Quality Care

Clinically Led

for healthier communities in Central Manchester

NHS

Central Manchester

Clinical Commissioning Group

NHS CENTRAL MANCHESTER CLINICAL COMMISSIONING GROUP (CMCCG)

CONSTITUTION

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FOREWORD

NHS Central Manchester Clinical Commissioning Group (CMCCG) was established in April 2010 in shadow form following a long history of GP commissioning in Central Manchester. With effect from April 2013, the CCG is the statutory organisation for the commissioning of health services in Central Manchester. As a mission statement, Central Manchester CCG has adopted:

'Informed by the views of local people and working closely with other health and social care professionals, NHS Central Manchester Clinical Commissioning Group will design and develop health services which are high quality, safe and affordable, and which will support communities to be the healthiest they can be'.

The CCG has 6 high level aims:

- To improve life expectancy
- To improve the quality of life for people with long term conditions
- To improve recovery from ill health and injury
- To ensure a good patient experience
- To ensure safe and effective services
- To work within our budget.

The CCG is a membership organisation made up of 31 practices of approximately 211,000 patients in Central Manchester. Its plans and targets therefore, stem from its membership. The CCG operates in four geographical locality groups to ensure that commissioning is led by the grass roots and is responsive to local need.

This constitution is confined to the governance remit which will impact on the relationship between practices and the CCG. CCG's have a range of functions which they are legally responsible to exercise. These functions are made up of statutory duties, which the CCG must do, and statutory powers, which allow CCGs the freedom to shape the way it meets its statutory duties.[1]

The functions of the Group arrange for the provision of services as part of the health service, and include: commissioning of healthcare services; specific cooperation duties; general duties; planning, agreeing and monitoring services; financial duties; governance; general duties applying to public or NHS bodies.

The CCG will continuously work with its key partner organisations, particularly Central Manchester University Hospitals NHS Foundation Trust, Manchester City Council, Manchester Mental Health and Social Care Trust and the North West Ambulance Services along with the multitude of other community and voluntary organisations involved with delivering high quality healthcare and promotion of good health and wellbeing. We seek to work together to achieve the best for the people of Central Manchester.

The CCG is ambitious and wishes to make big improvements to the health of its local population. This Constitution sets out formally how the CCG operates as an organisation, how it is governed and the standards which ensure it is open and transparent to patients and the public.

[1] Department of Health, *The Functions of Clinical Commissioning Groups*, 12 June 2012

1. INTRODUCTION AND COMMENCEMENT

1.1. Name

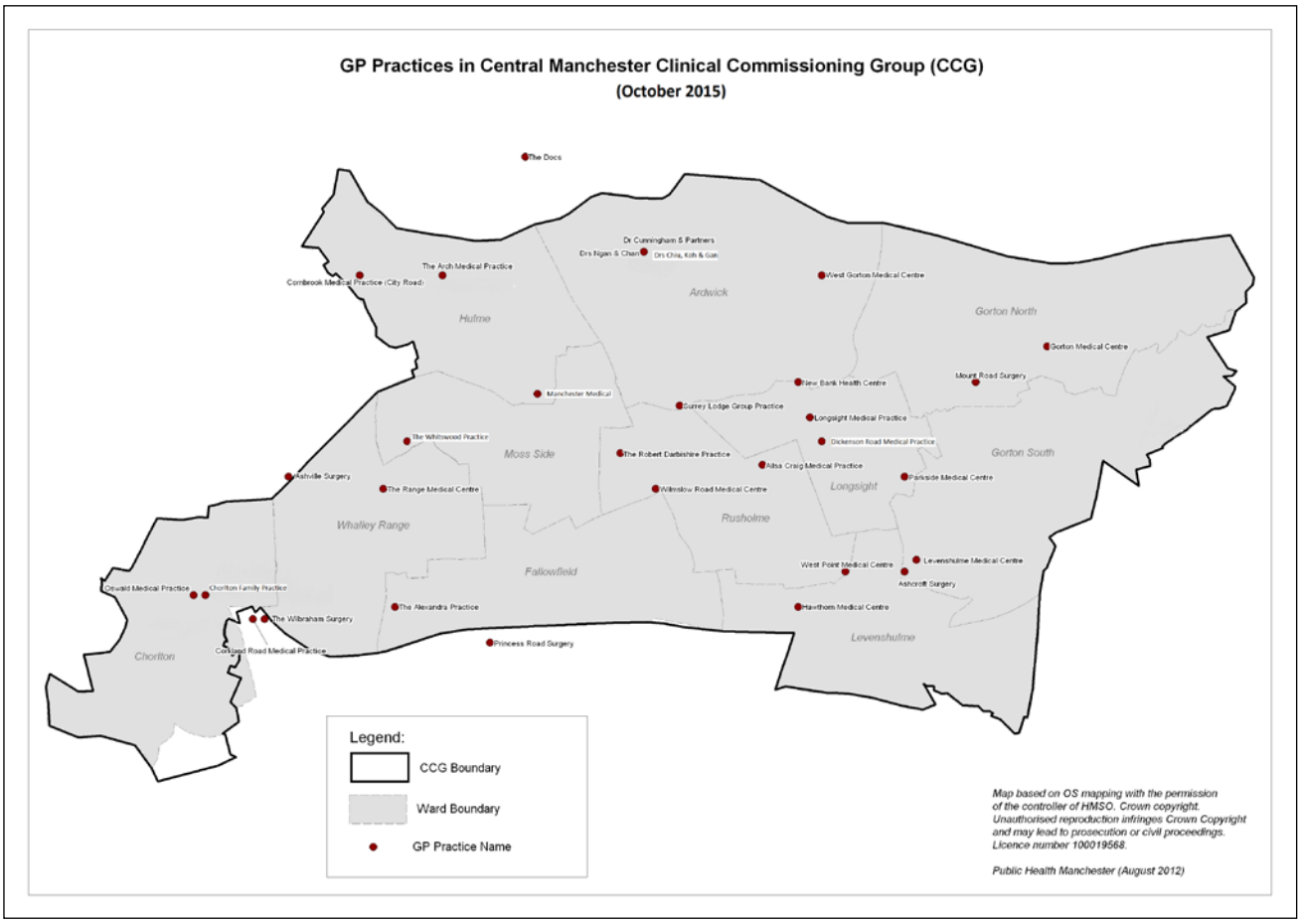
The name of this clinical commissioning group is NHS Central Manchester Clinical Commissioning Group (CMCCG).

1.2. Area Covered

The three NHS Manchester CCGs (North, Central and South) are fully co-terminus with Manchester City Council. The geographical area covered by NHS Central Manchester Clinical Commissioning Group partially covers this area.

