Gloucestershire Clinical Commissioning Group Governing Body

AGENDA

Meeting to be held at 2pm on Tuesday 2nd April 2013 in the Board Room, Sanger House, Brockworth, Gloucester GL3 4FE

No.	Item	Lead	Recommendation
1	Welcome	Dr Helen Miller	
2	Apologies for Absence	Dr Helen Miller	
3	Declarations of Interest	Dr Helen Miller	
4	Chair's Update	Dr Helen Miller	Information
5	Governance Arrangements	Mary Hutton	Approval
6	Annual Operating Plan	Mark Walkingshaw	Approval
7	Budget Planning 2013/14	Cath Leech	Approval
8	Partnership Agreements	Cath Leech	Approval
9	Any Other Business (AOB)	Dr Helen Miller	
10	Public Questions	Dr Helen Miller	
Date and time of next meeting: Tuesday 30th May 2013 at 2pm in Board Room at Sanger House			

Questions should be sent in advance to the Associate Director of Corporate Governance by 12 noon on Tuesday 26th March 2013. Questions must relate to items on the agenda.

Agenda Item 4

Gloucestershire Clinical Commissioning Group

Board Meeting Date	**Tuesday, 2nd April 2013**
Title	**Gloucestershire Clinical Commissioning Group (GCCG) Board Chair's Report**
Executive Summary	This report outlines the key issues addressed by GCCG in March 2013.
Key Issues	The key issues arising include: • The Risk Stratification Model • Living Well Project • Quality Strategy
Risk Issues	None
Financial Impact	None
Legal Issues (including NHS Constitution issues)	None
Impact on Equality and Diversity	None
Impact on Health Inequalities	None
Impact on Sustainable Development	None
Patient and Public Involvement	
Recommendation	This report is provided for information and the Board is requested to note the contents.
Author	Dr Helen Miller
Designation	Gloucestershire CCG Chair
Sponsoring Director (if not author)	

Gloucestershire Clinical Commissioning Group (GCCG)
Chair's Report

1 Introduction

1.1 This report outlines the key events affecting the Gloucestershire CCG in March.

2 Risk Stratification Model

2.1 Alan Thompson from Central Southern Commissioning Support Unit (CSCSU) provided Gloucestershire CCG members with an update on the implementation roll-out programme of the risk stratification and predicative model which identifies patients 'at risk' of hospitalisation.

2.2 In the development of the implementation plan for the risk stratification tool across the county, a number of areas must be considered:

- Link to service redesign
- Clinical leadership
- Extraction of primary care data and
- Communication and engagement

2.3 It is proposed to test the process of data extraction, input into the system and reporting outputs. This is largely a technology testing period which aims to ensure that data extraction works efficiently, data can be incorporated into a tool alongside secondary and community care data and review the reporting functionality.

2.4 Alan Thompson advised that pathfinder/pioneer surgeries should need to be involved and clear guidance would be given to practices before this takes place It was agreed that Dr Malcolm Gerald will support the data extraction for South Cotswolds and a Gloucester City lead will be identified.

3 Living Well Project

3.1 Mark Smith (MS), Vanguard Consultant for the Living Well programme and Dr Simon Opher (SO), Stroud & Berkeley Vale Locality gave an update to the CCG on the Living Well team who have been working in Dursley (there is a parallel adopter site in Tewkesbury). MS and SO updated the CCG on

the lessons learned from studying the current system and how the team are now 'designing for perfect' whilst keeping the person centred approach. The team in Dursley are now taking live demand over and above the cases that had been selected in partnership with the Lead GP Practice. The frontline team are empowered and using their skills and time to best effect which has produced high patient/person satisfaction with the GPs welcoming the approach.

3.2 The vital role of leaders across the system has been reinforced. In order for this programme to succeed and change the current system, providers and commissioners need to work collaboratively.

3.3 There is a key stage in the early summer where leaders will need to decide if they are committed to further scaling up of the pilot.

3.4 It was explained that outcome measures are being developed both in the work at the frontline with staff and the person/patient, as well as across the health and social care system. Early signs are that quality, efficiency and effectiveness are better and costs are less.

4 CCG Quality Development Session

4.1 On the 14th March an externally facilitated quality development session was held attended by GCCG Board members and key quality and commissioning managers from GCCG. The facilitator was Yvonne Sawbridge, Senior Fellow, Health Services Management Centre, University of Birmingham. Yvonne was previously Director of Quality and Nursing at South Staffordshire PCT and has been involved in the Francis Inquiry.

4.2 The aim of the session was to provide an opportunity to develop GCCGs approach to quality assurance and quality development and to start scoping GCCG Quality Strategy, taking into account the recommendations contained within the Francis report.

4.3 Attendees reviewed current areas of activity within the quality arena and identified strengths and areas for development. It was recognised that the current systems of quality assurance were robust and that there was a strong foundation from the PCT-legacy with constructive working relationships existing

with providers allowing a high level of transparency and scrutiny.

4.4 The session identified some key early priorities for action including:

- Quality and Performance reports to be combined to provide assurance of the quality of commissioned services through presentation of evidence across healthcare systems. Reports to be structured to include themed reviews and “prompts to debate questions”.
- Define more clearly what good quality care looks like to a patient and use this to inform a CCG-definition of quality. Determine how we use the quality system to meet the needs of the patient.
- Expand the use of “soft” data and triangulation of quality indicators through the development of assurance frameworks at a GCCG and a cross-provider level.
- Describe the important things that we can influence as commissioners.

4.5 Next steps will be discussed and agreed at the first GCCG Commissioning for Quality group meeting.

5 Recommendation

This report is provided for information and the Board is requested to note the contents.

Agenda Item 5

Gloucestershire Clinical Commissioning Group
Governing Body

Meeting Date	**2rd April 2013**
Title	**Governance Arrangements**
Executive Summary	This paper outlines the principal documents upon which the governance structure of the Gloucestershire Clinical Commissioning group is based. The Constitution establishes the principles and values of the Gloucestershire Clinical Commissioning Group (the CCG) in commissioning care for the health community of Gloucestershire. The document, which has been developed following a comprehensive consultation exercise, has been signed up to by all 85 member GP practices. The paper also presents twelve principal policies for approval and lists those policies of the former Gloucestershire PCT that are being recommended for adoption by the CCG. Finally, details are provided of the healthcare contracts created by the former Gloucestershire PCT that are being taken over by the CCG as well as details of those services currently in the process of being procured.
Key Issues	These are set out in the main body of the attached Constitution and policies.
Risk Issues:	The absence of a Constitution and a full range of policies covering all activities of the

Original Risk **Residual Risk**	CCG could result in inappropriate actions being taken that may not comply with legislation, national guidance or good practice. 3x3 = 9 0x3 = 0
Financial Impact	None
Legal Issues (including NHS Constitution)	Not Applicable.
Impact on Equality and Diversity	Not Applicable.
Impact on Health Inequalities	The are no direct health and equality implications contained within this report
Impact on Sustainable Development	The are no direct sustainability implications contained within this report
Patient and Public Involvement	Not applicable
Recommendation	The Board is asked to: • Note the content of this paper • Approve the Constitution including the revised: o Standing Orders; o Scheme of Reservation and Delegation; o Detailed Scheme of Delegation; o Prime Financial Policies; and o Terms of Reference for the principal committees. • Approve the twelve attached policies. • Adopt the listed polices of the former Gloucestershire PCT.
Author & Designation	Alan Potter, Associate Director Corporate Governance
Sponsoring Director (if not author)	Mary Hutton, Accountable Officer

Agenda Item 5

Gloucestershire Clinical Commissioning Group
Governing Body

2nd April 2013

Governance Arrangements

1. Introduction

1.1 The attached documents provide a framework upon which the governance structure of the Gloucestershire Clinical Commissioning Group (the CCG) is based.

1.2 The CCG was authorised by the NHS Commissioning Board in December 2012, with two conditions:

- The CCG must have a clear and credible integrated plan that meets authorisation requirements and
- The CCG must have a detailed financial plan that delivers financial balance, sets out how it will manage within its management allowance, and is integrated with the commissioning plan

1.3 Supporting planning documentation has since been forwarded to the NHSCB in order to discharge these conditions. A letter from the NHSCB is due imminently and a verbal update will be given at the Governing Body meeting.

1.4 The CCG submitted the relevant paperwork to the Information Commissioner's Office to satisfy the legal requirement for notification under the Data Protection Act (1998) on 22/3/12.

2. Constitution

2.1 The Constitution, shown at Appendix A, establishes the principles and values of the CCG in commissioning care for the health community of Gloucestershire.

2.2 The Constitution sets out the arrangements the CCG has made to discharge its functions, the role of its governing body, and its key processes for decision making, including arrangements for securing transparency in the decision making.

2.3 The document, which is based on the Model Constitution Framework issued by the NHSCB, was drafted in April 2012 and since that time has been developed following a comprehensive consultation exercise. All 85 member GP practices signed up to the Constitution.

2.4 The document has recently been reviewed and a number of amendments made. The principal changes made were:

- The removal of all references to the PCT to reflect the CCG as the new statutory organisation;
- Further detail regarding the Scheme of Reservation and Delegation and the Detailed Scheme of Delegation;
- Amendment of the Terms of Reference for the principal committees;
- Updated Prime Financial Policies in line with the former PCT's Standing Financial Instructions; and
- Updated Standing Orders to reflect the CCG as the new statutory organisation.

3. Governance Structure

3.1 As outlined in the Constitution, the Gloucestershire CCG has a governance structure as shown below:

- Governing Body
- Audit Committee
- Integrated Governance Committee (IGC)
- Remuneration and Terms of Service Committee

3.2 The proposed membership of the Governing Body and main Committees is as follows:

Role/Post (Person)	Governing Body	Audit Committee	Remuneration Committee	IGC
CCG Chair (Helen Miller)	✓	*	✓	✓
Deputy Clinical Chair (Andy Seymour)	✓	✓	✓	
GP Locality – Tewkesbury (Jeremy Welch)	✓		✓	
GP Locality – S. Cots (Malcolm Gerald)	✓			✓
GP Locality – N. Cots (Caroline Bennett)	✓			✓
GP Locality – Gloucester (Will Haynes)	✓			
GP Locality – Cheltenham (TBA)	✓			
GP Locality – Forest of Dean (Martin Gibbs)	✓			✓
GP Locality – Stroud (Charles Buckley/Hein Le Roux) Job-share	✓	✓ HLR		✓ CB
Accountable Officer (AO) (Mary Hutton)	✓	*	*	✓
Chief Financial Officer (CFO)	✓	*	*	✓
Director of Public Health(Shona Arora)	✓			✓
Director of Adult Social Care (Margaret Wilcox)	✓			
Registered Nurse (Julie Clatworthy)	✓			✓
Secondary Care Specialist (Steve Allder)	✓			✓
Lay Member – Governance (Colin Greaves)	✓	Chair	✓	✓
Lay Member – Business (Valerie Webb)	✓	✓	✓	✓

Role/Post (Person)	Governing Body	Audit Committee	Remuneration Committee	IGC
Lay Member – PPE & (Vice Chair) (Alan Elkin)	✓	✓	✓	✓
Lay Member – PPE (Rob Rees)	✓		✓	
Director of Quality and Assurance	✓			✓
Director of Transformation and Service Redesign	✓			
Director of Commissioning Implementation	✓			✓
Secretariat	*	*	*	*

Legend: Member = ✓ In attendance = *

4. Policies

4.1 The policies attached at Appendices B to M, have been compiled to support the approaches of the CCG outlined in the Constitution. The twelve policies are:

- Whistleblowing Policy
- Policy for Managing Conflict of Interest
- Procurement Strategy for the Purchase of Healthcare Services
- Policy of the Development, Ratification and Implementation of Policies and Related Procedural Documents ('Policy on Policies')
- Annual Leave Policy
- Counter Fraud Policy
- Appeals Policy
- Capability Policy
- Disciplinary Policy
- Grievance Policy
- Harassment and Bullying Policy
- Sickness Absence Policy

4.2 In addition to the above, the policies of the former NHS Gloucestershire, listed at Appendix N, will have continuing relevance to the CCG and it is recommended that these are adopted. All policies will be reviewed during 2013/14.

5. Healthcare contracts

5.1 A number of healthcare contracts set-up by the former Gloucestershire PCT are being transferred to the CCG. A list of theses existing contracts is provided for information at Appendix O.

5.2 The schemes below are currently being procured:

- GP Out of Hours
- Computerised Tomography
- Elective Care Services
- Endoscopy Services
- Magnetic resonance Imaging
- Non-obstetric Ultrasound

6. Recommendations

The Board is asked to:

- Note the content of this paper
- Approve the Constitution
- Approve the eleven attached policies
- Adopt the listed polices of the former Gloucestershire PCT.

7. Appendices

A. Constitution
B. Whistleblowing Policy
C. Policy for Managing Conflicts of Interest
D. Procurement Strategy for the Purchase of Healthcare Services
E. Policy of the Development, Ratification and Implementation of Policies and Related Procedural Documents ('Policy on Policies')
F. Annual Leave Policy
G. Counter Fraud Policy
H. Appeals Policy
I. Capability Policy
J. Disciplinary Policy
K. Grievance Policy
L. Harassment and Bullying Policy
M. Sickness Absence Policy
N. Policies of the former Gloucestershire PCT recommended for adoption
O. Healthcare contracts negotiated by the former Gloucestershire PCT being taken over by the Gloucestershire CCG

NHS

Gloucestershire Clinical Commissioning Group

Appendix A

Gloucestershire Clinical Commissioning Group

Constitution

Version 7 (1st April 2013)

CONTENTS

FOREWORD

Gloucestershire Clinical Commissioning Group (GCCG) will embed clinical leadership at the heart of commissioning in Gloucestershire, supporting transformation to the new model of Clinical Commissioning set out in the Health & Social Care Act 2012. Our approach is set out in our vision, values and mission statement:

Our Vision:

Joined up care for the people of Gloucestershire

Values/Aims:

We will:

- Ensure effective communication and engagement with clinicians, patients, carers, community partners and the public and clinicians;
- Use our clinical experience to ensure high quality, safe and efficient services for the people of Gloucestershire;
- Focus on clinical benefit and health outcomes – making best use of the money and resources available;
- Use our clinical experience to lead innovation and change – right care, right place, right time;
- Be accountable and transparent in our decision making.

Mission Statement

- To commission excellent and modern health services on behalf of the NHS for all people in Gloucestershire through effective clinical leadership, with particular focus on patient safety and continuous improvements in the patient experience.

This Constitution establishes the principles and values of GCCG in commissioning care for the health community of Gloucestershire.

It also describes the governing principles, rules and procedures that GCCG will establish to ensure probity and accountability in the day to day running of GCCG, to ensure decisions are taken in an open and transparent way and that the interests of patients and the public remain central to the values/aims of GCCG.

This Constitution applies to all member practices, GCCG employees, individuals working on behalf of the group including anyone who is a member of the group's governing body (including the governing body's audit and remuneration committees) and any other employee or other person working on behalf of the group.

This Constitution will be reviewed in September 2013 and updated as necessary to reflect the transfer of responsibility, and thereafter at least every 3 years with the involvement of clinicians, the public, patients, carers, community partners and staff.

1. INTRODUCTION AND COMMENCEMENT

1.1. Name

1.1.1. The name of this clinical commissioning group is Gloucestershire Clinical Commissioning Gloucestershire ("GCCG", "the group").

1.2. Statutory Framework

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

1.2.2. The NHS Commissioning Board 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 with constituent members. The members of the clinical commissioning group are responsible for determining the governing arrangements for their organisations, which they are required to set out in a constitution.[7]

1.3. Status of this Constitution

1.3.1. This constitution is made between the members of Gloucestershire Clinical Commissioning Group and has effect from 1 day of April 2013, when the NHS Commissioning Board established the group.[8] The Constitution will be published on the group's dedicated website, and will also be available on request from GCCG.

1.3.2. Documentation will be available upon request for inspection at:

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

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

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

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

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

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

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

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

Sanger House
5220 Valiant Court
Gloucester Business Park
Brockworth
Gloucestershire GL3 4FE

1.3.3 This information will also be available from Guide & PALS who can be contacted on 0800 0151548 or email: community.pals@glos.nhs.uk

1.4. Amendment and Variation of this Constitution

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

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

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

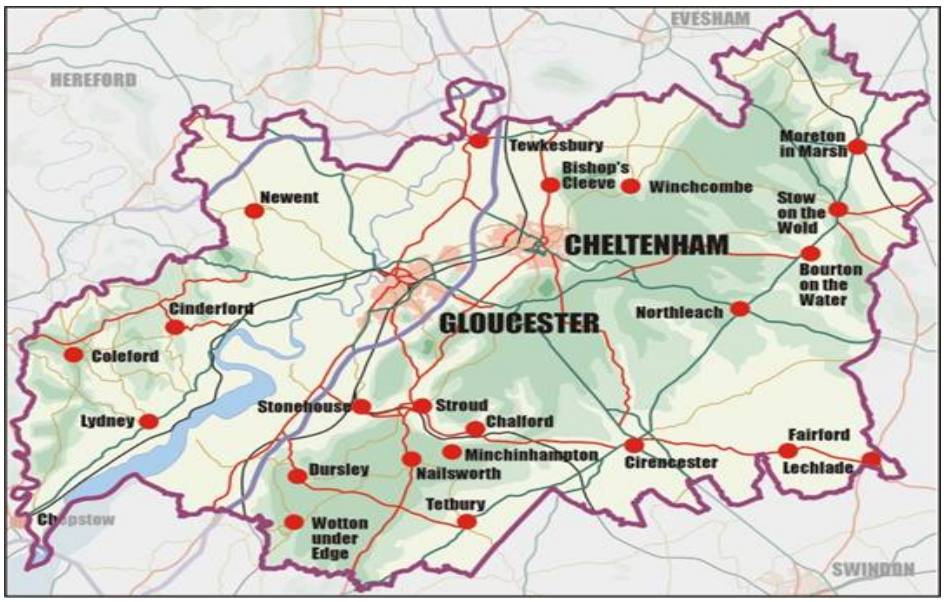
[9] See sections 14E and 14F of the 2006 Act, inserted by section 25 of the 2012 Act and any regulations issued

2. AREA COVERED

2.1. The geographical area covered by Gloucestershire Clinical Commissioning Group is coterminous with that covered by Gloucestershire County Council, covering 271,207 hectares with a population of **616,340** which is divided into the following District Councils:

- Cheltenham District Council;
- Cotswold District Council;
- Forest of Dean District Council;
- Gloucester District Council;
- Stroud District Council;
- Tewkesbury District Council.

2.2 All constituent practices are located within the same local authority boundary.



3. MEMBERSHIP

3.1. GP Practice Membership of Gloucestershire Clinical Commissioning Group

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

Practice Name	Address (Main Surgery Only)
Cheltenham Locality	
Berkeley Place Surgery	11 High Street, Cheltenham, Gloucestershire
Corinthian Surgery	St Paul's Medical Centre, 121 Swindon Road, Cheltenham
Crescent Bakery Surgery	Crescent Bakery, St Georges Place, Cheltenham
Leckhampton Surgery	Lloyd Davies House, 17 Moorend Park Road, Cheltenham
Overton Park Surgery	Overton Park Road, Cheltenham, Gloucestershire
Royal Crescent Surgery	11 Royal Crescent, Cheltenham, Gloucestershire
Royal Well Surgery	St Paul's Medical Centre, 121 Swindon Road, Cheltenham
Seven Posts Surgery	Prestbury Road, Cheltenham, Gloucestershire
Sixways Clinic	London Road, Charlton Kings, Cheltenham
Springbank Surgery	Springbank Way, Cheltenham, Gloucestershire
St Catherine's Surgery	St Paul's Medical Centre, 121 Swindon Road, Cheltenham
St George's Surgery	St Paul's Medical Centre, 121 Swindon Road, Cheltenham
Stoke Road Surgery	4 Stoke Road, Bishops Cleeve, Cheltenham
The Portland Practice	St Paul's Medical Centre, 121 Swindon Road, Cheltenham
Underwood Surgery	139 St George's Road, Cheltenham, Gloucestershire
Winchcombe Medical Centre	Greet Road, Winchcombe, Cheltenham
Yorkleigh Surgery	93 St George's Road, Cheltenham, Gloucestershire
Forest of Dean Locality	
Blakeney Surgery	Millend, Blakeney, Gloucestershire
Brunston Practice	Cinderhill, Coleford, Gloucestershire

Practice Name	Address (Main Surgery Only)
Coleford Health Centre	Railway Drive, Coleford, Gloucestershire
Dockham Road Surgery	Dockham Road Surgery, Cinderford, Gloucestershire
Drs Andrew, Edwards, Hayes & Cleary	Yorkley Health Centre, Bailey Hill, Yorkley, Lydney
Drybrook Surgery	Drybrook, Gloucestershire
Forest Health Care	The Health Centre, Dockham Road, Cinderford
Lydney Practice	The Health Centre, Albert Street, Lydney
Mitcheldean Surgery	Brook Street, Mitcheldean, Gloucestershire
Newnham Surgery	High Street, Newnham on Severn, Gloucestershire
Severnbank Surgery	Tutnalls Street, Lydney, Gloucestershire
Gloucester City Locality	
Barnwood Medical Practice	51 Barnwood Road, Gloucester, Gloucestershire
Bartongate Surgery	115 Barton Street, Gloucester, Gloucestershire
Cheltenham Road Surgery	16 Cheltenham Road, Gloucester, Gloucestershire
Gloucester City Health Centre	The Park, Gloucester, Gloucestershire
Gloucester Health Access Centre	Eastgate House, 121-131 Eastgate Street, Gloucester
Hadwen Medical Practice	Glevum Way Surgery, Abbeydale, Gloucester
Heathville Medical Practice	5 Heathville Road, Gloucester, Gloucestershire
Hucclecote Surgery	5A Brookfield Road, Hucclecote, Gloucestershire
Kingsholm Surgery	Alvin Street, Gloucester, Gloucestershire
London Road Medical Practice	97 London Road, Gloucester, Gloucestershire
Longlevens Surgery	19b Church Road, Longlevens, Gloucester
Matson Lane Surgery	Taylor House, 4 Matson Lane, Matson
Partners in Health	Pavilion Family Doctors, 153a Stroud Road, Gloucester
Quedgeley Medical Centre	Olympus Park, Quedgeley, Gloucester

Practice Name	Address (Main Surgery Only)
Rosebank Health	153b Stroud Road, Gloucester, Gloucestershire
Saintbridge Surgery	Askwith Road, Saintbridge, Gloucestershire
St. Johns Avenue Surgery	Churchdown, Gloucester, Gloucestershire
The College Yard Surgery	Mount Street, Westgate, Gloucester
The Surgery	Abbotswood Road, Brockworth, Gloucestershire
North Cotswolds Locality	
Chipping Campden Surgery	Back Ends, Chipping Campden, Glos
Cotswold Medical Practice	Moore Road, Bourton on the Water, Cheltenham
Mann Cottage Surgery	Oxford Street, Moreton in Marsh, Cheltenham
Stow Surgery	Well Lane, Stow on the Wold, Gloucestershire
White House Surgery	High Street, Moreton in Marsh, Gloucestershire
South Cotswolds Locality	
The Avenue Surgery	1 The Avenue, Cirencester, Gloucestershire
Hilary Cottage Surgery	Keble Lawns, Fairford, Gloucestershire
LechladeMedical Centre	Oak Street, Lechlade, Gloucestershire
The Park Surgery	Old Tetbury Road, Cirencester, Gloucestershire
Phoenix Surgery	9 Chesterton Lane, Cirencester, Gloucestershire
Rendcomb Surgery	Rendcomb, Cirencester, Gloucestershire
Romney House	41-43 Long Street, Tetbury, Gloucestershire
St Peter's Road Surgery	1 St Peter's Road, Cirencester, Gloucestershire
Stroud Locality	
Acorn Practice	May Lane Surgery, Dursley, Gloucestershire
Beeches Green Surgery	Beeches Green, Stroud, Gloucestershire
Chipping Surgery	Symn Lane, Wotton under Edge, Gloucestershire
Culverhay Surgery	Wotton under Edge, Gloucestershire

Practice Name	Address (Main Surgery Only)
Frithwood Surgery	45 Tanglewood Way, Bussage, Stroud
High Street Medical Centre	31 High Street, Stonehouse, Gloucestershire
Hoyland House	Gyde Road, Painswick, Gloucestershire
Locking Hill Surgery	Locking Hill, Stroud, Gloucestershire
Marybrook Medical Centre	Marybrook Street, Berkeley, Gloucestershire
Minchinhampton Surgery	Bell Lane, Minchinhampton, Gloucestershire
Prices Mill Surgery	New Market Road, Nailsworth, Gloucestershire
Regent Street Surgery	72 Regent Street, Stonehouse, Gloucestershire
Rowcroft Medical Centre	Stroud, , Gloucestershire
St Lukes Medical Centre	53 Cainscross Road, Stroud, Gloucestershire
Stonehouse Health Clinic	High Street, Stonehouse, Gloucestershire
Stroud Valleys Family Practice (Staniforth)	Beeches Green Health Centre, Stroud, Gloucestershire
The Orchard Medical Centre	Fairmead, Cam, Dursley, Gloucestershire
The Surgery	Whitminster Lane Frampton on Severn, Gloucestershire
Uley Surgery	42 The Street, Uley, Dursley, Gloucestershire
Walnut Tree Practice	May Lane Surgery, Dursley, Gloucestershire
Tewkesbury Locality	
Church Street Practice	77 Church Street, Tewkesbury, Gloucestershire
Holts Health Centre	Watery Lane, Newent, Gloucestershire
Jesmond House Practice	Chance Street, Tewkesbury, Gloucestershire
The Surgery	Corse, Staunton, Gloucester
Watledge Surgery	Barton Road, Tewkesbury, Gloucestershire

3.1.2. Appendix B of this constitution contains the list of member practices, together with the signatures of the practices representatives confirming their agreement to this Constitution.

3.2. Eligibility

3.2.1. Providers of primary medical services to a registered list of patients under a General Medical Services (GMS), Personal Medical Services (PMS) or Alternative Provider Medical Services (APMS) contract will be eligible to apply for membership of this group[10].

No GP practice shall become a member of GCCG unless that practice:

(a) is a holder of a primary medical contract;

(b) is a primary care services provider in the relevant Locality;

(c) has completed an application for membership to GCCG;

(d) has submitted an application to the NHS Commissioning Board and had its application approved; and

(e) has been entered into the Register of Members.

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

4. MISSION, VALUES AND AIMS

4.1. Mission

4.1.1. The mission of Gloucestershire Clinical Commissioning Group is to commission excellent and modern health services on behalf of the NHS for all people in Gloucestershire through effective clinical leadership, with particular focus on patient safety and continuous improvements in the patient experience.

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 and Aims

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

4.2.2. The values/aims that lie at the heart of the group's work are to:

- Ensure effective communication and engagement with patients, carers, community partners, the public and clinicians;
- Use our clinical experience to ensure high quality, safe and efficient services for the people of Gloucestershire;
- Focus on clinical benefit and health outcomes – making best use of the money and resources available;
- Use our clinical experience to lead innovation, variation, equity and change – right care, right place, right time;
- Be accountable and transparent in our decision making.

4.3. Principles of Good Governance

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

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

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

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

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11 Inserted by section 25 of the 2012 Act

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

13 See Appendix G

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

e) the Equality Act 2010;[15]

f) GCCG will adopt the 'Standards for Members of NHS Boards and Governing Bodies in England' which are under consultation at present.

4.4. Accountability

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

a) publishing its constitution;

b) appointing independent lay members and other healthcare professionals to its governing body;

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

d) meaningful engagement, communication and consultation with the population of Gloucestershire;

e) publishing annually a commissioning plan;

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

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

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

i) having a published and clear complaints process;

j) complying with the Freedom of Information Act 2000;

k) providing information to the NHS Commissioning Board as required.

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

a) Publishing a public-facing guide to GCCG setting out its priorities;

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[14] See Appendix H

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

b) A dedicated on-line presence, including social media channels.

4.4.3. The governing body of the group will throughout each year have an on-going role in reviewing the group's governance arrangements to ensure that the group continues to reflect the principles of good governance.

5. FUNCTIONS AND GENERAL DUTIES

5.1. Functions

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

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

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

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

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

d) determining the remuneration and travelling or other allowances of members of its governing body.

5.1.2. In discharging its functions the group will:

a) act[16], when exercising its functions to commission health services, consistently with the discharge by the Secretary of State and the NHS Commissioning Board of their duty to ***promote a comprehensive health and wellbeing service***[17] *and* with the objectives and requirements placed on the NHS Commissioning Board through *the mandate*[18] published by the Secretary of State before the start of each financial year by:

i) Specifying guidelines and policies that set out how GCGG, its committees, sub committees and employees are to exercise, monitor and report on GCCG's delegated powers and responsibilities;

ii) The GCCG Clinical Chair is the Vice Chair of Gloucestershire Health & Wellbeing Board (GH&WB) and is supported by a GP/Other Health Professional (OHP) Clinical Commissioning Lead.

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

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

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

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

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

i) Encouraging patient experience feedback from communities of interest;

ii) Making services accessible and information available in all formats as required through interpretation and translation contracts;

iii) Being an active participant at the Overview & Scrutiny Committee;

iv) Being a member of the Public Sector partnership;

v) Publishing at least annually, sufficient information to demonstrate compliance with this general duty across all GCCG functions;

vi) Preparing and publishing specific and measurable equality objectives, revising these at least every four years;

vii) Being committed to the equality agenda and recognises the value of the Equality Delivery Scheme in achieving the public sector equality duty.

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

i) Continuing to work with Public Health in refreshing and further developing the Joint Strategic Needs Assessment (JSNA). (The JSNA is accessible from the group's website, and is also available on request from GCCG.);

ii) Using the JSNA to underpin commissioning decisions and plans;

iii) Working with Gloucestershire Health & Wellbeing Board (GH&WB).

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[22] by:

a) Adhering to the duties as described in Section 14z2 of the Health & Social Care Act in relation to service change;

b) Adopting a Communication & Engagement Strategy;

c) Paying due regard to standards set out in the NHS Constitution in relation to public involvement;

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

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

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

d) Using GCCG toolkit to support engagement in localities.

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

a) Paying due regard to involvement throughout the communications cycle in order to ensure patient voice influences commissioning intentions;

b) Producing a guide for patients on the NHS Constitution (information available on website);

c) Continuing to support the role of GCCG GP Public & Patient Involvement Champion;

d) Ensuring provider contracts pay due regard to the NHS Constitution;

e) Continuing with the six-monthly stocktake with the NHS Commissioning Board on GCCG and all providers.

5.2.3. Act ***effectively, efficiently and economically***[24] :

a) See the attached Prime Financial Policies (Appendix F).

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

a) Prime Financial Policies;
b) Commissioning for Quality and Innovation (CQUINS) framework;
c) Robust commissioning contracts;
d) Best Practice Tariffs;
e) National Institute for Health & Clinical Excellence (NICE) Quality Standards;
f) Commissioning Outcomes Frameworks;
g) National and Local Audits;
h) Academic Health Service Networks;
i) Quality, Innovation, Productivity and Prevention (QIPP) transformational programmes.

5.2.5. Assist and support the NHS Commissioning Board in relation to the Board's duty to ***improve the quality of primary medical services***[26] by:

a) Continuously improving the quality of services and the patient experience within primary care, which is a key objective of GCCG, including;

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

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

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

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

- Patient access to services;
- Patient satisfaction surveys;
- Clinical audit;
- Primary Care clinical governance arrangements;
- Patient Safety;
- Health promotion;
- Reducing health inequalities;
- Reduce variation;
- Focus on clinical benefit and outcomes;
- Medications Management;
- Peer review and referral management.

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

a) Using the JSNA to underpin commissioning decision and plans. (The JSNA is accessible from the group's website, and is also available on request from GCCG.);

b) Using the Joint Health & Wellbeing Strategy, which is currently under development, using the principles outlined in the Marmot Review (Fair Society, Healthy Lives) on health inequalities. The framework for the strategy will map to Marmot's life course approach and address the areas for action set out in 'Healthy Lives Healthy People'.

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

a) Adopting a quality framework regarding patient experience which requires provider organisations to involve patients, their carers and representatives in decisions about their healthcare;

b) Adopting the new Individual Funding Request (IFR) process ('No decision about me without me');

c) The new Clinical Programme Groups will be charged with ensuring Public & Patient Involvement (PPE/PPI) in their work.

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

a) Adopting the 'Choice programme' and 'Choose Well Programme';

b) Adopting the new Individual Funding Request (IFR) process (supporting the principle of 'No decision about me without me');

c) Working with Patient Advice Liaison Service (PALS) to ensure patients can navigate through the healthcare system.

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

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

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

5.2.9. ***Obtain appropriate advice***[30] from persons who, taken together, have a broad range of professional or specialist expertise in health and social care and public health by working with and through:

a) Expert Patient Groups;
b) Locality Commissioning Groups and constituent practices;
c) Locality Commissioning Lay Members;
d) Agreeing changes and improvements to clinical services with secondary and tertiary services colleagues through appropriate forums, for example the Clinical Priorities Forum;
e) Working closely with Public Health professionals;
f) Working with the Registered Nurse or OHP on Governing Body to ensure a multi-professional view is sought and incorporated;
g) Social Care services;
h) Third sector providers.

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

a) Using an evidence-based best practice approach to the commissioning of services;
b) Ensuring that services commissioned are outcome-focused;
c) Measure improvements in patient health and experience;
d) Keeping abreast of any new advances in technology;
e) Being proactive in the management of medicines
f) Using tools such as the Annual Operating Plan (AOP), which outlines the opportunities for innovation and quality improvements that CCG intends to implement in2013/14 onwards.

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

a) Working with and through the Gloucestershire Research & Development Support Unit (R&DSU);
b) Improving the environment for health research by facilitating and encouraging sharing of best practice and working with other organisations;
c) Supporting the development of services and healthcare practice based upon clear evidence.

5.2.12. Have regard to the need to ***promote education and training***[33] for persons who are employed, or who are considering becoming employed, in an activity which involves or is connected with the provision of services as part of the health service in England so as to assist the Secretary of State for Health in the discharge of his related duty[34] by carrying out annual appraisal and personal development review with staff (annual appraisal documentation, guidance notes and training courses are available on the internal website).

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

5.2.13. Act with a view to ***promoting integration*** both of health services with other health services and of health services with health-related and social care services where the group considers that this would improve the quality of services or reduce inequalities[35] by being actively involved in:

- Gloucestershire Total Place;
- Joint Commissioning Partnership (JCP);
- Gloucestershire Health & Wellbeing Board (GH&WB);
- Leadership Gloucestershire;
- Childrens' Partnership;
- Safeguarding Boards.

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

5.3.1. ***Ensure its expenditure does not exceed the aggregate of its allotments for the financial year***[36]:

a) See Prime Financial Policies (Appendix F).

5.3.2. ***Ensure its use of resources*** *(both its capital resource use and revenue resource use)* ***does not exceed the amount specified by the NHS Commissioning Board for the financial year***[37]:

a) See Prime Financial Policies (Appendix F).

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

a) See Prime Financial Policies (Appendix F).

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

a) Embedding the continuous improvement to the quality of services within contractual agreements and monitoring outputs with all provider types;

b) Using the Commissioning for Quality & Innovation (CQUIN) payment framework to reward excellence, by linking a proportion of providers' income to the achievement of local quality improvement goals. The quality goals reflect local priorities, which are stretched and focused. They will concentrate on innovation and improvement to reduce variation and improve outcomes. They are influenced by:

35 See section 14Z1 of the 2006 Act, inserted by section 26 of the 2012 Act
36 See section 223H(1) of the 2006 Act, inserted by section 27 of the 2012 Act
37 See sections 223I(2) and 223I(3) of the 2006 Act, inserted by section 27 of the 2012 Act
38 See section 223J of the 2006 Act, inserted by section 27 of the 2012 Act
39 See section 223K(7) of the 2006 Act, inserted by section 27 of the 2012 Act

- Local and national priorities;
- Commissioner/provider discussions;
- Local clinical engagement;
- Patient and public engagement and involvement;
- Academic Health Service Networks;

c) In addition to the CQUIN framework, by including key performance and quality indicators within the contracts which are monitored on a monthly basis. Some indicators are nationally mandated, others are locally identified related to specific quality areas where the commissioners would wish to see a year on year improvement in performance;

d) All providers producing annual quality accounts which are reviewed by the GCCG and which will receive a formal sign off;

e) Having, for each main provider contract, a Clinical Quality Review Group. This is a sub group to the contract board and reviews quality issues with the provider, identifying any areas of concern, which then require remedial action plans to be implemented. The group considers progress against CQUIN schemes and output from the provider clinical audit programme, reviews Serious Incidents (SIs) and patient complaints, and oversees Never Events. It will also review the output from any Care Quality Commission (CQC) review and report, ensuring appropriate remedial actions are identified and implemented.

5.4. Other Relevant Regulations, Directions and Documents

5.4.1. The group will:

a) comply with all relevant regulations;

b) comply with directions issued by the Secretary of State for Health or the NHS Commissioning Board; and

c) have regard to guidance issued by the NHS Commissioning Board.

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 GOVERNING STRUCTURE

6.1. Authority to act

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

a) any of its members;

b) its governing body;

c) employees;

d) a committee or sub-committee of the group.

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

a) the group's scheme of reservation and delegation; and

b) for committees, their terms of reference.

6.2. Scheme of Reservation and Delegation[40]

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

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

b) those decisions that are the responsibilities of its governing body (and its committees), the group's committees and sub-committees, individual members and employees.

6.2.2. Gloucestershire 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 them, its governing body (and its committees)[41] and individuals must:

a) comply with the group's principles of good governance,[42]

b) operate in accordance with the group's scheme of reservation and delegation,[43]

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40 See Appendix D

41 See CCG Proposed Structure in Appendix J.

42 See section 4.4 on Principles of Good Governance above

43 See appendix D

c) comply with the group's standing orders,[44]

d) comply with the group's arrangements for discharging its statutory duties,[45]

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

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

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

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

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

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

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

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

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

6.4. Committees of the Group

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

6.5. Joint Arrangements

6.5.1 See Appendix J for a diagram showing CCG's Governance Structure.

6.5.2 GCCG will delegate authority to members or employees participating in joint arrangements to make decisions on its behalf (the group thereby retaining accountability for such decision). Therefore it will be the individual member / employee who has the delegated authority to make a decision rather than any joint arrangement. These arrangements will come into effect as of 1st April 2013.

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44 See appendix C

45 See chapter 5 above

6.5.3 The group has joint committees with the following local authority(ies):

a) Joint Commissioning Boards for Adults, Children, Mental Health and Learning Disabilities with Gloucestershire County Council.

6.6. The Governing Body

6.6.1 ***Functions*** - the governing body has the 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.[46]

a) ensuring that the group has appropriate arrangements in place to exercise its functions *effectively, efficiently and economically* and in accordance with the groups *principles of good governance*[47] (its main function);

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

c) approving any functions of the group that are specified in regulations;[48]that the membership will delegate to their governing body;

d) ensuring that the register(s) of interest is reviewed regularly, and updated as necessary;

e) ensuring that all conflicts of interest or potential conflicts of interest are declared.

6.6.2 ***Quorum*** - Any quorum of GCCG or it sub-committees shall exclude any member affected by a conflict of interest. If this paragraph has the effect of rendering the meeting inquorate, then the Chair shall decide whether to adjourn the meeting to permit the appointment or co-option of additional members.

6.6.3 ***Eligibility to Serve -*** People who are ineligible for appointment to GCCG Board include anyone who:

- is not eligible to work in the UK;
- has received a prison sentence or suspended sentence of 3 months or more in the last 5 years;
- is the subject of a bankruptcy order or interim order;
- has been dismissed (except by redundancy) by any NHS body;

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

47 See section 4.4 on Principles of Good Governance above

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

- is subject to a disqualification order set out under the Company Directors Disqualification Act 1986;
- has been removed from acting as a trustee of a charity.

6.6.4 ***Composition of the Governing Body*** - the governing body shall not have less than 18 and (in line with national guidance) will include some or all of:

- Clinical Chair;
- Deputy Clinical Chair;
- Vice Chair (Lay Member - Patient Public Engagement);
- Accountable Officer (AO);
- Chief Financial Officer (CFO);
- Seven GP Clinical Commissioning Leads or Other Healthcare Professional (OHP) Clinical Commissioning Leads;
- Three lay members (Patient Public Engagement, Business and Governance);
- Director of Public Health;
- Secondary Care Specialist;
- Registered Nurse;
- Director of Adult Social Care;
- Director of Commissioning Implementation (and Deputy AO);
- Director of Transformation and Service Redesign.

