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About this document

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

The Constitution applies to the following, all of whom are required to adhere to it:

• the Group’s Member Practices;
• the Group’s employees;
• individuals working on behalf of the Group;
• anyone who is a member of the Group’s Governing Body (including the Governing Body’s Audit, Finance, Corporate Governance and Risk Committee and Remuneration Committee); and
• anyone who is a member of any other committee(s) or sub-committees established by the Group or its Governing Body.

Appendix A provides a definition of key descriptions used in this Constitution.
1. **Introduction and commencement**

1.1. **Name**

1.1.1. The name of this clinical commissioning group is NHS Surrey Downs Clinical Commissioning Group (“the Group” or “Surrey Downs CCG”).

1.2. **Statutory framework**

1.2.1. Clinical commissioning groups are established under the Health and Social Care Act 2012 (“the 2012 Act”). 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”). 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 3.3.

1.2.2. The NHS Commissioning Board (hereafter referred to as NHS England) is responsible for determining applications from prospective groups to be established as clinical commissioning groups and undertakes an annual assessment of each established group. 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.

1.2.3. Clinical commissioning groups are clinically led membership organisations made up of general practices. The member practices 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.

1.3. **Status of this Constitution**

1.3.1. This Constitution is made between the Member practices of the Group and has effect from the first day of April 2013 (with amendment dates as set out at the beginning of this document), when NHS England established the Group. The Constitution is published on the Group’s website at www.surreydownsccg.nhs.uk

1.4. **Amendment and variation of this Constitution**

1.4.1. This Constitution can only be varied in two circumstances.

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

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

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1 See section 11 of the 2006 Act, inserted by section 10 of the 2012 Act
2 See section 275 of the 2006 Act, as amended by paragraph 140(2)(c) of Schedule 4 of the 2012 Act
3 Duties of clinical commissioning groups to commission certain health services are set out in section 3 of the 2006 Act, as amended by section 13 of the 2012 Act
4 See section 14C of the 2006 Act, inserted by section 25 of the 2012 Act
5 See section 14Z21 of the 2006 Act, inserted by section 26 of the 2012 Act
6 See sections 14Z21 and 14Z22 of the 2006 Act, inserted by section 26 of the 2012 Act
7 See in particular sections 14L, 14M, 14N and 14O of the 2006 Act, inserted by section 25 of the 2012 Act and Part 1 of Schedule 1A to the 2006 Act, inserted by Schedule 2 to the 2012 Act and any regulations issued
8 See section 14D of the 2006 Act, inserted by section 25 of the 2012 Act
9 See sections 14E and 14F of the 2006 Act, inserted by section 25 of the 2012 Act and any regulations issued
1.4.2. If the Group wishes to amend the Constitution, this must be done by passing a Special Resolution, either through a written resolution or by special resolution at a Council of Members meeting.

1.4.3. If an amendment to the Constitution is passed the Group must then apply to NHS England for formal approval.

2. **Area covered**

2.1.1. The geographical area covered by the Group is provided in the map below.

2.1.2. The Group is made up of 31 GP practices in an area that goes across four local authority areas. It covers the boroughs of Mole Valley and Epsom and Ewell. It also covers the east part of Elmbridge and the Banstead area (part of Reigate and Banstead Borough Council).

2.1.3. A full list of constituent Super Output Areas is available in Appendix C.
3. **Membership**

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

3.1.1. The current membership of Surrey Downs CCG is given in Appendix B. Practices may be organised in geographical or other agreed commissioning localities as determined by the Member Practices.

3.1.2. Commissioning Localities shall have appropriate governance arrangements agreed with the Governing Body for membership and meetings, implementation of the Group’s strategy, and meeting and reporting in areas such as quality, finance and performance.

3.2. **Eligibility**

3.2.1. Providers of primary medical services within the Surrey Downs CCG Area to a registered list of patients under a General Medical Services, Personal Medical Services or Alternative Provider Medical Services contract, will be eligible to apply for membership of this Group.

3.3. **Application for membership**

3.3.1. No practice shall become a Member of the Group unless that practice:

a) is eligible to become a Member Practice in accordance with paragraph 3.2 above;

b) has confirmed its acceptance of this Constitution;

c) following approval of its application by NHS England has been entered into the list of Member Practices set out in Appendix B to this Constitution.

3.4. **Cessation of membership**

3.4.1. A Member Practice ceases to be a Member if they are no longer eligible for membership through non-compliance with paragraph 3.2 above.

3.4.2. The Group shall notify NHS England in the event that it becomes aware that any Member Practice no longer meets the requirements of paragraph 3.2 or is proposing to merge with another Member Practice or a Member Practice of another Clinical Commissioning Group and shall propose any such amendments to this Constitution under the terms of paragraph 1.4 as are appropriate to reflect the circumstances.

3.4.3. Membership of the Group is not transferable and any proposed changes to the membership (including those arising from a merger of Member practices) shall be subject to the approval of NHS England.

3.4.4. In the instance of practice mergers or practice splits, the new practice(s) will automatically be entitled to become Members of the Group and the list of practices at Appendix B will be amended accordingly.

3.5. **Disputes**

3.5.1. Any dispute between a practice and the Group in respect of eligibility for membership of the Group will follow the Dispute Resolution Procedure (see Appendix K-2). The dispute resolution procedure describes an escalation route from Senior Officer (Chair of the Group), to Accountable Officer, then NHS England, with associated timescales for each stage towards achieving resolution.

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10 See section 14A(4) of the 2006 Act, inserted by section 25 of the 2012. Regulations to be made
3.6. **Surrey Local Medical Committee (the “LMC”)**

3.6.1. The Group will recognise the Surrey LMC as the statutory representative body for NHS General Practitioners and will consult with the LMC on those matters it is required to do so by statute and those affecting the interests of General Practitioners.

4. **Mission, values and aims**

4.1. **Mission**

4.1.1. The mission of the Group is that through focused clinical leadership and patient engagement we will revolutionise the delivery of local healthcare through our geographical localities, whilst living within our means, improving quality of care and health outcomes for our patients. Services will be local, affordable, responsive and measurable for the population we serve.

4.2. **Values**

4.2.1. The Group will commission healthcare that meets local needs, improves health and health outcomes for patients, reduces inequalities and promotes well-being.

4.2.2. The Group acknowledges that good corporate governance arrangements are critical to achieving the Group’s objectives. The Group will promote good governance and proper stewardship of public resources in pursuance of its goals and in meeting its statutory duties.

4.2.3. The values that lie at the heart of the Group's work as a fully federated organisation with strong clinical leadership at all levels of its organisation are:

a) the best quality care delivered within an effective and efficient healthcare system that improves health, patient outcomes and the wellbeing of people living within the geographical areas of the Group;

b) to become a ‘stakeholder’ owned organisation where responsibility is taken to ensure that national, regional and local commissioning strategies are translated through meaningful local delivery strategies;

c) all those that work with and are aligned to the organisation will share its values and will feel empowered to deliver improvements for its population;

d) the NHS is free at the point of delivery and the organisation takes a leadership role across the system to ensure all its services enshrine equality and diversity;

e) patient engagement and involvement is at the heart of commissioning and patients are an integral part of the organisation.

4.3. **Aims and objectives**

4.3.1. The Group’s principal aim is to narrow health inequalities, enhance quality and safety and involve patients in everything it does working within the money it has available.

4.3.2. The Group will act as a corporate body that meets all its statutory duties by discharging commissioning functions effectively, efficiently and economically on behalf of its Member Practices, public and patients.

4.3.3. To achieve this the Group’s aims are to:

a) work through a locality structure to actively involve Member practices in commissioning high quality care for our patients by developing supportive and enabling structures and processes that facilitate shared learning and shared best practice;

b) enact locality plans where they can reasonably be expected to result in improved
quality and improved patient outcomes whilst living within the resources available to
us and ensuring value for money;

c) actively harness local patient and public experience, knowledge and views to monitor
the quality of commissioned services in local communities.
d) use commissioning and contracting frameworks that retain the core values of general
practice in the process of modernisation across health, social and voluntary sector
systems and that:
i) empower patients and public to look after themselves and take action to
prevent ill health;
ii) ensure the design or redesign of quality care pathways is clinically led and
managerially supported;
iii) ensure continuous quality improvements and improved health outcomes for
our patients and public;
iv) harness innovation across the system that offers the biggest impact on
quality of life expectancy for patients and public;
v) ensure that all services are built on the principles of equality and diversity to
standardise access for all;
vi) share knowledge and encourage joint opportunities for training and
education that promotes best practices in commissioning and delivery of
services for patients and public;
vii) support delivery of more care closer to home based on sound planning,
common visions of Member practices and local and national priorities whilst
also ensuring value for money;
viii) monitor and measure health outcomes in a way that ‘adds value’ and is
meaningful to all our stakeholders;
ix) ensure equity of care across the CCG’s population, with patients and
practices across the Group benefiting equally from service improvements
and developments focus on prevention of ill health to keep people well and
work with providers to put contractual arrangements in place to support this.
e) work collaboratively with other partners, specifically other Clinical Commissioning
Groups, Surrey’s Health and Wellbeing Board and Commissioning Support Units to
achieve economies of scale and achieve strategic change;
f) use the knowledge from the Joint Strategic Needs Assessment and other stakeholders,
particularly local patients, public and carers to identify needs and gaps in services to
enable prioritisation of commissioning intentions.

4.4. Principles of good governance

4.4.1. In accordance with section 14L (2) (b) of the 2006 Act\(^\text{11}\), the Group will at all times observe
“such generally accepted principles of good governance” in the way it conducts its
business. These include:

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

b) The Good Governance Standard for Public Services;\(^\text{12}\)

\(^{11}\) 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 &

NHS Surrey Downs Clinical Commissioning Group’s Constitution
Version: 6.6 NHS Commissioning Board Effective Date: 24 July 2018
c) the standards of behaviour published by the Committee on Standards in Public Life (1995) known as the Nolan Principles (see Appendix G)

d) the seven key principles of the NHS Constitution (see Appendix H)

e) the Equality Act 2010.\textsuperscript{13}

f) The Standards for Members of NHS Boards and Governing Bodies in England\textsuperscript{14}.

4.5. \textbf{Accountability}

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

a) publishing its Constitution;

b) appointing independent Lay Members and non GP clinicians to its Governing Body;

c) holding meetings of its Governing Body in public (except for developmental seminars and confidential sessions where the Group considers that it would not be in the public interest in relation to all or part of a meeting);

d) publishing annually a Commissioning Plan;

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

f) meeting annually in public to present its Annual Report (which must be published);

g) producing Annual Accounts in respect of each financial year which must be externally audited;

h) having a published and clear complaints process;

i) complying with the Freedom of Information Act 2000;

j) providing information to NHS England as required.

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

5. \textbf{Functions and general duties}

5.1. \textbf{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 \textit{Functions of clinical commissioning groups: a working document}. They relate to:

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

i) all people registered with member GP practices, and

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

\textsuperscript{13} See \url{http://www.legislation.gov.uk/ukpga/2010/15/contents}

\textsuperscript{14} Standards for members of NHS boards and CCG governing bodies in England \url{http://www.professionalstandards.org.uk/publications/detail/standards-for-members-of-nhs-boards-and-clinical-commissioning-group-governing-bodies-in-england}
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\(^{15}\), when exercising its functions to commission health services, consistently with the
discharge by the Secretary of State and NHS England of their duty to \textit{promote a}
\textit{comprehensive health service}\(^{16}\) and with the objectives and requirements placed on
NHS England through \textit{the mandate}\(^{17}\) published by the Secretary of State before the
start of each financial year by:

i) delegating responsibility to the Accountable Officer to oversee how the Group
discharges this;

ii) requiring progress of delivery of the duty to be monitored through the Audit
Committee;

b) \textbf{meet the public sector equality duty}\(^{18}\) by:

i) delegating responsibility to the Accountable Officer to oversee how the Group
discharges this;

ii) requiring progress of delivery of the duty to be monitored through the Audit
Committee;

c) work in partnership with its local authorities to develop \textit{joint strategic needs}
\textit{assessments}\(^{19}\) and \textit{joint health and wellbeing strategies}\(^{20}\) by:

i) being an active member of Surrey’s Health and Wellbeing Board;

ii) ensuring that the Commissioning Plan, Annual Operating Plan and
Commissioning Outcome Framework take due account of the output and
agreements from the Health and Wellbeing Board and the Joint Strategic
Needs Assessment.

5.2. \textbf{General duties} - In discharging its functions the Group will:

5.2.1. make arrangements to \textit{secure public involvement} in the planning, development and
consideration of proposals for changes and decisions affecting the operation of
commissioning arrangements\(^{21}\) by:

a) enable the Lay Members for patient and public involvement to play a key
developmental and assurance role on the Governing Body;

b) working in partnership with patients and the public to ensure patient engagement and

\(^{15}\) See section 3(1F) of the 2006 Act, inserted by section 13 of the 2012 Act

\(^{16}\) See section 1 of the 2006 Act, as amended by section 1 of the 2012 Act

\(^{17}\) See section 13A of the 2006 Act, inserted by section 23 of the 2012 Act

\(^{18}\) See section 149 of the Equality Act 2010, as amended by paragraphs 184 and 186 of Schedule 5 of the 2012 Act

\(^{19}\) See section 116 of the Local Government and Public Involvement in Health Act 2007, as amended by section
192 of the 2012 Act

\(^{20}\) See section 116A of the Local Government and Public Involvement in Health Act 2007, as inserted by section
191 of the 2012 Act

\(^{21}\) See section 14ZZ of the 2006 Act, inserted by section 26 of the 2012 Act
involvement is active at practice, locality, committee and Governing Body level to secure the best outcomes for patients;

c) using different mediums to ensure meaningful two-way communication between patients, members of the public and key stakeholders;

d) publishing information about health services on the Group’s website and through other media;

e) encouraging and acting on feedback;

f) progressing delivery of the duty to engage, which will be monitored through the Audit Committee.

