NHS
South Manchester
Clinical Commissioning Group

South Manchester Clinical Commissioning Group

Constitution

March 2016

Version 3

Version Control

Last Updated	Updated By	What was changed
30th July 2014	Anoop Seera	Final version post Board approval.
January 9th 2015	Lucy Gartside	Joint Committees, No of Practices,
March 2015	Jason Kalugarama	Manchester Primary Care Co-Commissioning updates
March 2016	Jane Muirhead	Committees information and Primary Care update

Review: April 2017

CCG Committee Terms of Reference can be found at: https://www.southmanchesterccg.nhs.uk/publications

Foreword

Since 2005 the General Practitioners of South Manchester have been working together to improve health outcomes for their patients. This collaboration was formalised in April 2013 when the South Manchester Clinical Commissioning Group became a statutory organisation having fulfilled all the eligibility criteria with some facility.

There are twenty five member practices responsible for 167,000 South Manchester residents who live from Wythenshawe in the South, to Fallowfield in the north with Chorlton and Burnage at the west and east boundaries. The practices work together in local patches which are vehicles for sharing good practice and challenge.

The governance of SMCCG is through the Board on which sit five GP's, three lay members, a chief officer, a non-clinical vice-chair, an executive nurse, a hospital consultant and Chief Finance Officer. The Board is supported by experts in finance, performance, quality, and contracting. The voice of the patient is articulated to the board by the Patient and Public Advisory Group - PPAG.

As an organisation in its first year, we have managed the many legacy issues from the previous dispensation, delivered financial balance and started to commission differently. We have established new partnerships with our neighbouring CCG's, our local Hospital, the local authority, the voluntary sector and MacMillan. Our residents have some of the worst health outcomes in England and we know we cannot turn this around by ourselves. We are also taking this new organisation forward in the setting of national financial stringency, but our vision remains the same.

"To improve radically how health and social care is delivered and experienced in South Manchester, using evidence based medicine and new relationships, to provide high quality care that enhances outcomes within the resources available".

This statement embraces quality, innovation, productivity and prevention and will be underpinned by the better management in the community of long-term conditions, reforming how health systems and pathways work and the earlier detection of serious illness. Working with our colleagues in social care and the Living Longer Living Better programme the increasing numbers of frail elderly in our society will be bettered supported by our patch based Neighbourhood Teams.

This constitution underpins our aspirations for the health and wellbeing of the residents of South Manchester. It describes how we will operate and ensure accountability to our patients, the public purse and our member practices.

1. Introduction and Commencement

1.1. Name

1.1.1. The name of this clinical commissioning group is NHS South Manchester Clinical Commissioning Group and will be referred to as SMCCG throughout this document.

1.2. Statutory Framework

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

1.2.2. The NHS Commissioning Board (hereafter referred to as 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 was enacted on the 1st day of April 2013, when NHS England established the group.[8] Subsequent versions have been approved by members and ratified by the Board. This document is published on SMCCG's website.

1.4. Amendment and Variation of this Constitution

1.4.1. This constitution can only be varied in three circumstances.[9]

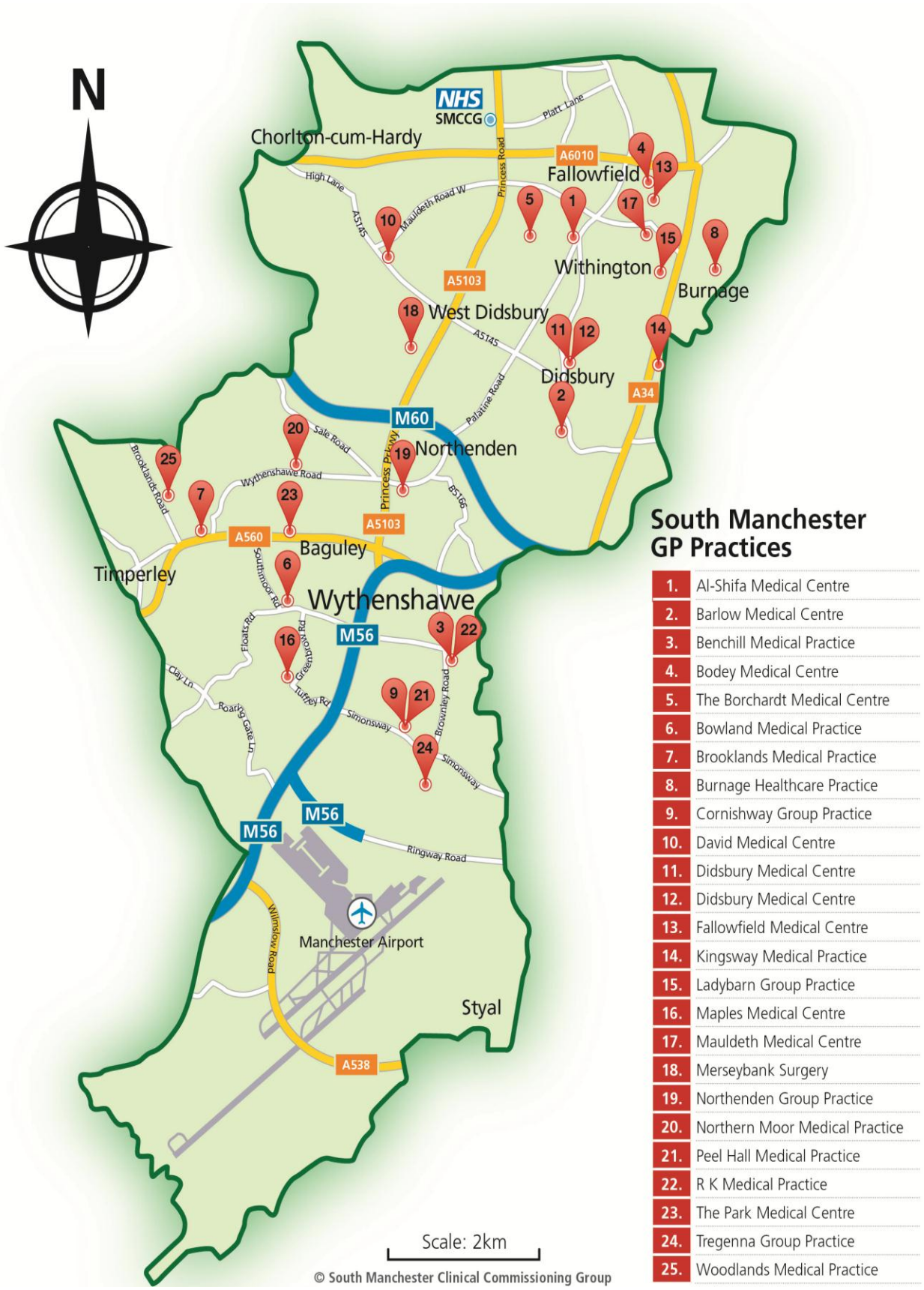
1.4.1.1. where the group applies to NHS England and that application is granted;
1.4.1.2. wherein the circumstances set out in legislation NHS England varies the group's constitution other than on application by the group.
1.4.1.3. Where representatives of the members by way of a majority, 75% of the eligible vote, agree at any specially convened meeting or Annual General Meeting to the specific amendment of variation to any aspect of the constitution.

