CCG Constitution belongs to its members. 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 CCG; to ensure that decisions are taken in an open and transparent way and that the interests of service users and the public remain central to the goals of the group. It will need to balance its accountabilities as both a statutory body and a membership organisation and the Constitution sets out in more detail how this will be achieved.

From April 2013, the CCG has responsibility for the commissioning of health services to meet the reasonable needs of the people of Hull and it uses this responsibility to work in effective collaboration with its partners to improve health, reduce health inequality and secure excellent quality services for all the local communities it serves.

I commend the CCG Constitution to you and look forward to working with all of you in Creating a Healthier Hull through the Hull 2020 Transformation Programme.

Dr Dan Roper
Chair
NHS Hull Clinical Commissioning Group (CCG)
1. INTRODUCTION AND COMMENCEMENT

1.1. Name

1.1.1. The name of this Clinical Commissioning Group is NHS Hull 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. NHS England is responsible for determining applications from prospective groups to be established as Clinical Commissioning Groups⁴ and undertakes an annual assessment of each established group.⁵ It has powers to intervene in a Clinical Commissioning Group where it is satisfied that a group is failing or has failed to discharge any of its functions or that there is a significant risk that it will fail to do so.⁶

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

1.3. Status of this Constitution

1.3.1. This constitution is made between the members of NHS Hull Clinical Commissioning Group and has effect from 18th day of January 2013, when NHS England established the group.⁸ The constitution is published on the group’s website at www.hullccg.nhs.uk.

¹ See section 11 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. This constitution can only be varied in two circumstances.\(^9\)

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

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

2. **AREA COVERED**

2.1. The geographical area covered by NHS Hull Clinical Commissioning Group is the city of Kingston upon Hull.

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\(^9\) See sections 14E and 14F of the 2006 Act, inserted by section 25 of the 2012 Act and any regulations issued
3. **MEMBERSHIP**

3.1. **Membership of the Clinical Commissioning Group**

3.1.1. The following practices comprise the members of NHS Hull Clinical Commissioning Group.

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<td>Newington Health Centre, 2 Plane Street, Hull, HU3 6BX</td>
</tr>
<tr>
<td>Awan &amp; Partners</td>
<td>Orchard 2000 Medical Centre, 480 Hall Road, Hull, HU6 9BS</td>
</tr>
<tr>
<td>Bridge Group Practice</td>
<td>The Orchard Centre, 210 Orchard Park Road, Hull, HU6 9BX</td>
</tr>
<tr>
<td>Burnbrae Medical Practice (Part of Haxby Group)</td>
<td>445 Holderness Road, Hull, HU8 8JS</td>
</tr>
<tr>
<td>Chauhan &amp; Partners</td>
<td>Clifton House Medical Centre, 263 – 265 Beverley Road, Hull, HU5 2ST</td>
</tr>
<tr>
<td>Chestnut Farm Surgery</td>
<td>174 Dunvegan Road, Hull, HU8 9LF</td>
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<tr>
<td>Choudhary AK &amp; Danda SR Practice</td>
<td>Bransholme South Health Centre, Goodhart Road, Hull, HU7 4DW</td>
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<tr>
<td>Chowdhury GM</td>
<td>Park Health Centre, 700 Holderness Road, Hull, HU9 3JR</td>
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<tr>
<td>Cook BF</td>
<td>Field View Surgery, 840 Beverley Road, Hull, HU6 7HP</td>
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<tr>
<td>Datta AK</td>
<td>Sutton Park Medical Practice, Littondale, Sutton Park, Hull, HU7 4BJ</td>
</tr>
<tr>
<td>Dave G</td>
<td>Laurbel Surgery, 14 Main Road, Bilton, Hull, HU11 4AR</td>
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<tr>
<td>Diadem Medical Practice</td>
<td>2 Diadem Grove, Bilton Grange, Hull, HU9 4AL</td>
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<tr>
<td>East Park Practice</td>
<td>Park Health Centre, 700 Holderness Road, Hull, HU9 3JR</td>
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<tr>
<td>Foulds &amp; Partners</td>
<td>Sydenham Group Practice, 215 Hessle Road, Hull, HU3 4BB</td>
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<td>Ghosh, Raghunath &amp; Partners</td>
<td>St Andrews Group Practice, Bransholme Health Centre, Goodhart Road, Hull, HU7 4DW</td>
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<td>Hendow GT</td>
<td>Bransholme Health Centre, Goodhart Road, Hull, HU7 4DW</td>
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<tr>
<td>Hussain SG &amp; Partners</td>
<td>Wilberforce Surgery, Wilberforce Health Centre, 6 – 10 Story Street, Hull, HU1 3SA</td>
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<tr>
<td>Joseph JC</td>
<td>Longhill Health Care Centre, 162 – 164 Shannon Road, Hull, HU8 9RW</td>
</tr>
<tr>
<td>Kingston Health Hull</td>
<td>Wheeler Street, Hull, HU3 5QE</td>
</tr>
<tr>
<td>Kingston Medical Centre</td>
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<td>Kingswood Surgery</td>
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<td>KV Gopal Surgery</td>
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<td>Macphie, Raghunath &amp; Partners</td>
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<td>Mallik MK</td>
<td>919 Spring Bank West, Hull, HU5 5BE</td>
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<td>Miller &amp; Partners</td>
<td>The Oaks Medical Centre, Council Avenue, Hull, HU4 6RT</td>
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<td>Morrill Street Group Practice</td>
<td>Morrill Street Health Centre, Morrill Street, Hull, HU9 2LJ</td>
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<td>Musil J</td>
<td>Princes Medical Centre, 2 Princes Avenue, Hull, HU5 3QA</td>
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<tr>
<td>Nayar JK</td>
<td>Newland Health Centre, 187 Cottingham Road, Hull, HU5 2EG</td>
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<td>New Green Surgery</td>
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<td>Percival &amp; Partners</td>
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<td>Poulase NA, Awan &amp; Basheer</td>
<td>Bransholme South Health Centre, Goodhart Road, Hull, HU7 4DW</td>
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<td>Priory Surgery</td>
<td>Haxby Group Priory Surgery, Priory Primary School, Priory Road, Hull, HU5 5RU</td>
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<td>Quays Medical Centre</td>
<td>Wilberforce Health Centre, 6 – 10 Story Street, Hull, HU1 3SA</td>
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<td>Raghunath &amp; Partners</td>
<td>Elliott Chappell Health Centre, 213 Hessle Road, Hull HU3 4BB</td>
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<td>Raut Partnership</td>
<td>Highlands Health Centre, Lothian Way, Hull, HU7 5DD</td>
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<td>Rawcliffe &amp; Partners</td>
<td>New Hall Surgery, Oakfield Court, Cottingham Road, Hull, HU6 8QF</td>
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<td>Rej AK</td>
<td>Southcoates Medical Centre, 255 Newbridge Road, Hull, HU9 2LR</td>
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<td>Riverside Medical Centre</td>
<td>The Octagon, Walker Street, Hull, HU3 2RA</td>
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<td>Roper &amp; Partners</td>
<td>Springhead Medical Centre, 376 Willerby Road, Hull, HU5 5JT</td>
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<td>Practice Name</td>
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<td>Shaikh Partnership</td>
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<td>St Andrews Group Practice</td>
<td>Newington Health Care Centre, 2 Plane Street, Hull, HU3 6BX</td>
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<td>St Andrews Northpoint</td>
<td>Bransholme South Health Centre, Goodhart Road, Hull, HU7 4DW</td>
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<td>Story Street Practice &amp; Walk in Centre</td>
<td>Wilberforce Health Centre, 6 – 10 Story Street, Hull, HU1 3SA</td>
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<tr>
<td>Sutton Manor Surgery</td>
<td>St Ives Close, Wawne Road, Hull, HU7 4PT</td>
</tr>
<tr>
<td>The Avenues Medical Centre</td>
<td>149 – 153 Chanterlands Avenue, Hull, HU5 3TJ</td>
</tr>
<tr>
<td>The Calvert Practice</td>
<td>110a Calvert Lane, Hull, HU4 6BH</td>
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<tr>
<td>Venugopal J &amp; Partners</td>
<td>Bransholme South Health Centre, Goodhart Road, Hull, HU7 4DW</td>
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<tr>
<td>Weir &amp; Partners</td>
<td>Marfleet Group Practice, Preston Road, Hull, HU9 5HH</td>
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<tr>
<td>Witvliet L</td>
<td>358 Marfleet Lane, Hull, HU9 5AD</td>
</tr>
<tr>
<td>Wolseley Medical Practice</td>
<td>Wolseley Medical Centre, Londesborough Street, Hull, HU3 1DS</td>
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<tr>
<td>Wong &amp; Partners</td>
<td>Faith House Surgery, 723 Beverley Road, Hull, HU6 7ER</td>
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<td>Yagnik RD</td>
<td>Park Health Centre, 700 Holderness Road, Hull, HU9 3JR</td>
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3.1.2. Appendix B of this constitution contains the list of practices, together with details of the dates of the signatures of the practice representatives confirming their agreement to this constitution.

3.2 Eligibility

3.2.1 Providers of primary medical services (as defined in Regulation 2 of the National Health Service (Clinical Commissioning Group) Regulations 2012 to a registered list of patients under a General Medical Services, Personal Medical Services or Alternative Provider Medical Services contract within the geographical area of NHS Hull Clinical Commissioning Group, will be eligible to apply for membership of the group10.

3.2.2 The Council of Members reserves the right to consider requests from any other practices meeting the eligibility criteria as and when they are received.

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10 See section 14A(4) of the 2006 Act, inserted by section 25 of the 2012. Regulations to be made...
3.3 Termination of Membership

3.3.1 A member practice ceases to be a member where that practice no longer meets the eligibility criteria. The Council of Members (CoM) may make a determination as to the ongoing membership of a member in circumstances where it believes that member is in serious breach of the requirements for membership of the CCG. In circumstances where the Council of Members determines that a member's membership be terminated, an application for an amendment to the Constitution shall be made to NHS England.

3.3.2 Any member practice if served with a notice of termination of membership shall have the right of appeal against that decision by application to the Council of Members.

3.3.3 The member practice shall, as soon as it becomes aware of any circumstances which may give rise to termination of membership, give notice in writing of those circumstances to the Council of Members, keep the Council of Members informed of any developments and provide such information and documents concerning the circumstances as the Council of Members requests.

4. VISION, VALUES AND AIMS

4.1 Vision

4.1.1 The vision of NHS Hull Clinical Commissioning Group is Creating a Healthier Hull.

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

4.2 Values

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

4.2.2 The values that lie at the heart of the group’s work are enshrined in the NHS Constitution, as follows:

a) **Respect and Dignity** – *NHS Hull Clinical Commissioning Group* values each person as an individual, respects their aspirations and commitments in life, and seeks to understand their needs, abilities and limits. It takes what others have to say seriously and is honest about its point of view and what it can and cannot do.

b) **Commitment to quality of Care** – *NHS Hull Clinical Commissioning Group* earns the trust placed in it by insisting on quality and striving to get the basics right every time: safety, confidentiality, professional and managerial integrity, accountability, dependable service and good communication. It welcomes feedback, learns from its mistakes and builds on its successes.
c) **Compassion** – *NHS Hull Clinical Commissioning Group* responds with humanity and kindness to each person’s pain, distress, anxiety or need. It searches through the work it undertakes for things it can do, however small, to give comfort and relieve suffering. It finds time for those it serves and works alongside. It does not wait to be asked to act, because it cares.

d) **Improving lives** – *NHS Hull Clinical Commissioning Group* strives to improve health and wellbeing and peoples experiences of the NHS. It values excellence and professionalism wherever it finds it – in the everyday things that make people’s lives better as much as in clinical practice, service improvements and innovation.

e) **Working together for patients** – *NHS Hull Clinical Commissioning Group* puts patients first in everything it does by reaching out to staff, patients, carers, families, communities and professionals outside the NHS. It puts the needs of patients and communities before organisational boundaries.

f) **Everyone counts** – *NHS Hull Clinical Commissioning Group* uses its resources for the benefit of the whole community and makes sure that nobody is left behind or excluded. It accepts that some people will need more help, that difficult decisions have to be taken and that if resources are wasted others’ opportunities are wasted. It recognises that we all have a part to play in making ourselves and our communities healthier.

### 4.3. **Aims**

4.3.1. The group’s aims are to:

a) Improve life expectancy and reduce health inequalities.

b) Provide more choice; improve access to and reduce waits for all health services.

c) Work with partners to ensure services are integrated with those of the voluntary sector, local authority and others, as appropriate.

d) Commission health care; that delivers quality outcomes; is focused on the need of the individual; that treats people with compassion and dignity and is delivered in the most appropriate setting.

e) Work with our partners to address the prevalence of smoking, obesity and substance misuse.

f) Reduce the variation in the quality of care.

g) Drive sustainable change to transform health care provision in Hull.
4.4. **Principles of Good Governance**

4.4.1. In accordance with section 14L(2)(b) of the 2006 Act,\(^\text{11}\) the group will at all times observe such generally accepted principles of good governance as are relevant to it 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;*\(^\text{12}\)

c) the standards of behaviour published by the *Committee on Standards in Public Life (1995)* known as the ‘Nolan Principles’;\(^\text{13}\)

d) the seven key principles of the *NHS Constitution;*\(^\text{14}\)

e) the Equality Act 2010.\(^\text{15}\)

4.5. **Accountability**

4.5.1. The group 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 in accordance with the Regulations (as amended from time to time);

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

d) publishing annually a commissioning plan;

e) complying with local authority health overview and scrutiny requirements;

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

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\(^{11}\) Inserted by section 25 of the 2012 Act

\(^{12}\) *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

\(^{13}\) See Appendix F

\(^{14}\) See Appendix G

g) producing annual accounts in respect of each financial year which must be externally audited;

h) having a published and clear complaints process;

i) complying with the Freedom of Information Act 2000;

j) providing information to NHS England as required.

4.5.2. In addition to these statutory requirements, the group will demonstrate its accountability by:

a) routinely publishing minutes of the governing body and its committees;

b) actively engaging with the public and its stakeholders in developing its commissioning plans; and

c) encouraging the development and engagement of Patient Participation Groups.

4.5.3. The governing body of the group 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.

5. FUNCTIONS AND GENERAL DUTIES

5.1. Functions

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

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

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

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

d) determining the remuneration and travelling or other allowances of members of its governing body.
5.1.2. In discharging its functions the group will:

a) act\textsuperscript{16}, 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\textsuperscript{17} and with the objectives and requirements placed on NHS England through the mandate\textsuperscript{18} published by the Secretary of State before the start of each financial year by:

i) delegating responsibility to the NHS Hull Clinical Commissioning Group governing body to promote a comprehensive health service.
ii) preparing and publishing an annual plan, which includes the objectives and duties placed upon the CCG.

b) meet the public sector equality duty\textsuperscript{19} by:

i) delegating responsibility to the NHS Hull Clinical Commissioning Group governing body to meet the public sector equality duty.
ii) having a lead for Equality & Diversity who is responsible for developing and implementing an Equality & Diversity Strategy

c) work in partnership with its local authority[ies] to develop joint strategic needs assessments\textsuperscript{20} and joint health and wellbeing strategies\textsuperscript{21} by:

i) appointing members to Hull Health and Wellbeing Board and monitor progress through the governing body.
ii) agreeing joint work between NHS Hull Clinical Commissioning Group and the local authority on health and wellbeing strategies and plans.

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

5.2.1. Make arrangements to secure public involvement in the planning, development and consideration of proposals for changes and decisions affecting the operation of commissioning arrangements\textsuperscript{22} by:

a) delegating responsibility to the NHS Hull Clinical Commissioning Group governing body for securing public involvement in the planning and development of commissioning services.

b) consulting with service users, their carers, their advocates and local community services to secure the best care for patients.

c) developing and implementing an engagement strategy that utilises a range of involvement processes to meet the needs of different patient groups and communities.