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

a) delegating responsibility to the Accountable Officer to oversee how the Group discharges this;

b) requiring progress of delivery of the duty to be monitored through the Audit Committee;

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

a) Ensuring that the Governing Body prepares the Group’s annual commissioning plan which will set out the Group’s plans to commission effectively, efficiently and economically and will detail the multi-agency governance arrangements.

b) measuring performance against the annual commissioning plan by reporting to the Governing Body at each meeting through appropriate reports.

c) ensuring that all business cases analyse the potential return on investment and all complex strategic issues are supported by an options appraisal.

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

a) delegating responsibility to the Governing Body to oversee how the Group discharges this;

b) requiring the Executive Management Team and the Quality Committee to ensure that service planning and business cases for new and enhanced services take due account of the need for continuous quality improvement.

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

a) using the Commissioning localities to support the delivery of general developments in primary care;

b) requiring progress of delivery of the duty to be monitored through the Executive Management Team;

c) considering the impact of any initiatives on primary care and any additional investment or resources required.

5.2.6. Have regard to the need to reduce inequalities by:

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22 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)
23 See section 14Q of the 2006 Act, inserted by section 26 of the 2012 Act
24 See section 14R of the 2006 Act, inserted by section 26 of the 2012 Act
25 See section 14S of the 2006 Act, inserted by section 26 of the 2012 Act
26 See section 14T of the 2006 Act, inserted by section 26 of the 2012 Act

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a) ensuring, via the Executive Management Team, the Audit Committee, the Quality Committee and the Remuneration Committee that the Annual Commissioning Plan and Annual Operating Plan include clear objectives, actions and targets for reducing inequalities;

b) ensuring that the Group uses the Joint Strategic Needs Assessment to underpin its plans, including input from the Health and Wellbeing Board and patient forums concerning inequalities;

c) requiring the Executive Management Team to ensure that service planning and associated business cases for new and enhanced services take due account of the agreed priorities and focus areas for reducing inequalities;

d) ensuring all plans and associated business cases are subject to proportionate Quality, Equality and Privacy Impact Assessment;

e) requiring the Executive Management Team, Audit Committee and the Quality Committee to oversee the overall adherence to fulfilling statutory duties.

5.2.7. **Promote the involvement of patients, their carers and representatives in decisions about their healthcare**\(^\text{27}\) by:

a) ensuring patients and carers have a voice on the Governing Body via the Lay Members with responsibility for championing patient, public and carers views;

b) ensuring that patients, carers and representatives’ views and involvement are effectively, demonstrably and transparently represented in planning and decision-making within the Group at commissioning locality and committee level;

c) working closely with local HealthWatch, practice participation groups and other patient groups to identify and act upon further improvements to patient involvement;

d) working in partnership with patients and the local community to secure the best care for them;

e) ensuring that specific patient and public engagement processes are in place to meet the needs of the different patient groups across the locality communities;

f) publishing information about health services on the Group’s website and through other media encouraging and acting on feedback;

g) requiring progress of delivery of the duty to be monitored though the Executive Management Team and the Audit Committee, and assuring its implementation through the Quality Committee.

5.2.8. **Act with a view to enabling patients to make choices**\(^\text{28}\) by:

a) encouraging all Member practices to embrace and integrate the values and principles set out in 4.2 of this Constitution to enhance patient choice;

b) working closely with the local HealthWatch organisation to act upon further improvements to patient involvement and patient choice;

c) requiring the Executive Management Team to ensure that service planning and commissioning priorities focus areas for improving patient choice;

d) working in partnership with patients and the local community to ensure patients are aware of their choices and to improve patient choice. This will include developing and publishing clinical outcome measures to inform patients when making their choice.

e) publishing information about patient choice on the Group’s website and through other media;

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

\(^\text{28}\) See section 14V of the 2006 Act, inserted by section 26 of the 2012 Act
5.2.9. **Obtain appropriate advice**\(^{29}\) from persons who, taken together, have a broad range of professional expertise in healthcare and public health by:

a) ensuring and using the clinical, management and patient expertise of the Governing Body, Executive Management Team and Commissioning localities to underpin the Group’s planning and performance;

b) being an active member of the Health and Wellbeing Board;

c) ensuring wide ranging stakeholder consultation on the Group’s Annual Operating Plan and Commissioning Plan;

d) using national, regional and local professional networks.

5.2.10. **Promote innovation**\(^{30}\) by:

a) ensuring that the Group’s commissioning and planning process promotes the use of innovation and best practice wherever possible;

b) delegating responsibility of the duty through the Group’s committee structures for promotion of innovation in service planning and implementation.

5.2.11. **Promote research and the use of research**\(^{31}\) by:

a) working closely with NHS England, Commissioning Support Units and national, regional and professional networks to ensure access to and appropriate use of wide based research to underpin our planning framework;

b) delegating responsibility of the duty through the Group’s committee structures to promote research and the use of research in service planning and implementation.

5.2.12. Have regard to the need to **promote education and training**\(^{32}\) 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\(^{33}\) by:

a) delegating responsibility to the Accountable Officer to oversee the discharge of this function within the Group and through Service Level Agreements with external stakeholders;

b) having a policy in place that all persons employed by the Group (including directly employed staff and clinical leads) will have a personal development plan aligned to their roles and responsibilities through their appraisal process. These plans will vary and will be specifically tailored for individual roles.

c) requiring that the CCG Annual Operating Plan, within its workforce strategy, includes processes and delivery of education and training opportunities;

d) requiring the Executive Management Team to oversee the adherence to fulfilling statutory duties;

e) working closely with external stakeholders, specifically NHS England, local authority, Health and Wellbeing Board and clinical networks to identify and/or develop joint

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

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

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

\(^{32}\) See section 14Z of the 2006 Act, inserted by section 26 of the 2012 Act

\(^{33}\) See section 1F(1) of the 2006 Act, inserted by section 7 of the 2012 Act
training and education opportunities.

5.2.13.  Act with a view to **promoting integration** of both local health services with other health services and local health services with health-related and social care services where the Group considers that this would improve the quality of services or reduce inequalities by:

a) delegating this duty from the Governing Body to committees to promote and deliver integration of health and social care services where appropriate and right for our patients, carers and public;

b) ensuring the Group shares and consults on its plans early to promote opportunities of integration that support enhanced outcomes for our patients, carers and public;

c) delegating responsibility to the Executive Management Team to oversee the adherence to fulfilling statutory duties and to ensure that services plans take due account of the agreed priorities and focus on areas where integration adds value.

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** by

a) delegating responsibility for ensuring expenditure does not exceed aggregated allotments to the Governing Body;

b) delegating responsibility for ensuring robust financial strategies, policies, systems, processes and governance arrangements are in place to the Chief Finance Officer;

c) delegating responsibility for seeking assurance on the robustness of financial arrangements to the Audit Committee;

d) adopting an annual financial plan and a financial strategy designed to meet the Group’s financial duties as part of the Integrated Plan; and

e) requiring the Chief Finance Officer to regularly monitor financial performance against the annual financial plan, and reporting to the Governing Body, the Executive Management Team, Finance and Performance Committee and the Audit Committee.

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

a) delegating responsibility for ensuring its use of resources does not exceed the amount specified by NHS England for the financial year to the Governing Body;

b) delegating responsibility for ensuring robust financial strategies, policies, systems, processes and governance arrangements are in place to the Chief Finance Officer;

c) delegating responsibility for seeking assurance on the robustness of financial arrangements to the Audit Committee;

d) adopting an annual financial plan and a financial strategy designed to meet the Group’s financial duties; and

e) requiring the Chief Finance Officer to regularly monitor financial performance against the annual financial plan, and reporting to the Governing Body, the Executive Management Team, the Finance and Performance Committee and the Audit Committee.

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34 See section 14Z1 of the 2006 Act, inserted by section 26 of the 2012 Act

35 See section 223H(1) of the 2006 Act, inserted by section 27 of the 2012 Act

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

5.3.3. **Take account of any directions issued by NHS England, in respect of specified types of resource use in a financial year, to ensure the Group does not exceed an amount specified by NHS England**\(^{37}\) by

a) delegating responsibility for complying with directions issued by NHS England, in respect of specified types of resource use, to the Governing Body;

b) delegating responsibility for ensuring robust financial strategies, policies, systems, processes and governance arrangements are in place to enable the Group to fulfil its statutory responsibility not to exceed its expenditure limits, as set by direction of NHS England, to the Chief Finance Officer;

c) delegating responsibility for seeking assurance on the robustness of financial arrangements to the Audit Committee;

d) adopting and updating an annual financial plan and a financial strategy designed to comply with directions issued by NHS England from time to time; and

e) requiring the Finance and Performance Committee to regularly monitor the use of specified types of resource which are subject to directions issued by NHS England from time to time, and reporting to the Governing Body.

5.3.4. **Publish an explanation of how the Group spent any payment in respect of quality made to it by NHS England**\(^{38}\) by:

a) requiring the Chief Finance Officer to regularly monitor and review payments in respect of quality made to the Group by NHS England, and report on the same to the Governing Body.

5.4. **Other relevant regulations, directions and documents**

5.4.1. The Group will:

a) comply with all relevant regulations;

b) comply with directions issued by the Secretary of State for Health or NHS England and
c) take account, as appropriate, of documents issued by NHS England.

5.4.2. The Group will develop and implement the necessary systems and processes to comply with these regulations and directions, documenting them as necessary in this constitution, its Scheme of Reservation and Delegation and other relevant Group policies and procedures.

6. **Decision making: The governing structure**

6.1. **Authority to act**

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

a) any of its Member practices;

b) its Governing Body;

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\(^{37}\) See section 223J of the 2006 Act, inserted by section 27 of the 2012 Act

\(^{38}\) See section 223K(7) of the 2006 Act, inserted by section 27 of the 2012 Act
c) employees;

d) a committee or sub-committee of the Group/Governing Body.

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**³⁹

6.2.1. The Group’s Scheme of Reservation and Delegation sets out:

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

b) those decisions that are the responsibilities of its Governing Body (and its committees), the Group’s committees and sub-committees, individual Member practices and employees.

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

6.3. **General**

6.3.1. When discharging functions of the Group that have been delegated, the Governing Body (and its committees, sub committees), committees and sub-committees of the Group and individuals must:

a) comply with the Group’s principles of good governance⁴⁰;

b) operate in accordance with the Group’s Scheme of Reservation and Delegation⁴¹;

c) comply with the Group's Standing Orders⁴²;

d) comply with the Group’s arrangements for discharging its statutory duties⁴³;

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;

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³⁹ Available on the CCG’s website – [www.surreydownsccg.nhs.uk](http://www.surreydownsccg.nhs.uk)
⁴⁰ See section 4.4 on Principles of Good Governance above
⁴¹ Available on the CCG’s website – [www.surreydownsccg.nhs.uk](http://www.surreydownsccg.nhs.uk)
⁴² See Appendix D “Standing Orders”
⁴³ See chapter 5 above
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 of the group have these general terms:

a) A committee of the Group shall be established with the agreement of the Governing Body and will be recorded in the terms of reference for each committee.

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

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

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

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

6.4.2. **The Council of Members**

a) The Group has delegated certain functions to its Member Practices, as set out in the Scheme of Delegation and Reservation.

b) In accordance with paragraph 7.1.1 below, each of the Group’s Member Practices has appointed a Membership Practice Representative to act on its behalf in matters relating to the Group.

c) The Council of Members shall comprise the Membership Practice Representatives (or their proxies appointed in accordance with Appendix D (Standing Orders)).

d) Meetings of the Council of Members shall be held in accordance with paragraph 3 of Appendix D (Standing Orders).

6.5. **Joint commissioning arrangements**

6.5.1. The governing body of the Group shall require, in all joint commissioning arrangements, that the lead clinician and lead manager of the lead Clinical Commissioning Group make a quarterly written report to the governing body and hold at least annual engagement events to review aims, objectives, strategy and progress and publish an annual report on progress made against objectives.

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

**Joint Commissioning with other Clinical Commissioning Groups**

6.5.3. The Group may wish to work together with other Clinical Commissioning Groups in the exercise of its commissioning functions.
6.5.4. The Group may make arrangements with one or more Clinical Commissioning Groups in respect of:

   a) delegating any of the Group’s commissioning functions to another Clinical Commissioning Group;
   b) exercising any of the commissioning functions of another Clinical Commissioning Group; or
   c) exercising jointly the commissioning functions of the Group and another Clinical Commissioning Group.

6.5.5. For the purposes of the arrangements described at paragraph 6.5.3, the Group may:

   a) make payments to another Clinical Commissioning Group;
   b) receive payments from another Clinical Commissioning Group;
   c) make the services of its employees or any other resources available to another Clinical Commissioning Group; or
   d) receive the services of the employees or the resources available to another Clinical Commissioning Group.

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

6.5.7. For the purposes of the arrangements described at paragraph 6.5.3 above, the Group may establish and maintain a pooled fund made up of contributions by any of the Clinical Commissioning Groups working together pursuant to paragraph 6.5.3(c) above. Any such pooled fund may be used to make payments towards expenditure incurred in the discharge of any of the commissioning functions in respect of which the arrangements are made.

6.5.8. Where the Group makes arrangements with another Clinical Commissioning Group as described at paragraph 6.5.3 above, the Group shall develop and agree with that Clinical Commissioning Group an agreement setting out the arrangements for joint working, including details of:

   a) how the parties will work together to carry out their commissioning functions;
   b) the duties and responsibilities of the parties;
   c) how risk will be managed and apportioned between the parties;
   d) financial arrangements, including, if applicable, payments towards a pooled fund and management of that fund;
   e) contributions from the parties, including details around assets, employees and equipment to be used under the joint working arrangements.

