NHS MID ESSEX
CLINICAL COMMISSIONING GROUP

CONSTITUTION

Version: 37.1

August 2017

Version Number	Date	Comment/Reason for Issue/Approving Body
23	March 2013	Records tracked updates including Conflicts of Interest section 8.2. Approved by Mid Essex CCG Board 28th March 2013
24	April 2013	Produced to accept tracked changes from Version 23 plus some minor title and formatting changes.
25	June 2013	Updated following May Board meeting approval on updates on Terms of Reference and resultant SFIs and Scheme of Reservation and Delegation.
26	August 2013	Updated following July Board meeting approval on updates on Terms of Reference and the establishment of the Financial Recovery and Transformation Committee. The updated Scheme of Reservation and Delegation was to follow the Board meeting as did not appear in the Board papers. The Board also approved the update of the Clinical Commissioning Committee's terms of reference but subject to the Clinical Commissioning Committee's agreement. In addition the North Essex Procurement terms of reference were included and the Exceptional Case Review Panel.
27	January 2014	The revised terms of reference for the Clinical Commissioning Committee have not been presented to the Clinical Commissioning Committee for agreement. Constitution updated to include the updated Scheme of Delegation and Reservation as approved at the January 2014 Board meeting which was revised to reflect the delegated powers to the Financial Recovery and Transformation Committee. The Detailed Scheme of Delegation was updated to reflect the Financial Recovery and Transformation Committee and also to adjust for time critical contract signatures that had previously only been designated AO and CFO – now "or" and one other Director. Contracts over specific values still require Committee or Board approval as appropriate in advance of signature. Minor typographical change also under 6.7.3. (c) and other numbering changes.
28	April 2014	Updated following the Board approval of the change of Board membership and equality and diversity executive lead.
29	September 2014	Updated following update on Board approved terms of reference of Board committee and Board membership changes including appointment of new Chairman.
30	November 2014	Updated to reflect changes to Executive structure (with consequenet need to amend voting rights to maintain minimum Board membership) and final sub-committee structure and Terms of Reference.
31	January 2015	Revised to reduce number of elected GP leads from 8 to 4 as per membership of CCG Board (section 6.7.2) and updated Role Description for Elected GP members (Appendix T)
32	March 2015	Revised to clarify Executive Leads for CCG statutory duties and powers (section 5.4) and to amend voting membership of Board (section 8.5.10)
33	October 2016	Revised to include joint commissioning arrangements with NHS England for the exercise of NHS functions (section 6.5.2.)
34	April 2016	Revised to include appointment of Director of Primary Care & Resilience and amended Board voting arrangements and changes to committee structure approved by CCG Board on 24 March 2016
35	August 2016	Revised to incorporate full model wording for amendments to CCGs' constitututions for Primary Care Joint Commissioning, as advised by NHS England (sections 6.5 to 6.7) and references to other joint working arrangements which are not formally Joint Committees removed.
36	December 2016	Revised to reflect changes to Executive Director Board membership as agreed at CCG Board meeting on 1 December 2016
37	June 2017	Revised to reflect establishment of STP Joint Committee with Basildon & Brentwood, Castle Point & Rochford, Southend and Thurrock CCGs
37.1	August 2017	Further amendments in light of feedback from NHS England on proposed constitutional changes

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FOREWORD

Dear Colleague

The NHS Mid Essex Clinical Commissioning Group (CCG) Constitution sets out how the CCG intends to do business as a statutory body through its Governance structure. The constitution is based upon the national template recommended by the National Commissioning Board.

As a CCG we take seriously our role on commissioning health care on behalf of our population. Fundamentally, this requires a governance arrangement that ensures we execute our statutory duties in a safe and considered manner.

This Constitution will be reviewed as a minimum on an annual basis with the next review taking place in August 2018.

The CCG's Constitution sets out the arrangements made by the CCG to meet its responsibilities for commissioning care for the people for which it is responsible. It describes the governing principles, rules and procedures that the group will establish to ensure probity and accountability in the day to day running of the clinical commissioning group; to ensure that decisions are taken in an open and transparent way and that the interests of patients and the public remain central to the goals of the group.

The Constitution meets with the requirements of the General Practitioners Committee as outlined in the GPC guidance: GPC constitution guidance.

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

- the group's member practices;
- the group's employees;
- individuals working on behalf of the group;
- anyone who is a member of the Clinical Commissioning Group Board
- anyone who is a member of any of the committee(s) or sub-committees established by the group or its Clinical Commissioning Group Board.

Dr. Caroline Dollery
Chair – NHS Mid Essex CCG

1. INTRODUCTION AND COMMENCEMENT

1.1. Name

1.1.1. The name of this clinical commissioning group is NHS Mid Essex Clinical Commissioning Group.

1.2. Statutory Framework

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

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

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

1.3. Status of this Constitution

1.3.1. This Constitution is made between the members of NHS Mid Essex Clinical Commissioning Group and has effect from the1st day of April 2013, when NHS England established the group.[8] The Constitution is published on the group's website at www. midessexccg.nhs.uk

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

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

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

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

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

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

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

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

1.3.2. This document will be made available upon request for inspection at the Mid Essex Clinical Commissioning Group Headquarters as set out under 1.3.3.

1.3.3. Copies will also be made available on application to:

NHS Mid Essex Clinical Commissioning Group
Wren House
Hedgerows Business Park
Colchester Road
Chelmsford
Essex
CM2 5PF

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 Mid Essex Clinical Commissioning Group includes the District of Braintree, Chelmsford City and the District of Maldon.

3. MEMBERSHIP

3.1. Membership of the Clinical Commissioning Group

3.1.1. The practices which comprise the membership of NHS Mid Essex Clinical Commissioning Group are listed at Appendix B.

3.1.2. Appendix B of this Constitution contains the list of practices confirming their agreement to this constitution.

3.2. Eligibility

3.2.1. Providers of primary medical services to a registered list of patients under a General Medical Services, Personal Medical Services or Alternative

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

Provider Medical Services contract, will be eligible to apply for membership of this group[10].

4. MISSION, VALUES AND AIMS

4.1. Mission

4.1.1. The mission of NHS Mid Essex Clinical Commissioning Group is:-

To improve the health of the community and of individuals.

To commission quality healthcare that is right for the individual, from the healthy who need advice to the unwell who need treatment.

To empower individuals and enable them to make the right choices about their own lifestyles and, when in need, to access the right care in the right place at the right time.

We will do this by working with local partners and making the best use of available resources.

We will take account of the needs of all and ensure that services we commission are seamless and delivered in a way that respects the dignity of the individual.

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:

a) *We are part of the communities we serve and use our local knowledge to inform our decision making.*

b) *We value people as individuals and for the contribution they make to our organisation at whatever level.*

c) *We put patients and their needs first.*

d) *We act with honesty, transparency and integrity.*

[10] See section 14A (4) of the 2006 Act, inserted by section 25 of the 2012.

e) *We are responsive and good listeners, caring about patients, communities and colleagues.*

f) *We make responsible decisions taking into account ethical values, clinical evidence and the views of others and uphold the principles of equality and diversity*

g) *We believe in working collaboratively with partners and communicating effectively with everyone.*

h) *We are innovative in our thinking and prepared to do things differently to lead to improvement.*

4.3. Aims

4.3.1. The group's aims are to ensure that:

- *Individuals in Mid Essex are healthy and supported to look after themselves as far as possible;*
- *Healthcare in Mid Essex is a beacon of excellence;*
- *As leaders of healthcare commissioning we will be respected and trusted by our peers and the communities we serve whilst demonstrating respect, care and dignity towards all;*
- *People will feel valued, encouraged and supported to make the right choices and use services appropriately;*
- *Services we commission will focus on quality, innovation, productivity and prevention and deliver the best possible care to communities and individuals and reduce health inequalities.*

4.4. Principles of Good Governance

4.4.1. In accordance with section 14L(2)(b) of the 2006 Act,[11] the group will at all times observe "such generally accepted principles of good governance" in the way it conducts its business. These include:

a) The highest standards of propriety involving impartiality, integrity and objectivity in relation to the stewardship of public funds, the management of the organisation and the conduct of its business;

b) The Good Governance Standard for Public Services;[12]

[11] Inserted by section 25 of the 2012 Act

c) The standards of behaviour published by the Committee on Standards in Public Life (1995) known as the 'Nolan Principles'[13]

d) The seven key principles of the NHS Constitution;[14]

e) The Equality Act 2010.[15]

4.5. Accountability

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

a) Publishing its Constitution;

b) Appointing independent lay members and non GP clinicians to its Clinical Commissioning Group Board;

c) Holding meetings of its Clinical Commissioning Group Board 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) Having due regard to local authority health overview and scrutiny requirements;

f) Publishing an annual report and meeting publically annually to present it;

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:

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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

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

a) Holding additional stakeholder events as part of its Communication and Engagement and Patient and Public Engagement (PPE) strategies;

b) Establishing a PPE Reference Group to work alongside the CCG board to ensure awareness of the patient and public perspectives.

4.5.3. The Clinical Commissioning Group Board will throughout each year have an on-going 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:

- all people registered with member GP practices, and
- 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 Clinical Commissioning Group Board 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 Clinical Commissioning Group Board.