6.6.5 **Appointment of the Clinical Chair and Vice Chair of the Governing Body**

- The Clinical Chair and Deputy Clinical Chair shall serve on GCCG Governing Body for a period in accordance with national guidance after which the positions shall be subject to reappointment. No Clinical Chair shall serve on the Board for a period that exceeds national guidance without a break as specified in national guidance.

- The Clinical Chair and Deputy Clinical Chair will be subject to national assessment and local appointment.

- Where the Clinical Chair is a GP, the Vice Chair shall be a lay member.

- The roles of the Clinical Chair and Accountable Officer shall not be held by the same individual.

- The Chair of the Audit and Remuneration Committees could be the Vice Chair of the Board but would be precluded from being its Clinical Chair.

- Where the Clinical Chair of the governing body is also the senior clinical voice of the group that person will take the lead in interactions with stakeholders, including the NHS Commissioning Board.

6.6.6 In respect of the governing body, subject to provision made in regulations, GCCG will set out in its standing orders:

- how the group will appoint such members of the governing body;
- the tenure of office;
- how such a person would resign from their post;
- the grounds for removal from office.

6.6.7 **The Clinical Chair;** The procedure for appointing the Clinical Chair of the governing body, is set out in the group's standing orders (see Appendix C of this Constitution) and is subject to national guidance.

6.6.8 **Seven GP/OHP Clinical Commissioning Leads acting on behalf of member practices;** The procedure for appointing the GP/OHP Clinical Commissioning Leads acting on behalf of members practices of the governing body, is set out in the group's standing orders (see Appendix C of this Constitution).

6.6.9 **Four lay members;** one to lead on audit, remuneration and conflict of interest matters; two to lead on patient and public engagement (one of whom being appointed as Non-clinical Vice-Chair) and one to lead on business (Vice Chair)

6.6.10 The procedure for appointing the lay members of the governing body is set out in the group's standing orders (subject to national guidance).

6.6.11 **One Registered Nurse;** The procedure for appointing the Registered Nurse of the governing body is set out in the group's standing orders (see Appendix C of this Constitution).

6.6.12 **One Secondary Care Specialist;** The procedure for appointing the Secondary Care Specialist of the governing body is set out in the group's standing orders (see Appendix C of this Constitution).

6.6.13 **The Accountable Officer (Manager);**

6.6.14 **The Chief Financial Officer (Manager);**

6.6.15 **Other individuals who do not fall into the above categories;** Director of Adult Social Care and Director of Public Health.

6.6.16 ***Committees of the Governing Body*** - the governing body has appointed the following committees and sub-committees:

a) **Audit Committee** – the audit committee, which is accountable to the group's governing body, 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. The governing body has approved and

keeps under review the terms of reference for the audit committee, which includes information on the membership of the audit committee[49].

In addition the group or the governing body has conferred or delegated the following functions, connected with the governing body's main function[50], to its audit committee: see Appendix K.

b) **Remuneration Committee** – the remuneration committee, which is accountable to the group's governing body, makes recommendations to the governing body on determinations about the remuneration, fees and other allowances for employees and for people who provide services to the group and on determinations about allowances under any pension scheme that the group may establish as an alternative to the NHS pension scheme. The governing body has approved and keeps under review the terms of reference for the remuneration committee, which includes information on the membership of the remuneration committee[51].

In addition the group or the governing body has conferred or delegated the following functions, connected with the governing body's main function, to its remuneration committee: see Appendix L.

c) **Integrated Governance Committee** (IGC)[52] - The Governing Body has approved and keeps under review the terms of reference for the Integrated Governance Committee, which includes information on the membership of the Commissioning for Quality Group (CfQG), which has been established to help the IGC discharge its duties and powers: see Appendix M. The Commissioning for Quality Group (CfQG)[53] reports to the Integrated Governance Committee which approves its terms of reference. providing assurance on the quality of services commissioned with a view to promoting a culture of continuous improvement and innovation with respect to service safety, clinical effectiveness and patient experience.

49 See appendix K for the terms of reference of the Audit Committee

50 See section 14L(2) of the 2006 Act, inserted by section 25 of the 2012 Act

51 See appendix L for the terms of reference of the Remuneration Committee

52 See appendix M for the terms of reference of the Integrated Governance Committee

53 See appendix N for the terms of reference of the Commissioning for Quality Group

7. ROLES AND RESPONSIBILITIES

7.1 Gloucestershire Clinical Commissioning Group (GCCG)

7.1.1 A key part of GCCG's commitment is to build GCCG as a 'membership organisation'.

7.1.2 GCCG membership comprises 85 practices from seven constituent localities. Each locality appoints one of the GPs or other healthcare professionals in the constituent practices to lead and chair the locality, and to sit as a member of the governing body as a GP Clinical Commissioning Lead or OHP Clinical Commissioning Lead. A locality's GP/OHP Clinical Commissioning Lead chairs and holds regular meetings involving the Commissioning Leads from each constituent practice of the locality.

7.2 GCCG Role will be to:

- Set a commissioning strategy and policy (which is responsive to the needs assessment and priorities for the population and reflects the views of individual localities).

- Implement a clinical strategy using a co-production approach and defining quality outcomes and best value that meets the needs of our population.

- Be clinical leaders - engaging member practices and the wider clinical community.

- Establish governance arrangements that establish GCCG as a membership organisation.

- Establish and lead a clinical programme-based approach to commissioning.

- Transparency and accountability with decision making.

- Manage devolved commissioning budgets.

- Support localities with the development of programmes and projects agreed with GCCG and where appropriate holding localities and others to account for delivery.

7.3 Locality Executive Groups

7.3.1 There is a need to review and strengthen engagement with constituent practices through the seven localities:

- Cheltenham;
- Forest of Dean;
- Gloucester City;
- North Cotswolds;
- South Cotswolds;

- Stroud & Berkeley Vale;
- Tewkesbury.

7.3.2 The establishment of localities is a key part of GCCG's commitment to building a 'membership organisation'.

7.3.3 A county-wide clinical commissioning group has been agreed with seven constituent localities, each with a Locality Lead (i.e. or other healthcare professional who will act as a conduit for the views of the locality on behalf of member practices sitting on GCCG. Each locality is chaired by a GP/OHP Clinical Commissioning Lead, has an executive and holds regular meetings involving the commissioning leads from each practice. This is in addition to other regular development sessions (including Practice Learning Time) and locality-specific project groups. [54]Terms of Reference for Locality Executive Groups can be found in Appendix P.

7.3.4 The commitment to the continuation of localities was designed to ensure:

- Two way engagement with constituent practices – sharing Gloucestershire wide developments, ensuring a two-way conversation on key issues, including monthly locality meetings on a bi-annual member practice council basis
- A locality approach to delivery of key service developments and a means to pilot new approaches;
- Continuity – in particular building on Practice Based Commissioning (PbC) as a mechanism for budgetary management;
- A focus for local service developments and Quality, Innovation, Productivity and Prevention (QIPP) delivery (including the management of demand);
- Maintain support to the PbC localities and ensuring good links with the local community, including Local Strategic Partnerships (LSPs), Councils and others.

7.3.5 Arrangements have been designed to increase the level of practice engagement to fulfil GCCG's ambition to establish a vibrant membership organisation.

7.4 Communications Approach

7.4.1 GCCG will be responsible for ensuring that patients and the public are properly consulted and involved in the commissioning cycle. This will include publishing a communication and engagement strategy. The communication and engagement strategy sets out how GCCG will communicate and engage with the local population including key stakeholders such as patients, carers, community representatives, the clinical community and the media.

[54] See appendix O for the terms of reference for Locality Executive Groups

7.4.2 GCCG will produce an e-bulletin, in addition to the prescribing newsletter published each month with key messages for practices hoping to reach all clinical staff and Practice Managers and will include links to further detail.

7.4.3 Face-to-face events such as commissioning and prescribing events support two-way communication and engagement.

7.4.4 Opportunities will be put in place using events planned for member practice representatives to meet with the locality executives of GCCG to discuss the activities and plans of GCCG.

7.4.5 Our GCCG Clinical leads are important ambassadors for GCCG and part of the communication structure. We anticipate that they will be supported in work-streams by other member clinicians, particularly those with a special interest. This will encourage a bottom-up approach to service redesign.

7.4.6 It is important to have close links with the Practice Managers Group to capture their knowledge and expertise. They are a vital resource when communicating with practices and effecting change. Using the Practice Manager's Network, it is anticipated Practice Managers will work collectively in their roles with GCCG to identify common issues and opportunities, feedback at locality level and to communicate and work with GCCG.

7.4.7 Community pharmacists and the Information Team will work with practices to understand both demand and capacity. Practice support pharmacists will work with practices to encourage and support safe and cost effective prescribing. Both will offer informal opportunities for communication regarding GCCG work.

7.4.8 GCCG is committed to expanding this approach to other areas of practice performance and the approach to comparing and reviewing practice will look at the following principles:

- A need to understand and where appropriate minimise variation;
- To support cost effective use of resources;
- To optimise health outcomes;
- To reduce health inequalities.

7.5 Role of GP/OHP Clinical Commissioning Leads:

7.5.1 The GP/OHP Clinical Commissioning Lead from each locality will play an important role in locality engagement as well as taking on a lead role on county-wide projects. GCCG will be responsible for supporting each other in locality role and in specialist lead areas. The GP/OHP Clinical Commissioning Leads:

- Provide a two-way engagement route for the governing body to communicate with practices and to gain practice input into the work of GCCG.

- Act as a vital source of intelligence for GCCG – on local health needs, the reality of services on the ground etc.

- Focus for devolved commissioning budget management – share performance information with practices and where appropriate challenge practice.
- Act as a vehicle to translate county-wide commissioning plans into 'operationalised' locality plans.
- Pilot new approaches.
- Liaise with local councillors, local people and local tertiary sector.

7.6 Practice Representatives

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

- Nominate commissioning and prescribing leads to:
  a) represent the practice at GCCG/locality meetings; and
  b) represent the needs of the practice's patient population within the GCCG;
- Actively engage with GCCG to help improve services within the area;
- Share all appropriate information and data and any other data relating to commissioning priorities to support delivery of equitable quality care of referral and other prescribing and emergency admissions data;
- Adopt the Clinical Programme Group approach, and follow the clinical pathways and referral protocols agreed by GCCG (except in individual cases where there are justified clinical reasons for not doing this) which are fed back appropriately;
- Manage the practice's prescribing budget within allocated resource;
- Participate in and deliver, as far as possible, the clinical, quality, safety effectiveness (and cost effective) strategies agreed by GCCG and GH&WB;
- Establish a practice reference group and other means determined, to obtain the views and experiences of patients and carers;
- Work constructively with the locality sub-committee/GCCG;
- Respond in a timely manner to reasonable commissioning-related information requests from GCCG.

7.7 Memorandum of Agreement

7.7.1 The effective participation of each member practice will be essential in developing and sustaining high quality commissioning arrangements.

7.7.2 A Memorandum of Agreement between individual member practices and GCCG clarifies the expectations and obligations of both parties[55].

7.7.3 The Memorandum of Agreement will document any commissioning agreements reached between the member practice and GCCG and will be the formal mechanism for determining eligibility to any future incentive payment (currently referred to as the Quality Premium). Accordingly it will be updated on an annual basis.

7.7.4 The Memorandum of Agreement includes:

- Parties to the Agreement;
- Values, Aims and Mission of GCCG;
- Commissioning responsibilities of the member practice;
- Responsibilities of GCCG;
- Annual commissioning objectives/targets agreed with the member practice;
- Monitoring arrangements and frequency of meetings;
- Practice budgets of the member practice;
- Dispute resolution;
- Review of the Agreement;
- Signatures to the Agreement.

7.8 Other Key Roles

7.8.1 GCCG will have, at times, specific 'tasks' where it will need GP or other healthcare professional input, working on behalf of GCCG. This will be on a voluntary basis where individuals are keen to be involved and/or are interested in the subject matter and where their practice is agreeable to them participating. Where this is deemed to be significant, and outside the role of normally-funded activities and/or responsibilities funded by the commissioning Locally Enhanced Service (LES), then GCCG will provide limited remuneration or backfill to allow full participation in the task on a time limited basis.

7.8.2 By using GPs and other healthcare professionals in this way, GCCG aspires to gain involvement from a broader membership of primary care in developing and delivering its work programme than just those members involved in GCCG and the executive leadership of the localities.

7.8.3 When working for GCCG, individuals from practices will need to be aware of GCCG policies and work within them. Specific attention is drawn to the 'Declaration of Interests and resolution of conflicts'[56].

[55] See appendix P - terms of reference for Memorandum of Understanding

[56] See Section 8 Standards of Business conduct and Managing Conflicts of Interest

7.9 All Members of GCCG's Governing Body

7.9.1 The Governing Body shall consist of a maximum of 23 members, of whom the majority shall be practising clinicians, as set out in paragraph 6.6.4.

7.9.2 All members of the Governing Body will share responsibility in ensuring that GCCG exercises its functions effectively, efficiently and with good governance and in accordance with the terms of GCCG's Constitution as agreed by its members.

7.9.3 This Constitution and any future iterations of it will be publicly available on GCCG's website, and will also be available on request from GCCG.

7.9.4 Individual members will bring their unique perspective, informed by their expertise and experience. This will underpin decisions made by the Governing Body and will help ensure that as far as reasonably practicable:

- The values and principles of the NHS Constitution are actively promoted;
- The interests of patients and the community remain at the heart of discussions and decisions;
- The Board and the wider GCCG acts in the best interests of the local population at all times;
- GCCG commissions the highest quality services and best possible outcomes for their patients within their resource allocation; and
- Good governance remains central at all times.

7.10 Clinical Chair of the Governing Body

7.10.1 The Clinical Chair of the Governing Body is responsible for:

- Leading the governing body, ensuring it remains continuously able to discharge its duties and responsibilities;
- Building and developing the group's governing body and its individual members;
- Ensuring that the group has proper constitutional and governance arrangements in place;
- Ensuring that, through the appropriate support, information and evidence, the governing body is able to discharge its duties;
- Supporting the Accountable Officer in discharging the responsibilities of the organisation;
- Contributing to building a shared vision of the aims, values and culture of the organisation;
- Leading and influencing to achieve clinical and organisational change to enable the group to deliver its commissioning intentions;
- Overseeing governance and particularly ensuring that the governing body and the wider group behave with the utmost transparency and responsiveness at all times;

- Ensuring that public and patients' views are heard and their expectations understood and, as far as possible, met;
- Ensuring that the organisation is able to account to its local patients, stakeholders and the NHS Commissioning Board;
- Ensuring that the group builds and maintains effective relationships, particularly with the Gloucestershire Health and Wellbeing Board (GH&WB).

7.11 The Deputy Clinical Chair of the Governing Body

7.11.1 The Deputy Clinical Chair of the governing body deputises for the Chair of the governing body where he or she has a conflict of interest or is otherwise unable to act.

7.12 Role of the Accountable Officer

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

7.12.2 The Board will select and appoint a Accountable Officer following ratification by the NHS Commissioning Board. The Accountable Officer will be an ex-officio member of the Board.

7.12.3 The Accountable Officer will have specific responsibilities for ensuring that GCCG complies with its financial duties, promotes quality improvements and demonstrates value for money.

7.12.4 The Accountable Officer must be either:

- A GP who is a member of GCCG;
- An employee of GCCG or any member of GCCG; or
- In the case of a joint appointment, an employee or any member of any of the groups in question or any member of those groups.

7.12.5 The Accountable Officer will be responsible for ensuring that GCCG 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.

7.12.6 The Accountable Officer will ensure that the regularity and propriety of expenditure is discharged, and that arrangements are put in place to ensure that good practice (as identified through such agencies as the Audit Commission and the National Audit Office) is embodied and that safeguarding of funds is ensured through effective financial and management systems.

7.12.7 The Accountable Officer will work closely with the Chair of the governing body and will ensure that proper constitutional, governance and development arrangements are put in place to assure the members (through the governing body) of the organisation's on-going capability and capacity to meet its duties and responsibilities. This will include arrangements for the on-going developments of its members and staff.

7.12.8 In addition to the Accountable Officer's general duties, where the Accountable Officer is also the senior clinical voice of the group he or she will take the lead in interactions with stakeholders, including the NHS Commissioning Board.

7.13 Role of the Chief Financial Officer

7.13.1 The Chief Financial Officer is a member of the governing body and is responsible for providing financial advice to the clinical commissioning group and for supervising financial control and accounting systems.

7.13.2 This role of Chief Financial Officer has been summarised in a national document[57] as:

a) being the governing body's professional expert on finance and ensuring, through robust systems and processes, the regularity and propriety of expenditure is fully discharged;

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

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

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

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

7.14 Role of Lay Members

7.14.1 There are four lay members appointed to the Governing Body, one with responsibility for audit, remuneration and conflict of interest matters, two with responsibility for patient and public participation matters (one of whom acts as non-clinical Vice Chair), and a fourth with responsibility for business matters.

7.14.2 The role and focus of the lay member with responsibility for audit, remuneration and conflict of interest matters is strategic and impartial, to provide an external view of the work of GCCG that is removed from the day-to-day running of the organisation. Specific responsibilities include:

- overseeing key elements of governance including audit, remuneration and managing conflicts of interest;

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

- chairing the Audit Committee; ensuring that the Governing Body and the wider CCG behaves with the utmost probity at all times; and

- ensuring that appropriate and effective whistle blowing and anti-fraud systems are in place.

7.14.3 The lay member with responsibility for patient and public participation matters will be a member of the local community and bring that insight to the work of the Governing Body. This member will ensure that all aspects of GCCG's business, the public voice of the local population, is heard and that opportunities are created and protected for patient and public empowerment in the work of the GCCG. Specific responsibilities include ensuring that:

- public and patients' views are heard and their expectations understood and met as appropriate;

- the Group builds and maintains an effective relationship with Local HealthWatch and draws on existing patient and public engagement and involvement expertise; and

- GCCG has appropriate arrangements in place to secure public and patient involvement and responds in an effective and timely way to feedback and recommendations from patients, carers and the public.

7.14.4 The lay member with responsibility for business matters will be a member of the local business community and bring that insight to the work of the Governing Body. This member will be removed from the day-to-day running of the organisation, but will have specific responsibilities ensuring that:

- a robust business infrastructure exists and oversees key elements of business including the development of business plans and conflicts of interest;

- act as a specialist reference point in business management;

- understand the impact and operational demands of delivering GCCG strategic priorities in the annual integrated plan, and oversees budgeting decisions around key projects.

7.15 Role of the Registered Nurse

7.15.1 The registered nurse on the governing body is to be filled by a qualified individual with a high level of professional expertise and knowledge. A key aspect of the role is to bring a broader view, from their perspective as a registered nurse, on health and care issues to underpin the work of the group, especially the contribution of nursing to patient care. Specific responsibilities include:

- giving an independent strategic clinical view on all aspects of CCG business;

- bringing detailed insights from nursing and perspectives into discussions regarding service re-design, clinical pathways and system reform.

7.16 Role of the Secondary Care Specialist

7.16.1 The purpose of the secondary care specialist is to bring an understanding of patient care in the secondary care setting to the work of the governing body. The individual appointed will have a high level of understanding of how care is delivered in a secondary care setting, preferably with experience working as a leader across more than one clinical discipline and/or specialty with a track record of collaborative working. A specific aspect of this role involves bringing appropriate insight to discussions regarding service redesign, clinical pathways and system reform.

7.17 Joint Appointments with other Organisations

7.17.1 At present GCCG does not have any joint appointments with other organisations.

7.17.2 Should joint appointments be made in the future, these joint appointments will be supported by a memorandum of understanding between the organisations who are party to these joint appointments.

8. STANDARDS OF BUSINESS CONDUCT AND MANAGING CONFLICTS OF INTEREST

8.1. Standards of Business Conduct

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

8.1.2. They must comply with the group's policy on business conduct, including the requirements set out in the policy for managing conflicts of interest. This policy is available on the group's website, and is also available on request from GCCG.

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 obligations 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. GPs who serve on GCCG also work for, or are partners running, general medical practices in the county. For the avoidance of doubt, in what follows there will be no prima facie conflict of interest sufficient to require a GP member of GCCG to withdraw from any discussion of services to be commissioned by GCCG from general medical practices if the service is to be offered to more practices than those to which the member, or members, involved in the discussion belong.

8.2.2. As required by section 14O of the 2006 Act, as inserted by section 25 of the 2012 Act, GCCG 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.

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

8.2.4. A conflict of interest will include:

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

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

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

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

e) any duty whatsoever imposed on any member of the Board or its sub-committees', CCG members/clinicians by any other codes of conduct to which the member is subject.

f) any other interest whatsoever that should be dutifully declared under The Health and Social Care Act 2012 and guidance issued by Department of Health from time to time.

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

h) if the individual is registered with the General Medical Council (GMC), any interest that the individual would be required to declare in accordance with paragraph 55 of the GMC's publication "Management for Doctors" or any successor code, including the referral of any patient to a provider in which the individual has an interest.

i) if the individual is registered with the Nursing and Midwifery Council (NMC) or other professional body would be required to declare in accordance with paragraph 7 of the NMC's publication Code of Professional Conduct or any successor code including the referral of any patient to a provider in which the individual has an interest.

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:

a) the members of the group;

b) the members of its governing body;

c) the members of its committees or sub-committees and the committees or sub-committees of its governing body; and

d) its employees.

8.3.2. The registers will be published on the group's website, and will also be available on request from GCCG.

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

8.3.4. 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 Accountable Officer will ensure that the registers of interest are reviewed regularly, and updated as necessary.

8.4. **Managing Conflicts of Interest: general**

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

8.4.2. The Accountable Officer will oversee the management of conflicts of interest on behalf of the group and 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 Accountable Officer and will include the requirement to put in writing to the relevant individual arrangements for managing the conflict of interests or potential conflicts of interests, within a week of declaration. The arrangements will confirm the following:

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

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

8.4.4. Where an interest has been declared, either in writing or by oral declaration, the declarer will ensure that before participating in any activity connected with the group's exercise of its commissioning functions, they have received confirmation

of the arrangements to manage the conflict of interest or potential conflict of interest from the Accountable Officer.

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

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

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

8.4.6. 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.

8.4.7. Where the Chair of any meeting of the group, including committees, sub-committees, or the governing body and the governing body's committees and sub-committees, has a personal interest, previously declared or otherwise, in relation to the scheduled or likely business of the meeting, they must make a declaration and the Vice 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 Vice Chair may require the chair to withdraw from the meeting or part of it. Where there is no Vice Chair, the members of the meeting will select one.

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

8.4.9. 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.

8.4.10. 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 Accountable Officer on the action to be taken.

8.4.11. These arrangements must be recorded in the minutes. This may include:

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

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

i) a member of the Clinical Commissioning Group who is an individual;

ii) an individual appointed by a member to act on its behalf in the dealings between it and the Clinical Commissioning Group;

iii) a member of a relevant Health and Wellbeing Board;

iv) a member of a governing body of another clinical commissioning group.

8.4.12. 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 Accountable Officer of the transaction.

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

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

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

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

8.6.3. Copies of this Procurement Strategy will be available on the group's dedicated website, and will also be available on request from GCCG.

9. GCCG AS AN EMPLOYER

9.1. GCCG 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. GCCG 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. Copies of this Code of Conduct, together with the other policies and procedures outlined in this chapter, will be available on the group's website, and will also be available on request from GCCG.

10. TRANSPARENCY, WAYS OF WORKING AND STANDING ORDERS

10.1. General

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

10.1.2. Key communications issued by the group, including the notices of procurements, public consultations, governing body meeting dates, times, venues, and certain papers will be published on the group's website, and will also be available on request from GCCG.

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

10.2. Standing Orders

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

a) ***Standing orders (Appendix C)*** – which sets out the arrangements for meetings and the appointment processes to elect the group's representatives and appoint to the group's committees, including the governing body;

b) ***Scheme of reservation and delegation (Appendix D)*** – which sets out those decisions that are reserved for the membership as a whole and those decisions that are the responsibilities of the group's governing body, the governing body's committees and sub-committees, the group's committees and sub-committees, individual members and employees;

c) ***Detailed Scheme of Delegation (Appendix E)***

d) ***Prime financial policies (Appendix F)*** – which sets out the arrangements for managing the group's financial affairs.

APPENDIX A
DEFINITIONS OF KEY DESCRIPTIONS USED IN THIS CONSTITUTION

2006 Act	National Health Service Act 2006
2012 Act	Health and Social Care Act 2012 (this Act amends the 2006 Act)
Accountable officer (AO)	an individual, as defined under paragraph 12 of Schedule 1A of the 2006 Act (as inserted by Schedule 2 of the 2012 Act), appointed by the NHS Commissioning Board, with responsibility for ensuring the group: • complies with its obligations under: o sections 14Q and 14R of the 2006 Act (as inserted by section 26 of the 2012 Act), o sections 223H to 223J of the 2006 Act (as inserted by section 27 of the 2012 Act), o paragraphs 17 to 19 of Schedule 1A of the NHS Act 2006 (as inserted by Schedule 2 of the 2012 Act), and o any other provision of the 2006 Act (as amended by the 2012 Act) specified in a document published by the Board for that purpose; • exercises its functions in a way which provides good value for money.
Area	the geographical area that the group has responsibility for, as defined in Chapter 2 of this constitution
Chair of the Governing Body	in line with national process, the individual appointed will act as chair of the governing body
Chief Financial Officer (CFO)	the qualified accountant employed by the group with responsibility for financial strategy, financial management and financial governance
Clinical Commissioning Group	a body corporate established by the NHS Commissioning Board in accordance with Chapter A2 of Part 2 of the 2006 Act (as inserted by section 10 of the 2012 Act)
Committee	a committee or sub-committee created and appointed by: • the membership of the group • a committee / sub-committee created by a committee created / appointed by the membership of the group • a committee / sub-committee created / appointed by the governing body
Financial year	this usually runs from 1 April to 31 March, but under paragraph 17 of Schedule 1A of the 2006 Act (inserted by Schedule 2 of the 2012 Act), it can for the purposes of audit and accounts run from when a clinical commissioning group is established until the following 31 March
GH&WB	Gloucestershire Health and Wellbeing Board
Governing Body	the body appointed under section 14L of the NHS Act 2006 (as inserted by section 25 of the 2012 Act), with the main function of ensuring that a clinical commissioning group has made appropriate arrangements for ensuring that it complies with: • its obligations under section 14Q under the NHS Act 2006 (as inserted by section 26 of the 2012 Act), and • such generally accepted principles of good governance as are relevant to it.
Governing body member	any member appointed to the governing body of the group

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

APPENDIX B - LIST OF MEMBER PRACTICES

Practice Name	Address (Main surgery Only)	Practice Representative's Signature & Date Signed
Cheltenham Locality		
Berkeley Place Surgery	11 High Street, Cheltenham, Gloucestershire	
Corinthian Surgery	St Paul's Medical Centre, 121 Swindon Road, Cheltenham	
Crescent Bakery Surgery	Crescent Bakery, St Georges Place, Cheltenham	
Leckhampton Surgery	Lloyd Davies House, 17 Moorend Park Road, Cheltenham	
Overton Park Surgery	Overton Park Road, Cheltenham, Gloucestershire	
Royal Crescent Surgery	11 Royal Crescent, Cheltenham, Gloucestershire	
Royal Well Surgery	St Paul's Medical Centre, 121 Swindon Road, Cheltenham	
Seven Posts Surgery	Prestbury Road, Cheltenham, Gloucestershire	
Sixways Clinic	London Road, Charlton Kings, Cheltenham	
Springbank Surgery	Springbank Way, Cheltenham, Gloucestershire	
St Catherine's Surgery	St Paul's Medical Centre, 121 Swindon Road, Cheltenham	
St George's Surgery	St Paul's Medical Centre, 121 Swindon Road, Cheltenham	
Stoke Road Surgery	4 Stoke Road, Bishops Cleeve, Cheltenham	
The Portland Practice	St Paul's Medical Centre, 121 Swindon Road, Cheltenham	
Underwood Surgery	139 St George's Road, Cheltenham, Gloucestershire	
Winchcombe Medical Centre	Greet Road, Winchcombe, Cheltenham	
Yorkleigh Surgery	93 St George's Road, Cheltenham, Gloucestershire	
Forest of Dean Locality		
Blakeney Surgery	Millend, Blakeney, Gloucestershire	
Brunston Practice	Cinderhill, Coleford, Gloucestershire	
Coleford Health Centre	Railway Drive, Coleford, Gloucestershire	
Dockham Road Surgery	Dockham Road Surgery, Cinderford, Gloucestershire	
Drs Andrew,	Yorkley Health Centre, Bailey Hill,	

Practice Name	Address (Main surgery Only)	Practice Representative's Signature & Date Signed
Edwards, Hayes & Cleary	Yorkley, Lydney	
Drybrook Surgery	Drybrook, Gloucestershire	
Forest Health Care	The Health Centre, Dockham Road, Cinderford	
Lydney Practice	The Health Centre, Albert Street, Lydney	
Mitcheldean Surgery	Brook Street, Mitcheldean, Gloucestershire	
Newnham Surgery	High Street, Newnham on Severn, Gloucestershire	
Severnbank Surgery	Tutnalls Street, Lydney, Gloucestershire	
Gloucester City Locality		
Barnwood Medical Practice	51 Barnwood Road, Gloucester, Gloucestershire	
Bartongate Surgery	115 Barton Street, Gloucester, Gloucestershire	
Cheltenham Road Surgery	16 Cheltenham Road, Gloucester, Gloucestershire	
Gloucester City Health Centre	The Park, Gloucester, Gloucestershire	
Gloucester Health Access Centre	Eastgate House, 121-131 Eastgate Street, Gloucester	
Hadwen Medical Practice	Glevum Way Surgery, Abbeydale, Gloucester	
Heathville Medical Practice	5 Heathville Road, Gloucester, Gloucestershire	
Hucclecote Surgery	5A Brookfield Road, Hucclecote, Gloucestershire	
Kingsholm Surgery	Alvin Street, Gloucester, Gloucestershire	
London Road Medical Practice	97 London Road, Gloucester, Gloucestershire	
Longlevens Surgery	19b Church Road, Longlevens, Gloucester	
Matson Lane Surgery	Taylor House, 4 Matson Lane, Matson	
Partners in Health	Pavilion Family Doctors, 153a Stroud Road, Gloucester	
Quedgeley Medical Centre	Olympus Park, Quedgeley, Gloucester	
Rosebank Health	153b Stroud Road, Gloucester, Gloucestershire	
Saintbridge Surgery	Askwith Road, Saintbridge,	

Practice Name	Address (Main surgery Only)	Practice Representative's Signature & Date Signed
	Gloucestershire	
St. Johns Avenue Surgery	Churchdown, Gloucester, Gloucestershire	
The College Yard Surgery	Mount Street, Westgate, Gloucester	
The Surgery	Abbotswood Road, Brockworth, Gloucestershire	
North Cotswolds Locality		
Chipping Campden Surgery	Back Ends, Chipping Campden, Glos	
Cotswold Medical Practice	Moore Road, Bourton on the Water, Cheltenham	
Mann Cottage Surgery	Oxford Street, Moreton in Marsh, Cheltenham	
Stow Surgery	Well Lane, Stow on the Wold, Gloucestershire	
White House Surgery	High Street, Moreton in Marsh, Gloucestershire	
South Cotswolds Locality		
The Avenue Surgery	1 The Avenue, Cirencester, Gloucestershire	
Hilary Cottage Surgery	Keble Lawns, Fairford, Gloucestershire	
LechladeMedical Centre	Oak Street, Lechlade, Gloucestershire	
The Park Surgery	Old Tetbury Road, Cirencester, Gloucestershire	
Phoenix Surgery	9 Chesterton Lane, Cirencester, Gloucestershire	
Rendcomb Surgery	Rendcomb, Cirencester, Gloucestershire	
Romney House	41-43 Long Street, Tetbury, Gloucestershire	
St Peter's Road Surgery	1 St Peter's Road, Cirencester, Gloucestershire	
Stroud Locality		
Acorn Practice	May Lane Surgery, Dursley, Gloucestershire	
Beeches Green Surgery	Beeches Green, Stroud, Gloucestershire	
Chipping Surgery	Symn Lane, Wotton under Edge, Gloucestershire	
Culverhay Surgery	Wotton under Edge, Gloucestershire	
Frithwood Surgery	45 Tanglewood Way, Bussage, Stroud	
High Street Medical	31 High Street, Stonehouse,	

Practice Name	Address (Main surgery Only)	Practice Representative's Signature & Date Signed
Centre	Gloucestershire	
Hoyland House	Gyde Road, Painswick, Gloucestershire	
Locking Hill Surgery	Locking Hill, Stroud, Gloucestershire	
Marybrook Medical Centre	Marybrook Street, Berkeley, Gloucestershire	
Minchinhampton Surgery	Bell Lane, Minchinhampton, Gloucestershire	
Prices Mill Surgery	New Market Road, Nailsworth, Gloucestershire	
Regent Street Surgery	72 Regent Street, Stonehouse, Gloucestershire	
Rowcroft Medical Centre	Stroud, Gloucestershire	
St Lukes Medical Centre	53 Cainscross Road, Stroud, Gloucestershire	
Stonehouse Health Clinic	High Street, Stonehouse, Gloucestershire	
Stroud Valleys Family Practice (Staniforth)	Beeches Green Health Centre, Stroud, Gloucestershire	
The Orchard Medical Centre	Fairmead, Cam, Dursley, Gloucestershire	
The Surgery	Whitminster Lane Frampton on Severn, Gloucestershire	
Uley Surgery	42 The Street, Uley, Dursley, Gloucestershire	
Walnut Tree Practice	May Lane Surgery, Dursley, Gloucestershire	
Tewkesbury Locality		
Church Street Practice	77 Church Street, Tewkesbury, Gloucestershire	
Holts Health Centre	Watery Lane, Newent, Gloucestershire	
Jesmond House Practice	Chance Street, Tewkesbury, Gloucestershire	
The Surgery	Corse, Staunton, Gloucester	
Watledge Surgery	Barton Road, Tewkesbury, Gloucestershire	

APPENDIX C – STANDING ORDERS

1. STATUTORY FRAMEWORK AND STATUS

1.1. Introduction

1.1.1. The standing orders will regulate the proceedings of the Gloucestershire Clinical Commissioning Group (GCCG) so that the group can fulfil its obligations, as set out largely in the 2006 Act, as amended by the 2012 Act and related regulations. They are effective from the date GCCG is established.

1.1.2. The standing orders, together with the group's scheme of reservation and delegation[58], provide a procedural framework within which the group discharges its business. They set out:

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

b) the appointment of member practice representatives;

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

d) the process to delegate powers,

e) the declaration of interests and standards of conduct.

These arrangements must comply, and be consistent where applicable, with requirements set out in the 2006 Act (as amended by the 2012 Act) and related regulations and take account as appropriate[59] of any relevant guidance.

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

1.2. Schedule of matters reserved to the clinical commissioning group and the scheme of reservation and delegation

1.2.1. The 2006 Act (as amended by the 2012 Act) provides the group with powers to delegate the group's functions and those of the governing body to certain bodies

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58 See Appendix D

59 Under some legislative provisions the group is obliged to have regard to particular guidance but under other circumstances guidance is issued as best practice guidance.

(such as committees) and certain persons. The group has decided that certain decisions may only be exercised by the group in formal session. These decisions and also those delegated are contained in the group's scheme of reservation and delegation (see Appendix D).

2. THE CLINICAL COMMISSIONING GROUP: COMPOSITION OF MEMBERSHIP, KEY ROLES AND APPOINTMENT PROCESS

2.1. Composition of Membership

2.1.1. Chapter 3 of the group's constitution provides details of the membership of the group (also see Appendix B).

2.2. Governing Structures

2.2.1. Chapter 6 of the group's constitution provides details of the governing structure used in the group's decision-making processes, whilst Chapter 7 of the constitution outlines certain key roles and responsibilities within the group and its governing body, including the role of practice representatives (paragraph 7.6 of the constitution).

2.2.2. The membership of the Governing Body shall be:

a) Chair; elected from the clinician members of the Governing Body
b) Not less than 18 members including the following:
    i) Deputy Clinical Chair;
    ii) Accountable Officer;
    iii) Chief Financial Officer;
    iv) Seven Clinical Commissioning Leads
    v) Four lay representatives (one as Vice Chair);
    vi) Secondary Care Specialist;
    vii) Registered Nurse.

2.2.3. The Governing Body will function as a corporate decision-making body. Their roles as members of the Governing Body will be to consider the key strategic and managerial issues facing the group in carrying out its statutory and other functions.

2.2.4. The group may from time to time delegate such functions as it deems appropriate to any and/or all of the governing structures. A list of reserved and delegated functions is included in the groups Scheme of Reservation and Delegation (See Appendix D)

2.3. Key Roles

2.3.1. Paragraph 6.6.4 of the group's constitution sets out the composition of the group's governing body whilst Chapter 7 of the group's constitution identifies certain key roles and responsibilities within the group and its governing body.

These standing orders set out how the group appoints individuals to these key roles.

2.3.2. The Accountable Officer, as described in paragraph 7.12 of the group's constitution, is subject to the following appointment process:

a) **Nominations** – subject to the national process as identified by the NHS CB. All GPs in member practices have the opportunity to apply.

b) **Eligibility** – compliance with criteria for each post and through sponsorship of GCCG and subject to the provisions of paragraph 6.6.3 of this constitution

c) **Appointment process** – national process as identified by the NHSCB;

d) **Grounds for removal from office** – subject to the Code of Conduct: code of accountability in the NHS publication or any superseding publication;[60]

e) **Notice period** – 6 months.

2.3.3. The **Clinical Chair**, as described in paragraphs 6.6.7 and 7.10 of the group's constitution, is subject to the following appointment process:

a) **Nominations** – subject to the national process as identified by the NHS CB. All GPs in member practices have the opportunity to apply;

b) **Eligibility** – compliance with the criteria for the post and through sponsorship of CCG and subject to the provisions of paragraph 6.6.3 of this constitution, as well as in line with the national guidance;

c) **Appointment process** – national process as identified by the NHSCB;

d) **Term of office** – 4 years;

e) **Eligibility for reappointment** – subject to national guidance;

f) **Grounds for removal from office** – subject to the provisions of paragraph 6.6.3 of this constitution pertaining to eligibility to serve on the governing body or following a vote of no confidence taken by two thirds or more of the Member Practice Council at a properly constituted meeting called in line with the provisions of this constitution ;

g) **Notice period** –6 months.

2.3.4. The **Deputy Clinical Chair**, as listed in paragraphs 6.6.7 and 7.11 of the group's constitution, is subject to the following appointment process:

a) **Nominations** – sponsorship through CCG;

[60] Code of Conduct: code of accountability in the NHS published by the DH NHS Appointments Commission

b) **Eligibility** – sponsorship through CCG and subject to the provisions of paragraph 6.6.3 of this constitution;

c) **Appointment process** – sponsorship through CCG;

d) **Term of office** – 4 years;

e) **Eligibility for reappointment** – subject to national guidance;

f) **Grounds for removal from office** – subject to the provisions of paragraph 6.6.3 of this constitution pertaining to eligibility to serve on the governing body or following a vote of no confidence taken by two thirds or more of the Member Practice Council at a properly constituted meeting called in line with the provisions of this constitution ;;

g) **Notice period** – 6 months.

2.3.5. The Chief Financial Officer (CFO), as listed in paragraph 7.13 of the group's constitution, is subject to the following appointment process:

a) **Nominations** – subject to the national process as identified by the NHSCB;

b) **Eligibility -** sponsorship through CCG/NHS and subject to the provisions of paragraph 6.6.3 of this constitution;

c) **Appointment process** – national process as identified by the NHSCB;

d) **Eligibility for reappointment** – subject to national guidance;

e) **Grounds for removal from office** – subject to the Code of Conduct: code of accountability in the NHS publication or any superseding publication

f) **Notice period** –6 months.