6.5.9. The liability of the Group to carry out its functions will not be affected where the Group enters into arrangements pursuant to paragraph 6.5.3 above.

6.5.10. Without prejudice to paragraph 5.4 the Group shall have regard to any guidance published by NHS England pursuant to Section 14Z8 of the 2006 Act in exercising its commissioning functions.

6.5.11. Only arrangements that are safe and in the interests of patients registered with member practices will be approved by the governing body.
6.6. **Joint commissioning arrangements with NHS England for the exercise of Group's functions**

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

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

6.6.3. The arrangements referred to in paragraph 6.6.2 above may include other Clinical Commissioning Groups.

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

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

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

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

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

6.6.8. Without prejudice to paragraph 5.4, the Group shall have regard to any guidance published by NHS England pursuant to Section 14Z8 of the 2006 Act in exercising its commissioning functions.

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

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

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

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

6.7.1. The Group may wish to work with NHS England and, where applicable, other Clinical Commissioning Groups to exercise specified NHS England’s functions.
6.7.2. The Group may enter into arrangements with NHS England and, where applicable, other Clinical Commissioning Groups to:

a) exercise such functions as specified by NHS England under delegated arrangements;

b) jointly exercise such functions as specified with NHS England.

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

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

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

6.7.6. Where the Group enters into arrangements with NHS England as described at paragraph 6.7.2 above, the parties will develop and agree a framework setting out the arrangements for joint working, including details of:

a) How the parties will work together to carry out their commissioning functions;

b) The duties and responsibilities of the parties;

c) How risk will be managed and apportioned between the parties;

d) Financial arrangements, including payments towards a pooled fund and management of that fund;

e) Contributions from the parties, including details around assets, employees and equipment to be used under the joint working arrangements.

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

6.7.8. Without prejudice to paragraph 5.4, the Group shall have regard to any guidance published by NHS England pursuant to Section 14Z8 of the 2006 Act in exercising its commissioning functions.

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

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

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

6.8. **Joint commissioning arrangements with Local Authorities**

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

6.9. **Current joint arrangements**

6.9.1. The Group has entered into following joint arrangements:
a) **Joint Commissioning Committee**

- NHS Guildford and Waverley Clinical Commissioning Group;
- NHS North West Surrey Clinical Commissioning Group
- NHS England
- Surrey County Council (inc. Section 75 agreement)

The Joint Commissioning Committee may establish sub-committees.

6.10. **The Governing Body**

The Governing Body may meet using the committees-in-common arrangement with other CCGs. The Chairs of the participating Governing Bodies will agree a convenor of the meetings on a rotating basis.

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

a) ensuring that the Group has appropriate arrangements in place to exercise its functions effectively, efficiently and economically and in accordance with the Group's principles of good governance44 (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;45

d) driving forward and overseeing the delivery of the Group’s strategy.

6.10.2. **Composition of the Governing Body** - the Governing Body shall not have less than eleven (11) members and comprises of:

a) the Clinical Chair;

b) Three GP clinical members appointed by way of a process agreed between the Governing Body and the Member Practices;

c) the Accountable Officer;

d) the Chief Finance Officer;

e) an independent Secondary Care Doctor;

f) an independent Registered Nurse;

g) One Lay Member to lead on patient and public participation and ensure patients and members of the public are involved in shaping local healthcare;

h) One Lay Member to lead on audit, finance, remuneration and conflict of interest, who will also be the vice chair of the Governing Body and Conflict of Interest guardian;

i) One General Lay Member;

j) any person who the Governing Body may appoint to act up for a member of the Governing Body during a period of incapacity or to temporarily fill a vacancy.

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44 See section 4.4 on Principles of Good Governance above
45 See section 14L(5) of the 2006 Act, inserted by section 25 of the 2012 Act

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6.10.3. **Other attendees at a Governing Body Meeting**

a) The Group’s executive officers are expected to be in attendance and be invited to speak on relevant matters. They may not vote.

b) The Governing Body may invite such other person(s) to attend all or any of its meetings, or part(s) of a meeting, in order to assist it in its decision-making and in its discharge of its functions as it sees fit. Any such person may speak and participate in debate, but may not vote.

6.10.4. **Committees of the Governing Body** - the Governing Body has appointed the following committees and sub-committees. For the avoidance of doubt, such committees may meet using the committees-in-common arrangement with other CCGs. The Chairs of the participating Committees will agree a convenor of the meetings on a rotating basis.

a) **Audit Committee** – the committee, which is accountable to the Group’s Governing Body, provides the Governing Body with an independent and objective view of the Group’s systems, information and compliance with laws, regulations and directions governing the Group. The committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Group’s activities that support the achievement of the Group’s objectives.

   The committee shall seek reports and assurances from members of the Governing Body and senior employees as appropriate, concentrating on the over-archching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness 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. The Governing Body has approved and keeps under review the terms of reference for the committee.

b) **Remuneration Committee** – the 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 committee, which includes information on the membership of the committee. In addition the Governing Body has delegated the following functions to the committee:

   i) arrangements for termination of employment and other contractual terms;

   ii) approval of all policies and procedures relating to staff management (excepting those that impact on remuneration);

   iii) approval of individual redundancy applications;

   iv) monitoring of performance in relation to HR, such as staff absence statistics and the service received from any Commissioning Support Unit;

   v) overseeing HR strategy and talent management arrangements.

c) **Primary Care Commissioning Committee** – the Primary Care Commissioning Committee, which is accountable to the Governing Body, will make decisions on the review, planning and procurement of primary care services in Surrey Downs. The Governing Body has approved and keeps under review the terms of reference for the Primary Care Commissioning Committee, which includes information on the membership and role of the Primary Care Commissioning Committee.
6.10.5. The Governing Body may appoint such other committees as it considers may be appropriate. For the avoidance of doubt, such committees may meet using the committees-in-common arrangement with other CCGs. The Chairs of the participating Committees will agree a convenor of the meetings on a rotating basis.

6.10.6. The following provisions govern the membership of the committees of the Governing Body:

a) The Remuneration Committee shall be comprised solely of members of the Governing Body.

b) The Audit Committee may include individuals who are not members of the Governing Body.

c) The other committees of the Governing Body may include individuals who are:

   i) Members, officers or Governing Body members of the Group or another clinical commissioning group;
   ii) Partners or employees of members of the Group or another clinical commissioning group;
   iii) Officers of NHS England; and/or
   iv) Any individual over 18 who resides in the United Kingdom.

6.11. Delegation of Functions by the Governing Body to individuals

6.11.1. In addition to the Accountable Officer and Chief Finance Officer, who have statutory roles, the Governing Body may delegate any of its functions to:

a) a member of the Governing Body;

b) a member of the Group;

c) a lay member (non-voting)

d) an officer of the Group;

e) an officer of another clinical commissioning group;

f) an officer of the CCG appointed CSU; or

g) an employee of the NHS Business Services Authority.

7. Roles and responsibilities

7.1. Member Practice Representatives

7.1.1. Member Practice Representatives represent their practice’s views and act on behalf of the practice in matters relating to the Group. The role of each Member Practice Representative is to:

a) enable communications between the Member Practices;

b) discuss and debate the views and wishes of the Member Practices;

c) agree priorities for commissioning and review progress of commissioning with Member Practices;

d) provide a forum for collective decision making through the Council of Members and Locality Sub-committee structures;

e) aid communications between the practices and health and social care providers;

f) encourage other members of the practice such as nurses to attend open meetings which will be held by the Group;
g) attend and vote on behalf of the Member Practice at Locality Sub-committee meetings and AGMs of the Group.

7.2. **Other GP and primary care health professional representatives**

7.2.1. In addition to the Member Practice Representatives identified in section 7.1 above, the Group may identify a number of other GPs / primary care health professionals from Member Practices to either support the work of the Commissioning Locality, Group and / or represent the Group rather than represent their own individual practices. These GPs and primary care health professionals will have agreed job outlines signed off by the Locality Committee and/or Governing Body.

7.3. **All members of the Governing Body**

7.3.1. Guidance on the roles of members of the Governing Body is set out in a separate guidance document\(^6\) issued by NHS England. In summary, each member of the Governing Body should share responsibility as part of a team to ensure that the Group exercises its functions effectively, efficiently and economically, with good governance and in accordance with the terms of this constitution. Each brings their unique perspective, informed by their expertise and experience. Each Governing Body member will have a job role description, linked to accountability, responsibility and remuneration.

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

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

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

b) building and developing the Governing Body and its individual members;

c) ensuring that the Group has proper constitutional and governance arrangements in place;

d) ensuring that, through the appropriate support, information and evidence, the Governing Body is able to discharge its duties;

e) supporting the Accountable Officer in discharging the responsibilities of the organisation;

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

g) leading and influencing to achieve clinical and organisational change to enable the Group to deliver its commissioning responsibilities;

h) overseeing governance and particularly ensuring that the Governing Body and the Group behaves with the utmost transparency and responsiveness at all times;

i) ensuring that public and patients’ views are heard and their expectations understood and, where appropriate as far as possible, met;

j) ensuring that the organisation is able to account to its local patients, stakeholders and NHS England;

k) ensuring that the Group builds and maintains effective relationships, particularly with the individuals involved in overview and scrutiny from the relevant local authority(ies).

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

7.5. **The Vice Chair (Lay)**

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

7.6. **Role of the Accountable Officer**

7.6.1. The Accountable Officer of the Group is a member of the Governing Body.

7.6.2. The role of the Accountable Officer has been summarised in a national guidance document\(^{47}\) as:

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

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

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

7.6.3. In addition the Group or the Governing Body has conferred or delegated the following duties to the Accountable Officer:

a) performing any of the functions and/or duties in paragraph 5.2 and/or any other paragraph of this Constitution, and the Scheme of Reservation and Delegation, which have been identified as being delegated to, or performed by, the Accountable Officer; and

b) such other functions or duties as may be conferred or delegated to the Accountable Officer from time to time.

7.6.4. 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 NHS England.

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

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

7.7.2. The role of the Chief Finance Officer has been summarised in a national document\(^{48}\) 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 the Group’s finances;

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\(^{47}\) See the latest version of NHS England’s *Clinical commissioning group governing body members: Role outlines, attributes and skills*

\(^{48}\) See the latest version of NHS England’s Clinical commissioning group governing body members: Role outlines, attributes and skills
c) overseeing robust audit and governance arrangements leading to propriety in the use of the Group’s resources;

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

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

f) ensuring the discharge of obligations by the Group under relevant financial directions including:

i) implementing the Group’s financial policies;

ii) maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;

iii) ensuring that sufficient records are maintained to show and explain the Group’s transactions, in order to disclose, with reasonable accuracy, the financial position of the Group at any time; and

iv) the preparation and maintenance of such accounts, certificates, estimates, records and reports as the Group may require for the purpose of carrying out its statutory duties; and

7.7.3. In addition, the Group or the Governing Body has conferred or delegated the following duties to the Chief Finance Officer:

a) performing any of the functions and/or duties in paragraphs 5.2, 5.3 and/or any other paragraphs of this Constitution, which have been identified as being delegated to the Chief Finance Officer; and

b) such other functions or duties as may be conferred or delegated to the Chief Finance Officer from time to time.

7.8. **Role of the Lay Members of the Governing Body**

7.8.1. As well as sharing responsibility with the other members for all aspects of the Group’s Governing Body business, as a lay member of the Group’s Governing Body lay members will bring specific expertise and experience to the work of the Governing Body. Their focus will be strategic and impartial, providing an external view of the work of the Group that is removed from the day-to-day running of the organisation. Their specific roles are set out below:

7.8.2. **Lay member with a lead role in audit, finance, remuneration and conflict of interest matters.** This role includes:

a) Chairing the Audit Committee;

b) working with the Chief Finance Officer and Accountable Officer to prepare the Annual Report and annual accounts, for the Governing Body;

c) working with the Chief Finance Officer and Accountable Officer to develop the Audit Plan;

d) working with the Accountable Officer to develop the Remuneration Policy and Procedure;
e) working with the Accountable Officer to develop the Conflict of Interest Policy and Procedure and ensure its ongoing implementation as the Conflict of Interest Guardian; and

f) providing expert advice and opinion to the Governing Body on matters relating to the portfolio areas.

7.8.3. **Lay member with a lead role in patient and public participation matters.** This role includes:

a) bringing specific expertise and experience to the work of the Governing Body, as well as his/her knowledge as a member of the community;

b) helping to ensure that the public voice of the local population is heard in all aspects of the CCG business and opportunities are created and protected for patient and public empowerment in the work of the CCG;

c) ensuring that patients and public views are heard and their expectations understood and met as appropriate;

d) ensuring that the CCG builds and maintains an effective relationship with local Healthwatch and draws on existing patient and public engagement and involvement expertise;

e) ensuring that the CCG has appropriate arrangements in place to secure public and patient involvement.

7.8.4. **Lay Member (non-voting)**

a) The group may appoint additional Lay Members (non-voting), who are not members of the Governing Body, but who provide additional capacity to the Lay Members (Voting) in the work of the Group.

b) The Lay Members (non-voting) work closely with the Lay Members (Voting) in performing duties delegated to them.

7.9. **Role of the GP Clinical Members on the Governing Body**

7.9.1. The GP Clinical Members (in addition to the Chair) are appointed or elected as a member of the Governing Body (in accordance with the Standing Orders) and represents the Group as a whole rather than their own individual Practice. The GP Clinical Members have an active role in the management and operation of the Group. As a member of the Clinical Commissioning Group they bring their unique understanding of the Group’s Members to the discussion and decision making of the Governing Body.