The extent of the coverage for CMCCG within Manchester City Council is defined in the 87 Lower Super Output Areas (LSOA'S).[2]

The map below shows the Central Manchester practices and the wards in which they sit. These wards are further grouped into four locality areas.[3]



1.3. Statutory Framework

[2] Appendix A, Lower Super Output Areas (LSOAs)
[3] Appendix B, List of Member Practices & Localities

a) NHS Central Manchester Clinical Commissioning Group (CMCCG) is established under the Health and Social Care Act 2012 ("the 2012 Act").[4] It is a statutory body which has 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").[5] The duties of the CCG 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.[6]

b) The NHS Commissioning Board (hereafter referred to as NHS England) is responsible for determining NHS CMCCG's application to be established as a clinical commissioning group[7] and it undertakes an annual assessment of the established group.[8] 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.[9]

c) NHS CMCCG is a clinically led membership organisation 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 this constitution.[10]

1.4. Status of this Constitution

a) This constitution is made between the members of NHS Central Manchester Clinical Commissioning Group and has effect from 15th February 2013, when NHS England established the Group.[11]

The constitution can be accessed in the following ways:

- Via the Group's website at: www.centralmanchesterccg.nhs.uk/publications
- Upon application for receipt by post:

  NHS Central Manchester Clinical Commissioning Group
  2nd Floor, Parkway 3
  Parkway Business Centre
  Princess Road
  Manchester
  M14 7LU
- Via 'Contact us' on the CCG Website - www.centralmanchesterccg.nhs.uk/contact-us

[4] See section 1I of the 2006 Act, inserted by section 10 of the 2012 Act
[5] See section 275 of the 2006 Act, as amended by paragraph 140(2)(c) of Schedule 4 of the 2012 Act
[6] 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
[7] See section 14C of the 2006 Act, inserted by section 25 of the 2012 Act
[8] See section 14Z16 of the 2006 Act, inserted by section 26 of the 2012 Act
[9] See sections 14Z21 and 14Z22 of the 2006 Act, inserted by section 26 of the 2012 Act
[10] 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
[11] See section 14D of the 2006 Act, inserted by section 25 of the 2012 Act

1.5. Amendment and Variation of this Constitution

a) This constitution can only be varied in two circumstances:[12]

i) where the Group applies to NHS England and that application is granted. The Group will have gone through a simple majority voting process prior to applying to NHS England;

ii) where in the circumstances set out in legislation NHS England varies the Group's constitution other than on application by the Group.

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

2. MISSION, VALUES AND AIMS

2.1. Mission, Values & Aims

a) The mission, values and aims of NHS Central Manchester Commissioning Group is stated in the Group's Inter-Practice Agreement (IPA).[13]

b) The IPA will be reviewed bi-annually and will take place as instructed by the Executive Team, with the approval of members to any proposed changes through locality.

c) The Group will promote good governance and proper stewardship of public resources in pursuance of its goals and in meeting its statutory duties.

2.2. Principles of Good Governance

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

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

ii) *The Good Governance Standard for Public Services*;[15]

iii) the standards of behaviour published by the *Committee on Standards in Public Life (1995)* known as the 'Nolan Principles'[16]

iv) the seven key principles of the *NHS Constitution*;[17]

v) the Equality Act 2010;[18]

vi) Standards for Members of NHS Boards and Governing Bodies in England.

2.3. Accountability

a) The Group will demonstrate its accountability to its member practices, local people, stakeholders and NHS England in a number of ways, including by:

i) publishing its Constitution;

ii) appointing independent lay members and non-GP clinicians to its Governing Body;

iii) holding meetings of its Governing Body in public (except where the Group considers that it would not be in the public interest in relation to all or part of a meeting);

[13] Appendix C, Inter-Practice Agreement (IPA)
[14] Inserted by section 25 of the 2012 Act
[15] *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
[16] Appendix D, The Nolan Principles
[17] Appendix E, The Seven Principles of the NHS Constitution
[18] See http://www.legislation.gov.uk/ukpga/2010/15/contents

iv) publishing annually a commissioning plan;

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

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

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

viii) having a published and clear complaints process which is compliant with the statutory framework for complaints handling;

ix) complying with the Freedom of Information Act 2000;

x) providing information to NHS England as required;

xi) liaising with the Local Medical Committee where CCG plans have mentioned impact upon primary care in their role as a provider.

b) In addition to these statutory requirements the Group will demonstrate its accountability through:

i) the Patient Public Advisory Group

ii) the Clinical Integrated Care Board

iii) the Locality Groups

iv) other various mechanisms as outlined in NHS CMCCG's Communication & Engagement strategy.

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

3. THE CLINICAL COMMISSIONING GROUP

3.1. The Group

NHS Central Manchester Clinical Commissioning Group (CMCCG or the Group) is the outward face of clinical commissioning dealing corporately with North West Commissioning Support Unit (NWCSU); acute, community and voluntary providers; the health and wellbeing board and the local authority. The Group is underpinned by member practices which collectively form localities.

3.1.1. Membership of the Group

a) Membership of NHS Central Manchester Clinical Commissioning Group is open to all practices that sit within, or take the majority of their patients from the wards of Ardwick, Chorlton, Fallowfield, Gorton North, Gorton South, Hulme, Levenshulme, Longsight, Moss Side, Rusholme and Whalley Range (see 1.2). It is also open to practices that lie outside of these wards but have formerly been members of CMCCG.

b) As a clinically led organisation, 31 general practices collectively form the membership of NHS Central Manchester Clinical Commissioning Group. The practices are further grouped into localities:

Locality	No of practices	Practice Name
Ardwick & Longsight	9	Ailsa Craig Medical Practice Drs Chiu, Koh & Gan Dr Cunningham & Partners Drs Ngan & Chan Longsight Medical Practice Parkside Medical Centre Surrey Lodge Group Practice Dickenson Road Medical Centre New Bank Health Centre
Chorlton, Whalley Range, Fallowfield	8	Ashville Surgery Corkland Road Medical Practice Chorlton Family Practice Oswald Medical Practice Princess Road Surgery The Range Medical Centre The Wilbraham Surgery The Alexandra Practice
Gorton & Levenshulme	7	Ashcroft Surgery Gorton Medical Centre Hawthorn Medical Centre Levenshulme Medical Centre Mount Road Surgery West Gorton Medical Centre West Point Medical Centre

Locality	No of practices	Practice Name
Hulme, Moss Side & Rusholme	7	The Arch Medical Practice Cornbrook Medical Practice The Docs The Robert Darbishire Practice The Whitswood Practice Manchester Medical Wilmslow Road Medical Centre

c) The Group may extend membership to any other practice seeking membership via formal request to the CMCCG Governing Body other than defined in 1.2 (area covered). Such applications will be assessed on an ad hoc basis by the Board with a recommendation to the next Group meeting for ratification. Reasons for leaving their current CCG must also be included. Further ratification from NHS England will also be required.

d) Membership is determined by signatory to this agreement by the practice representative who may be a partner or equivalent. The practice as a whole is considered to be a member of the Group.

e) Membership will continue thereafter unless the practice resigns.

f) Member practice agreement to this Constitution is confirmed in Appendix B, together with the practice addresses and signatures of practice representatives.

3.1.2. Eligibility

a) Providers of primary medical services to a registered list of patients under a General Medical Services, Personal Medical Services or Alternative Provider Medical Services contract, will be eligible to apply for membership of this Group.[19]

3.1.3. Termination of Membership

a) A member practice ceases to be a member if:

i) a member formally resigns from being a member of the group by giving at least 6 months written prior notice of their resignation to the Governing Body and that the written notice includes prior consent from NHS England.

ii) a member is a sole practitioner GP and he or she:
- dies
- is declared bankrupt
- ceases to be registered as a medical practitioner
- enters into partnership with any other medical practitioner, unless the other practice is an existing member. Where two practices merge, the two memberships will become one.

iii) a member is two or more individuals practising in partnership and:
- the conditions in Section 86(2) of the Act are no longer satisfied
- the partnership is dissolved.

iv) a member is a company limited by shares and:

[19] See section 14A (4) of the 2006 Act, inserted by section 25 of the 2012. Regulations to be made

- in respect of that company any one of the following occurs:

  - the conditions in Section 86(3) of the Act are no longer satisfied
  - a resolution is passed for voluntary winding up by reason of insolvency
  - a winding up order is granted
  - a resolution by its directors or members is passed to apply for an administration order
  - an administrator is appointed under the Insolvency Act 1986
  - a receiver or an administrative receiver is appointed over any of its assets or income
  - a statutory demand is issued under the Insolvency Act 1986 which is not discharged before it is advertised
  - it is unable to pay its debts as they fall due as determined by section 123 of the Insolvency Act 1986.