---

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

2. Area Covered

2.1. The geographical area covered by SMCCG are the **electoral wards** of Fallowfield, Old Moat, Withington, Burnage, Chorlton Park, East Didsbury, West Didsbury, Northenden, Brooklands, Baguley, Sharston, Woodhouse Park. The boundaries were confirmed by the NHS North of England on 21st December 2011.



South Manchester GP Practices

1.	Al-Shifa Medical Centre
2.	Barlow Medical Centre
3.	Benchill Medical Practice
4.	Bodey Medical Centre
5.	The Borchardt Medical Centre
6.	Bowland Medical Practice
7.	Brooklands Medical Practice
8.	Burnage Healthcare Practice
9.	Cornishway Group Practice
10.	David Medical Centre
11.	Didsbury Medical Centre
12.	Didsbury Medical Centre
13.	Fallowfield Medical Centre
14.	Kingsway Medical Practice
15.	Ladybarn Group Practice
16.	Maples Medical Centre
17.	Mauldeth Medical Centre
18.	Merseybank Surgery
19.	Northenden Group Practice
20.	Northern Moor Medical Practice
21.	Peel Hall Medical Practice
22.	R K Medical Practice
23.	The Park Medical Centre
24.	Tregenna Group Practice
25.	Woodlands Medical Practice

3. Membership of the CCG

3.1. The practices which comprise the members of SMCCG can be found on the SMCCG website, together with the signatures of the practice representatives confirming their agreement to this constitution.

3.2. Eligibility

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, within the geographical area covered by NHS South Manchester Clinical Commissioning Group, will be eligible to apply for membership of this group. GP locums whose primary place of work is NHS South Manchester CCG may apply to be members of the CCG. Any of the above may stand in elections for membership of the Board. GP locums exert their influence through discussions within their primary place of work.

NHS England will have the ultimate role in deciding whether a practice or individual practitioner should be approved as a member of NHS South Manchester Clinical Commissioning Group or otherwise.

3.2.1. Primary medical service providers who are not currently members and are eligible to be a member should apply, in writing, to the Chief Officer of NHS South Manchester Clinical Commissioning Group stating their reasons for wishing to be a member. This application will be considered by NHS South Manchester Clinical Commissioning Group's Board for a decision.

3.2.2. Where there is any disagreement, NHS England will have the ultimate role in deciding whether a practice should be approved as a member of NHS South Manchester Clinical Commissioning Group or otherwise. An appeals process will be facilitated by NHS England.

3.3. Termination of Membership

3.3.1. A member ceases to be a member if:

3.3.1.1. that member gives at least three months' prior written notice to the CCG of their intention to cease being a member of the CCG;

3.3.1.2. that member is a sole practitioner GP and he/she:

3.3.1.2.1. dies, following which, under NHS (GMS Contracts) Regs 2004 Sch 6 para 107 A and NHS (PMS Agreements) Regs 2004 Sch 5 para 99 A and as applicable in APMS, the contract will terminate at the end of the period of 7 days after the death of the GP, unless the CCG and the Contractors PRs agree (in writing) that it can continue for up to 28 days after the end of the initial 7 days;

3.3.1.2.2. ceases to be registered as a medical practitioner;

3.3.1.2.3. enters into partnership with any other medical practitioner, except where that medical practitioner or the partnership is an existing member;

3.3.1.2.4. ceases to be named on the performers list of the CCG other than in the event of a contingent removal;

3.3.1.2.5. is contingently removed from the performers list, where the CCG Board, in its absolute discretion, determines that the conditions placed on the Member's continued inclusion in the performers list would prevent or inhibit his/her ability to fulfil effectively his/her functions as a Member; is suspended from the performers list of the CCG but only during the period of such suspension;

3.3.1.2.5.1. that Member ceases to hold a contract for the provision of primary medical services;

3.3.1.2.5.2. that Practice merges with any other practice, unless that other practice is an existing Member (and for the avoidance of doubt where two Practices that are Members merge they shall be one Member thereafter for the purposes of this Interim Constitution).

3.3.2. Membership of the CCG is not transferable.

3.4 Member Representatives

3.4.1 Each practice shall be required to nominate representatives: one clinical/GP[10] and a non-clinical representative from within the nominating Member's Practice. Each practice may remove and replace their Member Representative at any time in writing to the Board. Each Member Representative shall be regarded as the clinical and non-clinical representatives of their appointing Member on the Practice Members.

3.4.2 Each Member authorises their Member Representatives to:

3.4.2.1 receive notice of, attend and vote at any meetings of the CCG Practice Members (whether an AGM or other meeting of the Practice Members and whether on a show of hands or on a poll), or sign any written resolution on behalf of that Member;

3.4.2.2 deal with and give directions as to resources, securities, benefits, documents, notices or other communications (in whatever form) arising by right of or received in connection with the Member's membership of the CCG.

3.4.3 For the avoidance of doubt, the CCG's Board and any of its sub-committees of persons acting on its behalf shall be entitled to treat any Member Representative as having the continuing authority given to that representative until it is notified of the removal of that Member Representative.

3.5 Meetings of the Members

3.5.1 Annual General Meeting

3.5.1.1 Unless agreed specifically to the contrary minutes of all formal meetings will be a matter of public record.

3.5.1.2 The matters to be considered at the AGM shall be as set out in the notice.

3.5.1.2.1 The AGM shall be open to the public.

3.5.1.3 The chair of the meeting may permit other persons who are not Member Representatives to attend and speak at the meeting, but not to vote.

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

3.5.2 **Meetings of The Board**

3.5.2.1 The Board or a minimum of 51% of the eligible vote can call a meeting of the members at any time by giving all the members at least fourteen days' notice.

3.5.2.2 Unless agreed specifically to the contrary minutes of all formal meetings will be a matter of public record.

3.5.2.3 The chair of the meeting may permit other persons who are not Member Representatives to attend and speak at the meeting, but not to vote.