5.1.2. In discharging its functions the group will:

a) Act[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***[17] *and* with the objectives and requirements placed on NHS England

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

[17] See section 1 of the 2006 Act, as amended by section 1 of the 2012 Act

through *the mandate*[18] published by the Secretary of State before the start of each financial year by:

i) delegating responsibility to;
   - the group's Clinical Commissioning Group Board (otherwise known as the 'governing body'), or
   - a committee or sub-committee of the group, or
   - an individual with lead responsibility to oversee its discharge (i.e. accountable officer, member or employee); or

ii) Requiring a policy which sets out how the group intends to discharge this duty

iii) Requiring progress of delivery of the duty to be monitored through the group's reporting mechanisms

The above arrangements are reflected within the Mid Essex Clinical Commissioning Group's Standing Orders / Scheme of Reservation and Delegation.

b) ***meet the public sector equality duty***[19] by:

i) **Equality and Diversity**

The CCG Board gives an absolute commitment to equality and diversity in respect of the services that we commission for the population of our local area and for our staff. The CCG Board has identified a Board member as the Equality and Diversity Lead and the Lay Member for patient and public engagement holds the equality and diversity champion role.

ii) The CCG will establish an equality and diversity group.

iii) **Under the Equality Act 2010, the CCG will exercise their functions, and have due regard to the:**

- Need to eliminate unlawful discrimination harassment and victimisation and other conduct prohibited by the 2010 Act.
- Advance equality of opportunity between people who share a protected characteristic and those who do not;
- Foster good relations between people who share a protected characteristic and those who do not

iv) The CCG will deliver this public sector duty by:

[18] See section 13A of the 2006 Act, inserted by section 23 of the 2012 Act

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

- Publishing annually sufficient information to demonstrate compliance with this general duty across all their functions;

- The annual review and publication of its equality objectives.

v) The Equality Delivery System2 has been adopted as the framework to review compliance with the Equality Act 2010 from which following external review with local interests, future priorities and actions have been identified.

vi) The meeting of the Public Sector Duty requirements and being compliant with the specific duties of the Equality Act 2010 have been met in relation to the publication of relevant proportionate information and in setting and publishing equality objectives.

c) work in partnership with its local authorities to develop ***joint strategic needs assessments***[20] and ***joint health and wellbeing strategies***[21] by:

i) Engaging in the development of the Essex Health and Wellbeing Board (EHWB) and having a clinical representative on this Board
ii) Chairing in the Mid Essex locality, the System Leadership Group, with key members from the Districts' local Health & Wellbeing Boards/Local Strategic Partnerships
iii) Supporting through the EHWB, the production of the Essex Joint Strategic Needs Assessment (EJSNA) and the Joint Health and Wellbeing Strategy
iv) Delegating responsibility to the Consultant in Public Health in the production and updating of the Districts' JSNA and the CCG's JSNA with a view to supporting informed commissioning between the NHS and Local Authorities at a local level
v) Delegating responsibility to the Consultant in Public Health to provide robust public health advice and to ensure that evidence-based practice is an integral part of all commissioned services, including health improvement services and that this is done through an agreed Memorandum of Understanding (MOU) between Essex Public Health Team (currently hosted by Essex County Council), and the CCG.
vi) Ensuring that the Essex Director of Public Health (a Board member of the EHWB), is responsible through his/her representative on the CCG Board (Consultant in Public Health) for ensuring that local needs within Mid Essex are addressed as part of the Essex Health and Wellbeing Strategy.

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

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

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

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[22] by:

a) Holding regular engagement events as part of the annual cycle of engagement
b) Engaging patient and public representation as part of our Transformation meetings
c) Inviting members of the public and/or locality forums to join Task and Finish groups to assist in commissioning decisions
d) Providing opportunities for the public to become a locality member via the group's website.

5.2.2 Promoting awareness of, and act with a view to securing health services that are provided in a way that promotes awareness of, and have regard to the NHS Constitution[23] by:

a) Identifying a CCG Board lead for the NHS Constitution
b) Leading the development of a culture that works to the spirit and requirements of the NHS Constitution
c) Establishing a policy which describes the way in which the CCG aims to deliver on the aims and rights of staff and patients within the NHS Constitution
d) Ensuring that the remits of the Finance and Performance and Quality and Governance Committees include the delivery of the NHS Constitution standards which includes requirements around access, choice, public engagement and involvement and minimum quality standards (including around privacy/dignity and confidentiality). Ensuring that the Finance and Performance and the Quality and Governance Committees review progress in detail on behalf of the Board on the achievement of targets such as the achievement of the 18 week referral to treatment target, waiting time targets for cancer services, reduction of health care acquired infections, reducing mortality rates in hospital services, complying with single sex accommodation
e) Utilising all contract levers available to ensure that the NHS Constitution patient rights are upheld, for example via annual Quality Accounts which each provider produces
f) Actively monitoring and acting on patient feedback regarding services received including review and reporting on complaints
g) Proactively working with staff to ensure continuous improvements on the rights of staff and establish mechanisms to engage with staff to enable two way promotion.

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

[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)

5.2.3 These arrangements will (as appropriate) be reflected in standing orders / scheme of reservation and delegation. The CCG will act ***effectively, efficiently and economically***[24] by:

a) Managing within approved resource and cash limit funding;
b) Using best practice commissioning procedures to ensure economy and value for money in our purchasing decisions;
c) Proactively managing the healthcare market and encouraging service innovation;
d) Ensuring that the Finance and Performance Committee will, on behalf of the Group and the CCG Board, have an assurance and scrutiny role on the planning and delivery of these responsibilities and of the operational business plan in general including the delivery of Quality Innovation Productivity and Prevention (QIPP) plans. The Finance & Performance Committee will receive best value reviews and benchmarking information and will ensure remedial action is taken when activity /performance issues/variances arise either against targets, or key assumptions made in drawing up activity/finance plans.
e) Ensuring that the Audit Committee will receive the external auditor's independent view on the Group's arrangements for ensuring effective, efficient and economic use of resources and make recommendations to the Board as required.

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

a) All contracts have quality based key performance indicators.
b) A full programme of Contractual Quality Performance Meetings are scheduled for each year.
c) The Quality and Governance Committee provides assurance and scrutiny and a Quality Report is received at each formal CCG Board.

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) Performance managing relevant indicators through the business of the Finance and Performance and Quality and Governance Committees
b) Practice visits by Delivery Leads and CCG clinicians
c) Dedicated support from Primary Care and Resiliencedirectorate.

5.2.6 Have regard to the need to ***reduce inequalities***[27] by:

a) Ensuring that arrangements are appropriate in regards to statutory responsibility:

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24 See section 14Q of the 2006 Act, inserted by section 26 of the 2012 Act
25 See section 14R of the 2006 Act, inserted by section 26 of the 2012 Act
26 See section 14S of the 2006 Act, inserted by section 26 of the 2012 Act
27 See section 14T of the 2006 Act, inserted by section 26 of the 2012 Act

b) Identifying a named clinical lead and Consultant in Public Health who will assume responsibility on behalf of the CCG Board, to review, implement and monitor the CCG's strategy in tackling local inequalities, in partnership with other agencies.
c) Establishing a Mid Essex System Leadership group, consisting of senior representatives from the District Councils and County Council and key stakeholders to provide a forum for agreeing local priorities in addressing local inequalities.
d) Ensuring robust monitoring and exception reporting systems to ensure the CCG's Board is kept informed on progress and how risks will be mitigated in delivering against planned strategy
e) Ensuring the development of local Joint Strategic Needs Assessments, both at CCG and District levels, and listening to interest group research and evidence on where inequalities exist and on evidence based approaches to tackling the gap in opportunities
f) Actively engaging with 'hard to reach' communities who lack the physical, emotional or social opportunities to be part of mainstream engagement
g) Innovating in ways of engaging and communicating with disadvantaged groups by working in partnership with other service commissioners, providers, voluntary sector and research /lobbying/think-tank 'best practice' organisations
h) Replicating the successes of tried and tested schemes in other parts of the NHS or from other global health care systems
i) Enhancing patient choice, as part of the CCG's Public and Patient Engagement strategy, in the selection of tailored services they receive thereby improving access, communication and health outcomes.
j) Reducing stigma by educating the public as well as NHS staff that inequalities exist and who are the at risk groups

5.2.7 ***Promote the involvement of patients, their carers and representatives in decisions about their healthcare***[28] by ensuring:

a) All Providers are required, via their contracts, to report patient and carer involvement
b) Active Patient Advice and Liason Services (PALS)
c) All service redesign has an element of public engagement
d) Active Locality Membership

5.2.8 Act with a view to ***enabling patients to make choices***[29] by:

a) Ensuring choice remains embedded in the CCG central referral system where patients are given the option of several providers
b) Extending the Choose and Book facility to Tier 2 services
c) Utilising existing choice arrangement for medical imaging

28 See section 14U of the 2006 Act, inserted by section 26 of the 2012 Act
29 See section 14V of the 2006 Act, inserted by section 26 of the 2012 Act

5.2.9 ***Obtain appropriate advice***[30] from persons who, taken together, have a broad range of professional expertise in healthcare and public health including:

a) Expertise in Healthcare and Public Health are incorporated in all levels of the CCG
b) GP, Nurse, and Secondary Care Consultant are Voting Board Members
c) Clinical majority on Live Well Committee
d) Locality Teams have clinical and practice engagement

5.2.10 ***Promote innovation***[31] by ensuring:

a) A range of Clinical, Public Health and Social Care representation is embedded within the governance framework for the CCG
b) Programme Boards Terms of Reference allow for innovation
c) A CCG Board lead for innovation (Director of Nursing & Quality)

5.2.11 ***Promote research and the use of research***[32] through:

The local area Clinical Local Research Network (CLRN) which coordinates and facilitates locally based research on behalf of the CCG, providing a wide range of support to the local research community.