2.3.6. The **Locality Clinical Commissioning Leads**, as listed in paragraph 6.6.8 and 7.5 of the group's constitution, are subject to the following appointment process:

a) **Nominations** – local election process carried out in conjunction with the LMC;

b) **Eligibility** –subject to the provisions of paragraph 6.6.3 of this constitution;

c) **Appointment process** – local election process carried out in conjunction with the LMC;

d) **Term of office** – subject to national guidance;

e) **Eligibility for reappointment** – subject to national guidance;

f) **Grounds for removal from office** – subject to the provisions of paragraph 6.6.3 of this constitution pertaining to eligibility to serve on the governing body or following a vote of no confidence taken by two thirds or more of the Member Practice Council at a properly constituted meeting called in line with the provisions of this constitution;

g) **Notice period** – 3 months.

2.3.7. The **Lay Members**, as listed in paragraphs 6.6.9 and 7.14 of the group's constitution, is subject to the following appointment process:

a) **Nominations** – local process based on national guidance;

b) **Eligibility** – subject to the provisions of paragraph 6.6.3 of this constitution;

c) **Appointment process** – national process;

d) **Term of office** – subject to national guidance;

e) **Eligibility for reappointment** – subject to national guidance;

f) **Grounds for removal from office** – subject to the provisions of paragraph 6.6.3 of this constitution;

g) **Notice period** –3 months.

2.3.8. The **Nurse Representative**, as listed in paragraphs 6.6.11 and 7.15 of the group's constitution, is subject to the following appointment process:

a) **Nominations** – local process;

b) **Eligibility** –subject to the provisions of paragraph 6.6.3 of this constitution;

c) **Appointment process** – appointment by Chair of CCG following nomination;

d) **Term of office** – subject to national guidance;

e) **Eligibility for reappointment** – subject to national guidance;

f) **Grounds for removal from office** – subject to the provisions of paragraph 6.6.3 of this constitution;

g) **Notice period** –3 months.

2.3.9. The **Secondary Care Specialist**, as listed in paragraphs 6.6.12 and 7.16 of the group's constitution, is subject to the following appointment process:

a) **Nominations** – subject to local process, ensuring there are no conflicts of interest in relation to CCG commissioning responsibilities;

b) **Eligibility** –subject to the provisions of paragraph 6.6.3 of this constitution;

c) **Appointment process** – appointment by Chair of CCG following nomination;

d) **Term of office** – subject to national guidance;

e) **Eligibility for reappointment** – subject to national guidance;

f) **Grounds for removal from office** – subject to the provisions of paragraph 6.6.3 of this constitution;

g) **Notice period** –3 months.

2.3.10. The roles and responsibilities of each of these key roles are described in paragraph 6.6. and Chapter 7 of the group's constitution.

3. MEETINGS OF THE CLINICAL COMMISSIONING GROUP

3.1. Calling meetings

3.1.1. Ordinary meetings of the group shall be held at regular intervals at such times and places as the group may determine and not less than annually.

3.1.2. The Chair of the group may call a meeting at any time.

3.2. Agenda, supporting papers and business to be transacted

3.2.1. Items of business to be transacted for inclusion on the agenda of a meeting need to be notified to the Associate Director Corporate Governance at least 10 working days (i.e. excluding weekends and bank holidays) before the meeting takes place.

3.2.2. The request should state whether the business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than ten working days before a meeting may be included on the agenda at the discretion of the Chair.

3.2.3. Supporting papers for such items need to be submitted at least 10 working days before the meeting takes place. The agenda and supporting papers will be circulated to all members of a meeting at least 5 working days before the date the meeting will take place.

3.2.4. The group may determine that certain matters will appear on every agenda for a meeting and shall be addressed prior to any other business being conducted.

The group may also determine that all papers presented should be in a prescribed format. However, the Chair may waive this requirement if, in their opinion, urgency requires that a paper be presented in another format.

3.2.5. Agendas and certain papers for the group's governing body – including details about meeting dates, times and venues - will be published on the group's website, and will also be available on request from GCCG.

3.3. Petitions

3.3.1. Where a petition compiled by practice members has been received by the group, the chair of the governing body shall include the petition as an item for the agenda of the next meeting of the governing body.

3.4. Chair of a meeting

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

3.4.2. If the chair is absent temporarily on the grounds of a declared conflict of interest the Vice Chair, if present, shall preside. If both the chair and Vice Chair are absent, or are disqualified from participating, or there is neither a chair or deputy, a member of the group, governing body, committee or sub-committee respectively shall be chosen by the members present, or by a majority of them, and shall preside.

3.5. Chair's ruling

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

3.6. Quorum

3.6.1 A quorum will be reached when at least seven members of the Governing Body are present. The attendees should **include specifically**:-

- the Chair or Vice Chair;
- the Accountable Officer (or deputy);
- the Chief Financial Officer (or deputy);
- One Lay Member
- Three GP/OHP Clinical Commissioning Leads acting on behalf of member practices.

3.6.2 If the Chair or a member has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of a declaration of a conflict of interest that person shall no longer count towards quorum. If a quorum is then not available for discussion and/or the passing of a

resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

3.6.3 The Accountable Officer (or deputy) will reserve the right to refer a decision to the Governing Body should an item or issue arise where it is judged that approval would secure essential corporate governance.

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

3.7 **Decision making**

3.7.3 Chapter 6 of the group's constitution, together with the scheme of reservation and delegation, sets out the governing structure for the exercise of the group's statutory functions. Generally it is expected that decision making at meetings will be by consensus of members. Should this not be possible then a vote of members will be required, the process for which is set out below:

3.7.4 For votes at meetings of the Governing Body:

- **Eligibility** – only designated members of the Governing Body are allowed to vote

- **Voting Process** - At the discretion of the Chair all questions put to the vote shall be determined by oral expression or by a show of hands, unless the Chair directs otherwise, or it is proposed, seconded and carried that a vote be taken by paper ballot;

- **Majority necessary to confirm a decision** – 75% of members required to make a decision;

- **Casting vote** – In the case of an equal vote, the person presiding (i.e. the Chair of the meeting) shall have a second and casting vote;

- **Dissenting views** – A motion may be proposed by the Chair of the meeting or any member present. It must also be seconded by another member.

3.7.5 Should a vote of the governing body be taken, the outcome of the vote, and any dissenting views, must be recorded in the minutes of the meeting.

3.7.6 For all other meetings of the group's committees and sub-committees, including the governing body's committees and sub-committees, the process for holding a vote is set out in the appropriate terms of reference.

3.8 Emergency powers and urgent decisions

3.8.3 The Chair of GCCG may call a meeting of the governing body at any time.

3.8.4 Once fully authorised the powers which GCCG has reserved to itself may, in an emergency or where an important decision must be made urgently, be exercised by the Chair or Vice Chair together with the Accountable Officer after having consulted at least two non-officer members. The exercise of such powers by the Chair (or Vice Chair) and Accountable Officer shall be reported to the next formal meeting of GCCG in public session for ratification. In the interim, the power remains with the Chair and the Accountable Officer.

3.8.5 One third or more of the member practices of GCCG may requisition a meeting in writing. If the Chair refuses, or fails, to call a meeting within seven days of a requisition being presented, the members signing the requisition may forthwith call a meeting.

3.9 Suspension of Standing Orders

3.9.3 Except where it would contravene any statutory provision or any direction made by the Secretary of State for Health or the NHS Commissioning Board, any part of these standing orders may be suspended at any meeting, provided at least two thirds of those members present at the meeting of the governing body signify their agreement to suspension.

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

3.9.5 A separate record of matters discussed during the suspension shall be kept. These records shall be made available to the governing body's audit committee for review of the reasonableness of the decision to suspend standing orders.

3.9.6 No formal business shall be transacted while the Standing Orders are suspended and the decision to do so shall be considered by the Audit Committee

3.10 Variation and amendment of Standing Orders

3.10.1 Standing Orders can be varied in the following situations:

a) upon a recommendation of the Chair and/or Accountable Officer included on the agenda for the meeting;

b) two-thirds of the members are present at the meeting where the variation or amendment is being discussed and that at least half of the members vote in favour of the amendment;

c) providing that any variation or amendment does not contravene a statutory provision, direction made by the Secretary of State or guidance issued by the National Commissioning Board.

3.11 Record of Attendance

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

3.12 Minutes

3.12.1 The minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting where they shall be signed by the person presiding at it.

3.12.2 The minutes will be formally signed off by the Chair of the meeting and (where appropriate) will be made available to attendees and members of the public.

3.13 Admission of public and the press

3.13.1 The group will hold meetings in public on a regular basis at such times and places as the Governing Body may determine. Members of the public and representatives of the press may attend all meetings of Governing Body.

3.13.2 The public and representatives of the press, shall be required to withdraw upon the Governing Body resolving as follows:

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

3.13.3 The above resolution shall be taken in public and there shall be a public statement, either on the agenda or made by the Chair of the meeting, setting out in broad terms the nature of the business to be discussed (which does not breach the confidentiality of the subject matter).

3.12.4 Matters to be dealt with by GCCG following the exclusion of representatives of the press, and other members of the public shall be referred to as "Part II meeting") and shall be confidential to the members of GCCG.

3.12.5 Members and officers or any employee of GCCG in attendance shall not reveal or disclose the contents of papers or minutes from a Part II meeting outside of GCCG, without the express permission of the Accountable Officer or Chair. This prohibition shall apply equally to the content of any discussion during the Part II meeting which may take place on such reports or papers.

4 APPOINTMENT OF COMMITTEES AND SUB-COMMITTEES

4.11 Appointment of committees and sub-committees

4.11.1 The group may appoint committees and sub-committees of the group, subject to any regulations made by the Secretary of State[61], and also make provision for the appointment of committees and sub-committees of its governing body. Where such committees and sub-committees of the group, or committees and sub-committees of its governing body, are appointed they are included in Chapter 6 of the group's constitution.

4.11.2 Other than where there are statutory requirements, such as in relation to the governing body's audit committee or remuneration committee, the group shall determine the membership and terms of reference of committees and sub-committees and shall, if it requires, receive and consider reports of such committees at the next appropriate meeting of the group.

4.11.3 The provisions of these standing orders shall apply where relevant to the operation of the governing body, the governing body's committees and sub-committee and any other committees and sub-committees of the group unless stated otherwise in the committee or sub-committee's terms of reference.

4.12 Terms of Reference

4.12.1 Terms of reference shall have effect as if incorporated into the constitution and are set out in Appendices to the Constitution.

4.13 Delegation of Powers by Committees to Sub-committees

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

4.14 Approval of Appointments to Committees and Sub-Committees

4.14.1 The group shall approve the appointments to each of the committees and sub-committees which it has formally constituted including those of the governing body. Where the group determines that persons, who are neither members nor employees, shall be appointed to a committee or sub-committee the terms of such appointment shall be within the powers of the group. The group shall define the powers of such appointees and shall agree such travelling or other allowances as it considers appropriate.

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[61] See section 14N of the 2006 Act, inserted by section 25 of the 2012 Act

5 DUTY TO REPORT NON-COMPLIANCE WITH STANDING ORDERS AND PRIME FINANCIAL POLICIES

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

6 USE OF SEAL AND AUTHORISATION OF DOCUMENTS

6.1 Clinical Commissioning Group's seal

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

a) the Accountable Officer;

b) the Chair of the Governing Body;

c) the Chief Finance Officer.

6.2 Execution of a document by signature

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

a) the Accountable Officer;

b) the Chair of the Governing Body;

c) the Chief Finance Officer.

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

7.1 Policy statements: general principles

7.1.1 The group will from time to time agree and approve policy statements / procedures which will apply to all or specific groups of staff employed by Gloucestershire Clinical Commissioning Group. The decisions to approve such policies and procedures will be recorded in an appropriate group minute and will be deemed where appropriate to be an integral part of the group's standing orders.

APPENDIX D – SCHEME OF RESERVATION & DELEGATION

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

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

1.2. GCCG remains accountable for all of its functions, including those that it has delegated.

1.3 The paragraphs below indicate GCCG has reserved and delegated decisions.

1.3.1 Regulation and Control

GCCG will:

- Make arrangements by which the members of GCCG approve the decisions that are reserved for the membership.

- Approve applications to the NHS Commissioning Board on any matter concerning changes to GCCG constitution, including terms of reference for the group's governing body, its committees, membership of committees, the overarching scheme of reservation and delegated powers, arrangements for taking urgent decisions, standing orders and prime financial policies.

- Exercise or delegate GCCG functions which have not been retained as reserved by the group, delegated to the governing body, delegated to a committee or sub-committee of the group or to one of its members or employees.

- Prepare GCCG's overarching scheme of reservation and delegation, which sets out those decisions of the group reserved to the membership and those delegated to the:

  - group's governing body;
  - committees and sub-committees of the group; or
  - igroup's members or employees,

  and sets out those decisions of the governing body reserved to the governing body and those delegated to the:

  - governing body's committees and sub-committees;
  - members of the governing body;
  - an individual who is member of the group but not the governing body or a specified person;

for inclusion in GCCG constitution.

- Approve GCCG overarching scheme of reservation and delegation.

- Prepare GCCG operational scheme of delegation, which sets out those key operational decisions delegated to individual employees of GCCG, not for inclusion in the group's constitution.

- Approve GCCG's operational scheme of delegation that underpins the group's 'overarching scheme of reservation and delegation' as set out in its constitution.

- Prepare detailed financial policies that underpin GCCG prime financial policies.

- Approve detailed financial policies.

- Approve arrangements for managing exceptional funding requests.

- Set out who can execute a document by signature / use of the seal.

1.3.2 Practice Member Representatives and Members of the Governing Body

Responsibilities of member practices to GCCG will include:

- Actively engage with GCCG to help improve services within the area.
- Share all appropriate information and data to support delivery of referral and other prescribing and emergency admissions data.
- Through a Clinical Programme Group approach, follow the clinical pathways and referral protocols agreed by GCCG (except in individual cases where there are justified clinical reasons for not doing this) which are fed back appropriately.
- Manage the practice's prescribing budget within allocated resource.
- Participate in and deliver, as far as possible, the clinical, quality, safety and cost effective strategies agreed by GCCG and GH&WB.
- Establish a practice reference group as a means of obtaining the views and experiences of patients and carers.
- Work constructively with the locality sub-committee/GCCG.
- Respond in a timely manner to reasonable information requests from GCCG.
- Approve the appointment of governing body members, the process for recruiting and removing non-elected members to the governing body (subject to any regulatory requirements) and succession planning.
- Approve arrangements for identifying the group's proposed Accountable Officer.

1.3.3 Strategy and Planning

GCCG will:

- Agree the vision, values and overall strategic direction of GCCG.
- Approve GCCG operating structure.
- Approve GCCG commissioning plan.

- Approve GCCG corporate budgets that meet the financial duties as set out in paragraph 5.3 of the main body of the constitution.
- Approve variations to the approved budget where variation would have a significant impact on the overall approved levels of income and expenditure or the group's ability to achieve its agreed strategic aims.

1.3.4 Annual Reports and Accounts

GCCG will:

- Approve GCCG annual report and annual accounts.
- Approve arrangements for discharging GCCG statutory financial duties.

1.3.5 Human Resources

GCCG will:

- Approve the terms and conditions, remuneration and travelling or other allowances for governing body members, including pensions and gratuities.
- Approve terms and conditions of employment for all employees of GCCG including, pensions, remuneration, fees and travelling or other allowances payable to employees and to other persons providing services to the group.
- Approve any other terms and conditions of services for GCCG's employees.
- Determine the terms and conditions of employment for all employees of the group.
- Determine pensions, remuneration, fees and allowances payable to employees and to other persons providing services to the group.
- Recommend pensions, remuneration, fees and allowances payable to employees and to other persons providing services to the group.
- Approve disciplinary arrangements for employees, including the Accountable Officer (where he/she is an employee or member of the clinical commissioning group) and for other persons working on behalf of the group.
- Review disciplinary arrangements where the Accountable Officer is an employee or member of another clinical commissioning group
- Approval of the arrangements for discharging GCCG's statutory duties as an employer.
- Approve human resources policies for employees and for other persons working on behalf of GCCG.

1.3.6 Quality and Safety

GCCG will:

- Approve arrangements, including supporting policies, to minimise clinical risk, maximise patient safety and to secure continuous improvement in quality and patient outcomes.
- Approve arrangements for supporting the NHS Commissioning Board in discharging its responsibilities in relation to securing continuous improvement in the quality of general medical services.

1.3.7 Operational and Risk Management

GCCG will:

- Prepare and recommend an operational scheme of delegation that sets out who has responsibility for operational decisions within GCCG.
- Approve GCCG's counter fraud and security management arrangements.
- Approve the group's risk management arrangements.
- Approve arrangements for risk sharing and or risk pooling with other organisations (for example arrangements for pooled funds with other clinical commissioning groups or pooled budget arrangements under section 75 of the NHS Act 2006).
- Approve a comprehensive system of internal control, including budgetary control, that underpin the effective, efficient and economic operation of GCCG.
- Approve proposals for action on litigation against or on behalf of GCCG.
- Approve GCCG arrangements for business continuity and emergency planning.

1.3.8 Information Governance

GCCG will:

- Approve GCCG's arrangements for handling complaints.
- Approve arrangements for ensuring appropriate confidentiality in relation to GCCG's records, including patients' medical records, and for the secure storage, management and transfer of information and data.

1.3.9 Tendering and Contracting

GCCG will:

- Approve GCCG contracts for any commissioning support.
- Approve GCCG contracts for corporate support (for example finance provision).

1.3.10 Partnership Working

GCCG will:

- Approve decisions that individual members or employees of CCG participating in joint arrangements on behalf of the group can make. Such delegated decisions must be disclosed in this scheme of reservation and delegation.
- Approve decisions delegated to joint committees established under section 75 of the 2006 Act.

1.3.11 Commissioning and Contracting for Clinical Services

GCCG will:

- Approve arrangements for discharging GCCG's statutory duties associated with its commissioning functions, including but not limited to promoting the involvement of each patient, patient choice, reducing inequalities, improvement

in the quality of services, obtaining appropriate advice and public engagement and consultation.

- Approve arrangements for co-ordinating the commissioning of services with other groups and or with the local authority(ies), where appropriate

1.3.12 Communications

GCCG will:

- Approve arrangements for handling Freedom of Information requests.
- Determine arrangements for handling Freedom of Information requests.

Policy Area	Decision	Reserved to the Membership	Reserved or delegated to Governing Body	Accountable Officer	Chief Financial Officer	Other (stated)
REGULATION AND CONTROL						
	Determine the arrangements by which the members of the group approve those decisions that are reserved for the membership.	✓				
	Consideration and approval of applications to the NHS Commissioning Board on any matter concerning changes to the group's constitution, including terms of reference for the group's governing body, its committees, membership of committees, the overarching scheme of reservation and delegated powers, arrangements for taking urgent decisions, standing orders and prime financial policies.	✓				
	Exercise or delegation of those functions of the clinical commissioning group which have not been retained as reserved by the group, delegated to the governing body or other committee or sub-committee or [specified] member or employee.			✓		
	Require and receive the declaration of interests from members of the Governing Body.		✓			
	Require and receive the declaration of interests from members, practice representatives and employees of the group.			✓		
	Approve arrangements for dealing with complaints		✓			
	Adopt the organisation structures, processes and procedures to facilitate the discharge by the group of its statutory and other functions and to agree modifications		✓			

Policy Area	Decision	Reserved to the Membership	Reserved or delegated to Governing Body	Accountable Officer	Chief Financial Officer	Other (stated)
	thereto.					
	Receive reports from committees that the group is required by statute or other regulation to establish and to take action upon those reports as necessary.		✓			
	Confirm the recommendations of the groups committees where the committees do not have executive powers.		✓			
	Approve arrangements relating to the discharge of the groups responsibilities as a corporate trustee for funds held on trust.		✓			
	Note the terms of reference of sub-committees established by committees of the group and/or Governing Body.		✓			
	Manage members of the group, practice representatives, members of the Governing Body or employees who are in breach of statutory requirements or the groups standing orders.		✓			
	Approve any urgent decisions taken by the Chair of the Governing Body and the Accountable Officer for ratification by the group in public session.		✓			
	Ratify or otherwise instances of failure to comply with the standing orders brought to the attention of the accountable officer. Such failures to be reported to the group in formal session.		✓			
	Approve procedure for the declaration of hospitality and/or hospitality received.		✓			

Policy Area	Decision	Reserved to the Membership	Reserved or delegated to Governing Body	Accountable Officer	Chief Financial Officer	Other (stated)
PRACTICE MEMBER REPRESENTATIVES AND MEMBERS OF THE GOVERNING BODY						
	Appoint and remove practice representatives.					✓ Member Practice
	Appoint the Chair of the Governing Body.		✓			
	Remove the Chair of the Governing Body in advance of their term of office expiring.	✓				
	Appoint the Deputy Chair(s) of the Governing Body.		✓			
	Remove the Deputy Chair(s) of the Governing Body in advance of their term of office expiring.	✓				
	Appoint and dismiss other committees (and individual members) that are directly accountable to the Governing Body.		✓			
	Appoint, appraise, discipline and dismiss employee members of the Governing Body.		✓			
	Confirm the appointment of members of any committee of the group as representatives of the group on outside bodies.		✓			
	Note the proposals of the Remuneration Committee and to note the proposals of the accountable officer for those staff not considered by the Remuneration Committee					
STRATEGY AND PLANNING						
	Define the strategic aims and objectives of the group.		✓			

Policy Area	Decision	Reserved to the Membership	Reserved or delegated to Governing Body	Accountable Officer	Chief Financial Officer	Other (stated)
	Identify key strategic risks, evaluate them and ensure adequate responses are in place and are monitored.		✓			
	Approve plans in respect of the application of available financial resource to support the agreed local commissioning priorities.		✓			
	Approve proposals for ensuring quality and developing clinical governance in services provided by the groups contractors having regard to any guidance issued by the National Commissioning Board		✓			
	Approve the group's annual commissioning strategy and plan.		✓			
	Approve outline and final business cases for capital investment if this represents a variation from the strategic plan.		✓			
	Approve all budgets of the group		✓			
	Approve annually the organisational development proposals of the group		✓			
	Ratify the Governing Body's proposals for the development of the group	✓				
	Ratify proposals for the acquisition, disposal or change of use of real property		✓			
	Approve banking arrangements.		✓			
	Approve proposals in individual cases fro the write off of losses or making special payments above the limits of delegation to		✓			

Policy Area	Decision	Reserved to the Membership	Reserved or delegated to Governing Body	Accountable Officer	Chief Financial Officer	Other (stated)
	the accountable officer and chief financial officer (for losses and special payments).					
	Approve individual compensation payments		✓			
	Approve the group's strategies as recommended by committees or the employee members of the Governing Body		✓			
	Ratify the group's strategies as recommended by the Governing Body	✓				
	Note the group's corporate and clinical policies as advised by committees with delegated powers of approval as contained in their terms of reference to approve policies on behalf of the Governing Body.		✓			
	Approve group policies as defined for Governing Body approval.		✓			
	Note group policies as approved by the Governing Body and/or its committees	✓				
ANNUAL REPORTS AND ACCOUNTS						
	Ratify the appointment (and where necessary dismissal) of External Auditors including arrangements for the separate audit of funds held on trust	✓				
	Receive the annual management letter received from the External Auditor, taking account of the advice, where appropriate, of the Audit Committee.		✓			
	Receive an annual report from the Internal Auditor and agree action on recommendations where appropriate of the Audit Committee.		✓			

Policy Area	Decision	Reserved to the Membership	Reserved or delegated to Governing Body	Accountable Officer	Chief Financial Officer	Other (stated)
	Receipt and approval of the group's Annual Report and Accounts.		✓			
	Receipt and approval of the Annual Report and Accounts for funds held on trust, if any.		✓			
	Receipt of such reports as the Governing Body sees fit from its committees and/or other committees of the group in respect of their exercise of powers delegated to them.		✓			
HUMAN RESOURCES						
	Approve the terms and conditions, remuneration and travelling and other allowances for members of the governing body, including pensions and gratuities.					✓ Remuneration Committee
	Approve terms and conditions of employment for all employees of the group, including, pensions, remuneration, fees and travelling or other allowances payable to employees and to other persons providing services to the group.					✓ Remuneration Committee
	Approve any other terms and conditions of service for the group's employees.					✓ Remuneration Committee
	Determine the terms and conditions of employment for all employees of the group.					✓ Remuneration Committee
	Determine pensions, remuneration, fees and allowances payable to employees and to other persons providing services to the group.					✓ Remuneration Committee

Policy Area	Decision	Reserved to the Membership	Reserved or delegated to Governing Body	Accountable Officer	Chief Financial Officer	Other (stated)
	Recommend pensions, remuneration, fees and allowances payable to employees and to other persons providing services to the group.					✓ Remuneration Committee
	Approve disciplinary arrangements for employees, including the Accountable Officer (where they are an employee and/or member of the clinical commissioning group) and for other persons working on behalf of the group.					✓ Remuneration Committee
	Review disciplinary arrangements where the Accountable Officer is an employee or member of another clinical commissioning group.					✓ Remuneration Committee
	Approval of the arrangements for discharging the group's statutory duties as an employer.					✓ Remuneration Committee
	Approve human resources policies for employees and for other persons working on behalf of the group.					✓ Remuneration Committee
QUALITY AND SAFETY						
	Approve arrangements, including supporting policies, to minimise clinical risk, maximise patient safety and to secure continuous improvement in quality and patient outcomes.					✓ Integrated Governance Committee
	Approve arrangements for supporting the NHS Commissioning Board in discharging		✓			

Policy Area	Decision	Reserved to the Membership	Reserved or delegated to Governing Body	Accountable Officer	Chief Financial Officer	Other (stated)
	its responsibilities in relation to securing continuous improvement in the quality of general medical services.					
OPERATIONAL AND RISK MANAGEMENT						
	Prepare and recommend an operational scheme of delegation that sets out who has responsibility for operational decisions within the group.			✓		
	Approve the group's counter fraud and security management arrangements.					✓ Audit Committee
	Approve the group's risk management arrangements.					✓ Integrated Governance Committee
	Approve arrangements for risk sharing and or risk pooling with other organisations (for example arrangements for pooled funds with other clinical commissioning groups or pooled budget arrangements under section 75 of the NHS Act 2006).					✓ Integrated Governance Committee
	Approval of a comprehensive system of internal control, including budgetary control, that underpin the effective, efficient and economic operation of the group.					✓ Audit Committee
	Approve proposals for action on litigation against or on behalf of the clinical commissioning group.		✓			
	Approve the group's arrangements for business continuity and emergency planning.			✓		

Policy Area	Decision	Reserved to the Membership	Reserved or delegated to Governing Body	Accountable Officer	Chief Financial Officer	Other (stated)
INFORMATION GOVERNANCE						
	Approve the group's arrangements for handling complaints.					✓ Integrated Governance Committee
	Approval of the arrangements for ensuring appropriate and safekeeping and confidentiality of records and for the storage, management and transfer of information and data.					✓ Integrated Governance Committee
TENDERING AND CONTRACTING						
	Approval of the group's contracts for any commissioning support.		✓			
	Approval of the group's contracts for corporate support (for example finance provision).		✓			
PARTNERSHIP WORKING						
	Approve decisions that individual members or employees of the group participating in joint arrangements on behalf of the group can make. Such delegated decisions must be disclosed in this scheme of reservation and delegation.		✓			
	Approve decisions delegated to joint committees established under section 75 of the 2006 Act.		✓			

Policy Area	Decision	Reserved to the Membership	Reserved or delegated to Governing Body	Accountable Officer	Chief Financial Officer	Other (stated)
COMMISSIONING AND CONTRACTING FOR CLINICAL SERVICES						
	Approval of the arrangements for discharging the group's statutory duties associated with its commissioning functions, including but not limited to promoting the involvement of each patient, patient choice, reducing inequalities, improvement in the quality of services, obtaining appropriate advice and public engagement and consultation.					✓ Integrated Governance Committee
	Approve arrangements for co-ordinating the commissioning of services with other groups and or with the local authority(ies), where appropriate.					✓ Integrated Governance Committee
COMMUNICATIONS						
	Approving arrangements for handling Freedom of Information requests.					✓ Integrated Governance Committee
	Determining arrangements for handling Freedom of Information requests.					✓ Integrated Governance Committee

APPENDIX E – DETAILED SCHEME OF DELEGATION

- The Detailed Delegated Limits outlined below represent the lowest level to which authority within the CCG is delegated

- Delegation to lower levels or other offices is not permitted without the specific authority of in writing of the Accountable Officer or the Chief Finance Offier. All items concerning Finance must be carried out in accordance with Prime Financial Polices and Standing Orders.

- Delegated authority may be exercised by a **formally nominated deputy** in the absence of the primary delegate.

- In certain circumstances the limits of authorisation in this document may be temporarily amended. Such amendments will be communicated by the Accountable Officer or Chief Finance Officer using cascade e-mails.

Reference Document	Delegated Matter	Delegated Authority - Commissioner	Scope of Delegation
Prime Financial Policies - Sec 7	**1. Management of Budgets** Responsibility to keep expenditure within budgets and to ensure that budgets are only used for the type of expenditure for which they have been set. At individual budget level (Pay and Non Pay) At Directorate level All Other Areas Accountable officer for the CCG	 Budget Holder Director Chief Finance Officer Accountable Officer	
Prime Financial Policies - Sec 11	**2. Maintenance/Operation of Bank Accounts** a) Approval of banking arrangements	Chief Finance Officer Governing Body	In accordance with PFP

Reference Document	Delegated Matter	Delegated Authority - Commissioner	Scope of Delegation
	b) Variation to approved signatories	Chief Finance Officer	
Prime Financial Policies - Sec 17	**3. Non Pay Revenue and Capital Expenditure / Requisitioning / Ordering** a) Payment of Goods and Services • Stock/non-stock requisitions up to £1,000 • Stock/non-stock requisitions up to £10,000 • Stock/non stock requisitions up to £249,999 • Stock/non stock requisitions from £250,000 to £499,999	Budget Manager Budget Holder Directors Chief Finance Officer	

Reference Document	Delegated Matter	Delegated Authority - Commissioner	Scope of Delegation
	• Stock/non stock requisitions from £500,000 to £999,999 • Stock/non stock requisitions from £1,000,000	Accountable Officer Governing Body	
	b) Authorisation of Payments against an signed NHS Contract or signed s75 or s256 with the Local Authority	Accountable Officer Chief Finance Officer, Director, Deputy Director of Commissioning, Deputy CFO	
Prime Financial Policies - Sec 7	**f) Approval of Virements** Between commissioning budgets up to £50,000 or between admin budgets/provider patient services non-recurrently up to £10,000 Between commissioning budgets up to £100,000 or between admin budgets recurrently and/or up to £50,000	Budget Holder Chief Finance Officer	

Reference Document	Delegated Matter	Delegated Authority - Commissioner	Scope of Delegation
	Above £100,000 between commissioning budgets or above £50,000 between admin budgets	Accountable Officer	
	g) Orders exceeding 36 month period	Accountable Officer or Chief Finance Officer	
	h) All contracts for Non Health Care goods & services and subsequent variations to contracts	As section 3a	
	i) Prepayments over £1,500	Chief Finance Officer or Deputy CFO	
Prime Financial Policies - Sec 18	**4. Capital Schemes** a) Delegated Limits for Capital Investment for buildings, PFI, IM&T and equipment investments, and property leases		

Reference Document	Delegated Matter	Delegated Authority - Commissioner	Scope of Delegation
	• Up to £35 million	NHS Commissioning Board Department of Health and HM Treasury	
	• From £35 million and above		
	• Selection of Architects, quantity surveyors, consultant engineer and other professional advisors within EU regulations	Accountable Officer or Chief Finance Officer	
	• Financial monitoring and reporting on all capital scheme expenditure	Chief Finance Officer	
Prime Financial Policies - Sec 13	**5. Quotation, Tendering & Contract Procedures including secondary,**		

Reference Document	Delegated Matter	Delegated Authority - Commissioner	Scope of Delegation
	primary and community healthcare services (Values are the total value of expenditure including VAT for the total duration of any time period committed to)		
	a) No requirement to obtain quotes for single items up to £1,000 or for items to be purchased using a nationally negotiated contract (via Purchasing and Supply Agency)	As per section 3	
	b) 2 written quotes for expenditure between £1,000 and £5,000.	As per section 3	
	c) Obtaining a minimum of **3 written quotations** for goods/services from £5,000 to £50,000	As per section 3	
	d) Obtaining a minimum of **3 written competitive tenders** for goods and	As per section 3	

Reference Document	Delegated Matter	Delegated Authority - Commissioner	Scope of Delegation
	services from £50,000 process by Purchasing & Supplies Dept e) Contracts above EU OJEU limits, process by Purchasing & Supplies Dept f) Approval to accept quote/tender other than the lowest that meet the award criteria Quotations & tenders < £100,000 Tenders > £100,000	 Chief Finance Officer / Deputy CFO Chief Finance Officer	 Report to Audit & Assurance Committee
	g) Waiving of quotations & Tenders subject to SOs & PFP Up to £99,000 £100,000 - £249,999	 Chief Finance Officer Accountable Officer	

Reference Document	Delegated Matter	Delegated Authority - Commissioner	Scope of Delegation
	£ 250,000 + Opening Quotations: Opening Tenders:	Governing Body Directors and Senior Managers Accountable Officer and Directors, Deputy CFO, Associate Director of Corporate Governance	
Prime Financial Policies - Sec 12	**6. Setting of Fees and Charges** a) Private Patient, Overseas Visitors, Income Generation and other patient related services b) Price of NHS Contracts c) Price of Non NHS Contracts	 Chief Finance Officer or Deputy CFO Chief Finance Officer or Deputy CFO Chief Finance Officer or Deputy CFO	

Reference Document	Delegated Matter	Delegated Authority - Commissioner	Scope of Delegation
	7. Income Collection • Cancellation of invoices incorrectly raised <£75,000 • Cancellation of invoices incorrectly raised >£75,000 • Authority to pursue legal action for bad debts • Write off of bad debt <£5,000 • Write off of bad debt >£5,000 • Approval of write offs relating to over payment of salary	Deputy CFO Chief Finance Officer Chief Finance Officer Deputy CFO Chief Finance Officer Chief Finance Officer	
Prime Financial Policies - Sec 14	**8. Agreement and Signing of Contracts for the purchasing of Health Care and Agreements with the Local Authority** **Signing of Health Care Contracts** 3 years or less, and less than £1,000,000	Director of Commissioning Implementation	

Reference Document	Delegated Matter	Delegated Authority - Commissioner	Scope of Delegation
	3 years or less, and £1,000,000 or greater Variations to contracts **Signing of Agreements between the PCT and the Local Authority**	Accountable Officer Director of Commissioning Implementation Accountable Officer / Chief Finance Officer or Director of Commissioning Implementation	
Prime Financial Policies - Sec 7	**9. Engagement of Staff Not On the Establishment** a) Non Medical Consultancy Staff or total commitment is <£20,000 in one year where budget is available >£20,000 or where no budget available	Accountable Officer and Chief Finance Officer	

Reference Document	Delegated Matter	Delegated Authority - Commissioner	Scope of Delegation
	b) Engagement of CCG's Solicitors	Associate Director of Corporate Governance	
	c) Booking of Bank or Agency Staff	Budget Manager	
Prime Financial Policies - Sec 20	**10. Expenditure on Charitable and Endowment Funds**	Designated Fund Managers in accordance with procedures and limits laid down for charitable funds by the corporate trustee	
	11. Agreements/Licences/Leases a) Preparation of all tenancy agreements/licences for all staff subject to PCT Policy on accommodation for staff b) Initial review of all proposed lease	Director responsible for Estates	

Reference Document	Delegated Matter	Delegated Authority - Commissioner	Scope of Delegation
	agreements to assess financial implications of lease agreement	Deputy CFO	
	c) Authorisation to sign leases/licences	NHS Commissioning Board	
	Signature of all tenancy agreements/licences (as above)	Accountable Officer or Chief Finance Officer	
	d) extensions to existing licences and leases }	Chief Finance Officer	
	e) Letting of premises to outside organisations }	Chief Finance Officer	
	f) Approval of rent based on professional assessment	Chief Finance Officer	
Prime Financial Policies - Sec 18	**12.Condemning & Disposal** Maintain losses and special payments register	Chief Finance Officer	

Reference Document	Delegated Matter	Delegated Authority - Commissioner	Scope of Delegation
	a) Items obsolete, obsolescent, redundant, irreparable or cannot be required cost effectively 1) with current/estimated purchase price <£499 2) with current purchase new price >£500+ 3) Disposal of mechanical and engineering plant (subject to estimated income exceeding £1,000 per sale) b) Disposal of property or land	Budget Manager Chief Finance Officer Chief Finance Officer Governing Body	
	13.Losses, Write –off & Compensation a) Losses of cash due to: 1) Theft, Fraud, etc		

Reference Document	Delegated Matter	Delegated Authority - Commissioner	Scope of Delegation
	2) Overpayments of Salaries, wages, fees & allowances 3) Other Causes including un-vouched or incompletely vouched payments, overpayments other than those included under item 2: physical losses of cash and cash equivalents, e.g. stamps due to fire (other than arson), accident and similar causes		
	Up to £1,000 Up to £15,000 Over £15,000 Novel, contentious or repercussive cases Special severance payments (Dear Accounting Officer letter DAO (GEN) 11/05)	Chief Finance Officer Accountable Officer Governing Body NHS Commissioning Board prior to submission to DH HM Treasury	
	b) Fruitless payments (including abandoned capital Schemes)		

Reference Document	Delegated Matter	Delegated Authority - Commissioner	Scope of Delegation
	Up to £1,000 Up to £15,000 Over £15,000 Novel, contentious or repercussive cases Special severance payments (Dear Accounting Officer letter DAO (GEN) 11/05)	Chief Finance Officer Accountable Officer Governing Body NHS Commissioning Board prior to submission to DH HM Treasury	
	c) Bad debts and claims abandoned:- 1) Private patients (Sect. 65/ 66 NHS Act 1977) 2) Overseas visitors (Sect. 121 NHS Act 1977) 3) Cases other than 1) – 2) Up to £1,000 Up to £15,000 Over £15,000 Novel, contentious or repercussive cases Special severance payments (Dear	 Chief Finance Officer Accountable Officer Governing Body NHS Commissioning Board prior to submission to DH	

Reference Document	Delegated Matter	Delegated Authority - Commissioner	Scope of Delegation
	Accounting Officer letter DAO (GEN) 11/05)	HM Treasury	
	d) Damage to buildings, their fittings, furniture and equipment and loss of equipment and property in stores and in use due to: 1) Culpable causes e.g. theft, fraud, arson or sabotage whether proved or suspected, neglect of duty or gross carelessness 2) Other causes Up to £1,000 Up to 15,000 Over £15,000 Novel, contentious or repercussive cases Special severance payments (Dear	 Chief Finance Officer Accountable Officer Governing Body NHS Commissioning Board prior to submission to DH	

Reference Document	Delegated Matter	Delegated Authority - Commissioner	Scope of Delegation
	Accounting Officer letter DAO (GEN) 11/05)	HM Treasury	
	e) Compensation payments made under legal obligation	Governing Body	
	f) Extra contractual payments to contractors Up to £1,000 Up to £15,000 Over £15,000 Novel, contentious or repercussive cases Special severance payments (Dear Accounting Officer letter DAO (GEN) 11/05)	 Chief Finance Officer Accountable Officer Governing Body NHS Commissioning Board prior to submission to DH HM Treasury	
	g) Ex gratia payments to patients & staff for loss of personal effects Up to £1,000 Up to £15,000 Over £15,000	 Chief Finance Officer Accountable Officer Governing Body	

Reference Document	Delegated Matter	Delegated Authority - Commissioner	Scope of Delegation
	Novel, contentious or repercussive cases Special severance payments (Dear Accounting Officer letter DAO (GEN) 11/05) h) For clinical negligence (negotiated settlements following legal advice) where the guidance relating to such payments has been applied (including plaintiffs costs) • Up to £1,000 • Up to £15,000 • Over £15,000 Novel, contentious or repercussive cases Special severance payments (Dear Accounting Officer letter DAO (GEN) 11/05)	NHS Commissioning Board prior to submission to DH HM Treasury Chief Finance Officer Accountable Officer Governing Body NHS Commissioning Board prior to submission to DH HM Treasury	