\textsuperscript{16} See section 3(1F) of the 2006 Act, inserted by section 13 of the 2012 Act
\textsuperscript{17} See section 1 of the 2006 Act, as amended by section 1 of the 2012 Act
\textsuperscript{18} See section 13A of the 2006 Act, inserted by section 23 of the 2012 Act
\textsuperscript{19} See section 149 of the Equality Act 2010, as amended by paragraphs 184 and 186 of Schedule 5 of the 2012 Act
\textsuperscript{20} See section 116 of the Local Government and Public Involvement in Health Act 2007, as amended by section 192 of the 2012 Act
See section 116A of the Local Government and Public Involvement in Health Act 2007, as inserted by section 191 of the 2012 Act

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

d) publishing information about how people can get involved in health services on the group’s website and through other media.
e) providing simple means through which feedback can be provided and implementing effective means through which this can be considered as part of the commissioning and planning of services.

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**²³ by:

a) delegating responsibility to the NHS Hull Clinical Commissioning Group governing body for ensuring that significant service decisions and strategies take due cognizance of the NHS Constitution

b) publishing the NHS Constitution on the group’s website and intranet site.

5.2.3. Act **effectively, efficiently and economically**²⁴ by:

a) delegating responsibility to the NHS Hull Clinical Commissioning Group governing body to ensure that the group acts in an effective, efficient and economical manner.

b) having a committee of the governing body which includes in its terms of reference the requirement to assist the Chief Officer to ensure that the organisation acts efficiently, effectively and economically.

c) producing business cases for all significant service proposals and authorisation in accordance with the appropriate detailed financial policies of the CCG.

5.2.4. Act with a view to **securing continuous improvement to the quality of services**²⁵ by:

a) delegating responsibility to the NHS Hull Clinical Commissioning Group governing body to ensure that the group acts to secure continuous improvement to the quality of services.

b) having a member of NHS Hull Clinical Commissioning Group governing body with lead responsibility for assuring the quality of services.

5.2.5. Assist and support NHS England in relation to the Board’s duty to **improve the quality of primary medical services**²⁶ by:

a) delegating responsibility to the NHS Hull Clinical Commissioning Group governing body to assist and support NHS England to improve the quality of primary medical services.

b) establishing and maintaining an effective working relationship with NHS England Area Team.

²³ 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)
²⁴ See section 14Q of the 2006 Act, inserted by section 26 of the 2012 Act
5.2.6. Have regard to the need to reduce inequalities\(^{27}\) by:

a) delegating responsibility to the NHS Hull Clinical Commissioning Group governing body to have regard to the need to reduce inequalities.

b) actively participating in Hull Health and Wellbeing Board.

5.2.7. Promote the involvement of patients, their carers and representatives in decisions about their healthcare\(^{28}\) by:

a) delegating responsibility for ensuring that service users, their carers and representatives are involved in decisions about their healthcare to NHS Hull Clinical Commissioning Group governing body.

b) working in partnership with service users, their carers, their advocates and local community services to secure the best care for patients.

c) developing and implementing an engagement strategy which utilises a range of involvement processes that meet the needs of different patient groups and communities.

d) publishing information about how people can get involved in health services on the group’s website and through other media.

e) providing simple means through which feedback can be provided and implementing effective means through which this can be considered as part of the commissioning and planning of services.

5.2.8. Act with a view to enabling patients to make choices\(^{29}\) by:

a) delegating responsibility to the NHS Hull Clinical Commissioning Group governing body for considering how service users are able to make choices and shared decision making.

5.2.9. Obtain appropriate advice\(^{30}\) from persons who, taken together, have a broad range of professional expertise in healthcare and public health by:

a) delegating responsibility to the NHS Hull Clinical Commissioning Group governing body to ensure that the group is able to obtain appropriate advice.

b) making sure that there is a mix of members and attendees on the NHS Hull CCG Governing Body and Council of Members.

c) having arrangements in place to ensure that the group is able to access other specialised advice, as appropriate, for example from the commissioning support unit and legal agencies.

5.2.10. Promote innovation\(^{31}\) by:

a) delegating responsibility to the NHS Hull Clinical Commissioning Group governing body to promote innovation.

b) having innovation as one of the group’s core values.

\(^{27}\) See section 14R of the 2006 Act, inserted by section 26 of the 2012 Act

\(^{28}\) See section 14S of the 2006 Act, inserted by section 26 of the 2012 Act

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

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

\(^{31}\) See section 14V of the 2006 Act, inserted by section 26 of the 2012 Act

\(^{18}\)
5.2.11. *Promote research and the use of research*\(^{32}\) by:

a) delegating responsibility to the NHS Hull Clinical Commissioning Group governing body to promote research and the use of research.
b) having a member of NHS Hull Clinical Commissioning Group governing body with lead responsibility to promote research and the use of research.
c) operating devolved arrangements with the Humber, York and North Yorkshire Primary Care Research Collaborative hosted by the North Yorkshire and Humber Commissioning Support Unit.
d) Working in partnership with the Yorkshire and Humber Academic Health Science Network, National Institute Health Research Local Research Networks and other organisation’s or institutions involved with promoting research and the use of research in healthcare.

5.2.12. Have regard to the need to *promote education and training*\(^{33}\) 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\(^{34}\) by:

a) delegating responsibility to the NHS Hull Clinical Commissioning Group governing body to promote education and training.

5.2.13. Act with a view to *promoting integration* of both health services with other health services and health services with health-related and social care services where the group considers that this would improve the quality of services or reduce inequalities\(^{35}\) by:

a) delegating responsibility to the NHS Hull Clinical Commissioning Group governing body to promote integration.

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

5.3.1. *Ensure its expenditure does not exceed the aggregate of its allotments for the financial year*\(^{36}\) by:

a) delegating responsibility for financial governance to the NHS Hull Clinical Commissioning Group governing body.
b) having robust financial governance arrangements in place that are overseen by an Integrated Audit and Governance Committee.
c) establishing risk management and risk sharing arrangements within the group and with other organisations as appropriate

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\(^{32}\) See section 14Y of the 2006 Act, inserted by section 26 of the 2012 Act  
\(^{33}\) See section 14Z of the 2006 Act, inserted by section 26 of the 2012 Act  
\(^{34}\) See section 1F(1) of the 2006 Act, inserted by section 7 of the 2012 Act  
\(^{35}\) See section 14Z1 of the 2006 Act, inserted by section 26 of the 2012 Act
See section 223H(1) of the 2006 Act, inserted by section 27 of the 2012 Act

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**\(^\text{37}\) by:

a) delegating responsibility for financial governance to the NHS Hull Clinical Commissioning Group governing body.
b) having robust financial governance arrangements in place that are overseen by an Integrated Audit and Governance Committee.
c) establishing risk management and risk sharing arrangements within the group and with other organisations as appropriate

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**\(^\text{38}\) by:

a) delegating responsibility for financial governance to the NHS Hull Clinical Commissioning Group governing body.
b) having robust financial governance arrangements in place that are overseen by an Integrated Audit and Governance Committee.

5.3.4. **Publish an explanation of how the group spent any payment in respect of quality** made to it by NHS England\(^\text{39}\) by:

a) publishing audited annual accounts and summary financial statements.

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; and
c) take account, as appropriate, 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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\(^{37}\) See sections 223I(2) and 223I(3) of the 2006 Act, inserted by section 27 of the 2012 Act

\(^{38}\) See section 223J of the 2006 Act, inserted by section 27 of the 2012 Act

\(^{39}\) 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. NHS Hull CCG 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.
   e) other entities as agreed by NHS Hull Clinical Commissioning Group governing body but subject to any restrictions imposed by the 2006 Act, the 2012 Act, associated Regulations or NHS England guidance.

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

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

6.2. **Scheme of Reservation and Delegation**

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

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

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

6.3. **General Arrangements**

6.3.1. In discharging functions of the group that have been delegated to its governing body and its committees, committees, joint committees, sub committees and individuals must:

   a) comply with the group’s principles of good governance,
   b) operate in accordance with the group’s scheme of reservation and delegation,
   c) comply with the group’s standing orders,
   d) comply with the group’s arrangements for discharging its statutory duties.

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40 See Appendix D
41 See section 4.4 on Principles of Good Governance above
42 See appendix D
43 See appendix C
44 See chapter 5 above
e) where appropriate, ensure that member practices have had the opportunity to contribute to the group’s decision making process.

6.3.2. When discharging their delegated functions, 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:

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

6.4. Committees of the Group

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

a) Council of Members.

6.4.2. The Council of Members can create such other committees as it so resolves from time to time in the future.

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

6.5. Joint commissioning arrangements with other Clinical Commissioning Groups

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

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

• delegating any of the CCG’s commissioning functions to another CCG;
• exercising any of the commissioning functions of another CCG; or
• exercising jointly the commissioning functions of the CCG and another CCG.
6.5.3. For the purposes of the arrangements described at paragraph 6.5.2, the CCG may:
• make payments to another CCG;
• receive payments from another CCG;
• make the services of its employees or any other resources available to another CCG; or
• receive the services of the employees or the resources available to another CCG.

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

6.5.5. For the purposes of the arrangements described at paragraph 6.5.2 above, the CCG may establish and maintain a pooled fund made up of contributions by any of the CCGs working together pursuant to paragraph 6.5.3 above. Any such pooled fund may be used to make payments towards expenditure incurred in the discharge of any of the commissioning functions in respect of which the arrangements are made.

6.5.6. Where the CCG makes arrangements with another CCG as described at paragraph 6.5.2 above, the CCG shall develop and agree with that CCG an agreement setting out the arrangements for joint working, including details of:
How the parties will work together to carry out their commissioning functions;
• The duties and responsibilities of the parties;
• How risk will be managed and apportioned between the parties;
• Financial arrangements, including, if applicable, payments towards a pooled fund and management of that fund;
• Contributions from the parties, including details around assets, employees and equipment to be used under the joint working arrangements.

6.5.7. The liability of the CCG to carry out its functions will not be affected where the CCG enters into arrangements pursuant to paragraph 6.5.2 above.

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

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

6.5.10. The governing body of the CCG shall require, in all joint commissioning arrangements that the lead clinician and lead manager of the lead CCG make a quarterly written report to the governing body and hold at least annual engagement events to review aims, objectives, strategy and progress and publish an annual report on progress made against objectives.
6.5.11. Should a joint commissioning arrangement prove to be unsatisfactory the governing body of the CCG can decide to withdraw from the arrangement, but has to give six months’ notice to partners, with new arrangements starting from the beginning of the next new financial year.

6.6. **Joint commissioning arrangements with NHS England for the exercise of CCG functions**

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

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

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

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

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

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

- How the parties will work together to carry out their commissioning functions;
- The duties and responsibilities of the parties;
- How risk will be managed and apportioned between the parties;
- Model wording for amendments to CCGs’ constitutions;
- 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.

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

6.6.8. The CCG will act in accordance with any further guidance issued by NHS England on co-commissioning.
6.6.9. Only arrangements that are safe and in the interests of patients registered with member practices will be approved by the governing body.

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

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

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

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

6.7.2. The CCG may enter into arrangements with NHS England and, where applicable, other CCGs to:
• Exercise such functions as specified by NHS England under delegated arrangements;
• Jointly exercise such functions as specified with NHS England.

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

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

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

6.7.6. Where the CCG enters into arrangements with NHS England as described at paragraph 6.7.2 above, the parties will develop and agree a framework setting out the arrangements for joint working, including details of:
• How the parties will work together to carry out their commissioning functions;
• The duties and responsibilities of the parties;
• How risk will be managed and apportioned between the parties;
• Financial arrangements, including payments towards a pooled fund and management of that fund;
• Contributions from the parties, including details around assets, employees and equipment to be used under the joint working arrangements.

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

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

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

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

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

6.8. The Governing Body

6.8.1. 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 this constitution. 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 (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) those matters delegated to it within the Constitution, including:

i) compliance with running costs whilst ensuring sustainable functions.

ii) the delivery and implementation of any guidance or standards issued by any relevant regulatory body.

iii) delivery of targets, policies and standards agreed by the group.

iv) the provision of appropriate assurance against strategic risks.

v) delivery of the outcomes and milestones set out in the Commissioning
vi) effective liaison with and reporting to Members and NHS England (as appropriate).

vii) that the CCG governance arrangements are reviewed to ensure that they are robust and are complied with by all Members of the CCG.

viii) that all relevant law and policy is complied with and the NHS Hull CCG Governing Body adheres to the obligations placed on it and the CCG.

ix) that the group remains accountable to Members and the public.

x) that CCG policies and procedures are implemented and adhered to at all times.

xi) that as far as reasonably practical:

a. effective and inclusive communication links are maintained to ensure that the views of Members are properly considered as part of the decision making process

b. plans are in place that address local inequalities

c. delivery of the group’s vision, values, aims, culture and strategic direction.

d. engagement with the Health & Wellbeing Board.

e. effective public involvement in the decisions of the group.

f. the promotion of safe and high quality services.

g. co-ordinated and prioritised plans for the demand, financial and investment needs of the group are developed.

45 See section 14L(3)(c) of the 2006 Act, as inserted by section 25 of the 2012 Act

46 See section 4.4 on Principles of Good Governance above

6.8.2. **Composition of the Governing Body** - the governing body shall not have less than 19 members and comprises of:

a) 12 clinical / healthcare professional members:

i) Up to 10 representatives of member practices (one of whom shall be the CCG Chair) (elected by the Council of Members from the body of GPs currently on the local Performers List for Hull, or having been on it within the last 5 years);

ii) 1 registered nurse other than one excluded under Regulation 12(1) (appointed);

iii) 1 secondary care specialist doctor, other than one excluded under Regulation 12(1) (appointed).

b) 3 lay members (appointed; one of whom shall be the vice-chair):

i) one to lead on audit, remuneration and conflict of interest matters, who has qualifications, expertise or experience such as to enable to express informed views about financial management and audit matters;

ii) one to lead on patient and public participation matters, who has knowledge about the area set out in Section 2.1 of this Constitution
such as to enable the person to express informed views about the
discharge of the CCG’s functions;

iii) one to lead on strategic change.

c) 3 officer members (appointed):

i) the Chief Officer (appointed);
ii) the Chief Finance Officer (appointed);
iii) the Senior Officer for Commissioning (appointed):

d) 1 other member (elected);

i) a practice manager

6.8.3. **Quoracy:** The NHS Hull CCG Governing Body will normally be quorate, subject to standing order 3.7.2., if there are 6 members present, with at least:

a) The Chair or Vice-Chair.
b) 2 GPs (in addition to the chair if present).
c) One Officer Member.

6.8.4. Membership of the Governing Body shall be conditional upon the relevant Member continuing to be eligible for membership in terms of the NHS (Clinical Commissioning Group) Regulations 2012, and any other Regulations and compliance with any guidance issued by NHS England.

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

6.8.6 **Integrated Audit and Governance Committee** – the committee, which is accountable to the group’s governing body, provides the governing body with an independent and objective view of the assurances available and controls in place with regards to governance systems and information maintained by the group and compliance with laws, regulations and directions governing the group. The governing body has approved and keeps under review the terms of reference for the Integrated Audit and Governance Committee, which includes information on its membership.

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

6.8.8 **Joint Commissioning Committee** - the Joint Commissioning Committee which is accountable to the Group’s Governing Body and to the NHS England Area
Team has been established 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].

6.8.9 **Other committees and sub-committees** – will be established and approved by the governing body, as appropriate. The governing body will approve and keep under review the terms of reference for any committee(s) or sub-committee(s) it establishes. In particular, it will ensure that quality, patient outcomes, planning and commissioning are included in relevant Terms of Reference.

6.8.10 The governing body will publish papers considered at its meetings except where the governing body considers that it would not be in the public interest to do so in relation to a particular paper or part of a paper.