7.9.2. The GP Clinical Members will be responsible for one or more portfolios as agreed by the Governing Body.

7.10. **Role of the Secondary Care Doctor as clinical member on the Governing Body**

7.10.1. As well as sharing responsibility with the other members for all aspects of the Group’s Governing Body business, this clinical member will bring a broader view, on health and care issues to underpin the work of the Group. In particular, they will bring to the Governing Body an independent understanding of patient care in the secondary care setting.

7.11. **Role of the Registered Nurse as clinical member on the Governing Body**

7.11.1. As well as sharing responsibility with the other members for all aspects of the Group’s Governing Body business, this person will bring an independent view, from their perspective as a registered nurse, on health and social care issues. This will include
advising on the treatment and prevention of ill health, as well as health promotion, to underpin the work of the Group, especially the contribution of nursing to patient care.

7.12. **Indemnity for Members**

7.12.1. Members of the Group, members of committees and sub-committees of the Group, the Governing Body and its committees and sub-committees who act in good faith will not have to meet out of their personal resources any personal civil liability which is incurred in the execution or purported execution of their Group functions, save where they have acted recklessly.

7.13. **Joint appointments with other organisations**

7.13.1. The Group has the option to create joint appointments with other organisations.

7.13.2. Any such 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. Members, Governing Body members, Member Practice Representatives and employees of the Group will at all times comply with this constitution and be aware of their responsibilities as outlined in it.

8.1.2. All Member Practices, members of the Governing Body, Member Practice Representatives and employees of the Group must comply with the Group’s arrangements for managing actual or potential conflicts of interest including the Conflicts of Interest Policy (available on the Group’s website at www.surreydownsccg.nhs.uk).

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

8.2. Conflicts of Interest

8.2.1. Conflict of Interest Policy

8.2.2. The Group has a Conflicts of Interest Policy that is available on the Group’s website. A summary of the key provisions is included in this Constitution document.

8.2.3. Where an individual who is involved in the Group’s decision-making (including: a member of the Governing Body; a Practice Lead; an employee of the Group; a member of a committee or sub-committee of the Group or a member of a committee or sub-committee of the Governing Body) has an interest (including pecuniary, personal or family interest whether actual or potential and whether that interest is direct or indirect), or becomes aware of an interest which could lead to a conflict of interests in the event of the Group considering an action or decision in relation to that interest, such interest must be considered as a potential conflict, and is subject to the provisions of this Constitution and the Conflicts of Interest Policy.

8.2.4. Register of Interests

8.2.5. The Group will maintain one or more registers of interests which shall record all relevant personal or business interests or positions of influence of:

(a) the Member Practices;

(b) anyone working for a Member Practice who is involved in CCG business/decision making processes)

(c) the members of the Governing Body;

(d) the members of the Group’s committees or sub-committees and the committees or sub-committees of its Governing Body;

(e) employees of the Group;

(f) individuals contracted to work on major projects (for instance, significant procurements)

8.2.6. The register(s) will be published on the Group’s website and in the Annual Report, where stipulated, and made available to the public on request.

With regard to (e), employees on Agenda for Change Grade 8a and below will not be published but subject to Freedom of Information (FOI) (names would be redacted in accordance with Model Publication Scheme (MPS).
With regard to f) these will not be published but subject to Freedom of Information (FOI) (names would be redacted in accordance with Model Publication Scheme (MPS).

8.2.7. The Group Secretary will ensure that the register(s) of interest is (are) reviewed regularly and updated as necessary.

8.2.8. **Special Meeting Arrangements**

8.2.9. Where more than fifty per cent (50%) of the members of the meeting are required to withdraw from a meeting or part of it, owing to the arrangements agreed for the management of conflicts of interest or potential conflicts of interests, the chair (or vice chair) will determine whether or not the discussion can proceed on the basis of whether the meeting is quorate.

8.2.10. Where the meeting is not quorate, the discussion will be deferred until such time as a quorum can be created. This may include:

a) Requiring another of the Group’s committees or sub-committees, the 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:

- A member of the Group who is an individual;
- an individual appointed by a Member to act on its behalf in the dealings between it and the Group;
- a member of a relevant Health and Wellbeing Board;
- a member of the Governing Body of another Clinical Commissioning Group.

These arrangements must be recorded in the minutes.

8.2.11. **Managing Breaches in the Conflict of Interest Policy**

8.2.12. All Group members and staff have a duty to report a suspected breach of the Conflicts of Interest Policy to the Director of Governance and Compliance or the Conflict of Interest Guardian. A suspected breach may also be reported by a patient, member of the public or the media.

8.2.13. An investigation of the suspected breach will take place using the “Process for managing breaches of the Group’s Conflict of Interest Policy”. This available as an appendix of the Group’s Conflict of Interest Policy and is available on the Group’s website.

8.3. **Transparency in procuring and managing services**

8.3.1. The Group recognises the importance in making decisions about the services it procures in a way that does not call into question the motives behind any 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.

8.3.2. Anyone seeking information in relation to a procurement, or participating in a procurement, or otherwise engaging with the 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.

8.3.3. Anyone contracted to provide services or facilities directly to the 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.
8.3.4. The Group will publish a Procurement Policy approved by the Governing Body which will ensure that:

a) all relevant clinicians (not just those representing Member Practices 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.

8.3.5. Copies of this Procurement Policy will be available on the Group’s website.
9. **The group as an employer**

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

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

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

9.4. The Group will provide such management and associated functions in house as the Governing Body feels appropriate for the Group to adequately dispense its statutory and related duties. The Governing Body will take this decision on advice from the Accountable Officer.

9.5. 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.

9.6. 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.

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

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

9.9. 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.

9.10. 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.

9.11. The Group recognises and confirms that nothing in or referred to in this Constitution (including in relation to the issue of any press release or other public statement or disclosure) will prevent or inhibit the making of any protected disclosures (as defined in the Employment Rights Act 1996, as amended by the Public Interest Disclosure Act 1998) by any member of the Group, any member of its Governing Body, any member of any of its committees or sub-committees or the committees or sub-committees of its Governing Body, or any employee of the Group or any of its members, nor will it affect the rights of any worker (as defined in the Act) under that Act.

9.12. Copies of this Code of Conduct, together with the other policies and procedures outlined in this chapter, will be available on the Group’s website at www.surreydownsccg.nhs.uk.
10. Transparency, ways of working and Standing Orders

10.1. General
10.1.1. The Group will publish annually a Commissioning Plan and an Annual Report, presenting the Group’s Annual Report to a public meeting.
10.1.2. Key communications issued by the Group, including the notices of procurements, public consultations, Governing Body meeting dates, times, venues, and certain papers will be published on the Group’s website at www.surreydownsccg.nhs.uk.
10.1.3. The Group may use other means of communication, including circulating information by post, or making information available in venues or services accessible to the public.

10.2. Standing Orders
10.2.1. This constitution is also informed by a number of documents which provide further details on how the Group will operate. They are available on the Group’s website and include the Group’s:
10.2.2. Standing Orders (Appendix D) – 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;
10.2.3. Scheme of Reservation and Delegation (Appendix K-1) – 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 Member Practices and employees;
10.2.4. Prime Financial Policies (Appendix F) – which sets out the arrangements for managing the Group’s financial affairs.

10.3. Dispute resolution
10.3.1. The Governing Body shall adopt a procedure to govern any disputes that may arise between the Council of Members and the Governing Body in relation to the interpretation and application of their respective powers and obligations under this Constitution, having consulted with the Council of Members about the procedure.
## Appendix A

### Definitions of key descriptions used in this Constitution

<table>
<thead>
<tr>
<th>Definition</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2006 Act</strong></td>
<td>National Health Service Act 2006</td>
</tr>
<tr>
<td><strong>2012 Act</strong></td>
<td>Health and Social Care Act 2012 (this Act amends the 2006 Act)</td>
</tr>
<tr>
<td><strong>Accountable Officer</strong></td>
<td>An individual, fulfilling the statutory role of the Group's Accountable Officer, as defined under paragraph 12 of Schedule 1A of the 2006 Act</td>
</tr>
<tr>
<td></td>
<td>(as inserted by Schedule 2 of the 2012 Act), appointed by the NHS Commissioning Board, with responsibility for ensuring the group:</td>
</tr>
<tr>
<td></td>
<td>• complies with its obligations under:</td>
</tr>
<tr>
<td></td>
<td>o sections 14Q and 14R of the 2006 Act (as inserted by section 26 of the 2012 Act),</td>
</tr>
<tr>
<td></td>
<td>o sections 223H to 223J of the 2006 Act (as inserted by section 27 of the 2012 Act),</td>
</tr>
<tr>
<td></td>
<td>o paragraphs 17 to 19 of Schedule 1A of the NHS Act 2006 (as inserted by Schedule 2 of the 2012 Act), and</td>
</tr>
<tr>
<td></td>
<td>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;</td>
</tr>
<tr>
<td></td>
<td>• exercises its functions in a way which provides good value for money.</td>
</tr>
<tr>
<td><strong>Chair</strong></td>
<td>The individual appointed by the Group to act as chair of the Governing Body</td>
</tr>
<tr>
<td><strong>Chief Finance Officer</strong></td>
<td>The qualified accountant employed by the Group with responsibility for financial strategy, financial management and financial governance</td>
</tr>
<tr>
<td><strong>Clinical Commissioning Group</strong></td>
<td>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)</td>
</tr>
<tr>
<td><strong>Committee</strong></td>
<td>A committee or sub-committee created and appointed by:</td>
</tr>
<tr>
<td></td>
<td>• the membership of the Group;</td>
</tr>
<tr>
<td></td>
<td>• the Governing Body on behalf of the Group;</td>
</tr>
<tr>
<td></td>
<td>• the Governing Body.</td>
</tr>
<tr>
<td><strong>Committee in Common</strong></td>
<td>A meeting arrangement where the equivalent committee of more than one CCG meets at the same time, place and has the same agenda.</td>
</tr>
<tr>
<td><strong>Convenor</strong></td>
<td>Where the Governing Body or one of its committees is using a “Committees in Common” meetings arrangement with one or more other CCGs, the chairs will agree who will convene the meetings on a rotating basis.</td>
</tr>
<tr>
<td><strong>Financial year</strong></td>
<td>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</td>
</tr>
<tr>
<td><strong>Group</strong></td>
<td>NHS Surrey Downs Clinical Commissioning Group, whose constitution this is</td>
</tr>
</tbody>
</table>
| **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 of 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. |
| **Joint Committee** | A special committee set up by more than one CCG, that may also include a Local Authority, which may be given delegated powers to make decisions for all participating organisations. |
| **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. |
| **Lay Member (non-voting)** | A lay member (non-voting) is an individual who is appointed to assist the work of the Governing Body. The individual is not a member of the Group, a Governing Body member 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). |
| **Member** | A provider of primary medical services to a registered patient list, who is a member of this Group (see table in 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 the 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. |
| **Regulations** | The National Health Service (Clinical Commissioning Groups) Regulations 2012 |
| **Senior Independent Member** | One of the two lay members for Governance who also acts as the Vice Chair of the CCG and the Chair of the Audit Committee and is an independent member to whom other members of the Governing Body can refer or who can facilitate the CCG disputes procedure set out at Appendix K-2. |
| **Special Resolution** | A Special Resolution of the Members passed:  
- at a Membership meeting with at least 75% of the votes cast by those Members attending (by their Practice Lead/Alternate Practice Lead or by proxy) and a quorum of 75% of the Group’s Membership.  
OR  
- the execution of a written resolution by at least 75% of the Members who return the written resolution to the Secretary by the long-stop date - provided that at least 75% of the Members return the written resolution to the Secretary by the long-stop date. |
## Appendix B

### Surrey Downs CCG Member Practices

<table>
<thead>
<tr>
<th>Practice</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>H81028 - DORKING MEDICAL PRACTICE</td>
<td>NEW HOUSE SURGERY, 142A SOUTH STREET, DORKING, SURREY, RH4 2QR</td>
</tr>
<tr>
<td>H81068 - BROCKWOOD MEDICAL PRACTICE</td>
<td>THE SURGERY, TANNERS MEADOW, BROCKHAM, BETCHWORTH, SURREY, RH3 7NJ</td>
</tr>
<tr>
<td>H81072 - MEDWYN SURGERY</td>
<td>MEDWYN SURGERY, REIGATE ROAD, DORKING, SURREY RH4 1SD</td>
</tr>
<tr>
<td>H81113 - LEITH HILL PRACTICE</td>
<td>NORTHBROOK SURGERY, WARWICK ROAD, SOUTH HOLMWOOD, Nr.DORKING, SURREY, RH5 4NP</td>
</tr>
<tr>
<td>H81161 - RIVERBANK SURGERY</td>
<td>WESTCOTT STREET, WESTCOTT, RH4 3PA</td>
</tr>
<tr>
<td>H81038 - LITTLETON SURGERY</td>
<td>LITTLETON SURGERY, BUCKLAND HOUSE, Esher Park Avenue, Esher, SURREY, KT10 9NY</td>
</tr>
<tr>
<td>H81078 - GLENLYN MEDICAL CENTRE</td>
<td>GLENLYN MEDICAL CENTRE, 115 MOLEY PARK ROAD, EAST MOLEY, SURREY KT8 0JX</td>
</tr>
<tr>
<td>H81086 - THORKHILL SURGERY</td>
<td>THORKHILL SURGERY, THORKHILL GARDENS, THAMES DITTON, KT7 0UP</td>
</tr>
<tr>
<td>H81099 - ESHER GREEN SURGERY</td>
<td>ESHER GREEN SURGERY, ESHER GREEN DRIVE, Esher, SURREY, KT10 8BX</td>
</tr>
<tr>
<td>H81109 - CAPELFIELD SURGERY</td>
<td>CAPELFIELD SURGERY, ELM ROAD, CLAYGATE, Esher, SURREY, KT10 0EH</td>
</tr>
<tr>
<td>H81128 – VINE MEDICAL CENTRE</td>
<td>THE VINE MEDICAL CENTRE, 69 PEMBERTON ROAD, EAST MOLEY, SURREY, KT8 9LJ</td>
</tr>
<tr>
<td>H81672 – THE GROVES, HINCHLEY WOOD</td>
<td>THE GROVES: HINCHLEY WOOD, 3 STATION APPROACH, HINCHLEY WOOD, SURREY, KT10 0SP</td>
</tr>
<tr>
<td>H81016 - FAIRFIELD MEDICAL CENTRE</td>
<td>FAIRFIELD MEDICAL CENTRE, LOWER ROAD, GREAT BOOKHAM, LEATHERHEAD, SURREY, KT23 4DH</td>
</tr>
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<td>H81017 – ASHLEA MEDICAL PRACTICE</td>
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### Appendix C

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## 1. STATUTORY FRAMEWORK AND STATUS

### 1.1. Introduction

#### 1.1.1. These Standing Orders have been drawn up to regulate the proceedings of the NHS Surrey Downs Clinical Commissioning Group 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 the Group is established.