- if the member operates under an Alternative Provider Medical Services (APMS) contract and any of the relevant termination provisions apply:

  - NHS England removes a member of the CCG in accordance with the Act;
  - that practice merges with any other practice, unless that other practice is an existing member.

v) if the member practice ceases to be eligible for membership
vi) if a member practice no longer holds a primary medical services contract.

b) Membership of the CCG is not transferable.

3.2. The Group's Commissioning Functions & Discharge of Functions

3.2.1. Commissioning Functions

CCGs have a range of functions which they are legally responsible to exercise. These functions are made up of statutory duties and statutory powers. The statutory powers allow CCGs the freedom to shape the way it meets its statutory duties.

The functions of the Group arrange for the provision of services as part of the health service.

The commissioning 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 *The Functions of Clinical Commissioning Groups,* 12 June 2012.

They relate to:

i) 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;

ii) commissioning emergency care for anyone present in the Group's area;

iii) paying its employees' remuneration, fees and allowances in accordance with the determinations made by its Governing Body and determining any other terms and conditions of service of the Group's employees;

iv) determining the remuneration and travelling or other allowances of members of its Governing Body.

3.2.2. Discharge of Statutory Functions

In order to exercise the statutory functions outlined in 3.2.1, the Group will:

i) act,[20] 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,***[21] and with the objectives and requirements placed on NHS England through *the mandate*[22] published by the Secretary of State before the start of each financial year by:

- establishing a Governing Body, and committees of the Governing Body;
- drawing up a Scheme of Reservation and Delegation and Prime Financial Policies to make clear the delegated accountability to the Governing Body, Committees and Executive Management;
- developing and sharing an annual commissioning plan (as a minimum in draft form) prior to the start of each financial year with member practices in accordance with the Act, the NHS England Mandate, Central Manchester's Joint Strategic Needs Assessment, the Joint Health and Wellbeing strategy and other relevant guidance;
- making the commissioning plan available to the public by publishing it on the CCG's website;
- implementing and monitoring delivery through Governing Body committees to the Governing Body through governance and reporting arrangements.

ii) ***meet the public sector equality duty***[23] by:

- delegating the responsibility to implement and deliver the Equality Strategy and the Action Plan to the Accountable Officer, who has the lead responsibility for discharging the public sector Equality Sector Duty;
- requiring the Accountable Officer to support the process of monitoring progress, by ensuring the strategy adopts and effectively uses the Equality Delivery System (EDS) toolkit to deliver this duty through committees with specific and measurable objectives;
- requiring the Accountable Officer to ensure the strategy follows best practice guidance issued by the Equality and Diversity Council (EDC) and ensuring equality objectives are set at least every four years;
- requiring the Governing Body to approve the plan and to monitor its implementation and these arrangements annually;
- publishing annually a report to demonstrate compliance with this general duty across all functions;
- working in partnership with patients, public and staff to raise awareness of and promote the positive aspects of diversity and inclusion;
- ensuring that equality is embedded into the CCG culture and that it is incorporated in its values, processes and behaviours;

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

- undertaking and publishing on its website Equality Impact Assessments (EIA) on all plans, service changes and policy;

- ensuring the CCG website includes Equality & Diversity.

iii) work in partnership with its local authority to develop ***joint strategic needs assessments***[24] and ***joint health and wellbeing strategies***[25] by:

- being active and committed representatives on the Manchester Health and Wellbeing Board where we will:

  - promote integration and partnership, and promote joined up commissioning plans across the NHS, social care and public health;
  - support commissioning and pooled budget arrangements;
  - promote partnership working and integrated delivery of public services across the NHS, social care, public health and other services;
  - fulfilling our duty to consult/inform the Overview & Scrutiny Committee where required.

- working in partnership with Manchester City Council (MCC) in the development of the Joint Strategic Needs Assessment (JSNA), through the steering group and on a strategic level through the Health and Wellbeing Board.

[24] See section 116 of the Local Government and Public Involvement in Health Act 2007, as amended by section 192 of the 2012 Act
[25] See section 116A of the Local Government and Public Involvement in Health Act 2007, as inserted by section 191 of the 2012 Act

3.2.3. General Duties in Discharging its Functions

Further discharge of the Group's statutory functions will:

a) Make arrangements to ***secure public involvement*** in the planning, development and consideration of proposals for changes and decisions affecting the operation of commissioning arrangements[26] by:

i) following and adhering to the Statement of Principles:

- to effectively communicate and engage with local communities to achieve our vision to improve health and health services in Central Manchester;
- to ensure our vision and priorities are conveyed, shaped and implemented through an ongoing relationship with all our stakeholders and within a culture of sustained partnerships, dialogue, openness and responsiveness;
- this requires that we can understand and act on what really matters to people and bring them with us as active partners in decisions about their health and health services.

ii) delivering the above statement using the voice of patients and their communities which will inform:

- our quality improvement work by contributing towards needs assessments, strategy development and service redesign;
- our quality assurance work by highlighting patient, carer and community experience to inform our monitoring and evaluation of existing services, care pathways, providers and healthcare interventions.

We will ensure that:

- a visible commitment is made to fully engage with patients and the public, supported with available resources;
- patient, public involvement and patient experience is valued and local people's views have an identifiable impact on our decision making;
- barriers to involvement are reduced;
- our patient and public engagement mechanisms and methods are sufficiently varied to meet the needs of our diverse population.

iii) monitoring and reporting compliance against these statement of principles through:

- our Patient and Public Advisory Group;
- our Governance Committee; and
- our Board.

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

Our Clinical Reform and Redesign Committee will ensure that patients and the public views drive our service redesign work and our Quality & Performance Committee will consider patient experience alongside safety and effectiveness metrics to assess the quality of local services.

b) ***Promote awareness of, and act with a view to ensuring that health services are provided in a way that promotes awareness of, and have regard to the NHS Constitution***[27] by:

i) promoting the principles in the NHS Constitution within our organisation and making clear employees' duties to uphold it;

ii) cross-referencing our commissioning and operational planning to the NHS Constitution;

iii) actively promoting the NHS Constitution via the Group's website, and in our engagement with the public, providers of services, patients and other key stakeholders;

iv) measuring and reporting local health services against the commitments within the NHS Constitution to the Governing Body;

v) requiring progress of delivery of this duty to be monitored through various Governing Body committees and sub-committees to the Board.

c) Act ***effectively, efficiently and economically***[28] by:

i) meeting the statutory obligations of operating separate Audit and Remuneration Committees as committees of the Group;

ii) ensuring the Group operates within the corporate governance framework (Standing Orders, the Scheme of Reservation & Delegation and Prime Financial Policies);

iii) implementing the QIPP (Quality, Innovation, Productivity & Prevention) approach towards commissioning within our financial challenges as outlined in the Financial Development Plan and Operational Plan to ensure we keep within our running cost allowances.