6.8.11 The governing body will publish the following information relating to determinations made under subsection (3)(a) and (b) of section 14L of the 2006 Act (remuneration, fees and allowances, including allowances payable under certain pension schemes):

6.8.12 In relation to each senior employee of the CCG, any determination of the employee’s salary (which need only specify a band of £5,000 into which the salary falls), or of any travelling and other allowances payable to the employee, including any allowances payable under a pension scheme established under paragraph 11(4) of Schedule 1A to the 2006 Act;

6.8.13. Any recommendation of the remuneration committee in relation to any such determination.

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47 See appendix H for the terms of reference of the Integrated Audit and Governance Committee
48 See appendix I for the terms of reference of the remuneration committee
7. **ROLES AND RESPONSIBILITIES**

7.1. **Practice Representatives**

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

a) act as a conduit for communication between the group and their practice.

b) attend or ensure representation at the Council of Members meetings.

c) participate in matters reserved to the Council of Members.

7.2. **All Members of the Group’s Governing Body**

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

7.3. **The Chair of the Council of Members**

7.3.1. The Chair of the Council of Members is responsible for:

a) leading the Council of Members, ensuring it remains continuously able to discharge its duties and responsibilities as set out in this constitution;

b) ensuring that, through the appropriate support, information and evidence, the Council of Members is able to discharge its duties;

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

d) leading and influencing to achieve clinical change to enable the group to deliver its commissioning responsibilities;

e) ensuring that the group builds and maintains effective clinical & professional relationships.

f) facilitating effective communication between the Council of Members and governing body.

7.4. **The Chair of the Governing Body**

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

a) leading the Governing Body, ensuring it remains continuously able to discharge its duties and responsibilities as set out in this constitution;

b) building and developing the group’s governing body and its individual members;

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49 Draft *clinical commissioning group Governing Body Members – Roles Attributes and Skills*, NHS Commissioning Board Authority, October 2012
c) ensuring that the group has proper constitutional and governance arrangements in place;
d) ensuring that, through the appropriate support, information and evidence, the governing body is able to discharge its duties;
e) supporting the accountable officer in discharging the responsibilities of the organisation;
f) contributing to building a shared vision of the aims, values and culture of the organisation;
g) leading and influencing to achieve clinical and organisational change to enable the group to deliver its commissioning responsibilities;
h) overseeing governance and particularly ensuring that the governing body and the wider group behaves with the utmost transparency and responsiveness at all times;
i) ensuring that public and patients’ views are heard and their expectations understood and, where appropriate as far as possible, met;
j) ensuring that the organisation is able to account to its local patients, stakeholders and NHS England.
k) ensuring that the group builds and maintains effective relationships, particularly with the individuals involved in overview and scrutiny from the relevant local authority.
l) 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.

7.5. **The Vice Chair of the Governing Body**: The Vice Chair of the Governing Body deputises for the Chair of the Governing Body where he or she has a conflict of interest or is otherwise unable to act.

7.6. **Role of the Accountable Officer**

7.6.1. The Accountable Officer of the group is a member of the governing body.

7.6.2. This role of Accountable Officer has been summarised in a national document\(^\text{50}\) as:

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

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.

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\(^{50}\) See the latest version of the NHS Commissioning Board Authority's *Clinical commissioning group governing body members: Role outlines, attributes and skills*
7.6.3. 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.

7.7. **Role of the Chief Finance Officer**

7.7.1. 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.

7.7.2. This role of Chief Finance Officer has been summarised in a national document\(^5\) 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 on the group’s finances;

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

d) being able to advise the Governing Body on the effective, efficient and economic use of the group’s allocation to remain within that allocation and deliver required financial targets and duties; and

e) producing the financial statements for audit and publication in accordance with the statutory requirements to demonstrate effective stewardship of public money and accountability to NHS England.

7.8. **Role of the Registered Nurse**

7.8.1. The Registered Nurse on the Governing Body will bring a broader view, from their perspective as a registered nurse, on health and care issues to underpin the work of the CCG, especially the contribution of nursing to patient care.

7.8.2. This role of Registered Nurse has been summarised in the NHS Commissioning Board guidance *Clinical Commissioning Group Governing Body Members: Role outlines, attributes and skills* (*October 2012*) as:

a) Being a Registered Nurse who has developed a high level of professional expertise and knowledge;

b) Being competent, confident and willing to give an independent strategic clinical view on all aspects of CCG business;

c) Being highly regarded as a clinical leader, probably across more than one clinical discipline and / or specialty – demonstrably able to think beyond their own professional viewpoint;

d) Taking a balanced view of the clinical and management agenda and drawing on their specialist skills and knowledge to add value;

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e) Utilising evidence based methodology to bring detailed insights from a nursing perspective into discussions regarding service re-design, clinical pathway development and system reform; and

f) Being able to contribute a generic view from the perspective of a registered nurse whilst putting aside specific issues relating to their own clinical practice or employing organisations circumstances.

7.9. Role of the Secondary Care Doctor

7.9.1. This clinical member of the Governing Body will bring a broader view on health and care issues to underpin the 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 Secondary Care Doctor must be a consultant, either currently employed or in employment at some time in the period of 10 years ending with the date of the individual’s appointment to the governing body.

7.9.3 The role of the Secondary Care Doctor has been summarised in the NHS Commissioning Board guidance *Clinical Commissioning Group governing body members: Role outlines, attributes and skills* (October 2012) as:

a) Bringing a high level of understanding of how care is delivered in a secondary care setting;

b) Being competent, confident and willing to give an independent strategic clinical view on all aspects of CCG business;

c) Being highly regarded as a clinical leader, preferably with experience working as a leader across more than one clinical discipline and/or specialty with a track record of collaborative working;

d) Having the ability to take a balanced view of the clinical and management agenda, and draw on their in depth understanding of secondary care to add value

e) Being able to 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; and

f) Being able to provide an understanding of how secondary care providers work within the health system to bring appropriate insight to discussions regarding service redesign, clinical pathways, policy formation and health system reform.

7.10. Role of the Lay Member with a Lead Role in Overseeing Governance

7.10.1. The role of the Lay Member with a lead role in overseeing governance is to bring specific expertise and experience to the work of the governing body and to ensure that the governing body and the wider CCG behaves with the utmost probity at all times. Their focus will be strategic and impartial, providing an external view of the work of the CCG that is removed from the day-to-day running of the organisation.

7.10.2 Good practice would also suggest that this person would also have a specific role in ensuring that appropriate and effective whistle blowing and anti-fraud systems are in place.

7.10.3 *The National Health Service (Clinical Commissioning Groups) Regulations 2012* require that the appointed individual must have qualifications, expertise or
experience such as to enable the person to express informed views about financial management and audit matters.

7.10.4 The role of the Lay Member with a lead role in overseeing governance has been summarised in the NHS Commissioning Board guidance Clinical Commissioning Group Governing Body Members: Role outlines, attributes and skills (October 2012) as:

a) Having the skills, knowledge and experience to 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) Possessing an understanding of the role of audit in wider accountability frameworks;
c) Having an understanding of the resource allocations devolved to NHS bodies and a general knowledge of the accounting regime within which a CCG operates;
d) Offering an independent view on possible internal conflicts of interest; and
e) Having recent and relevant financial and audit experience is essential – sufficient to enable them to competently engage with financial management and reporting in the organisation and associated assurances.

7.11. Role of the Lay Member with a Lead Role in Championing Patient and Public Involvement

7.11.1 The Lay Member with a lead role in championing patient and public involvement is a member of the Governing Body and is responsible for providing an independent strategic and impartial view of the work of the CCG.

7.11.2 The role is to express informed views about the discharge of the CCG’s functions, and in particular 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.

7.11.3 The role is further summarised in the NHS Commissioning Board guidance Clinical Commissioning Group Governing Body Members: Role outlines, attributes and skills (October 2012) as:

a) Ensuring that public and patients’ views are heard and their expectations understood and met as appropriate;
b) Ensuring the CCG builds and maintains an effective relationship with Local Healthwatch and draws on existing patient and public engagement and involvement expertise; and
c) Ensures 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 public.

7.12. GP or other Healthcare Professionals acting on behalf of Member Practices

7.12.1 The role of GP acting on behalf of member practices has been summarised in the NHS Commissioning Board guidance Clinical Commissioning Group Governing Body Members: Role outlines, attributes and skills (October 2012).
7.12.2 As well as sharing responsibility with the other members for all aspects of the CCG governing body business, the individuals acting on behalf of member practices will bring the unique understanding of those member practices to the discussion and decision making of the Governing Body as their particular contribution. In addition, in undertaking the role GP’s should:

a) have the confidence of the member practices in the CCG, demonstrating an understanding of all of the member practices, of the issues they face and what is important to them;
b) be competent, confident and willing to give an unbiased strategic clinical view on all aspects of CCG business;
c) be highly regarded as a clinical leader, beyond the boundaries of a single practice or profession – demonstrably able to think beyond their own professional viewpoint;
d) have an in-depth understanding of a specific locality(ies) if the CCG has decided to operate in this way;
e) be able to take a balanced view of the clinical and management agenda and draw on their specialist skills to add value; and
f) be able to contribute a generic view from the perspective of a member practice in the CCG, whilst putting aside specific issues relating to their own practice circumstances.

7.13. Joint Appointments with other Organisations

a) The group has no joint appointments with other organisations however NHS Hull Clinical Commissioning Group Governing Body may agree joint appointments, as appropriate.

b) All such joint appointments would be supported by a memorandum of understanding between the organisations who are party to them.

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

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

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 F.
8.1.2. They must comply with the group's statement on business conduct, including the requirements set out in the statement for managing conflicts of interest. This information can be found in Section 8 of this constitution and a copy is available on the group's website at www.hullccg.nhs.uk. A Conflicts of Interest policy is under development to meet the requirements set out in NHS England Managing Conflicts of Interest: Statutory Guidance for CCGs. Once approved by the group and the governing body the policy shall supercede the statement relating to conflicts of interest in Section 8.2. A copy of the Conflicts of Interest policy will be available on the group's website at www.hullccg.nhs.uk.

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

8.2. Conflicts of Interest

8.2.1. As required by section 14O of the 2006 Act, as inserted by section 25 of the 2012 Act, the Clinical Commissioning Group will make arrangements to manage conflicts and potential conflicts of interest 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, group member, member of the governing body, or a member of a committee or a sub-committee of the group or its Governing Body has an interest, or becomes aware of an interest either directly or via a third party which could lead to a conflict of interests in the event of the group considering an action or decision in relation to that interest, that must be considered as a potential conflict, and is subject to the provisions of this constitution.

8.2.3. A conflict of interest will include:

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

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

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

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

e) where an individual is closely related to, or in a relationship, including friendship, with an individual in the above categories.
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 group will maintain one or more registers of the interests of:

a) the members of the group;
b) the members of its governing body;
c) the members of its committees or sub-committees and the committees or sub-committees of its governing body;
d) its employees, and
e) commissioning support unit staff embedded within the group.

8.3.2. The registers will be available for viewing on the group's website at www.hullccg.nhs.uk.

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 Chair, as soon as they are aware of it and in any event no later than 28 days after becoming aware.

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

8.3.5. The Senior Officer with responsibility for corporate governance will ensure that the register of interest is reviewed regularly, and updated as necessary.

8.4. Managing Conflicts of Interest: general

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

8.4.2. The Senior Officer with responsibility for corporate governance 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. Arrangements for the management of conflicts of interest are to be determined by the lay member with responsibility for conflict of interest matters in consultation with the Senior Officer with responsibility for corporate governance 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:

a) when an individual should withdraw from a specified activity, on a temporary or permanent basis;
b) monitoring of the specified activity undertaken by the individual, either by a line manager, colleague or other designated individual.

8.4.4. 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 group’s exercise of its commissioning functions, they have received confirmation of the arrangements to manage the conflict of interest or potential conflict of interest from the senior officer with responsibility for corporate governance.

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

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

b) has previously been declared, in relation to the scheduled or likely business of the meeting, the individual concerned will bring this to the attention of the chair of the meeting, together with details of arrangements which have been confirmed for the management of the conflict of interests or potential conflict of interests. The chair of the meeting will then determine how this should be managed and inform the member of their decision.

c) 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 group, including committees, sub-committees, or the Governing Body and the Governing Body’s committees and sub-committees, has a personal interest, previously declared or otherwise, in relation to the scheduled or likely business of the meeting, they must make a declaration and the Deputy Chair will act as Chair for the relevant part of the meeting. Where arrangements have been confirmed for the management of the conflict of interests or potential conflicts of interests in relation to the chair, the meeting must ensure these are followed. Where no arrangements have been confirmed, the 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 by consensus of those members present.

8.4.7. Any declarations of interests, and arrangements agreed in any meeting of the Clinical Commissioning Group, 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 group’s standing orders. Where the meeting is not quorate, owing to the absence of certain members, the discussion will be deferred until such time as a quorum can be convened. Where a quorum cannot be convened from the membership of the
meeting, owing to the arrangements for managing conflicts of interest or potential conflicts of interests, the chair of the meeting shall consult with the lay member with responsibility for conflict of interest matters or senior officer with responsibility for corporate governance on the action to be taken.

8.4.10. This may include:

a) requiring another of the group’s committees or sub-committees, the group’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,

b) 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 group can progress the item of business:

   i) a member of the Clinical Commissioning Group who is an individual;
   ii) an individual appointed by a member to act on its behalf in the dealings between it and the Clinical Commissioning Group;
   iii) a member of a relevant Health and Wellbeing Board;
   iv) a member of a governing body of another Clinical Commissioning Group;
   v) a member of the NHS England Area Team.

c) These arrangements must be recorded in the minutes.

8.4.11. In any transaction undertaken in support of the Clinical Commissioning Group’s exercise of its commissioning functions (including conversations between two or more individuals, e-mails, correspondence and other communications), individuals must ensure, where they are aware of an interest, that they conform to the arrangements confirmed for the management of that interest. Where an individual has not had confirmation of arrangements for managing the interest, they must declare their interest at the earliest possible opportunity in the course of that transaction, and declare that interest as soon as possible thereafter. The individual must also inform either their line manager (in the case of employees), or the senior officer with responsibility for corporate governance of the transaction.

8.4.12. The Senior Officer with responsibility for corporate governance 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 Group

8.5.1. Anyone seeking information in relation to a procurement, or participating in a procurement, or otherwise engaging with the Clinical Commissioning Group in relation to the potential provision of services or facilities to the group, will be required to make a declaration of any relevant conflict / potential conflict of interest.
8.5.2. Anyone contracted to provide services or facilities directly to the Clinical Commissioning Group will be subject to the same provisions of this constitution in relation to managing conflicts of interests. This requirement will be set out in the contract for their services.

8.6. **Transparency in Procuring Services**

8.6.1. 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.

8.6.2. The group will publish a Procurement Strategy approved by its governing body which will ensure that:

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

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

8.6.3. Copies of this Procurement Strategy will be available on the group’s website at www.hullccg.nhs.uk.

8.7. **Confidentiality**

8.7.1 In this Clause 0 those who owe a duty of confidentiality are:

a) members of the group;

b) employees of the group;

c) individuals working on behalf of the group;

d) members of the Governing Body; and/or

e) any member of a committee or sub-committee of the group or the Governing Body;

8.7.2 Confidential information is:

a) Where information is provided which it is explicitly stated shall be treated as confidential, or

b) When information is disclosed from one person to another, where it is reasonable to expect the information will be held in confidence.

8.7.3 Information is not confidential:

a) Where it is or becomes public knowledge other than as a direct or indirect result of the information being disclosed in breach of the undertaking in this Clause 0; or

b) Where the person holding the information can establish that they received or held the information from a source not connected with:

   i) their membership of the group;
ii) their employment by the group;
iii) their work for the group;
iv) their membership of the Governing Body; and/or
v) their membership of a of a committee or sub-committee of the group or the Governing Body;

as applicable and that the source was not under any obligation of confidence in respect of the information; or

c) Where the person holding the information can establish that the information was known to them before the date on which they:

i) became a member of the group;
ii) became an employee of the group;
iii) began working on behalf of the group;
iv) became a member of the Governing Body; and/or
v) became a member of a committee or sub-committee of the group or the Governing Body;

as applicable and that they were not under any obligation of confidence in respect of the information.