#### 1.1.2. The Standing Orders, together with the Group’s scheme of reservation and delegation and the Group’s Prime Financial Policies, provide a procedural framework within which the Group discharges its business. They set out:

- **a)** the appointment of Practice Representatives;
- **b)** the appointment of the Governing Body;
- **c)** the procedure to be followed at meetings of the Group, 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;
- **f)** 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 of the relevant guidance.

#### 1.1.4. The Standing Orders, Scheme of Reservation and Delegation and Prime Financial Policies have effect as if incorporated into the Group’s Constitution. Group Members, employees, members of the Governing Body, members of the Governing Body’s committees and sub-committees, members of the Group’s committees and sub-committees and persons working on behalf of the Group should be aware of the existence of these documents and, where necessary, be familiar with their detailed provisions. Failure to comply with the Standing Orders, Scheme of Reservation and Delegation and Prime Financial Policies may be regarded as a disciplinary matter that could result in dismissal.

### 1.2. Schedule of matters reserved to the Group and the Scheme of Reservation and Delegation

#### 1.2.1. The 2006 Act (as amended by the 2012 Act) provides the Group with powers to delegate the Group’s functions and those of the Governing Body to certain bodies (such as committees) and certain persons. The Group has decided that certain decisions may only be exercised by the Group in formal session. These decisions and also those delegated are contained in the

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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.
2. The Clinical Commissioning Group: Composition of membership, key roles and appointment process

2.1. Composition of membership

2.1.1. Chapter 3 of the Group’s Constitution provides details of the membership of the Group (also see Appendix B).

2.1.2. Chapter 6 of the Group’s Constitution provides details of the governing structure used in the Group’s decision-making processes, whilst Chapter 0 of the Constitution outlines certain key roles and responsibilities within the Group and its Governing Body, including the role of GP Clinical Members (paragraph 7.1 of the Constitution).

2.2. Key roles

2.2.1. Paragraph 6.10.2 of the Group’s Constitution sets out the composition of the Governing Body whilst Chapter 0 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. Council of Members Roles

2.3.1. Practice Representatives as referred to in paragraph 7.1 of the Constitution are subject to the following appointment process;

a) Nominations – By GPs within their Practice

b) Eligibility – any GP or Healthcare Professional employed or engaged by a member of the Group.

c) Appointment process – each Member Practice shall appoint one (1) Practice Representative and one authorised deputy, known as the Alternate Practice Representative. The name of the Practice Representative and deputy must be submitted to the relevant Commissioning Locality Chair;

d) Authority – for the avoidance of doubt, the Governing Body shall be entitled to treat any Practice Representative as having continuing authority given to him/her until it is notified in writing of the removal of that Practice Representative in accordance with Paragraph 2.2.10(b) and any provision of this Constitution that requires delivery or notification to a Member shall be deemed to have been satisfied if delivery or notification is made to or served on the relevant Practice Representative.

e) Term of office – Each Member shall determine the term of office for their Practice Representative and Alternate Practice Representative.

f) Eligibility for reappointment – Each Member shall determine the terms for reappointment.

g) Grounds for removal from office include –

i) If the Practice Lead or Alternate Practice Lead ceases to be a clinician in the Area;

ii) Any Member can remove their Practice Lead and/or Alternate Practice Lead by notice in writing to the Governing Body;

iii) Where, in the reasonable opinion of the Governing Body (having taken...
appropriate professional advice in cases where it is deemed necessary), it is
deemed that the Practice Lead or Alternate Practice Lead has developed a
mental or physical illness which prohibits or inhibits his/her ability to
undertake his/her role.

h) **Notice period** – Members must ensure one individual is named as their Practice Lead
and one individual is named as their Alternate Practice Lead at all times. Notice periods
shall be determined by each Member.

**Governing Body Roles**

2.3.2. **GP Clinical Member** - The three GP Clinical Members as listed in paragraph 6.10.2.b) of the
Group’s Constitution are subject to an appointment process.

a) **Nominations** – Not applicable

b) **Eligibility**: -
   
i) a practising GP working a in Member practice (GPs may be partners,
salaried doctors or locums.);
ii) not be the Accountable Officer, the Chief Finance Officer;
iii) be on the GMC register;

c) **Appointment process** - A panel will meet to review applications against the criteria set
in the Governing Body GP Role Description and Person Specification. The panel will
consist of:
   
i) SDCCG’s Clinical Chair
ii) Lay Member for Governance and Vice Chair
iii) Accountable Officer
iv) NHS England South (South East) Medical Director
v) LMC representative;
   
   Formal interview and selection by above panel;
   
The panel will make their recommendation for appointment to the Remuneration
Committee, which will review the appointment process and approve the formal
appointment;

d) **Term of Office** – A GP Member may hold office for a period of up to three (3) years;

e) **Eligibility for reappointment** – A GP Member shall be eligible for re-appointment at the
end of their term but may not serve more than three (3) consecutive terms or nine (9)
years whichever is the lesser;

f) **Grounds for removal from office** – A GP Member shall cease to hold office:
   
i) if he/she ceases to meet the eligibility criteria set out in sub-paragraph
   2.2.3(b) (Eligibility) above;
ii) in accordance with the post holder’s Contract of Employment and
   Employment legislation;
iii) if any of the grounds set out in Paragraph “Eligibility to Serve” apply.

g) **Notice period** - A GP Member shall give three (3) months’ notice in writing to the
Governing Body of his/her resignation from office at any time during his/her term of
office.

2.3.3. **The Clinical Chair of the Governing Body**, as listed in paragraph 6.10.2.a) of the Group’s
Constitution, is subject to the following appointment process:

a) **Nominations** – Interested candidates may apply for the role, demonstrating how they
meet the essential requirements of the person specification and how they would
undertake the role. A panel consisting of members of the Remuneration Committee and
any others deemed appropriate may assess the candidates’ suitability for the role of 
Clinical Chair by holding screening interviews and produce a shortlist of suitable 
candidates for the role;

b) **Eligibility** – Any GP Clinical Representative who has passed any nationally mandated 
assessment process for Clinical Commissioning Group Chairs.

c) **Appointment process** – Election process for all short listed candidates, with election by 
all Members of the Governing Body passing an Ordinary Resolution at the AGM;

d) **Term of Office** – Unless specified otherwise, the Clinical Chair may hold office for a 
period of up to three (3) years;

e) **Eligibility for reappointment** – The Clinical Chair shall be eligible for re- appointment at 
the end of his/her term but may not serve more than three (3) consecutive terms or nine 
(9) years whichever is the lesser;

f) **Grounds for removal from office include**-

i) The Clinical Chair ceases to meet the eligibility criteria above;

2.3.4. The **Accountable Officer** as listed in paragraph 6.10.2.c) of the Group’s Constitution, is 
subject to the following appointment process:

a) **Nominations** – subject to (d) below, not applicable;

b) **Eligibility** – Accountable Officer must:

i) either be:

- an individual who is a Member of the Group or of any body that is a Member Practice 
of the Group or, in the case of a joint appointment, an individual who is a member of 
any of the Clinical Commissioning Groups in question or of any body that is a 
member of any of those Clinical Commissioning Groups; or

- an employee of the Group or of any Member Practice of the Group or, in the case of 
a joint appointment, an employee of any of the Clinical Commissioning Groups in 
question or of any member of those Clinical Commissioning Groups;

ii) not be an individual subject to any of the grounds set out in paragraph 2.2.16 
below; and

iii) have passed any nationally mandated assessment process.

c) **Appointment process** – The Accountable Officer shall be appointed by NHS England.

d) **Term of office** – unless the Group determines otherwise from time to time this shall be a 
substantive appointment;

e) **Eligibility for reappointment** – subject to (d) above, not applicable;

f) **Grounds for removal** from office include –

i) The Accountable Officer is disqualified from membership of a clinical 
commissioning group Governing Body under the CCG Regulations and/ or in 
accordance with his or her contract of employment.

ii) if any of the grounds set out in Paragraph “Eligibility to Serve” apply.

2.3.5. The **Chief Finance Officer** as listed in paragraph 6.10.2.d) of the Group’s Constitution is 
subject to the following appointment process:

a) **Nominations** – not applicable;
b) **Eligibility** – The Chief Finance Officer must:
   i) not be the Group's Accountable Officer;
   ii) hold a qualification of one of the individual CCAB bodies;
   iii) not be an individual subject to any of the grounds set out in paragraph 2.2.16 below; and
   iv) have passed any nationally mandated assessment process;

c) **Appointment process** – Appointments, to be made by the Governing Body, shall be via open advert and selection against competencies based on current national guidance by NHS England;

d) **Term of Office** –– the period of his/ her employment as the Chief Finance Officer of the Group;

e) **Eligibility for reappointment** – not applicable;

f) **Grounds for removal from office** include –

   i) The Chief Finance Officer is disqualified from membership of a clinical commissioning group Governing Body under the CCG Regulations and / or in accordance with his or her contract of employment

   ii) if any of the grounds set out in Paragraph “Eligibility to Serve” apply.

g) **Notice** period - As set out in the contract of employment.

2.3.6. **The Lay Members** as listed in paragraph 6.66.10.2(f) and (g) of the Constitution are subject to the following appointment process:

a) **Nominations** – not applicable;

b) **Eligibility** -

   i) a Lay Member must be an individual who is not:
      - a Member of the Group;
      - a practising Healthcare Professional;
      - an individual of the description set out in Schedule 4 to the Regulations;
      - an individual of the description set out in paragraph 2.2.16 below;

   ii) the Lay Member who leads on audit, finance, remuneration and conflict of interest matters must have qualifications, expertise or experience such as to enable the person to express informed views about financial management and audit matters; and

   iii) the Lay Member who is to lead on patient and public participation matters must be a person who has knowledge about the Area such as to enable the person to express informed views about the discharge of the Group's functions, but they do not have to live in the immediate catchment area.

c) **Appointment process** – Open advert. Selection against competencies based on current national guidance on NHS England’s website.

d) **Term of Office** – A Lay Member may hold office for a period of up to three (3) years

e) **Eligibility for reappointment** – A Lay Member shall be eligible for re-appointment at the end of his term but may not serve more than three (3) consecutive terms or nine (9) years whichever is the lesser;

f) **Grounds for removal from office** – A Lay Member shall cease to hold office if:

   i) he/she ceases to meet the eligibility criteria set out in sub-paragraph 2.2.4(b)
(Eligibility) above; and/or

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<td>ii) if any of the grounds set out in Paragraph “Eligibility to Serve” apply;</td>
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<td>g) <strong>Notice Period</strong> - A Lay Member shall give three (3) months’ notice in writing to the Governing Body of his/her resignation from office at any time during his/her term of office.</td>
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### 2.3.7. The Vice Chair (Lay), as listed in paragraph 7.5 of the Constitution is the Lay Member with Audit, Finance & Remuneration. responsibilities.