Reference Document	Delegated Matter	Delegated Authority - Commissioner	Scope of Delegation
	For Clinical negligence where the guidance relating to such payments has not been applied • Up to £1,000 • Up to £5,000 • Over £5,000 Novel, contentious or repercussive cases Special severance payments (Dear Accounting Officer letter DAO (GEN) 11/05)	Chief Finance Officer Accountable Officer Governing Body NHS Commissioning Board prior to submission to DH HM Treasury	
	i) For personal injury claims involving negligence where relevant guidance has been applied (including plaintiffs costs) • Up to £1,000 • Up to £15,000 • Over £15,000	Chief Finance Officer Accountable Officer Governing Body	

Reference Document	Delegated Matter	Delegated Authority - Commissioner	Scope of Delegation
	Novel, contentious or repercussive cases Special severance payments (Dear Accounting Officer letter DAO (GEN) 11/05) For personal injury claims involving negligence where legal advice obtained and relevant guidance has not been applied • Up to £1,000 • Up to £5,000 • Over £5,000 Novel, contentious or repercussive cases Special severance payments (Dear Accounting Officer letter DAO (GEN) 11/05)	NHS Commissioning Board prior to submission to DH HM Treasury Chief Finance Officer Accountable Officer Governing Body NHS Commissioning Board prior to submission to DH HM Treasury	

Reference Document	Delegated Matter	Delegated Authority - Commissioner	Scope of Delegation
	j) Other clinical negligence cases & personal injury claims Up to £1,000 Up to £15,000 Over £15,000 Novel, contentious or repercussive cases Special severance payments (Dear Accounting Officer letter DAO (GEN) 11/05)	 Chief Finance Officer Accountable Officer Governing Body NHS Commissioning Board prior to submission to DH HM Treasury	
	k) Other, except cases of maladministration where there was no financial loss by claimant All	 Governing Body	
	1) Others 2) Maladministration where there was no financial loss by claimant		

Reference Document	Delegated Matter	Delegated Authority - Commissioner	Scope of Delegation
	3) Patient referrals outside the UK and EEA guidelines 4) Extra statutory and extra regulationary payments All	Governing Body	
Prime Financial Policies - Sec 4	**14.Reporting of Incidents to the Police** a) Where a criminal offence is suspected • criminal offence of a violent nature • other b) Where a fraud is involved	Appropriate Manager Chief Finance Officer or Accountable Officer	
Prime Financial Policies - Sec 12	**15.Petty Cash Disbursements (not applicable to central Cashiers Office)** • General Expenditure up to £25 per item	As determined by the Chief Finance Officer	
	16.Receiving Hospitality		

Reference Document	Delegated Matter	Delegated Authority - Commissioner	Scope of Delegation
	Applies to both individual and collective hospitality In excess of £25.00 per item received	Declaration required in CCG Hospitality Register	
Prime Financial Policies - Sec 3	**17. Implementation of Internal and External Audit Recommendations**	Budget Manager or Director	
Prime Financial Policies - Sec 2	**18. Maintenance & Update of PCT Financial Procedures**	Chief Finance Officer	
Prime Financial Policies - Sec 16	**19. Personnel & Pay** a) Authority to fill funded post on the establishment with permanent staff including the ability to alter skill mix within existing budget b) Authority to appoint staff to post not on the funded establishment c) The granting of additional salary	 HR Lead and Budget Holder Accountable Officer HR Lead & Relevant	

Reference Document	Delegated Matter	Delegated Authority - Commissioner	Scope of Delegation
	increments to staff within budget d) All requests for upgrading or regrading shall be dealt with in accordance with CCG Procedure	Director	
	e) <u>Establishments</u> 1) Additional staff to the agreed establishment with specifically allocated finance. 2) Additional staff to the agreed establishment without specifically allocated finance	Director with the Chief Finance Officer Accountable Officer and Chief Finance Officer	
	f) <u>Pay</u> a) Authority to complete standing data forms effecting pay, new starters, variations and leavers	HR Lead and Budget Manager	

Reference Document	Delegated Matter	Delegated Authority - Commissioner	Scope of Delegation
	b) Authority to complete and authorise positive reporting forms	Budget Manager	
	c) Authority to authorise overtime	Budget Holder	
	d) Authority to authorise mileage claims, subsistence expenses & exam fees	Budget Manager	
	e) Submission of travel and subsistence claims within 3 months of incurring expenditure	Employee	
	f) Authorisation of travel expenses over 3 months old	Chief Finance Officer	Exceptional circumstances only, supplies procedure should be followed
	g) Authorisation of non travel, subsistence or exam fees through expenses claim form	Chief Finance Officer	
	Approval of Performance Related Pay Assessment	Line/Departmental Manager	

Reference Document	Delegated Matter	Delegated Authority - Commissioner	Scope of Delegation
	g) <u>Leave</u> a) Approval of annual leave b) Compassionate leave up to 3 days c) Compassionate leave up to 6 days d) Special leave arrangements • Paternity leave • Carers leave 3/5 days e) Leave without pay	} } } } As per CCG policy } } } } } }	
	f) Time off in lieu	Line manager	
	g)Maternity Leave – paid and unpaid	As per CCG policy	
	h) <u>Sick Leave</u> • Extensions of sick leave beyond CCG terms and Conditions • Return to work part-time on full pay day to assist recovery in excess of PCT terms and conditions • Extension of sick leave on full pay	Director in conjunction with HR Lead Director in conjunction with HR Lead Accountable Officer or Chief Finance Officer and	

Reference Document	Delegated Matter	Delegated Authority - Commissioner	Scope of Delegation
	in excess of PCT terms and conditions	HR Lead	
	i) <u>Study Leave</u> • Study leave outside the UK • All study leave (UK) in excess of PCT training procurement	 Accountable Officer Accountable Officer or Director	
	j) <u>Removal Expenses, Excess Rent and House Purchases</u> Authorisation of payment of removal expenses in accordance with PCT policy incurred by officers taking up new appointments (providing consideration was promised at interview) Up to £5,000 Over £5,000 to £8,000 maximum	 Director Accountable Officer or Chief Finance Officer	
	k) <u>Grievance Procedure</u> All grievances cases must be dealt with strictly in accordance with the	 HR Lead	 CCG Grievance Procedure

Reference Document	Delegated Matter	Delegated Authority - Commissioner	Scope of Delegation
	Grievance Procedure and the advice of the Human Resource Manager must be sought when the grievance reaches the level of General Manager		
	l) <u>Authorised Car & Mobile Phone Users</u> • Requests for new posts to be authorised as car users • Requests for existing post to be authorised as car users from the current financial year– standard, regular or lease car users • Requests for existing post to be authorised as car users from the prior to current financial year– standard, regular or lease car users • Requests for new posts to be authorised as mobile telephone users	Director and HR Lead Director and HR Lead Chief Finance Officer Budget Holder & HR Lead	

Reference Document	Delegated Matter	Delegated Authority - Commissioner	Scope of Delegation
	m) Renewal of Fixed Term Contract	Director	
	n) Redundancy	Accountable Officer / Chief Finance Officer and HR Lead	Redeployment and Redundant policy
	o) Ill Health Retirement Decision to pursue retirement on the grounds of ill-health	Chief Finance Officer and HR Lead	
	p) Dismissal	Director or nominated deputy	Disciplinary policy
Prime Financial Policies - Sec 15	**25. Insurance Policies and Risk Managment**	Accountable Officer / Associate Director Corporate Governance	
	26. Patients' & Relatives' Complaints a) Overall responsibility for ensuring that all complaints are dealt with effectively b) Responsibilty for ensuring complaints	Accountable Officer and Associate Director of Patient and Public Involvement	

Reference Document	Delegated Matter	Delegated Authority - Commissioner	Scope of Delegation
	relating to directorate are investigated thoroughly c) Medico – Legal Complaints - Co ordination of their managment	Accountable Officer and Associate Director Corporate Governance	
	27.Relationships with Press a) Non-Emergency General Enquiries • Within Hours • Outside Hours b) Emergency • Within Hours • Outside Hours	Communications Manager Manager on call or Associate Director of Communications Communications Manager Manager on call or Associate Director of Communications	

Reference Document	Delegated Matter	Delegated Authority - Commissioner	Scope of Delegation
	28.Infectious Diseases & Notifiable Outbreaks	Manager on call or Health Protection Unit Contact or Director of Public Health	
	31.Facilities for staff not employed by the PCT to gain practical experience Professional Recognition, Honary Contracts, & Insurance of Medical Staff Work experience students	HR Lead HR Lead	
	32. Review of Fire Precautions	Director responsible for Health & Safety	
	33.Review of all statutory compliance legislaton and Health and Safety requirements including control of Substances Hazardous to Health Regulations	Director responsible for Health & Safety	
	34.Review of Medicines Inspectorate Regulations	Head of Medicines Management	

Reference Document	Delegated Matter	Delegated Authority - Commissioner	Scope of Delegation
	35. Review of compliance with environmental regulations, for example those relating to clean air and waste disposal	Director responsible for Estates	
	36. Review of PCT's compliance with the Data Protection Act	Chief Finance Officer	
	37. Monitor proposals for contractual arrangments between the PCT and the outside bodies	Appropriate Director	
	38. Review the PCT's compliance with the Access to Records Act	Chief Finance Officer	
	39. Review of the PCT's compliance Code of Practice for handling confidential information in the contracting environment and the compliance with "safe Haven" per EL 92/60	Chief Finance Officer	
	40. The keeping of a Declaration of Interests Register (a) Board and Executive Committee	Associate Director of Corporate Governance	

Reference Document	Delegated Matter	Delegated Authority - Commissioner	Scope of Delegation
	Members (b) Staff members		
	41.Attestation of sealings in accordance with Standing Orders (a) custody (b) register of sealings	Chair/Accountable Officer	
	42. The keeping of the register of Sealings	Accountable Officer	
	43. The keeping of the Hospitality Register	Accountable Officer	
Prime Financial Policies – Sec 19	**44. Retention of Records**	Associate Director of Corporate Governance	
	46. Security Management	Director responsible for Local Security	
	48. Contractor's Responsibilities Ensuring contractors and their employees are aware of any requirement to comply with Standing Orders and Prime Financial Policies	All employees	

SUMMARY OF KEY RESPONSIBILITIES OF ALL EMPLOYEES UNDER STANDING ORDERS AND PRIME FINANCIAL POLICIES

Responsibility:	**Of**
To comply with all procedures implemented by the Governing Body, Accountable Officer or Chief Financial Officer to ensure compliance with Standing Orders and Prime Financial Policies	All employees
To report instances of non-compliance with Standing Orders and Prime Financial Policies	All employees
To act in such a way as to maintain the security of all CCG property	All employees
To report losses immediately to the Chief Financial Officer following the process laid down	All employees
To inform the Chief Financial Officer following the process laid down of any income due to the PCT in respect of their area of responsibility	All employees
To inform the appropriate person, in accordance with the guidance and options laid down, of any suspicion of fraud or corruption	All employees
To declare in accordance with the procedures laid down, any gifts or hospitality or sponsorship received	All employees
To declare in accordance with the procedures laid down any interests which may conflict with fulfilment of their role	All employees
To comply with the Standards of Business Conduct for NHS Staff	All employees
To set in place arrangements to maintain the security of all CCG property within their area of responsibility	Senior managers
To comply with the Code of Conduct for NHS Managers	Senior Managers
To comply with Protocol for Avoidance of Potential Conflicts of Interest and Potential Unfair Competitive Advantage.	All staff as appropriate

APPENDIX F - PRIME FINANCIAL POLICIES

1. INTRODUCTION

1.1. General

1.1.1. These prime financial policies and supporting detailed financial policies shall have effect as if incorporated into the group's constitution.

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

1.1.3. In support of these prime financial policies, the Governing Body has prepared more detailed procedures, approved by the Chief Finance Officer known as *detailed financial* procedures. The group refers to these prime financial policies and detailed financial procedures together as the clinical commissioning group's financial policies.

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

1.1.5. A list of the Clinical Commissioning Group's detailed financial procedures will be published and maintained on the group's website. Documentation will also be available upon request for inspection at:

Sanger House
5220 Valiant Court
Gloucester Business Park
Brockworth
Gloucestershire GL3 4FE

This information will also be available from Guide & PALS who can be contacted on 0800 0151548 or email: community.pals@glos.nhs.uk

1.1.6. Should any difficulties arise regarding the interpretation or application of any of the prime financial policies then the advice of the Chief Finance Officer must be sought before acting. The user of these prime financial policies should also be familiar with and comply with the provisions of the group's constitution, standing orders and scheme of reservation and delegation.

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

1.2. Overriding Prime Financial Policies

1.2.1. If for any reason these prime financial policies are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next formal meeting of the governing body's audit committee for referring action or ratification. All of the group's members and employees have a duty to disclose any non-compliance with these prime financial policies to the Chief Finance Officer as soon as possible.

1.3. Responsibilities and delegation

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

1.3.2. All Governing Body members and employees who carry out a financial function must keep financial records and discharge their duties in a manner that is satisfactory to the Chief Finance Officer

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

1.4. Contractors and their employees

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

1.5. Amendment of Prime Financial Policies

1.5.1. To ensure that these prime financial policies remain up-to-date and relevant, the Chief Finance Officer will review them at least annually. Following consultation with the Accountable Officer and scrutiny by the governing body's audit committee, the Chief Finance Officer will recommend amendments, as fitting, to the governing body for approval. As these prime financial policies are an integral part of the group's constitution, any amendment will not come into force until the group applies to the NHS Commissioning Board and that application is granted.

2. INTERNAL CONTROL

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

2.1. The governing body is required to establish an audit committee with terms of reference agreed by the governing body (see paragraph 6.6.6 (a) of the group's constitution for further information).

2.2. The Accountable Officer has overall responsibility for the group's systems of internal control.

2.3. The Chief Finance Officer will ensure that:

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

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

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

3. AUDIT

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

3.1. In line with the terms of reference for the governing body's audit committee, the person appointed by the group to be responsible for internal audit and the Audit Commission appointed external auditor will have direct and unrestricted access to audit committee members and the chair of the governing body, Accountable Officer and Chief Finance Officer for any significant issues arising from audit work that management cannot resolve, and for all cases of fraud or serious irregularity.

3.2. The person appointed by the group to be responsible for internal audit and the external auditor will have access to the audit committee and the Accountable Officer to review audit issues as appropriate. All audit committee members, the chair of the governing body and the Accountable Officer will have direct and unrestricted access to the head of internal audit and external auditors.

3.3. The Chief Finance Officer will ensure that:

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

b) the governing body approves any changes to the provision or delivery of assurance services to the group.

3.4. The Chief Finance Officer or designated internal or external auditor is entitled without necessarily giving prior notice to require and receive:

a) Access to all records, documents and correspondence relating to any financial or other relevant transactions including documents of a confidential nature with regards to the business of the Clinical Commissioning Group.

b) Access at all reasonable times to any land, premises or property of the Clinical Commissioning Group.

c) Explanations concerning any matter under investigation

4. FRAUD AND CORRUPTION

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

4.1. The governing body's audit committee will satisfy itself that the group has adequate arrangements in place for countering fraud and shall review the outcomes of counter fraud work. It shall also approve the counter fraud work programme.

4.2. The governing body's audit committee will ensure that the group has arrangements in place to work effectively with NHS Protect.

5. EXPENDITURE CONTROL

5.1. The group is required by statutory provisions[62] to ensure that its expenditure does not exceed the aggregate of allotments from the NHS Commissioning Board and any other sums it has received and is legally allowed to spend.

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

5.3. The Chief Finance Officer will:

a) provide reports to the National Commissioning Board in the form required by the NHS Commissioning Board;

[62] See section 223H of the 2006 Act, inserted by section 27 of the 2012 Act

b) report the financial position of the Clinical Commissioning Group to the governing body.

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

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

6. ALLOTMENTS[63]

6.1. The group's Chief Finance Officer will:

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

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

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

7. COMMISSIONING STRATEGY, BUDGETS, BUDGETARY CONTROL AND MONITORING

POLICY – the group will produce and publish an annual operating plan which spans the medium term (i.e. the current and next financial years) and includes reference to the QIPP programme and commissioning intentions, and that explains how the group proposes to discharge its financial duties. The group will support this with comprehensive medium-term financial plans and annual budgets.

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

7.2. Prior to the start of the financial year the Chief Finance Officer will, on behalf of the Accountable Officer, prepare and submit budgets for approval by the governing body.

7.3. The Chief Financial Officer shall monitor financial performance against budget and plan, periodically review them, and report to the governing body. This report

63 See section 223(G) of the 2006 Act, inserted by section 27 of the 2012 Act.

should include explanations for variances. These variances must be based on any significant departures from agreed financial plans or budgets.

7.4. Financial monitoring information will also incorporate an assessment of the forecast outturn position based on levels of expenditure being incurred and the risks to non-achievement of the plan.

7.5. The Accountable Officer is responsible for ensuring that information relating to the group's accounts or to its income or expenditure, or its use of resources is provided to the NHS Commissioning Board as requested.

7.6. The governing body will approve consultation arrangements for the group's commissioning strategy[64]

8. ANNUAL ACCOUNTS AND REPORTS

POLICY – the group will produce and submit to the NHS Commissioning Board accounts and reports in accordance with all statutory obligations[65], relevant accounting standards and accounting best practice in the form and content and at the time required by the NHS Commissioning Board.

8.1. The Chief Finance Officer will ensure the group:

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

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

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

d) considers the external auditor's management letter and fully address all issues within agreed timescales; and

e) publishes the external auditor's management letter on the group's website.. Documentation will be available upon request for inspection at:

Sanger House
5220 Valiant Court
Gloucester Business Park
Brockworth
Gloucestershire GL3 4FE

64 See section 14Z13 of the 2006 Act, inserted by section 26 of the 2012 Act

65 See paragraph 17 of Schedule 1A of the 2006 Act, as inserted by Schedule 2 of the 2012 Act.

This information will also be available from Guide & PALS who can be contacted on 0800 0151548 or email: community.pals@glos.nhs.uk

9. INFORMATION TECHNOLOGY

POLICY – the group will ensure the accuracy and security of the group's computerised financial data.

9.1. The Chief Finance Officer is responsible for the accuracy and security of the group's computerised financial data and shall:

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

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

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

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

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

10. ACCOUNTING SYSTEMS

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

10.1. The Chief Finance Officer will ensure:

a) the group has suitable financial and other software to enable it to comply with these policies and any consolidation requirements of the NHS Commissioning Board;

b) that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and

timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

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

11. BANK ACCOUNTS

POLICY – the group will keep enough liquidity to meet its current commitments.

11.1. The Chief Finance Officer will:

a) review the banking arrangements of the group at regular intervals to ensure they are in accordance with Secretary of State directions[66], best practice and represent best value for money;

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

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

11.2. The Accountable Officer shall approve the banking arrangements.

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

POLICY – the group will:

- operate a sound system for prompt recording, invoicing and collection of all monies due;
- seek to maximise its potential to raise additional income only to the extent that it does not interfere with the performance of the group or its functions;[67]
- ensure its power to make grants and loans is used to discharge its functions effectively.[68]

12.1. The Chief Financial Officer is responsible for:

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

b) establishing and maintaining systems and procedures for the secure handling of cash and other negotiable instruments;

66 See section 223H(3) of the NHS Act 2006, inserted by section 27 of the 2012 Act

67 See section 14Z5 of the 2006 Act, inserted by section 26 of the 2012 Act.

68 See section 14Z6 of the 2006 Act, inserted by section 26 of the 2012 Act.

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

d) developing effective arrangements for making grants or loans.

13. TENDERING AND CONTRACTING PROCEDURE

POLICY – the group:

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

13.1. The group shall ensure that the firms / individuals invited to tender (and where appropriate, quote) are among those on approved lists or where necessary a framework agreement. Where in the opinion of the Chief Finance Officer it is desirable to seek tenders from firms not on the approved lists, the reason shall be recorded in writing to the Accountable Officer or the group's governing body.

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

a) the group's standing orders;

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

c) take into account as appropriate any applicable NHS Commissioning Board or the Independent Regulator of NHS Foundation Trusts (Monitor) guidance that does not conflict with (b) above.

13.3. In all contracts entered into, the group shall endeavour to obtain best value for money. The Accountable Officer shall nominate an individual who shall oversee and manage each contract on behalf of the group.

14. COMMISSIONING

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

14.1. The group will coordinate its work with the NHS Commissioning Board, other clinical commissioning groups, local providers of services, local authority(ies), including through Health & Wellbeing Boards, patients and their carers and the voluntary sector and others as appropriate to develop robust commissioning plans.

14.2. The Accountable Officer will establish arrangements to ensure that regular reports are provided to the governing body detailing actual and forecast expenditure and activity for each contract.

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

15. RISK MANAGEMENT AND INSURANCE

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

15.1. The CCG will adopt a Risk Management Strategy that will outline the organisation's approach to managing risk. A key feature of the strategy will be the maintenance of a Risk Register that will be used to record and monitor risks. It is intended that the Risk Register will be presented to each meeting of the Integrated Governance Committee to providing on going oversight and review.

15.2. An Assurance Framework will also be maintained to provide details of the assurances that will be provided to the Board regarding the achievement of the organisation's Annual Objectives. The Assurance Framework will identify gaps in assurances and controls regarding the objectives, along with details of the major risks that have been identified. The Assurance Framework will also be presented to each meeting of the Integrated Governance Committee as part of the oversight and review activity.

16. PAYROLL

POLICY – the group will put arrangements in place for an effective payroll service.

16.1. The Chief Finance Officer will ensure that the payroll service selected:

a) is supported by appropriate (i.e. contracted) terms and conditions;

b) has adequate internal controls and audit review processes;

c) has suitable arrangements for the collection of payroll deductions and payment of these to appropriate bodies.

16.2. In addition the Chief Finance Officer shall set out comprehensive procedures for the effective processing of payroll.

17. NON-PAY EXPENDITURE

POLICY – the group will seek to obtain the best value for money goods and services received.

17.1. The governing body will approve the level of non-pay expenditure on an annual basis and the Accountable Officer will determine the level of delegation to budget managers.

17.2. The Accountable Officer shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

17.3. The Chief Finance Officer will:

a) advise the Accountable Officer on the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in the scheme of reservation and delegation;

b) be responsible for the prompt payment of all properly authorised accounts and claims;

c) be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable.

18. CAPITAL INVESTMENT, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

POLICY – the group will put arrangements in place to manage capital investment, maintain an asset register recording fixed assets and put in place polices to secure the safe storage of the group's fixed assets.

18.1. The Accountable Officer will:

a) ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon plans;

b) be responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost;

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

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

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

19. RETENTION OF RECORDS

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

19.1. The Accountable Officer shall:

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

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

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

20. TRUST FUNDS AND TRUSTEES

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

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

APPENDIX G - NOLAN PRINCIPLES

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

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

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

c) **Objectivity** – In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards

d) and benefits, holders of public office should make choices on merit.

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

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

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

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

Source: *The First Report of the Committee on Standards in Public Life* (1995)[69]

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

APPENDIX H – SEVEN KEY PRINCIPLES OF THE NHS CONSTITUTION

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

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

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

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

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

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

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

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

should be transparent and clear to the public, patients and staff. The Government will ensure that there is always a clear and up-to-date statement of NHS accountability for this purpose

Source: *The NHS Constitution: The NHS belongs to us all* (March 2012)[70]

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

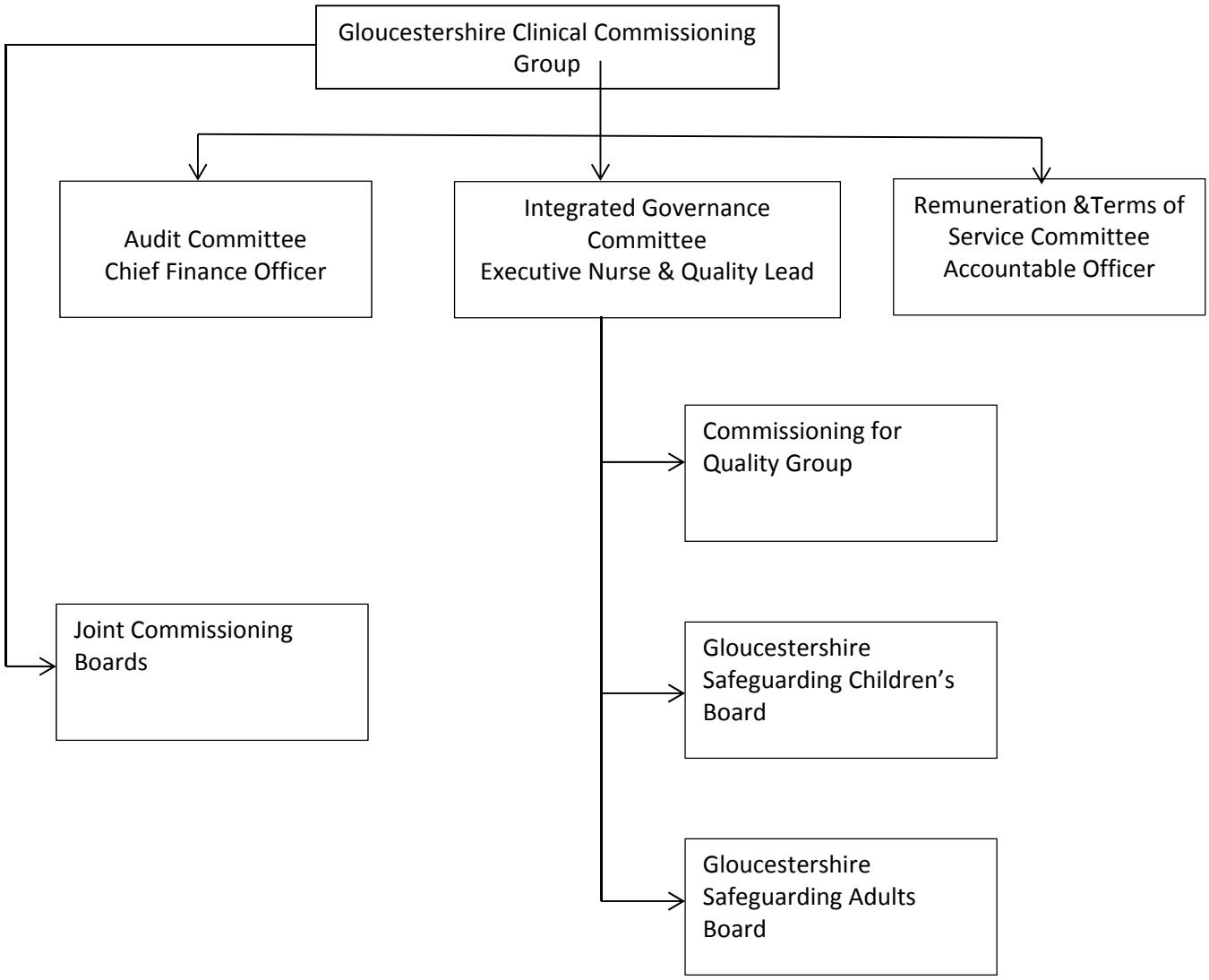
APPENDIX I – CHECKLIST FOR A CLINICAL COMMISSIONING GROUP'S CONSTITUTION

Essential/ Optional	Content	Included
Essential	The constitution must specify: • the **name of the clinical commissioning group**; • the **members of the group**; and • the **area of the group** The name of the group must comply with such requirements as may be prescribed	✓
Essential	The constitution must specify the **arrangements made by the clinical commissioning group for the discharge of its functions** (including its functions in determining the terms and conditions of its employees)	✓
Optional	The arrangements may include provision: • for the appointment of committees or sub-committees of the clinical commissioning group; and • for any such committees to consist of or include persons other than members or employees of the clinical commissioning group	✓
Optional	The arrangements may include provision for any functions of the clinical commissioning group to be exercised on its behalf by: • any of its members or employees; • its governing body; or • a committee or sub-committee of the group	✓
Essential	The constitution must specify the **procedure to be followed by the clinical commissioning group in making decisions**	✓
Essential	The constitution must specify the **arrangements made by the clinical commissioning group for discharging its duties in respect of registers of interest and management of conflicts of interest** as specified under section 14O(1) to (4) of the 2006 Act, as inserted by section 25 of the 2012 Act	✓
Essential	The constitution must also specify the **arrangements made by the clinical commissioning group for securing that there is transparency about the decisions of the group and the manner in which they are made** The provisions made above must secure that there is effective participation by each member of the clinical commissioning group in the exercise of the group's functions	✓
Essential	The constitution must specify the **arrangements made by the clinical commissioning group for the discharge of the functions of its governing body**	✓
Essential	The arrangements must include: • provision for the appointment of the audit committee and remuneration committee of the governing body	✓

Essential/ Optional	Content	Included
Optional	The arrangements may include: • provision for the audit committee (but not the remuneration committee) to include individuals who are not members of the governing body • provision for the appointment of other committees or sub-committees of the governing body. These may include provision for a committee or sub-committee to include individuals who are not members of the governing body but are: o members of the clinical commissioning group, or o individuals of a description specified in the constitution	✓
Optional	The arrangements may include provision for any functions of the governing body to be exercised on its behalf by: • any committee or sub-committee of the governing body, • a member of the governing body; • a member of the clinical commissioning group who is an individual (but is not a member of the governing body); or • an individual of a description specified in the constitution	✓
Essential	The constitution must specify the **procedure to be followed by the governing body in making decisions**	✓
Essential	The constitution must also specify the **arrangements made by the clinical commissioning group for securing that there is transparency about the decisions of the governing body and the manner in which they are made** This provision must include provision for meetings of governing bodies to be open to the public, except where the clinical commissioning group considers that it would not be in the public interest to permit members of the public to attend a meeting or part of a meeting	✓
Essential	In its constitution, the clinical commissioning group must describe the **arrangements** which it has made and include a statement of the principles which it will follow in implementing those arrangements, **to secure that individuals to whom health services are being or may be provided pursuant to its commissioning arrangements are involved** (whether by being consulted or provided with information or in other ways): • in the planning of the commissioning arrangements by the group; • in the development and consideration of proposals by the group for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals or the range of health services available to them; and • in decisions of the group affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact	✓

Appendix J

Gloucestershire Clinical Commissioning Group
Proposed Governance Structure



Appendix K

NHS Gloucestershire Clinical Commissioning Group

Governing Body Audit Committee

Terms of Reference

1. Introduction

1.1. The audit committee (the committee) is established in accordance with NHS Gloucestershire Clinical Commissioning Group's constitution. These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the committee and shall have effect as if incorporated into the constitution.

2. Membership

2.1. The committee shall be appointed by the clinical commissioning group as set out in the clinical commissioning group's constitution and may include individuals who are not on the governing body.

2.2. The membership of the audit committee shall include:-

- the lay member of the Governing Body with a lead role in overseeing key elements of governance
- two other lay members
- two GP Governing Body members

2.3. The lay member on the governing body, with a lead role in overseeing key elements of governance, will chair the audit committee.

2.4. In the event of the chair of the committee being unable to attend all or part of the meeting, he or she will nominate a replacement from within the membership to deputise for that meeting.

2.5. The Chair of the Governing Body shall not be a member of the Audit Committee.

2.6. Members of the committee shall cease to be members of the committee if they are no longer members of the Governing Body.

2.7. The members from the GP practices shall not be in the majority

3. Attendance

3.1. The committee shall invite the Chief Finance Officer, the respective internal and external auditors and a representative of NHS Protect/Counter Fraud to attend meetings of the committee.

3.2. Additionally the committee may invite any individual to attend any or part of its meetings.

3.3. The committee may invite any person to attend meetings to provide advice and/or expertise as required. Any such person shall not be a member of the committee and shall withdraw upon request.

3.4. Any individual invited to attend the committee may contribute to the proceedings and provide advice and/or guidance to the committee as requested.

3.5. Notwithstanding the above provisions external audit, internal audit and local counter fraud and security management providers will have full and unrestricted rights of access to the committee in respect of their **audit** functions.

4. Secretary

4.1. The committee secretary shall be the Company Secretary.

5. Quorum

5.1. The quorum of the committee shall be three members, two of whom must be lay members.

6. Frequency and notice of meetings

6.1. The committee shall meet not less than four times each financial year.

6.2. The Chair of the committee may convene additional meetings as required.

6.3. The external auditor or internal auditor may requisition a meeting of the committee if it is deemed necessary.

6.4. Written notice of meetings and the agenda shall be provided to committee members of the committee not less than 5 working days before the meeting.

6.5. Notice of committee meetings and the agenda shall also be provided to the Accountable Officer, Chief Financial Officer and the clinical commissioning group employee responsible for internal audit.

6.6. The committee shall meet in private with the internal and external auditors not less than annually.

6.7. The committee shall meet with the Accountable Officer not less than annually to discuss and consider the process for assurance that supports the statement on internal control.

7. Remit and responsibilities of the committee

7.1. The committee shall critically review the clinical commissioning group's financial reporting and internal control principles and ensure an appropriate relationship with both internal and external auditors is maintained.

7.2. The key duties of the committee are:-

Integrated governance, risk management and internal control

7.3. The committee shall review the establishment of an effective system of integrated governance, risk management and internal control, across the whole of the clinical commissioning group's activities that support the achievement of the clinical commissioning group's objectives.

7.4. In particular, the committee will review the adequacy and effectiveness of:

- all risk and control related disclosure statements (in particular the governance statement), together with any appropriate independent assurances, prior to endorsement by the clinical commissioning group.
- the underlying assurance processes that indicate the degree of achievement of clinical commissioning group objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements.
- the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certification.
- the policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the NHS Counter Fraud and Security Management Service.

7.5. In carrying out this work the committee will primarily utilise the work of internal audit, external audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of governance, risk management and internal control, together with indicators of their effectiveness.

7.6. This will be evidenced through the committee's use of an effective assurance framework to guide its work and that of the audit and assurance functions that report to it.

Internal Audit

7.7. The committee shall ensure that there is an effective internal audit function that meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the audit committee, Accountable Officer and clinical commissioning group. This will be achieved by:

- Consideration of the provision of the internal audit service, the cost of the audit and any questions of resignation and dismissal.
- Review and approval of the internal audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation, as identified in the assurance framework.
- Considering the major findings of internal audit work (and management's response) and ensuring co-ordination between the internal and external auditors to optimise audit resources.
- Ensuring that the internal audit function is adequately resourced and has appropriate standing within the clinical commissioning group.
- An annual review of the effectiveness of internal audit.

External audit

7.8. The committee shall review the work and findings of the external auditors and consider the implications and management's responses to their work. This will be achieved by:

- Consideration of the performance of the external auditors, as far as the rules governing the appointment permit.
- Discussion and agreement with the external auditors, before the audit commences, on the nature and scope of the audit as set out in the annual plan, and ensuring co-ordination, as appropriate, with other external auditors in the local health economy.
- Discussion with the external auditors of their local evaluation of audit risks and assessment of the clinical commissioning group and associated impact on the audit fee.
- Review of all external audit reports, including the report to those charged with governance, agreement of the annual audit letter before submission to the clinical commissioning group and any work undertaken outside the annual audit plan, together with the appropriateness of management responses.

Other assurance functions

7.9. The audit committee shall review the findings of other significant assurance functions, both internal and external and consider the implications for the governance of the clinical commissioning group.

7.10. These will include, but will not be limited to, any reviews by Department of Health arm's length bodies or regulators/inspectors (for example, the Care Quality Commission and NHS Litigation Authority) and professional bodies with responsibility for the performance of staff or functions (for example, Royal Colleges and accreditation bodies).

Counter fraud

7.11. The committee shall satisfy itself that the clinical commissioning group has adequate arrangements in place for countering fraud and shall review the outcomes of counter fraud work. It shall also approve the counter fraud work programme.

Management

7.12. The committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

7.13. The committee may also request specific reports from individual functions within the clinical commissioning group as they may be appropriate to the overall arrangements.

Financial reporting

7.14. The audit committee shall monitor the integrity of the financial statements of the clinical commissioning group and any formal announcements relating to the clinical commissioning group's financial performance.

7.15. The committee shall ensure that the systems for financial reporting to the clinical commissioning group, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the clinical commissioning group.

7.16. The audit committee shall review the annual report and financial statements before submission to the governing body and the clinical commissioning group, focusing particularly on:

- The wording in the governance statement and other disclosures relevant to the terms of reference of the committee;
- Changes in, and compliance with, accounting policies, practices and estimation techniques;
- Unadjusted mis-statements in the financial statements;
- Significant judgements in preparing of the financial statements;
- Significant adjustments resulting from the audit;
- Letter of representation; and
- Qualitative aspects of financial reporting.

8. Relationship with the governing body

Authority

8.1. The committee is authorised by the Governing Body to obtain professional advice, including the appointment of external advisor and/or consultants, related to its functions as it deems fit at the expense of the clinical commissioning group.

8.2. The committee shall recommend appropriate action(s) should be taken by the Governing Body in allowing the committee to fulfill its terms of reference.

Monitoring and Reporting

8.3. The minutes of each meeting of the committee shall be formally recorded and retained by the clinical commissioning group. The minutes shall be submitted to the Governing Body.

8.4. The Chair of the committee shall report the outcome and any recommendations of the committee to the Governing Body and draw to the attention of the Governing Body any issues that require disclosure to the Council of Members and/or require executive action.

8.5. The committee shall report to the Governing Body annually on its work in support of the Statement of Internal Control, specifically commenting on the fitness for purpose of the Assurance Framework.

9. Policy and best practice

9.1. The committee shall have regard to current good practice; policies; and guidance issued by the National Commissioning Board, the clinical commissioning group and other relevant bodies.

10. Conduct of the committee

10.1. The committee shall conduct its business in accordance with these terms of reference and the clinical commissioning group's governance arrangements.

Appendix L

NHS Gloucestershire Clinical Commissioning Group

Governing Body Remuneration Committee

Terms of Reference

1. Introduction

1.1 The remuneration committee (the committee) is established in accordance with NHS Gloucestershire Clinical Commissioning Group's constitution, standing orders and scheme of delegation. These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the committee and shall have effect as if incorporated into the clinical commissioning group's constitution and standing orders.

2. Membership

2.1 The committee shall be appointed by the clinical commissioning group from amongst its governing body members. The members shall include:-

- All Lay members of the Governing Body
- CCG Chair
- 2 GP members of the Governing Body

2,2 The non-clinical Vice Chair shall be the Chair of the committee.

2.3 No one other than the members of the committee is entitled to be present at committee meetings. The Accountable Officer will only attend when the remuneration and terms of service of other Directors is being discussed

2.4 The committee may invite any person to attend meetings to provide advice and/or expertise as required. Any such person shall not be a member of the committee and shall withdraw upon request.

3. Secretary

3.1 The committee secretary shall be the Company Secretary

4. Quorum

4.1 The quorum of the committee shall be three members.

5. Frequency and notice of meetings

5.1 The committee shall meet not less than twice a year.

5.2 Written notice of the date, venue and agenda shall be circulated to all committee members not less than 5 working days before the proposed date.

5.3 The Chair of the committee may convene additional meetings as required.

5.4 The minutes of committee meetings shall be circulated as soon as is practicable after the meeting to which they relate to members of the committee and the Accountable Officer.

6. Remit and responsibilities of the committee

6.1 The committee shall make recommendations to the governing body on determinations about pay and remuneration for employees of the clinical commissioning group and people who provide services to the clinical commissioning group and allowances under any pension scheme it might establish as an alternative to the NHS pension scheme.

6.2 Specifically the committee shall undertake the following:-

6.2.1 determine the policy regarding terms of service and remuneration of the members of the Governing Body having regard to the provisions of national arrangements where appropriate;

6.2.2 have delegated authority to review the performance and determine the individual remuneration arrangements including any performance related pay for members of the Governing Body;

6.2.3 consult with the Accountable Officer and Chair of the Governing Body in relation to their proposals relating to the remuneration of members of the Senior Management Team;

6.2.4 approve any changes to the standard contract of employment for members of the Governing Body, where applicable, including termination arrangements taking into account relevant guidance and current good practice;

6.2.5 agree terms for the termination of a contract having regard to HM Treasury guidance and current good practice;

7. Relationship with the governing body

Authority

7.1 The committee is authorised by the Governing Body to obtain legal advice, remuneration or other professional advice, including the appointment of external advisor and/or consultants, related to its functions as it deems fit at the expense of the clinical commissioning group.

7.2 The committee shall recommend appropriate action(s) should be taken by the Governing Body in allowing the committee to fulfill its terms of reference.

Monitoring and Reporting

7.3 The minutes of each meeting of the committee shall be formally recorded and retained by the clinical commissioning group. The minutes shall be submitted to the Governing Body.

7.4 The Chair of the committee shall report the outcome and any recommendations of the committee to the Governing Body.

8. Policy and best practice

8.1 The committee shall have regard to current good practice; policies; and guidance issued by the National Commissioning Board, the clinical commissioning group and other relevant bodies.