8.7.4 Each recipient shall at all times use all reasonable endeavours to keep confidential any Confidential Information and shall not use or disclose any such Confidential Information except:

a) for any use for which the Confidential Information was disclosed to them;
b) to a Recipient’s professional advisers where such disclosure is for a proper purpose related to the operation of the group; or
c) with the consent in writing of the Governing Body or the Member to which the information relates (as applicable); or
d) as may be required by law or regulation; or
e) to any tax authority to the extent it concerns the Recipient; or
f) if the information comes within the public domain (otherwise than as a result of the breach of this Clause 0).

8.7.5 The obligations of each of the Recipients in this Clause 0 shall continue without limit in time and shall survive the termination of the Recipients’ membership of any group, Governing Body, committee or sub-committee or employment as the case may be.

8.7.6 None of the Recipients shall make or permit or authorise the making of any press release or other public statement or disclosure concerning the group or any of the members without the prior consent of the Chair of the Governing Body or the Accountable Officer; or, in the event that neither are available, another member of the Governing Body nominated by the Chair for that purpose. 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. **THE GROUP AS AN 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 discharge their responsibilities effectively.

9.9. The group will adopt a Code of Conduct for staff and will maintain and promote effective 'whistleblowing' procedures to ensure that concerned staff have means through which their concerns can be voiced.

9.10. Copies of this Code of Conduct, together with the other policies and procedures outlined in this chapter, will be available on the group’s website at www.hullccg.nhs.uk.
10. **TRANSPARENCY, WAYS OF WORKING AND STANDING ORDERS**

10.1. **General**

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

10.1.2. Key communications issued by the group, public consultations, governing body meeting dates, times, venues, and certain papers will be published on the group’s website at www.hullccg.nhs.uk. The group will also utilise public procurement websites as appropriate.

10.1.3. 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.

10.1.4. 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 by 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 any of its members, nor will it affect the rights of any worker (as defined in that Act) under that Act.

10.2. **Standing Orders**

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

   a) *Standing orders (Appendix 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 sets out the arrangements for managing the group’s financial affairs.
## APPENDIX A
DEFINITIONS OF KEY DESCRIPTIONS USED IN THIS CONSTITUTION

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2006 Act</strong></td>
<td>National Health Service Act 2006, as amended by the 2012 Act</td>
</tr>
<tr>
<td><strong>2012 Act</strong></td>
<td>Health and Social Care Act 2012 (this Act amends the 2006 Act)</td>
</tr>
</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 NHS England, with responsibility for ensuring the group:  
  - complies with its obligations under:  
    - sections 14Q and 14R of the 2006 Act (as inserted by section 26 of the 2012 Act),  
    - sections 223H to 223J of the 2006 Act (as inserted by section 27 of the 2012 Act),  
    - paragraphs 17 to 19 of Schedule 1A of the NHS Act 2006 (as inserted by Schedule 2 of the 2012 Act), and  
    - any other provision of the 2006 Act (as amended by the 2012 Act) specified in a document published by the Board for that purpose;  
  - exercises its functions in a way which provides good value for money. |
| **Area**                                | the geographical area that the group has responsibility for, as defined in Chapter 2 of this constitution |
| **Chair of the Council of Members**     | the GP elected to act as chair of the Council of Members                  |
| **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 |
| **Council of members**                  | a committee of the Group comprising the GP Practice Representatives to exercise those functions set out in this Constitution |
| **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 Hull Clinical Commissioning Group, whose constitution this is          |
| **Governing body**                      | the body appointed under section 14L of the NHS Act 2006 (as inserted by section 25 of the 2012 Act), with the main function of ensuring that a clinical commissioning group has made appropriate arrangements for ensuring that it complies with:  
  - its obligations under section 14Q under the NHS Act 2006 (as inserted by section 26 of the 2012 Act), and |
<table>
<thead>
<tr>
<th>Role</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Governing body member</strong></td>
<td>any member appointed or elected to the governing body of the group</td>
</tr>
<tr>
<td><strong>Lay member</strong></td>
<td>a lay member of the governing body, appointed by the group. A lay member is an individual who is not a member of the group or a healthcare professional (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>Member</strong></td>
<td>a provider of primary medical services to a registered patient list, who is a members of this group (see tables in Chapter 3 and Appendix B)</td>
</tr>
<tr>
<td><strong>Practice representatives</strong></td>
<td>an individual GP appointed by a practice (who is a member of the group) to act on its behalf in the dealings between it and the group, under regulations made under section 89 or 94 of the 2006 Act (as amended by section 28 of the 2012 Act) or directions under section 98A of the 2006 Act (as inserted by section 49 of the 2012 Act)</td>
</tr>
</tbody>
</table>
| **Registers of interests** | registers a group is required to maintain and make publicly available under section 14O of the 2006 Act (as inserted by section 25 of the 2012 Act), of the interests of:  
  • the members of the group;  
  • the members of its governing body;  
  • the members of its committees or sub-committees and committees or sub-committees of its governing body; and  
  • its employees. |
## APPENDIX B - LIST OF MEMBER PRACTICES
(Practice signatures obtained on as separate document)

<table>
<thead>
<tr>
<th>Practice Name</th>
<th>Address</th>
<th>Practice Representative's Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>AH Tak &amp; Dr M Sadik</td>
<td>Newington Health Centre, 2 Plane Street, Hull, HU3 6BX</td>
<td>Dr AH Tak</td>
</tr>
<tr>
<td>Awan &amp; Partners</td>
<td>Orchard 2000 Medical Centre, 480 Hall Road, Hull, HU6 9BS</td>
<td>Dr RK Awan</td>
</tr>
<tr>
<td>Bridge Group Practice</td>
<td>The Orchard Centre, 210 Orchard Park Road, Hull, HU6 9BX</td>
<td>Dr M Brown</td>
</tr>
<tr>
<td>Burnbrae Medical Practice</td>
<td>445 Holderness Road, Hull, HU7 8JS</td>
<td>Dr C Fairhurst</td>
</tr>
<tr>
<td>(Part of Haxby Group)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chauhan &amp; Partners</td>
<td>Clifton House Medical Centre, 263 – 265 Beverley Road, Hull, HU5 2ST</td>
<td>Dr P Chawla</td>
</tr>
<tr>
<td>Chestnut Farm Surgery</td>
<td>174 Dunvegan Road, Hull, HU8 9LF</td>
<td>Dr A Khan</td>
</tr>
<tr>
<td>Choudhary AK &amp; Danda SR Practice</td>
<td>Bransholme South Health Centre, Goodhart Road, Hull, HU7 4DW</td>
<td>Dr AK Choudhary</td>
</tr>
<tr>
<td>Chowdhury GM</td>
<td>Park Health Centre, 700 Holderness Road, Hull, HU9 3JR</td>
<td>Dr GM Chowdhury</td>
</tr>
<tr>
<td>Cook BF</td>
<td>Field View Surgery, 840 Beverley Road, Hull, HU6 7HP</td>
<td>Dr BF Cook</td>
</tr>
<tr>
<td>Datta AK</td>
<td>Sutton Park Medical Practice, Littondale, Sutton Park, Hull, HU7 4BJ</td>
<td>Dr R Raut</td>
</tr>
<tr>
<td>Dave G</td>
<td>Laurbel Surgery, 14 Main Road, Bilton, Hull, HU11 4AR</td>
<td>Dr G Dave</td>
</tr>
<tr>
<td>Diadem Medical Practice</td>
<td>2 Diadem Grove, Bilton Grange, Hull, HU9 4AL</td>
<td>Dr A Turnbull</td>
</tr>
<tr>
<td>East Park Practice</td>
<td>Park Health Centre, 700 Holderness Road, Hull, HU9 3JR</td>
<td>Dr A Bunting</td>
</tr>
<tr>
<td>Galea &amp; Partners</td>
<td>The Oaks Medical Centre, Council Avenue, Hull, HU4 6RT</td>
<td>Dr I Galea</td>
</tr>
<tr>
<td>Ghosh, Raghunath &amp; Partners</td>
<td>St Andrew Group Practice, Goodhart Road, Hull, HU7 4DW</td>
<td>Dr S Richardson</td>
</tr>
<tr>
<td>Haxby Group Orchard Park Surgery</td>
<td>The Orchard Centre, 210 Orchard Park Road, Hull, HU6 9BX</td>
<td>Dr F Scott</td>
</tr>
<tr>
<td>Hendow GT</td>
<td>Bransholme Health Centre, Goodhart Road, Hull, HU7 4DW</td>
<td>Dr GT Hendow</td>
</tr>
<tr>
<td>Hussain SG &amp; Partners</td>
<td>Wilberforce Surgery, Wilberforce Health Centre, 6 – 10 Story Street, Hull, HU1 3SA</td>
<td>Dr F Grada</td>
</tr>
<tr>
<td>Joseph JC</td>
<td>Longhill Health Care Centre, 162 – 164 Shannon Road, Hull, HU8 9RW</td>
<td>Dr JC Joseph</td>
</tr>
<tr>
<td>Practice Name</td>
<td>Address</td>
<td>Practice Representative's Name</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>--------------------------------------------------</td>
<td>--------------------------------</td>
</tr>
<tr>
<td>Kingston Health Hull</td>
<td>Wheeler Street, Hull, HU3 5QE</td>
<td>Dr DYF Yu</td>
</tr>
<tr>
<td>Kingston Medical Centre</td>
<td>151 Beverley Road, Hull, HU3 1TY</td>
<td>Dr M Findley</td>
</tr>
<tr>
<td>Kingswood Surgery</td>
<td>Haxby Group, Kingswood Health Centre, 10 School Lane, Hull, HU7 3JQ</td>
<td>Dr F Scott</td>
</tr>
<tr>
<td>KV Gopal Surgery</td>
<td>Bransholme South Health Centre, Goodhart Road, Hull, HU7 4DW</td>
<td>Dr KV Gopal</td>
</tr>
<tr>
<td>Macphie, Raghunath &amp; Partners</td>
<td>Newington Health Centre, 2 Plane Street, Hull, HU3 6BX</td>
<td>Dr S Richardson</td>
</tr>
<tr>
<td>Malczewski GS</td>
<td>Longhill Health Care Centre, 162 – 164 Shannon Road, Hull, HU8 9RW</td>
<td>Dr GS Malczewski</td>
</tr>
<tr>
<td>Mallik MK</td>
<td>919 Spring Bank West, Hull, HU5 5BE</td>
<td>Dr MK Mallik</td>
</tr>
<tr>
<td>Morrill Street Group Practice</td>
<td>Morrill Street Health Centre, Morrill Street, Hull, HU9 2LJ</td>
<td>Dr S Islam</td>
</tr>
<tr>
<td>Musil J</td>
<td>Princes Medical Centre 2 Princes Avenue, Hull, HU5 3QA</td>
<td>Dr P Queenan</td>
</tr>
<tr>
<td>Nayar JK</td>
<td>Newland Health Centre, 187 Cottingham Road, Hull, HU5 2EG</td>
<td>Dr JK Nayar</td>
</tr>
<tr>
<td>New Green Surgery</td>
<td>Morrill Street, Hull, HU9 2LJ</td>
<td>Dr KM Tang</td>
</tr>
<tr>
<td>Newland Group Practice</td>
<td>Alexandra Health Centre, 61 Alexandra Road, Hull HU5 2NT</td>
<td>Dr S Al-Saad</td>
</tr>
<tr>
<td>Northpoint</td>
<td>Bransholme South Health Centre, Goodhart Road, Hull, HU7 4DW</td>
<td>Dr M Hancocks</td>
</tr>
<tr>
<td>Palooran, George &amp; Koshy</td>
<td>Bransholme South Health Centre, Goodhart Road, Hull, HU7 4DW</td>
<td>Dr G Palooran</td>
</tr>
<tr>
<td>Percival &amp; Partners</td>
<td>Alexandra Health Centre, 61 Alexandra Road, Hull, HU5 2NT</td>
<td>Dr PS Chia</td>
</tr>
<tr>
<td>Poulose NA, Awan &amp; Basheer</td>
<td>Bransholme South Health Centre, Goodhart Road, Hull, HU7 4DW (now)</td>
<td>Dr NA Poulose</td>
</tr>
<tr>
<td>Priory Surgery</td>
<td>Haxby Group Priory Surgery, Priory Primary School, Priory Road, Hull, HU5 5RU</td>
<td>Dr F Scott</td>
</tr>
<tr>
<td>Quays Medical Centre</td>
<td>Wilberforce Health Centre, 6 – 10 Story Street, Hull, HU1 3SA</td>
<td>Dr R Kasivel</td>
</tr>
<tr>
<td>Raghunath &amp; Partners</td>
<td>St Andrews Group Practice, Elliott Chappell Health Centre, 213 Hessle Road, Hull, HU3 4BB</td>
<td>Dr S Richardson</td>
</tr>
<tr>
<td>Raut Partnership</td>
<td>Highlands Health Centre, Lothian Way, Hull, HU7 5DD</td>
<td>Dr R Raut</td>
</tr>
<tr>
<td>Rawcliffe &amp; Partners</td>
<td>New Hall Surgery, Oakfield Court, Cottingham Road, Hull, HU6 8QF</td>
<td>Dr V Rawcliffe</td>
</tr>
<tr>
<td>Practice Name</td>
<td>Address</td>
<td>Practice Representative's Name</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>-------------------------------------------------------------------------</td>
<td>--------------------------------</td>
</tr>
<tr>
<td>Rej AK</td>
<td>Southcoates Medical Centre, 255 Newbridge Road, Hull, HU9 2LR</td>
<td>Dr AK Rej</td>
</tr>
<tr>
<td>Riverside Medical Centre</td>
<td>The Octagon, Walker Street, Hull, HU3 2RA</td>
<td>Dr Kasivel</td>
</tr>
<tr>
<td>Roper &amp; Partners</td>
<td>Springhead Medical Centre, 376 Willerby Road, Hull, HU5 5JT</td>
<td>Dr G Curran</td>
</tr>
<tr>
<td>Shaikh Partnership</td>
<td>Longhill Health Care Centre, 162 – 164 Shannon Road, Hull, HU9 9RW</td>
<td>Dr N Shaikh</td>
</tr>
<tr>
<td>St Andrews Group Practice</td>
<td>Newington Health Care Centre, 2 Plane Street, Hull, HU3 6BX</td>
<td>Dr S Richardson</td>
</tr>
<tr>
<td>Story Street Practice &amp; Walk in Centre</td>
<td>Wilberforce Health Centre, 6 – 10 Story Street, Hull, HU1 3SA</td>
<td>Dr A Bunting</td>
</tr>
<tr>
<td>St Andrews Northpoint</td>
<td>Bransholme South Health Centre, Goodhart Road, Hull, HU7 4DW</td>
<td>Dr S Richardson</td>
</tr>
<tr>
<td>Sutton Manor Surgery</td>
<td>St Ives Close, Wawne Road, Hull, HU7 4PT</td>
<td>Dr A Oehring</td>
</tr>
<tr>
<td>Sydenham Group Practice</td>
<td>215 Hessle Road, Hull, HU3 4BB</td>
<td>Dr P Caldwell</td>
</tr>
<tr>
<td>The Avenues Medical Centre</td>
<td>149 – 153 Chanterlands Avenue, Hull, HU5 3TJ</td>
<td>Dr B Thompson</td>
</tr>
<tr>
<td>The Calvert Practice</td>
<td>110a Calvert Lane, Hull, HU4 6BH</td>
<td>Dr J Pinto</td>
</tr>
<tr>
<td>Venugopal J &amp; Partners</td>
<td>Bransholme South Health Centre, Goodhart Road, Hull, HU7 4DW</td>
<td>Dr J Venugopal</td>
</tr>
<tr>
<td>Weir &amp; Partners</td>
<td>Marfleet Group Practice, Preston Road, Hull, HU9 5HH</td>
<td>Dr L Yu</td>
</tr>
<tr>
<td>Witvliet L</td>
<td>358 Marfleet Lane, Hull, HU9 5AD</td>
<td>Dr L Witvliet</td>
</tr>
<tr>
<td>Wolseley Medical Centre</td>
<td>Wolseley Medical Centre, Londesborough Street, Hull, HU3 1DS</td>
<td>Dr K Pande</td>
</tr>
<tr>
<td>Wong &amp; Partners</td>
<td>Faith House Surgery, 723 Beverley Road, Hull, HU6 7ER</td>
<td>Dr A Melville</td>
</tr>
<tr>
<td>Yagnik RD</td>
<td>Park Health Centre, 700 Holderness Road, Hull, HU9 3JR</td>
<td>Dr RD Yagnik</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 NHS Hull Clinical Commissioning Group so that group can fulfil its obligations, as set out largely in the 2006 Act, as amended by the 2012 Act and related regulations. They are effective from the date the group is established.