The CLRN is responsible for overseeing the research management and governance ensuring all research is conducted in the appropriate manner.

Mid Essex Clinical Commissioning Group supports research in its activities through:

a) The Quality and Governance Committee receive regular reports from the Essex and Hertfordshire CLRN.
b) Key performance indicators pertaining to research and research governance within the Acute Provider Contract. These are monitored within Quality Contractual Performance Meetings.
c) All business cases being supported by relevant research
d) Any service redesign being supported by Public Health Colleagues who undertake a research review

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 ensuring that:

30 See section 14W of the 2006 Act, inserted by section 26 of the 2012 Act
31 See section 14X of the 2006 Act, inserted by section 26 of the 2012 Act
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

a) Access to facilities to promote and deliver the education and training will be made available
b) Contractually all providers are bound to ensure relevant training is available
c) The Director of Nursing & Quality participates on the County Workforce Group
d) There is Delegation to the Director of Nursing & Quality of the responsibility to ensure that the Group's staff and contractors are appropriately skilled and trained.
e) In discharging this responsibility, the Director of Nursing & Quality will be advised by the Quality and Governance Committee in respect of criteria and measures that should be in place to ensure that service delivery staff (including contractors) are appropriately trained and up to date with latest requirements and best professional practice.

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) Establishing integrated commissioning arrangements reported to the CCG Live Well Committee that is:
    i. Chaired by the CCG Chair and Clinical GP leads with input tothe System Leadership group agenda
    ii. Supported by the Director of Primary Care & Resilience tooversee the planning, operation and reporting responsibility

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) Appointing an Accountable Officer to be answerable to the National Commissioning Board on behalf of the Group;
b) Appointing a Chief Finance Officer to oversee the planning, operation and reporting of this responsibility;
c) Operating clear and robust arrangements for financial management including well defined delegation of authority and accurate reporting and forecasting arrangements
d) Establishing a Finance & Performance Committee to ensure regular and detailed examination of financial performance and make recommendations to the CCG Board as required
e) Establishing a Savings Programme Board to ensure the achievement of and future delivery of the CCG's financial recovery.

35 See section 14Z1 of the 2006 Act, inserted by section 26 of the 2012 Act
36 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 capital and revenue resource)* ***does not exceed the amount specified by NHS England for the financial year***[37] by, in addition to the arrangements set out in 5.3.1:

a) Having a clear and comprehensive medium term planning process with regular discussion at Finance & Performance Committee and CCG Board;
b) Ensuring correlation between financial and commissioning plans and assumptions.

5.3.3 ***Take account of any directions issued by NHS England, in respect of specified types of resource used in a financial year, to ensure that the group does not exceed an amount specified by NHS England*** [38] by

a) Nominating the Chief Finance Officer to maintain a detailed account of specified resources received and the criteria for utilisation;
b) Maintaining accurate and auditable accounts of the utilisation of the resources;
c) Operating robust forecasting arrangements to ensure that expenditure is contained within the allocated resource;
d) Maintaining and reporting evidence to demonstrate adherence to utilisation criteria.

5.3.4 ***Publish an explanation of how the group spent any payment in respect of quality*** made to it by the NHS England[39] by

a) Appointing a Chief Finance Officer who will ensure that appropriate recording and reporting arrangements are in place to meet statutory financial reporting and NHS England requirements;
b) Appointing an Accountable Officer who, together with the Chief Finance Officer, will certify statements of account.

5.4 **Executive Leads** – to support delivery of the group's functions and duties as outlined above, lead responsibility for these areas has been designated to the following Executive Officers:

Function / Duty	**Lead Executive Director**
Commissioning health services to meet the reasonable needs of patients registered with member GP practices and unregistered residents within the CCG area	Director of Clinical Commissioning
Commissioning emergency care for residents within the CCG area	Director of Primary Care & Resilience
Paying CCG employees' remuneration, fees and allowances and determining	Accountable Officer

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

any other terms and conditions of service	
Determining the remuneration and allowances of members of the CCG Board	Accountable Officer
Duty to promote a comprehensive health service	Accountable Officer
Duty to meet the Public Sector Equality Duty	Director of Corporate Services
Duty to work in partnership with local authorities to develop JSNAs and joint health and wellbeing strategies	Accountable Officer
Duty to secure public involvement in the CCG's planning and development of services	Director of Corporate Services
Duty to promote awareness of and have regard to the NHS Constitution	Director of Nursing & Quality
Duty to act effectively, efficiently and economically	Chief Finance Officer
Duty to secure continuous improvement in the quality of services	Director of Nursing & Quality
Duty to improve the quality of primary medical services	Director of Primary Care & Resilience
Duty to reduce health inequalities	Accountable Officer
Duty to promote the involvement of patients, their carers and representatives in decisions about their healthcare	Director of Corporate Services
Duty to enable patients to make choices	Director of Clinical Commissioning
Duty to obtain appropriate advice from persons who have professional expertise in healthcare and public health	Accountable Officer
Duty to promote innovation	Director of Nursing & Quality
Duty to promote research	Director of Nursing & Quality
Duty to promote education and training	Director of Nursing & Quality
Duty to promote integration	Accountable Officer
Duty to ensure expenditure does not exceed the CCG's financial allocation	All Directors accountable Lead: Accountable Officer
Duty ensure use of resources does not exceed the amount specified by NHS England	All Directors accountable Lead: Accountable Officer
Duty to take account of any directions issued by NHS England in respect of resources	Chief Finance Officer
Duty to publish an explanation of how the CCG spent any quality payments	Chief Finance Officer

5.5 Other Relevant Regulations, Directions and Documents

5.5.1 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.

5.2.9 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.

5.6 Accountability

5.6.1 The Clinical Commissioning Group will hold additional stakeholder events as part of its Communication and Engagement and Patient and Public Involvement strategies (Appendix J)[40]

5.6.2 The Clinical Commissioning Group Board will throughout each year have an on-going role in reviewing the group's governance arrangements to ensure that the group continues to reflect the principles of good governance.

6 DECISION MAKING: THE GOVERNING STRUCTURE

6.1 Authority to act

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

a) any of its members;
b) its Clinical Commissioning Group Board;
c) employees;
d) a committee or sub-committee of the group.

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

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

[40] See Appendix J for Communications and Engagement Strategy

6.2 Scheme of Reservation and Delegation[41]

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

a) those decisions that are reserved for the membership as a whole;
b) those decisions that are the responsibilities of its Clinical Commissioning Group Board (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.

6.2.3 The CCG Scheme of Reservation and Delegation is attached as Appendix D

6.3 General

6.3.1 In discharging the functions of the group that have been delegated to its Clinical Commissioning Group Board as 'the governing body' (and its committees), the Finance and Performance Committee, Quality and Governance Committee, Audit Committee, Remuneration and Terms of Service Committee, Live Well Committee, relevant joint committees (i.e. Sustainability and Transformation Partnership (STP) Joint Committee and Primary Care Commissioning Committee), supporting sub committees, and individuals must:

a) Comply with the group's principles of good governance,[42]
b) Operate in accordance with the group's scheme of reservation and delegation,[43]
c) Comply with the group's standing orders,[44]
d) Comply with the group's arrangements for discharging its statutory duties,[45]
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, the Clinical Commissioning Group committees, sub-committees and any joint committees must also operate in accordance with their approved terms of reference.

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

a) Identify the roles and responsibilities of those clinical commissioning groups who are working together;

41 See Appendix D for Scheme of Reservation and Delegation
42 See section 4.4 on Principles of Good Governance above
43 See Appendix D
44 See appendix C
45 See chapter 5 above

b) Identify any pooled budgets and how these will be managed and reported in annual accounts;
c) Specify under which clinical commissioning group's or other relevant partner'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:[46]

a) Finance and Performance Committee (accountable to the CCG Board)
b) Quality and Governance Committee (accountable to the CCG Board
c) Audit Committee (accountable to the CCG Board)
d) Remuneration and Terms of Service Committee (accountable to the CCG Board)
e) Live Well Committee (accountable to the Board)
f) Primary Care Joint Commissioning Committee
g) STP Joint Committee

6.4.2 Committees may establish their own sub-committees to assist them in discharging their respective responsibilities and may delegate responsibilities to the sub-committees but the Committees remain accountable for the discharge of their responsibilities.