iv) reporting and proactively managing the NHS CMCCG's financial, performance, QIPP and risk sharing arrangements through the Finance & Contracting Committee and Governance Committee;

d) Act with a view to ***securing continuous improvement to the quality of services***[29] by:

i) embedding quality in the culture of the organisation through its mission;

ii) specifically writing quality into the roles of Governing Body members;

iii) establishing robust governance arrangements through the Governance Committee, that places an emphasis on assuring the Group of the quality and safety of services that it commissions;

iv) delegating the responsibility of monitoring quality to the Clinical Quality & Performance Committee. The Group will ensure effective measurement of quality

[27] 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)
[28] See section 14Q of the 2006 Act, inserted by section 26 of the 2012 Act
[29] See section 14R of the 2006 Act, inserted by section 26 of the 2012 Act

and working with provider organisations through leveraging quality and patient experience systems (e.g. CQUIN, Advancing Quality and PROMS), contract monitoring, and delivery of the EDS toolkit to ensure maximum patient benefit, in an integrated health economy approach;

v) putting in place performance management systems that assess quality, patient safety processes, patient complaints, trends and acting on information;

vi) working jointly with other commissioning organisations to ensure continuous improvement in the quality of the system wide services;

vii) regularly reporting to the National Reporting and Learning System;

viii) ensuring this duty is discharged in line with the Terms of Reference laid out for the Clinical Quality & Performance Committee.

e) Assist and support NHS England in relation to its duty to ***improve the quality of primary medical services***[30] by:

i) supporting practices by encouraging member practices to share clinical best practice in locality meetings;

ii) delegating this responsibility to the Clinical Reform and Redesign Committee, and Clinical Quality & Performance Committee;

iii) delivering/adhering with the terms of reference for these groups;

iv) monitoring progress of the delivery of this duty through these committees.

f) Assist and support NHS England in its responsibility to ***improve the quality of specialised services*** by:

i) forming collaborative arrangements with Greater Manchester CCGs to have a formal dialogue with the local office of NHS England;

ii) ensuring effective reporting and monitoring through the Clinical Reform and Redesign Committee, Finance & Contracting Committee, as well as the Executive Team and Governing Body.

g) Have regard to the need to ***reduce inequalities***[31] by:

i) delivering the three main strands of the Commissioning Strategy:

- service reform and integrated care to ensure people get effective care at the right time;
- quality of care to ensure the best evidence based interventions are made;
- public health, prevention and partnerships to promote health lifestyles and early identification of ill health.

ii) introducing a Memorandum of Understanding between the CCG and Public Health Team within Manchester City Council which includes actions to tackle inequalities through City-Wide Teams;

iii) focusing upon the key areas of ill health and causes of shortened life expectancy;

[30] See section 14S of the 2006 Act, inserted by section 26 of the 2012 Act
[31] See section 14T of the 2006 Act, inserted by section 26 of the 2012 Act

iv) having specific committees and lead roles focused upon these areas with accountability through to the Governing Body;

v) measuring progress against key indicators related to life expectancy, identification of chronic disease and achievement of quality indicators;

vi) delivering the requirements of the EDS toolkit.

h) ***Promote the involvement of patients, their carers and representatives in decisions about their healthcare***[32] by:

i) ensuring that the NHS Constitution is widely and freely available to the public, communities, patients and carers through the CCG website, member practices and patient participation groups;

ii) entering into partnership with local people. Working in a collaborative way to help inform, inspire and enable people to make healthier choices in their daily lives;

iii) complying with the NHS England guidance to ensure that patients, and their carers or representatives are fully involved in decisions about their own care, actively managing their health and working with clinicians to decide on the best care and treatment;

iv) involving patients in this way can reduce the impact of disease and improve outcomes, whilst also ensuring that services are accessed appropriately.

We will deliver this by:

- promoting the involvement of patients and carers across the health and social care economy through the Clinical Integrated Care Board;
- using our contracts with providers to ensure that they work in partnership with patients;
- reviewing and improving the provision of patient education and self management initiatives in Central Manchester;
- publishing information on our website and in our annual plans which will identify how the group has acted as a result of all feedback.

i) Act with a view to ***enabling patients to make choices***[33] by:

i) ensuring that patients are informed about the options they have so they can be fully involved in managing their care;

ii) ensuring patients are empowered to make choices about how their health is managed;

We will support local people and carers to exercise choice by:

- improving the information available to local people about available treatments and services, using our website to promote links to services such as NHS Choices;
- using the referral gateway to offer a choice of provider to patients who require hospital care;

[32] See section 14U of the 2006 Act, inserted by section 26 of the 2012 Act
[33] See section 14V of the 2006 Act, inserted by section 26 of the 2012 Act

- learning lessons from the Personal Health Budgets Continuing Care pilot implementing them in other areas if appropriate;
- promoting results of PROMS data to local clinicians, enabling them to have better informed discussions with patients about treatment options.

j) ***Obtain appropriate advice***[34] from persons who, taken together, have a broad range of professional expertise in healthcare and public health by:

i) taking advice and guidance from local professional groups when commissioning for the community and voluntary sector, primary and secondary services;

ii) working through the Clinical Integrated Care Board (CICB) and its sub-committees to ensure a broader input into commissioning plans and service models;

iii) working with Public Health Manchester to ensure evidence based interventions are incorporated into our service redesign, clinical senates and strategic clinical networks as they become established;

iv) complying with board membership to include GP representation, a secondary care doctor and a registered nurse. A dedicated public health consultant will also sit in attendance;

v) discharging this function to the Clinical Quality and Performance Committee, and Clinical Reform and Redesign Committee which will both be led by the Clinical Director.

k) ***Promote innovation***[35] by:

i) allocating funding for practice and locality level innovation and projects;

ii) forging links with local universities and other academic institutions;

iii) forging links with national organisations promoting innovations in healthcare;

iv) promoting/building within the culture of the organisation a desire to innovate via the Clinical Reform and Redesign Committee and Clinical Integrated Care Board.

l) ***Promote research and the use of research***[36] by:

i) assessing best practice and research findings and incorporating into service redesign and specifications;

ii) forging links with local universities and other academic institutions;

iii) forging links with national organisations promoting innovations in healthcare.

m) Have regard to the need to ***promote education and training***[37] 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[38] by:

i) having Locality Chairs in post to capture, influence and coordinate education and training in primary care;

[34] See section 14W of the 2006 Act, inserted by section 26 of the 2012 Act
[35] See section 14X of the 2006 Act, inserted by section 26 of the 2012 Act
[36] See section 14Y of the 2006 Act, inserted by section 26 of the 2012 Act
[37] See section 14Z of the 2006 Act, inserted by section 26 of the 2012 Act
[38] See section 1F(1) of the 2006 Act, inserted by section 7 of the 2012 Act

ii) having structures in place to engage with providers about implementing the CCG's Commissioning Strategy and Operational Plans;

iii) monitoring the progress of delivery through the Group's Clinical Quality and Performance Committee.

n) 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[39] by:

i) working through the Clinical Integrated Care Board, a multi agency board including health and social care;

ii) delivering one of the three priority work streams within our Commissioning Strategy which is focused on integrating care.