9. Conduct of the committee

9.1 The committee shall conduct its business in accordance with these terms of reference and the clinical commissioning group's governance arrangements.

Appendix M

NHS Gloucestershire Clinical Commissioning Group

Integrated Governance Committee

Terms of Reference

1. Purpose

1.1 The aim of the Integrated Governance Committee is to ensure that controls are in place and are operating efficiently and effectively to deliver the principal objectives of the Governing Body and to set in place processes to manage identified risks, minimising the Clinical Commissioning Groups exposure to corporate, financial and clinical risks.

2. Membership

2.1 The committee shall be appointed by the clinical commissioning group from amongst its governing body members. The members shall include:-

- 3 Lay Members
- Clinical Chair
- Accountable Officer
- Chief Financial Officer
- Director of Public Health
- Registered Nurse
- Director of Quality and Assurance
- Director of Commissioning Implementation
- 2 Clinical Commissioning Leads

2.1 One of the Lay Members and the Registered Nurse shall be the Chair of the committee.

2.2 The committee may invite any person to attend meetings to provide advice and/or expertise as required. Any such person shall not be a member of the committee and shall withdraw upon request.

3. Secretary

3.1 The committee secretary shall be the Company Secretary.

4. Quorum

4.1 Four members of the committee must be present including at least one clinician member and two lay members for the quorum to be established.

5. Frequency and notice of meetings

5.1 The committee shall meet not less than six times a year.

5.1 Written notice of the date, venue and agenda shall be circulated to all committee members not less than 5 working days before the proposed date.

5.2 The Chair of the committee may convene additional meetings as required.

5.3 The minutes of committee meetings shall be circulated by the Chair as soon as is practicable after the meeting to which they relate to all members of the committee.

6. Remit and responsibilities of the committee

6.1 The committee is responsible for the overall development of the Integrated Governance Strategy and to ensure that the appropriate governance plans and mechanisms are in place and being monitored across the following areas:-

- Corporate Governance
- Clinical Governance
- Risk Management
- Commissioning and Contracting
- Information Governance
- Safeguarding Agenda
- Health and Safety

6.1 Specifically the committee shall undertake the following:-

6.1.1 Monitor the effectiveness of the systems to control and reduce Healthcare Acquired Infections;

6.1.2 Monitor and facilitate Clinical Commissioning Gloucestershire compliance against external standards, good practice guidance and legislation;

6.1.3 Receive assurances that appropriate systems are in place for the development and review of care pathways, clinical policies and the implementation of NICE guidance;

6.1.4 Receive assurances that response to reports from external agencies relevant to integrated governance, e.g. Care Quality Commission, Audit Commission, Health and Safety Executive, NHS Litigation Authority;

6.1.5 Monitor the Risk Register and Board Assurance Framework ensuring that risks are appropriately prioritised and adequately controlled and that all high and extreme risks are communicated to the Governing Body;

6.1.6 Ensure that key performance indicators for clinical quality, efficiency, patient safety and risk management are developed and monitored for all commissioned and directly provided services;

6.1.7 Ensure that effective monitoring of near misses, incidents, accidents, complaints, claims and Serious Incidents (SIs) is undertaken and that appropriate management action has been taken promptly in the organisation;

6.1.8 Review the committee arrangements to ensure that they remain structurally fit for purpose and to make recommendations for amendments to the Governing Body as appropriate and;

6.1.9 Receive reports from the Local Safeguarding Children's Board.

7. Relationship with the governing body

Authority

7.1 The committee is authorised to conduct its activities that provide assurance to the Governing Body in relation to the following:-

7.1.1 There is an appropriate and fit for purpose range of systems, policies and procedures in place to manage all risks;

7.1.2 It has fulfilled its responsibility to manage risk by providing evidence of compliance with all risk management processes

7.1.3 The Assurance Framework accurately reflects the organisations objectives and that the associated risks are identified together with the measures and controls to manage these principal risks;

7.2 The committee shall recommend appropriate action(s) should be taken by the Governing Body in allowing the committee to fulfil its terms of reference.

Monitoring and Reporting

7.3 The minutes of each meeting of the committee shall be formally recorded and retained by the clinical commissioning group. The minutes shall be submitted to the Governing Body.

7.4 The Chair of the committee shall report the outcome and any recommendations of the committee to the Governing Body.

8. Policy and best practice

8.1 The committee shall have regard to current good practice; policies; and guidance issued by the National Commissioning Board, the clinical commissioning group and other relevant bodies.

9. Conduct of the committee

9.1 The committee shall conduct its business in accordance with these terms of reference and the clinical commissioning group's governance arrangements.

Appendix N – Commissioning for Quality Terms of Reference – to be agreed

Appendix O – Locality Executive Group Terms of Reference – to be agreed

Clinical Commissioning Gloucestershire and Member Practices

Memorandum of Understanding

1. Memorandum of Understanding

1.1 The Memorandum of Understanding is between individual member practices and CCG and clarifies the expectations and obligations of both parties. It is designed to encourage productive and supportive engagement between the CCG and its Member Practices.

1.2 The Memorandum of Understanding documents the commissioning agreements reached between the member practice and CCG and will be the formal mechanism for determining eligibility to any future incentive payment (currently referred to as the Quality Premium). Accordingly it will be updated on an annual basis.

2. Parties to the Agreement

2.1 This Memorandum of Understanding is between the following parties;

- Clinical Commissioning Gloucestershire (CCG) and its Member Practices.

3. Mission, Values and Aims of the CCG

3.1 Mission

3.1.1 The mission of CCG is to commission excellent and modern health services on behalf of the NHS for all people in Gloucestershire through effective clinical leadership, with particular focus on clinical effectiveness, patient safety and continuous improvements in the patient experience.

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

3.2 Values and Aims

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

3.2.2 The values/aims that lie at the heart of the group's work are to:

- Ensure effective communication and engagement with clinicians, patients, carers, community partners and the public.
- Use our clinical experience to ensure high quality, safe and efficient services for the people of Gloucestershire;

- Focus on clinical benefit and health outcomes – making best use of the money and resources available;
- Use our clinical experience to lead innovation and change – right care, right place, right time;
- Be accountable and transparent in our decision making

4. Commissioning responsibilities of Member Practices Practice Representatives

4.1 Practice Representatives

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

- Nominate commissioning and prescribing leads to:

  a) represent the practice at CCG/locality meetings; and
  b) represent the needs of the practice's patient population within the CCG;

- Actively engage with CCG to help improve services within the area and support effective commissioning by contributing to the development of commissioning intentions and contract development and review.

- Share all information and data, including referral, prescribing and admissions data, as appropriate, that relates to CCG's commissioning priorities of delivering equitable quality care.

- Be familiar with the Clinical Programme Group approach, and follow the clinical pathways and referral protocols where defined and agreed by CCG (except in individual cases where there are justified clinical reasons for not doing this) which are fed back appropriately;

- Manage the practice's commissioning and prescribing budget within allocated resources within the context of the risk share agreements agreed by the CCG. Support and assistance will continue to be provided to help member practices achieve this in the form of information and analysis, management support and specialist advice and support in areas such as prescribing.

- Participate in developing, as well as delivering the clinical, quality, safety effectiveness (and cost effective) strategies agreed by CCG and GH&WB (recognising the impact of such will have been assessed by the CCG).

- Promote the establishment of a practice reference group and other means determined, to obtain the views and experiences of patients and carers;

- Work constructively with the locality sub-committee/CCG;

- Respond in a timely manner to reasonable commissioning-related information requests from CCG.

4.2 Locality Groups

4.2.1 The county-wide clinical commissioning group will comprise seven constituent localities. Each Locality will have an appointed Locality Lead and Executive team. Each Locality will also have an elected Locality Liaison Lead who will act as a conduit for the views of the locality as a part of their role as a member of the CCG Governing Body. Each locality will hold regular executive meetings as well as regular meetings involving the commissioning leads from each constituent practice. Such meetings will be in addition to other regular development sessions including Practice Learning Time and other locality-specific project groups.

4.2.2 The seven Locality groups are;

- Cheltenham;
- Forest of Dean;
- Gloucester City;
- North Cotswolds;
- South Cotswolds;
- Stroud & Berkeley Vale;
- Tewkesbury.

4.3 Structure and Frequency of Meetings

4.3.1 The group will meet regularly and be chaired by a locality GP (as agreed by the GP members of the group).

4.4 Practice Budgets

4.4.1 The full scope of the commissioning budget and detail of locality and practice level commissioning budgets and risk share agreements will be issued annually to practices for agreement.

4.5 Governance and reporting

4.5.1 Governance arrangements are as set out in the Locality Commissioning Agreement for 2012/13. Member Practices and their Executive Groups are responsible for delivering the requirements of the agreement at locality level.

4.5.2 Reporting is to the Clinical Commissioning Group Board. The locality will report to the Clinical Commissioning Group Board on a quarterly basis via their lead GP.

4.5.3 Locality group papers and minutes are to be shared with all constituent GPs and practice managers, and the Clinical Commissioning Group Board and be available to the public on request.

5. CCG responsibility to the development of a Member Organisation

5.1 A key part of CCG's commitment is to build CCG as a 'membership organisation'.

5.2 CCG membership currently comprises 85 practices from seven constituent localities. Each locality appoints GPs or other healthcare professionals in the constituent practices to lead and chair the locality. Each locality will also have an elected Locality Liaison Lead who will be a member of the Governing Body of the CCG. Each Locality Liaison Lead will hold regular meetings involving the Commissioning Leads from each constituent practice of the locality.

5.3. CCG Role will be to:

- Set a commissioning strategy and policy (which is responsive to the needs assessment and priorities for the population and reflects the views of individual localities).
- Implement a clinical strategy using a co-production approach with the localities and defining quality outcomes and best value that meets the needs of our population.
- Provide a clinical leadership role by engaging member practices and the wider clinical community.
- Establish governance arrangements that establish CCG as a membership organisation.
- Establish and lead a clinical programme-based approach to commissioning.
- Ensure transparency and accountability in its decision making processes.
- Manage the commissioning budgets devolved to it.
- Support locality inspired projects where agreed and prioritised with CCG (with financial and management support) and where appropriate hold localities and others to account for their delivery.

6. Annual Commissioning Objectives

6.1 CCG will set annual commissioning objectives and targets that are outcome based and can demonstrate an improvement in the health of the local population. These will be agreed through the development of annual commissioning objectives/targets with each locality group.

7. Review of the Agreement

7.1 The agreement will be reviewed annually by CCG; any proposed changes will go to member practices for discussion prior to agreement.

8. Signatories to the Agreement

Member Practice Name:

Member Practice signatory:

Chair of the CCG:

Date:

Clinical Commissioning Gloucestershire

Disputes Resolution Process

1 Purpose

This paper outlines the approach Clinical Commissioning Gloucestershire (CCG) will adopt to address concerns/disputes raised by member practices in any of the following areas:

- The CCG's approach to the delivery of its commissioning responsibilities;
- The commissioning responsibilities of member practices;
- The CCG's approach to delivery of its duty to support the NHS Commissioning Board in continuously improving the quality of primary care services.

2 Background

It is expected that use of the dispute resolution process will be the last resort. The CCG, its constituent localities and practices will make all efforts to resolve issues locally in conjunction with the LMC (as appropriate), and demonstrate effective processes have been engaged at all levels in the CCG. This may include the following involvement in informal resolution processes:

- Escalating the seniority of staff involved in any dispute, for example by involving the Chair/Deputy Clinical Chair or Chief Officer/Deputy Chief Officer.
- Involving third parties who could also act as advisors, conciliators or arbitrators.
- Using staff from another CCG.

Where agreement cannot be reached using informal resolution processes it will be necessary to invoke the local CCG resolution process outlined below.

3 Local Resolution Process

3.1 Stage 1 Informal Process:

Individual member practice concerns should be raised in the first instance with the CCG Locality Liaison Lead GP. This should be in writing clearly stating the basis of the dispute, including where applicable the concerns and the rationale behind the dispute.

The CCG Locality Liaison Lead GP should endeavour to find an informal resolution to the problem through discussion and mediation, involving others as necessary. The CCG Liaison Lead GP will review concerns/evidence relative to the dispute and will try to find a resolution within 14 days.

The member practice may submit evidence in support of the dispute or the CCG may request further evidence/clarification from them.

If no resolution is found within 14 days the matter is to be referred by either party for consideration by the Local Dispute Resolution Panel.

At this stage the formal process will commence.

3.2 Stage 2 The Formal Local Process:

If a member practice is not satisfied that their issues have been satisfactorily addressed through the informal process they may lodge a request for "Formal Local Dispute Resolution" in writing, including the grounds for the request, to the Deputy Clinical Chair of the CCG. Under these circumstances the CCG will set up a Local Dispute Resolution Panel (LDRP) to hear the dispute and resolve the dispute where possible.

The local dispute panel should consist of:

- Governing Body lay member (Chair).
- Deputy Clinical Chair.
- CCG Locality Liaison Lead GP from a different locality from the practice.
- Deputy Chief Officer OR Chief Financial Officer OR Director of Transformation and Service Re-Design.
- LMC Representative.

The panel may also seek advice from external bodies such as the Local Area Team of the NHS Commissioning Board.

Should any members of the LDRP find it necessary to declare an interest in a dispute that is being considered, the Chair will approach another CCG representative to secure alternative panel members from within that CCG.
In the event that this approach is unsuccessful other CCGs will be approached until a suitable alternative panel member from another CCG can be secured.
If a member practice requests a formal dispute resolution, the CCG shall acknowledge receipt of the request in writing within 2 working days. The acknowledgement will explain the procedure to be carried out by the CCG.

The Hearing

The Chair of the LDRP, on being satisfied that all attempts at local resolution have been exhausted will arrange a meeting of the LDRP to hear the dispute as soon is practically possible. All parties shall be notified of the date and time of the LDRP meeting. The hearing shall be held within 25 working days of the request being lodged (where possible) by the member practice to the CCG. The Chair of the LDRP will ensure that at least 10 working days' notice of the date of the hearing will be given to all participants.

Documentation

All the relevant documentation, including the request for Formal Local Dispute Resolution will be passed to the chair and then to panel members before the hearing. The Chair will, where necessary, seek relevant documentation from the parties involved at least 5 working days before the hearing. Documentation that is received late will not be considered. Any documentation will be shared with all relevant panel members.

Procedure at LDRP Meeting

- The Discussions of the panel shall remain confidential.
- The Chair of the panel will ensure written record/minutes are kept of the meeting.
- All written and verbal evidence will be considered.
- Should the member practice choose to attend the LDRP they and the CCG presenting officer (generally the CCG Locality Liaison Lead GP) will be asked to present their cases and may call witnesses. Members of the panel will be given the opportunity to ask any questions relevant to the case.
- Following the presentation of their case the member practice and CCG presenting officer shall withdraw and the panel will deliberate.
- The panel will reach a decision on the case before them and notify the member practice in writing, including any recommendations within 7 working days of the hearing.
- Where appropriate the decision will be reported to a meeting of the CCG Executive Team/Governing Body for information.

3.3 Stage 3 Appeal Panel

The Appeals panel will be convened when necessary to consider appeals against LDRP decisions. The Appeals panel should consist of the following (none of whom should have been previously involved in the case)

- Clinical Chair of another CCG.
- A Clinical member of the Governing Body.
- CCG Accountable Officer or Deputy
- LMC Representative.

Process

- The member practice wishing to appeal against a LDRP decision must notify the CCG Accountable Officer of their intention, in writing, within one month of their receipt of the decision.
- The Appeals Panel will consider whether the original decision of the LDRP followed due process.
- The Appeals Panel will only consider written evidence.
- The Appeals Panel will consider if:
  - The CCG correctly followed its own procedures (all received documentation was available and considered within a reasonable timescale) and/or
  - All important facts were taken into account when the decision was made.
- If these criteria are met the Panel will dismiss the appeal.
- If the criteria are not met then the following actions are available:

- If the Panel finds that some aspect of the procedure was not followed, they will assess the significance of the procedural breach and decide on the appropriate action.
- If the Panel finds that important facts were not taken into account, they shall refer the case back to the original LDRP for re-consideration.

- If the case is referred back to the LDRP following re-consideration of the case, the LDRP decision will then be final.
- The Chair of the Appeal Panel will write to the member practice within five working days of the hearing setting out the Appeal Panel's decision.

Clinical Commissioning Gloucestershire
Joined up care

Gloucestershire Clinical Commissioning Group

Appendix B

Policies and Procedures

Whistleblowing Policy
(Raising Concerns at Work)

DOCUMENT HISTORY

Date	Author/Editor	Summary of Changes	Version No
March 2013	Simeon Foreman	Draft Policy	1

CONTENTS

1 Introduction

1.1 All of us at some time or other may have concerns about what is happening at work. Usually these concerns are easily resolved. However, when a concern feels serious because it's about possible danger to patients, public or colleagues, professional misconduct or financial malpractice (including fraud, bribery or corruption), it can be difficult to know what to do. You may be worried about raising such issues, perhaps feeling it is none of your business or that it is only a suspicion. You may feel that raising the matter would be disloyal to colleagues, to managers or to the Trust. You may have already said something but found that you spoke to the wrong person or raised the issue in the wrong way and are not sure what, if anything to do next.

1.2 All employees have a duty to raise any risks or concerns related to the workplace if it is in the public interest to make such a disclosure. Employees making a disclosure in the interests of the public under a Whistle Blowing Policy have legal rights to protection from victimisation. To be awarded this protection you must:

- make the disclosure in good faith (which means with honest intent and without malice)
- reasonably believe that the information is substantially true
- reasonably believe you are making the disclosure to the right 'prescribed person'

1.3 If something is troubling you which you think we should know about or look into, please use this policy. If however, you are aggrieved about your personal position, please use the Grievance Policy which is available on the intranet. If you are suffering from bullying and harassment from an individual please refer to the Bullying and Harassment Policy.

2 Scope of the Policy

This policy applies to you whether you are in a permanent or temporary post, on the bank, an agency/contract worker or a volunteer. It applies to all areas of the organisation without exception.

3 Aims and Objectives

3.1 Your Safety

The Governing Body is committed to this policy. If you raise genuine concerns under this policy, you will not be at risk of losing your job or suffering any form of retribution as a result provided that you are acting in good faith. It does not matter if you are mistaken or if there is an innocent explanation for the concern, therefore please do not think we will ask you to prove it. Of course, we do not extend this assurance to someone who has maliciously raised a matter they know is untrue and this may be considered misconduct under the Trusts Disciplinary Policy.

3.2 Your Confidence

We will not tolerate the harassment or victimisation of anyone who raises genuine concerns. However, we recognise that you may nevertheless be anxious. If so, you can ask to talk to someone in private. If you ask us not to disclose your identity, we will not do so without your agreement first. If the situation arises where we are not able to resolve the concern without revealing your identity (for instance because evidence is needed in court), we will discuss with you on how we can proceed.

3.3 Anonymous Reports

Remember that if you do not tell us who you are, it will be much more difficult for the concern to be investigated and for us to protect your position or give you feedback. All anonymous reports will be looked into but it may not be appropriate for the matter to be dealt with under this policy.

3.4 Representation

If you raise a concern you will have the right to seek and be represented by a trade union representative or work colleague at all stages.

4 Raising Concerns Internally

4.1 If you have a concern that you feel needs to be raised, then the following options are available to you:

1. Internal disclosure to your Line Manager/Locality Lead or equivalent.

2. Internal disclosure to a Designated Officer. For Gloucestershire Clinical Commissioning Group "The CCG" this is Director of Nursing or the Chief Finance Officer.

3. Internal disclosure to the Accountable Officer (Mary Hutton) and Lay Members.

4.2 You can initially raise your concerns with any of the above persons; however we would encourage you to initially raise them with those identified on point 1 and 2 above. If your concerns remain unresolved after utilising these options we encourage you to raise them with either the Accountable Officer or Lay Member. If your concerns are of such gravity you may wish to raise them immediately with a Lay Member and this option is open to you.

4.3 All issues raised under this policy will be reported to the Clinical Chair of the CCG (Helen Miller) within 10 working days of receipt. Line managers and designated officers are responsible for ensuring this takes place. Contact details for the chair are:

Helen Miller, Clinical Chair
CCG
Sanger House
5220 Valiant Court
Gloucester Business Park
Brockworth
Gloucester
GL3 4FE
Telephone: 0300 4211652

4.4 We recommend that if you raise a concern via correspondence the envelope is clearly marked *"confidential"* and *"to be opened by addressee only"* to help us maintain your confidentiality as far as possible.

5 Process for Internal Disclosure to your Line Manager/ Locality Lead or equivalent

All managers have an ongoing responsibility for the provision and operation of this policy within the workplace.

You can meet with your manager or another relevant senior manager to discuss your concerns, or alternatively you may prefer to put your concerns in writing. All attempts will be made to resolve the matter informally and your manager will take the necessary steps to do this and record them and send the details to the Clinical Chair of the CCG within 10 working days of the notification of the concern. You should make clear at the outset and both agree that the provisions of this policy are being used and followed.

6 Process for Internal Disclosure to a Designated Officer

The designated officers are a contact you can choose to raise your concerns with initially under the provision of this policy, or if your concerns have not been resolved through the informal route via your manager or relevant senior manager.

Contact details of Designated Officers are:

Director of Nursing (VACANT)
Sanger House
5220 Valiant Court
Gloucester
Business Park
Brockworth
Gloucester
GL3 4FE
Telephone:0300 4211500

Chief Finance Officer (Cath Leech)
Sanger House
5220 Valiant Court
Gloucester
Business Park
Brockworth
Gloucester
GL3 4FE
Telephone:0300 4211437

If you feel the issues raised have not been addressed by the Designated Officer you can escalate this to the Accountable Officer, Lay Member or the Clinical Chair.

7 Process for Internal Disclosure to the Accountable Officer, Lay Member or Clinical Chair

If you wish to raise an issue directly with the Accountable Officer or Lay Member or escalate a previously reported unresolved concern the address is as follows:

Sanger House
5220 Valiant Court
Gloucester Business Park
Brockworth
Gloucester
GL3 4FE
Telephone: 0300 4211636

You are able to raise concerns with any **Lay Member,** the following Lay Members have been specifically identified to be nominated contacts:

- **Ms Valerie Webb**
- **Mr Alan Elkin**

Communications to Lay Members should be made through the Accountable Officer's Office at Sanger House.

8 Resolving Concerns

Upon receipt of a concerns an initial meeting will be held where you can outline the issue; this meeting will be held in the strictest confidence. You will be offered an option to make a verbal or written statement; in either case, the manager/designated officer will write a brief summary of the meeting which will be mutually agreed between both of you.

An investigation may be commissioned and will be undertaken by an appropriately trained and experienced member of staff. This may be the person to whom you addressed your concerns.

Once the investigation has been concluded, you will receive a response within 10 working days of the final outcome for consideration of the concern. You will also be kept up to date of the progress of the investigation by the appointed Investigating Officer.

9 Referral to the Chair for matters relating to the Accountable Officer or Directors

If your concern relates to the Accountable Officer or a Director you should raise the concerns directly with the Clinical Chair, who will in turn commission an appropriate investigation.

10 If you are dissatisfied

While the Trust cannot guarantee that you will be satisfied with the response, it is the Trust's aim to handle the matter fairly and properly. By using this policy, you will help us to achieve this. If you remain dissatisfied having exhausted the internal procedure after raising them at the highest levels within the organisation (i.e. with the Accountable Officer or the Clinical Chair) there may be circumstances where you wish to raise your concerns externally. Further information is in section 11.

11 External contacts

Whilst we hope that this policy gives you the reassurance for you to raise any matters internally, we recognise that there may be circumstances where you wish to seek advice or report matters to bodies outside of the Trust.

You are encouraged to resolve all issues internally however should you feel it is necessary to go outside of the organisation to resolve your concerns you may be expected to provide a higher level of proof to substantiate your concerns.

You can raise concerns with the appropriate regulator, such as Care Quality Commission or:

- Public sector finance – External Auditors
- Fraud & fiscal irregularities - Serious Fraud Office, Inland Revenue, Custom & Excise, Counter Fraud Office
- Health & safety dangers – Health & Safety Executive
- Environmental dangers – Environmental Agency
- Charities Commission
- Occupational Pensions Regulatory Authority
- Data Protection Register
- Department of Health (020 7210 4850/dhmail@dh.gsi.gov.uk)
- Prevent (anti-terrorism)

These bodies have their own procedures relating to investigations which you can inquire about and follow.

Public Concern at Work will be able to advise you on such an option if you wish (see section 12).

12 Independent Advice

If you are unsure whether or how to raise a concern or you want free independent advice at any stage you may contact the charity *Public Concern at Work* on 020 7404 6609. Advice can also be sought by all employees of the organisation through Care First an independent confidential service for advice or counselling available 24 hours a day 365 days a year on 0800 174319

13 Monitoring and Review

The Governing Body will be responsible for auditing the effectiveness of this policy. The policy will be monitored and activity under this policy will be reported by the Clinical Chair at scheduled Governing Body meetings.

This policy will be reviewed after 3 years or earlier on the request of either the CCG or staff side of the recognised consultative forum.

14 Further Help

Sources of further help are as follows:

- Human Resources Department
- Local Counter Fraud Officer
- Information Governance Officer
- Occupational Health Department
- Trade Unions/ Staff Organisations
- Public Concern at Work
- Care First

Gloucestershire Clinical Commissioning Group

Appendix C

POLICY FOR MANAGING CONFLICTS OF INTEREST

This document may be made available to the public and persons outside of the CCG as part of the CCG's compliance with the Freedom of Information Act 2000.

CONTENTS

1. INTRODUCTION

1.1. Managing conflicts of interest appropriately is essential for protecting the integrity of the overall NHS Commissioning system and to protect CCGs and GP practices from any perceptions of wrong doing. The CCG needs to display the highest level of transparency so that it can demonstrate that conflicts of interest are managed in a way that does not undermine the probity and accountability of the organisation.

1.2. Conflicts of interest are not possible to avoid in all instances, however, recognising where and how they arise and dealing with them appropriately will enable the CCG to demonstrate proper governance and decision making with regard to the use of public funds.

1.3 The Procurement Strategy for the Purchase of Healthcare Services considers conflicts of interest that mat exist when commissioning services from GP practices.

2. PURPOSE

2.1. This policy sets out how Gloucestershire CCG will manage conflicts of interest arising in respect of the following:-

- the operation of the CCGs Governing Body
- the procurement of services.

3. ROLES AND RESPONSIBILITIES

3.1. All members of the Governing Body are collectively responsible for decisions and equally obliged to avoid, and/or manage, any real or perceived material conflicts of interest in accordance with this policy.

4. DEFINITION

4.1. A conflict of interest occurs where an individual's ability to exercise judgement or act in one role is, or could be, impaired or otherwise influenced by his or her involvement in another role or relationship.

4.2. The individual does not need to exploit his or her position or obtain an actual benefit, financial or otherwise. A potential for competing interests and/or a perception of impaired judgement or undue influence can also be a conflict of interest.

4.3. Types of conflicts of interest that can arise include the following:-

- direct financial interest
- indirect financial interest
- non-financial personal interest
- conflicts of loyalty

Direct Financial Interest

4.4. This is the most recognisable conflict of interest and arises when a Governing Body member obtains, or is perceived to obtain, a direct financial benefit over and above the agreed remuneration and terms of service package. Examples include:-

- the award of a contract to a company or other business with which a governing body member is involved
- the sale of assets at below market value to a Governing Body member

Indirect Financial Interest

4.5. This arises when a close relative of a Governing Body member benefits from the decisions of the CCG. Governing Body members will benefit indirectly if their financial affairs are bound with those of the relative in question through the legal concept of 'joint purse', as would be the case if the relative were the spouse, partner, dependent child of the Governing Body member, or directly connected in some other way. For example, the Governing Body member being involved in a decision to award a contract to an organisation where the member's spouse is a director.

Non Financial Personal Interest

4.6. These occur where Governing Body members receive no financial benefit, but are influenced by external factors. For instance:

- to gain some other intangible benefit or kudos
- awarding contracts to friends or personal business contacts.

Conflicts of Loyalty

4.7. Governing Body members may have competing loyalties between the CCG to which they owe a primary duty and some other person or entity, including their GP practice, and patients.

5. POLICY DETAILS

5.1. Duty of Governing Body Members

5.1.1. The Governing Body of Gloucestershire CCG has ultimate responsibility for all actions carried out by staff and committees throughout the CCG's activities. This responsibility includes the stewardship of significant public resources and the commissioning of healthcare to the community.

5.1.2. It is therefore the duty of the Governing Body to ensure the organisation inspires confidence and trust amongst its patients, staff, partners, funders and suppliers by demonstrating integrity and avoiding any potential or real situations of undue bias or influence in the decision-making of the CCG.

5.1.3. This conflict of interest policy respects the seven principles of public life promulgated by the Nolan Committee. The seven principles are:

- selflessness
- integrity
- objectivity
- accountability
- openness
- honesty
- leadership.

5.1.4. The Governing Body has a legal obligation to act in the best interests of Gloucestershire CCG, and in accordance with the group's constitution and terms of establishment created by the NHS Commissioning Board, and to avoid situations where there may be a potential conflict of interest.

5.2. Declarations of Interest

5.2.1. It is not possible, or desirable, to define all instances in which an interest may be a real or perceived conflict. It is for each individual to exercise their judgement in deciding whether to register any interests that may be construed as a conflict. Individuals can seek guidance from the Associate Director Corporate Governance, but may decide to declare when in doubt.

5.2.2. Accordingly Governing Body members are required to declare any relevant and material interests, and any gifts or hospitality offered and received in connection with their role in the clinical commissioning group. Interests that may impact on the work of the Governing Body and should be declared include:-

- any directorships of companies likely to be engaged with the business of the clinical commissioning group
- previous or current employment or consultancy positions
- voluntary or remunerated positions, such as trusteeship, local authority positions, other public positions
- membership of professional bodies or mutual support organisations
- investments in unlisted companies, partnerships and other forms of business, major shareholdings and beneficial interests
- gifts or hospitality offered to you by external bodies and whether this was declined or accepted in the last twelve months
- any other conflicts that are not covered by the above.

5.2.3. A declaration of interests form listing the types of interest that should be declared is attached at Appendix 1. The declaration of interests form must be completed in the following instances:-

On Appointment

5.2.4. Applicants for any appointment to the CCG Governing Body or its Committees are required to declare any relevant interests. If any potential conflicts of interests arise these will be considered on a case by case basis.

5.2.5. If it is considered that any individual has a material interest in an organisation which provides/is likely to provide substantial business to the CCG they shall not be entitled to be a member of the Governing Body. A material interest can be defined as being so significant that the individual would be unable to make a full and proper contribution to the Governing Body as this interest would preclude them from having involvement in the majority of discussions and decisions.

Annually

5.2.6. All interests will be confirmed on an annual basis.

Meetings of the Governing Body

5.2.7. All members of the Governing Body will be required to declare any interests in any agenda item before it is discussed or as soon as it becomes apparent, albeit if an interest is declared in the Register of Interests. Declarations of interest will be recorded in minutes of meetings accordingly.

Change of Role or Responsibility

5.2.8. Where an individual changes role or responsibility within the CCG or its Governing Body, any change to the individual's interests should be declared.

Other Change of Circumstances

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

5.3. Register of Interests

5.3.1. Interests will be recorded on the CCG's Register of Interests as and when they are declared. They should be reported to the Associate Director Corporate Governance who will maintain the register on behalf of the Accountable Officer. The register will be accessible by the public and inspection of the register of board members' interests will be encouraged, as appropriate. A proforma Register of Interests is attached at Appendix 2.

5.4. Exclusion of Individuals on Account of an Interest

5.4.1. All Governing Body members are required to declare their interests in relation to any items on the agenda at the start of each meeting. Where the conflict is material to the discussion of the board, that member shall withdraw from discussions pertaining to that agenda item, the conflict and the action will be recorded in the minutes of the meeting and the register of interests updated accordingly.

5.4.2. It is the responsibility of the Associate Director Corporate Governance to monitor quorum and advise the chair accordingly to ensure it is maintained throughout the discussion and decision of the agenda item. Should the withdrawal of the conflicted director result in the loss of quorum, the item cannot be decided upon at that meeting.

5.4.3. Where permitted under the CCG's constitution or the conditions of its establishment, the governing body has the power to waive restrictions on any clinical professional member participating in the business of the Governing Body, where to authorise such a conflict would be in the interests of the CCG. The application of a waiver can, therefore, be used in the following situations:-

- a member of the Governing Body is a clinical professional providing healthcare services to the CCG that do not exceed the average for other practices and NHS entities commissioned to provide services by the clinical commissioning group; or
- where the Governing Body member has a pecuniary interest arising out of the delivery of some professional service on behalf of the CCG, and the conflict has been adjudged by the Chair and the governance lay member not to bestow any greater pecuniary benefit to other professionals in a similar relationship with the CCG.

5.4.4. Where the Chair and the governance lay member have approved the use of the waiver, the Chair must have discussed it with the Accountable Officer before the meeting. In such circumstances where the waiver is used, the Governing Body member:-

- must disclose their interest as soon as practicable at the start of the meeting
- may participate in the discussion of the matter under consideration; but
- must not vote on the subject under discussion.

5.4.5. The minutes of the meeting will formally record that the waiver has been used, and that this policy and the governing document provisions have been observed in managing that authorised conflict. Where a member has withdrawn from the meeting

for a particular item, the Associate Director Corporate Governance will ensure that the minutes for that member do not contain such information that may compound the potential conflict, but do not unnecessarily disadvantage the member in their performance of their functions and legal responsibilities.

5.5. Decisions Taken With an Interest

5.5.1. In the event of the Governing Body having to decide upon a question in which a member has an interest, all decisions will be made by vote, with a simple majority required. A quorum must be present for the discussion and decision; interested parties will not be counted when deciding whether the meeting meets quorum. Interested board members must not vote on matters affecting their own interests, even where the use of the waiver has been approved by the chairman and used.

5.5.2. All decisions under a conflict of interest will be recorded by the Associate Director Corporate Governance and reported in the minutes of the meeting. The report will record:-

- the nature and extent of the conflict
- an outline of the discussion
- the actions taken to manage the conflict
- use of the waiver and reasons for its implementation.

5.5.3. Where a Governing Body member benefits from the decision, this will be reported in the annual report and accounts, as a matter of best practice. All payments or benefits in kind to Governing Body members will be reported in the CCG's accounts and annual report, with amounts for each Governing Body member listed for the year in question.

5.6. Commissioning Services from GP Practices

5.6.1. The CCG will abide by the code of conduct attached at Appendix 3 which sets out additional safeguards to use when commissioning services for which GP practices could be potential providers.

6. CONSULTATION

6.1. All members of the Governing Body and the Associate Director Corporate Governance are to be consulted on this policy.

7. TARGET AUDIENCE

7.1. The target audience for the policy is the CCG Governing Body and Members.

8. COMMUNICATION

8.1. The policy will be sent to members of the Governing Body and the wider CCG membership via email and placed on the Trust intranet site.

9. TRAINING

9.1. There are no training requirements associated with this policy.

10. REFERENCES FOR THIS POLICY

10.1. Please find listed below details of organisations used in researching this protocol.

- NHS Commissioning Board – Towards establishment: *Creating responsive and accountable clinical commissioning groups* (February 2012)
- NHS Commissioning Board – Towards establishment: *Technical Appendix 1 - Managing conflicts of interest (*February 2012)
- NHS Commissioning Board – Code of Conduct: *Managing conflicts of interest where GP practices are potential providers of CCG commissioned services (*June 2012)
- ICSA Guidance Note 120228 – *Model conflicts of interest policy for clinical commissioning group board members* (February 2012)
- NHS Confederation / RCGP Centre for Commissioning – *Managing conflicts of interest in clinical commissioning groups* (September 2011)

APPENDIX 1

Template Declaration of Interest

Gloucestershire Clinical Commissioning Group

Member, governing body member, committee and sub-committee member and employee declaration form: financial and other interests

This form is required to be completed in accordance with the CCG's Constitution.

Notes:

- Within 28 days of a relevant event, CCG members, the members of its Governing Body, members of its committees or sub-committees (including those of its Governing Body) and employees need to register their financial and other interests.
- If any assistance is required in order to complete this form, then the member or employee should contact the Associate Director Corporate Governance.
- The completed form should be sent by both email and signed hard copy to the Associate Director Corporate Governance.
- Any changes to interests declared must also be registered within 28 days of the relevant event by completing and submitting a new declaration form.
- The register will be published or otherwise made accessible to members of the public on request.
- Governing Body members, committee and sub-committee members and employees completing this declaration form must provide sufficient detail of each interest so that a member of the public would be able to understand clearly the sort of financial or other interest that person has and the circumstances in which a conflict of interest with the business or running of the CCG might arise.
- If in doubt as to whether a conflict or potential conflict of interests could arise, a declaration of the interests should be made.

Interests that must be declared:

1. Roles and responsibilities held within member practices;
2. Directorships, including non-executive directorships, held in private companies or PLCs;
3. Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the CCG;
4. Shareholdings (more than 5%) of companies in the field of health and social care;
5. Positions of authority in an organisation (e.g. charity or voluntary organisation) in the field of health and social care;
6. Any connection with a voluntary or other organisation contracting for NHS services;
7. Research funding/grants that may be received by the individual or any organisation they have an interest or role in; and
8. Any other role or relationship which the public could perceive would impair or otherwise influence the individual's judgement or actions in their role within the CCG whether such interest are those of the individual themselves or a family member, close friend or other acquaintance of the individual

Declaration:

Name:		
Position within the CCG:		
Interests		
Type of Interest	**Details**	**Personal interest or that of a family member, close friend or other acquaintance?**
Roles and responsibilities held within member practices		
Directorships, including non-executive directorships, held in private companies or PLCs		
Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the CCG		
Shareholdings (more than 5%) of companies in the field of health and social care		
Positions of authority in an organisation (e.g. charity or voluntary organisation) in the field of health and social care		
Any connection with a voluntary or other organisation contracting for NHS services		
Research funding/grants that may be received by the individual or any organisation they have an interest or role in		
Other specific interests?]		
Any other role or relationship which the public could perceive would impair or otherwise influence the individual's judgement or actions in their role within the CCG		

To the best of my knowledge and belief, the above information is complete and correct. I undertake to update as necessary the information provided and to review the accuracy of the information provided regularly and no longer than annually. I give my consent for the information to be used for the purposes described in the CCG's Constitution and published accordingly.

Signed:

Date:

Gloucestershire Clinical Commissioning Group

Appendix E

POLICY FOR THE DEVELOPMENT, RATIFICATION AND IMPLEMENTATION OF POLICIES AND RELATED PROCEDURAL DOCUMENTS ('POLICY FOR POLICIES')

VERSION	
POLICY NO	
AUTHOR	
SPONSOR	
APPROVED BY	
APPROVAL DATE	
REVIEW DATE	

This document may be made available to the public and persons outside of the CCG as part of the CCG's compliance with the Freedom of Information Act 2000.

CONTENTS

1. INTRODUCTION

1.1. To ensure robust governance, organisations need formal written documents, such as policies, which communicate standard corporate organisational ways of working. These help clarify strategic and operational requirements and ensure consistency within day to day practice. In addition they can improve the quality of work, increase the successful achievement of objectives and support patient safety, quality and experience. It is recognised that systems need to be in place to ensure policies are user friendly, up-to-date and easily accessible.

1.2. A common format and approval structure for policies will reinforce corporate identity. More importantly, this will help to ensure that policies and related procedures in use are current and reflect an organisational approach. It will also avoid confusion and assist employees to readily access information within the document in a consistent manner.

2. PURPOSE

2.1. Gloucestershire Clinical Commissioning Group intends that its organisational policies should provide a clear understanding of what is expected of employees and are understood by member practices.

2.2. Whilst this document is particularly relevant to staff that are given responsibility for writing or reviewing policies it is equally important that all employees understand the relevance of having these in place.

2.3. This document outlines the process for policy development from inception through to ratification and implementation across the organisation.

3. ROLES AND RESPONSIBILITIES

3.1. The Governing Body

3.1.1. The Governing Body has formally delegated responsibility to the Integrated Governance Committee to ratify all policies. The responsibility of the Governing Body is to receive formal notification from the Committee that policies have been ratified in line with this policy. The Governing Body will be responsible for the formal approval of policies that have been deemed by the Committee to require Board ratification.