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:

6.5.2.1 delegating any of the CCG's commissioning functions to another CCG;
6.5.2.2 exercising any of the commissioning functions of another CCG; or
6.5.2.3 exercising jointly the commissioning functions of the CCG and another CCG

6.5.3 For the purposes of the arrangements described at paragraph 6.5.2, the CCG may:

[46] Full Terms of Reference for all the committees of the CCG and its Governing Body are available on the CCG's website at: http://midessexccg.nhs.uk/about-us/our-key-documents/meccg-committee-terms-of-reference

6.5.3.1 make payments to another CCG;
6.5.3.2 receive payments from another CCG;
6.5.3.3 make the services of its employees or any other resources available to another CCG; or
6.5.3.4 receive the services of the employees or the resources available to another CCG.

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

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

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

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

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

Committee, 12 months' written notice is required and the agreement of NHS England;

6.5.12 The group has entered into joint arrangements with the following clinical commissioning group(s):

a) STP Joint Committee with Basildon & Brentwood CCG, Thurrock CCG, Castle Point and Rochford CCG and Southend CCG.

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;
- 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 that the Director of Primary Care and Resilience of the CCG makes 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 that the Director of Primary Care and Resilience of the CCG makes 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.

6.7.12 The CCG has entered into joint commissioning arrangements with NHS England for the exercise of NHS England's functions in respect of:

a) Primary Care Commissioning Committee

6.8 Clinical Commissioning Group Board

6.8.1 Functions - the Clinical Commissioning Group Board has the following functions conferred on it by sections 14L(2) and (3) of the 2006 Act, inserted by section 25 the 2012 Act, together with any other functions connected with its main functions as may be specified in regulations or in this constitution.[47] The Clinical Co**mmissioning Group Board has responsibility for:**

6.8.1.1 **Ensuring that the group has appropriate arrangements in place to exercise its functions *effectively, efficiently and economically* and in accor**dance with the groups *principles of good governance*[48] (its main function);

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

48 See section 4.4 on Principles of Good Governance above

6.8.1.2 Determining through delegation to its Remuneration and Terms of Service Committee 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;

6.8.1.3 Approving any functions of the group that are specified in regulations;[49]

6.8.1.4 Determining any additional functions which the CCG is conferring on the Clinical Commissioning Group Board which are connected with its main functions. The group's functions which have been delegated by the group's membership to the Clinical Commissioning Group Board are captured in the Scheme of Reservation and Delegation (Appendix D).

6.8.2 ***Composition of the Clinical Commissioning Group Board -*** the Clinical Commissioning Group Board shall not have less than 14 members and comprises of:

- The Chair *;*
  The Chair will appointed by the Board from the cohort of four GPs elected by the Mid Essex GPs and will be the Clinical Lead of the CCG

- The Vice Chair (Clinical) will also be selected by the board from the cohort of four GPs elected by the Mid Essex GPs

- Two additional elected GP representatives of the Mid Essex GP community *.*
  The appointment process for the GP members of the Board will be conducted by North and South Essex Local Medical Committees Limited in accordance with the appropriate process and principles.

- Three lay members , one of whom will be the Deputy Chair *(Lay Member);*

  - one to lead on audit, and conflict of interest matters and act as Deputy Chair and Conflicts of Interest Guardian,
  - one to lead on patient and public participation matters;
  - one to lead on commercial and remuneration matters.

- One registered nurse – Director of Nursing and Quality*;*

- One secondary care specialist doctor*;*

- The Accountable Officer *;*

[49] See section 14L(5) of the 2006 Act, inserted by section 25 of the 2012 Act

- Managing Director;
- The Chief Finance Officer*;*
- Director of Clinical Commissioning
- Medical Director
- Director of Primary Care & Resilience
- Director of Corporate Services
- Director of Acute Commissioning (i*n attendance*)
- Local Authority representative *(in attendance)*
- Public Health representative *(in attendance)*

6.8.3 ***Committees of the Clinical Commissioning Group Board*** - the Clinical Commissioning Group Board has appointed the following committees and sub-committees:

- Audit Committee;
- Remuneration and Terms of Service Committee
- Finance and Performance Committee;
- Quality and Governance Committee
- Live Well Committee
- Joint Primary Care Commissioning Committee

a) Audit Committee – the audit committee, which is accountable to the group's Clinical Commissioning Group Board, provides the Clinical Commissioning Group Board with an independent and objective view of the group's financial systems, financial information and compliance with laws, regulations and directions governing the group in so far as they relate to finance, good corporate governance, emergency planning, resilience and response and business continuity management, and the Group's responsibility to act effectively, efficiently and economically The Clinical Commissioning Group Board has approved and keeps under review the terms of reference for the Audit Committee, which includes information on the membership of the Audit Committee.[50]

b) Remuneration and Terms of Service Committee – the remuneration committee, which is accountable to the group's Clinical Commissioning Group Board, has delegated responsibility for making decisions on behalf of the Board on all aspects of the remuneration and terms of service of the Accountable Officer and Directors (and any assessment of their

[50] Full Terms of Reference of Audit Committee available from the CCG's website at: http://midessexccg.nhs.uk/about-us/our-key-documents/meccg-committee-terms-of-reference

performance). The committee will ensure that fairness, equity and consistency are applied in this process. The Clinical Commissioning Group Board has approved and keeps under review the terms of reference for the Remuneration and Terms of Service committee, which includes information on the membership of the committee.[51]

c) Finance and Performance Committee – the Finance and Performance Committee scrutinises and provides the CCG Board with assurance on the delivery of the CCG's remit in respect of overall financial and service performance for all commissioned services and running costs. It monitors on behalf of the CCG Board, delivery of the CCG's financial targets and operational and performance targets.

d) Quality and Governance Committee - the Quality and Governance Committee has the following key purposes:

- To seek assurance upon and scrutinise the quality and safety performance of the commissioning of elective hospital care, rehabilitation, urgent and emergency care (including out of hours services), community health services, services for children and younger persons, maternity services, mental health and learning disability services.

- To oversee the development, implementation and monitoring of the CCG's governance arrangements by providing assurances on the systems and processes by which the CCG leads, directs and controls its functions in order to achieve organisational objectives

e) Live Well Committee – the Live Well Committee will promote and champion the Live Well vision within the Mid Essex Health and Social Care System and oversee the implementation of all aspects of the Live Well health and wellbeing programmes. It will co-develop strategies and plan safe, efficient pathways to deliver the five Live Well domains, plus Connect Well. It will oversee the work of the Start Well, Be Well and Stay Well, and Age Well and Die Well Groups

6.8.4 In addition the group or the governing body has conferred or delegated the following functions, connected with the governing body's main function, to the following joint committees:

a) Joint Primary Care Commissioning Committee, which will 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.[51]

[51] Full Terms of Reference of Remuneration and Terms of Service Committee and Primary Care Commissioning Committee available from the CCG's website at http://midessexccg.nhs.uk/about-us/our-key-documents/meccg-committee-terms-of-reference

b) STP Joint Committee, which will enable the participating CCGs, where appropriate, to act collectively in the planning, securing and monitoring of services to meet the needs of the population of Mid and South Essex, as well as represent the STP footprint for services commissioned over a larger area.[52]

7.0 ROLES AND RESPONSIBILITIES

7.1 Practice Representatives

a) Practice representatives represent their practice's views and act on behalf of the practice in matters relating to the group.

7.1.2 General

a) The CCG is a membership organisation and will act as an agent of its member practices listed in Appendix B.
b) This change in status and culture will be underpinned by a number of bilateral accountability measures detailed in an Accountability Agreement.

7.1.3 Regular Meetings

a) All member practices should receive one visit per year from representatives of the CCG to discuss practice level commissioning issues and priorities.
b) In addition to the AGM, there will be at least two other CCG meetings for all member practices that do not have the public in attendance.

7.1.4 Survey of Practices

a) The Board will undertake an annual survey of its member practices to obtain feedback on levels of satisfaction and perceived engagement with the commissioning process.
b) North and South Essex LMCs Ltd and EQUIP will jointly produce a questionnaire for use by the Board in respect of such survey.
c) The results will be analysed by North and South Essex LMCs Ltd and EQUIP and feedback, in the form of a written report, provided to the Board.
d) The report will be discussed at one of the CCG's public Board meetings.

7.1.5 Power of Recall

a) The GP members of the Board will be appointed following a process conducted by North and South Essex LMCs Ltd.
b) Safeguards must exist to guard against the possibility of the Board becoming out of touch with the views and needs of its member practices.

[52] Full Terms of Reference of STP Joint Committee available from the CCG's website at http://midessexccg.nhs.uk/about-us/our-key-documents/meccg-committee-terms-of-reference

c) A Power of Recall therefore forms part of the Constitution. This will allow the GP members to be recalled following an AGM called by at least 75% of the CCG's constituent GPs, provided that the response rate is at least 50% of eligible GPs.