[39] See section 14Z1 of the 2006 Act, inserted by section 26 of the 2012 Act

3.2.4. General Financial Duties – the Group will perform its functions so as to:

a) ***Ensure its expenditure does not exceed the aggregate of its allotments for the financial year***[40] by:

i) keeping accurate accounts;

ii) supporting member practices to achieve balanced budgets;

iii) managing our resources effectively;

iv) delegating responsibility to:

- the Group's 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).

v) requiring progress of the delivery of the duty to be monitored through the Group's Finance & Contracting Committee.

b) ***Ensure its use of resources*** *(both its capital resource use and revenue resource use)* ***does not exceed the amount specified by NHS England for the financial year***[41] by:

i) sharing information between practices;

ii) providing support with managing areas including referrals, prescribing, LINk, PPAG and locality meetings;

iii) using our performance dashboard;

iv) monitoring practices to ensure they take ownership of their budgets;

v) delegating responsibility to:

- the Group's 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).

vi) requiring progress of the delivery of the duty to be monitored through the Group's Finance & Contracting Committee[46] mechanism.

c) ***Take account of any directions issued by NHS England, in respect of specified types of resource use in a financial year, to ensure the Group does not exceed an amount specified by NHS England***[42] by:

i) having in place contingency funds;

ii) effectively managing budgets;

iii) delegating responsibility to:

- the Group's Governing Body, or
- a committee or sub-committee of the Group, or

[40] See section 223H(1) of the 2006 Act, inserted by section 27 of the 2012 Act
[41] See sections 223I(2) and 223I(3) of the 2006 Act, inserted by section 27 of the 2012 Act
[42] See section 223J of the 2006 Act, inserted by section 27 of the 2012 Act

- an individual with lead responsibility to oversee its discharge (i.e. Accountable Officer, member or employee).

iv) requiring progress of the delivery of the duty to be monitored through the Group's Finance and Contracting Committee mechanism.

d) ***Publish an explanation of how the Group spent any payment in respect of quality*** made to it by NHS England[43] by:

i) delegating responsibility to:

- the Group's 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).

ii) requiring progress of the delivery of the duty to be monitored through the Group's reporting mechanisms – Finance and Contracting Committee.

3.2.5. Other Relevant Regulations, Directions and Documents

a) The Group will:

i) comply with all relevant regulations;

ii) comply with directions issued by the Secretary of State for Health or NHS England; and

iii) take account, as appropriate, of documents issued by NHS England.

b) 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.

3.3. Decision Making of the Group

3.3.1. Authority to Act

a) NHS Central Manchester Clinical Commissioning Group is accountable for exercising the statutory functions of the Group. It may grant authority to act on its behalf to:

i) any of its members of the Group or of the Group's committees;

ii) its Governing Body or members of its committees or sub-committees;

iii) employees.

b) 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:

i) the Group's Scheme of Reservation and Delegation; and

ii) for committees, their terms of reference.

[43] See section 223K(7) of the 2006 Act, inserted by section 27 of the 2012 Act

3.3.2. Scheme of Reservation & Delegation[44]

a) The Group's Scheme of Reservation and Delegation sets out:

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

ii) those decisions that are the responsibilities of its Governing Body (and its committees), the Group's committees and sub-committees, individual members and employees.

b) NHS CMCCG remains accountable for all of its functions, including those that it has delegated.

3.3.3. Committees of the Group

a) The Governing Body on behalf of the Group may appoint other committees of the Group as it considers may be appropriate and delegate to them the exercise of any functions of the Group which in its discretion it considers to be appropriate except insofar as this Constitution has reserved or delegated the exercise of the Group's functions to its members, employees or a committee or sub-committee of the Group or Governing Body.

b) A committee of the Group may consist of or include persons other than members or employees of the Group.

c) A committee of the CCG can include a joint committee of the CCG and one or more other clinical commissioning groups and/or one or more local authorities and/or NHS England.

Name	Type	Accountable to
Citywide Joint Clinical Commissioning Committee	Joint Committee	3 Manchester CCG Boards
Greater Manchester Healthier Together Joint Committee	Joint Committee	12 Greater Manchester CCG Boards

1) Citywide Joint Clinical Commissioning Committee

The Citywide Joint Clinical Commissioning Committee holds a strategic role to ensure that strategies across all jointly commissioned services are delivered and patient safety and quality of care is maintained throughout all commissioning arrangements. Jointly commissioned services include mental health, continuing healthcare, children's and specialised commissioning.

2) Greater Manchester Healthier Together Joint Committee

The Greater Manchester CCGs have established an association of them known as the Association of Greater Manchester Clinical Commissioning Groups (Association). The CCG members who are voting members of the Committee have decided to work together on the Healthier Together programme. To this end, the CCGs have agreed to establish a Joint Committee which shall be responsible for the more significant (Level B) decision making in relation to the Healthier Together programme.

[44] Appendix G, Scheme of Reservation and Delegation

d) Committees will only be able to establish their own sub-committees, to assist them in discharging their respective responsibilities, if this responsibility has been delegated to them by the Governing Body on behalf of the Group or the committee they are accountable to.

e) All decisions taken in good faith at a meeting of any committee or sub-committee shall be valid even if there is any vacancy in its membership or it is discovered subsequently that there was a defect in the calling of the meeting, or the appointment of a member attending the meeting.

3.3.4. Joint commissioning arrangements with other Clinical Commissioning Groups

a) The Group may work together with other Clinical Commissioning Groups in the exercise of its commissioning functions.

b) The Group may make arrangements with one or more Clinical Commissioning Groups in respect of:

i) Delegating any of the Group's commissioning functions to another Clinical Commissioning Group;
ii) Exercising any of the commissioning functions of another Clinical Commissioning Group; or
iii) Exercising jointly the commissioning functions of the Group and another Clinical Commissioning Group.

c) For the purposes of the arrangements described at paragraph 3.3.4b, the Group may:

i) Make payments to another Clinical Commissioning Group;
ii) Receive payments from another Clinical Commissioning Group; or
iii) Make the services of its employees or the resources made available to another Clinical Commissioning Group;
iv) Receive the services of the employees or the resources made available by another Clinical Commissioning Group.

d) Where the Group makes arrangements with one or more Clinical Commissioning Groups which involve all of the Clinical Commissioning Groups exercising any of their commissioning functions jointly, a joint committee may be established to exercise those functions.

e) For the purposes of the arrangements described at paragraph 3.3.4b above, the Group may establish and maintain a pooled fund made up of contributions by all of the Clinical Commissioning Groups working together pursuant to paragraph 3.3.4biii 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.

f) Where the Group makes arrangements with one or more other Clinical Commissioning Groups as described at paragraph 3.3.4b above, the Group shall develop and agree with that Clinical Commissioning Group/those Clinical Commissioning Groups 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.

g) Arrangements made pursuant to paragraph 3.3.4b above do not affect the liability of the Group for the exercise of any of its functions.

h) The Group will act in accordance with any further guidance issued by NHS England on co-commissioning.

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

j) The governing board 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.

k) 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.

l) The Group has entered into joint arrangements with NHS North Manchester and NHS South Manchester to commission city-wide services and share some support functions. The three CCGs will meet as a forum.

i) The purpose of the forum is:

- to provide a means of discussion and an arena for managing the Manchester City-Wide Teams that the CCGs have agreed to share;
- to discuss any matters relating to the Manchester City-Wide Teams as deemed necessary;
- to act as a forum for discussion of issues between the three Manchester CCGs, requiring agreement by the three organisations or as agreed by the joint Chairs.

ii) The arrangements of this joint arrangement are outlined in detail in the Memorandum of Understanding[45]

iii) NHS CMCCG may leave the arrangement to enter new shared arrangements via Board decision.

3.3.5. Joint commissioning arrangements with NHS England for the exercise of Clinical Commissioning Group functions

a) The Group may work together with NHS England in the exercise of its commissioning functions.

b) The Group and NHS England may make arrangements to exercise any of the Group's commissioning functions jointly.