1.1.2. The standing orders, together with the group’s scheme of reservation and delegation\(^\text{52}\) and the group’s prime financial policies\(^\text{53}\), provide a procedural framework within which the group discharges its business. They set out:

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

b) the appointment of member practice representatives;

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

d) the process to delegate powers,

e) 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\(^\text{54}\) of any relevant guidance.

1.1.3. The standing orders, scheme of reservation and delegation and prime financial policies have effect as if incorporated into the group’s constitution. Group members, employees, members of the governing body, members of the governing body’s committees and sub-committees, members of the group’s committees and sub-committees and persons working on behalf of the group should be aware of the existence of these documents and, where necessary, be familiar with their detailed provisions. Failure to comply with the standing orders, scheme of reservation and delegation and prime financial policies may be regarded as a disciplinary matter that could result in dismissal.

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\(^{52}\) See Appendix D

\(^{53}\) See Appendix E

\(^{54}\) Under some legislative provisions the group is obliged to have regard to particular guidance but under other circumstances guidance is issued as best practice guidance.
1.2. Schedule of matters reserved to the clinical commissioning group and the scheme of reservation and delegation

1.2.1. The 2006 Act (as amended by the 2012 Act) provides the group with powers to delegate the group’s functions and those of the governing body to certain bodies (such as committees) and certain persons. The group has decided that certain decisions may only be exercised by the group in formal session. These decisions and also those delegated are contained in the group’s scheme of reservation and delegation (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 group’s constitution provides details of the membership of the group (also see Appendix B).

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

2.2. Key Roles

2.2.1. Eligibility to roles will be subject to compliance with the Regulations, as appropriate.

2.2.2. Council of Members: The composition of the group’s Council of Members shall be one GP representative nominated by each CCG member. Members may authorise another GP to act on their behalf by enactment of a suitable proxy notice in accordance with the requirements contained in section 3.8.4. of these standing orders.

2.2.3. A chair and vice chair for the Council of Members shall be elected for a 2 year period by the members of the Council of Members.

2.2.4. The chair of the Council of Members shall also be a member of the governing body.

2.2.5. The election process shall be enacted by the Local Medical Committee (LMC) in accordance with the process and requirements determined by the Council of Members.

2.2.6. The chair and vice chair must be current members of the Council of Members and comply with any requirements under the Act, the Regulations or guidance. If that ceases to be the case they shall automatically be removed from post.
2.2.7. The chair and vice chair shall be expected to give 3 months’ notice or shorter by mutual agreement of a decision to resign in writing to the Council of Members, and any such resignation shall be placed on the agenda of the next meeting.

2.2.8. Standing attendees at the meeting shall be those officers who are members of the governing body. Other attendees shall be invited as determined by the Chair / Vice chair of the Council of Members as appropriate to the business of the meeting.

2.2.9. **Governing Body:** Paragraph 6.6.2 of the group’s constitution sets out the composition of the group’s governing body whilst Section 7 of the group’s constitution identifies certain key roles and responsibilities within the group and its governing body. These standing orders set out how the group appoints individuals to these key roles.

2.2.10. To avoid significant conflicts of interest, no member of the governing body shall have a direct pecuniary interest in any provider organisation(s)* which in total have a contract value with the group that exceeds 1% of the CCG’s total programme allocation.

2.2.11. The job description of each role on the governing body shall establish responsibilities, tenure, eligibility, term of office, grounds for removal from office, and mechanism/notice period for resignation from office. The job description for elected members shall be agreed with the Council of Members.

2.2.12. Up to ten GPs shall be elected from the body of GPs currently on the local Performers List for Hull, or having been on it within the last 5 years, and shall be elected by the Council of Members using the voting methodology as set out in section 3.8.2. of these Standing Orders. The tenure shall normally be a 2 year period, but this may be varied as determined by the Council of Members by up to 12 months (up or down) to support continuity within the governing body membership. The election process shall be enacted by the Local Medical Committee (LMC) in accordance with the process and requirements determined by the Council of Members.

2.2.13. The Chair of the governing body shall not be the chair of the Council of Members.

2.2.14. All other appointed posts on the governing body shall be appointed through a process determined jointly by the chair of the Governing Body and the Accountable Officer, taking into account such national guidance or directives as relevant.

2.2.15. All appointments shall be ratified at a meeting of the Council of Members.

*Note: provider organisations that are taken into account in clause 2.2.10. shall exclude PMS and GMS primary care contracts
3. MEETINGS OF THE CLINICAL COMMISSIONING GROUP – COUNCIL OF MEMBERS AND GOVERNING BODY

3.1. Calling meetings

3.1.1. Council of Members: Ordinary meetings of the Council of Members shall be held at regular intervals and at such times and places as the group may determine, but on not less than 6 occasions per year. One meeting will be the Annual General Meeting. The chair may call additional meetings as and when required in response to member’s reasonable requests or as part of the necessary discharge of the Council of Member’s responsibilities.

3.1.2. A minimum of 21 days advance notice shall be given to each member of the Council of Members. The accidental omission to give notice of a meeting to, or the non-receipt of notice of a meeting by, any person entitled to receive notice shall not invalidate the proceedings at that meeting.

3.1.3. Governing body: Ordinary meetings of the CCG governing body shall be held at regular intervals and at such times and places as the group may determine, but on not less than 6 occasions each year. These meetings shall be held in public, save for where it is resolved that it would be prejudicial to the public interest for the public and press to remain. One meeting of the governing body shall be the Annual Public Meeting. The chair may call additional meetings as and when required in response to member’s reasonable requests or as part of the necessary discharge of the governing body’s responsibilities.

3.1.4. A minimum of 5 days advance public notice will be given for an ordinary meeting of the governing body.

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 administrator of the meeting at least 14 days before the meeting takes place. Supporting papers for such items need to be submitted at least 9 days before the meeting takes place. The agenda and supporting papers will be circulated to all members of a meeting at least 7 days before the date the meeting will take place.

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

3.2.3. The documentation for meeting held in public shall be made available upon application in writing or in person to NHS Hull CCG, Second Floor, Wilberforce Court, Alfred Gelder Street, Hull HU1 1UY.

3.3. Petitions

3.3.1. Where a petition has been received by the group, the chair of the governing body shall include the petition as an item for the agenda of the next meeting of the
governing body. In order for a petition to be considered at a meeting of the governing body, a minimum of 10% of members are required to be co-signatories to it.

3.4. Chair of a Meeting

3.4.1. At any meeting of the group or its governing body or of a committee or sub-committee, the chair of the group, governing body, committee or sub-committee, if any and if present, shall preside. If the chair is absent from the meeting, the vice chair, if any and if present, shall preside.

3.4.2. If the chair is absent temporarily on the grounds of a declared conflict of interest the vice chair, if present, shall preside. If both the chair and vice chair are absent, or are disqualified from participating, a member of the group, governing body, committee or sub-committee respectively shall be chosen by the members present, or by a majority of them, to preside.

3.5. Chair's Ruling

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

3.6. Quorum - Council of Members

3.6.1. 33% of the persons entitled to vote upon the business to be transacted at the Council of Members shall constitute a quorum, each being either a Member Representative or a proxy for a Member Representative. No formal business is to be transacted if the persons attending do not constitute a quorum.

3.7. Quorum - Governing Body

3.7.1. The quorum for the governing body shall normally be a minimum of 6 members, subject to standing order 3.7.2., including:

   a) The chair or vice-chair,
   b) 2 GPs (in addition to the chair, if present), and
   c) One officer member

3.7.2. Should exceptional circumstances arise that require there to be no GP present for a specific agenda item (e.g. due to conflicts of interest affecting all GP members present at the meeting) the chair may declare the meeting quorate to make a decision only if the view taken by the governing body accords with a recorded recommendation or decision taken by the Council of Members on that same matter. If the view of the governing body does not accord with that of the Council of Members, no decision shall be taken and the matter shall be adjourned to the next meeting of the governing body.
3.7.3. Where the circumstances in section 3.7.2 arise and:

a) there is no relevant decision or recommendation from the Council of Members, or
b) a decision is urgent, or
c) the governing body and Council of Members are unable to come to a common view, or
d) the same conflicts of interest exist with the Council of Members as with the GP members of the governing body,

the chair of the governing body shall determine how to obtain GP advice to enable a decision to be taken. Options could include requesting GP governing body member(s) from another CCG, or a GP from NHS England local office to provide that advice.

3.7.4. Deputies appointed with formal acting-up status for officer members may count towards quoracy and vote, as appropriate, for the period that the formal acting-up status applies. Deputies for officer members without formal acting-up status may attend meetings but shall not vote or count towards quoracy.

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

3.8. Decision Making

3.8.1. Chapter 6 of the group’s Constitution, together with the scheme of reservation and delegation, sets out the governing structure for the exercise of the group’s statutory functions. Generally it is expected that all the decisions shall be determined by consensus wherever possible. Where that is not achieved, decisions shall be determined through voting of those present as set out below.

3.8.2. Council of Members:

a) Each Member Representative will be entitled to the number of votes resulting from the following calculation:

One vote per 1,000 patients (rounded to the nearest whole 1000). In the case of a practice with less than 500 registered patients the Member Representative will be entitled to one vote. The apportionment of votes will be updated annually based on the number of registered patients within the practice at 1st April of each year.

b) Decisions of the Council of Members must be decided by a majority vote.

c) In the case of an equality of votes, the chair of the meeting shall have a second and casting vote.

d) All votes will be recorded and available on request to Members of the CCG.
e) No objection may be raised to the qualification of any person voting at a meeting except at the meeting or adjourned meeting at which the vote objected to is tendered, and every vote not disallowed at the meeting is valid.

f) Any such objection must be referred to the chair of the meeting whose decision is final.

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

3.8.3. Governing Body:

a) Each member present shall have a single vote. Matters put to a vote shall be determined by a simple majority of the votes of members present and voting on the matter. In the case of an equal vote, the person presiding (ie: the chair of the meeting) shall have a second and casting vote.

3.8.4. Proxy Votes Council of Members

a) Proxy appointments will only be considered valid if they are received in writing (a “proxy notice”) and:

i) state the name and address of the Member Representative appointing the proxy.

ii) identify the GP appointed to be that Member Representative’s proxy and the meeting in relation to which that person is appointed;

iii) is signed by or on behalf of the Member Representative appointing the proxy, or is authenticated by the relevant Member; and

iv) is delivered to the CCG in accordance with any instructions contained in the notice of the meeting to which they relate

b) The CCG may require proxy notices to be delivered in a particular form and may specify different forms for different purposes. Proxy notices may specify how the proxy appointed under them is to vote (or that the proxy is to abstain from voting) on one or more resolutions. Unless a proxy notice indicates otherwise, it must be treated as allowing the person appointed as having the discretion to vote on any ancillary or procedural resolutions put to the meeting, and appointing that person as a proxy in relation to any adjournment of the meeting to which it relates as well as the meeting itself.

c) If a proxy notice is not executed by the Member Representative appointing the proxy, it must be accompanied by written evidence of the authority of the person who executed it to execute it on the relevant Member’s behalf.
3.8.5. Revoking of proxy notices

a) An appointment under a proxy notice may be revoked by delivering to the CCG a notice in writing given by or on behalf of the Member Representative by whom or on whose behalf the proxy notice was given. A notice revoking a proxy appointment only takes effect if it is delivered before the start of the meeting or adjourned meeting to which it relates.

3.8.6. No votes by proxy will be permitted at meetings of the governing body.

3.8.7. For all other of the group’s committees and sub-committees, including the governing body’s committees and sub-committees, the details of the process for holding a vote shall be set out in the appropriate terms of reference.

3.9. **Emergency Powers and Urgent Decisions**

3.9.1. The chair or (in the absence of the chair) the vice chair may call an emergency meeting or request an emergency decision from members as and when they deem it to be necessary, providing that a minimum of 5 days notice is provided and quoracy can be achieved.

3.9.2. The chair or, in the absence of the chair, the vice chair after having consulted two other members shall in an emergency or for an urgent decision have authority to take chair’s action i.e. take a decision on behalf of the meeting membership where it is neither practical or reasonable to call a meeting or reach a decision through the normal routes. All such decisions shall be reported to the members as soon as practicable and shall be recorded in the minutes of the next available meeting.

3.10. **Suspension of Standing Orders**

3.10.1. Except where it would contravene any statutory provision or any direction made by the Secretary of State for Health or NHS England, any part of these standing orders may be suspended at any meeting, provided 50% of members are in agreement.

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

3.10.3. A separate record of matters discussed during the suspension shall be kept. These records shall be made available to the governing body’s Integrated Audit & Governance Committee for review of the reasonableness of the decision to suspend standing orders.

3.11. **Record of Attendance**

3.11.1. The names of all members of the meeting present at the meeting shall be recorded in the minutes of the group’s meetings. The names of all members of the governing body present shall be recorded in the minutes of the governing body meetings. The names of all members of the governing body’s committees /
sub-committees present shall be recorded in the minutes of the respective governing body committee / sub-committee meetings.

3.12. Minutes

3.12.1. Minutes shall be taken at all Council of Members, governing body and governing body committee meetings, and confirmed as a true record at the subsequent meeting.

3.12.2. All approved minutes (except those specific elements that are deemed confidential in nature) shall be placed on the group’s intranet (or equivalent) along with all meeting papers and shall thereby be available to all the CCG’s members.

3.12.3. Minutes of the governing body public meetings shall be made available, once approved, to any member of the public through the CCG website or upon application in writing or in person to NHS Hull CCG, Second Floor, Wilberforce Court, Alfred Gelder Street, Hull HU1 1UY.

3.13. Admission of Public and the Press

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

- ‘that representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest’, Section 1 (2), Public Bodies (Admission to Meetings) Act 1960.

3.13.2. Public and press shall not normally be admitted to other group meetings.

3.14. General disturbances

3.14.1. The Chairman (or Vice-Chairman if one has been appointed) or the person presiding over the meeting shall give such directions as he 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 CCG’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 CCG to complete its business without the presence of the public’. Section 1(8) Public Bodies (Admissions to Meetings) Act 1960.

3.15. Use of Mechanical or Electrical Equipment for Recording or Transmission of Meetings

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

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

4.1. **Appointment of Committees and Sub-committees**

4.1.1. The group may appoint committees and sub-committees of the group, subject to any regulations made by the Secretary of State\(^\text{55}\), and make provision for the appointment of committees and sub-committees of its governing body. Where such committees and sub-committees of the group, or committees and sub-committees of its governing body, are appointed they are included in Chapter 6 of the group’s constitution.

4.1.2. Other than where there are statutory requirements, such as in relation to the governing body’s integrated audit & governance committee or remuneration committee, the group 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 group.