7.1.6 Responsibilities of Member Practices

a) The responsibilities of member practices to the CCG are:

- Nominating commissioning and prescribing leads to a) represent the practice at CCG/locality meetings and b) represent the needs of the practice's patient population within the CCG.
- Actively engaging with the CCG to help improve services within the area.
- Sharing appropriate referral, prescribing and emergency admissions data.
- Following the clinical pathways and referral protocols agreed by the CCG (except in individual cases where there are justified clinical reasons for not doing this).
- Managing the practice's prescribing budget.
- Participating in and delivering, as far as possible, the clinical and cost effective strategies agreed by the CCG.
- Establishing a practice reference group as a means of obtaining the views and experiences of patients and carers.
- Working constructively with the locality sub-committee/CCG.
- Responding in a timely manner to reasonable information requests from the CCG.

7.1.7 Memorandum of Agreement (Accountability Agreement)

a) The effective participation of each member practice will be essential in developing and sustaining high quality commissioning arrangements.
b) A Memorandum of Agreement between individual member practices and the CCG will be put in place as a means of clarifying the expectations and obligations of both parties.
c) The Memorandum will document any agreements reached between the member practice and the CCG and will be the formal mechanism for determining eligibility to any future incentive payment (currently referred to as the Quality Premium).
d) The Memorandum of Agreement will include (inter alia):-

- Parties to the Agreement
- Aims and objectives of the CCG
- Responsibilities of the member practice
- Responsibilities of the CCG
- Annual objectives/targets agreed with the member practice
- Monitoring arrangements, frequency of meetings, data returns
- Details of any financial incentives agreed with the member practice
- Indicative budgets of the member practice (when these come into effect).
- Financial resources made available by the CCG to support the member practice's involvement in commissioning in the relevant financial year
- Dispute resolution arrangements
- Arrangements for the review of the Agreement
- Signatures to the Agreement

7.1.8 Other GP and Primary Care Health Professionals

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

7.1.8.2 GP members of the Clinical Commissioning Group will take clinical leadership responsibility for:-

- Developing an understanding of budgetary management and undertaking robust monitoring of health care budgets.
- Providing clinical overview and scrutiny of the identification, planning and development of new services.
- Communicating effectively with constituent GPs to facilitate co-operation and engagement.
- Providing clinical overview and scrutiny of the decommissioning of ineffective, non-cost beneficial services.
- Developing the CCG as a sustainable commissioning organisation that will meet Department of Health authorisation assurance requirements
- Actively promoting the values of the CCG. The values espoused by the CCG are :

    - We are part of the communities we serve and use our local knowledge to inform our decision making.
    - We value people as individuals and for the contribution they make to our organisation at whatever level.
    - We put patients and their needs first.

- We act with honesty, transparency and integrity.
- We are responsive and good listeners, caring about patients, communities and colleagues.
- We make responsible decisions taking into account ethical values, clinical evidence and the views of others and uphold the principles of equality and diversity
- We believe in working collaboratively with partners and communicating effectively with everyone.

7.2 All Members of the Group's Clinical Commissioning Group Board

7.2.1 Each member of the Clinical Commissioning Group Board shares responsibility as part of a team to ensure that the group exercises its functions effectively, efficiently and economically, with good governance and in accordance with the terms of this constitution. Each brings their unique perspective, informed by their expertise and experience.

7.2.2 The Standing Orders set out how members of the Clinical Commissioning Group Board:-

7.2.2.1 Are to be appointed;
7.2.2.2 Their tenure of office;
7.2.2.3 How they would resign from their post;
7.2.2.3 The grounds for removal from office.

7.3 The Chair of the Clinical Commissioning Group Board

7.3.1 The chair of the Clinical Commissioning Group Board is responsible for:

- Leading the Clinical Commissioning Group Board, ensuring it remains continuously able to discharge its duties and responsibilities as set out in this constitution;
- Building and developing the group's Clinical Commissioning Group Board and its individual members;
- Ensuring that the group has proper constitutional and governance arrangements in place;
- Ensuring that, through the appropriate support, information and evidence, the Clinical Commissioning Group Board is able to discharge its duties;
- Supporting the accountable officer in discharging the responsibilities of the organisation;
- Contributing to building a shared vision of the aims, values and culture of the organisation;
- Leading and influencing to achieve clinical and organisational change to enable the group to deliver its commissioning responsibilities;
- Overseeing governance and particularly ensuring that the Clinical Commissioning Group Board and the wider group behaves with the utmost transparency and responsiveness at all times;

- Ensuring that public and patients' views are heard and their expectations understood and, where appropriate as far as possible, are met
- Ensuring that the organisation is able to account to its local patients, stakeholders and NHS England;
- Ensuring that the group builds and maintains effective relationships, with Mid Essex system partners including those involved in overview and scrutiny from the relevant local authority(ies) taking the lead in interactions with stakeholders, including NHS England.

7.4 The Deputy and Vice Chair roles of the Clinical Commissioning Group Board

7.4.1 The Deputy Chair (Lay Member) of the Clinical Commissioning Group Board deputises for the chair of the Clinical Commissioning Group Board where he or she has a conflict of interest or is otherwise unable to act.

7.4.2 The Vice Chair (Clinical) of the Clinical Commissioning Group Board deputises for the chair on business of a clinical nature where a clinician needs to act.

7.5 Role of the Accountable Officer

7.5.1. The Accountable Officer of the group is a member of the Clinical Commissioning Group Board.

7.5.2. This role of the Accountable officer has been summarised in a national document[53] as:

7.5.3 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;

7.5.4 Ensuring at all times 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.

7.5.5 Working closely with the chair of the Clinical Commissioning Group Board, the accountable officer will ensure that proper constitutional, governance and development arrangements are put in place to assure the members (through the Clinical Commissioning Group Board) of the organisation's on-going capability and capacity to meet its duties and responsibilities. This will include arrangements for the on-going developments of its members and staff.

53 See the latest version of NHS England's *Clinical commissioning group Clinical Commissioning Group members: Role outlines, attributes and skills*

7.6 Role of the Chief Finance Officer

a) Being the Clinical Commissioning Group Board'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 monitor and report upon 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 Clinical Commissioning Group Board 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;
f) Procuring value for money Information and Technology (IT) and estates support services.

7.7 Joint Appointments with other Organisations

7.7.1 The group has no joint appointments with other organisations at the current time.

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 Clinical Commissioning Group Board will at all times comply with this constitution and be aware of their responsibilities as outlined in it. They should act in good faith and in the interests of the group and should follow the *Seven Principles of Public Life*, set out by the Committee on Standards in Public Life (the Nolan Principles) The Nolan Principles are incorporated into this constitution at Appendix F.

8.1.2 They must comply with the group's policy on business conduct, including the requirements set out in the policy for managing conflicts of interest. This policy will be available on the group's website at www.midessexccgnhs.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. The NHS Code of Accountability requires Board members and Committee members to declare interest which are relevant and material to the NHS Board of which they are a member. All existing Board members and members of the Board's formal Committees should declare such interests. Any members appointed subsequently should do so on appointment.

8.2.2. 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. This will include the appointment of a Conflicts of Interest Guardian, as required by the mandatory guidance for CCGs on Managing Conflicts of Interest.

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

8.2.4. Examples of interests that will be deemed to be relevant and material include:

- A direct pecuniary interest: where an individual may financially benefit from the consequences of a commissioning decision (e.g., as a provider of services).

- An indirect pecuniary interest: e.g., where an individual is a partner, member or shareholder in an organisation that will benefit financially from the consequences of a commissioning decision.

- 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 (e.g., where an individual is a trustee of a voluntary provider that is bidding for a contract).

- 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 values (e.g., a reconfiguration of hospital services which might result in the closure of a busy clinic next door to an individual's house).

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

- Roles and responsibilities held within member practices.

- Membership of a Partnership (whether salaried or profit sharing) seeking to enter into any contracts which relate to the functions exercised by the CCG.

- Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the CCG.

- Directorships, including non-Executive Directorship held in private or public limited companies seeking to enter into contracts which relate to the functions exercised by the CCG.

- Material Shareholdings of companies in the field of health and social care seeking to enter into contracts which relate to the functions exercised by the CCG.

- Positions of authority in an organisation (e.g. charity or voluntary organisation) in the field of health and social care.

- Any interest that they (if they are registered with the General Medical Council) would be required to declare in accordance with paragraph 55 of the GMC's publication Management for Doctors or any successor guidance.

- Any interest that they (if they are registered with the Nursing and Midwifery Council) would be required to declare in accordance with paragraph 7 of the NMCs publication Code of Professional Conduct or any successor Code.

- Any interest which does or might constitute a conflict of interest in relation to the specification for or award of any contract to provide goods or services which relate to the functions exercised by the CCG.

- Any research funding or grants that may be received by the individual or any organisation they have an interest or role in.

    - Any role or relationship which the public could perceive would impair or otherwise influence the individual's judgement or actions in their role within the CCG

8.2.5 The dispute resolution process is set out in Appendix H[54].

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

8.2.7 A Declaration of Interest form needs to be provided at the start of employment or when commencing as a member of the CCG, annually refreshed and following any updates provided during the year. The

[54] See Appendix I

Declaration of Interest form is to be completed for all those who will be making decisions. *(Guidance is provided to aid in the completion of the Declaration of Interests form)*

8.3 Recording Declarations of Interests

8.3.1. The Head of Corporate Governance will maintain a register of all relevant and material interests and positions of influence declared by CCG members and employees together with the date that the interest was declared.