3.5.3 **Attendance and speaking at General Meetings/Quarterly Meetings**

3.5.3.1 The CCG's Board may make whatever arrangements it considers appropriate to enable those attending a Meeting to exercise their rights to speak or vote at it.

3.5.3.2 Member Representatives may participate in meetings by telephone or by the use of video conferencing facilities and/or webcam, where such facilities are available. Participation in a meeting in any of these manners shall be deemed to constitute presence in person at the meeting.

3.5.3.3 The accidental omission to provide notice of a meeting to, or the non-receipt of notice of a meeting by, any person entitled to receive notice shall not invalidate the proceedings at that meeting.

3.5.3.4 The chair of the meeting may permit other persons who are not Member Representatives to attend and speak at the meeting, but not to vote.

3.5.4 **Quorum for Meetings**

3.5.4.1 No business other than the appointment of the chair of the meeting is to be transacted at a meeting if the persons attending it do not constitute a quorum.

3.5.4.2 A minimum of 50% of the persons entitled to vote[11] upon the business to be transacted, each being a Member Representative or a proxy for a Member Representative, shall be a quorum.

3.5.5 **Chairing Meetings**

3.5.5.1 The Chair shall chair General Meetings if present and willing to do so. If not present and willing to chair the meeting, the Vice Chair shall chair the General Meeting if present and willing to do so.

3.5.5.2 If the Chair and Vice Chair are unwilling to chair the meeting or are not present within ten minutes of the time at which a meeting was due to start the Patch Chairs present, or if no Patch Chairs are present, those present at the meeting must appoint a chair of the meeting, and the appointment of the chair of the meeting must be the first business of the meeting. Where Patch Chairs are present at the meeting then any such chair of the meeting shall be appointed from amongst their number.

3.6 Voting

3.6.1 Every Member shall have the right to vote according to their Member's Practice List:

3.6.1.1 a GP Practice with less than, or equal to, 1 Whole Time Equivalent (WTE) GP of whatever status (partner, salaried) may have 1 member vote;

11 See SMCCG website for List of Member Practices

3.6.1.2 a GP Practice with more than one WTE GP of whatever status and a patient list of more than one but less than or equal to 5,000 may have 2 voting members;

3.6.1.3 a GP Practice with more than one WTE GP of whatever status and a patient list more than 5,001 but less than or equal to 10,000 may have 3 voting members;

3.6.1.4 a GP Practice with more than one WTE GP of whatever status and a patient list more than 10,001 and up to 15,000 may have 4 voting members;

3.6.1.5 a GP Practice with more than one WTE GP of whatever status and a patient list more than 15,001 and up to 20,000 may have 5 voting members;

3.6.1.6 a GP Practice with more than one WTE GP of whatever status and a patient list more than 20,001 may have 6 voting members.

3.6.2 In the case of an equality of votes, the chair of the meeting shall be entitled to a casting vote.

3.6.3 **Content of proxy notices**

3.6.3.1 Proxies may only validly be appointed by a notice in writing (a "proxy notice") which:

3.6.3.1.1 states the name and address of the Member Representative appointing the proxy;

3.6.3.1.2 identifies the person appointed to be that Member Representative's proxy and the meeting in relation to which that person is appointed;

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

3.6.3.1.4 is delivered to the CCG's Board in accordance with any instructions contained in the notice of the meeting to which they relate.

3.6.3.2 The CCG's Board notices to be delivered in a particular form, and may specify different forms for different purposes.

3.6.3.3 Proxy notices may specify how the proxy appointed under them is to vote (or that the proxy is to abstain from voting) on one or more resolutions.

3.6.3.4 Unless a proxy notice indicates otherwise, it must be treated as:

3.6.3.4.1 allowing the person appointed under it as a proxy discretion as to how to vote on any ancillary or procedural resolutions put to the meeting, and

3.6.3.4.2 appointing that person as a proxy in relation to any adjournment of the General Meeting to which it relates as well as the meeting itself.

3.6.4 **Delivery of proxy notices**

3.6.4.1 An appointment under a proxy notice may be revoked by delivering to the CCG's Board a notice in writing given by or on behalf of the member representative by whom or on whose behalf the proxy notice was given.

3.6.4.2 A notice revoking a proxy appointment only takes effect if it is received by the CCG Board before the start of the meeting or adjourned meeting to which it relates.

3.6.4.3 If a proxy notice is not executed by the member representative appointing the proxy, it must be accompanied by written evidence of the authority of the person who executed it to execute it on the relevant Member's behalf.

3.7 The Board and Elected Membership

3.7.1 Advertisements for the position(s) will be circulated to member representatives to share with their colleagues and these will include relevant information:

3.7.1.1 The role requirements (in the form of a job description and/or person specification);

3.7.1.2 The anticipated sessional requirements;

3.7.1.3 The term of office (this will usually be for three years or the nearest to that period ending 31st March);

3.7.1.4 The remuneration given for that period in time;

3.7.1.5 The format that an application should take;

3.7.1.6 The closing date;

3.7.1.7 The person to whom applications should be returned; and

3.7.1.8 Any other information relevant to the advertisement.

3.7.2 Individual GPs will self-nominate and apply for the role(s). Applications received after the closing date may not be considered (this will be at the discretion of the Chief Officer).

3.7.3 Informal shortlisting and/or interviews will take place by the Chief Officer and other relevant personnel to ensure that the applicants have the skills or experience required for the role(s) for which they have applied;

3.7.3.1 The persons determined to have the skills and or experience will be notified to the members for them to elect their preferred candidate for the role(s);

3.7.3.2 A specific period (usually three weeks) will be identified for the election and a Returning Officer will be identified to collect the votes in accordance with the minimum number of votes required for each Member;

3.7.3.3 Those elected will be notified to ensure they remain willing to take on the role and thereafter the Members will be notified of the outcome;

3.7.3.4 In the event of a person not wishing to accept the role any candidate with the second highest number of votes will be offered the role.

3.7.4 **Termination of Appointment:** A person shall not be eligible to be a GP representative on SMCCG's Board, Practice Manager representative or Member Lead and shall cease to hold that position as soon as he/she:

3.7.4.1 is removed by the members;

3.7.4.2 if a sole practitioner, ceases to be a Member;

3.7.4.3 if a partner of a partnership that is a Member, ceases to be a partner in that partnership or if that partnership ceases to be a Member;

3.7.4.4 if a shareholder, officer or employee of a Member, ceases to hold any shares in or remain engaged as an officer or employee of that Member (as applicable) or if the relevant Member ceases to be a Member;

3.7.4.5 that person resigns as, and such resignation has taken effect in accordance with its terms;

3.7.4.6 dies or is declared bankrupt;

3.7.4.7 where that person is a GP they cease to be included on the performers list of the CCG other than in the event of a contingent removal;

3.7.4.8 where that person is a GP they are contingently removed from the performers list of the CCG and the CCG's Board in its absolute discretion determines that the conditions placed on the Member Lead would prevent or inhibit his/her ability to fulfil effectively their functions as a Member Lead;

3.7.4.9 where that person is a GP they are suspended from the performers list of the CCG but only during the period of such suspension;

3.7.4.10 where that person is a GP they cease to be registered as a medical practitioner;

3.7.4.11 where there are issues of poor conduct, gross misconduct or poor performance, and are continually not performing their role competently.