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

4.3. **Delegation of Powers by Committees to Sub-committees**

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

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\(^{55}\) See section 14N of the 2006 Act, inserted by section 25 of the 2012 Act

4.4. **Approval of Appointments to Committees and Sub-Committees**

4.4.1. The group shall approve the appointments to each of the committees and sub-committees which it has formally constituted including those the governing body. The group shall agree such travelling or other allowances as it considers appropriate.
5. DUTY TO REPORT NON-COMPLIANCE WITH STANDING ORDERS AND PRIME FINANCIAL POLICIES

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

6. USE OF SEAL AND AUTHORISATION OF DOCUMENTS

6.1. Clinical Commissioning Group's Seal

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

a) the Chief Officer;
b) the Chair of the Governing Body;
c) the Chief Finance Officer;
d) other Directors of the CCG;

6.2. Execution of a Document by Signature

6.2.1. The following individuals are authorised to execute a document on behalf of the group by their signature.

a) the Chief Officer;
b) the Chair of the Governing Body;
c) the Chief Finance Officer;
d) other Directors of the CCG;

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

7.1. Policy Statements: General Principles

7.1.1. The group will from time to time agree and approve policy statements / procedures which will apply to all or specific groups of staff employed by NHS Hull CCG. The decisions to approve such policies and procedures will be recorded in an appropriate group minute and will be deemed where appropriate to be an integral part of the group’s standing orders.
APPENDIX D – SCHEME OF RESERVATION & DELEGATION

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

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

1.2. The clinical commissioning group remains accountable for all of its functions, including those that it has delegated.
<table>
<thead>
<tr>
<th>Policy Area</th>
<th>Decisions reserved to the Council of Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>REGULATION AND CONTROL</td>
<td>Determine the arrangements by which the members of the group approve those decisions that are reserved for the membership.</td>
</tr>
<tr>
<td>REGULATION AND CONTROL</td>
<td>Consideration and approval of applications to NHS England on any matter concerning changes to the group’s constitution, including terms of reference for the group’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>
</tr>
<tr>
<td>REGULATION AND CONTROL</td>
<td>Approval of the CCG Constitution</td>
</tr>
<tr>
<td>REGULATION AND CONTROL</td>
<td>Approval of the CCG’s vision, values and overall strategic direction</td>
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<tr>
<td>REGULATION AND CONTROL</td>
<td>Approval of Standards of Business Conduct Policy</td>
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<tr>
<td>REGULATION AND CONTROL</td>
<td>Approval of Conflicts of Interest Policy</td>
</tr>
<tr>
<td>COMMISSIONING</td>
<td>Approval of Annual Commissioning Plan</td>
</tr>
<tr>
<td>LEADERSHIP</td>
<td>Election of chair and vice-chair of the Council of Members</td>
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<tr>
<td>LEADERSHIP</td>
<td>Election of GP representatives to the governing body</td>
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<tr>
<td>LEADERSHIP</td>
<td>Approval of job descriptions of elected members of the governing body</td>
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<tr>
<td>LEADERSHIP</td>
<td>Ratify lay representatives to the governing body</td>
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<td>LEADERSHIP</td>
<td>Ratify practice manager member to the governing body</td>
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<tr>
<td>LEADERSHIP</td>
<td>Ratify appointment of the chair of the governing body</td>
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<tr>
<td>Policy Area</td>
<td>Decisions delegated or reserved to the governing body</td>
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<tr>
<td>REGULATION AND CONTROL</td>
<td>Determine the arrangements to ensure that the group exercises its functions effectively, efficiently and economically and in accordance with the groups principles of good governance</td>
</tr>
<tr>
<td>REGULATION AND CONTROL</td>
<td>Approve any functions of the group that are specified in regulations</td>
</tr>
<tr>
<td>REGULATION AND CONTROL</td>
<td>Approve Terms of Reference of any committees and sub-committees of the CCG</td>
</tr>
<tr>
<td>STRATEGY</td>
<td>Approval of the governing body annual workplan</td>
</tr>
<tr>
<td>REGULATION AND CONTROL</td>
<td>Approval of CCG’s operational structure</td>
</tr>
<tr>
<td>REGULATION AND CONTROL</td>
<td>Approval of any other policies that are not otherwise included in the Constitution or delegated to other committees or sub-committees (including policies for use of the seal and arrangements for managing exceptional funding requests)</td>
</tr>
<tr>
<td>REGULATION AND CONTROL</td>
<td>Determine arrangements to ensure compliance with Standards of Business Conduct and Conflicts of Interest Policies and Registers of Interest are maintained</td>
</tr>
<tr>
<td>REGULATION AND CONTROL</td>
<td>Provision of assurance of strategic risk</td>
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<tr>
<td>Policy Area</td>
<td>Decisions delegated or reserved to the governing body</td>
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<td>------------------------------------------------------</td>
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<tr>
<td>REGULATION AND CONTROL</td>
<td>Determine arrangements to ensure the CCG meets its duty to:</td>
</tr>
<tr>
<td></td>
<td>1. Promote a comprehensive health service</td>
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<td></td>
<td>2. Meet the public sector equality duty</td>
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<td></td>
<td>3. Secure public involvement in the planning and development of commissioning services</td>
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<td></td>
<td>4. Ensure that significant service decisions and strategies take due cognisance of the NHS Constitution</td>
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<tr>
<td></td>
<td>5. Ensure that the group acts to secure the continuous quality improvement to the quality of services</td>
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<td></td>
<td>6. Assist and support NHS England to improve the quality of primary medical services</td>
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<td></td>
<td>7. Have regard of the need to reduce inequalities</td>
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<tr>
<td></td>
<td>8. Ensure that service users, their carers and advocates are involved in decisions about their healthcare</td>
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<td></td>
<td>9. Ensure that patients are able to make choices about their healthcare</td>
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<td></td>
<td>10. Ensure that the group is able to obtain appropriate advice</td>
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<td></td>
<td>11. Promote innovation</td>
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<td></td>
<td>12. Promote research and the use of research</td>
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<td></td>
<td>13. Promote education and training</td>
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<td></td>
<td>14. Promote integration</td>
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<tr>
<td></td>
<td>15. Ensure financial governance</td>
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<tr>
<td>Policy Area</td>
<td>Decisions delegated or reserved to the governing body</td>
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</tr>
<tr>
<td>REGULATION AND CONTROL</td>
<td>Determine the arrangements necessary to ensure:</td>
</tr>
<tr>
<td></td>
<td>1. compliance with running costs whilst maintaining sustainable functions.</td>
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<tr>
<td></td>
<td>2. the delivery and implementation of any guidance or standards issued by any relevant regulatory body.</td>
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<tr>
<td></td>
<td>3. delivery of targets, policies and standards agreed by the group.</td>
</tr>
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<td></td>
<td>4. the provision of appropriate assurance against strategic risks</td>
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<td></td>
<td>5. delivery of the outcomes and milestones set out in the Commissioning Strategy.</td>
</tr>
<tr>
<td></td>
<td>6. effective liaison with and reporting to Members and the NHS England (as appropriate).</td>
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<td></td>
<td>7. that the CCG governance arrangements are reviewed to ensure that they are robust and are complied with by all Members of the CCG.</td>
</tr>
<tr>
<td></td>
<td>8. that all relevant law and policy is complied with and the NHS Hull CCG Governing Body adheres to the obligations placed on it and the CCG.</td>
</tr>
<tr>
<td></td>
<td>9. that the group remains accountable to Members and the public.</td>
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<td></td>
<td>10. that CCG policies and procedures are implemented and adhered to at all times.</td>
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<td></td>
<td>11. that as far as reasonably practical:</td>
</tr>
<tr>
<td></td>
<td>a) effective and inclusive communication links are maintained to ensure that the views of Members are properly considered as part of the decision making process</td>
</tr>
<tr>
<td></td>
<td>b) plans are in place that address local inequalities</td>
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<tr>
<td></td>
<td>c) delivery of the group’s vision, values, aims, culture and strategic direction.</td>
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<tr>
<td></td>
<td>d) engagement with the Health &amp; Wellbeing Board.</td>
</tr>
<tr>
<td></td>
<td>e) effective public involvement in the decisions of the group.</td>
</tr>
<tr>
<td></td>
<td>f) the promotion of safe and high quality services.</td>
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<tr>
<td></td>
<td>g) co-ordinated and prioritised plans for the demand, financial and investment needs of the group are developed.</td>
</tr>
<tr>
<td>REGULATION AND CONTROL</td>
<td>Approving joint commissioning arrangements with other CCGs</td>
</tr>
<tr>
<td>REGULATION AND CONTROL</td>
<td>Approve appointment of joint committees with local authorities under section 75 of the NHS Act 2006.</td>
</tr>
<tr>
<td>REGULATION AND CONTROL</td>
<td>Approval of delegated decision-making authority to individuals for the purpose of making decisions under joint arrangements with Other CCGs.</td>
</tr>
<tr>
<td>REGULATION AND CONTROL</td>
<td>Performance monitoring against commissioning plans</td>
</tr>
</tbody>
</table>
### Decisions delegated to the Integrated Audit & Governance Committee

<table>
<thead>
<tr>
<th>REGULATION AND CONTROL</th>
<th>Decision</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Approve the appointment of internal auditors</td>
</tr>
<tr>
<td></td>
<td>Approve counter fraud and security management arrangements</td>
</tr>
<tr>
<td></td>
<td>Determine whether the CCG's financial systems and financial information provisions are adequate and appropriate and advise the governing body accordingly</td>
</tr>
<tr>
<td></td>
<td>Determine the adequacy or otherwise of the assurance available for the groups system of control and risk management arrangements and advise the governing body accordingly</td>
</tr>
</tbody>
</table>

### Decisions delegated to the Remuneration Committee

<table>
<thead>
<tr>
<th>REGULATION AND CONTROL</th>
<th>Decision</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Determine the remuneration and conditions of service of the senior team / governing body</td>
</tr>
</tbody>
</table>

### Decisions delegated to the Accountable Officer

<table>
<thead>
<tr>
<th>REGULATION AND CONTROL</th>
<th>Decision</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Exercise or delegation of those functions of the clinical commissioning group which have not been retained as reserved by the group, delegated to the governing body or other committee or sub-committee or specified member or employee.</td>
</tr>
<tr>
<td></td>
<td>Determination of operational or other arrangements and policies that are not otherwise included in the Constitution or delegated to other committees or sub-committees, specified member or employee.</td>
</tr>
<tr>
<td></td>
<td>Ensure arrangements are in place for partnership working with local authorities under section 75 of the NHS Act 2006</td>
</tr>
</tbody>
</table>

### Decisions delegated to the Chief Finance Officer

<table>
<thead>
<tr>
<th>REGULATION AND CONTROL</th>
<th>Decision</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Determine arrangements to ensure sound system of financial control</td>
</tr>
<tr>
<td></td>
<td>Develop detailed financial policies that underpin the group’s prime financial policies</td>
</tr>
<tr>
<td></td>
<td>Produce 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</td>
</tr>
<tr>
<td></td>
<td>Develop arrangements to ensure value for money in all contracts entered into.</td>
</tr>
</tbody>
</table>
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 group’s constitution.

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

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

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

1.1.5. A list of the group’s detailed financial policies will be published and maintained on the group’s website at www.hullccg.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 group’s constitution, standing orders and scheme of reservation and delegation.

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

1.2. Overriding Prime Financial Policies

1.2.1. If for any reason these prime financial policies are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next formal meeting of the governing body’s Integrated Audit & Governance Committee for referring action or ratification. All of the group’s members and employees have a duty to disclose any non-compliance with these prime financial policies to the chief finance officer as soon as possible.
1.3. **Responsibilities and delegation**

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

1.3.2. The financial decisions delegated by members of the group are set out in the group’s scheme of reservation and delegation (see Appendix D).

1.4. **Contractors and their employees**

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

1.5. **Amendment of Prime Financial Policies**

1.5.1. To ensure that these prime financial policies remain up-to-date and relevant, the chief finance officer will review them at least annually. Following consultation with the accountable officer and scrutiny by the governing body’s Integrated Audit & Governance committee, the chief finance officer will recommend amendments, as fitting, to the governing body for approval. As these prime financial policies are an integral part of the group’s constitution, any amendment will not come into force until the group applies to NHS England and that application is granted.

2. **INTERNAL CONTROL**

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

2.1. The governing body is required to establish an Integrated Audit & Governance committee with terms of reference agreed by the governing body (see paragraph 6.7.1. of the group’s constitution for further information).

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

2.3. The chief finance officer will ensure that:

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

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

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

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

3.1. In line with the terms of reference for the governing body’s Integrated Audit & Governance Committee, the person appointed by the group to be responsible for internal audit and the Audit Commission appointed external auditor will have direct and unrestricted access to Integrated Audit & Governance 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 group to be responsible for internal audit and the external auditor will have access to the Integrated Audit & Governance committee and the accountable officer to review audit issues as appropriate. All Integrated Audit & Governance committee members, the chair of the governing body and the accountable officer will have direct and unrestricted access to the head of internal audit and external auditors.

3.3. The chief finance officer will ensure that:

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

b) the governing body’s Integrated Audit & Governance Committee approves any changes to the provision or delivery of assurance services to the group.

4. **FRAUD AND CORRUPTION**

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

4.1. The governing body’s Integrated Audit & Governance Committee will satisfy itself that the group 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 Integrated Audit & Governance Committee will ensure that the group has arrangements in place to work effectively with NHS Protect.
5. **EXPENDITURE CONTROL**

5.1. The group is required by statutory provisions\(^56\) to ensure that its expenditure does not exceed the aggregate of allotments from NHS England and any other sums it has received and is legally allowed to spend.

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

5.3. The chief finance officer will:

   a) provide reports in the form required by NHS England;

   b) ensure money drawn from NHS England is required for approved expenditure only is drawn down only at the time of need and follows best practice;

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

6. **ALLOTMENTS\(^57\)**

6.1. The group’s chief finance officer will:

   a) periodically review the basis and assumptions used by NHS England for distributing allotments and ensure that these are reasonable and realistic and secure the group’s entitlement to funds;

   b) prior to the start of each financial year submit to the governing body for approval a report showing the total allocations received and their proposed distribution including any sums to be held in reserve; and

   c) regularly update the governing body on significant changes to the initial allocation and the uses of such funds.

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\(^{56}\) See section 223H of the 2006 Act, inserted by section 27 of the 2012 Act

\(^{57}\) See section 223(G) of the 2006 Act, inserted by section 27 of the 2012 Act.
7. COMMISSIONING STRATEGY, BUDGETS, BUDGETARY CONTROL AND MONITORING

**POLICY** – the group will produce and publish an annual commissioning plan\(^{58}\) that explains how it proposes to discharge its financial duties. The group will support this with comprehensive medium term financial plans and annual budgets.

7.1. The accountable officer will compile and submit to the governing body a commissioning strategy which takes into account financial targets and forecast limits of available resources.

7.2. Prior to the start of the financial year the chief finance officer will, on behalf of the accountable officer, prepare and submit budgets for approval by the governing body.

7.3. The chief 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.

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

7.5. The governing body will approve consultation arrangements for the group’s commissioning plan\(^{59}\).

8. ANNUAL ACCOUNTS AND REPORTS

**POLICY** – the group will produce and submit to NHS England accounts and reports in accordance with all statutory obligations\(^{60}\), relevant accounting standards and accounting best practice in the form and content and at the time required by NHS England.

8.1. The chief finance officer will ensure the group:

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

b) prepares the accounts according to the timetable approved by the governing body;

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

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\(^{58}\) See section 14Z11 of the 2006 Act, inserted by section 26 of the 2012 Act.

\(^{59}\) See section 14Z13 of the 2006 Act, inserted by section 26 of the 2012 Act.