8.3.2. The interests declared will be included on the NHS Mid Essex CCG Board Register of Interests.

8.3.3. All interests declared will be published in the Annual Reports for NHS Mid Essex CCG and made available via the MECCG website at www.midessexccg.nhs.uk .

8.3 4 Where an individual changes role or responsibility within a CCG any change to the individual's interests should be declared.

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

8.2.6. The Accountable Officer will ensure that the Register of Interests is received regularly and updated as necessary.

8.2.7. All formal meetings of the CCG and the CCG Board and its committees and sub-committees will commence with an agenda item which requires the declaration of relevant interests of the attendees in relation to the business of the agenda.

8.4 Declaring Interests at Meetings

8.4.1. At all meetings including external and public meetings, all CCG members should 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 CCG Board, as soon as they are aware of it and in any event no later than 28 days after becoming aware. Even if the interest has already been declared in the Register of Interests, it should be declared in meetings where matters relating to that interest are discussed. All interests declared will be recorded in the minutes of meetings, as well as being included on the Register.

8.5 Managing Conflicts of Interests

8.5.1 The Accountable Officer will ensure that for every interest declared, either in writing or by oral declaration, arrangements are in place to manage the conflict of interests or potential conflict of interests, to ensure the integrity of

the group's decision making processes, seeking advice from the Conflicts of Interest Guardian as appropriate.

8.5.2 The Chair will determine the management arrangements of conflicts of interests and will be required to put in writing to the relevant individual arrangements for managing the conflict of interests or potential conflict of interests within a week of declaration where there will be a conflict or potential conflict of interest. The arrangements will confirm the following:-

- When an individual should withdraw from a specified activity, on a temporary or permanent basis;
- Monitoring of the specified activity undertaken by the individual, either by a line manager, colleague or other designated individual.

8.5.3 Where an interest has been declared, 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 Chair.

8.5.4 Where no arrangements have been confirmed by the chair, 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.

8.5.5 Where an individual member, employee or person providing services to the group is aware of an interest which has <u>not</u> been declared, either in the register or orally, they will declare this at the start of the meeting

8.5.6. Where the chair of any meeting 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 arrangements have not been confirmed, the deputy chair may require the chair to withdraw from the meeting or part of it.

8.5.7. The quorum of the Board shall be <u>a minimum of</u> 50% total voting members (8). No business shall be transacted unless the clinical cohort is in the majority.

8.5.8. The composition of the Clinical Commissioning Group Board is as follows and shall not have less than 14 voting members:-

Position	**Status**	**Clinical or Non Clinical**
Chair	Boardmember	Clinical
Deputy Chair (Lay Member Governance)	Board member	Non Clinical
Vice Chair	Board member	Clinical

Lay Member (PPE)	Board member	Non Clinical
Lay Member (Commercial)	Board member	Non Clinical
GP (elected)	Board member	Clinical
GP (elected)	Board member	Clinical
Registered nurse – DoN	Board member	Clinical
Secondary care specialist doctor	Board member	Clinical
Accountable Officer	Board member	Non Clinical
Managing Director	Board member	Clinical
Director of Clinical Commissioning	Board member	Clinical
Chief Finance Officer	Board member	Non Clinical
Medical Director	Board member	Clinical
Director of Primary Care & Resilience	Board member	Non Clinical
Director of Corporate Services	Board member	Non Clinical
Director of Acute Commissioning	Co-opted member	Non Clinical
Essex County Council representative	Co-opted member	N/A
Public Health Consultant	Co-opted member	N/A

(16 voting members (9 clinical, 7 non-clinical) and 19 members in total)

Any Chair approved deputies attending will carry voting rights.

8.5.9 Any quorum of the Board or its sub-committees shall exclude any member affected by a conflict of interest under paragraph 8.3 of the Constitution. If this paragraph has the effect of rendering the meeting **inquorate**, then the Chair shall decide on one of the following options which may include:-

(a) Inviting on a temporary basis one or more of the following to make up the quorum (where these are permitted members of the CCG Board or committee in question) so that the group can progress the item of business

- a member of the CCG who, in order to achieve quoracy is either an elected GP deputy or a named executive deputy and where this arrangement is not possible, for the Chair and Accountable Officer to agree the appropriateness of other deputies
- a CCG individual appointed by a member to act on its behalf in the dealings between it and the CCG
- a CCG member of the relevant Health and Wellbeing Board

(b) Adjournment of the item and to reconvene the meeting when appropriate membership can be ensured.

(c) These arrangements must be included in the minutes.

8.5.10 In the event that none of these maintain quoracy, the Chair is at liberty to stand down selected voting members from the non-clinical managerial and Lay members to ensure that clinicians are in the majority.

8.5.11 The proviso of this arrangement is that the stand down of any one of the non clinical managerial members would not be in preference to the stand down of a Chair approved voting deputy of another function, unless the matter relates to a decision where financial approval is required, in which case the Chair would decide who to stand down.

The stand down would be in accordance with the following order:-

1st to stand down – Director of Corporate Services
2nd to stand down – Lay member (Commercial)

8.5.12 In the event that the actions set out in 7.8 do not achieve quoracy, the Chair can decide to invite a member of one of the following where that member does not have a conflict of interest:-

- a member of the relevant Health and Wellbeing Board
- a member of a CCG Board of another CCG

8.5.13 In the event that the actions set out in 7.9 do not achieve quoracy, the Chair can decide to adjourn the item and to reconvene the Board when appropriate membership can be ensured.

8.5.14 Managing Conflicts of Interest: contractors and people who provide services to the group

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

- 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 Clinical Commissioning Group Board which will ensure that:

- 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;

- service redesign and procurement 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. midessexccg.nhs.uk

9. THE GROUP AS EMPLOYER

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

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

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

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

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

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

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

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

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

9.11 Copies of this Code of Business Conduct, together with the other policies and procedures outlined in this chapter, will be available on the group's website at www. midessexccg.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, including the notices of procurements, public consultations, Clinical Commissioning Group Board meeting dates, times, venues, and certain papers will be published on the group's website at www.midessexccg.nhs.uk

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.

10.2 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:

10.2.2 ***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 Clinical Commissioning Group Board;

10.2.3 ***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 Clinical Commissioning

Group Board, the Clinical Commissioning Group Board's committees and sub-committees, the group's committees and sub-committees, individual members and employees;

10.2.4 ***Standing Financial Instructions (Appendix E)*** – which sets out the arrangements for managing the group's financial affairs.

APPENDIX A

DEFINITIONS OF KEY DESCRIPTIONS USED IN THIS CONSTITUTION

2006 Act	National Health Service Act 2006
2012 Act	Health and Social Care Act 2012 (this Act amends the 2006 Act)

Accountable Officer	an individual, as defined under paragraph 12 of Schedule 1A of the 2006 Act (as inserted by Schedule 2 of the 2012 Act), appointed by the NHS Commissioning Board, with responsibility for ensuring the group:
	• complies with its obligations under:
	  ○ sections 14Q and 14R of the 2006 Act (as inserted by section 26 of the 2012 Act),
	  ○ sections 223H to 223J of the 2006 Act (as inserted by section 27 of the 2012 Act),
	  ○ paragraphs 17 to 19 of Schedule 1A of the NHS Act 2006 (as inserted by Schedule 2 of the 2012 Act), and
	  ○ any other provision of the 2006 Act (as amended by the 2012 Act) specified in a document published by the Board for that purpose;
	• exercises its functions in a way which provides good value for money.

Area	the geographical area that the group has responsibility for, as defined in Chapter 2 of this constitution
Chair of the Clinical Commissioning Group	the individual appointed by the group to act as chair of the Clinical Commissioning Group
Chief Finance Officer	the qualified accountant employed by the group with responsibility for financial strategy, financial management and financial governance
Clinical Commissioning Group	a body corporate established by the NHS Commissioning Board in accordance with Chapter A2 of Part 2 of the 2006 Act (as inserted by section 10 of the 2012 Act)
Committee	a committee or sub-committee created and appointed by: • the membership of the group • a committee / sub-committee created by a committee created / appointed by the membership of the group • a committee / sub-committee created / appointed by the Clinical Commissioning Group
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 Mid Essex Clinical Commissioning Group, whose constitution this is
Clinical Commissioning Group Board	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 Board has made appropriate arrangements for ensuring that it complies with: • its obligations under section 14Q under the NHS Act 2006 (as inserted by section 26 of the 2012 Act), and • such generally accepted principles of good governance as are relevant to it.

Clinical Commissioning Group member	any member appointed to the Clinical Commissioning Board of the group
Lay member	a lay member of the Clinical Commissioning Group, appointed by the group. A lay member is an individual who is not a member of the group or a healthcare professional (i.e. an individual who is a member of a profession regulated by a body mentioned in section 25(3) of the National Health Service Reform and Health Care Professions Act 2002) or as otherwise defined in regulations
Member	a provider of primary medical services to a registered patient list, who is a members of this group (see tables in Chapter 3 and Appendix B)
Practice representatives	an individual appointed by a practice (who is a member of the group) to act on its behalf in the dealings between it and the group, under regulations made under section 89 or 94 of the 2006 Act (as amended by section 28 of the 2012 Act) or directions under section 98A of the 2006 Act (as inserted by section 49 of the 2012 Act)
Registers of interests	registers a group is required to maintain and make publicly available under section 14O of the 2006 Act (as inserted by section 25 of the 2012 Act), of the interests of: • the members of the group; • the members of its Clinical Commissioning Group; • the members of its committees or sub-committees and committees or sub-committees of its Clinical Commissioning Group; and • its employees.