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<td>b) <strong>Eligibility</strong> – not applicable;</td>
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<td>c) <strong>Appointment process</strong> – not applicable;</td>
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<td>d) <strong>Term of Office</strong> – not applicable;</td>
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<td>e) <strong>Eligibility for reappointment</strong> – not applicable;</td>
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<td>f) <strong>Grounds for removal</strong> – not applicable;</td>
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<td>g) <strong>Notice period</strong> – not applicable.</td>
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### 2.3.8. The Registered Nurse as listed in paragraph 6.10.2.f) of the Group’s Constitution is subject to the following appointment process:

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<tr>
<td>a) <strong>Nominations</strong> – not applicable;</td>
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<td>b) <strong>Eligibility</strong> – the Registered Nurse must:</td>
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<td>i) be a current registered nurse, other than one who is an employee or member (including shareholder) of, or a partner in, any of the following:</td>
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<td>• a person who is a provider of primary medical services for the purposes of Chapter A2 of the 2006 Act;</td>
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<td>• a body which provides any relevant service to a person for whom the Group has responsibility as provided for in the subsection (1A), and regulations made under subsections (1B) and (1D) of section 3 of the 2006 Act;</td>
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<td>ii) not be an individual subject to any of the grounds set out in paragraph 2.2.16 below; and</td>
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<td>iii) have no conflicts of interest as defined by national guidance on the NHS England website;</td>
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<td>c) <strong>Appointment process</strong> – Open advert. Selection against competencies based on current national guidance on the NHS England website by the Governing Body.</td>
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<td>d) <strong>Term of Office</strong> – A Registered Nurse may hold office for a period of up to three (3) years</td>
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<td>e) <strong>Eligibility for reappointment</strong> – A Registered Nurse shall be eligible for re-appointment at the end of his/her term but may not serve more than three (3) consecutive terms or nine (9) years whichever is the lesser;</td>
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<td>f) <strong>Grounds for removal from office</strong> –</td>
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<td>i) A registered nurse shall cease to hold office if:</td>
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<td>ii) he/she ceases to meet the eligibility criteria set out in paragraph “Eligibility” above; and/or</td>
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<td>iii) if any of the grounds set out in Paragraph “Eligibility to Serve” apply.</td>
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<td>g) <strong>Notice Period</strong> - A registered nurse shall give three (3) months’ notice in writing to the Governing Body of his/her resignation from office at any time during his/her term of</td>
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2.3.9. The **Secondary Care Doctor** as listed in paragraph 6.10.2.e) of the Group’s Constitution is subject to the following appointment process:

a) **Nominations** – not applicable;

b) **Eligibility** – the Secondary Care Doctor must:

   i) be a registered medical practitioner who is, or has been at any time in the period of ten (10) years ending with the date of the individual's appointment to the Governing Body, an individual who fulfils (or fulfilled) all the following conditions:

   - the individual’s name is included in the Specialist Register kept by the General Medical Council under section 34D of the Medical Act 1983, or the individual is eligible to be included in that Register by virtue of the scheme referred to in subsection (2)(b) of that section;
   - the individual holds a post as an NHS consultant (as defined in section 55(1) of the Medical Act 1983) or in a medical speciality in the armed forces (meaning the naval, military, or air forces of the Crown, and includes the reserve forces within the meaning of section 1(2) of the Reserve Forces Act 1996 (power to maintain reserve forces);
   - the individual’s name is not included in the General Practitioner Register kept by the General Medical Council under section 34C of the Medical Act 1983

   ii) not be an employee or member (including shareholder) of, or a partner in, any of the following:

   - a person who is a provider of primary medical services for the purposes of Chapter A2 of the 2006 Act;
   - a body which provides any Relevant Service to a person for whom the Group has responsibility as provided for in the subsection (1A), and regulations made under subsections (1B) and (1D) of section 3 of the 2006 Act

   iii) not be an individual subject to any of the grounds set out in paragraph 2.2.16 below; and

   iv) have no conflicts of interest as defined by national guidance on the NHS England website;

c) **Appointment process** – Open advert. Selection against competencies based on current national guidance on the NHS England website by the Governing Body.

d) **Term of Office** – A Secondary Care Doctor may hold office for a period of up to three (3) years;

e) **Eligibility for reappointment** – A Secondary Care Doctor shall be eligible for reappointment at the end of his/her term but may not serve more than three (3) consecutive terms or nine (9) years whichever is the lesser;

f) **Grounds for removal from office** – A Secondary Care Doctor shall cease to hold office if:

   i) he/she ceases to meet the eligibility criteria set out in sub-paragraph 2.2.6(b) (Eligibility) above; and/or

   ii) if any of the grounds set out in paragraph 2.2.16 below apply;

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50 See comment at footnote 26 above
g) **Notice period** - A Secondary Care Doctor shall give three (3) months' notice in writing to the Governing Body of his/her resignation from office at any time during his/her term of office.

### 2.4. **Key roles - generic**

#### 2.4.1. The roles and responsibilities of each of these key roles are set out either in paragraph 6.10.2 or Chapter 7 of the Group’s Constitution.

#### 2.4.2. All nominations must make a Declaration of Interests and during the selection (ie before appointment) an assessment must be made whether the candidate can fulfil the role with their other interests.

#### 2.4.3. Where more than one person is appointed jointly to a post, those persons shall count for the purpose of paragraph 6.10. of the Group's Constitution as one person.

#### 2.4.4. Having regard to the Group’s intention to always appoint into those of its Governing Body member roles which require Group election, those persons that it considers are the most suitably qualified and experienced persons for the role, the Group shall be entitled (save to the extent required otherwise by law or where such action would result in the composition of the Governing Body no longer having a clinical majority) from time to time and by passing a Special Resolution to disapply any particular qualification or limitation referred to in this Constitution in respect of any such election.

#### 2.4.5. For the avoidance of doubt, those members of the Governing Body who are appointed pursuant to an election process by the Member practices of the Group may also be removed from the Governing Body by the Member practices of the Group passing a Special Resolution in accordance with paragraph 3.9.

#### 2.4.6. Without in any way delegating its responsibilities in respect of the same, the Group shall be entitled, from time to time, to request that the Local Medical Committee observe and oversee its election processes in respect of those members of the Governing Body that are appointed by such election processes.

#### 2.4.7. **Eligibility to Serve** – People who are ineligible for appointment to the Governing Body include anyone who:

- a) is not eligible to work in the UK;

- b) has received a prison sentence or suspended sentence of 3 months or more in the last 5 years;

- c) is the subject of a bankruptcy order or interim order;

- d) has been dismissed (except by redundancy) by any NHS body;

- e) is subject to a disqualification order under the Company Directors Disqualification Act 1986; or

- f) has been removed from the position of trustee to a charity.

- g) is a Member of Parliament, Member of the European Parliament or member of the London Assembly;

- h) is a member of a local authority in England and Wales or of an equivalent body in Scotland or Northern Ireland;

- i) is an individual who, by arrangement with the Group, provides it with any service or facility in order to support the Group in discharging its commissioning functions (being the functions of the Group in arranging for the provision of services as part of the health service), or an employee or member (including shareholder) of, or a partner in, a body which does. For the avoidance of doubt, the services and facilities referred to in this
Meetings of the Clinical Commissioning Group

3. Council of Members' Meetings

3.1. Calling meetings

3.1.1. Ordinary meetings of the Council of Members shall be held at regular intervals at such times and places as the Chair of the Council of Members may determine.

3.1.2. The Chair or one third of the total number of Member Practices can call a special meeting of the Council of Members' by giving all Member practices at least twenty-one (21) days notice.

3.1.3. Planned ordinary meeting dates of the Council of Members' Meetings will be notified to Member Practices at least annually. Planned meeting dates will be published on the Group's website at www.surreydownsccg.nhs.uk and a hard copy posted at the Group's headquarters.

3.2. Annual General Meeting

3.2.1. The Council of Members will hold one meeting a year in public for the purpose of presenting the Annual Report and Annual Accounts to members of the public (AGM).

3.2.2. The AGM shall be held at such time and such place as the Chair shall determine, having consulted with the other members of the Governing Body.

3.2.3. The AGM shall be held in public in premises that are easily accessible by members of the public.

3.2.4. Notice of the AGM will be given to all Governing Body members and to all Members; and published on the Group’s website and at the Group’s offices; at least 10 working days before the meeting.

3.2.5. A substantial proportion of the AGM will be given over to hearing and responding to the views and questions of the public.

3.2.6. The minutes of the AGM shall be published on the Group’s website.

3.2.7. Standing Orders shall apply to the conduct of the AGM together with such other Standing Orders relating to meetings of the Council of Members as the chair of the meeting considers appropriate.

3.3. Agenda, supporting papers and business to be transacted

3.3.1. Items of business to be transacted for inclusion on the agenda of a meeting need to be notified to the Chair at least fifteen (15) working days before the meeting takes place. Supporting papers for such items need to be submitted at least seven (7) working days before the meeting takes place. Any items notified to the chair of the meeting less than 15 working days before a meeting may be included on the agenda at the discretion of the chair.

3.3.2. The agenda shall usually be sent to the Practice Representatives at least fourteen (14) days before the meeting together with the supporting papers, but will certainly be dispatched no later than seven (7) days before the meeting, save in emergency. The Council of Members
may determine that certain matters shall appear on every agenda for a meeting and shall be addressed prior to any other business being conducted (such matters may be identified within these Standing Orders or following subsequent resolution shall be published on the Group’s website).

3.4. **Petitions**

3.4.1. Where a petition has been received by the Group, the Chair shall include the petition as an item for the agenda of the next meeting of the Governing Body.

3.5. **Chair of a meeting**

3.5.1. The Chair, if present, shall chair Council of Members meetings. If the Chair is absent from the meeting, a nominated Vice Chair, if any and if present, shall preside.

3.5.2. 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 nor vice chair, a Practice Representative present at Council of Members meeting shall be chosen by the Member practices present, or by a majority of them, and shall preside.

3.6. **Chair’s ruling**

3.6.1. The decision of the Chair 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.

3.7. **Quorum**

3.7.1. One third of persons entitled to vote upon the business to be transacted, each being a GP Clinical Member, shall be a quorum for the Council of Members' Meeting.

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

3.7.3. Proxies for GP Clinical Members validly appointed in accordance with paragraph 3.8 below will count towards the quorum.

3.7.4. If any GP Clinical Members 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 the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at the meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

3.8. **Decision making**

3.8.1. Chapter 6 of the Group's Constitution, together with the Scheme of Reservation and Delegation, sets out the governing structure for the exercise of the Group’s statutory functions. Generally it is expected that at the Council of Members meetings decisions will be reached by consensus. Should this not be possible then a vote of members of the Council of Members will be required, the process for which is set out below:

3.8.2. At any Council of Members’ Meeting a resolution put to the vote of the meeting shall be decided upon a show of hands.

3.8.3. At Council of Members’ Meetings resolutions shall be put to the vote by the Chair of the
meeting and there shall be no requirement for the resolution to be proposed or seconded by any person.

3.8.4. A declaration by the Chair at a Council of Members' Meeting that a resolution has been carried or lost and an entry into the minutes of the meeting shall be conclusive evidence of the fact.

3.8.5. On a show of hands, every GP Clinical Member present in person shall have one vote.

3.8.6. Every question which is not the subject of a formal resolution but is nevertheless to be put to the vote at a Council of Members meeting shall be determined by a majority of the votes of those eligible to vote, present, and voting on the question. In the case of an equal vote, the Chair of the meeting shall have an additional and casting vote.

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

3.8.8. For all other of the Group’s committees and sub-committees, including the Governing Body’s committees and sub-committee, the details of the process for holding a vote are set out in the appropriate terms of reference.

3.9. Special Resolution Matters

3.9.1. A Special Resolution of the Members is passed:
- at a Membership meeting with at least 75% of the votes cast by those Members attending (by their Practice Lead/Alternate Practice Lead or by proxy) and a quorum of 75% of the Group's Membership.
  OR
- the execution of a written resolution by at least 75% of the Members who return the written resolution to the Secretary by the long-stop date - provided that at least 75% of the Members return the written resolution to the Secretary by the long-stop date.

3.9.2. The following matters are considered by the Group to be of such significance that, in place of passing an Ordinary Resolution, they require a Special Resolution to carry a vote:

a) any change to this Constitution which also requires the approval of NHS England;

b) any resolution proposed by a Member Practice to remove any member of the Governing Body. In these circumstances, the Member Practice proposing such resolution must notify the Governing Body not less than twenty-one (21) days in advance of the next Council of Members Meeting of such a proposal, a separate resolution must be proposed in respect of each member of the Governing Body and not more than one such resolution may be voted upon at any Council of Members Meeting.

c) Where resolutions are proposed in respect of multiple members of the Governing Body, they will be presented, in a phased manner, at successive Council of Members meetings, in the same order as they are received. The member of the Governing Body that is the subject of such resolution shall be entitled to circulate written representations to any or all Member practices of the Group before the Council of Members meeting at which such resolution is to be voted upon and shall also be entitled to address the Member practices at such meeting, in advance of any such vote. If a vote is carried in respect of such removal, that person shall accept the termination of their appointment on the same period of notice as would have applied had they voluntarily resigned (to afford the Group the opportunity to then elect a replacement);

d) disapplying any qualification or limitation otherwise applicable to an applicant for a Governing Body member role, as described in paragraph 2;
e) suspension of any of the Standing Orders at a Council of Members Meeting, as described in paragraph 6.13.

3.10. **Proxy notices**

3.10.1. Proxies for Member GP Clinical Members may only validly be appointed by a notice in writing (a "proxy notice") which:

a) states the name and address of the Member GP Clinical Member appointing the proxy;

b) identifies the person appointed to be that Member GP Clinical Member’s proxy and the Council of Members Meeting in relation to which that person is appointed;

c) is signed by or on behalf of the Member GP Clinical Member appointing the proxy, or is authenticated by the relevant Member Practice; and

d) is delivered to the Council of Members meeting in accordance with this Constitution and any instructions contained in the notice of the Council of Members Meeting to which they relate.

e) The Governing Body may require proxy notices to be delivered in a particular form, and may specify different forms for different purposes.

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

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

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

b) appointing that person as a proxy in relation to any adjournment of the Council of Members Meeting to which it relates as well as the meeting itself.

c) An appointment under a proxy notice may be revoked by delivering to the Governing Body a notice in writing given by or on behalf of the GP Clinical Member by whom or on whose behalf the proxy notice was given.

3.10.4. A notice revoking a proxy appointment only takes effect if it is delivered before the start of the meeting or adjourned meeting to which it relates.

3.10.5. If a proxy notice is not executed by the GP Clinical Member appointing the proxy, it must be accompanied by written evidence of the authority of the person who executed it to execute it on the relevant Member Practice’s behalf.

3.11. **Resolutions in writing**

3.11.1. The Council of Members may use the process for adopting a written to enable it to transact business between meetings of the Council of Members. The process for adopting a written resolution shall not be used to replace meetings of the Council of Members.

3.11.2. **Proposing written resolutions**

3.11.3. At the Vice Chair’s request, the Secretary of the Council of Members shall propose a written resolution to the Council of Members.