4. Mission, Values and Aims

4.1. Mission

4.1.1. The mission of SMCCG is to improve radically how health and social care is delivered and experienced in South Manchester, using evidence-based medicine and new relationships, to provide high quality care, which enhances outcomes within the resources available.

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 our objectives and the values that lie at the heart of SMCCG's work are:

4.2.1.1. We believe health care is a human right and not a market commodity;

4.2.1.2. We believe every clinician has responsibility for the quality and cost of care;

4.2.1.3. We believe care should be arranged around the needs of the individual patient;

4.2.1.4. We believe multidisciplinary education should underpin all service and pathway redesign;

4.2.1.5. We believe partnership working should be founded on a sharing of costs and benefits;

4.2.1.6. We believe health and social care should take shared responsibility for individuals, creating a seamless experience for patients and carers;

4.2.1.7. We believe local people should be involved in the planning and design of local services;

4.2.1.8. We will encourage and support innovation within commissioning and service provision;

4.2.1.9. We will bring commissioners and providers together to design local healthcare;

4.2.1.10. We will manage our budgets effectively to ensure best value for our patients and a financially sustainable future;

4.2.1.11. We will endeavour to treat patients in the community when clinically appropriate;

4.2.1.12. We will deliver healthcare according to clinical evidence and best practice;

4.2.1.13. We will prescribe the most clinically appropriate, cost effective medicines;

4.2.1.14. We will work to prevent ill health, to create a self-reliant, resilient and healthy population;

4.2.1.15. We will empower patients to manage their own care through education, information and support;

4.2.1.16. We will forge strong relationships with local people, Manchester City Council, secondary care providers and the voluntary and community sector to support our commissioning activity;

4.2.1.17. We believe that, by working together, local GPs can transform local health services.

4.3. Aims

4.3.1. SMCCG's aims are to:

4.3.1.1. Align local activities with our Commissioning Strategic Plan using our culture and values to support this.

4.3.1.2. Review and re-shape structures and business processes to support the emerging CCG and commissioning partnerships.

4.3.1.3. Capitalise on the commitment, skills and capabilities of our clinical and managerial leaders and enhance these to achieve authorisation and deliver our Commissioning Strategic Plan.

4.3.1.4. Fulfil our role as local leaders in respect of talent management, workforce planning and workforce development.

4.3.1.5. Align to the Commissioning Strategy/Operational Plan there is the Transformational Agreement Plan, that will continue with ensuring progress is made, in transforming community services by commissioning clinical pathways that deliver:

4.3.1.5.1. Care Closer to Home through services which are conveniently located

4.3.1.5.2. Promote self-care and active lifestyles

4.3.1.5.3. Greater efficiencies and are value for money

4.3.1.5.4. Positive patient experience.

4.4. Principles of Good Governance

4.4.1. In accordance with section 14L(2)(b) of the 2006 Act,[12] the group will at all times observe "such generally accepted principles of good governance" in the way it conducts its business. These include:

4.4.1.1. 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;

4.4.1.2. *The Good Governance Standard for Public Services*;[13]

4.4.1.3. the standards of behaviour published by the *Committee on Standards in Public Life (1995)* known as the 'Nolan Principles';[14]

4.4.1.4. the seven key principles of the *NHS Constitution*;[15]

4.4.1.5. the Equality Act 2010.[16]

---

12 Inserted by section 25 of the 2012 Act

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

14 See SMCCG website for Nolan Principles

15 See SMCCG website for Seven Key Principles of NHS Constitution

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

4.5. Accountability

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

4.5.1.1. publishing its constitution;

4.5.1.2. appointing independent lay members and non GP clinicians to its Board;

4.5.1.3. holding meetings of its 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);

4.5.1.4. publishing annually a commissioning plan;

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

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

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

4.5.1.8. having a published and clear complaints process, referenced in the Communications and Engagement Strategy;

4.5.1.9. Monitoring performance of local trusts, identifying failing services and responding to Serious Untoward Incidents (SUIs) and issues pertaining to patient safety. Ensuring statistical reports of breaches and patient experience data are addressed through the Quality and Performance Committee which reports to the Board and the National Reporting and Learning System;

4.5.1.10. complying with the Freedom of Information Act 2000;

4.5.1.11. providing information to NHS England as required.

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

4.5.2.1. Publishing our commissioning and operational policies;

4.5.2.2. Holding engagement events about service redesign;

4.5.2.3. Making relevant information available on our web page;

4.5.2.4. Responding to requests for information under the Freedom of Information Act.

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

5. Functions and General Duties

5.1. Functions

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

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

5.1.1.1.1. all people registered with member GP practices, and

5.1.1.1.2. people who are usually resident within the area and are not registered with a member of any clinical commissioning group;

5.1.1.2. commissioning emergency care for anyone present in the group's area;

5.1.1.3. paying its employees' remuneration, fees and allowances in accordance with the determinations made by its Board and determining any other terms and conditions of service of the group's employees;

5.1.1.4. determining the remuneration and travelling or other allowances of members of its Board.

5.1.2. In discharging its functions the group will:

5.1.2.1. act,[17] 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***[18] *and* with the objectives and requirements placed on NHS England through *the mandate*[19] published by the Secretary of State before the start of each financial year by:

5.1.2.1.1. Delegating responsibility to:

5.1.2.1.1.1. the group's Board, or
5.1.2.1.1.2. a committee or sub-committee of the Board or authorised to work on behalf of the group, or
5.1.2.1.1.3. an individual with lead responsibility to oversee its discharge (i.e. Chief Officer, member or employee).

5.1.2.1.2. Having Standing Orders and Standing Financial Instructions in place and mechanisms in place to ensure adherence to these.