APPENDIX B - LIST OF MEMBER PRACTICES

PRACTICE	ADDRESS	CODE
Baddow Village Surgery	Longmead Avenue, Great Baddow, Chelmsford CM2 7EZ	F81114
Beacon Health	Danbury Medical Centre, 52 Maldon Road, Danbury, CM3 4QL	F81100
North Chelmsford HCC	Sainsbury's, 2 White Hart Lane, Chelmsford, CM2 5EF	Y02611
Moulsham Lodge	158 Gloucester Avenue, Chelmsford CM2 9LG	F81035
Sutherland Lodge Surgery	115 Baddow Road, Chelmsford CM2 7PY	F81117
Writtle Surgery	16a Lordship Road, Writtle CM1 3EH	F81098
Tennyson House Surgery	20 Merlin Place, Chelmsford CM1 4HW	F81122
Whitley House Surgery	Crompton Building, Writtle Road, Chelmsford CM1 3RW	F81057
Beauchamp House Surgery	37 Baddow Road, Chelmsford CM2 0DB	F81083
The Surgery, Humber Road	27 Humber Road Chelmsford CM1 7PE	F81127
Chelmer Village Surgery	Ashton Place, Chelmer Village, Chelmsford CM2 6ST	F81665
The Surgery, Dickens Place	Chelmsford CM1 4UU	F81024
Melbourne House Surgery	Parkside Medical Centre, Melbourne Avenue CM1 2DY	F81074
Rivermead Gate Medical Centre	123 Rectory Lane, Chelmsford CM1 1TR	F81071
Stock Surgery	Common Road, Stock CM4 9NF	F81040
Little Waltham & Black Notley Surgery	The Surgery, Brook Hill, Little Waltham CM3 3LL Notley Green, Great Notley, Braintree CM7 8US	F81105
Greenwood Surgery	Tylers Ride, South Woodham Ferrers CM3 3JX	Y00589
Kingsway Surgery	42 Kings Way, South Woodham Ferrers CM3 5QH	F81170
Brickfields Surgery	Brickfields Road, South Woodham Ferrers CM3 3JX	F81721
Wyncroft Surgery	3 Prior Road, Bicknacre CM3 4EY	F81674
The Coggeshall Surgery	Stoneham Street, Coggeshall CO6 1UH	F81730
Castle Surgery	10 Falcon Square, Castle Hedingham CO9 3BY	Y00293

PRACTICE	ADDRESS	CODE
The Elizabeth Courtauld	Factory Lane West, Halstead CO9 1EX	F81068
Hilton House	77 Swan Street, Sible Hedingham CO9 3HT	F81138
The Pump House	Nonancourt Way (off Massingham Drive, Earls Colne CO6 2SW	F81119
Brimpton House	59 High Street, Kelvedon CO5 9AE	F81738
Kelvedon and Feering Health Centre	46 High Street, Kelvedon CO5 9AG	F81011
Freshford (Freshwell)	Wethersfield Road, Finchingfield, CM7 4BQ	F81020
Tollesbury Surgery	25 High Street, Tollesbury CM9 8RG	F81076
Longfield Medical Centre	Princes Road, Maldon CM9 5DF	F81022
Blackwater Medical Centre	Princes Road, Maldon CM9 5GP	F81099
Blyths Meadow	Trinovantian Way, Braintree CM7 3JN	F81683
Church Lane surgery (St Lawrence)	Braintree College, College Lane, Braintree CM7 5SN	F81014
Silver End	Broadway, Silver End, Witham CM8 3RQ	Y05023
Blandford	Mace Avenue, Braintree, CM7 2AE	F81132
Mount Chambers	92 Coggeshall Road, Braintree CM7 9BY	F81087
The Burnham Surgery	Foundary Lane, Burnham on Crouch CM0 8SJ	F81126
Dengie Medical Partnership	Tillingham Medical Centre, 61 South Street, Tillingham CM0 7TH	F81183
William Fisher Medical Centre	High Street, Southminster CM0 7AY	F81130
The Trinity Medical Practice	1 The Drive, Maylandsea CM3 6AB	F81751
The Laurels Surgery	Juniper Road, Boreham CM3 3DX	F81149
The Surgery, Douglas Grove	Witham CM8 1TE	F81173
The Surgery Collingwood Road	40 Collingwood Road, Witham CM8 2DZ	F81635
Fern House Surgery	125 - 129 Newland Street, Witham CM8 1BH	F81030
Witham Health Centre	4 Mayland Road, Witham CM8 2UX	F81193

Lower Super Output Areas

E01021375	Braintree 001A	E01021374	Braintree 011E
E01021376	Braintree 001B	E01021360	Braintree 012A
E01021414	Braintree 001C	E01021361	Braintree 012B
E01021430	Braintree 001D	E01021367	Braintree 012C
E01021398	Braintree 002A	E01021369	Braintree 012D
E01021406	Braintree 002B	E01021380	Braintree 012E
E01021407	Braintree 002C	E01021347	Braintree 013A
E01021382	Braintree 003A	E01021371	Braintree 013B
E01021397	Braintree 003B	E01021384	Braintree 013C
E01021399	Braintree 003C	E01021385	Braintree 013D
E01021400	Braintree 003D	E01021386	Braintree 013E
E01021387	Braintree 004A	E01021377	Braintree 014A
E01021388	Braintree 004B	E01021378	Braintree 014B
E01021391	Braintree 004C	E01021379	Braintree 014C
E01021392	Braintree 004D	E01021401	Braintree 014D
E01021393	Braintree 004E	E01021402	Braintree 014E
E01021404	Braintree 005A	E01021403	Braintree 014F
E01021411	Braintree 005B	E01021362	Braintree 015A
E01021412	Braintree 005C	E01021417	Braintree 015B
E01021413	Braintree 005D	E01021418	Braintree 015C
E01021389	Braintree 006A	E01021419	Braintree 015D
E01021390	Braintree 006B	E01021426	Braintree 015E
E01021408	Braintree 006C	E01021428	Braintree 015F
E01021409	Braintree 006D	E01021423	Braintree 016A
E01021410	Braintree 006E	E01021425	Braintree 016B
E01021349	Braintree 007A	E01021427	Braintree 016C
E01021351	Braintree 007B	E01021429	Braintree 016D
E01021352	Braintree 007C	E01021415	Braintree 017A
E01021355	Braintree 007D	E01021416	Braintree 017B
E01021356	Braintree 007E	E01021420	Braintree 017C
E01021381	Braintree 007F	E01021422	Braintree 017E
E01021354	Braintree 008A	E01033460	Braintree 017F
E01021357	Braintree 008B	E01033461	Braintree 017G
E01021358	Braintree 008C	E01033462	Braintree 017H
E01021359	Braintree 008D	E01021348	Braintree 018A
E01021350	Braintree 009A	E01021394	Braintree 018B
E01021353	Braintree 009B	E01021395	Braintree 018C
E01021365	Braintree 009D	E01021396	Braintree 018D
E01033458	Braintree 009E	E01021424	Braintree 018E
E01033459	Braintree 009F		
E01021364	Braintree 010A		
E01021366	Braintree 010B		
E01021383	Braintree 010C		
E01021405	Braintree 010D		
E01021368	Braintree 011A		
E01021370	Braintree 011B		
E01021372	Braintree 011C		
E01021373	Braintree 011D		