\(^{60}\) See paragraph 17 of Schedule 1A of the 2006 Act, as inserted by Schedule 2 of the 2012 Act.
d) considers the external auditor’s management letter and fully address all issues within agreed timescales; and

e) publishes the external auditor’s management letter on the group’s website at www.hullccg.nhs.uk

9. INFORMATION TECHNOLOGY

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

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

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

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

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

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

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

10. ACCOUNTING SYSTEMS

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

10.1. The chief finance officer will ensure:

a) the group has suitable financial and other software to enable it to comply with these policies and any consolidation requirements of NHS England;
b) that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

10.2. Where another health organisation or any other agency provides a computer service for financial applications, the chief finance officer shall periodically seek assurances that adequate controls are in operation.

11. BANK ACCOUNTS

<table>
<thead>
<tr>
<th>POLICY – the group will keep enough liquidity to meet its current commitments</th>
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</thead>
</table>

11.1. The chief finance officer will:

a) review the banking arrangements of the group at regular intervals to ensure they are in accordance with Secretary of State directions\(^{61}\), best practice and represent best value for money;

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

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

11.2. The Integrated Audit & Governance Committee shall approve the banking arrangements.

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

<table>
<thead>
<tr>
<th>POLICY – the group will</th>
</tr>
</thead>
<tbody>
<tr>
<td>• operate a sound system for prompt recording, invoicing and collection of all monies due</td>
</tr>
<tr>
<td>• seek to maximise its potential to raise additional income only to the extent that it does not interfere with the performance of the group or its functions(^{62})</td>
</tr>
<tr>
<td>• ensure its power to make grants and loans is used to discharge its functions effectively(^{63})</td>
</tr>
</tbody>
</table>

12.1. The Chief Financial Officer is responsible for:

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

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\(^{61}\) See section 223H(3) of the NHS Act 2006, inserted by section 27 of the 2012 Act

\(^{62}\) See section 14Z5 of the 2006 Act, inserted by section 26 of the 2012 Act.

\(^{63}\) See section 14Z6 of the 2006 Act, inserted by section 26 of the 2012 Act.
b) establishing and maintaining systems and procedures for the secure handling of cash and other negotiable instruments;

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

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

13. TENDERING AND CONTRACTING PROCEDURE

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

13.1. The group shall ensure that the firms / individuals invited to tender (and where appropriate, quote) are among those on approved lists or where necessary a framework agreement. Where in the opinion of the chief finance officer it is desirable to seek tenders from firms not on the approved lists, the reason shall be recorded in writing to the accountable officer or the group’s Integrated Audit & Governance Committee.

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

a) the group’s standing orders;

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

c) take into account as appropriate any applicable NHS England 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 group shall endeavour to obtain best value for money. The accountable officer shall nominate an individual who shall oversee and manage each contract on behalf of the group.
14. COMMISSIONING

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

14.1. The group will coordinate its work with NHS England, 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 relevant committee of the governing body detailing actual and forecast expenditure and activity for each contract.

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

15. RISK MANAGEMENT AND INSURANCE

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

15.1. The Integrated Audit & Governance Committee shall have oversight of the preparation of risk and assurance frameworks which shall be submitted, at least annually, to the governing body for approval.

15.2. The Integrated Audit & Governance Committee shall advise the governing body as regards the management of risk, establishment of controls and adequacy or otherwise of the assurances available with respect to these controls.

15.3. The senior officer with responsibility for corporate governance, in consultation with the Chief Officer and Chief Finance Officer, shall have responsibility for the preparation of the risk and assurance framework.

15.4. The CCG shall participate in the Risk Pooling Schemes managed by the NHS Litigation Authority or shall enter into such contracts of insurance as it may from time to time be permitted by law so to do in accordance with arrangements approved by the Audit Committee.

16. PAYROLL

POLICY – the group will put arrangements in place for an effective payroll service
16.1. The chief finance officer will ensure that the payroll service selected:
   a) is supported by appropriate (i.e. contracted) terms and conditions;
   b) has adequate internal controls and audit review processes;
   c) has suitable arrangements for the collection of payroll deductions and
      payment of these to appropriate bodies.

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

17. **NON-PAY EXPENDITURE**

<table>
<thead>
<tr>
<th>POLICY</th>
<th>the group will seek to obtain the best value for money goods and services received</th>
</tr>
</thead>
</table>

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 officer will:

   a) 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;
   
   b) be responsible for the prompt payment of all properly authorized
      accounts and claims;
   
   c) be responsible for designing and maintaining a system of verification,
      recording and payment of all amounts payable.

18. **CAPITAL INVESTMENT, FIXED ASSET REGISTER AND SECURITY OF ASSETS**

<table>
<thead>
<tr>
<th>POLICY</th>
<th>the group will put arrangements in place to manage capital investment, maintain an asset register recording fixed assets and put in place polices to secure the safe storage of the group’s fixed assets</th>
</tr>
</thead>
</table>

18.1. The Chief Officer will

   a) ensure that there is an adequate appraisal and approval process in
      place for determining capital expenditure priorities and the effect of each
      proposal upon plans;
b) be responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost;

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

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

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

19. RETENTION OF RECORDS

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

19.1. The Chief Officer shall:

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

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

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

20. TRUST FUNDS AND TRUSTEES

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

20.1. The Chief Finance Officer shall ensure that each trust fund which the group is responsible for managing is managed appropriately with regard to its purpose and to its requirements.
APPENDIX F - NOLAN PRINCIPLES

1. The principles of public life (the ‘Nolan Principles’) apply to anyone who works as a public office-holder. This includes all those who are elected or appointed to public office, nationally and locally, and all people appointed to work in the civil service, local government, the police, courts and probation services, NDPBs, and in the health, education, social and care services. All public office-holders are both servants of the public and stewards of public services. The principles also have application to all those in other sectors delivering public services. The seven principles are:

a) **Selflessness** – Holders of public office should act solely in terms of the public interest.

b) **Integrity** – Holders of public office must avoid placing themselves under any obligation to people or organisations that might try inappropriately to influence them in their work. They should not act or take decisions in order to gain financial or other material benefits for themselves, their family, or their friends. They must declare and resolve any interests and relationships.

c) **Objectivity** – Holders of public office must act and take decisions impartially, fairly and on merit, using the best evidence and without discrimination or bias.

d) **Accountability** – Holders of public office are accountable to the public for their decisions and actions and must admit themselves to the scrutiny necessary to ensure this.

e) **Openness** – Holders of public office should act and take decisions in an open and transparent manner. Information should not be withheld from the public unless there are clear and lawful reasons for so doing.

f) **Honesty** – Holders of public office should be truthful.

g) **Leadership** – Holders of public office should exhibit these principles in their own behaviour. They should actively promote and robustly support the principles and be willing to challenge poor behaviour wherever it occurs.

Source: *The Committee on Standards in Public Life* (2013)

64 Available at http://www.public-standards.gov.uk/
APPENDIX G – THE SEVEN KEY PRINCIPLES OF THE NHS CONSTITUTION

The NHS Constitution sets out seven key principles that guide the NHS in all it does:

1. **The NHS provides a comprehensive service, available to all** - irrespective of gender, race, disability, age, sexual orientation, religion or belief. It has a duty to each and every individual that it serves and must respect their human rights. At the same time, it has a wider social duty to promote equality through the services it provides and to pay particular attention to groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population.

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

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

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

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

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

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

Source: *The NHS Constitution: The NHS belongs to us all* (March 2012)
APPENDIX H - NHS HULL CLINICAL COMMISSIONING GROUP

INTEGRATED AUDIT AND GOVERNANCE COMMITTEE
TERMS OF REFERENCE

1. PURPOSE

1.1 NHS Hull Clinical Commissioning Group (CCG) Board has resolved to establish an Integrated Audit & Governance Committee in accordance with its Constitution, Standing Orders and Scheme of Delegation. These Terms of Reference set out the membership, remit, responsibilities and reporting arrangements of the Committee and shall have effect as if incorporated into the CCG’s Constitution and Standing Orders.

1.2 The Integrated Audit & Governance Committee is responsible for providing assurance to the CCG Board on the processes operating within the organisation for risk, control and governance. It assesses the adequacy of assurances that are available with respect to financial, corporate, clinical and information governance.

The committee is able to direct further scrutiny, both internally and externally where appropriate, for those functions or areas where it believes insufficient assurance is being provided to the CCG Board.

1.3 Links and interdependencies

The Integrated Audit and Governance Committee is the primary committee for all strategic risk, control and governance matters of the organisation, it will seek suitable information and assurance from independent sources, such as internal / external audit, as well as from internal sources, such as executive officers / senior managers and other committees of the board, in particular:

- The Quality and Performance Committee.
- The Planning and Commissioning Committee, and
- The Remuneration Committee.

The Integrated Audit and Governance Committee is chaired by a lay member of the CCG board. In which case the term “Chairman” is to be read as a reference to the Chairman of the Committee as the context permits, and the term “member” is to be read as a reference to a member of the Committee also as the context permits.

2. ACCOUNTABILITY

2.1 The Integrated Audit and Governance Group is directly accountable to the CCGB for overseeing and providing assurance on the matters detailed under Section 11 (Remit).

3. AUTHORITY

3.1 The Integrated Audit and Governance Committee is authorised by the CCGB to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Integrated Audit and Governance Committee.
Subject to such directions as may be given by the Board, it may establish sub-committees as appropriate and determine the membership and terms of reference of such. The Standing Orders and Prime Financial Policies of the CCG, as far as they are applicable, shall apply to the Integrated Audit and Governance Committee and its sub-committees.

The Integrated Audit and Governance Committee is authorised by the CCGB to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

4. REPORTING ARRANGEMENTS

4.1 All meetings shall be formally minuted and a record kept of all reports/documents considered.

The reporting arrangements to the CCG Board shall be through the submission of a written Chair’s Report on the progress made and assurances received to the next CCG Board meeting. The report shall, where necessary, include details of any recommendations requiring ratification by the CCGB.

The Integrated Audit and Governance Committee will report to the CCGB at least annually on its work in support of the Annual Governance Statement, specifically commenting on the ‘fitness for purpose’ of the Board Assurance Framework (CAF); the completeness and ‘embeddedness’ of risk management in the organisation, and the integration of governance arrangements.

Copies of the Minutes are a standing item on the CCGB. The Committee will provide an Annual Workplan to the CCG Board for approval and an Annual Report from the Committee.

4.2 Disclosure/Freedom of Information Act (FOI)

The senior officer with responsibility for corporate governance will be responsible for ensuring that FOI requirements in relation to the Committee’s minutes and reports are met. The chair of the committee will seek the advice of the senior officer with responsibility for corporate governance in relation to any matters where an exemption as defined within the Freedom of Information Act 2000 is believed to apply.

5. MEMBERSHIP

5.1 The Membership of the Integrated Audit and Governance Committee is listed at Appendix 1. The chair of the CCGB shall not be a member of the Committee.

Members are required to attend 4 out of 6 of scheduled meetings. Attendance will be monitored throughout the year and any concerns raised with the Chair and relevant Member.

Any changes to the Integrated Audit and Governance Committee must be approved by the CCG Board.
6. **APPOINTMENT OF CHAIR**

6.1 The Chair shall be appointed by the CCG Board, and shall be a lay member, who has qualifications, expertise or experience such as to enable to express informed views about financial management and audit matters. The Vice-Chair shall be determined by the Group.

7. **QUORACY**

- The quorum for meetings shall be:
  
  Two members including one Lay Member

If a quorum has not been reached, then the meeting may proceed if those attending agree but any record of the meeting should be clearly indicated as notes rather than formal Minutes, and no decisions may be taken by the non-quorate meeting of the Committee.

8. **ATTENDANCE**

8.1 The Chief Financial Officer, the Associate Director of Corporate Affairs and the Director of Quality and Clinical Governance/Executive Nurse or a suitable representative for each and appropriate Internal and External Audit representatives shall normally attend meetings, however, at least once a year the Committee should meet privately with the Internal and External Auditors.

The Chief Officer should be invited to attend, at least annually, to discuss with the Committee the process for assurance that supports the Annual Governance Statement.

Other Directors/Managers should be invited to attend, particularly when the Committee is discussing areas of risk or operations that are the responsibility of those Directors/Managers.

9. **MEETINGS**

9.1 Meetings shall be administered in accordance with the CCG Constitution, Standing Orders and Prime Financial Policies.

Meetings of the Integrated Audit and Governance Committee shall be held bi-monthly (an additional meeting will be arranged to receive the Annual Accounts). The External Auditor or Head of Internal Audit may request a meeting if they consider that one is necessary.

The Chief Finance Officer will ensure the Group is supported administratively, and will oversee the following:

- agreement of agenda with the Chair and attendees and the collation/circulation of papers;
- taking the Minutes and keeping a record of matters arising and issues to be carried forward, and
• advising the Committee on pertinent issues/areas.

An Annual Schedule of Meetings shall be agreed at, or before, the last meeting each year in order to circulate the schedule for the following year.

10. CONFIDENTIALITY

10.1 All Members are expected to adhere to the CCG Constitution and Standards of Business Conduct and Conflicts of Interest Arrangements.

11. REMIT

11.1 Governance, Risk Management and Internal Control

The Integrated Audit and Governance Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the organisation’s activities (both clinical and non-clinical) that supports the achievement of the organisation’s objectives.

In particular, the Committee will review the adequacy and effectiveness of:

• All risk and control-related disclosure statements (in particular, the Annual Governance Statement together with any accompanying Head of Internal Audit statement, External Audit opinion or other appropriate independent assurances, prior to endorsement by the CCG Board);

• the underlying assurance processes that indicate the degree of achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements;

• the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certification, and

• the policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the Counter Fraud and Security Management Service.

In carrying out this work, the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from Directors/Managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and Internal Control, together with indicators of their effectiveness. This will be evidenced through the Committee’s use of an effective Board Assurance Framework (BAF) to guide its work and that of the audit and assurance functions that report to it.

11.2 Internal Audit

The Committee shall ensure that there is an effective Internal Audit function established by management that meets mandatory NHS Internal Audit Standards
and provides appropriate independent assurance to the Chief Officer and the CCG Board. This will be achieved through:

- Consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal;

- reviewing and approving the Internal Audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Board Assurance Framework (BAF);

- consideration of the major findings of Internal Audit work (and management response) and ensuring co-ordination between the Internal and External Auditors to optimise audit resources;

- ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation, and

- an Annual Review of the effectiveness of Internal Audit.

11.3 External Audit

The Committee shall review the work and findings of the External Auditor appointed by the Audit Commission and consider the implications and management response to their work. This will be achieved through:

- Consideration of the appointment and performance of the External Auditor, as far as the Audit Commission’s rules permit;

- discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan, and ensuring co-ordination, as appropriate, with other External Auditors in the local health economy;

- discussion with the External Auditors of their local evaluation of audit risks and assessment of the CCG and associated impact on the Audit Fee, and

- reviewing all External Audit reports (including the report to those charged with governance), agreement of the Annual Audit Letter before submission to the CCG Board and any work undertaken outside the Annual Audit Plan, together with the appropriateness of management response.

11.4 Other Assurance Functions

The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications to the governance of the organisation.

These will include, but not be limited to, any reviews by Department of Health Arms-length Bodies (ALBs) or regulators/inspectors (e.g. the Care Quality Commission, NHS Litigation Authority, etc.) and professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc.).
In addition, the Integrated Audit and Governance Committee will review the work of other committees within the organisation, whose work can provide relevant assurance to the Committee’s own scope of work. This will particularly include the Planning and Commissioning Committee and the Quality and Performance Committee.

11.5 Counter Fraud

The Committee shall satisfy itself that the organisation has adequate arrangements in place for countering fraud and shall review the outcomes of counter fraud work.

11.6 Management

The Committee shall request and review reports and positive assurances from Directors/Managers on the overall arrangements for governance, risk management and Internal Control.

They may also request specific reports from individual functions within the organisation as they may be appropriate to the overall arrangements.