[45] Appendix I, Manchester CCG's: Memorandum of Understanding

c) The arrangements referred to in paragraph 3.3.5b above may include other Clinical Commissioning Groups.

d) Where joint commissioning arrangements are entered into pursuant to paragraph 3.3.5b above, the parties may establish a joint committee to exercise the commissioning function in question.

e) Arrangements made pursuant to paragraph 3.3.5b above may be on such terms and conditions (including terms as to payment) as may be agreed between NHS England and the Group.

f) Where the Group makes arrangements with NHS England (and one or more other Clinical Commissioning Groups if relevant) as described at paragraph 3.3.5b above, the Group 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.

g) Arrangements made pursuant to paragraph 3.3.5b above do not affect the liability of the Group for the exercise of any of its functions.

h) The Group will act in accordance with any further guidance issued by NHS England on co-commissioning.

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

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

k) 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.

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

a) The Group may work with NHS England and, where applicable, other Clinical Commissioning Groups, to exercise specified NHS England Board functions.

b) The Group may enter into arrangements with NHS England and, where applicable, other Clinical Commissioning Groups, to:

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

c) Where arrangements are made for the Group and, where applicable, other Clinical Commissioning Groups to exercise functions jointly with NHS England, a joint committee may be established to exercise the functions in questions.

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

e) For the purposes of the arrangements described at paragraph 3.3.6b above, NHS England and the Group may establish and maintain a pooled fund made up of contributions by all 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.

f) Where the Group enters into arrangements with NHS England as described at paragraph 3.3.6b 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, 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.

g) Arrangements made pursuant to paragraph 3.3.6b above do not affect the liability of NHS England for the exercise of any of its functions.

h) The Group will act in accordance with any further guidance issued by NHS England on co-commissioning.

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

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

k) 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.

3.3.7. Joint commissioning arrangements with local authorities

a) The Group may enter into joint commissioning arrangements with one or more local authorities pursuant to Section 75 of the 2006 Act.

3.3.8. Committee Compliance for the Discharge of Functions

a) In discharging the functions of the Group that have been delegated to its Governing Body, committees, joint committees, sub-committees and individuals; each must:

i) comply with the Group's principles of good governance;[46]

ii) operate in accordance with the Group's Scheme of Reservation and Delegation;[47]

iii) comply with the Group's Standing Orders;[48]

iv) comply with the Group's arrangements for discharging its statutory duties;[49]

v) where appropriate, ensure that member practices have had the opportunity to contribute to the Group's decision making process.

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

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

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

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

iii) specify under which clinical commissioning group's Scheme of Reservation and Delegation and supporting policies the collaborative working arrangements will operate;

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

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

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

3.4. Standards of Business Conduct and Managing Conflicts of Interest

3.4.1. Standards of Business Conduct

a) Employees; members of the Group and its committees (as defined in 3.3.3); and members of the Governing Body and its committees (as defined in 4.3.1) 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 D.

[46] See section 2.4 on Principles of Good Governance
[47] Appendix G, Scheme of Reservation & Delegation
[48] Appendix F, Standing Orders
[49] See section 3.2

b) They must comply with the Group's Conflict of Interest Policy, including the requirements outlined in 3.4.2. The CCG shall have regard to guidance published by NHS England on the discharge of CCG functions in respect of conflicts of interest.

This policy is available on the Group's website at:
https://www.centralmanchesterccg.nhs.uk/our-policies

c) 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.

3.4.2. Conflicts of Interest

a) 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.

b) Where an individual, i.e. an employee; member of the Group or of its committees; or member of the Governing Body or of its committees 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.

c) A conflict of interest will include:

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

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

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

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

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

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

3.4.3. Declaring and Registering Interests

a) The Group will maintain one or more registers of the interests of:

i) the members of the Group and of its committees;

ii) the members of its Governing Body and of its committees;

iii) its employees.

b) The registers can be accessed in the following ways:

- on the Group's website at: https://www.centralmanchesterccg.nhs.uk/publications
- upon application for receipt by post:

  NHS Central Manchester Clinical Commissioning Group
  2nd Floor, Parkway 1
  Parkway Business Centre
  Princess Road
  Manchester
  M14 7LU
- Via 'Contact us' on the CCG Website - www.centralmanchesterccg.nhs.uk/contact-us

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

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

e) The Accountable Officer will ensure that the register of interest is reviewed regularly, and updated as necessary.

3.4.4. Transparency in Procuring Services

a) 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.

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

i) 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;

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

iii) the Managing Conflicts of Interest "Code of Conduct", published by NHS England, is taken into consideration. This document provides advice and guidance in respect to additional safeguards when commissioning services from GP practices or GP provider consortia.[50]

c) Copies of this Procurement Strategy are available:

from the Group's website at:

- https://www.centralmanchesterccg.nhs.uk/our-policies
- upon application for receipt by post:

  NHS Central Manchester Clinical Commissioning Group
  2nd Floor, Parkway 1
  Parkway Business Centre
  Princess Road
  Manchester
  M14 7LU

- Via 'Contact us' on the CCG Website - www.centralmanchesterccg.nhs.uk/contact-us

3.5. The Group as Employer

3.5.1. 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.

3.5.2. 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.

3.5.3. 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.

3.5.4. 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.

3.5.5. 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.

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

3.5.7. The Group will ensure that it complies with all aspects of employment law.

[50] Code of Conduct: Managing Conflicts of Interest where GP practices are potential providers of CCG commissioned services http://www.commissioningboard.nhs.uk/resources/resources-for-ccgs/

3.5.8. 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.

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

3.5.10. 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.

3.5.11. Copies of this Code of Conduct, together with the other policies and procedures outlined in this chapter, are available:
from the Group's website at:

- https://www.centralmanchesterccg.nhs.uk/our-policies
- upon application for receipt by post:
  NHS Central Manchester Clinical Commissioning Group
  2nd Floor, Parkway 1
  Parkway Business Centre
  Princess Road
  Manchester
  M14 7LU
- Via 'Contact us' on the CCG Website - www.centralmanchesterccg.nhs.uk/contact-us

3.6. Transparency, Ways of Working and Standing Orders

3.6.1. General

a) The Group will publish annually a commissioning plan and an annual report, and present the Group's annual report at a public meeting.

b) Key communications issued by the Group, including the notices of procurements, public consultations, Governing Body meeting dates, times, venues, and certain papers are published:

- on the Group's website at: https://www.centralmanchesterccg.nhs.uk/
- upon application for receipt by post:
  NHS Central Manchester Clinical Commissioning Group
  2nd Floor, Parkway 3
  Parkway Business Centre
  Princess Road
  Manchester
  M14 7LU
- Via 'Contact us' on the CCG Website - www.centralmanchesterccg.nhs.uk/contact-us

3.6.2. Standing Orders

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

a) ***Standing Orders (Appendix F)*** – which sets out the arrangements for meetings and the appointment processes to elect the Group's representatives and appoint to the Group's committees, including the Governing Body;

b) ***Scheme of Reservation and Delegation (Appendix G)*** – which sets out those decisions that are reserved for the membership as a whole and those decisions that are the responsibilities of the Group's Governing Body, the Governing Body's committees and sub-committees, the Group's committees, individual members and employees;

c) ***Prime Financial Policies (Appendix H)*** – which sets out the arrangements for managing the Group's financial affairs.