E01021538	Chelmsford 001A	E01021578	Chelmsford 010B	E01021614	Chelmsford 019D
E01021539	Chelmsford 001B	E01021582	Chelmsford 010D	E01021615	Chelmsford 019E
E01021540	Chelmsford 001C	E01021627	Chelmsford 010E	E01021605	Chelmsford 020A
E01021541	Chelmsford 001D	E01033140	Chelmsford 010F	E01021606	Chelmsford 020B
E01021542	Chelmsford 002A	E01033141	Chelmsford 010G	E01021607	Chelmsford 020C
E01021543	Chelmsford 002B	E01021551	Chelmsford 011A	E01021608	Chelmsford 020D
E01021587	Chelmsford 002C	E01021632	Chelmsford 011B	E01021609	Chelmsford 020E
E01021590	Chelmsford 002D	E01021633	Chelmsford 011C	E01021610	Chelmsford 020F
E01021591	Chelmsford 002E	E01021634	Chelmsford 011D	E01021593	Chelmsford 021A
E01021550	Chelmsford 003A	E01021635	Chelmsford 011E	E01021594	Chelmsford 021B
E01021597	Chelmsford 003B	E01021636	Chelmsford 011F	E01021595	Chelmsford 021C
E01021598	Chelmsford 003C	E01021556	Chelmsford 012A		
E01021600	Chelmsford 003D	E01021577	Chelmsford 012B		
E01021601	Chelmsford 003E	E01021579	Chelmsford 012C		
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E01021619	Chelmsford 004C	E01021548	Chelmsford 013A		
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E01021624	Chelmsford 004F	E01021564	Chelmsford 013D		
E01021536	Chelmsford 005A	E01021571	Chelmsford 013E		
E01021537	Chelmsford 005B	E01021562	Chelmsford 014A		
E01021568	Chelmsford 005D	E01021563	Chelmsford 014B		
E01033142	Chelmsford 005E	E01021565	Chelmsford 014C		
E01033144	Chelmsford 005F	E01021566	Chelmsford 014D		
E01021576	Chelmsford 006A	E01033137	Chelmsford 014F		
E01021588	Chelmsford 006B	E01033145	Chelmsford 014G		
E01021589	Chelmsford 006C	E01021557	Chelmsford 015A		
E01021592	Chelmsford 006D	E01021558	Chelmsford 015B		
E01021596	Chelmsford 006E	E01021583	Chelmsford 015C		
E01021618	Chelmsford 007A	E01021585	Chelmsford 015D		
E01021621	Chelmsford 007B	E01021586	Chelmsford 015E		
E01021622	Chelmsford 007C	E01021533	Chelmsford 016A		
E01021625	Chelmsford 007D	E01021535	Chelmsford 016B		
E01021626	Chelmsford 007E	E01021569	Chelmsford 016C		
E01021544	Chelmsford 008A	E01021570	Chelmsford 016D		
E01021545	Chelmsford 008B	E01021572	Chelmsford 016E		
E01021546	Chelmsford 008C	E01021552	Chelmsford 017A		
E01021547	Chelmsford 008D	E01021553	Chelmsford 017B		
E01021628	Chelmsford 008E	E01021554	Chelmsford 017C		
E01021629	Chelmsford 008F	E01021555	Chelmsford 017D		
E01021573	Chelmsford 009A	E01021559	Chelmsford 017E		
E01021575	Chelmsford 009B	E01021602	Chelmsford 018B		
E01021599	Chelmsford 009C	E01021604	Chelmsford 018D		
E01021631	Chelmsford 009E	E01033143	Chelmsford 018E		
E01033138	Chelmsford 009F	E01021611	Chelmsford 019A		
E01033139	Chelmsford 009G	E01021612	Chelmsford 019B		
E01021574	Chelmsford 010A	E01021613	Chelmsford 019C		

E01021908	Maldon 001A
E01021909	Maldon 001B
E01021910	Maldon 001C
E01021911	Maldon 001D
E01021882	Maldon 002A
E01021883	Maldon 002B
E01021912	Maldon 002C
E01021913	Maldon 002D
E01021884	Maldon 003A
E01021885	Maldon 003B
E01021886	Maldon 003C
E01021887	Maldon 003D
E01021888	Maldon 003E
E01021889	Maldon 004A
E01021890	Maldon 004B
E01021891	Maldon 004C
E01021892	Maldon 004D
E01021893	Maldon 005A
E01021894	Maldon 005B
E01021895	Maldon 005C
E01021896	Maldon 005D
E01021897	Maldon 005E
E01021898	Maldon 005F
E01021901	Maldon 006A
E01021904	Maldon 006B
E01021905	Maldon 006C
E01021906	Maldon 006D
E01021907	Maldon 006E
E01021873	Maldon 007A
E01021874	Maldon 007B
E01021875	Maldon 007C
E01021899	Maldon 007D
E01021900	Maldon 007E
E01021902	Maldon 007F
E01021903	Maldon 007G
E01021878	Maldon 008C
E01021879	Maldon 008D
E01021880	Maldon 008E
E01021881	Maldon 008F
E01033057	Maldon 008G

APPENDIX C - STANDING ORDERS

http://midessexccg.nhs.uk/about-us/our-key-documents/nhs-mid-essex-constitution/2634-appendix-c-standing-orders/file

APPENDIX
C.Standing Orders.dc

APPENDIX D – SCHEME OF RESERVATION & DELEGATION and DETAILED SCHEME OF DELEGATION

http://midessexccg.nhs.uk/about-us/our-key-documents/nhs-mid-essex-constitution/2633-appendix-d-scheme-of-reservation-and-delegation-and-detailed-scheme-of-delegation/file

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APPENDIX E –

STANDING FINANCIAL INSTRUCTIONS

http://midessexccg.nhs.uk/about-us/our-key-documents/nhs-mid-essex-constitution/2632-appendix-e-standing-financial-instructions/file

SFIs

APPENDIX F - NOLAN PRINCIPLES

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

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

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

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

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

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

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

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

Source: *The First Report of the Committee on Standards in Public Life* (1995)[55]

[55] Available at http://www.public-standards.gov.uk/

APPENDIX G – 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)[56]

[56] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_132961

APPENDIX H –

DISPUTE RESOLUTION PROCEDURE

Background

It is almost inevitable that on occasions practices will disagree with decisions made by their commissioning group or in some cases, actions taken by other practices that impact on them. It is important that all practices have the ability to appeal against any such decisions and have the right to request that any dispute is resolved by means of an agreed Dispute Resolution Procedure that forms part of the commissioning group's constitution.

The arrangements to deal with disputes arising from the new commissioning responsibilities will follow closely the procedures previously in place in a number of PCTs which involved a three staged process.

Stage 1: The Informal Process

Informal resolution helps develop and sustain a partnership approach between practices and between practices and commissioning groups.

Each party should involve the LMC at this stage in either an advisory or mediation role.

It is a requirement that the Informal Process must have been exhausted before either party is able to escalate the dispute to Stage 2: The Local Dispute Resolution Panel.

Stage 2: The Formal Local Process

In cases where either party remains dissatisfied with the outcome of Stage 1, then they have the right to request Formal Local Dispute Resolution in writing, including grounds for the request to the Accountable Office of the commissioning group.

Other than in cases, which in the opinion of the Accountable Officer and following consultation with the LMC, are considered to be frivolous or vexatious, a Local Dispute Resolution Panel (LDRP) will be convened to hear the dispute and make a determination.

<u>Members of the LDRP</u>

The Panel will consist of:-

- A clinical member of the Board of another commissioning group.
- A GP conciliator (from a Panel to be established by the LMCs).
- An LMC representative (from a different part of Essex).
- Panel Secretary (non-voting).

The Panel will agree its own Chairman.

The Hearing

The hearing will be held within 20 working days of the request being lodged. At least 7 working days' notice of the hearing date will be given to all participants.

Documentation

All relevant documentation will be provided to all parties and panel members at least 5 working days before the hearing.

Procedure at the LDRP Hearing

The discussion of the Panel will remain confidential. The Panel Secretary will keep a record of the hearing.

The Appellant will be asked to present their case. Members of the Panel will be given the opportunity to ask any questions relevant to the case.

The Respondent will be asked to present their response. Members of the Panel will be given the opportunity to ask any questions relevant to the case.

The Appellant and the Respondent will then withdraw.

Following the presentation of the facts the Panel will deliberate and reach a decision on the case based on a majority of the voting panel members.

The Panel Chair will notify both parties of the decision including any recommendations in writing within 7 days after the hearing.

If either party disputes the decision of the LDRP and the decision relates directly to provisions in its GMS/PMS contract, then it may refer the matter to the Family Health Services Appeal Unit (FHSAU) of the NHS Litigation Authority in line with relevant NHS Regulations, for dispute resolution under the "NHS Dispute Resolution Procedure".

Stage 3: Appeal to The Secretary of State through the FHSAU – NHS Dispute Resolution Procedure

Written requests must be directed to the FHSAU, 1 Trevelyan Square, Boar Lane, Leeds, LS1 6AE within three years beginning on the date on which the matter giving rise to the dispute happened or should reasonably have come to the attention of the party wishing to refer the dispute.

Disputes should be addressed directly to the FHSAU and must include:-

- The names and addresses of the parties to the dispute.
- A copy of the contract.
- A brief statement describing the nature and circumstances of the dispute.

Inter Practice Disputes

It is envisaged that the Stage 2 Formal Process will be used in the main to deal with disputes between individual practices and commissioning groups.

In cases where the dispute is between practices and it is an issue that warrants formal dispute resolution, then the same process and timescales will apply.

The only proposed change is that the LMC representative on the LDRP will be a representative from an LMC outside of Essex. It is extremely unlikely that any disputes between practices will be appropriate for referral to the Secretary of State for determination as detailed in Stage 3.

APPENDIX I –

MANAGING CONFLICTS OF INTEREST: REVISED STATUTORY GUIDANCE FOR CCGS

CoI Guidance for CCGs

http://midessexccg.nhs.uk/about-us/our-key-documents/nhs-mid-essex-constitution/2631-appendix-i-managing-conflicts-of-interests-revised-statutory-guidance-for-ccgs/file

APPENDIX J

COMMUNICATIONS AND ENGAGEMENT STRATEGY

http://midessexccg.nhs.uk/about-us/our-key-documents/nhs-mid-essex-constitution/2630-appendix-j-communications-and-engagement-strategy/file

Comms &
Engagement Strategy