3.2. Integrated Governance Committee

3.2.1. The responsibility of the Committee is to formally ratify policies with the assurance that they have been through the correct process. The Committee is also responsible for ensuring that any policies that need ratification by the Governing Body are subject to review prior to submission.

3.3. Policy Sponsor

3.3.1. All policies must have a named sponsor which will usually be a member of the Senior Management Team. The sponsor must ensure that an appropriate author is nominated to develop this within the requirements of this document.

3.3.2. Sponsors must also ensure that, through management lines, all staff have an awareness of all policies. Particular emphasis needs to be given to those that are specifically relevant to their area of work.

3.4. Policy Authors

3.4.1. Authors are responsible for ensuring that policies they are developing are in line with this policy and adopt the Policy Template attached at Appendix 2 which provides a guide to what is required.

4. DEFINITION

4.1. Policy

4.1.1. A policy is a statement of intent, which staff are expected to follow and should state responsibility and accountability. It is not open to interpretation, or professional judgement and is non negotiable. It forms the 'why and what' for the whole organisation and details any local variations.

4.2. Procedures

4.2.1. Procedures should reflect the policy and provide the details necessary in order to implement the policy and state 'how' things will be done. The following are types of procedural documents that can be used:-

- **Protocol** – is a procedure which must be followed and applies to the whole organisation. It describes specific intent, plans or processes, and specifies the criteria/boundaries which must be adhered to. It supports individuals or groups of staff to implement the protocol and is related to the specific skills and knowledge required.
- **Guidelines –** are recommendations which should be followed unless there are reasons not to. Individuals would be allowed to use their professional judgement and local variations would be permitted based on risk and needs assessments. Guidelines should be evidence based/referenced and be a set of principles/best practice which underpin a procedure. They may be based on national best practice or professional manuals.
- **Process** – is a step by step method on how to do something and can be, for example, a flow chart.

5. POLICY DETAILS

5.1. All policies and related documents must be produced by using the Policy Template attached at Appendix 1. Requirements in respect of format and content are detailed on the template itself. It is important that the development of policies and related procedures are linked to service priorities and that they do not duplicate other work either nationally or locally.

5.2. New Policy

5.2.1. An author may be requested to develop a new policy based on organisational needs, changes in legislation or national requirements.

5.3. Revision of An Existing Policy

5.3.1. An author who is reviewing an existing policy is expected to review the contents of the current version for its continued relevance and to ensure that the organisational history, where necessary, is carried forward to the new policy.

5.4. Policy Development Process

5.4.1. All policies should be developed in accordance with this policy and the policy template. This will provide the author with the opportunity to ensure that it is compliant with all aspects of the policy development process.

6. CONSULTATION

6.1. Consultation should be to secure the support and experience from all relevant individuals and groups. It is vital to the success of the implementation of any policy that the expertise and experience of all relevant parties has been considered, particularly those who will be expected to implement the requirements.

6.2. The consultation process is an opportunity to influence the policy content and should not be considered only as an exercise to satisfy the checklist requirements.

6.3. A draft policy when sent out to stakeholders should be as near to the 'final' draft version as possible and include all relevant references with details of associated documentation. This will help to ensure that the stakeholders are able to review and make appropriately informed comments.

7. TARGET AUDIENCE

7.1. The target audience for the policy is all CCG Staff and Members

8. COMMUNICATION

8.1. External Stakeholders

8.1.1. Appropriate expert groups and other stakeholders should be consulted in the drafting of policies before they are presented for approval. Consideration needs to be given to whether the consultation with these groups requires a different method of discussion, "sounding out" or presentation.

8.2. Internal Stakeholders

8.2.1. In some cases it will be appropriate for the policy to be shared with a group or committee who will act as a body of expertise for the purposes of the review. They will be asked to give a group/committee considered view. The author should link with the group chair to facilitate this.

8.2.2. In all instances it is important to identify every internal stakeholder who could have an interest in the policy and authors should use local expertise to do this. Consideration also needs to be given to who the policy will affect, both directly and indirectly.

9. TRAINING

9.1. The Associate Director Corporate Governace will provider assistance with the interpretation of this Policy.

10. REFERENCES

10.1. The author will provide an evidence base for the policy with up-to-date references. It is recommended that all references are cited in full using an agreed uniform approach to referencing.

11. APPROVAL OF POLICIES

11.1. Following consultation and consideration of responses the policy can be put forward for approval and formal ratification. The author is required to complete the Policy Authorisation Form which forms part of the policy submission to the relevant group for approval.

11.2. The relevant group will review the policy against the criteria for approval and a decision will be made at the meeting regarding whether it is deemed ready to go forward for formal ratification at the Integrated Governance Committee.

11.3. If the policy is not deemed to be ready for formal ratification, the Group will agree with the author where amendment or clarification is required and consider a resubmission following adoption of the agreed changes to the policy.

12. FORMAL RATIFICATION

12.1. All policies will be formally ratified by the Integrated Governance Committee who have delegated powers from the Governing Body to undertake this responsibility.

12.2. Members of the committee will have full access to the policies being presented for ratification and the policy authorisation form must be completed in all cases.

13. DISSEMINATION TO STAFF

13.1. All ratified policies will be added to the staff intranet page and staff will be informed of any new policies and updates requiring attention through the CCGs internal communication systems e.g. staff newsletter

13.2. The policy will also be made available on the Website unless after discussion with FOI lead it will not be made public.

13.3. The CCG will ensure that policy documents are available on request in Braille, large print, symbols or in languages other than English. Any requests should be made to the Policy Co-ordinator.

14. IMPLEMENTATION AND COMPLIANCE

14.1. Induction

14.1.1. Forming part of the induction process there is a requirement to make staff aware of the importance of policies and procedures and the need to follow them.

14.2. Managers

14.2.1. Managers are responsible for ensuring that all staff are aware of new policies, changes to existing policies and have access to current policies and procedures whether via the intranet or hard copy. Managers should keep copies of evidence that staff have been sent policies via email or have read hard copies. All new staff at their local induction should be shown where and how to access policies

15. REVIEW OF POLICIES

15.1. All policies will be subject to annual review, or if there is a requirement following the issue of new guidance from external bodies e.g. NHS Commissioning Board

16. AUDIT

16.1. The Policy Co-ordinator will schedule Audits on an annual basis to check that:

- Staff have access to Policies either via the Intranet or in hard copy
- These policies are the most up to date
- Current policies are in the correct format
- Policies have been implemented adequately

APPENDIX ONE

POLICY AUTHORISATION FORM

1

NAME OF POLICY:	* complete all boxes below
JOB TITLE OF AUTHOR:	*
SPONSOR:	*
NAME OF GROUP: (if applicable)	*

2

EQUALITY AND DIVERSITY

An Equality & Diversity assessment has been completed *(Please contact the Equality & Diversity Lead)*	**Date Completed:** *

CONSULTATION

NAME OF GROUP (S) (complete where relevant)	**DATE CONSIDERED**
Name of Local Committee or Specialist Group?	*
Name of Countywide Committee or Specialist Group? County Wide Policy YES / NO	*
Other relevant Forum/Individual?	*

3

APPROVED BY GOVERNING BODY / AUTHORISED GROUP / DIRECTOR

NAME i.e. Governing Body	**DATE APPROVED**
*	*
TO BE REVIEWED BY: (Author)	**DATE TO BE REVIEWED:**
*	*

4

TO BE COMPLETED BY CO-ORDINATOR

DATE PUT ONTO POLICY REGISTER:	
POLICY NUMBER:	
DATE PLACED ON INTRANET:	

POLICY UPDATES/CHANGES

(AFTER BOARD/DESIGNATED GROUP APPROVAL)

Date	Summary of Changes	Author/Editor	Approved by	Version

APPENDIX ONE

The Policy Authorisation Form is part of the overall policy template and forms the front of the document and must be completed in all cases

Equality and Diversity - Part 2 of the form

The policy should be checked to see if it has any adverse effect on any personal group covered by Discrimination Legislation. In order to do this an 'Impact Assessment' must be completed. Further advice can be obtained from the Equality and Diversity Lead.

Approval & Review - Part 3 of the form

Once the Policy has been approved the name of the group / individual and date of approval should be included. The policy document should be sent to the Policy Co-ordinator to log on the Policy Register.

Review and amendments are the responsibility of the Author and Director of the Policy and a date for review must be set and included on the form. However, the Policy Co-ordinator will give a reminder to an author when a policy is overdue a review. The review date must be at least annually.

If, after a review, changes are made the document must be resubmitted, by the Author, for approval and therefore the 'Policy for Policies' must be followed again. Any changes should be included in the necessary 'Policy updates/changes' section at the beginning of the document.

Trust Policy Spreadsheet ' Information Register'- Part 5 of the form

The Policy Co-ordinator will input the approved policy onto the Policy Register and allocate a Policy Number which will be inserted onto the authorisation form and also communicated to the Author via email. The Policy Co-ordinator will also ensure that after a review a new version number is allocated and noted on the register.

Gloucestershire Clinical Commissioning Group

POLICY TITLE

VERSION	
POLICY NO	
AUTHOR	
SPONSOR	
APPROVED BY	
APPROVAL DATE	
REVIEW DATE	

This document may be made available to the public and persons outside of the CCG as part of the CCG's compliance with the Freedom of Information Act 2000.

CONTENTS

APPENDIX ONE

(This contents list is a standard list that should be followed but other items may be added as deemed appropriate)

APPENDIX ONE

1. INTRODUCTION

1.1. *Insert text – why this document is needed

1.2. The document should detail why the policy is needed and therefore before the author begins to write the policy they must ensure the following:-

- *Adequate consultation has been undertaken to ensure there is a need for a policy document and to ascertain staff/users ideas/views. The reason for a new policy must be stated in the background of the paper*
- *There is no other document already approved. This can be done by searching the policies section on the Intranet and by checking within Gloucestershire Health Community (as detailed below)*

2. PURPOSE

2.1. *Insert text - what the policy aims to achieve

3. ROLES AND RESPONSIBILITIES

3.1. *Insert text – who is responsible for updating/amending the policy and monitoring and compliance

4. DEFINITION

4.1. *Insert text – whether it is a policy, protocol, guideline etc and why – see policy for policies for definitions

5. POLICY DETAILS

5.1. *Insert text – actual details of the policy

5.2. The Author and Sponsor will be responsible for assuring the accuracy and relevance of the policy and should ensure that it reflects current NHS best practice. They should research and benchmark against other organisations' practice, particularly in the same sector or location. These organisations should be noted in the 'References' section of the document.

6. CONSULTATION

6.1. *Insert text – who is to be consulted and timescale

6.2. The author should provide assurance that appropriate consultation has taken place and that the policy has been considered accordingly within the CCG. Sufficient time must be allowed to enable proper consultation on policies before submission to the Governing Body or authorised group. Consultation could take place with the following:-

- *Professional or service area groups within the trust who may have an interest*
- *Directors*
- *Individuals hosted elsewhere*
- *Countywide counterparts*
- *Patient & Public Involvement Group*
- *Integrated Governance Committee*
- *Gloucestershire Health Community i.e. CCGs and Trusts*
- *Service users/external stakeholders if appropriate*
- *Other partners as deemed appropriate*

7. TARGET AUDIENCE

7.1. *Insert text – all staff or specific staffing grps i.e. community nurses

7.2. The Target Audience you wish your policy document to be aimed should be detailed whether it is relevant to 'all staff' or specific groups 'community nurses'.

8. COMMUNICATION

8.1. *Insert text – how is the policy to be communicated to staff

8.2. The Policy should include a section on how the Author is going to communicate the policy to staff. In the first, and 'ideal' instance an email should be sent however in some instances the Author may decide that it would be appropriate for paper copies to be sent as well.

8.3. Email - An Author will need to decide whether 'all staff' should be informed or whether specific areas of staff need to be informed. The 'Communications Cascade' email group should be used when 'all staff' need to be informed. This can be found in the address book on the email system. The email should contain details of the new policy and direct staff to the Intranet. The Policy Co-ordinator will ensure that the Policy is placed on the Trust Intranet/Website and is highlighted in 'The Face'.

8.4. Paper – If it is deemed absolutely necessary then paper copies can be sent along with the email as an attachment. It is recognised that there will be valid operational or training reasons for managers and staff to have copies of policies as working documents. The Author must ensure that the attachment copy is ran off from the Intranet as this will ensure that the copy is up to date and has all the relevant spreadsheet information included. They must also input the 'Issue date' on the document which can be found in the Footer, this is the date when they ran if off from the Intranet. The document states on the front cover that 'Hard copies of this policy can only be assured to be accurate on the date of issue marked on the document. The most up to date policy will always be available under Policies and Procedures on the PCT's Intranet.'

8.5. The Policy Template includes a sentence stating 'this document may be made available to the public and persons outside of the Trust as part of the Trust's compliance with the Freedom of Information Act 2000'. If an author finds this inappropriate it must be discussed with the FOI Lead.

9. TRAINING

9.1. *Insert text

9.2. Where there is a training element to the policy this should be detailed here along with relevant training details, any contact names and numbers. Any training should be discussed with the Human Resources department.

10. REFERENCES

10.1. *Insert text

10.2. List here any organisations or publications that have been used for research purposes.

Appendix F

ConSultHR

NHS
Central Southern
Commissioning Support Unit

Annual Leave Policy

We encourage and expect everyone to take the full entitlement to Annual Leave within the leave year that runs 1st April – 31st March; it is an important part of your work life balance to support your wellbeing.

Local managers will define rules for requesting and authorising annual leave to ensure an appropriate level of staffing is available at all times. In accordance with the Working Time Regulations, managers reserve the right to allocate leave to meet peaks and troughs of activity and ensure that all staff take the required amount of leave. There may also be times when no leave is allowed due to specific business or service needs.

When using this policy you may wish to refer to Working Time Regulations, or other policies such as Short Term (unpaid) Leave, Sickness Absence and Equality and Diversity and the User Guide that accompanies this annual leave policy

This policy applies to everyone who works in the CS CSU or client organisation

Annual leave is:

A combination of the statutory leave described in the Working Time Regulations and the additional leave entitlement arising from your contract of employment:

- **The legal minimum leave that you are responsible for taking each year is 28 days including bank Holidays (pro rata for part time staff)**
- **Your entitlement to paid Annual Leave is in your contract of employment.**
- **Your entitlement to Bank Holidays is in your contract of employment.**

All addressed in this policy:

1) PRINCIPLES:

1.1 This policy is designed to ensure that the authorisation, calculation and recording of your entitlement is consistent and accurate. To ensure parity across all types of contracts, we calculate leave on an hourly basis (rounded up).

1.2 On returning to NHS employment, previous periods of NHS service count towards your entitlement to annual leave. We also recognise previous employment under NHS terms and conditions of employment (refer to Agenda for Change handbook)

1.3 All leave must be authorised by the appropriate manager. Generally and in line with the working time regulations, you should request your leave in advance by least twice the amount of time that you wish to take off. Local rules may increase the amount of time required.

1.4 Leave should always be allocated/authorised in a fair and consistent manner. Each department should have robust procedures agreed locally for the allocation of annual leave and associated cover arrangements.

1.5 If a manager needs to allocate leave then, under the working time regulations, they must give you advance notice of at least twice the amount of time that they wish you to take off.

1.6 At least 75% of your leave entitlement should be booked by 31st December.

1.7 As long as you have taken your statutory leave, (28 days including bank holidays pro-rated for part time staff) you may request authorisation to carry forward up to one week of normal working hours, which is added to the following year's entitlement.

1.8 You continue to accrue annual leave during sickness. If you have a prolonged period of sick leave, which prevents you taking your annual leave, you must request to carry forward your statutory minimum holiday entitlement (currently pro rata up to 28 days) into the next leave year. Your manager can require you to use this accrued leave to facilitate a phased return to work.

1.9 Annual leave accrues during maternity, paternity and adoption leave – please refer to those policies,

1.10 If you are unwell during your annual leave, you should contact your line manager in order for it to be re-credited as soon as possible. You will be required to produce a medical or self-certificate regarding this absence.

1.11 You are strongly advised not to incur any expenses (e.g. flights, hotels) prior to agreeing your annual leave with your manager.

1.12 In very exceptional operational circumstances (e.g. pandemic flu), we may require you to forego your booked annual leave. In these cases, the Trust will reimburse you for any expenses incurred, which are not covered by holiday insurance. You will be able to book this annual leave again at another time or carry it over to the next leave year if needed.

1.13 You need to ensure that your holiday schedule allows time for you to recover from travelling so that you are fit to return to work.

1.14 Subject to the demands of the service, people who resign should take any outstanding leave during their notice period. Where this is not possible, any outstanding leave entitlement will be paid in full subject to the appropriate weekly calculation. If too much annual/bank holiday leave has been taken, and you cannot make up the time prior to leaving, this will be deducted from your final pay

1.15 Everyone involved will take steps to eliminate unlawful discrimination, promote equality of opportunity, and provide for good relations between people of diverse groups. The following characteristics are protected by the Equality Act (2010); age, disability, gender, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, and sexual orientation, in addition to offending background, trade union membership, or any other personal characteristic.

2) ROLES & RESPONSIBILITIES

Senior Managers

2.1 Senior Managers is the generic term for Heads of Function, Associate Directors, Directors and Accountable Officers and they will:

2.1.1 Define and cascade the local rules to govern the allocation, authorisation and recording of leave. This includes arrangements for authorising carrying forward leave.

Line Managers

2.2.1 Monitor leave arrangements to ensure that the required staffing levels are available to meet business and service needs and allocate/authorise leave in line with local rules.

2.2.2 Ensure staff take at least the legally required minimum amount of leave.

Staff

2.3 .1Plan ahead to make personal leave requests in plenty of time to allow proper authorisation whilst accepting that line managers may need to refuse an application in the needs of fairness to others and/or to meet business or service needs.

2.3.2 Use the required processes to request leave.

ConSultHR

2.4 The role of **ConsultHR** is to:

2.4.1 Provide advice and guidance to everyone on the application of this policy through **ConsultHR** and to support the manager.

3) PROCEDURES:

3.1 Annual Leave

3.1.1 All annual leave requests should be made using the process agreed for your department and authorised by the manager/ supervisor. .

3.1.2 If you are employed on a part-time basis, your annual leave entitlement will be calculated on a pro-rata basis (see Chart B in the User Guide).

3.2 Bank and Statutory Holidays

3.2.1 Chart C in the User Guide shows you how to calculate your entitlement.

3.2.2 If you work or are on call on a Bank or Statutory Holiday, you are entitled to time off in lieu, subject to a maximum of 7½ hours at plain rates, in addition to the appropriate payment for the duties undertaken.

3.2.3 If you work in excess of these 7½ hours, you will be paid these additional hours at the appropriate rate for the time worked (note that a Bank or Statutory Holiday should be defined as only those hours of normal duty that fall within the period of 24 hours from midnight to midnight).

3.2.4 You are not entitled to an additional day off if sick on a Bank or Statutory Holiday.

3.2.5 Everybody, regardless of length of shift, will be entitled to the maximum number of Bank Holiday hours as set out. (See User Guide).

3.2.6 If you work part time, you will be entitled to receive a pro-rata Bank or Statutory Holiday allocation, irrespective of actual days worked (see Chart C in the User Guide).

3.2.7 If you work only part of the year you will be entitled to receive Bank or Statutory Holiday based on the number of completed weeks (see Question 11 in the User Guide for the calculation).

3.2.8 When a Bank or Statutory Holiday falls on a day you would normally work, and your department is closed, you should deduct the number of hours that you would have worked on that day from your Bank Holiday entitlement. In situations where a pro-rata entitlement is less than the amount of hours that will be taken when the department is closed, and with the agreement from your manager, you may work additional hours to make up the time.

4) DISATISFACTION:

4.1.1 If you do not agree with a decision based on the application of this policy you may raise this in accordance with the Grievance Policy

5) REVIEW PERIOD:

5.1 The policy and procedure will be reviewed after 3 years or at the request of management or staff side or more frequently if employment legislation dictates.

If you want to find out more…

At any stage, you can seek further advice by accessing the user guide or contacting ConSultHR :

- **Telephone 01793889417**
- **email consulthr.cscsu@nhs.net**

Gloucestershire Clinical Commissioning Group

Appendix G

Counter Fraud Policy

Version	Version 1.0
Policy No	
Author	
Sponsor	
Approved by	
Approval date	
Review date	

CONTENTS

COUNTER FRAUD POLICY

INTRODUCTION

1. GENERAL

1.1 One of the basic principles of public sector organisations is the proper use of public funds. It is therefore important that all those who work in the public sector are aware of the risk of, and means of, enforcing the rules against fraud and other illegal acts involving dishonesty (for example: offences contrary to the Fraud Act 2006, fraud related matters contained in the Theft Acts 1968 and 1978 and the Proceeds of Crime Act 2002). For simplicity, all such offences are referred to as "fraud", except where the context indicates otherwise. This document sets out Gloucestershire CCG's policy and procedures for managing cases
of suspected or detected fraud and corruption.

1.2 The Governing Body has existing procedures in place that reduce the likelihood of fraud occurring. These include Standing Orders, Prime Financial Policies, documented procedures and systems of internal control and risk assessment. Additionally the Governing Body endeavours to ensure that a culture of zero tolerance to fraud exists in the CCG.

1.3 This document intends to provide direction and assistance to employees dealing with suspected cases of fraud or corruption.

1.4 "Fraud" covers any activity involving dishonesty and deception that can drain value and resources from Gloucestershire CCG, directly or indirectly, whether or not there is personal benefit to the fraudster.

PUBLIC SERVICE VALUES

2. CODE OF CONDUCT FOR NHS BOARDs

2.1 The Code of Conduct for NHS Boards sets out the following public service values. It states that high standards of corporate and personal conduct, based on the recognition that patients come first, have been a requirement throughout the NHS since its inception.

Accountability

Everything done by those who work in the organisation must be able to stand the tests of parliamentary scrutiny, public judgments on propriety and professional codes of conduct.

Probity

Absolute honesty and integrity should be exercised in dealing with NHS patients, assets, staff, suppliers and customers.

Openness

The organisation's activities should be sufficiently public and transparent to promote confidence between the organisation and its patients, staff and the public.

2.2 All those who work in the organisation should be aware of, and act in accordance with, these values.

THE CCG GOVERNING BODY'S COMMITMENT ON FRAUD

3. ELIMINATION OF FRAUD

3.1 The Governing Body is absolutely committed to maintaining an honest, open and well- intentioned atmosphere within Gloucestershire CCG. It is therefore also committed to the elimination of any fraud against or within Gloucestershire CCG, and to the rigorous investigation of any cases brought to its attention.

3.2 The Governing Body encourages anyone having reasonable suspicions of fraud to report them. It is also the Governing Body's policy that no employee will suffer, in any way, because of reporting reasonably held suspicions. For these purposes "reasonably held suspicions" shall mean any suspicions other than those, which are raised maliciously and found to be groundless.

3.3 This policy is issued in response to the updated Secretary of State's Directions of November 2004 (NHS Act 1977– Directions to NHS Trusts regarding counter fraud) and incorporates the requirements of Prime Financial Policies and the NHS Counter Fraud and Corruption Manual.

PROCEDURE

ROLES AND RESPONSIBILITIES

4. EMPLOYEES & CONTRACTORS

4.1 All employees and staff of other organisations performing work for the CCG, such as the Commissioning Support Unit (CSU), have a duty to protect the assets of Gloucestershire CCG. Assets include information and goodwill as well as property.

4.2 Guidance to employees and contractor staff is attached as Appendix 1 & 2.

4.3 All employees and contractor staff have a right and a duty to report any suspicions of fraud or corruption. This should be done through Gloucestershire CCG's Local Counter Fraud Specialist (LCFS), the Chief Finance Officer or the NHS Fraud and Corruption Reporting Line. See Appendix 1 & 2 for telephone numbers). These arrangements do not replace CCG procedures for handling complaints, grievances or incident reporting.

4.4 If managers receive any allegations of fraud and corruption, they must take them seriously, but must not conduct any investigation into the allegation themselves. They should report any matters to the Trust's Local Counter Fraud Specialist.

4.5 The Human Resources service shall provide advice and guidance, to those conducting an investigation, of any requirements relating to matters of employment law and in other procedural matters, such as disciplinary and complaints procedures.

5. GLOUCESTERSHIRE CCG (ACCOUNTABLE OFFICER/CHIEF FINANCE OFFICER)

5.1 The Accountable Officer and Chief Finance Officer are responsible for ensuring compliance with the Secretary of State's Directions on Counter Fraud.

5.2 Gloucestershire CCG is responsible for maintaining a named and accredited person, nominated to act as its Local Counter Fraud Specialist (LCFS).

5.3 Gloucestershire CCG will facilitate and co-operate with the NHS Counter Fraud & Security Management Service (CFSMS) and its LCFS, giving them prompt access to CCG staff, workplaces and relevant documentation, particularly in relation to:

- investigating alleged cases of fraud and corruption;
- quality inspections;
- fraud measurement exercises;
- national or local proactive exercises;
- fraud prevention reviews;
- reporting arrangements;
- Publicity.

6. CHIEF FINANCE OFFICER

6.1 The Chief Finance Officer is responsible for monitoring compliance with the Secretary of State's Directions and with any other instructions issued by CFSMS.

6.2 The Chief Finance Officer is responsible for ensuring that an adequate Counter Fraud provision is in place including:

Agreement with the LCFS on an annual Counter Fraud work plan, which will be subject to scrutiny and approval by the Audit Committee, in relation to covering all aspects of Counter Fraud activity and to meet the needs of Gloucestershire CCG:

- anti-fraud culture
- deterrence
- prevention
- detection
- investigation
- sanctions
- redress
- strategic/mandatory

6.3 The Chief Finance Officer will liaise and reach agreement with the LCFS, CFSMS and NHS solicitors where the appropriate sanction is considered prosecution, before either party takes any further action. Such liaison will also take place before any referral of a case to the Police or any other body prior to any investigative action, unless where a scene of crime needs to be preserved and the Police called as quickly as possible.

6.4 The Chief Finance Officer shall inform and consult the Accountable Officer in cases where the loss may be above the delegated limit or where the incident may lead to adverse publicity.

7. COMMISSIONING SUPPORT UNIT (CSU)

7.1 Where an employee of the CSU discovers or has a suspicion of fraud relating to Gloucestershire CCG then they shall follow the same protocol as if they were an employee of Gloucestershire CCG

7.2 If the CSU discovers or has a suspicion of fraud concerning one of their

employees which relates to Gloucestershire CCG then the CSU shall report this to the CCG nominated contact as per the procedure and the CCG and the CSU shall agree which counter fraud department will lead any investigation.

8. LOCAL COUNTER FRAUD SPECIALIST (LCFS)

8.1 The LCFS represents the CCG when dealing with fraud matters.

8.2 The LCFS will report all cases where fraud or corruption is thought to be present to the Chief Finance Officer, so that agreement on the most appropriate course(s) of action can be reached. The Chief Finance Officer and LCFS will consider further action in accordance with the NHS Counter Fraud and Corruption Manual.

8.3 The LCFS will report to the Chief Finance Officer and Audit Committee, details of systems weaknesses identified following investigations or other proactive work.. Any recommendations for changes to systems/processes will also be recorded and monitored for progress by the LCFS, Chief Finance Officer and Audit
Committee.

8.4 The LCFS will be entitled to attend any Audit Committee meeting and have a right of access to all Audit Committee members and to the Chairman and Accountable Officer of the CCG.

9. AUDITORS

9.1 External Audit and the Gloucestershire CCG's Internal Auditors will report any systems weaknesses detected in the course of their work that may allow fraud to take place, to the LCFS. A protocol between internal audit and the LCFS will define the process for the sharing of this information.

INVESTIGATIONS WITH CLINICAL IMPLICATIONS

When investigating suspicions of fraud, it is important to consider whether there may be any clinical or health and safety implications, which could have an adverse impact on the organisation. In such cases, the overriding consideration must be one of patient care.

It must be appreciated that every case is different, and it is therefore not possible to provide definitive guidance.

In such an instance, the LCFS is responsible for ensuring that the Chief Finance Officer is informed of the potential risk at the earliest opportunity. The Chief Finance Officer, or designated deputy, will decide which of his/her senior colleagues should be informed and consulted before reaching a decision. Any appropriate professional body may also be notified. It is essential this happens to ensure that the Chief Finance Officer's decision can take account of the full consideration of the clinical and non- clinical risks facing the organisation. To ensure that the investigation is not compromised however, it is vital that the number of people aware of the investigation is kept to an absolute minimum. If in any doubt, advice should be sought from the

Regional Counter Fraud team or the NHS Counter Fraud and Security Management's Legal Services Unit.

It may be essential for immediate action to be taken. All previously agreed parties should be involved in this process, and should be kept informed of any action taken and the outcomes. Any decision to contact or suspend / exclude the individual(s) under suspicion must involve the Chief Finance Officer, Head of Human Resources and the LCFS.

Fraud investigations will not compromise clinical issues and / or patient care.

2.1 Appendix 1 – Fraud Reporting Guidance

REPORTING FRAUD OR CORRUPTION

This document is designed to outline the action to be taken where fraud or other illegal acts are discovered or suspected. Managers are encouraged to copy this to staff and to display it on staff notice boards in their department.

Staff concerned about how to raise their suspicion can receive independent and confidential advice from their Local Counter Fraud Specialist, the NHS Fraud and Corruption Reporting Line, from the charity "Public Concern at Work" or from the Trust's own whistleblower contact (see below and Appendix for contact details).

DEFINITIONS

FRAUD

A dishonest act by a person in order to make a gain (or attempted gain) for themselves or another, cause loss to another or expose another to the risk of loss. The law has been simplified by the introduction of the Fraud Act 2006..

Section 2 Fraud by false misrepresentation (eg. false timesheets)
Section 3 Fraud by failing to disclose information (eg. Not declaring criminal convictions)
Section 4 Fraud by abuse of position (eg. Inappropriate authorisation)

Section 6 Possession of articles for use in frauds (eg. fake qualifications)
Section 7 Making or supplying articles for use in frauds (eg. Selling false qualification certificates
Section 11 Obtaining services dishonestly (eg. Obtaining free NHS treatment)

Other offences under which charges may be brought following a fraud investigation are (this list is not exhaustive):

THEFT A person is guilty of theft if he/she dishonestly appropriates property belonging to another with the intention of permanently depriving the other of it (S1(1) Theft Act 1968)

Property includes money and all other property, real or personal, including things in action and other intangible property. (S4(1) Theft Act 1968)

FORGERY A person is guilty of forgery if he/she makes a false instrument with the intention that he/she or another shall use it to induce someone to accept it as genuine. Also links to section 7 Fraud Act 2006
(S1 Forgery and Counterfeiting Act 1987)

IDENTITY CARDS

It is an offence for a person to be in possession or control of an identity document to which he is not entitled, or of apparatus, articles or materials for making false identity documents…
(Identity Cards Act 2006 section 25-30)

COMPUTER MISUSE

Section 1 Unauthorised access to computer material

Section 2 Unauthorised access with intent to commit or facilitate commission of further offences

Section 3 Unauthorised modification of computer material
(Computer Misuse Act 1990 [c.18])
These may also constitute a breach of the Trust's IT Policy.

CORRUPTION

Corruption is defined as the offering, giving, soliciting or acceptance of an inducement or reward, which may influence the action of any person.

Listed below are just a few examples of fraud that have been discovered in the NHS.

- Submitting false or forged timesheets.
- Falsifying travel and/ or expense claims.
- People working elsewhere whilst off sick within the NHS.
- Patient falsification of prescription claim forms.
- Outside agencies duplicating invoices for payment by the NHS.
- Contractors claiming payment for merchandise they have not delivered.
- The unauthorised selling of CCG property or assets.

2.2 WHO TO CONTACT

Anyone (staff, patients, visitors or the public) having reasonable suspicions of fraud or corruption should raise them through the following reporting arrangements:

(a) Directly contact the Trust's LCFS, Sallie Cheung – 01452 318826 or (sallie.cheung@glos.nhs.uk); or

(b) Contact the NHS Fraud and Corruption Reporting Line – 0800 028 4060; or

(c) Contact the Chief Finance Officer – Cath Leech 0300 421 1934

(d) Trust Whistleblowing contact – Alan Elkin

(e) Where staff have raised suspicions with a line manager or Director the latter must <u>immediately</u> inform the LCFS or Chief Finance Officer.

All reports, whether verbal or written, will be treated in confidence by trained staff and any information professionally assessed and evaluated.

WHEN TO CONTACT – timeliness

It is essential that all employees act at the time of their concerns, as time is likely to be of the utmost importance to prevent further loss to the Trust.

However, staff must not confront any individual that they suspect. Nor should staff contact the police directly. They must contact the LCFS or Chief Finance Officer.

Staff should keep or copy any document that arouses their suspicions but should not go looking for more!

WARNING SIGNS

The following examples or circumstances may provide an indication of fraud, and should therefore alert both managers and staff.

The examples are not in themselves 'conclusive' proof of fraud.

- Altered documents (correcting fluid, different pen or handwriting).
- Duplicate claim forms.
- Claim form details not readily checkable.
- Changes in normal patterns, of e.g. cash takings or travel claim details.
- Text erratic or difficult to read or with details missing.
- Delay in completion or submission of claim forms.
- Lack of vouchers or receipts in support of expense claims, etc.
- Staff seemingly living beyond their means.
- Staff under constant financial or other stress.
- Staff choosing not to take annual leave (and so preventing others becoming involved in their work), especially if solely responsible for a 'risk' area.
- Complaints from public or staff.
- Always working late.
- Refusal of promotion.
- Insistence on dealing with a particular individual.

2.3 Appendix 2 – Further guidance

ACTING ON YOUR SUSPICIONS - SOME DO's AND DON'Ts

If you suspect fraud or corruption within the workplace, there are a few simple guidelines that should be followed:

DO	o Make an immediate note of your concerns. o Where possible note all relevant details, such as what was said in telephone or other conversations, the date, time and the names of any parties involved. o Convey your suspicions to the Local Counter Fraud Specialist (LCFS), Director of Finance or the NHS Fraud and Corruption Reporting Line. o Deal with the matter promptly. Any delay may cause the Trust to suffer further financial loss.
DON'T	o Do nothing. o Be afraid of raising your concerns. You will not suffer any recrimination from the Trust as a result of voicing a reasonably held suspicion and any matter you raise will be dealt with sensitively and confidentially. o Approach or accuse any individuals directly. o Try to investigate the matter yourself. There are special rules surrounding the gathering of evidence for use in criminal cases. Any attempt to gather evidence by people who are unfamiliar with these rules may damage the case. The LCFS is trained in handling investigations in accordance with the **NHS** Counter Fraud and Corruption Manual. o Convey your suspicions to anyone other than those with the proper authority. o Speak or write to representatives of the press, TV, radio, or to another third party without the express authority of the Accountable Officer. (Care needs to be taken to ensure that nothing is done that could give rise to an action for slander or libel. Remember individuals are innocent unless proved otherwise. It is possible that there may be other explanations for what is occurring)

ACTION TO BE TAKEN IF YOU DISCOVER OR SUSPECT FRAUD OR CORRUPTION

FRAUD	**false representation** **failing to disclose information** **abuse of position.**	These needs to be reported IMMEDIATELY. You therefore must discuss your suspicions or what you have discovered with one of the following; □ **LCFS on** 01452 318826 (Sallie Cheung) □ **The Chief Finance Officer on 0300 421 1934 (**Cath Leech) □ **The Fraud & Corruption Reporting Line on** 0800 028 40 60 □ **Whistleblowing Contact** Alan Elkin
CORRUPTION	Where someone is influenced by bribery, payment or benefit in kind to unreasonably use their position to give some advantage to another.	
THEFT	Includes any **dishonest appropriation of property.**	These need to be reported **IMMEDIATELY** to the Local Security Management Specialist (LSMS) or out of hours to the Senior on-call manager.

DO'S & DON'TS FOR FRAUD If you are suspicious or have concerns

- □ **DO** tell someone – confidentiality will be respected.
- □ **DO** keep or copy any document that arouses your suspicions
- □ **DO NOT** confront the individual with your suspicions.
- □ **DO NOT** try to investigate your suspicions yourself.

Further information can be found on the CCG's Website and Intranet or by contacting the Local Counter Fraud Specialist.

Appendix H

ConSultHR

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Appeals Policy

There are occasions when employees may need to formally exercise their right to question or complain about decisions regarding their employment.

An appeal is an opportunity to question a decision previously reached under a formal policy or procedures. An independent panel reviews the original decision to decide if it was fair and reasonable.

When using this policy you may also refer to policies covering Grievance, Disciplinary, Capability, Sickness Absence and Banding review Policies.

This policy applies to everyone who works in the CS CSU or client organisation

An appeal is:

Where a member of staff uses a formal process to request an appeal hearing to consider their opinion that they have:

- **Been treated wrongly**
- **Been treated unfairly**
- **Been treated unreasonably**

All addressed in this policy:

1) PRINCIPLES:

1.1 An appeal hearing reviews a formal sanction or decision if the member of staff concerned feels the decision was wrong, unfair or unreasonable i.e. too severe. It is not a rehearing but considers whether previous proceedings were followed according to policy and decides if the outcome was appropriate.

1.2 No new evidence can be submitted at an appeal hearing

1.3 A wrong decision is one that does not comply with policy or legislation.

1.4 An unfair decision is one not made objectively, based on the facts or is made in a discriminatory manner.

1.5 An unreasonable decision means that the weight of the sanction does not fit the offence or the outcome did not logically flow from the information available.

1.6 Disliking the sanction or decision is not sufficient grounds for appeal.

1.7 If the appeal overturns or modifies the initial decision the case will be used use as a learning opportunity to review policy, procedures, training and/or support provided to managers.

1.8 Everyone involved will take steps to eliminate unlawful discrimination, promote equality of opportunity, and provide for good relations between people of diverse groups. The following characteristics are protected by the Equality Act (2010); age, disability, gender, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, and sexual orientation, in addition to offending background, trade union membership, or any other personal characteristic.

2) ROLES & RESPONSIBILITIES

Senior Executives

2.1 Senior Executives is the generic term for The Chair of the Board, Chief Executive, Accountable Officer and Managing Director and they will:

2.1.1 Promote a culture of fairness that welcomes the opportunity to address and resolve appeals.

2.1.2 Respond positively to any escalated appeal and either take or arrange appropriate action.

Senior Managers

2.1 Senior Managers is the generic term for Heads of Function, Associate Directors, and Directors. They will:

2.1.1 Promote the policy and ensure its effective implementation ensuring consistency of approach and application.

2.1.2 Ensure that all managers understand their responsibilities for action and confidentiality, and receive appropriate training in handling appeals.

Line Managers

2.2 The role of the Manager is to:

2.2.1 Have an understanding of the policy and apply it appropriately and consistently.

2.3.3 Maintain confidentiality where this policy applied.

ROLES & RESPONSIBILITIES (cont)
Staff

2.3 The role of the member of staff is to:

2.3.1 Consider a decision or sanction carefully and objectively before deciding to raise an appeal on the basis that it is wrong, unfair or unreasonable.

2.3.2 Provide enough details to allow full consideration of your appeal including the names of any witnesses that you wish to call.

ConSultHR
2.4 The role of **ConsultHR** is to:

2.4.1 Provide advice and guidance to everyone on the application of this policy through ConsultHR and to support the manager.

3) PROCEDURE

3.1 Making an appeal:

3.1.1 Refer to the Appeal Guide for guidance to complete the form in the appendix and submit it to the appropriate person within 14 days of the contested decision.

3.1.2 Use the designated form to make sure the recipient correctly identifies your appeal. This will also ensure you are confident that you have provided all of the required information including the reason for your appeal, the outcome you hope to achieve and details of any witnesses you intend to call.

3.1.2 Send your appeal form via email to ConSultHR and they will liaise with a suitable manager to chair the appeal hearing.

3.1.3 You will receive a written invitation to an appeal hearing within 7 days of receiving your appeal and it will give you at least 7 days' notice of the hearing date. This notification will also inform you if there is an intention to call any witnesses.

3.2 The appeal hearing panel will be three people:

3.2.1 A manager who is at least the level of the line manager's manager, another manager of the same level and a Consult HR representative who have not been previously involved in any way will form the appeal-hearing panel for any reason except dismissal.

3.2.2 A manager who is at least a Senior Manager, plus another manager of the same level and a Consult HR representative who have not been previously involved in any way will form the appeal-hearing panel following dismissal.