4. THE GOVERNING BODY (the Board)

4.1. Composition of the Governing Body

4.1.1. Overview

The Governing Body, also referred to as the Board, shall not have less than the statutory posts required in the regulations and indicated in the table below. The Board will not include individuals who are not eligible to be members of the Governing Body as identified in the governance regulations. The Governing Body comprises of:

Post	Appointed/Elected	Statutory Post
a) the Chair	Elected Member	✓
b) the Vice Chair*		✓
c) a Clinical Director	Elected Member	
d) x4 Locality Members	Elected Member	
e) x1 Practice Manager for Practice Management Development and Delivery	Elected Member	
f) x2 Lay Members (*one of whom will fulfil the Vice Chair post) • one to lead on audit, remuneration and conflict of interest matters, • one to lead on patient and public participation matters.	Appointed Non-Executive post	✓
g) Additional Lay Member for Finance	Appointed Non-Executive post	
h) x1 Registered Nurse	Appointed Non-Executive post	✓
i) x1 Secondary Care Specialist Doctor	Appointed Non-Executive post	✓
j) the Accountable Officer	Appointed Executive post	✓
k) a Chief Finance Officer who will hold a joint position across all 3 Manchester CCG's	Appointed Executive post	✓

The Board structure may be changed with the exception of statutory posts.

4.1.2. Roles & Responsibilities

a) **All members of the Governing Body**

Guidance on the roles of members of the Group's Governing Body is set out in a separate document.[51] In summary, each member of the Governing Body should share responsibility as part of a team to ensure that the Group exercises its functions effectively, efficiently and economically, with good governance and in accordance with the terms of this constitution. Each brings their unique perspective, informed by their expertise and experience. A summary of the roles of all statutory posts are detailed below. Role descriptions of locality members are detailed in section 6.1.

b) **The Chair of the Governing Body**

The Chair of the Board is responsible for:

- Overall clinical leadership of the Group and the Board;
- Strategic oversight of the organisation from a clinical perspective;
- Engagement with practices in commissioning;
- Working with CMCCG's key partners and stakeholders;
- Strategic leadership of the annual and long term strategic plans (QIPP);
- Leading decision making;
- To ensure good governance of the organisation.

This list is an overview as the role will need to be flexible as policy emerges and the new organisation evolves its way of working. The Chair may need to adapt their role to ensure the CCG optimises its delivery of its commissioning duties.

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

c) **The Vice Chair of the Governing Body**

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

The Vice Chair will be a lay person who will be elected by the Board.

d) **Role of the Accountable Officer**

The Accountable Officer of the Group is a member of the Governing Body and has been summarised in a national document[54] as:

- 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;

- At all times ensuring that the regularity and propriety of expenditure is discharged, and that arrangements are put in place to ensure that good practice

[51] See the latest version of the NHS Commissioning Governing body Authority's *Clinical Commissioning Group Governing Body Members: Role outlines, attributes and skills*

(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;

- Working closely with the Chair of the Governing Body, the Accountable Officer will ensure that proper constitutional and development arrangements are put in place to assure the members (through the Governing Body) of the organisation's ongoing capability and capacity to meet its duties and responsibilities. This will include arrangements for the ongoing developments of its members and staff.

e) **Joint Appointments with other Organisations – Chief Finance Officer**

The Group has the following joint appointment with NHS North and NHS South Manchester Clinical Commissioning Groups.

The joint appointment is supported by a Memorandum of Understanding between the organisations who are party to these joint appointments.

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

The role of the Chief Finance Officer has been summarised in a national document[52] as:

- Being the Governing Body's professional expert on finance and ensuring, through robust systems and processes, the regularity and propriety of expenditure is fully discharged;
- Making appropriate arrangements to support and monitor the Group's finances;
- Overseeing robust audit and governance arrangements leading to propriety in the use of the Group's resources;
- Being able to advise the Governing Body on the effective, efficient and economic use of the Group's allocation to remain within that allocation and deliver required financial targets and duties; and
- 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) **Lay Member (Governance Lead)**

- Oversee key elements of governance, including audit, remuneration and managing conflicts of interest;
- Chairing the CCG's Audit Committee;
- Ensuring that the governing body and the wider CCG behave with the utmost probity at all times;
- Ensuring that appropriate and effective whistle-blowing and anti-fraud systems are in place.

g) **Lay Member (Patient and Public Involvement Lead)**

- Ensures that the CCG considers the public voice of the local population and that the CCG engages with patients and public in the work that it is responsible for;

[52] See the latest version of the NHS Commissioning Governing body Authority's *Clinical Commissioning Group Governing Body Members: Role outlines, attributes and skills*

- Chairing the Patient and Public Advisory Group;
- Ensuring that the governing body and the wider CCG behave with the utmost probity at all times.

h) **Lay Member (Finance Lead)**

- Oversee key elements of finance, including identification and mitigation of financial risks, and the assessment of value for money in all investment decisions;
- Chairing the CCC's Finance & Contracting Committee;
- Ensuring that the governing body and the wider CCG behave with the utmost probity at all times.

i) **Registered Nurse**

- Bring a nursing perspective into the commissioning decision making process;
- Hold a scrutiny role relating to clinical governance and safeguarding;
- Support the development of a culture of quality in provision and commissioning.

j) **Clinical Director**

- Strategic lead for clinical commissioning, clinical governance, quality and education;
- Lead role in the Clinical Integrated Care Board's work programme and chair some of the Boards sitting underneath;
- Deputy for the Chair in executive functions and clinical matters.

k) **Practice Development and Delivery Board Member**

- Ensure delivery of commissioning priorities within General Practice;
- Act as champion for IM&T, ensuring the view of practices and patients are considered in the development and delivery of the IM&T Strategy;
- Set the strategic direction for development of practice management and organisational development with regard to commissioning and education;
- Support the CCG in the delivery of effective contract and finance management.

l) **Secondary Care Specialist Doctor**

- Bring a perspective of secondary care to commissioning decisions;
- Provide an understanding of how secondary care providers work within the health system;
- Hold a scrutiny role relating to clinical governance and safeguarding;
- Support the development of a culture of quality in provision and commissioning.

4.2. Functions of the Governing Body

The Governing Body has the following functions conferred on it by sections 14L(2) and (3) of the 2006 Act, inserted by section 25 the 2012 Act, together with any other functions connected with its main functions as may be specified in regulations or in this constitution.[53]

The Governing Body may also have functions of the clinical commissioning group delegated to it by the Group. Where the Group has conferred additional functions on the Governing Body connected with its main functions, or has delegated any of the Group's functions to its Governing Body, these are set out from paragraph 6.6.1(d) below. The Governing Body has responsibility for:

a) Assuring delivery and governance

i) ensuring that the Group has appropriate arrangements in place to exercise its functions *effectively, efficiently and economically* and in accordance with the Group's *principles of good governance*[54] (its main function);
ii) ensuring delivery of the long term strategy and the annual commissioning plan;
iii) ensuring delivery of all statutory duties including public engagement, financial balance and meeting core targets;
iv) ensuring delivery by localities and practices and holding to account where necessary;
v) accountability for safety, quality, access and responsiveness of services commissioning by the CCG;

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

c) approving any functions of the Group that are specified in regulations;[55]

d) setting strategy and shaping culture:

i) developing a vision for the organisation;
ii) leading by example;
iii) developing the NHS CMCCG strategy based upon the JSNA, HWB strategy, practice views, patient and public views, and the views of the partners and shareholders;
iv) development with practitioners, practices and localities to ensure grass roots clinical commissioning;
v) develop proactive relationships with partners and stakeholders.

e) making decisions

i) make decisions according to the Scheme of Reservation and Delegation, to seek approval from the Group for significant decisions and to enable sub-board and locality decision making;
ii) to arbitrate where decisions cannot be reached at a sub-board level.