5.1.2.1.3. Having robust governance arrangements in place that are monitored through an Audit Committee.

5.1.2.2. ***meet the public sector equality duty***[20] by:

5.1.2.2.1. Working in partnership with patients, public and staff to raise awareness of and promote the positive aspects of diversity and inclusion;

---

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

18 See section 1 of the 2006 Act, as amended by section 1 of the 2012 Act

19 See section 13A of the 2006 Act, inserted by section 23 of the 2012 Act

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

5.1.2.2.2. requiring the Chief Officer to implement an Equality Strategy and the annual Action Plan with specific and measurable objectives;

5.1.2.2.3. Publishing annually a report to demonstrate compliance with this general duty across all functions;

5.1.2.2.4. Undertaking and publishing on its website equality impact assessments on all plans, service changes and policy;

5.1.2.2.5. requiring the Board to approve the plan and to monitor its implementation and these arrangements annually;

5.1.2.2.6. Using the Equality Delivery System (EDS) and Equality Delivery System 2 (EDS2) Toolkit to demonstrate the group delivers against all protected characteristics.

5.1.2.3. work in partnership with its local authority[ies] to develop ***joint strategic needs assessments***[21] and ***joint health and wellbeing strategies***[22] by:

5.1.2.3.1. Having appropriate representation as members of Manchester's Health and Wellbeing Board;

5.1.2.3.2. Having systems and processes in place to work in partnership with Manchester City Council to achieve partnership working and promote public health.

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

5.2.1. Make arrangements to ***secure public involvement*** in the planning, development and consideration of proposals for changes and decisions affecting the operation of commissioning arrangements[23] by working with our PPAG to:

5.2.1.1. work in partnership with patients and the local community to secure the best care for them;

5.2.1.2. adapt engagement activities to meet the specific needs of the different patient groups and communities;

5.2.1.3. publish information about health services on our website and through other media encouraging and acting on feedback through the Public and Patient Advisory Group as detailed in the Communications and Engagement Strategy.

5.2.2. ***Promote awareness of, and act with a view to securing that health services are provided in a way that promotes awareness of, and have regard to the NHS Constitution***[24] by:

5.2.2.1. Including information in our literature and on our website specifying our policies and the Constitution;

5.2.2.2. Acting consistently with regards to decision making and commissioning actions by delegating responsibility to the Board and appropriate committees;

---

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

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

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

24 See section 14P of the 2006 Act, inserted by section 26 of the 2012 Act and section 2 of the Health Act 2009 (as amended by 2012 Act)

5.2.2.3. Monitoring progress of delivery via robust reporting mechanisms as described in the Communications and Engagement Strategy.

5.2.3. Act ***effectively, efficiently and economically***[25] by:

5.2.3.1. Commissioning value for money services by following our QIPP programme and commissioning intentions;

5.2.3.2. Focussing on maximising patient care resources;

5.2.3.3. Being innovative using best practice models and evidence.

5.2.4. Act with a view to ***securing continuous improvement to the quality of services***[26] by:

5.2.4.1. Implementing our Commissioning Strategy;

5.2.4.2. Ensuring on-going discussions with our provider organisations about long term strategy and plan as referenced in our SLAs;

5.2.4.3. Defining robust outcomes and putting in place measures with our providers;

5.2.4.4. Listening to the feedback of our patients' experiences as detailed in the Communications and Engagement Strategy.

5.2.5. Assist and support NHS England in relation to the Board's duty to ***improve the quality of primary medical services***[27] by:

5.2.5.1. Hearing the views of Clinicians via LINK, patch and quarterly meetings;

5.2.5.2. Reporting any complaints or concerns as detailed in the Communications and Engagement Strategy;

5.2.5.3. Sharing good practice across our GP member practices and the wider footprint via LINK, patch and quarterly meetings;

5.2.5.4. Sharing performance data in an open and transparent way between practices e.g. referrals, prescribing, acute care.

5.2.6. Have regard to the need to ***reduce inequalities***[28] by:

5.2.6.1. Being aware of key demographic data pertinent to health inequalities and actively seeking to address them when opportunities arise;

5.2.6.2. Using members' excellent access to communities and local people, to influence health inequalities as practitioners, commissioners and community leaders;

5.2.6.3. Working with partners in the development of the local JSNA to understand the local inequalities gaps and identify what conditions are responsible;

5.2.6.4. Providing and commissioning accessible and equitable medical care that will address the priorities identified within the JSNA;

---

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

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

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

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

5.2.6.5. Helping patients to navigate a complex health system;

5.2.6.6. Applying the broad principles of the Marmot review to strategy, planning and commissioning process;

5.2.6.7. Clinical Commissioning Committee is formally responsible for ensuring the CCG has regard to the need to reduce health inequalities in access to, and the outcomes from healthcare.

5.2.7. ***Promote the involvement of patients, their carers and representatives in decisions about their healthcare***[29] by:

5.2.7.1. Ensuring shared decision making is promoted in the consulting room;

5.2.7.2. Involving the Patient and Public Advisory Group

5.2.7.2.1. The South Manchester Clinical Commissioning Group Patient and Public Advisory Group consists of local people and is chaired by the Board lay representative with a responsibility for patient and public involvement. The role of the group is to provide advice and guidance to the South Manchester Clinical Commissioning Group Board and other committees informing, reviewing and advising on South Manchester Clinical Commissioning Group decision making from a patient, public and community perspective.

5.2.8. Act with a view to ***enabling patients to make choices***[30] by:

5.2.8.1. Implementing the principles of informed shared decision making;

5.2.8.2. Applying NHS choice mechanisms and principles. Manchester Integrated Referral Gateway: This gateway allows for triage of referrals into the most appropriate clinical setting, utilising all services available as efficiently and effectively as possible. Patient choice of secondary care provider occurs at practice consultation and the referral form includes a section to complete 4 secondary care provider options. The MICG data collection will be used to inform service or pathway redesign.

5.2.9. ***Obtain appropriate advice***[31] from persons who, taken together, have a broad range of professional expertise in healthcare and public health by:

5.2.9.1. Utilising the skills of our healthcare professionals who have a diverse background from professional primary, secondary and tertiary care and public health staff;

5.2.9.2. Having regard to the JSNA, Clinician to Clinician meetings with UHSM;

5.2.9.3. Listening to the views from professionals in member practices;

5.2.9.4. Seeking advice from specialists for specific issues;

5.2.9.5. Having in place a range of clinical leads, for example for Long term conditions, musculoskeletal.

5.2.10. ***Promote innovation***[32] by:

5.2.10.1. Putting the patient at the heart of everything we do;

---

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

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

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

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

5.2.10.2. Involving patients, the public, practitioners and commissioners in pathway re-design e.g. listening to patient ideas through QIPP processes;

5.2.10.3. Developing Integrated systems to reduce duplication and increase efficiency;

5.2.10.4. Continuously developing our workforce.

5.2.11. ***Promote research and the use of research***[33] by:

5.2.11.1. Working with local, national and International partners and stakeholders to develop research in our health economy, for example Manchester Health Sciences Centre (MAHSC);

5.2.11.2. Facilitating the use of best practice, for example Script Switch.

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

5.2.12.1. Having robust appraisal systems and learning and development processes;

5.2.12.2. Continuously developing our workforce, medical students and trainee practitioners in South Manchester as described in our Organisational Development plan.