3.3 You have the right to be accompanied at your appeal hearing by a representative of a trade union, professional organisation or a workplace colleague. It is your responsibility to make such arrangements.

3.4 At the hearing:

3.4.1 The person bringing the appeal is invited to outline their case including asking any witnesses to speak on their behalf.

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3.4.2 Manager who made the decision being appealed will have the opportunity to ask questions of the member of staff and witnesses.

3.4.3 Managers hearing the appeal shall have the opportunity to ask questions .

3.4.4 The management side will then have the opportunity to present their case and call witnesses.

3.4.5 The staff member or their or the representative shall have the opportunity to ask questions of the management side and their witnesses.

3.4.6 The appeal-hearing managers then have the opportunity to ask questions of the management side and their witnesses.

3.4.6 Management side shall have the opportunity to re-examine witnesses.

3.4.6 After all parties have had opportunity to "sum up", the appeal hearing will end to allow the hearing panel to consider what they have heard to form a decision.

3.4.7 Where possible, the outcome is given verbally but the panel may, at their discretion, communicate the outcome in writing especially if there is a reason why they need longer to consider the outcome.

3.4.8 Even if the outcome is delivered verbally, it will always be confirmed in in writing within 7 days of the hearing.

3.5 There is no further right of appeal

4) REVIEW PERIOD:

4.1 The policy and procedure will be reviewed after 3 years or at the request of management or staff side or more frequently if employment legislation dictates.

If you want to find out more…

At any stage, you can seek further advice by accessing the user guide or contacting ConSultHR :

- **Telephone 01793889417**
- **email consulthr.cscsu@nhs.net**

Appendix I

ConSultHR

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Capability Policy

The Organisation has the right and responsibility to establish realistic and clearly defined work standards and staff are trained, supported and monitored against these standards.

Where there is an identified failure in performance, we will, as part of the process of encouragement and support, discuss with the employee the reasons giving rise to that situation and agree steps to improve performance to the required level.

This policy applies to everyone who works in the CS CSU or client organisation. For a Doctor or Dentist also refer to the Department of Health 'Maintaining High Professional Standards in the Modern NHS' document.

Capability is:

When a member of staff meets the requirements of their job description whilst working in a manner considered acceptable for that role.

Failure to demonstrate the required level of capability can arise for a wide range of reasons including:

- **Failure to gain or maintain an essential qualification or registration**
- **Job moving beyond a person's capability due to changing service needs, altered processes or new technology**
- **Long term degenerative conditions not leading to long term sickness absence (note these are probably covered by DDA so reasonable adjustments are required)**

All are addressed in this policy:

1) PRINCIPLES:

1.1 We will provide appropriate training, development and support for you to carry out your job effectively.

1.2 We will ensure that you clearly understand what we expect of you in your role and what we mean by good performance.

1.3 Everyone will have reasonable targets and timescales for achievement with regular constructive feedback on their performance.

1.4 Managers will address all issues of capability in a sensitive, objective and confidential manner.

1.5 We will provide training and support to your manager to ensure that they act in a fair and unbiased way when dealing with performance issues.

1.6 Managers will address issues of poor performance promptly and outside of any annual review process.

1.7 We accept that organisational change can be an influencing factor affecting performance. In these circumstances, we will consult you about the effects of such change and provide you with appropriate training for your new role.

1.8 The safety of the public, patients and other staff members are always taken into consideration, should there be a shortfall in a staff member's performance. Steps should be taken to minimise these risks and in these circumstances, it may be necessary to move you to a different role to support you and give the necessary supervision whilst this process is ongoing.

1.9 Everyone involved will take steps to eliminate unlawful discrimination, promote equality of opportunity, and provide for good relations between people of diverse groups. The following characteristics are protected by the Equality Act (2010); age, disability, gender, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, and sexual orientation, in addition to offending background, trade union membership, or any other personal characteristic.

2) ROLES & RESPONSIBILITIES

Senior Managers

2.1 Senior Managers is the generic term for Heads of Function, Associate Directors, Directors and Accountable Officers and they will:

2.1.1 Ensure effective, fair and consistent application.

ROLES & RESPONSIBILITIES (cont)

2.1.2 Support managers to understand their responsibilities for action and confidentiality, and arrange appropriate training and support.

2.1.3 Act as the officer empowered to dismiss.

Line Managers

2.2 The role of the Line Manager is to:

2.2.1 Ensure all staff understand the standards and operational procedures that are expected.

2.2.2 Review these standards and expectations regularly throughout the year.

2.2.3 Ensure that an appropriately qualified manager addresses the standards, if the performance issue relates to a professional qualification or registration. NB. If there is any concern that allowing the practitioner to continue to work in the clinical area may put patient care at risk, seek further advice from the organisation's lead for the designated profession.

2.2.4 Consider that, in some circumstances, where performance is causing concern in a way that might affect a service, patient care, or other members of staff, then it may be necessary to move the member of staff to a different role. Whilst this process is on-going, the member of staff should receive the necessary support and supervision.

Staff

2.3 As a member of staff, you:

2.3.1 Have the right to be accompanied at all formal meetings by a Trade Union representative or workplace colleague.

2.3.2 Are expected to attend Occupational health appointments arranged on your behalf. You can also self-refer to Occupational Health.

2.3.3 Will have a clear explanation of where you are not meeting expectations of your job, and be provided with evidence-based examples and opportunity to comment on the identified performance issues

2.3.5 Receive a clear explanation of the process to address poor performance and the potential outcomes, ensuring that you have fully understood it.

2.3.6 Have the opportunity to address your performance with the offer of appropriate support, training opportunities and your manager will seek to gain your agreement to a realistic and achievable development plan.

ConSultHR

2.4 The role of **ConsultHR** is to:

2.4.1 Provide advice and guidance to everyone on the application of this policy**.**

2.4.2 **S**upport the manager at stage two or three of the capability policy at a capability hearing if a final warning or dismissal is possible.

3) PROCEDURE

3.1 The Informal Route

3.1.1 Before implementing the formal stage, your manager will attempt to resolve any issues of poor performance through discussion with you on a one to one basis when they should make it clear that if your performance fails to meet the required standard then the formal procedure will follow.

3.1.2 This meeting will identify the aspects of your performance that need to improve, the actions required of you to address this and the support available to you.

3.1.3 We consider a discussion of this nature as business as usual support and is often provided during routine one to one meetings. However, if your performance does not improve within a reasonable timescale, (circa 1 to 3 months) your manager will use the formal procedure to ensure clarity over the performance levels required.

3.2 The Formal Route - First Stage

3.2.1 Managers will contact *ConsultHR*.

3.2.2 A meeting will be arranged with you and confirmed in writing with at least **7 days' notice**. You have the right to be accompanied at this meeting by a Trade Union representative or workplace colleague.

3.2.3 The letter will provide a clear explanation of where the required standards have not been met and any supporting documentation will be enclosed.

3.2.4 The meeting will give you the opportunity to comment on your performance and to indicate what support is needed to improve.

3.2.5 We will agree a **Performance Improvement Plan** with you (See Appendix 3, CAP16 of the User Guide).

3.2.6 We will provide any appropriate support and training to assist you to improve.

3) PROCEDURE (Cont)

3.2.7 We will agree a timescale with you, (circa 1 to 3 months) for reaching the required standard and will set a review date. Please refer to User Guide for further guidance on timescales.

3.2.8 It will be made clear to you what may happen if you do not reach the agreed standards.

3.2.9 Written records will be kept of the meeting and a copy of the agreed performance improvement plan will be provided to you and your representative.

3.2.10 We may seek advice from other professionals where appropriate.

3.2.11 At the review meeting, if your performance has reached a satisfactory level, you will be informed and encouraged to maintain this standard. Details of the improved performance will be noted on page 2 of the Performance Improvement Plan (Appendix 3, CAP16 of the User Guide) and confirmed in writing to you and your representative.

3.2.12 If your performance has not met a satisfactory level, your case could be referred to your manager's line manager, or other appropriate manager of a similar level, who must seek advice from ConSultHR.

3.3 The Formal Route - Second Stage

3.3.1 A meeting will be arranged with you and confirmed in writing with at least 7 days' notice. You have the right to be accompanied by a Trade Union representative or a workplace colleague.

3.3.2 At the meeting, your performance and the improvement plan will be discussed fully and you will have opportunity to comment.

3.3.3 We will confirm that failure to reach required standards will lead to a further formal meeting with a senior manager.

3.3.4 We will agree a timescale with you for reaching the required standard and will set a reasonable review date.

3.3.5 If your performance reaches required standards details will be noted on page 2 of the Performance Improvement Plan (Appendix 3, CAP16 of the User Guide) and confirmed in writing.

3.3.6 If your performance has still not reached a satisfactory level following the appropriate time period, a further meeting will be arranged under stage 3 of the policy.

3.4 The Formal Route - Third Stage

3.4.1 The hearing is conducted by at least a Senior Manager one level above the employee with authority to dismiss, assisted by another manager and a ConSultHR representative if the outcome has the possibility to be dismissal.

3.4.2 If you are in a Trade Union and have not previously contacted your Union representative, we advise you to do so. Alternatively, you might like to identify a workplace colleague to accompany you.

3.4.3 The meeting will be confirmed to you in writing with at least 7 days' notice.

3.4.4 The letter will give a clear explanation of where we believe you have not met the required standards and provide any supporting evidence.

3.4.5 The Manager who has addressed your performance issues at the second stage will prepare a summary report with relevant documentation for the Senior Manager. A copy will be sent to you with the letter of notification in advance of the meeting along with any other appropriate documentation e.g. an up to date Occupational Health report.

3.4.6 At the meeting your performance will be discussed fully with you and you will have opportunity to comment before the Senior Manager decides on next steps that will usually be one of the following options.

3.4.7 Further time to improve and/or new objectives and in this case, the Senior Manager will provide you with formal confirmation of how your performance must improve, together with an action plan detailing the agreed time period, in writing. An updated copy of page 2 of the performance Improvement Plan (Appendix 3, CAP 16 of the User Guide) will also be provided.

3.4.8 Transfer to a different post if a suitable alternative post is vacant; the organisation will not create a job especially for you. You will need to agree to the alteration of your contract in writing and acknowledge that, in such circumstances pay protection arrangements do not apply.

3.4.9 Dismissal on the grounds of failing to demonstrate the required capability.

3.4.10 Action taken will be confirmed in writing within 7 days of the decision. You will be informed of your right of appeal.

NOTE: Further advice will be sought from the organisation's Lead for the designated profession in terms of referral to any Professional or Registration Body.

9) APPEALS PROCEDURE:

9.1 Please refer to the separate Appeals Procedure.

10) REVIEW PERIOD

10.1 The policy and procedure will be reviewed after 3 years or at the request of management or staff side or more frequently if employment legislation dictates.

If you want to find out more…

At any stage, you can seek further advice by accessing the user guide or contacting ConSultHR :

- **Telephone 01793889417**
- **email consulthr.cscsu@nhs.net**

Appendix J

ConSultHR

NHS
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Disciplinary Policy

We will always let you know the standards of conduct we expect from you and if your behaviour is unacceptable, we will let you know promptly so that we can help you reach an acceptable standard. We will always treat you fairly, and with dignity, in an open yet confidential manner, if you are subject to disciplinary action.

This policy applies to everyone who works in the CS CSU or client organisation. For a Doctor or Dentist also refer to the Department of Health 'Maintaining High Professional Standards in the Modern NHS' document.

Disciplinary is for misconduct issues.

- **If issues relate to sickness absence, follow the sickness absence policy.**
- **If issues relate to unsatisfactory performance, follow the capability policy.**

1) PRINCIPLES:

1.1 We will always try to deal with any conduct issue informally through one-to-one discussions and counselling.

1.2 If an informal approach fails to resolve the issue, or the misconduct issue is serious, then the formal disciplinary process will be followed:

1.3 We will deal with each case as fairly, thoroughly and quickly as possible.

1.4 If you are subject to the formal procedure, we will inform you of the nature of the allegation in writing (see section 10 below: Rights of Staff).

1.5 We will make you aware of your rights to be accompanied at all formal hearings by a representative of a trade union, professional organisation or a workplace colleague.

1.6 Unless it is a case of gross misconduct, no one is dismissed for a first breach of discipline.

1.7 We will not take action against a trade union representative/official of a recognised trade union or professional association, until the initial circumstances are discussed with a full time officer/senior official of the union/association concerned.

1.8 You will not be subject to disciplinary action without a thorough investigation into the allegations.

1.9 If you suspect someone of a financial offence you must report it to the person with overall responsibility for finance within the organisation and/or Counter Fraud immediately and prior to any other action.

1.10 If you suspect someone of a Child or Adult safeguarding offence you must reported it to the person with overall responsibility for safeguarding within the organisation and the Director of HR immediately and prior to any other action.

1.11 We will always make sure you understand why you are subject to disciplinary action and the possible consequences, together with your right of appeal.

1.12 Everything about your case will be kept strictly confidential and only released to people who are authorised to receive this information.

1.13 Where offences are committed outside of the work place, we will only consider disciplinary action if they have a significant bearing on your employment.

1.14 We do not regard suspension as a disciplinary sanction and it carries no assumption of guilt. The decision to suspend is not taken lightly, and will only occur when deemed necessary.

1.15 Where possible, investigations are complete within four weeks.

1.16 In exceptional circumstances, and with the employee's agreement, the employee can transfer to a vacant post a band below their current job as an alternative to dismissal and in this case, pay protection does not apply.

1.17 If issues relate to clinical practice then guidance issued by the professional body will apply and referral is made above Senior Manager level.

1.18 Everyone involved will take steps to eliminate unlawful discrimination, promote equality of opportunity, and provide for good relations between people of diverse groups. The following characteristics are protected by the Equality Act (2010); age, disability, gender, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, and sexual orientation, in addition to offending background, trade union membership, or any other personal characteristic.

2) ROLES & RESPONSIBILITIES:

Senior Managers

2.1 Senior Managers is the generic term for Heads of Function, Associate Directors, and Directors. They will:

2.1.1 Promote the policy and ensure its effective implementation.

2.1.2 Ensure that all managers understand their responsibilities for action and confidentiality and receive appropriate training.

2.1.3 Ensure consistency of approach.

2.1.4 Be designated as the officer empowered to dismiss as described in the organisation's Scheme of Delegation (this may exceptionally be delegated to a deputy).

Line Managers

The role of the Line Manager is to:

2.2.1 Intervene early when there are concerns regarding conduct and trust.

2.2.2 Promote understanding and a constructive outlook to help staff address conduct issues.

2.2.3 Ensure that everyone understands acceptable standards of conduct and behaviour - to instigate this procedure when standards of behaviour and conduct require this.

Staff

2.3 The role of the member of staff is to:

2.3.1 Demonstrate acceptable standards of conduct and behaviour and maintain the level of trust that must exist between employer and employee.

2.3.2 Attend a disciplinary hearing prepared to participate fully but recognise that failure to attend will result in the hearing proceeding in your absence.

2.3.2 Attend a disciplinary hearing as a witness if requested to do so.

ConSultHR

2.4 The role of **ConsultHR** is to:

2.4.1 Provide advice and guidance to everyone on the application of this policy.

2.4.2 Support the manager dealing with an alleged offence at a disciplinary hearing.

3) PROCEDURE:

3.1 If you are subject to formal action under this disciplinary procedure, and you do not have on line access to **ConsultHR,** we will supply you with a copy of the Disciplinary Policy and User Guide.

3.2 You have the right to be accompanied at formal disciplinary hearings, by either a trade union representative or a workplace colleague.

3.3 We give a minimum of **7 days**' notice of a disciplinary hearing to allow you to arrange representation. It is your responsibility to make such arrangements.

4) SUSPENSION:

4.1 Suspension is not a disciplinary action and carries no assumption of guilt.

4.2 However, we may decide to suspend you for any of the following reasons:

- Where there is an allegation of gross misconduct.
- Where it is necessary for the protection of you, other people or public funds.
- Where your presence in the workplace could prevent a thorough investigation.
- To avoid undue pressure being placed on a member of staff under investigation.

4.3 We do not take a decision to suspend lightly, and this only occurs when essential.

4.4 You may be suspended by any manager with delegated authority from a Senior Manager in line with the Scheme of Delegation.

4.5 If you are suspended, you will receive written confirmation from a Senior Manager within **7 days** of the date of suspension giving you the reason for the decision and the terms of the suspension.

4.6 We recognise suspension from duty has an impact both on you and your employer, and therefore we will review the need for this at least monthly. However, you will also be updated weekly, or as agreed with you on the progress of the investigation by the officer conducting the investigation.

4.7 You will receive normal pay, including allowances, during your suspension.

4.8 We will make every effort to contact your trade union if applicable, prior to suspension. In cases where this is just not possible, we advise you to contact your trade union representative as a matter of urgency. If you are not in a trade union, you may wish to speak to a workplace colleague. The unavailability of a trade union representative should not delay the suspension process. In such cases, we offer you the opportunity to be accompanied by a workplace colleague.

5) THE INFORMAL ROUTE:

The informal disciplinary route consists of the following steps:

5.1 The line manager will always try to deal with any conduct issue informally through one-to-one discussions and counselling.

5.2 When the informal approach fails to resolve the problem, or the misconduct issue is serious, then the formal disciplinary process will be followed.

6) THE FORMAL ROUTE:

The disciplinary route consists of the following steps:

6.1 **Senior Manager** is made aware of an incident or formal complaint.

6.2 **Senior Manager** seeks advice on the case from **ConsultHR** and actions it appropriately.

6.3 **Senior Manager** appoints an investigating officer to complete an investigation. There can be no disciplinary hearing without this.

6.4 **Investigating Officer and/or a Counter Fraud, Safeguarding Children or Adults Specialist** conducts interviews with anyone who may have relevant information.

6.5 Witness statements may be used as part of the disciplinary hearing. If witnesses' statements are used at a Hearing these witnesses must be available on the day of the Hearing to give evidence.

6.6 **Investigating Officer and/or a Counter Fraud, Safeguarding Children or Adults Specialist** will decide:

- Whether there is no case to answer.
- Whether counselling is appropriate or if a disciplinary hearing is necessary.

6.7 **Investigating issues under the umbrella of Safeguarding Children or Adults**

- Immediately escalate any allegations about a safeguarding issue to the organisation's designated safeguarding lead and the Director of HR.
- If it is a potential child or adult safeguarding issue, they will refer to statutory guidance and the appropriate local Child or Adult safeguarding policy.
- The Director of HR is the responsible officer for liaising with the Local Authority Designated Officer who will lead any cross agency investigations. No action to suspend the staff member or discuss the situation with them can proceed without the express authorisation of the HR Director. Refer to local policies for more information on these processes.
- Inappropriate conduct by a staff member is then managed via this policy.

7) DISCIPLINARY HEARING:

7.1.1 The hearing is conducted by a Disciplining Manager who is:

- A line manager at least one level above the employee assisted by another manager and a ConsultHR representative if the outcome has the possibility to be a warning.
- At least a Senior Manager one level above the employee assisted by another manager and a ConsultHR representative if the outcome has the possibility to be dismissal.

7.1.2 The Disciplining Manager will ensure that you are given at least 7 days written notice, informing you of the requirement to attend a disciplinary hearing and will detail:

- The date, time and place of the hearing.
- The nature of the alleged offence (enclosing copies of any relevant statements and correspondence, etc.).
- Your right to representation.
- Who will be present; including the identity of witnesses.
- Possible outcome of the hearing.

7.1.3 We request that you submit relevant documents to the **Disciplining Manager** at least 2 days in advance of the hearing.

If you are in a trade union it is important that you contact your representative immediately on receipt of the letter.

Another manager and a ConsultHR representative accompany the Disciplining Manager if the outcome could be a final warning or dismissal.

The **Disciplining Manager** may also seek advice from a professional advisor (who has not been involved in the proceedings) as appropriate.

7.2 **The hearing chaired by Disciplining Manager the will follow this format:**

7.2.1 The **Investigating Officer** will first present the findings of the investigation and call witnesses as appropriate.

7.2.2 You and your representative will have the right to question all witnesses and the investigating officer.

7.2.3 **The Disciplining Manager** will have the right to question the investigating officer and witnesses.

7.2.4 The **Investigating Officer and/or a Counter Fraud, Safeguarding Children or Adults Specialist** may re-examine any witnesses.

7.2.5 You and your representative will then respond on

7) DISCIPLINARY HEARING (cont)

7.2.6 **Your representative** can help you put across your point of view and ask clarifying questions of managers and witnesses but they may not answer questions posed directly to you

7.2.7 The Investigating Officer will have the right to question you and witnesses.

7.2.8 The **Disciplining Manager** will have the right to question you and witnesses.

7.2.9 You or your representative may re-examine any witnesses.

7.2.10 The Disciplining Manager may also, at any time question any party, or adjourn the hearing to allow further evidence or witnesses to be called.

7.2.11 The **Investigating Officer** will sum up their case followed by you or your representative. No new evidence shall be introduced at this stage.

7.3 The preparation of any records will be the separate responsibility of you and the disciplining manager. You are advised to keep your own notes. The Disciplining Manager will appoint a note taker to make contemporaneous notes. These will not be verbatim but will record key points. A copy of these notes will be provided to the employee who may decide to share them with their representative.

7.4 At the conclusion of the disciplinary hearing, the disciplining manager will adjourn the proceedings to consider the appropriate action. In most cases, a decision will be given that day.

8) DISCIPLINARY SANCTIONS:

8.1 In deciding to impose any disciplinary sanctions, in accordance with this procedure, a **Disciplining Manager** must always:

- Act within the Scheme of Delegation and in good faith to reach a conclusion based on the balance of probability, having taken into consideration mitigating circumstances.

There are three levels for formal disciplinary sanctions:

8.2 Level 1 – Formal Warning

8.2.1 Appropriate in cases involving offences of minor misconduct, or where attempts at counselling have failed to secure improvement. This Formal warning will remain on record for a period of 12 months. Written confirmation of the outcome will be sent to you and your representative within 7 days of the hearing.

8.3 Level 2 – Final Warning

8.3.1 Appropriate where there is a current formal warning on file, or where serious misconduct is proven. Final warning will remain on record for a period of 2 years. Written confirmation of the outcome will be sent to you and your representative within 7 days of the hearing.

8.4 Level 3 – Dismissal

8.4.1 This is appropriate in cases of gross misconduct or if you have a current final warning on file. You may be summarily dismissed (i.e. dismissed without notice or a payment in lieu of notice) only in the event of gross misconduct. Written confirmation of the outcome is sent to you **within 7 days of the hearing.**

9) APPEALS PROCEDURE:

9.1 Please refer to the separate Appeals Procedure.

10) RIGHTS OF STAFF:

Where you have been advised of the possibility of disciplinary action, you will have the right to be:

10.1 Represented by an accredited Trade Union representative or a workplace colleague.

10.2 Advised in writing of the alleged misconduct prior to any disciplinary hearing taking place.

10.3 Allowed time to brief a representative, to take advice and prepare a case.

10.4 Made aware of the Senior Manager who has the authority to discipline or dismiss.

10.5 Reminded of the right of appeal and how to make an appeal.

11) ROLE OF COUNSELLING:

11.1 It is expected that minor disciplinary matters will be resolved through informal counselling but should not be seen as part of the formal disciplinary process.

11.3 Counselling should describe shortcomings in conduct, and improvement encouraged. You will be given the opportunity to discuss any underlying problems that could contribute to difficulties at work.

11.4 Counselling should end with a clear understanding by both manager and yourself on what needs to be done, and if appropriate, how conduct will be reviewed, over what period of time, and the potential consequences of your conduct not improving.

11.5 Managers must ensure that the counselling interview does not turn into an investigatory interview or disciplinary hearing.

11.6 Managers can also use counselling in support of disciplinary action, to encourage improved conduct.

12) EXAMPLES OF MATTERS OF MISCONDUCT, WHICH MAY RESULT IN DISCIPLINARY ACTION:

MISCONDUCT WILL NORMALLY BE RESOLVED INFORMALLY, BUT REPEATED OCCURRENCES MAY LEAD TO FORMAL STEPS.

Examples are:

- Poor timekeeping.
- Discourteous or unacceptable behaviour.
- Borrowing property without authorisation (including excessive use of the Internet at inappropriate times).
- Damage caused by carelessness.
- Smoking in contravention of the non-smoking policy.

MISCONDUCT, WHICH MAY LEAD TO FORMAL DISCIPLINARY ACTION:

Examples are:

- Failure to respond to written warnings.
- Unauthorised absence.
- Wilful refusal to carry out a lawful and reasonable instruction by an authorised person i.e. a more senior manager.
- Any discriminatory practice or action
- Failure to comply with working procedures or safety regulations.
- Disclosure of information in breach of Confidentiality, and Data Protection requirements.
- Prolonged or repeated unauthorised absence from work.
- Inappropriate use or misuse of Social Media channels (e.g. Facebook).

GROSS MISCONDUCT, WHICH MAY LEAD TO IMMEDIATE DISMISSAL AFTER APPROPRIATE INVESTIGATION & HEARING

Examples are:

- Bringing the organisation into disrepute
- Physical violence.
- Contravention of the organisation's Equality and Diversity policy, including bullying and harassment.
- Fraud or falsification of records.
- Theft or fraudulent misuse of the organisations property or name (e.g. phones, cars or computers).
- Deliberate damage.
- Incapability to work through alcohol or substance misuse.
- Negligence which causes loss or damage to property or injury to other personnel.
- Illegal activity on the organisations premises or with the organisations property.
- Infringement of health and safety rules.
- Breaches of trust and confidence.
- Soliciting or accepting a bribe or commission.
- Improper use of email or Internet facilities or other methods of communication.
- Breach of health and safety rules.
- Anything that calls into question an employee's honesty or integrity.

13) GRIEVANCE:

13.1 Grievances raised by an employee whilst subject to disciplinary proceedings will usually be heard only when the disciplinary process has been completed. In instances where the grievance has bearing on the disciplinary proceedings, it can be raised as a relevant issue in the course of the proceedings and disciplinary proceedings may be suspended. Where an initial investigation into the complaint finds that the grievance and disciplinary cases are related it may be appropriate to deal with both matters concurrently. If the grievance complaint is found to have no bearing on the matters being investigated under the disciplinary process the disciplinary proceedings will continue.

14) REVIEW PERIOD:

14.1 The policy and procedure will be reviewed after 3 years or at the request of management or staff side or more frequently if employment legislation dictates.

If you want to find out more…

At any stage, you can seek further advice by accessing the user guide or contacting ConSultHR :

- **Telephone 01793889417**
- **email consulthr.cscsu@nhs.net**

Appendix K

ConSultHR

NHS
Central Southern
Commissioning Support Unit

Grievance Policy

We aim to resolve grievances as quickly as possible and, wherever practicable, at the level at which they arise. We recognise that a decision to raise a grievance is not taken lightly and assure the employee they can do so without the fear of recrimination and that we aim to reach resolution with minimum delay.

This policy applies to everyone who works in the CS CSU or client organisation.

Grievance is:

A source of dissatisfaction regarding an individual's employment or the application and/or interpretation of their terms and conditions of employment:

- **Working practices**
- **Application of policies and procedures**
- **Perceived unfair treatment**
- **Deductions from pay**

All are addressed in this policy:

This policy does not apply to:

- **Matters over which the organisation has no control e.g. application of the law**
- **Issues covered by separate policies and/or procedures such as discipline, absence management or banding issues.**

1) PRINCIPLES:

1.1 You have the right to be accompanied by a Trade Union representative or a workplace colleague at any stage in the procedure to resolve your grievance.

1.2 We expect that most grievances will be resolved informally in discussion between you, and your manager.

1.3 If the informal stages do not resolve your concerns, there is a formal grievance procedure for you to follow. This is a confidential process designed to deal with your concerns in a prompt, fair, consistent and transparent way.

1.4 The procedure will be operated within the time constraints set out at each stage. However if these timescales cannot be met, the time period can be extended if everyone agrees.

1.5 The stage at which you start the formal procedure depends on the nature of the grievance and the seniority of the member(s) of staff against whom the grievance is raised

1.6 Once a grievance has been lodged the "status quo" (original position) where practicable will operate until the procedure is exhausted.

1.7 We will always confirm the outcome of a grievance in writing with the reasons we made in coming to the decision.

1.8 Grievances raised by an employee whilst subject to disciplinary proceedings will usually be heard only when the disciplinary process has been completed. In instances where the grievance has bearing on the disciplinary proceedings, it can be raised as a relevant issue in the course of the proceedings and disciplinary proceedings may be suspended. Where an initial investigation into the complaint finds that the grievance and disciplinary cases are related it may be appropriate to deal with both matters concurrently. If the grievance complaint is found to have no bearing on the matters being investigated under the disciplinary process the disciplinary proceedings will continue.

1.9 Everyone involved will take steps to eliminate unlawful discrimination, promote equality of opportunity, and provide for good relations between people of diverse groups. The following characteristics are protected by the Equality Act (2010); age, disability, gender, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, and sexual orientation, in addition to offending background, trade union membership, or any other personal characteristic.

2) ROLES & RESPONSIBILITIES

Senior Managers

2.1 Senior Managers is the generic term for Heads of Function, Associate Directors, and Directors. They will:

2.1.1 Promote the policy and ensure its effective implementation ensuring consistency of approach and application.

2.1.2 Ensure that all managers understand their responsibilities for action and confidentiality, and receive appropriate training in handling grievances.

Line Managers

2.2 The role of the Manager is to:

2.2.1 Have an understanding of the policy and to be able to apply it appropriately.

2.2.2 Promote understanding and a constructive outlook to help staff address any problems identified.

2.2.3 Ensure consistency of approach

Staff

2.3 The role of the member of staff is to:

2.3.1 Ensure that staff understand what a grievance is and is not.

2.3.2 Try to resolve the matter informally in the first place.

2.3.3 Maintain confidentiality where this policy is being applied.

ConSultHR

2.4 The role of **ConsultHR** is to:

2.4.1 Provide advice and guidance to everyone on the application of this policy through **ConsultHR** and to support the manager dealing with a grievance.

Stage 1 – Informal Resolution

3.1.1 If you wish to raise a matter of concern you should first discuss it with your line manager or next level manager as soon as possible but not normally later than 1 month of an incident occurring. It is in everyone's best interests to resolve issues at this stage, and every effort should be made to do so.

3) PROCEDURE

3.1.2 We expect this stage to be concluded within 1 month, but this may be extended if you both agree.

Stage 2 – Formal Resolution

3.2.1 Where it has not been possible to resolve your grievance informally, you can raise it formally, **within 10 days** of learning of the outcome, using the following steps:

- Complete the Notification of Grievance form (available in user guide) setting out a clear and detailed statement of the issues, and the desired outcome.
- Pass the form to the appropriate manager.

3.2.2 The appropriate manager is normally your line manager. However, should your line manager be the person you have a grievance against, send this to their line manager.

3.2.3 If your line manager has already heard your grievance informally, they will either ask another manager at their level to hear your grievance or escalate it to their line manager dependent on the issue at the heart of your grievance.

3.2.4 The appropriate manager will acknowledge receipt of your grievance, and log the case with ConsultHR (See User Guide), We aim to resolve the grievance **within 10 days** of receipt of the form. This will include meeting you to discuss the issue.

3.2.5 Following consideration of the grievance we will advise you in writing of the outcome, and the reasons for this decision **within 10 days** of the meeting, or as agreed with you at the meeting. We will return any original documentation to you at this stage if requested.

3.2.6 Should you not accept the decision you may appeal.

APPEALS PROCEDURE:

4.1 Please refer to the separate Appeals Procedure.

5) REVIEW PERIOD:

5.1 The policy and procedure will be reviewed after 3 years or at the request of management or staff side or more frequently if employment legislation dictates.

If you want to find out more…

At any stage, you can seek further advice by accessing the user guide or contacting ConSultHR :

- **Telephone 01793889417**
- **email consulthr.cscsu@nhs.net**

Appendix L

ConSultHR

NHS
Central Southern
Commissioning Support Unit

Harassment & Bullying Policy

We are committed to creating a work environment free of harassment and bullying for all employees, where everyone is treated with dignity and respect and protected from harassment, intimidation and other forms of bullying at work. Harassment and bullying at work in any form is completely unacceptable and will not be tolerated so any allegation of bullying and harassment will be investigated and, if appropriate disciplinary action will be taken.

We recognise a decision to make an allegation of bullying, harassment is not taken lightly, and we will not tolerate victimisation of anyone that takes this significant step.

This policy applies to everyone who works in the CS CSU or client organisation.

Harassment is:
Unwanted conduct considered objectionable by the recipient because it causes them humiliation, offence and distress (or other detrimental effect) on an isolated or a repetitive basis:

- **Physical contact –from touching to serious assault,**
- **Verbal – unwelcome remarks, suggestions and propositions, malicious gossip, unacceptable jokes and banter, or offensive language**
- **Non-verbal – gestures, intimidation, or aggressive behaviour, offensive literature or pictures, graffiti and computer imagery, isolation, non-co-operation or exclusion from social activities**

Bullying is:
Unacceptable behaviour as perceived by the employee, which subjects the individual to:

- **Unwelcome attention, intimidation, humiliation, ridicule, or violation of an individual's dignity.**
- **Offensive, intimidating, malicious, abusive, or insulting behaviour.**
- **Abuse of power or unfair sanctions which makes the recipient feel upset, threatened or vulnerable.**
- **Deliberately undermining a competent employee by imposing unreasonable workloads or frequent unjustified criticism.**

Victimisation is:
Unfair or less favourable treatment of a member of staff because he / she made a complaint in good faith

All are addressed in this policy:

1) PRINCIPLES:

1.1 This policy is to prevent and reduce all forms of offensive behaviour, whether it is unlawful or not.

1.2 It is the recipient's perception that determines what 'harassing behaviour' is to them and not the motives of the perpetrator that will be the determining factor. Therefore, behaviour, acceptable in one context, can be perceived as harassment in another.

1.3 Harassment can be carried out by individuals or groups and can equally be directed at individuals or groups, whether colleagues or subordinates, managers or supervisors. It can refer to an isolated incident or repeated actions.

1.4 Complaints of harassment and bullying are handled sensitively and speedily with recourse to formal procedures only where this is necessary. Everything about your concern is treated in the strictest confidence and only released to people authorised to receive this information.

1.5 Alleged perpetrators will be made aware of the impact of their behaviour, whether intentional or not, and given an opportunity to correct their behaviour. In the most serious cases, disciplinary action up to and including dismissal may be necessary.

1.6 Intimidation, retaliation or victimisation of anyone making a complaint or of anyone providing evidence is totally unacceptable and regarded as a disciplinary offence.

1.7 If an allegation of harassment or bullying is against a recognised trade union representative, the Trade Union's Regional Officer must be informed. The trade union representative is entitled to be represented throughout the process by the Regional Officer.

PRINCIPLES (cont)

1.8 No employee will be victimised for making a complaint of harassment and no manager shall threaten either explicitly or implicitly that an employee's complaint of harassment will be used as a basis for decisions affecting that employee. Such conduct is treated as a serious disciplinary offence.

1.9 Managers and employees alike should note that the organisation's liability may extend to both "official" and "unofficial" social activities. These may be deemed an extension of the workplace. The organisation may have a duty of care in respect of such matters and will investigate all complaints of inappropriate or improper conduct whether they are alleged to have occurred in or outside the workplace

1.10 Employees are responsible for their own behaviour. They should act at all times in accordance with the Organisation's Values. However, the behaviour of people in the workplace can vary on a daily basis. Employees who normally appear civil can occasionally appear impatient or pre-occupied. This policy and procedure is not intended to deal with occasional lapses of good manners unless a pattern of behaviour emerges that is perceived to be offensive or intimidatory.

1.11 Everyone involved will take steps to eliminate unlawful discrimination, promote equality of opportunity, and provide for good relations between people of diverse groups. The following characteristics are protected by the Equality Act (2010); age, disability, gender, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, and sexual orientation, in addition to offending background, trade union membership, or any other personal characteristic.

2) ROLES & RESPONSIBILITIES

Senior Executives

2.1 Senior Executives is the generic term for The Chair of the Board, Chief Executive, Accountable Officer and Managing Director and they will:

2.1.1 Promote a culture of dignity and respect that welcomes the opportunity to address and resolve concerns.

2.1.2 Respond positively to any escalated concerns and either take or arrange appropriate action.

Senior Managers

2.2 Senior Managers is the generic term for Heads of Function, Associate Directors, and Directors. They will:

2.2.1 Promote this policy, to ensure its effective implementation.

2.2.2 Ensure that all line managers understand their responsibilities for confidentiality and action and that they receive appropriate training.

2.2.3 Ensure consistency of approach.

Line Managers

2.3 Line Managers will:

2.3.1 Actively and regularly bring this policy to the attention of all staff in order to promote its aims, ensuring that staff are aware of their responsibilities and the expectations of behaviour.

2.3.2 Ensure that their own behaviour is beyond reproach and act in ways to maintain the dignity of all staff – particularly when managing issues of poor performance or conduct.

2.3.3 Be responsive and supportive to any member of staff who may raise concerns regarding harassment, bullying or victimisation.

2.3.4 Ensure that all complaints are taken seriously and dealt with promptly, sensitively and confidentially.

2.3.5 Take reasonable steps to ensure no further harassment problems or victimisation occurs after a complaint is raised.

Staff

2.4.1 Contribute to a working environment in which the dignity of others is respected, regardless of any differences.

2.4.2 Be prepared to adjust behaviour if it is brought to their attention that it is unwanted or offensive.

2.4.3 Support colleagues who are victims of harassment and report incidences witnessed.

Conduct themselves in a manner that does not demonstrate harassing or bullying type behaviour

ConSultHR

2.4 The role of **ConsultHR** is to:

2.4.1 Provide advice and guidance to everyone on the application of this policy through **ConsultHR** and to support the manager.

3) PROCEDURE

3.1 Harassment, bullying or victimisation may be addressed using either Informal or Formal procedures.

3.2 Any complaint should be made **within 3 months** of the most recent alleged incident. We will then seek to resolve the issue as speedily as possible.

3.3 Confidential advice on how to proceed can be obtained from Managers, ConSultHR, or Trade Union Representative.

3.4 The outcome of an investigation under the Formal procedure will usually be completed **within 2 months.**

Informal Procedure

3.5.1 Complainants should seek to inform the alleged harasser that their behaviour is unwelcome, either individually or with the support of a colleague or Trade Union representative.

3.5.2 Should the unwelcome behaviour continue, complainants should inform their line manager.

3.5.3 The line manager should address any complaint **within 7 days**.

3.5.4 The line manager should gather further facts – NOT begin a FORMAL investigation - in order to discuss the issue again with the complainant and agree a course of action to resolve the unwelcome behaviour.

3.5.5 If the alleged harasser is the complainant's line manager, then their manager should be informed.

3.5.6 If the unwelcome behaviour continues or if the complainant is dissatisfied with the outcome, they can then escalate the matter through the Formal procedure by completing Appendix 1 (found in the User Guide).

Formal Procedure

3.6.1 The Formal procedure should be activated by completing appendix 1 (User Guide).This should occur when the Informal procedure has failed to resolve the issue or where the complaint is sufficiently serious that it warrants a Formal investigation.

3.6.2 Both the complainant and the alleged harasser have the right to be accompanied at all formal investigation meetings by a Trade Union representative, or workplace colleague.

3.6.3 If the line manager decides that the formal procedure will be used, based on their initial fact-finding, then contact between the individuals involved should be minimised. This could be by a temporary transfer of one party to another site or exceptionally by special paid leave for one party. Suspension is only authorised by a senior manager and is used as a final option; it will be made clear that this is not a presumption of guilt.

3.6.4 A suitable manager with no previous involvement in the case will be appointed to investigate the matter. The Investigating Manager should be of the same or higher level of seniority as the complainant's line manager AND be from a different work area OR management team.

3.6.5 The outcome of the investigation should normally be shared with the complainant **within 2 months.**

3.6.6 Once a complaint has been made, counter allegations or complaints may arise and should be dealt with strictly in the order in which they are made. Counter allegations should be dealt with separately unless directly and demonstrably relevant to the case.

3.6.7 If the investigation finds 'no case to answer', verbal feedback followed by a confirmation in writing will be given to all individuals concerned in the case.

The focus will then be on developing an action plan to ensure effective future working arrangements and relations (e.g. through mediation, provision of appropriate training, or exceptionally separating the parties etc), which should include arrangements for review. The relevant senior manager will make any such decision with full consideration of all factors including the needs of the service.