[53] See section 14L(3)(c) of the 2006 Act, as inserted by section 25 of the 2012 Act
[54] See section 2.4 on Principles of Good Governance
[55] See section 14L(5) of the 2006 Act, inserted by section 25 of the 2012 Act

f) exercising any other functions of the Group which are not otherwise reserved or delegated.

4.3. Decision Making of the Governing Body (the Board)

4.3.1. Committees of the Governing Body

	Name	Type	Accountable to
1	Finance & Contracting	Committee	Board
2	Governance	Committee	Board
3	Clinical Reform & Redesign	Committee	Board
4	Clinical Quality & Performance	Committee	Board
5	Executive Team	Committee	Board
6	Audit	Committee	Board
7	Remuneration	Committee	Board
8	Primary Care Commissioning	Committee	Board

The Governing Body may appoint such other committees as it considers may be appropriate. A committee of the Governing Body may consist of or include individuals other than members or employees of the Group.

The audit committee may include individuals who are not members of the Governing Body. Other committees of the Governing Body may include individuals who are:

a) Members, officers of governing body members of the Group or another clinical commissioning group;

b) Partners or employees of Members of the Group or another clinical commissioning group; and

c) Officers of NHS England.

The Board may at any point disestablish any committee with the exception of statutory committees (Audit Committee and Remuneration Committee).

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

The Governing Body has appointed the following committees. These committees are accountable to the Board. The Governing Body has approved and keeps under review the terms of reference for these committees which also include information about its membership:

1) **Finance & Contracting Committee**
This committee ensures that all issues relating to finance, contracting information and performance relevant to NHS Central Manchester CCG are discussed and key actions and recommendations reported to the Board.

2) **Governance Committee**
This committee is responsible for giving assurance to the Board that the organisation is well run and its key areas of risks are known and managed sufficiently.

In addition, the Group has conferred/delegated the following functions, connected with the Governing Body's main function to the sub-committee of this group known as the Integrated Governance Group. The committee acts as the operational arm of the Governance Committee which will undertake detailed work relating to governance. This group is shared with NHS North and NHS South CCGs due to the overlapping areas of responsibility and provider organisations.

3) **Clinical Reform & Redesign Committee**
This committee is responsible for overseeing work relating to service improvement and commissioning within Central Manchester.

4) **Clinical Quality & Performance Committee**
This committee is responsible for promoting a culture of quality within Central Manchester as a means by which the Group's strategic objects are met.

5) **Executive Team**
The Executive Team is responsible for the operational delivery of organisational objectives and the effective running of the organisation. They will also advise and support the Board in setting strategic direction and decision making in line with the Scheme of Reservation and Delegation.

6) **Audit Committee**
The Audit Committee provides the Governing Body 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.

7) **Remuneration Committee**
The Remuneration Committee makes recommendations to the Governing Body on determinations about the pay and remuneration, fees and other allowances for employees and for people who provide services to the Group and on determinations about allowances under any pension scheme that the Group may establish as an alternative to the NHS pension scheme.

8) **Primary Care Commissioning Committee**
The Committee shall carry out the functions relating to the commissioning of primary medical services. This includes the monitoring of contracts, design of PMS and APMS contracts, taking contractual action such as issuing branch/remedial notices and removing a contract, commissioning Enhanced Services (including 'Directed Enhanced Services' and 'Locally Commissioned Services'/'Local Improvement Schemes'), design of local incentive schemes as an alternative to the Quality Outcomes Framework (QOF), decision making on whether to establish new GP practices in an area, approving practice mergers, making decisions on 'discretionary' payment (e.g.

returner/retainer schemes) and promoting quality improvement within GP practice service provision. A CCG lay member will chair the group.

i. Committee Compliance for the Discharge of Functions

1. In discharging the functions of the Group that have been delegated to its Governing Body, committees, joint committees, sub-committees and individuals; each must:

   a. comply with the Group's principles of good governance,[56]

   b. operate in accordance with the Group's Scheme of Reservation and Delegation,[57]

   c. comply with the Group's Standing Orders,[58]

   d. comply with the Group's arrangements for discharging its statutory duties,[59]

   e. where appropriate, ensure that member practices have had the opportunity to contribute to the Group's decision making process.

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

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

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

   b. identify any pooled budgets and how these will be managed and reported in annual accounts;
   c. specify under which clinical commissioning group's Scheme of Reservation and Delegation and supporting policies the collaborative working arrangements will operate;

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

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

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

[56] See section 2.4 on Principles of Good Governance
[57] Appendix G, Scheme of Reservation & Delegation
[58] Appendix F, Standing Orders
[59] See section 3.2

5. LOCALITIES

a. Localities

i. The key function of the locality is to help, support and encourage the practices to deliver the best possible healthcare outcomes within the available resources. GPs are uniquely placed to view the whole patient pathway. They can use this unique perspective to redesign services which are clinically led, audit driven, and under whole pathway and performance managed redesign.

ii. As part of this work, localities are able to commission a greater range of integrated services in community settings, all designed around the needs of individuals, with general practice central to service delivery.

iii. The mandate is therefore from member practices, through their locality to CMCCG. Practices will not have a direct relationship with the Group's Governing Body, but rather channel all work through the locality via locality meetings. The locality will therefore continue and retain the power to influence and shape the direction of NHS CMCCG.

6) MEMBER PRACTICES

a. GP Practice Representatives (Locality Member)

i. GP practice representatives represent their practice's views and act as the commissioning lead on behalf of the practice in matters relating to the Group. Unless there are extenuating circumstances, practices are expected to attend locality and Group meetings as stated in the annual commissioning plan. Practice representation on the CCG Board is in the form of a "locality member" who is elected to the board. This Board member fulfils the Chair role of his/her corresponding locality meetings.

GP leads must come with a mandate to vote. Other staff may attend, however, they cannot vote as it remains one vote per member practice.

b. GP Locality Member (Chair of Locality)

i. The role of each GP Locality Member is:

1. **To represent the locality practices as their Board member**
   a. To make arrangements for locality meetings. To maintain ongoing engagement with local practices to ensure a representative view;
   b. To canvas practice views on specific issues where necessary;
   c. To represent the locality at the Board and other meetings taking into account practice views in decision making and development of plans;
   d. To act as the advocate of the population of the locality in commissioning decisions and ensure strategies reflect their needs;
   e. To form relationships with stakeholders within the locality and ensure patient and public involvement in commissioning.

2. **To support the implementation of the CCGs commissioning plans within their locality**
   a. To communicate decisions, plans and other relevant information to locality members;
   b. To promote the work of the Group and build support to deliver commissioning plans;
   c. To promote service/pathway development at a locality level and bring the resources of the CCG to develop it;
   d. To work within the locality to promote quality and tackle variation by improving practice through the locality working together;
   e. To ensure delivery of commissioning objectives at a practice level;
   f. To work alongside CCG colleagues to support practices to develop and implement action plans where they are deemed necessary as per the process within the Inter-Practice Agreement.

3. To develop the role of the locality as an emerging commissioning model

a. To work with the CCG Board and staff to develop the locality way of working through sharing best practice and innovation.

This list is not exhaustive. The role will need to be flexible as policy emerges and the new organisation evolves its way of working. Localities are very much a new way of working within Central Manchester and therefore this role may change significantly.