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[36] by:

5.2.13.1. Working collaboratively with partners and the voluntary sector.

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***[37] by:

5.3.1.1. Keeping accurate accounts;

5.3.1.2. Supporting member practices to achieve balanced budgets by providing contemporaneous information and incentives via Q&P and LES mechanisms and support from LINK managers;

5.3.1.3. Managing our resources effectively;

5.3.1.4. Delegating responsibility to:

5.3.1.4.1. the group's Board, or

5.3.1.4.2. a committee or sub-committee of the group, or

33 See section 14Y of the 2006 Act, inserted by section 26 of the 2012 Act
34 See section 14Z of the 2006 Act, inserted by section 26 of the 2012 Act
35 See section 1F(1) of the 2006 Act, inserted by section 7 of the 2012 Act
36 See section 14Z1 of the 2006 Act, inserted by section 26 of the 2012 Act
37 See section 223H(1) of the 2006 Act, inserted by section 27 of the 2012 Act

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

5.3.2. ***Ensure its use of resources*** *(both its capital resource use and revenue resource use)* ***does not exceed the amount specified by NHS England for the financial year***[38] by

5.3.2.1. Sharing information between practices;

5.3.2.2. Support with referrals, prescribing, LINK and patch meetings;
5.3.2.3. Using our performance dashboard;

5.3.2.4. Monitoring practices to ensure they take ownership of budgets;

5.3.2.5. Delegating responsibility to:

5.3.2.5.1. the group's Board, or

5.3.2.5.2. a committee or sub-committee of the group, or

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

5.3.2.6. Requiring progress of delivery of the duty to be monitored through the group's reporting mechanisms, i.e. Finance and Performance Committee.

5.3.3. ***Take account of any directions issued by NHS England, in respect of specified types of resource use in a financial year, to ensure the group does not exceed an amount specified by NHS England***[39] by

5.3.3.1. Having in place contingency funds;

5.3.3.2. Effective budget management.

5.3.4. ***Publish an explanation of how the group spent any payment in respect of quality*** made to it by NHS England[40] by

5.3.4.1. Delegating responsibility to:

5.3.4.1.1. the group's Board, or

5.3.4.1.2. a committee or sub-committee of the group, or

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

5.3.4.2. Requiring progress of delivery of the duty to be monitored through the group's reporting mechanisms, i.e. Quality and Governance Committee.

5.4. **Other Relevant Regulations, Directions and Documents**

5.4.1. The group will:

5.4.1.1. comply with all relevant regulations;

---

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

39 See section 223J of the 2006 Act, inserted by section 27 of the 2012 Act

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

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

5.4.1.3. take account, as appropriate, of documents issued by NHS England;

5.4.1.4. Have systems in place to take account of safeguarding as detailed in organisational structure and governance arrangements found in the Organisational Development Plan;

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

6. Decision Making: The Governance Structure

6.1. Authority to act

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

6.1.1.1. any of its members;

6.1.1.2. its Board;

6.1.1.3. employees;

6.1.1.4. 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:

6.1.2.1. the Group's scheme of reservation and delegation; and

6.1.2.2. for committees, their terms of reference.

6.2. Scheme of Reservation and Delegation[41]

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

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

6.2.1.2. those decisions that are the responsibilities of its 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.

6.3. General

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

6.3.1.1. comply with the group's principles of good governance;[42]

6.3.1.2. operate in accordance with the group's scheme of reservation and delegation;[43]

6.3.1.3. comply with the group's standing orders;[44]

6.3.1.4. comply with the group's arrangements for discharging its statutory duties;[45]

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

---

41 See SMCCG website for Scheme of Reservation and Delegation

42 See section 4.4 on Principles of Good Governance above

43 See SMCCG website for Scheme of Reservation and Delegation

44 See SMCCG website for Standing Orders

45 See chapter 5 above

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

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

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

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

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

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

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

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

6.4. Committees of the group

6.4.1. The group's Board on behalf of the CCG may appoint such committees of the CCG 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 Board.

6.4.2. A committee of the group may consist of or include persons other than members or employees of the group.

6.4.3. A committee of the group includes a joint committee of the group and one or more other clinical commissioning groups and/or one or more local authorities and/or NHS England.

6.4.4. 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 on behalf of the group of the committee they are accountable to.

6.4.5. 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.

6.5. Joint Arrangements

SMCCG will work collaboratively and have joint arrangements in place with neighbouring CCG's and joint committees with local authorities to ensure we commission the best possible services/achieve quality outcomes for patients. All initiatives will have SLAs in place detailing lines of accountability and decision-making processes. The joint work programmes are detailed in the Commissioning Plan.

Joint commissioning arrangements with other Clinical Commissioning Groups

6.5.1 The group may wish to work together with other clinical commissioning groups in the exercise of its commissioning functions.

6.5.2 The group may make arrangements with one or more clinical commissioning groups in respect of:

6.5.2.1 delegating any of the group's commissioning functions to another clinical commissioning group;

6.5.2.2 exercising any of the commissioning functions of another clinical commissioning group; or

6.5.2.3 exercising jointly the commissioning functions of the group and another clinical commissioning group.

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

6.5.3.1 make payments to another clinical commissioning group;

6.5.3.2 receive payments from another clinical commissioning group;

6.5.3.3 make the services of its employees or any other resources available to another clinical commissioning group; or

6.5.3.4 receive the services of the employees or the resources available to another clinical commissioning group.

6.5.4 Where the group makes arrangements which involve all the clinical commissioning groups 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 group may establish and maintain a pooled fund made up of contributions by any of the clinical commissioning groups 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 group makes arrangements with one or more other clinical commissioning groups as described at paragraph 6.5.2 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.

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

6.5.8 The group 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 Board.

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 regular written reports 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 group's Board can decide to withdraw from the arrangement, but has to give six months' notice to partners, with new arrangements starting from the beginning of the next new financial year.

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

1) 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.
2) The arrangements of this joint arrangement are outlined in detail in the Memorandum of Understanding.
3) NHS SMCCG may leave the arrangement to enter new shared arrangements via Board decision.

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

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

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

6.6.3 The arrangements referred to in paragraph 6.6.2 above may include other clinical commissioning groups.

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 group.