3.11.4. A written resolution is proposed by giving notice of the proposed resolution to the Practices Representatives. Such notice shall stipulate:

a) the proposed resolution; and

b) the long-stop date by which the written resolution is to be adopted, which shall be not less than ten (10) days from the date the written resolution is dispatched by the
3.11.5. Notice of a proposed written resolution must be given in writing to each Practices Representative. Notice by e-mail or post is permitted.

3.11.6. **Adopting written resolutions**

3.11.7. A proposed written resolution shall be adopted if:

a) the majority of the Practices Representatives who return the proposed written resolution to the Secretary of the Council of Members by the long-stop date have executed the proposed written resolution; or

b) where a Special Resolution is required, at least 75% of the Members who return the written resolution to the Secretary by the long-stop date - provided that at least 75% of the Members return the written resolution to the Secretary by the long-stop date.

3.11.8. The written resolution may be returned to the Secretary of the Council of Members by e-mail or post.

3.11.9. Once a written resolution has been adopted, it shall be treated as if it had been a decision taken at a meeting of the Council of Members in accordance with these Standing Orders.

3.11.10. The Secretary of the Council of Members shall ensure that the Group keeps a record, in writing, of all written resolutions of the Council of Members for at least six (6) years from the date of their adoption.

3.12. **Record of Attendance**

3.12.1. The names of all Member Practices present at a Council of Members meeting shall be recorded in the minutes of the Council of Members meeting.

3.13. **Minutes**

3.13.1. The Chair will identify a suitable individual to record the minutes of each Council of Members meeting.

3.13.2. The minutes of the Council of Members meeting will be formally signed off by the Council of Members at its next meeting. No discussion shall take place upon the minutes except upon their accuracy or where the chair of the meeting considers discussion appropriate.

3.13.3. Draft minutes will be made available to Member Practices no later than five business days after the Council of Members meeting to which they relate.

3.14. **Admission of public and the press**

3.14.1. The Annual General Meeting of the Council of Members Meetings, at which the Group presents the Annual Report to the public, shall be public.

3.14.2. Meetings of the Council of Members will be held in private.

3.14.3. The Chair may determine to hold a Council of members meeting in public having considered the nature of the subject matter of such a meeting. Where a Council of Members Meeting is open to the public, the Chair may resolve that the public be excluded from the meeting, whether for the whole or part of the proceedings on the grounds that publicity would be prejudicial to the public interest or the interests of the Group by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of the business to be transacted or the proceedings.

3.14.4. Discussions and decision-making following exclusion of the public and representatives of the...
press shall be minuted in accordance with paragraph 3.13, except that such minutes shall be treated in accordance with the confidential nature of the business.

| 3.14.5. | Where the public and representatives of the press are excluded, Member practices, employees and other persons remaining present at the Council of Members Meeting are required not to disclose confidential information from papers, minutes or discussions outside of the Group, without the express permission of the Governing Body. |

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4.1.1. The Group may have a seal for executing documents where necessary. The seal shall be kept by the Accountable Officer or a nominated manager by him/her in a secure place.

4.1.2. Where it is necessary that a document shall be sealed, the seal shall be affixed in the presence of two of the following persons and shall be attested by them:

   a) the Accountable Officer
   b) the Chair of the Governing Body;
   c) the Chief Finance Officer;
   d) the Managing Director.

4.1.3. The Chief shall keep a register in which he/she, or another manager of the Group authorised by him/her, shall enter a record of the sealing of every document. This register is to be presented to the Governing Body annually.

   a) The seal shall be used in the following situations unless agreed otherwise by the Governing Body;
   b) all contracts for the purchase/lease of land and/or building
   c) all contracts for capital works exceeding £100,000;
   d) all lease agreements where the annual lease charge exceeds £10,000 per annum and the period of the lease exceeds five years;
   e) any other lease agreement where the total payable under the lease exceeds £100,000;
   f) any contract or agreement with organisations other than NHS or other government bodies including local authorities where the annual costs exceed or are expected to exceed £100,000.

4.2. Execution of a document by signature

4.2.1. The designation of individuals authorised to execute a document on behalf of the Group by their signature is as set out in the Group’s scheme of delegation. Documents relating to contracts, or the transfer of significant assets must be signed by at least one of the following:

   a) the Accountable Officer
   b) the Clinical Chair; and
   c) the Chief Finance Officer; and
   d) the Managing Director.

5. Overlap with other Clinical Commissioning Group Policy statements/procedures and regulations

5.1. Policy statements: general principles

5.1.1. 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 the 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.
# The Governing Body

## 6. Meetings of the Governing Body

### 6.1. Calling meetings

**6.1.1.** Ordinary meetings of the Governing Body will be held at regular intervals at such times and places as the Governing Body may determine.

**6.1.2.** An extraordinary meeting of the Governing Body can be called at the request of the Chair of the Governing Body.

**6.1.3.** One-third of the members of the Governing Body may requisition a meeting of the Governing Body by a request to the Chair in writing. If the Chair refuses, or fails, to call a meeting within seven (7) days of the requisition being presented, the members signing the requisition may forthwith call a meeting.

**6.1.4.** Meetings of the Governing Body (excluding seminars for the purpose of Governing Body Development) must be open to the public unless the Governing Body resolves that the public be excluded from the meeting, whether for the whole or part of the proceedings, on the grounds that it would not be in the public interest to permit members of the public to attend all or part of the meeting by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of the business to be transacted or the proceedings.

**6.1.5.** The Governing Body Secretary (on receiving a request from five (5) members of the Governing Body to call a meeting of the Governing Body) or, if no Secretary has been appointed, any member of the Governing Body receiving such a request, shall call a meeting of the Governing Body by issuing a notice within five (5) Business Days of being requested to do so.

### 6.2. Notice of meetings

**6.2.1.** Notice of any Governing Body meeting must indicate:

- a) its proposed date and time, which must be at least seven (7) days after the date of the notice, except where a meeting to discuss an urgent issue is required (in which case as much notice as reasonably practicable in the circumstances should be given);

- b) where it is to take place;

- c) an agenda of the items to be discussed at the meeting and any supporting papers; and

- d) if it anticipated that members of the Governing Body participating in the meeting will not be in the same place, how it is proposed that they should communicate with each other during the meeting.

**6.2.2.** Notice of a Governing Body meeting must be given to each member of the Governing Body in writing.

**6.2.3.** Failure to effectively serve notice on all members of the Governing Body does not affect the validity of the meeting, or of any business conducted at it.

### 6.3. Agenda and supporting papers
6.3.1. **Item notification** - Items of business to be transacted for inclusion on the agenda of the Governing Body need to be notified to the chair of the meeting at least fifteen (15) working days (i.e. excluding weekends and bank holidays) before the meeting takes place. Supporting papers for such items usually need to be submitted at least twelve (12) working days before the meeting takes place. The notification to the chair should state whether the item of business is proposed to be transacted in the presence of the public. Any item notified to the chair less than 15 working days before a meeting may be included on the agenda at the discretion of the chair.

6.3.2. Before each meeting of the Governing Body, a written notice specifying the business proposed to be transacted shall be delivered to every member of the Governing Body or sent by post to the usual place of residence of each member so as to be available to members at least six (6) working days before the meeting.

6.3.3. The notice of a Governing Body meeting shall be signed by the Chair or by an officer authorised by the Chair to sign on their behalf. Want of service of such a notice on any member of the Governing Body shall not affect the validity of a meeting.

6.3.4. In the case of a Governing Body meeting called by members of the Governing Body in default of the Chair calling the meeting, the notice shall be signed by those members. No business shall be transacted at the meeting other than that specified on the agenda, or emergency motions allowed under Standing Order.

6.3.5. The agenda shall be sent to members at least six (6) days before the meeting and supporting papers, whenever possible, shall accompany the agenda, but will certainly be dispatched no later than four (4) working days before the meeting, save in emergency. The Governing Body may determine that certain matters shall appear on every agenda for a meeting and shall be addressed prior to any other business being conducted (such matters may be identified within these Standing Orders or following subsequent resolution shall be published on the Group’s website).

6.3.6. The date, time, venue, agenda and all papers related to the agenda of all Governing Body meetings will be made public with at least seven days notice on the Group's website.

6.3.7. The Chair can determine items that need to be discussed in private in line with statute and national guidance for example matters of staff discipline, or where patient or commercial confidentiality is likely to be breached.

6.3.8. The agenda for any meeting of the Governing Body that is to be held in private and any papers relating to items that are to be discussed in private shall not be made public.

6.4. **Quorum**

6.4.1. The quorum is one-third of the whole number of the Chair and the members which must include:
- The Chair (or Vice Chair-Lay)
- AO or CFO
- One Lay Member
- One GP Clinical Member (or one independent clinical member where all the GP Clinical Representatives present have a conflict of interest for the decision.)
  - The chair has a casting vote, if necessary.

6.4.2. If the total number of members of the Governing Body for the time being is less than the quorum required, the Governing Body must not take any decision other than:
  - a) than the appointment of the chair of the meeting
b) make a decision to call a Council of Members Meeting so as to enable the Member Practices, acting through their Practice Representatives, to appoint further members of the Governing Body to fill any vacancies.

| 6.4.3. | The Governing Body may co-opt such other person(s) to attend all or any of its meetings, or part(s) of a meeting, in order to assist in its decision making and in its discharge of its functions as it sees fit. Any such person may speak and participate in debate but may not vote. |
| 6.4.4. | A representative in attendance on behalf of a member of the Governing Body will count towards the quorum if notified in advance to the Chair as acting in a formal deputising capacity, provided that the Chair accepts the deputising arrangements. |
| 6.4.5. | If any member of the Governing Body is 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 the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at the meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business. |
| 6.4.6. | In situations where all of the GP Clinical Members on the Governing Body have a conflict of interest (as determined in accordance with the Group’s Conflicts of Interest Policy) in relation to any matter to be considered at a meeting, the Chair of the Governing Body or Vice Chair (Lay) (as appropriate) will decide whether they can take part in the discussions prior to being excluded for the vote in line with the Group’s Conflicts of Interest Policy. |
| 6.4.7. | Each of the Accountable Officer and the Chief Finance Officer may appoint a nominated deputy to attend meetings on their behalf from time to time. |
| 6.4.8. | Where the office of a member of the Governing Body is shared jointly by more than one person: |
| | a) Either or both of those persons may attend or take part in meetings of the Governing Body and; |
| | b) The presence of either or both of those persons shall count as the presence of one person for the purposes of this Standing Order. |

| 6.5. | **Chair of meeting** |
| 6.5.1. | At any meeting of the Governing Body, the Chair, if present, shall preside. If the Chair is absent from the meeting, the Vice Chair (Lay) will preside. |
| 6.5.2. | If the Chair of the Governing Body is absent temporarily on the grounds of a declared conflict of interest, the Vice Chair (Lay), if present, shall preside. |
| 6.5.3. | If both the Chair of the Governing Body and the Vice Chair (Lay) are absent, or are disqualified from participating, or there is neither a Chair of the Governing Body or a Vice Chair (Lay), a member of the Governing Body shall be chosen by the members of the Governing Body present, or by a majority of them, and shall preside. |

| 6.6. | **Chair’s ruling** |
| 6.6.1. | The decision of the Chair 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. |

| 6.7. | **Voting at Governing Body meetings** |
| 6.7.1. | Generally, it is expected that at Governing Body meetings decisions will be reached by
consensus. Should this not be possible then a vote of members will be required, the process for which is set out below:

| 6.7.2. | Any decision of the Governing Body must be decided by a simple majority decision of those eligible to vote. |
| 6.7.3. | At any meeting of the Governing Body, on a show of hands, every member of the Governing Body present shall have one vote. If the numbers of votes for and against a proposal are equal, the Chair or other person chairing the meeting has a casting vote. |
| 6.7.4. | At any Governing Body meeting a resolution put to a vote of the meeting shall be decided on a show of hands. |
| 6.7.5. | At Governing Body meetings resolutions shall be put to the vote by the Chair of the meeting and there shall be no requirement for the resolution to be proposed or seconded by any person. |
| 6.7.6. | A declaration by the Chair of the meeting that a resolution has on a show of hands been carried or lost and an entry into the minutes, with any dissenting views, of the meeting shall be conclusive evidence of the fact. |
| 6.7.7. | If a member of the Governing Body so requests, their vote shall be recorded in the minutes by name. |
| 6.7.8. | Where the office of a member of the Governing Body is shared jointly by more than one person and, both are present at a meeting: |
|   a) | they should only cast one vote if they agree; |
|   b) | If they are in disagreement no vote should be cast. |

6.8. **Written resolutions**

6.8.1. A resolution in writing signed or approved by the required majority of the members of the Governing Body entitled to receive notice of a meeting of the Governing Body. The resolution may consist of more than one document in the same form each signed or approved by one or more persons.

6.9. **Petitions**

6.9.1. Where a petition has been received by the Group, the Chair of the Governing Body shall include the petition as an item for the agenda for the next meeting of the Governing Body.

6.10. **Emergency powers and urgent decisions**

6.10.1. The Governing Body will delegate responsibility for emergency powers and urgent decisions to the Accountable Officer, the Chief Finance Officer and the Chair of the Governing Body.

6.10.2. In the event of an urgent decision being required, this shall be taken by:

- the Accountable Officer and the Chair of the Governing Body; or

- if the Accountable Officer is unavailable, the Chief Finance Officer and the Chair of the Governing Body;

who must consult at least one clinical and one non-clinical member of the Governing Body prior to taking the decision.

6.10.3. Urgent decisions must be reported to the next Governing Body meeting following the urgent decision for ratification by the full meeting together with a report detailing the grounds on which it was decided to take the decision on an urgent basis and the efforts made to contact
the relevant other members of the Governing Body prior to taking the decision.