11.7 Financial Reporting

The Committee shall monitor the integrity of the financial statements of the CCG and any formal announcements relating to the CCG’s performance.

It should ensure that the systems for financial reporting to the CCG Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the CCG Board.

The Committee shall review the Financial Statements to be included in the Annual Report before submission to the CCG Board, focusing particularly on:

- The wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee;
- Changes in, and compliance with, accounting policies and practices and estimation techniques;
- Unadjusted mis-statements in the Financial Statements;
- Significant judgements in preparation of the Financial Statements;
- Significant adjustments resulting from the audit;
- Letter of Representation, and
- Qualitative aspects of financial reporting.

11.8 Risk
The Committee shall:

- Ensure effective risk management systems are in place including, but not limited to, the Board Assurance Framework (BAF); complaints; claims; incidents (including Serious Untoward Incidents (SUIs)); statutory and mandatory training; staff experience; risk assessments and registers, and inspections accreditations;

- Provide a process for scrutiny of high risks identified on the Board Assurance Framework (BAF) and Risk Register;

- Develop and monitor governance policies;

- Oversee and monitor the development of Research Governance structures, systems and processes;

- Monitor health, safety and security systems and processes required in order to deliver sound health, safety and security;

- Oversee and monitor the development of information governance structures, systems and processes required in order to deliver sound information governance;

- Monitor the use of the CCG seal;

- Ensure a sound governance process is in place to monitor standards in relation to independent contractors and providers of healthcare, and

- Ensure effective safeguarding systems are in place.

12. REVIEW OF THE TERMS OF REFERENCE

The Terms of Reference will be reviewed not less than annually and submitted to the governing body for approval as necessary.
APPENDIX I

INTEGRATED AUDIT & GOVERNANCE COMMITTEE

MEMBERSHIP

Membership of the Committee is determined and approved by the CCG Board and will comprise:

Members

- Lay Member – audit, remuneration and conflict of interest matters, who has qualifications, expertise or experience such as to enable to express informed views about financial management and audit matters (Chair)
- Lay Member – Strategic Change (Vice Chair)
- Lay Member - Patient and Public Involvement
- CCGB GP Member

In Attendance (as and when required)

- Chief Finance Officer
- Head of Finance
- Associate Director of Corporate Affairs
- Director of Quality and Clinical Governance/Executive Nurse
- External Audit
- Internal Audit Manager
- Counter Fraud Manager
- Director of Commissioning and Partnerships
- Chief Officer

N.B. Nominated deputies to attendees may be appointed subject to approval by the Chair.
APPENDIX I – TERMS OF REFERENCE
REMUNERATION COMMITTEE

1. PURPOSE

1.1 NHS Hull Clinical Commissioning Group (CCG) governing body has established a Remuneration Committee in accordance with its Constitution, Standing Orders and Scheme of Delegation. These Terms of Reference set out the membership, remit, responsibilities and reporting arrangements of the Committee and shall have effect as if incorporated into the CCG’s Constitution and Standing Orders.

1.2 The purpose of the Committee is to advise and assist the governing body in meeting its responsibilities on determinations about the remuneration, fees and other allowances for employees and for people who provide services to the group and on determinations about allowances under any pension scheme that the group may establish as an alternative to the NHS pension scheme. In so doing the Committee will have proper regard to the organisation’s circumstances and performance and to the provisions of any national agreements and NHS Commissioning Board guidance as necessary.

1.2 Links and interdependencies
The Remuneration Committee will provide an opinion to the Integrated Audit and Governance Committee on the adequacy of controls and assurances available with respect to those matters set out in the Remuneration Committee’s Terms of Reference.

2. ACCOUNTABILITY

2.1 The Remuneration Committee is accountable to the governing body for those matters detailed under Section 11 (Remit).

3. AUTHORITY

3.1 The Remuneration Committee is authorised to investigate any activity within its Terms of Reference. It may seek any information it requires from employees and all employees are directed to co-operate with any request made by the Remuneration Committee.

3.2 The Remuneration Committee is authorised and may seek independent assurance or other expert advice, as necessary, in order to meets its objectives.

4. REPORTING ARRANGEMENTS

4.2 All meetings shall be formally minuted and a record kept of all reports/documents considered.

4.3 The reporting arrangements to the governing body shall be through the submission of a written Chair’s Report on the progress made and assurances received to the next available governing body meeting. The report shall, where necessary, include details of any recommendations requiring ratification by the governing body.
4.4 The Remuneration Committee will set out an annual review of the achievement of its objectives via an annual workplan in an annual report to the governing body. Copies of the minutes of the committee will be received for information at the next available meeting of the governing body.

4.5 Freedom of Information Act (FOI) requirements

The senior officer with responsibility for corporate governance will be responsible for ensuring that FOI requirements in relation to the Committee’s minutes and reports are met. The chair of the committee will seek the advice of the senior officer with responsibility for corporate governance in relation to any matters where an exemption as defined within the Freedom of Information Act 2000 is believed to apply.

5. MEMBERSHIP

5.1 The Membership of the Remuneration Committee is listed at Appendix 1. Executive officers of the CCG are not eligible to be members. The Committee will be chaired by the lay member with responsibility for audit, remuneration and conflict of interest matters.

6. APPOINTMENT OF CHAIRS

6.1 The Chair shall be appointed by the governing body and the Vice-Chair by the Committee.

7. QUORACY

7.1 The quorum for meetings shall be three members including a minimum of two lay members.

7.2 If a quorum has not been reached, then the meeting may proceed if those attending agree but any record of the meeting should be clearly indicated as notes rather than formal Minutes, and no decisions may be taken by the non-quorate meeting of the Committee.

8. ATTENDANCE

8.1 The Chair of the Committee may invite senior officers of the CCG, Commissioning Support Unit or other independent advisors to attend the Committee, as appropriate.

8.2 The Accountable Officer and Chief Finance Officer shall normally attend meetings, however, the CCG Conflict of Interest Policy shall remain in place for all those in attendance.

9. MEETINGS

9.1 The Committee shall meet not less than bi-annually and on other such occasions as agreed between the chair of the Committee and the chair of the CCGC. The frequency of meeting should be such as to ensure the Committee achieves its annual workplan.
9.2 Meetings shall be administered in accordance with the CCG’s Constitution, Standing Orders and other relevant frameworks.

9.3 The Accountable Officer’s office will ensure suitable administrative support is provided to the Committee.

10. CONFIDENTIALITY

10.1 The Committee will conduct its business in accordance with the codes of conduct set out for all governing body members and good governance practice as laid out in the Constitution. External or independent advisors will adhere to established standards of business confidentiality.

11. REMIT

11.1 The purpose of the Committee is to:

11.1.1 Make recommendations to the governing body on determinations about pay and remuneration for employees of the CCG and people who provide services to the CCG and allowances under any pension scheme it might establish as an alternative to the NHS pension scheme.

11.1.2 Determine the remuneration and conditions of service of the senior team / governing body.

11.1.3 Review the performance of the Accountable Officer and other senior team members and determine annual salary awards, if appropriate.

11.1.4 Consider the severance payments of the Accountable Officer and other senior staff, seeking HM Treasury approval, as appropriate, in accordance with the guidance ‘Managing Public Money’.

12. REVIEW OF THE TERMS OF REFERENCE

12.1 The Terms of Reference will be reviewed not less than annually and submitted to the governing body for approval as necessary.
MEMBERSHIP

Membership of the Committee is determined and approved by the governing body and will comprise:

Members

- Lay Member – Audit, remuneration and conflict of interest matters (Chair)
- Lay Member – Strategic change (Vice Chair)
- Lay Member – Patient and Public Participation
- CCG Chair

In Attendance (as and when required)

- Chief Officer
- Chief Finance Officer
- Associate Director Human Resources & Organisation Development
- Other CCG Senior Officers
- CSU Officers
- Other independent advisors as necessary
APPENDIX I – TERMS OF REFERENCE
JOINT COMMISSIONING COMMITTEE

Introduction
1. Simon Stevens, the Chief Executive of NHS England, announced on 1 May 2014 that NHS England was inviting Clinical Commissioning Groups (CCGs) to expand their role in primary care commissioning and to submit expressions of interest setting out the CCG’s preference for how it would like to exercise expanded primary medical care commissioning functions. One option available was that NHS England and CCGs would jointly commission primary medical services.

2. The NHS England and NHS Hull Clinical Commissioning Group joint commissioning committee is a joint committee with the primary purpose of jointly commissioning primary medical services for the people of Hull.

3. Hull 2020 is the plan for integrated service transformation in Hull. It is the culmination of our aspirations for the future of the people of Hull. This is a time of unique challenge in public funded services, but Hull 2020 brings with it the opportunity to radically change the services we offer in order to meet the needs of the whole population and work towards a better and healthier future for the people we serve.

The Hull 2020 vision is:

“In 2020 we will work together better to enable the people of Hull to improve their own health, resilience, wellbeing and to achieve their aspirations for the future.”

The future role, shape and sustainability of primary care services, and particularly general medical services, will be critical to the delivery of the Hull 2020 vision.

Statutory Framework
4. The National Health Service Act 2006 (as amended) (“NHS Act”) provides, at section 13Z, that NHS England’s functions may be exercised jointly with a CCG, and that functions exercised jointly in accordance with that section may be exercised by a joint committee
of NHS England and the CCG. Section 13Z of the NHS Act further provides that arrangements made under that section may be on such terms and conditions as may be agreed between NHS England and the CCG.

5. [Include reference to statutory provisions used to jointly exercise CCG functions, if any have been delegated by the CCG to the joint committee. This is permitted by section 14Z9 of the NHS Act 2006 (as amended). If such arrangements are made, the CCG will need to formally delegate the functions in question to the joint committee. A draft delegation has been prepared and is set out as Schedule 1 to this document.] – Scheme of delegation to be agreed

6. Section 14Z9 of the NHS Act was amended by Legislative Reform Order (2014/2436) (“LRO”) to enable the joint exercise by NHS England and a CCG of any of the CCGs commissioning functions and any other functions of the CCG which are related to the exercise of those functions. Where such arrangements are made, the LRO enabled them to be exercised by a joint committee established between the parties.

Role of the Joint Committee
7. The role of the 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].

8. These roles include the following activities:

- GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action such as issuing branch/remedial notices, and removing a contract);

- Newly designed enhanced services (“Local Enhanced Services” and “Directed Enhanced Services”);

- Design of local incentive schemes as an alternative to the Quality Outcomes Framework (QOF);
• Decision making on whether to establish new GP practices in an area;

• Approving practice mergers;

• Making decisions on ‘discretionary’ payment (e.g., returner/retainer schemes).

9. In performing its role the Joint Committee will exercise its management of the functions in accordance with the agreement entered into between NHS England and NHS Hull Clinical Commissioning Group, which will sit alongside the delegation and terms of reference.

Geographical coverage
10. The Joint Committee will comprise NHS England Area Team – Yorkshire and Humber, and the NHS Hull CCG. It will undertake the function of jointly commissioning primary medical services for Hull.

Membership
11. The Joint Committee shall consist of:
   a) Voting members
      • NHS Hull CCG Governing Body Vice Chair, Lay Representative Strategic Change - Chair
      • NHS Hull CCG Governing Body Registered Nurse Representative
      • NHS Hull CCG Chief Officer
      • NHS Hull CCG Chief Finance Officer
      • NHS Hull CCG Director of Commissioning and Partnerships
      • NHS Hull CCG Director of Quality and Clinical Governance/Executive Nurse
      • NHS Hull CCG Governing Body Lay Representative Patient and Public Involvement – Vice Chair
      • NHS Hull CCG Governing Body Lay Representative Audit and Governance
      • NHS England – 2 Member Representatives (to be determined)
      • NHS Hull CCG Governing Body GP Member without a pecuniary interest
• Director of Public Health, Hull City Council

b) Non-voting attendees
• NHS Hull CCG Governing Body GP Members (minimum of 3)
• Healthwatch Representative – Delivery Manager
• LMC representation
• NHS Hull CCG Senior Commissioning Manager
• NHS Hull CCG Commissioning Lead – Primary Care
• NHS Hull CCG Governing Body Practice Manager representative
• Health and Wellbeing Board Representative – Elected Member

c) The membership will meet the requirements of NHS Hull Clinical Commissioning Group’s constitution.

12. The Chair of the Joint Committee shall be a Lay Representative of the NHS Hull CCG Governing Body.

13. The Vice Chair of the Joint Committee shall be the Registered Nurse Representative of the NHS Hull CCG Governing Body.

14. There will be a standing invitation to HealthWatch, the Local Medical Committee and the Health and Wellbeing Board.

Meetings and Voting
15. The Joint Committee shall adopt
the Standing Orders of NHS Hull Clinical Commissioning Group insofar as they relate to the:
a) Notice of meetings;
b) Handling of meetings;
c) Agendas;
d) Circulation of papers; and
e) Conflicts of interest.

16. Each member of the Joint Committee shall have one vote. The Joint Committee shall reach decisions by (a simple majority of members present, but with the Chair having a second and deciding vote, if necessary).
17. The quorum for meetings shall be six members including a minimum of two lay members inclusive of the Chair (or Vice Chair in the Chair's absence) and representation from NHS England.

If a quorum has not been reached, then the meeting may proceed if those attending agree but any record of the meeting should be clearly indicated as notes rather than formal Minutes, and no decisions may be taken by the non-quorate meeting of the Committee.

18. The Joint Committee shall meet not less than bi-monthly and on other such occasions as agreed between the chair of the Joint Committee and the chair of the CCG Board. The frequency of meeting should be such as to ensure the Committee achieves its annual work-plan.

19. Meetings of the Joint Committee:

a. Shall, subject to the application of 7(b), be held in public.

b. The Joint Committee may resolve to exclude the public from a meeting that is open to the public (whether during the whole or part of the proceedings) whenever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time.

20. Members of the Joint Committee have a collective responsibility for the operation of the Joint Committee. They will participate in discussion, review evidence and provide objective expert input to the best of their knowledge and ability, and endeavour to reach a collective view.

21. The Joint Committee may call additional experts to attend meetings on an ad hoc basis to inform discussions.

22. Members of the Joint Committee shall respect confidentiality requirements as set out in the Standing Orders referred to above
unless separate confidentiality requirements are set out for the joint committee in which event these shall be observed.

23. NHS Hull Clinical Commissioning Group will provide secretariat.

24. The secretariat to the Joint Committee will:
   a) Circulate the minutes and action list of the committee within 5 working days of the meeting to all members.
   b) Present the minutes and action notes to Area Team – Yorkshire and Humber of NHS England and the governing body of NHS Hull Clinical Commissioning Group.

Decisions
25. The Joint Committee will make decisions within the bounds of its remit.

26. The decisions of the Joint Committee shall be binding on NHS England and NHS Hull Clinical Commissioning Group.

27. Decisions will be published by both NHS England and NHS Hull Clinical Commissioning Group.

28. The secretariat will produce an executive summary report which will be presented to Area Team – Yorkshire and Humber of NHS England and the governing body of NHS Hull Clinical Commissioning Group bi-monthly for information.

Key Responsibilities

The key responsibilities of the joint committee will be to develop primary medical services in Hull which are consistent with the Hull 2020 vision. Specifically the joint committee will:

- undertake needs assessments for primary medical services
- plan the provision and commissioning of primary medical services
- undertake reviews of primary medical services
• co-ordinate a common approach to the commissioning of primary medical services

• manage relevant primary medical services budgets

Review of Terms of Reference
29. These terms of reference will be formally reviewed by NHS England Area Team – Yorkshire and Humber and NHS Hull Clinical Commissioning Group in April of each year, following the year in which the joint committee is created, and may be amended by mutual agreement between NHS England Area Team – Yorkshire and Humber and NHS Hull Clinical Commissioning Group at any time to reflect changes in circumstances which may arise.

[Signature provisions]

Schedule 1 – Delegation by CCG to joint committee – to be attached once agreed