6.6.6 Where the group makes arrangements with NHS England (and one or more other clinical commissioning groups if relevant) as described at paragraph 6.6.2 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.

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

6.6.8 The group 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 Board.

6.6.10 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 regular written reports 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 group may wish to work with NHS England and, where applicable, other clinical commissioning groups, to exercise specified NHS England functions.

6.7.2 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.

6.7.3 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 question.

6.7.4 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.

6.7.5 For the purposes of the arrangements described at paragraph 6.7.2 above, NHS England and the group 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 group 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 group enter into arrangements pursuant to paragraph 6.7.2 above.

6.7.8 The group 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 group's Board.

6.7.10 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 regular written reports 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 group's Board can decide to withdraw from the arrangement, but has to give six months' notice to partners, with new arrangements starting from the beginning of the next new financial year after the expiration of the six months' notice period.

6.8 Joint commissioning arrangements with local authorities

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

6.9 The Board

6.9.1 ***Functions*** - the 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. The Board has responsibility for:

6.9.1.1 ensuring that the group has appropriate arrangements in place to exercise its functions *effectively, efficiently and economically* and in accordance with the groups *principles of good governance*[46] (its main function);

6.9.1.2 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;

6.9.1.3 approving any functions of the group that are specified in regulations.[47]

6.9.2 ***Composition of the Board***[48] - the Board shall not have less than ten members and comprises of:

6.9.2.1 the chair (must be a representative of a member practice and a GP);

6.9.2.2 four representatives of member practices (1 to represent views of locum/salaried GP's, 1 to act as Clinical Lead);

6.9.2.3 three lay members:

6.9.2.4 one registered executive nurse;

6.9.2.5 one secondary care specialist doctor;

6.9.2.6 the Chief Officer;

6.9.2.7 the Chief Finance Officer.

6.9.3 **The CCG Board** as the governing body (which is accountable to the Member Practices and NHS England has the following committees:

46 See section 4.4 on Principles of Good Governance above

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

48 See SMCCG website for current board composition

6.9.3.1 **Communication and Engagement Committee** (which is accountable to the Board)

6.9.3.2 **Audit Committee**, accountable to the Board provides the 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. The 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.

6.9.3.3 **Finance Committee** (which is accountable to the Board)

6.9.3.4 **Quality and Performance Committee** (which is accountable to the Board)

6.9.3.5 **Corporate Governance Committee** (which is accountable to the Board)

6.9.3.6 **Remuneration Committee** – the remuneration committee, which is accountable to the group's Board makes recommendations to the Board on determinations about the remuneration, fees and other allowances for employees, Board members, and for people who provide services to the group and on determinations about allowances under any pension scheme that the group may establish as an alternative to the NHS pension scheme. The Board has approved and keeps under review the terms of reference for the remuneration committee, which includes information on the membership of the remuneration committee. This Committee will be established following authorisation of the group and in cooperation with NHS Greater Manchester and/or NHS England.

6.9.3.7 **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.

6.9.3.8 **Clinical Commissioning Committee (**which is accountable to the Board).

6.9.4 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.

6.9.5 Terms of reference shall have effect as if incorporated into the Constitution and are available on the CCG Website at: https://www.southmanchesterccg.nhs.uk/publications

7. Roles and Responsibilities

7.1 Practice Representatives

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

7.1.1 Share any information provided by the CCG at patch meetings within their practice;

7.1.2 Review activities at patch and CCG events providing advice and guidance, and linking the CCG's priorities and needs with local practice priorities and needs and vice versa; and

7.1.3 Providing the practice view on issues and decisions at patch and CCG events.

7.2 Other GP and Primary Care Health Professionals

7.2.1 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 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:

7.2.1.1 Provide advice and expertise on specific pathways/care/service specialities;

7.2.1.2 Provide clinical leadership in a specific area or to support the improvement in the quality of services and provide peer support to individuals;

7.2.1.3 Provide support to the CCG on engaging with practices to identify preferred methods of delivery or agreed outcomes as part of achieving the CCG's vision and aims.

7.3 All Members of the Group's Board

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

7.4 The Chair of the Board

7.4.1 The Chair of the Board is responsible for:

7.4.1.1 Delivery of the organisation's objectives with the rest of the NHS South Manchester CCG leadership team;

7.4.1.2 Sharing responsibility with the other members for all aspects of the CCG Board business, you will bring a broader view, from your perspective as a lay person to underpin the work of the CCG;

7.4.1.3 Share responsibility as part of and leader of the team to ensure that the CCG exercises its functions effectively, efficiently and in accordance with the terms of the CCG constitution;

7.4.1.4 Bringing their perspective, informed by their expertise and experience, to support decisions made by the Board as a whole and will help ensure that:

7.4.1.4.1 the interests of patients and the community remain at the heart of discussions and decisions;

7.4.1.4.2 the Board and the wider CCG acts in the best interests of the local population at all times;

7.4.1.4.3 the CCG commissions the highest quality services and best possible outcomes for their patients within their resource allocation;

7.4.1.5 Building and developing the CCG Board and its individual members;

7.4.1.6 Ensuring that the CCG has proper constitutional and governance arrangements in place;

7.4.1.7 Supporting the Chief Officer in discharging the responsibilities of South Manchester CCG;

7.4.1.8 Leading the achievement of clinical and organisational change to enable the CCG to deliver its commissioning intentions;

7.4.1.9 Building and maintaining effective relationships, particularly with those organisations and people associated with overview and scrutiny of the CCG; and

7.4.1.10 Ensuring the CCG is accountable to its partners including patients, NHS Greater Manchester and the National Commissioning Governing body.

7.5 The Vice Chair of the Board

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

7.6 Role of the Chief Officer

7.6.1 The Chief Officer of the group is a member of the Board and the role has been summarised in a national document as:

7.6.1.1 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;

7.6.1.2 at all times ensuring that the regularity and propriety of expenditure is discharged, and that arrangements are put in place to ensure that good practice (as identified through such agencies as the Audit Commission and the National Audit Office) is embodied and that safeguarding of funds is ensured through effective financial and management systems;

7.6.1.3 working closely with the chair of the Board, the Chief Officer will ensure that proper constitutional, governance and development arrangements are put in place to assure the members (through the Board) of the organisation's ongoing capability and capacity to meet its duties and responsibilities. This will include arrangements for the ongoing developments of its members and staff;

7.6.1.4 Any other areas that the Chair and/or the Board considers appropriate to ensuring the delivery of the CCG's vision and aims.