3.6.8 If after investigation there is 'a case to answer', the Investigating Manager as above may consider:

- Whether the issue will be resolved through counselling, training, or some other action plan.
- Whether re-deployment of one or several of the individuals involved may resolve the issue.
- Whether the complaint needs to be dealt with through the Disciplinary Policy.

3.6.9 Should the complaint require action under the Disciplinary Policy, then copies of all statements made during the investigation will be made available to the alleged harasser and the complainant.

4) AFTER FORMAL INVESTIGATION:

4.1 Line managers must ensure the member of staff who has raised the complaint is not treated less favourably than other staff.

4.2 If after the investigation there is a reasonable belief that the complaint has been malicious in nature, then disciplinary action may be taken against a complainant.

4.3 Where a member of the medical staff, nursing or other professional staff is found to have been involved in a case of harassment or bullying, they may be reported to the General Medical Council or Nursing and Midwifery Council, or other relevant professional organisation.

5) MONITORING AND REVIEW:

5.1 Several confidential methods will be used to meet defined organisational needs to ensure that the Policy is implemented correctly and reviewed regularly:

- Using the case management system in HR
- Through staff support service reports
- The annual attitude survey
- The annual Equality and Diversity reports,
- Reports on the service are compiled on a monthly basis and communicated managers.
- Statistics are monitored to enable trend analysis and interventions to be planned as appropriate.

5.2 Where a member of ConsultHR is involved, either formally or informally, in advising either a member of staff or a manager, the incident will be recorded anonymously by type (sexual, racial, bullying, other), Directorate and whether the action being taken is formal or informal.

5.3 The policy and procedure will be reviewed after 3 years or at the request of management or staff side or more frequently if employment legislation dictates.

If you want to find out more…

At any stage, you can seek further advice by accessing the user guide or contacting ConSultHR :

- **Telephone 01793889417**
- **email consulthr.cscsu@nhs.net**

Appendix M

ConSultHR

NHS
Central Southern
Commissioning Support Unit

Sickness Absence Policy

A high level of sickness absence poses a serious problem for everyone and it is important that we manage this in a way that allows our services to run effectively, whilst at the same time providing a compassionate response to the ill health of individuals.

We aim to reduce rates of sickness absence by ensuring that a healthy workplace exists. We encourage a culture which provides sympathetic and practical support but does not tolerate abuse of the sick leave provisions.

This policy applies to everyone who works in the CS CSU or client organisation.

Sickness absence is:

There are many different types of sickness absence, which can be:

- **Long term**
- **Persistent short term**
- **Intermittent short term**
- **Absence related to disability**

Which are all addressed in this policy:

1) PRINCIPLES:

1.2 The process will be fair and consistent with all decisions made objectively.

1.3 We will encourage anyone who fails to reach agreed attendance standards to improve to an acceptable level of attendance.

1.4 We will monitor and review absence on a regular basis to proactively deal with issues because we believe that early intervention, supportive measures, regular case management and good communication are essential for managers to manage sickness absence effectively.

1.5 We have a legal duty not to discriminate against staff with impairments and to make reasonable adjustments to enable them to work. When managing absence, we refer to the Disability Discrimination Act (DDA). (See Appendix VIII)

1.6 The Organisation has the right to dismiss you whilst you are receiving sick pay entitlement as long as all other due processes are exhausted.

1.7 You and your manager will make every effort to minimise absence and facilitate your earliest return to work whilst assuring that your health is not adversely affected.

1.1 Everyone involved will take steps to eliminate unlawful discrimination, promote equality of opportunity, and provide for good relations between people of diverse groups. The following characteristics are protected by the Equality Act (2010); age, disability, gender, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, and sexual orientation, in addition to offending background, trade union membership, or any other personal characteristic.

2) ROLES & RESPONSIBILITIES

Senior Managers

2.1 Senior Managers is the generic term for Heads of Function, Associate Directors, Directors and Accountable Officers and they will:

2.1.1 Promote this policy and ensure its effective implementation, investigating high levels of sickness when highlighted as indicated in 1.3.

2.1.2 Ensure that all managers understand their responsibilities for action, confidentiality and receive appropriate training.

2.1.3 Ensure consistency of approach.

2.1.4 Be designated as the officer empowered to dismiss (this may be exceptionally designated to their deputy).

Line Managers

2.2 Line Managers are responsible for:

2.2.1 Highlighting any absence due to injury, disease or health condition attributable to their employment if it causes authorised sickness absence or phased return to work with reduced or no pay as specific arrangements will apply as detailed in the NHS Terms and Conditions Handbook.

2.2.2 Ensuring absence is promptly and confidentially recorded and that all statements of fitness for work (fit notes) and self-certificates are sent to Payroll promptly. State the staff employee number on all documentation and timesheets; explain any return to work arrangements.

ROLES & RESPONSIBILITIES (cont)

2.2.3 Ensuring staff are aware of their responsibilities for communicating with their Manager about their absence. Arrange the receipt of fit notes and self-certificates provided by staff before sending to payroll.

2.2.4 Conduct return to work interviews as required and make occupational health referrals when required and/or advised by ConSultHR.

2.2.5 Ensuring that sickness absence records of staff are reviewed regularly and take appropriate follow-up action including advising if half pay or nil pay is due.

2.2.6 Ensuring that disability related absence is reviewed regularly in the light of obligations to make reasonable adjustments.

2.2.7 Communicating to all staff the financial costs and impact on colleagues of sickness absence, including key targets and milestones and review triggers.

2.2.8 Maintaining contact with staff who are absent on long-term sickness in a sensitive manner and to an extent that is reasonable in the circumstances; examples could include telephone contact or home visits as needed.

2.2.9 Ensuring that staff who have been absent due to sickness are contacted on each occasion on their return to work and that return to work discussions are carried out in a sympathetic way and documented (see User Guide).

2.2.10 Contacting Occupational Health Service (OHS) via the established process, and using this service to seek early guidance.

2.2.11 Ensuring the person concerned is made fully aware of the reasons for referral to the OHS and, wherever practicable acting upon advice on sickness absence issues from the OHS and Ask HR as appropriate. Staff will sign the referral to the OHS.

2.2.12 Reviewing a range of options, which can support and facilitate staff in the workplace and aid return to work programmes. In determining what action is possible as a result of the advice on a fit note, managers must consider whether a revised workplace risk assessment is required and to keep it under review (See User Guide)

2.2.13 Ensuring that Payroll is notified as soon as possible when staff are absent from work due to an accident or industrial disease.

2.2.14 Ensuring that the Health and Safety Executive is notified in line with RIDDOR (Reporting of Injuries, Diseases, Dangerous Occurrence Regulations) and organisational reporting procedures (please refer to relevant Health and Safety policies).

Staff

2.3 When sick, staff will:

2.3.1 Be aware of and abide by the policy for the notification and certification of sickness absence. You must notify your line manager via the local process as far in advance of your start time as is possible and always within the first hour of your expected time of arrival. Failure to comply will result in the absence being recorded as unpaid absence.

2.3.2 Attend the OHS when so requested.

2.3.3 Not unreasonably withhold consent to allow the OHS to contact your GP or specialist when necessary.

2.3.4 Undertake work on reduced hours or in an alternative capacity, for rehabilitative purposes, where recommended by the OHS and can be arranged by your line manager.

2.3.5 Attend meetings relating to your sickness absence with managers as far as reasonably practicable in the workplace or, with your agreement, at home.

2.3.6 Report any sickness occurring during your annual leave to your line manager reported as soon as reasonably practicable (in line with normal reporting procedures). You will be required to produce a statement of fitness for work (fit note) or self-certificate (see User Guide) regarding this absence.

2.3.7 Not be entitled to an additional day off if sick on a statutory holiday.

2.3.8 If you are sick while you are abroad, provided you have a valid medical certificate from the country in which you are unwell, the normal rules for payment of SSP will apply.

2.3.9 Have the right to be accompanied by a Trade Union representative or a workplace colleague, and this is confirmed in correspondence, when managers arrange formal meetings regarding sickness absence. This includes those occasions when it is necessary to visit you at home. Details of sickness absence to be discussed will be made available.

2.3.10 Have an obligation not to undertake any other work or other activity whilst off sick that either hinders or is detrimental to your return to work, as this is usually considered as misconduct or fraudulent activity. Each case is unique and considered individually.

ConSultHR

2.4 An appropriate ConsultHR representative will:

2.4.1 Provide information relating to sickness absence, including in terms of frequency and levels of absence, for individuals and whole departments regularly as required as well as responding to individual requests. This is facilitated through HR Business Partners.

2.4.2 Provide advice and guidance to everyone through **ConsultHR**, encouraging consistent and fair management of sickness absence.

2.4.3 Advise on the handling of individual cases as appropriate.

2.4.4 Support managers in close liaison with the OHS in adopting a range of options that can facilitate a healthy workplace and aid return to work programmes.

2.4.5 Record advice about individual sickness absence cases on the HR Case Management System and provide agreed absence data.

The Occupational Health Service (OHS)

2.5 The OHS will:

2.5.1 Provide a confidential, independent medical opinion on matters relating to employment and health. Managers will normally refer staff to the OHS but staff can also self-refer on a confidential basis and the report only goes to the manager if the individual consents. The referring manager receives the occupational health assessment. Disclosure of medical details requires the individual's consent. The individual has a copy of the assessment.

2.5.2 Determine when further medical advice is necessary, whether this be from a GP or specialist. The OHS takes responsibility for seeking these reports.

2.5.3 Provide expertise for employee assessment and workplace assessment; also support for stress and mental and psychological health problems as far as reasonably practicable.

2.5.4 Provide advice to managers on the potential impact of issues relating to compliance with DDA.

The Payroll Department

2.6 The Payroll provider will:

2.6.1 Ensure that sickness absence dates and reasons for absence are recorded and maintained accurately and promptly on receipt of notification of absence.

2.6.2 Notify any member of staff and their Line Manager/ **ConsultHR**, when that member of staff enters half or nil occupational sick pay, prior to this occurring.

2.6.3 Ensure that sick pay entitlements are in accordance with the Agenda for change Terms and Conditions of Service Handbook.

3) PROCEDURE

What to do if you are unwell

3.1 **Notification/Certification of Absence**

3.1.1 If you are absent due to ill health you **must** inform your immediate supervisor or manager in the required manner. Notification of your absence by a third party is only acceptable in extreme circumstances when you are incapable of doing so.

3.1.2 In addition to this initial notification, you must give your line manager an indication of the anticipated return date. You must notify the manager immediately if you are not able to return on the previously stated date or if you intend to return on an earlier date. This will help the manager organise the department to minimise any disruption to services and to your colleagues.

3.1.3 On return to work you will be required to complete the 'Return to Work Discussion Record' (See User Guide) with your manager

3.1.4 If you are off sick for a period of up to seven calendar days you must provide your manager with a self-certificate, which will support the return to work discussion (see User Guide).

3.1.5 If you are off sick for a period of more than seven calendar days you must provide your manager with a statement of fitness for work (fit note) signed by a medical practitioner. This must be dated no more than four days after the seventh calendar day of absence and cover the period from the 7th day of absence. You must send this to your manager during the second week of your absence.

3.1.6 If the period of absence extends beyond that stated on the fit note, a new one will be required, which must cover continuous dates and must be provided within four days of the expiry of the old fit note.

3.1.7 If your doctor has advised that you 'may be fit for work' on your fit note, and your manager cannot make the adaptations or adjustments to facilitate a return to work, the reasons for this will be explained to you. This fit note will then be used as if the doctor had advised 'not fit for work'. Sick pay will continue. In this case, you do not need to return to your doctor for a new statement to confirm this until the end of statement period as stated on the form. On the date the note expires, you need another form.

3.1.8 In some cases, your manager may require you to provide a fit note from the first day of absence. This may be particularly appropriate if you are subject to formal attendance management processes. You can reclaim the cost of any such 'fit note'.

3.1.9 If you fail to notify your sickness absence you will be considered to be absent without leave, and therefore without pay. Your manager will need to take the steps set out in the User Guide in conjunction with **ConsultHR**.

Types of Sickness Absence

3.2 **Short Term Sickness**

3.2.1 An episode is an unbroken period of sickness absence and includes instances where a member of staff becomes unwell and goes home part of the way through a day.

3.2.2 In managing short-term sickness, managers are not questioning whether the sickness related absence is genuine, rather that the level of absence is unacceptable, particularly in cases where a member of staff appears to take leave regularly because of sickness without an identified underlying problem. (If the absence is due to disability, this is taken into account in the recording of the absence and the application of this policy.)

3.2.3 Managers must ensure that the reasons for the sickness absence are discussed on every occasion a member of staff returns from a period of sickness absence, irrespective of frequency. Care is needed to ensure that this is handled in a sympathetic and supportive manner, and it may be appropriate to offer referral to the OHS, counselling service, or other relevant service for advice and support.

3.3 **Persistent Short Term Sickness**

3.3.1 In line with the absence management 'triggers' in force at the time your manager will review your sickness record (see User Guide). The return to work discussion form should be completed and signed, before you are provided with a copy.

3.3.2 At this return to work interview, your manager will discuss the level of your absence, taking account of previous periods of sickness absence. See 3.2.2. A letter of concern about your level of absence is issued at this stage, if appropriate.

3.3.3 At this stage, it may be appropriate to refer you to the Occupational Health Service for an assessment. Your manager will meet you again after receiving an OHS report. If there are underlying issues, OHS will advise on appropriate action/support. This may come under the Disability Discrimination Act. Also, it may be necessary to review the working pattern, hours, or other duties that could enable you to reduce your sickness absence.

3.3.4 Where the OHS indicates there are no underlying conditions requiring further action your manager will continue to review your attendance.

3.3.5 If there is further sickness, the manager will refer to the absence management 'triggers' to inform their next steps. Those absences related to underlying conditions are considered on an individual basis, and may preclude Stage 1 being invoked at this point.

Formal Procedural Stages

3.4 **Stage 1**

3.4.1 A meeting is arranged with you and you have the right to be accompanied by a Trade Union representative, or workplace colleague. Notification of the meeting is provided to you in writing, with at least 7 **days**' notice, and a copy of this procedure will accompany the letter to you.

3.4.2 The letter will provide a clear explanation of where you have not met the required attendance standards. Any supporting documentation, including a copy of the Sickness Policy and User Guide and dates of sickness absences is enclosed.

3.4.3 The meeting will provide you with the opportunity to comment on your attendance, and the up-to-date Occupational Health report where appropriate, to indicate what you need to assist in improving your attendance.

3.4.4 The manager will identify with you, the improvement required with you by agreeing an Attendance Improvement Plan with reasonable targets included. A review date will be set, which would normally be six months following a Stage 1 meeting but may be earlier where appropriate.

3.4.5 Your manager will provide any appropriate support that may assist your improved attendance.

3.4.6 Your manager will inform you of the possible consequences of failure to meet your Attendance Improvement Plan.

3.4.7 Agreed written records of the meeting and Attendance Improvement Plan is kept, a copy of which is provided to you and your representative.

3) PROCEDURE (contd)

3.4.8 At the agreed date, if attendance has reached a satisfactory level, or if satisfactory improvement is shown, you will be informed and encouraged to maintain this level of attendance. This is confirmed in writing to you and your representative. Should there be no further cause for concern during the next 12 months then the problem is considered resolved.

3.5 **Stage 2**

3.5.1 If a satisfactory improvement has not been achieved, by the Stage 1 review date, an up-to-date Occupational Health report will be obtained. This report is made available to your manager, who must seek advice from **ConsultHR**. A Stage 2 meeting is arranged with you, and you have the right to be accompanied by your Trade Union representative, or a workplace colleague. Notification of the meeting is provided to you in writing with at least **7 days**' notice.

3.5.2 The letter will provide a clear explanation of where you have not met the required Attendance Improvement Plan and will enclose any supporting documentation, including dates of sickness absences and up-to-date Occupational Health report.

3.5.3 At the meeting, your manager will:

- Allow you to comment and provide an explanation
- Seek to reach an agreement with you on a further Attendance Improvement Plan with reasonable targets included, time period and review date for meeting this.
- Discuss with you your working patterns and anything else that could enable you to reduce your sickness absence.
- Provide further support and advice to assist you to meet your Attendance Improvement Plan.
- Confirm that failure to reach a satisfactory level of improvement will lead to a further, formal meeting with a Senior Manager, which could result in dismissal.

3.5.4 If attendance has reached a satisfactory level, or if satisfactory improvement is shown, you will be informed and encouraged to maintain this level of attendance. This is confirmed in writing to you. Should there be no further cause for concern during the next 12 months; the problem is considered resolved.

3.6 **Stage 3**

3.6.1 Where standards of improvement are not achieved, following the appropriate period, a Senior Manager at least one level above you will invite you to a hearing. The senior manager will be assisted by another manager and a ConsultHR representative because the outcome has the possibility to be dismissal.

3.6.2 You have the right to be accompanied by a Trade Union representative or a workplace colleague.

3.6.3 The letter of invitation will provide at least 7 days' notice, an up to date occupational health report (if appropriate) a clear explanation of where you have not met the required standard, and include any supporting documentation/ evidence. The manager who has addressed the issues of poor attendance at Stage 2 will prepare a summary report with relevant documentation for the Senior Manager. A copy will be sent to you and your representative, with letter of notification together with an up-to-date Occupational Health report.

3.6.4 The failure to meet satisfactory standards is discussed at the meeting, and you will be provided with the opportunity to comment.

3.6.5 The Senior Manager will consider the following options:

- Further time for improvement. If further time is allowed, the Senior Manager will provide you and your representative with formal confirmation of the corrective action and the agreed period in writing. It will also be confirmed if failure to reach a satisfactory standard of improvement could lead to a further review of your working time or dismissal.
- Review of your working pattern/changes in your hours/changes in duties that could enable you to reduce your sickness absence. (Issue of pay protection should be considered on an individual basis)
- Dismissal

3.6.6 If you are dismissed you will be given the right of appeal in your final letter. This will be to a formal panel established in accordance with the Appeals Procedure.

Other Sickness Absence

3.7 **Long Term Sickness**

3.7.1 You are on long-term sickness when it is known that an absence is likely to last for a period of 4 weeks or more, or where a period of 4 weeks has elapsed since the start of the absence.

3.7.2 If they have not already done so, your manager should seek advice after 4 weeks sickness absence by contacting OHS to seek advice and the appropriateness of a full referral. An action plan is agreed between the OHS advisor and your manager.

3.7.3 If a full referral has been made, your manager should always meet you to discuss the outcome and recommendations of the OHS. You will be reminded of your right to be accompanied at all stages of the process.

3.7.4 At 8 weeks of sickness, your manager will review the action plan and seek further advice. The OHS will consider whether restricted duties or alternative work would enhance the rehabilitation process, and may recommend some form of redeployment (see next section below). It is important to consider a range of options to facilitate a speedy return to work where appropriate.

3.7.5 Where your manager is informed that you are entering half pay, your manager will review the action plan with **ConsultHR** and notify you.

3.7.6 The Senior Manager has the discretion to extend the period of sick pay on full or half pay in exceptional circumstances after taking appropriate HR advice.

3.7.7 Where your manager believes that you will be unable to return to work due to sickness absence, or in reasonable time before you enter nil pay, a full referral involving the OHS must be arranged. You, your manager and OHS need to be aware of the difference between a medical follow-up of an ongoing problem, and a final medical review for the purposes of assessing whether a member of staff is fit or otherwise to return to work before the expiry of their pay (see also para 3.7.9)

3.7.8 It may be appropriate at this stage to consider ill health retirement options in discussion with the OHS and **ConsultHR** (HR Representative) and the appropriate senior manager.

3.7.9 In the event of failure of the organisation to undertake a final sickness review meeting (as highlighted in 3.7.7 above), then the following will apply:

- Sick pay for those who have exhausted sick pay entitlements should be reinstated at half pay, after 12 months of continuous sickness absence, in the following circumstances:

  - Staff with more than 5 years reckonable service – sick pay is reinstated if sick pay entitlement is exhausted before a final review meeting for long-term absence has taken place.
  - Staff with less than 5 years reckonable service – sick pay will be reinstated if sick pay entitlement is exhausted and a final review does not take place within 12 months of the start of their sickness absence.
  - Reinstatement of sick pay should continue until the final review meeting has taken place. Reinstatement of sick pay is not retrospective for any period of zero pay in the preceding 12 months of continuous absence.

3.7.10 Staff will accrue leave entitlement as determined by the Agenda for Change Terms and Conditions of Service Handbook. Manager are asked to note that staff absent due to long term sickness must carry forward their full Working Time Regulations entitlement of annual leave (28 days inc Bank Holidays pro rata) into a new leave year.

Mixed short and long sickness absence

3.8 There may be circumstances where your absences mix both short and long-term sickness, without actually triggering management action under the appropriate sections above. In such circumstances, it will be the number of absences that will commence management action, and the process for managing short-term absence is used. However, your manager will still be required to take sympathetic account of absences caused by long-term conditions.

4) REHABILITATIVE REDEPLOYMENT

4.1 An outcome of referral to the OHS may be a written recommendation that you will cease to be on sick leave and will return to work temporarily in another capacity. If advice is received directly from a general practitioner or specialist, this can be discussed with the Special consideration will also be given to any effect on incapacity benefit that you receive. To aid rehabilitation we have discretion to allow you to return to work on reduced hours which may include working from home. Any such arrangements need to be consistent with Statutory Sick Pay rules.

4.2 **Reduced Hours** – Where you return on reduced hours you will receive payment for the hours actually worked, provided that this is not less than you would have received had you remained on sick leave. This return to work must be seen as a temporary reduction in hours, undertaken on medical advice and will be for a finite period, usually of not more than one month (unless medical advice exceptionally indicates a longer period) and may be phased. At the conclusion of this period you must return to full duties unless agreement is reached with your manager to the contrary.

4.3 **Alternative work -** You may return to work for rehabilitation on restricted duties, reduced responsibility or in a supernumerary capacity. If your manager cannot accommodate you, by agreement you may be placed in another department. However, in these circumstances the manager of the department to which you are contracted will continue to pay your salary. After normal sick pay has expired you will receive payment for the hours undertaken at the band worked. Employment on a reduced responsibility basis or in a supernumerary capacity will also only be undertaken for a finite period to assist in rehabilitation. At the conclusion of this period you just return to full duties unless agreement is reached with your manager to the contrary.

5) PERMANENT REDEPLOYMENT

5.1 The organisation is committed to making every effort to support you if you're unable to continue in your existing role through health or disability. Prior to considering termination of your employment, your manager will explore the following in discussion with **ConsultHR.**

5.1.1 Under the Disability Discrimination Act 1995, managers have a duty to make any reasonable adjustments to an existing post that would assist someone who develops a disability to overcome their difficulties in work. This may include adjustments such as modifications to the hours or duties of the post, as well as to equipment or premises. In all cases advice should be sought from the OHS and **ConsultHR** (see User Guide).

5.1.2 A member of staff must also be considered for permanent redeployment to alternative work. Although the organisation has no obligation to create alternative work, managers will consider sympathetically any request to provide alternative work in another established vacancy. In addition, where alternative posts can accommodate reasonable adjustments, enabling a disabled member of staff to continue working, managers have a duty of care to undertake these adjustments. In all cases, advice is sought from the OHS.

5.1.3 Permanent redeployment may be available to you where such action is recommended by the OHS, and is agreed between you and your manager.

5.1.4 If a potentially suitable vacancy is identified, OHS advice will ensure that the post is appropriate.

5.1.5 If you accept a suitable post at a lower grade, you will retain your previous level of basic pay (increments and annual pay rises) for one year, and before moving to the established rate for the job. The excess cost is funded by the original department'. You should seek further information and advice with regard to the impact on your pension. ConsultHR will provide contact details for the Pensions department.

5.1.6 If you accept a post on the same grade but on reduced hours, you will receive payment protection of your previous hours for one year, and before moving to the established rate for the job. The original department funds the excess cost.

5.1.7 Where you accept a lower graded post with reduced hours, you can choose whether to accept protection of either your previous pay or hours.

5.1.8 If no suitable post is identified, or you do not accept a post deemed suitable, this could result in the termination of your contract of employment. You will have the right of appeal in these circumstances.

6) UNABLE TO WORK IN ANY CAPACITY WITHIN THE ORGANISATION

6.1 Where the OHS confirms that you are permanently unable to return to work in any capacity, the HR representative will arrange for ill health pension retirement forms to be sent to you if appropriate. At the agreed date of termination, you are paid for any outstanding annual leave and will receive in lieu a sum equivalent to contractual notice.

6.2 If you do not accept that you are unable to return work, or where exceptionally serious differences of views arise, an independent OH assessment may be undertaken. In such circumstances, we use an external Occupational Health Doctor arranged by the ConSult representative.

7) TERMINATION OF EMPLOYMENT

7.1 Unfortunately, in situations where there is little likelihood of your return to the required performance level, the organisation will consider terminating your employment. Unless the OHS indicates you are likely to return to work within three months of your sick pay ending, an appropriate manager will work through the procedure shown below. Please note that a dependent on all the information available, a manager can decide to use this procedure whilst an employee is still in receipt of sick pay.

7.1.1 Staff will be invited to a meeting with an appropriate manager and ConsultHR (HR Representative) at which the decision to terminate the contract of employment will be communicated. ConsultHR will ensure that employees are advised on where to receive appropriate information on any additional benefits to which they may be entitled.

7.1.2 In all cases where termination of employment is the outcome, the Senior Manager must endorse and confirm in writing the termination of a contract of employment on the grounds of ill health. In law, this is a dismissal, whether or not the employment is terminated by mutual consent. In all cases, it will be necessary to show that there has been an ongoing review of the situation, which the member of staff has been consulted on their future (in the case of long-term sickness, this should include their prognosis), given the opportunity to discuss the intended actions, and considered for alternative work. Seek advice from **ConsultHR** and an up-to-date medical opinion from the OHS obtained within **three months** prior to the date of termination.

7.1.3 Anyone on long-term sickness whose service is terminated with or without their agreement will be given the right of appeal in their final letter. This will be to a formal panel established in accordance with the Appeals Procedure.

7.1.4 Where it is known that staff will not be able to return to work and this is confirmed by medical opinion, the Senior Manager may consider making a payment to the member of staff for early termination of their contract of employment. This will normally only be permissible when a person enters half pay, and the amount to be paid will be the full entitlement to half pay, plus notice pay payable at full pay rates.

7.1.5 Staff on long-term sickness whose service is terminated, with or without their agreement, are entitled to the payment of their accrued holiday entitlement as described in the Agenda for Change Conditions of Service see para 3.7.10.

8) CONTACT WITH INFECTIOUS DISEASES

8.1 Staff who are exposed to an infectious or notifiable disease must notify their line manager immediately. Staff who are required by the organisation to refrain from work following such contact will be granted special leave with normal pay in accordance with their terms and conditions of employment. This will not be regarded as part of their annual leave entitlement or as sick leave.

8.2 No action must be taken either by staff or managers under the Management of Sickness Absence Procedure which might conflict with the need to protect patients and staff from cross-infection.

8.3 Unless a member of staff becomes ill with the infectious or notifiable disease in question, such leave will not be regarded as sick leave.

9) APPLICATION DISCIPLINARY PROCEDURE

9.1 Where a manager takes action because it seems an employee has abused the sickness provisions/arrangements, this is a matter of conduct managed via the Disciplinary Policy. This includes non-disclosure of a known health problem at the time of appointment, which would have precluded employment.

10) APPEALS

10.1 Any appeal in relation to the application of this policy is dealt with in accordance with the Appeals Policy.

11) REVIEW PERIOD

11.1 This policy will be reviewed after 3 years or at the request of either management or staff side.

If you want to find out more…

At any stage, you can seek further advice by accessing the user guide or contacting ConSultHR :

- **Telephone 01793889417**
- **email consulthr.cscsu@nhs.net**

Appendix N

Policies of the former Gloucestershire PCT recommended for adoption by the Gloucestershire Clinical Commissioning Group

Human Resources Policies (other than those appended separately)
Health, Safety and Environment Policies
Risk Management
Serious Incident
Incident
Compliments, Comments, Concerns and Complaints (4Cs)
Individual Funding Requests
Effective Clinical Commissioning Policies
Translating and interpretation
Patient Group Directions
Data Protection
Use of e-mail
Intellectual Property
Being Open
Information Governance Management System
Records Management
Freedom of Information
Information Lifecycle
Confidentiality audit
IT security
Data quality
Creation/filing of corporate records
Knowledge Management.

Appendix O

Healthcare contracts negotiated by the former Gloucestershire PCT being taken over by the Gloucestershire CCG

Provider Name	Type of Service	Description:
2GETHER NHS FOUNDATION TRUST	Mental Health / LD	MH & LD Services
Acorns Childrens Hospice	Community Health Services	Hospice Care Children
Active Assistance	Continuing Health Care	CHC - Individual Patient Plan
Alliance Medical Limited	Community Health Services	Direct Access Diagnostic Services (MRI)
Alzheimers Society	Community Health Services	Gloucestershire Dementia Advisor Services
Aspects 2 Ltd	Learning Disability (LD)	LD - Individual Patient Plan
Avon and Wiltshiire Mental Health Partnership Trust	Mental Health / LD	MH & LD Services
BMI Healthcare - Ridgeway Swindon and Bath	Acute	Acute Hospital Services
BMI Healthcare Limited - Ridgeway Hospital	Community Health Services	Direct Access Diagnostic Services (CT)
Care UK Specialist Medical Imaging Ltd	Community Health Services	Direct Access Diagnostic Services (Non-Obstetric Ultrasound)
Carers Gloucestershire - Advice & Advocacy	Mental Health / LD	MH & LD Carers Advice & Advocacy
Carers Gloucestershire - Care and Respite	Mental Health / LD	MH & LD Carers Care & Respite
Carers Gloucestershire - Community Hospital Support	Mental Health / LD	MH & LD Carers Community Hospital Support
Carers Gloucestershire - LD Support	Mental Health / LD	MH & LD Carers Support
Carers Gloucestershire - MH Support	Mental Health / LD	MH Carers Support
Circle Hospital Partnership (Bath)	Acute	Acute Hospital Services
Cleeve Hill Healthcare	Community Health Services	Community Health Rehabilitation
Cobalt Unit Appeal Fund	Community Health Services	Direct Access Diagnostic Services (MRI and CT)
Community Case Management Services Ltd	Continuing Health Care	CHC - Individual Patient Plan
Concordia Health Ltd	Community Health Services	Direct Access Diagnostic Services (Non-Obstetric Ultrasound)
Connect	Community Health Services	Stroke Befriending Service
Cotswold Care Hospice	Continuing Health Care	Hospice Care
Cotswold Medical Practice	Community Health Services	Intermediate Residential Care Unit
Diagnostic Health Systems Ltd	Community Health Services	Direct Access Diagnostic Services (Non-Obstetric Ultrasound)
Fairford Home Nursing	Continuing Health Care	Hospice Care
Global Diagnostics Ltd	Community Health Services	Direct Access Diagnostic Services (MRI and Non-Obstetric Ultrasound)
Gloucestershire Care Services	Community Health Services	Community Health Services
Gloucestershire Hospitals NHS Foundation Trust	Acute	Acute Hospital Services
Gloucestershire Young Carers	Mental Health / LD	MH & LD Young Carers Support
GP Care UK Ltd	Community Health Services	Direct Access Diagnostic Services (Non-Obstetric Ultrasound)
Great Oaks Hospice	Continuing Health Care	Hospice Care
Great Western Ambulance Service - 999	Ambulance	Ambulance 999
Great Western Ambulance Service (SWAST)	Ambulance	Ambulance Out of Hours Primary Care
Great Western Ambulance Service (SWAST)	Ambulance	Patient Transport (non Taxi)
Great Western Hospitals NHS Foundation Trust	Acute	Acute Hospital Services
Great Western Hospitals NHS Foundation Trust	Community Health Services	Direct Access Diagnostic Services (MRI, CT and Non-Obstetric Ultrasound)
Hadwen Medical Practice	Community Health Services	Looked After Children Initial Healthcare Assessment

Provider Name	Type of Service	Description:
Harmoni HS Limited	Other	NHS111 Contract
Heart of England NHS Foundation Trust	Acute	Acute Hospital Services
Inclusion Care	Mental Health / LD	MH/LD - Individual Patient Plan
Independent Health Group	Community Health Services	Hernia Procedures
InHealth Limited	Community Health Services	Direct Access Diagnostic Services (MRI, CT and Non-Obstetric Ultrasound)
Intermediate Surgical Services	Acute	Carpal Tunnel Assesment & surgery
Kates Home Nursing	Continuing Health Care	Hospice Care
Marie Curie	Continuing Health Care	Hospice Care
Marie Stopes International	Community Health Services	Vasectomy Services
North Bristol NHS trust	Acute	Acute Hospital Services
Nuffield Health - Cheltenham Hospital	Acute	Acute Hospital Services
Oxford Fertility Clinic	Acute	IVF Services
Oxford University Hospitals Trust	Acute	Acute Hospital Services
Paradise House - Novalis Trust	Learning Disability (LD)	LD - Individual Patient Plan
Prime Diagnostics Limited	Acute	Direct Access Diagnostic Services
Ramsay Health Care UK Operations Limited - The Winfield	Acute	Acute Hospital Services
Royal National Hospital for Rheumatic Diseases	Acute	Acute Hospital Services
Royal United Hospital, Bath	Acute	Acute Hospital Services
Severn Care	Mental Health / LD	MH/LD - Individual Patient Plan
SG Radiology and Associates Ltd	Community Health Services	Direct Access Diagnostic Services (MRI)
South Warwickshire NHS Foundation Trust	Acute	Acute Hospital Services
St Michaels Hospice	Continuing Health Care	Hospice Care
Stroke Association	Community Health Services	Stroke Club Service
Stroud Court Community Trust	Learning Disability (LD)	LD - Individual Patient Plan
Sue Ryder Care	Continuing Health Care	Hospice Care
Tetbury Hospital Trust Limited	Acute	Acute Hospital Services - Outpatients & Daycases
The Lawns	Learning Disability (LD)	LD - Individual Patient Plan
Thornbury Community Services	Continuing Health Care	CHC - Individual Patient Plan
Turning Point - The Willows	Learning Disability (LD)	LD - Individual Patient Plan
University Hospitals Bristol NHS Foundation Trust	Acute	Acute Hospital Services
Voyage Care	Learning Disability (LD)	LD - Individual Patient Plan
Worcestershire Acute Hosputals Trust	Acute	Acute Hospital Services
Wye Valley NHS Trust	Acute / Community	Acute Hospital Services

Agenda Item 8

Gloucestershire Clinical Commissioning Group
Governing Body

Meeting Date	**2rd April 2013**
Title	**Partnership Agreements between Gloucestershire CCG and Gloucestershire County Council (GCC) 2013/14**
Executive Summary	This paper provides details of the s256 and s75 agreements entered into by Gloucestershire CCG and Gloucestershire County Council in 2013/14.
Key Issues	Partnership agreements enable joint working to be further progressed between organisations and resultant benefits to be achieved.
Risk Issues: **Original Risk** **Residual Risk**	These budgets total £97.5m and are a significant proportion of the CCG's budget. Monitoring of agreements needs to be robust in order to ensure that the outcomes anticipated are being obtained.
Financial Impact	The budgets included total £97.5m and are a significant proportion of the CCG's budget. Monthly financial monitoring will be produced in order to ensure that risk issues are identified early.
Legal Issues (including NHS Constitution)	N/A
Impact on Equality and Diversity	N/A
Impact on Health Inequalities	N/A
Impact on Sustainable Development	N/A

Patient and Public Involvement	N/A
Recommendation	The Board is asked to approve the partnership agreements.
Author & Designation	Cath Leech Chief Finance Officer
Sponsoring Director (if not author)	

Agenda Item 8

Gloucestershire Clinical Commissioning Group Governing Body

2nd April 2013

Partnership Agreements between Gloucestershire CCG and Gloucestershire County Council (GCC) 2013/14

1. Gloucestershire Joint Funding Arrangements

NHS Gloucestershire (NHSG) had joint arrangements with Gloucestershire County Council (GCC) of £136m. NHSG contributed £107m to these arrangements and GCC £29m. These arrangements covered a range of services including mental health, funding for specialist placements, some community services for adults and children and joint management arrangements.

The proposal for 2013/14 is that these arrangements are rolled forward with the appropriate changes relating to the changed commissioning environment and service variations. These arrangements will be reviewed periodically and updated to reflect agreed changes. A list of the partnership agreements is shown at appendix 1.

2. Section 256 Arrangements

Section 256 Agreements form part of the NHS Act 2006. They allow NHS organisations to make payments to Local Authority where the transfer of funds will secure more health gain than the equivalent expenditure of money in the NHS.

In 2013/14 there will be 23 section 256 agreements with a combined value of £16.5m, one agreement is currently being finalised and an update will be provided once complete. The majority of funds are allocated to re-ablement and joint funded placements.

3. Section 75 Agreements

Section 75 Agreements form part of the NHS Act 2006, and are a power available only to NHS and Local Authority bodies. They make provisions for NHS and local authority bodies to:

- Undertake each other's functions, i.e. in commissioning or provision
- Create pooled funds. These might be used for commissioning from a single pot or to integrate the resources of provision, i.e. some or all staff and their functions to be merged and delivered from within a single pool of service.

In 2012/13 Section 75 Agreements in place between NHSG and GCC were adult Mental Health, continuing health care and funded nursing care and for Child and Adolescent Mental Health.

In 2013/14 there will be a further 2 areas included in the Section 75 agreements. These are Carers and community equipment (previously S256 agreements).

All of these agreements are covered by an overarching governance framework that is supported by monthly monitoring by service area.

4. Reporting Mechanism

There is monthly finance and performance reporting to the Joint Commissioning Partnership Executive (JCPE). Membership of the JCPE includes the CCG senior officers, social services and public health and minutes from the JPCE will be reported to the GCCG Board.

5. Summary

During 2012/13 all of the partnership agreements were updated and refreshed by service managers and finance colleagues in NHSG and GCCG. This now means that these agreements have a detailed description of the service provided and measurable benefits that will be delivered by having the joint funding arrangements in place.

The Section 75 agreements have also been updated to reflect service changes with the providers covered by the agreement.

6. Recommendation

The Board is asked to approve the partnership agreements.

Appendix 1

Section 256 Agreements 2013/14

PCT Agreement Number	Service Areas	Proposed Agreement Values (2013/14)
	Joint Funding- Complex Care Packages	
1	LD JF	3,082,731
2	LD CHC	769,561
3	LD Private Placements (figure to be agreed)	
4	PD	103,507
	Sub-Total	**3,955,799**
5	**MDT Reablement**	**1,534,869**
	Joint-Commissioning Managers	
6	OP Joint Commissioning Manager Mgr	36,267
6	LD Joint Commissioning Manager	49,505
6	Lead Commissioner Children's Health + Secr'l Spt	54,009
	Sub-Total	**139,781**
	Additional Care Management Posts	
7	Care Manager- Tewkesbury Town Surgery	40,811
8	Sue Ryder-Palliative Care Social Worker	69,556
9	Dilke- Care Mgr	23,803
10	Social Worker- Charlton Lane	29,137
11	Marina Court- Therapy/ Wellbeing Co-ordinator	14,000
	Sub-Total	**177,307**
	Other Adult Services	
12	Carers Newspaper	7,908
	Sub-Total	**7,908**
13	**Joint Funded OT Post Falls Service**	**11,000**
14	**Joint Funding - Children's Agency**	**180,000**
	Children's Services	
15	Children with Disabilities Residential Services	237,932
16	James Hopkins	41,026
	Sub-Total	**278,958**
17	**Telecare**	**173,419**
18	**Home Improvement**	**25,000**
19	**Health Watch (new agreements for 2013/14)**	**90,000**
20	**NHS Funding for Social Care**	**9,055,000**
21	**DiP Workers (Department of Health funding)**	**203,000**
22	**Ashley House / Jubilee Lodge**	**513,000**
23	**Village Agents**	**162,000**

Total s256 Agreements with PCT (Commissioning)	**16,507,041**

s75 agreements

	Community Equipment Services Pooled Budget	**2,600,000**
	Carers S75	**1,061,000**
	Mental Health s75	**49,700,000**
	CAMHs	**6,200,000**
	Occupational therapy	**1,296,000**
	CHC and FNC s75 agreement	**20,275,000**

Total S75 agreements 2013/14	**81,132,000**

Total Partnership Agrements 2013/14	**97,639,041**