7.7 Role of the Chief Finance Officer

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

7.7.2 This role of Chief Finance Officer has been summarised in a national document[49] as:

7.7.2.1 being the Board's professional expert on finance and ensuring, through robust systems and processes, the regularity and propriety of expenditure is fully discharged;

7.7.2.2 making appropriate arrangements to support, monitor on the group's finances;

7.7.2.3 overseeing robust audit and governance arrangements leading to propriety in the use of the group's resources;

7.7.2.4 being able to advise the 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

7.7.2.5 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.

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

8. Standards of Business Conduct & 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 Board (and its committees) will at all times comply with this constitution and be aware of their responsibilities as outlined in it. They should act in good faith and in the interests of the group and should follow the *Seven Principles of Public Life*, set out by the Committee on Standards in Public Life (the Nolan Principles) which is available on the SMCCG website.

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 SMCCG website.

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

8.2 Conflicts of Interest

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

8.2.2 Where an individual, i.e. an employee, group member, member of the Board, or a member of a committee or a sub-committee of the group or its 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.

8.2.3 A conflict of interest will include:

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

8.2.3.2 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;

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

8.2.3.4 outside employment with another organisation;

8.2.3.5 commercial sponsorship (deals whereby sponsorship is linked to the purchase of particular products to supply from particular sources are not allowed);

8.2.3.6 preferential rates or benefits in kind for private transactions carried out with organisations where individuals have had or may have (with the knowledge at the time) official dealings;

8.2.3.7 a gift over the value of £25 where this is not received on behalf of a team or department;

8.2.3.8 offers of hospitality which might reasonably be seen to compromise the individual's personal judgement or integrity;

8.2.3.9 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);

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

8.2.4 Where there are declarations made, there are three potential actions:

8.2.4.1 to be noted;

8.2.4.2 to include member in discussion but exclude from voting;

8.2.4.3 to exclude member from the discussion and exclude from voting.

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

8.3 Declaring and Registering Interests

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

8.3.1.1 the members of the group;

8.3.1.2 the members of its Board;

8.3.1.3 the members of its committees or sub-committees and the committees or sub-committees of its Board; and

8.3.1.4 its employees.

8.3.2 The registers will be published on the SMCCG website.

8.3.3 Individuals will declare any interest that they have, in relation to a decision to be made in the exercise of the commissioning functions of the group, in writing to the Board, as soon as they are aware of it and in any event no later than 28 days after becoming aware. A declaration form can be found at Appendix A of the Conflicts of Interest Policy.

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

8.3.5 The Chief Officer will ensure that the register of interest is reviewed regularly, and updated as necessary.

8.4 Managing Conflicts of Interest: general

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

8.4.2 The Chief Officer and lay member of the Board with responsibility for managing conflicts will ensure that for every interest declared, either in writing or by oral declaration, arrangements are in place to manage the conflict of interests or potential conflict of interests, to ensure the integrity of the group's decision making processes.

8.4.3 Arrangements for the management of conflicts of interest are to be determined by the Chief Officer and the lay member of the Board with responsibility for managing conflicts and will include the requirement to put in writing to the relevant individual arrangements for managing the conflict of interests or potential conflicts of interests, within a week of declaration. The arrangements will confirm the following:

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

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

8.4.4 Where an interest has been declared, either in writing or by oral declaration, the declarer will ensure that before participating in any activity connected with the group's exercise of its commissioning functions, they have received confirmation of the arrangements to manage the conflict of interest or potential conflict of interest from the Chief Officer and lay member overseeing the management of conflicts.

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

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

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

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

8.4.6 Where the chair of any meeting of the group, including committees, sub-committees, or the Board and the Board's committees and sub-committees, has a personal interest, previously declared or otherwise, in relation to the scheduled or likely business of the meeting, they must make a declaration and the deputy chair will act as chair for the relevant part of the meeting. Where arrangements have been confirmed for the management of the conflict of interests or potential conflicts of interests in relation to the chair, the meeting must ensure these are followed. Where no arrangements have been confirmed, the deputy chair may require the chair to withdraw from the meeting or part of it. Where there is no deputy chair, the members of the meeting will select one.

8.4.7 Any declarations of interests, and arrangements agreed in any meeting of the clinical commissioning group, committees or sub-committees, or the Board, the Board's committees or sub-committees, will be recorded in the minutes.

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

8.4.9 In making this decision the chair will consider whether the meeting is quorate, in accordance with the number and balance of membership set out in the group's standing orders. Where the meeting is not quorate, owing to the absence of certain members, the discussion will be deferred until such time as a quorum can be convened. Where a quorum cannot be convened from the membership of the meeting, owing to the arrangements for managing conflicts of

interest or potential conflicts of interests, the chair of the meeting shall consult with the lay member of the Board with responsibility for managing conflicts, and the finance officer on the action to be taken.

8.4.10 This may include:

8.4.10.1 requiring another of the group's committees or sub-committees, the group's Board or the Board's committees or sub-committees (as appropriate) which can be quorate to progress the item of business, or if this is not possible,

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

8.4.10.2.1 a member of the clinical commissioning group who is an individual;

8.4.10.2.2 an individual appointed by a member to act on its behalf in the dealings between it and the clinical commissioning group;

8.4.10.2.3 a member of a relevant Health and Wellbeing Board;

8.4.10.2.4 a member of a Board of another clinical commissioning group.

These arrangements must be recorded in the minutes.

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

8.4.12 The Chief Officer and lay member of the Board with responsibility for managing conflicts will take such steps as deemed appropriate, and request information deemed appropriate from individuals, to ensure that all conflicts of interest and potential conflicts of interest are declared.

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

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

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

8.6 Transparency in Procuring Services

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

8.6.2 The group will publish a Procurement Strategy approved by its Board which will ensure that:

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

8.6.2.2 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 SMCCG website.

9. South Manchester Clinical Commissioning Group as an Employer

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

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

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

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

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

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

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

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

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

9.10 SMCCG's Code of Conduct, together with the other policies and procedures outlined in this chapter, will be available on the SMCCG website.

10. Transparency, ways of working, disputes and standing orders

10.1. **General**

10.1.1. SMCCG 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, Board meeting dates, times, venues, and certain papers will be available on the SMCCG website.

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

10.1.4. The CCG has a process for the management of disputes, please see the SMCCG website.

10.2. **Standing Orders**

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

10.2.1.1. ***Standing orders*** – 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 Board;

10.2.1.2. ***Scheme of reservation and delegation*** – 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 Board, the Board's committees and sub-committees, the group's committees and sub-committees, individual members and employees;

10.2.1.3. ***Prime financial policies*** – which sets out the arrangements for managing SMCCG's financial affairs.