6.11. **Record of attendance**

6.11.1. The names of all members present at the meeting of the Governing Body shall be recorded in the minutes of the Governing Body meeting.

6.12. **Minutes**

6.12.1. The Chair will identify a suitable individual to record the minutes of each Governing Body meeting.

6.12.2. The draft minutes of a Governing Body meeting shall be submitted at the next meeting for review as to accuracy. Acceptance of the minutes, with any amendments, shall be recorded in the minutes of the Governing Body meeting at which they are presented for review.

6.12.3. Where appropriate, approved minutes will be made available to the public by publishing them with the agenda and papers of the meeting to which they relate. Minutes or sections of minutes which are of a confidential nature which would not be disclosed under the Freedom of Information Act will not be made available on the Group’s website.

6.13. **Suspension of Standing Orders**

6.13.1. Except where it would contravene any statutory provision or any direction made by the Secretary of State for Health or NHS England or the rules relating to the quorum of the meeting, any part of these Standing Orders may be suspended at any meeting of the Governing Body, provided that at least two-thirds of the whole number of the members of the Governing Body are present and that at least two-thirds of those members present signify their agreement to such suspension.

6.13.2. In addition, those present must include:

a) a member of the Governing Body who is an employee of the Group or holds a paid appointment or office with the Group, and

b) a member of the Governing Body who is not an employee of the Group or holds a paid appointment or office with the group.

6.13.3. A decision to suspend Standing Orders together with the reasons for doing so shall be recorded in the minutes of the meeting.

6.13.4. A separate record of matters discussed during the suspension shall be kept and made available to the Chair and Members of the Group.

6.13.5. No formal business shall be transacted while Standing Orders are suspended.

6.13.6. The Audit Committee shall review every decision to suspend Standing Orders.


6.14.1. The Governing Body will publish papers considered at meetings of the Governing Body, except where the Governing Body considers that it would not be in the public interest to do so in relation to a particular paper or part of a paper.

6.14.2. Subject to paragraph 1.36, the Governing Body shall publish the following information relating to determinations made under subsection (3)(a) and (b) of section 14L of the 2006 Act (which relates to remuneration, fees and allowances, including allowances payable under certain

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**NHS Surrey Downs Clinical Commissioning Group’s Constitution**

Version: 6.6 NHS Commissioning Board Effective Date: 24 July 2018
a) in relation to each senior employee of the Group, any determination of the employee's salary or of any travelling and other allowances payable to the employee, including any allowances payable under a pension scheme established under paragraph 11(4) of Schedule 1A to the 2006 Act;

b) any recommendation of the Remuneration Committee in relation to any such determination.

c) Information as to the determination of a senior employee’s salary need specify only a band of £5,000 into which the salary determined falls.

6.14.3. The Governing Body must not publish any information referred to in paragraph 1.36 if the Governing Body considers that it would not be in the public interest to publish it.

6.14.4. In paragraph 6.14.2.c), a ‘senior employee' means an employee who has authority over or responsibility for directing or controlling the exercise of the Group's functions.

6.15. **Admission of public and the press**

6.15.1. Meetings of the Governing Body will be open to the public except where the 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.

6.15.2. The public meetings of the Governing Body will be announced for the period ahead via the Group’s website. The agenda and papers for upcoming meetings and past ones (including minutes as approved) will be available from the website. Two spare sets of agendas and papers will be produced for the benefit of the public who might arrive at the meeting without any.

6.15.3. The chair of the meeting may make whatever arrangements he or she considers appropriate to enable those attending a meeting to listen or contribute, including to exercise their rights to speak or vote.

6.15.4. Any members of the public who attend a meeting of the Governing Body have no right to speak other than by invitation from the chair of the meeting.

6.15.5. The chair of the meeting may exclude any member of the public from a meeting if they are interfering with or preventing its proper conduct.

6.15.6. The Governing Body must pass the following resolution to exclude the public on the grounds of confidentiality:

6.15.7. “That representatives of the press and other members of the public be excluded from the remainder of this meeting due to the confidential nature of the business to be transacted – publicity on which would be prejudicial to the public interest, Section 1 (2), Public Bodies (Admission to Meetings) Act 1960”

6.15.8. Where it is anticipated that members of the public will be excluded from a meeting, due to the nature of the business scheduled for the meeting, the public agenda will identify the topic for which such exclusion is to be considered.

6.15.9. A meeting can consider an emergency resolution to exclude the public/press, or to adjourn to a private place, if any of those present are disrupting its business and will not leave on request.

6.15.10. Matters to be dealt with by the Governing Body following the exclusion of representatives of the press, and other members of the public, shall be confidential to the members of the Governing Body and any employees of the Group or other individuals in attendance at the meeting.
6.15.11. When the public/press are excluded from a meeting, the members of the Governing Body, employees of the Group and any other individuals in attendance at the meeting will be required not to disclose outside the meeting the contents of papers marked “In Confidence”, minutes headed “Items Taken in Private” or the content of any discussions without the express permission of the chair of the meeting. The discussion may identify a future point at which the contents will no longer be confidential and the minutes shall record this.

6.16. **Committees and Sub-Committees of the Governing Body**

6.16.1. The Governing Body may arrange for any of its functions to be exercised on its behalf by any committee or sub-committee of the Governing Body.

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

6.16.3. At any meeting of a committee or sub-committee of the Governing Body, the chair of the relevant 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.

6.16.4. If the chair is absent temporarily on the grounds of a declared conflict of interest the vice chair of the committee, if present, shall preside. If both the chair and vice chair are absent, or are disqualified from participating, or there is neither a chair nor a vice chair of the committee, a member of the committee shall be chosen by the members present, or by a majority of them, and shall preside.

6.16.5. The quorum for each committee and sub-committee and the status of representatives shall be set out in the terms of reference for the relevant committee or sub-committee. Conflicts of interest in relation to these committees shall be dealt with in accordance with the Group’s Conflicts of Interest Policy.

6.16.6. At each meeting of a committee or sub-committee, the names of all members of the committee or sub-committee present at the meeting shall be recorded in the minutes of the meeting.

6.16.7. The details of the process for holding a vote shall be set out in the terms of reference for the committee or sub-committee.

6.16.8. Meetings of committees and sub-committees of the Governing Body shall be held in private. Unless they are a member of a committee or sub-committee of the Governing Body, no member of the public or press shall attend meetings of committees or sub-committees except by the express permission of the Chair of that committee or sub-committee.

6.16.9. The provisions of these standing orders shall apply where relevant to the operation of the Governing Body’s committees and sub-committee unless stated otherwise in the committee or sub-committee’s terms of reference.

6.17. **Recording of meetings and observers at meetings**

6.17.1. Use of Mechanical or Electrical Equipment for Recording or Transmission of Meetings
- Nothing in these Standing Orders shall be construed as permitting the introduction by the public, or press representatives, of recording, transmitting, video or similar apparatus into any meetings. Such permission shall be granted only upon resolution of the members of the relevant meeting.

6.17.2. Observers at meetings - The members of a meeting will decide what arrangements and terms and conditions it feels are appropriate to offer in extending an invitation to observers to attend and address any meetings and may change, alter or vary these terms and conditions as it deems fit.
6.18. **Indemnity**

6.18.1. Members of the Governing Body who act honestly and in good faith will not have to meet out of their personal resources any personal civil liability which is incurred in the execution or purported execution of their Governing Body functions, save where they have acted recklessly.
Appendix F

Prime Financial Policies

Adopted from Guildford & Waverley CCG - Prime Financial Policies approved: July 2015. These policies will be reviewed in 2018 to ensure they are compliant with best practice.

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 Clinical Commissioning 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 CCG’s Scheme of Reservation and Delegation.

1.1.3. In support of these prime financial policies, the Group has prepared more detailed policies, developed by the Chief Finance Officer, agreed by the Audit Committee and approved by the Group’s Governing Body or where consistent with the Scheme of Delegation, Audit Committee known as the detailed financial policies. The Group refers to these prime and detailed financial policies together as the Clinical Commissioning Group’s financial policies.

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

1.1.5. A list of the Group’s detailed financial policies will be published and maintained on the Group’s website within the Group's Corporate Governance Handbook.

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, or Accountable 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. 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. 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 by the Chief Finance Officer for referring action or ratification.

1.3. Responsibilities and delegation

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

1.3.2. The financial decisions delegated by members of the Group are set out in the Group's Scheme of Reservation and Delegation.

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 material amendment will not come into force until the Group applies to NHS England and that application is granted.

2. INTERNAL CONTROL (also refer to Detailed Financial Policies, paragraph 2)

**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 as set out in the Group’s Constitution.

2.2. The Accountable Officer has overall responsibility for the Group’s systems of internal control.

2.3. In support of the Accountable Officer, 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** (also refer to Detailed Financial Policies, paragraph 3)

   **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's Audit Committee approves any changes to the provision or delivery of assurance services to the Group.

4. **FRAUD, CORRUPTION AND BRIBERY** (also refer to Detailed Financial Policies, paragraph 4)

   **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 and vigorously 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.

4.3. The Bribery Act 2010, which repealed existing corruption legislation, has introduced the offences of offering and receiving a bribe. It also places specific responsibility on organisations to have sufficient and adequate procedures in place to prevent bribery and corruption taking place. Under the Bribery Act 2010, Bribery is defined as “Inducement for
an action which is illegal, unethical or a breach of trust. Inducements can take the form of gifts, loans, rewards or other privileges”. Corruption is broadly defined as “the offering or acceptance of inducements, gifts, favours, payment or benefit-in-kind which may influence the action of any person. Corruption does not always result in a loss. The corrupt person may not benefit directly from their deeds; however, they may be unreasonably using their position to give some advantage to another”. To demonstrate that the organisation has sufficient and adequate procedures in place and to demonstrate openness and transparency, all staff are required to comply with the requirements of the Prime Financial Policies.

5. **EXPENDITURE CONTROL**

5.1. The Group is required by statutory provisions\(^{51}\) to ensure that its expenditure does not exceed the aggregate of allotments from NHS England and any other sums it has received and is legally allowed to spend.

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

5.3. The Chief Finance Officer will:

   a) provide reports in the form required by NHS England;
   
   b) ensure money drawn from NHS England is required for approved expenditure only is drawn down only at the time of need and follows best practice;
   
   c) be responsible for ensuring that an adequate system of monitoring financial performance is in place to enable the Group to fulfil its statutory responsibility not to exceed its expenditure limits, as set by direction of NHS England.

6. **ALLOCATIONS\(^{52}\)**

6.1. The Group’s Chief Finance Officer will:

   a) periodically review the basis and assumptions used by NHS England for distributing allocations and ensure that these are reasonable and realistic and secure the group’s entitlement to funds;
   
   b) prior to the start of each financial year submit to the Governing Body for approval a report showing the total allocations received and their proposed distribution including any sums to be held in reserve; and
   
   c) regularly update the Governing Body on significant changes to the initial allocation and the uses of such funds.

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\(^{51}\) See section 223H of the 2006 Act, inserted by section 27 of the 2012 Act

\(^{52}\) See section 223(G) of the 2006 Act, inserted by section 27 of the 2012 Act.
7. COMMISSIONING STRATEGY, BUDGETS, BUDGETARY CONTROL AND MONITORING (also refer Detailed Financial Policies, paragraph 5)

**POLICY** – the Group will produce and publish an annual commissioning plan\(^{53}\) that explains how it proposes to discharge its financial duties. The Group will support this with comprehensive medium term financial plans and annual budgets.

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

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

7.3. The Chief Finance Officer shall monitor financial performance against budget and plan, periodically review them, and report to the Governing Body. This report should include explanations for variances. These variances must be based on any significant departures from agreed financial plans or budgets.

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

7.5. The Governing Body will approve consultation arrangements for the Group’s commissioning plan\(^{54}\).

8. ANNUAL ACCOUNTS AND REPORTS

**POLICY** – the Group will produce and submit to NHS England accounts and reports in accordance with all statutory obligations\(^{55}\), relevant accounting standards and accounting best practice in the form and content and at the time required by NHS England.

8.1. The Chief Finance Officer will ensure the Group:

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

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

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\(^{53}\) See section 14Z11 of the 2006 Act, inserted by section 26 of the 2012 Act.

\(^{54}\) See section 14Z13 of the 2006 Act, inserted by section 26 of the 2012 Act.

\(^{55}\) See paragraph 17 of Schedule 1A of the 2006 Act, as inserted by Schedule 2 of the 2012 Act.
e) publishes the external auditor’s management letter on the Group’s website.

9. INFORMATION TECHNOLOGY (also refer to Detailed Financial Policies, paragraph 6)

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

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

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

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

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

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

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

10. ACCOUNTING SYSTEMS

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

10.1. The Chief Finance Officer will ensure:

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

b) that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.
10.2. Where another health organisation or any other agency provides a computer service for financial applications, the Chief Finance Officer shall periodically seek assurances that adequate controls are in operation.

11. BANK ACCOUNTS (also refer to Detailed Financial Policies, paragraph 7)

**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\(^\text{56}\), 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 Governing Body shall approve the banking arrangements.

12. INCOME, FEES AND CHARGES AND SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS (also refer to Detailed Financial Policies, paragraph 8)

**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\(^\text{57}\)

- ensure its power to make grants and loans is used to discharge its functions effectively\(^\text{58}\)

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;

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\(^{56}\) See section 223H(3) of the NHS Act 2006, inserted by section 27 of the 2012 Act

\(^{57}\) See section 14Z5 of the 2006 Act, inserted by section 26 of the 2012 Act.

\(^{58}\) 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 NHS England Authority 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 (also refer to Detailed Financial Policies, paragraph 9)

**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 Governing Body may only negotiate contracts on behalf of the Group, and the Group may only enter into contracts, within the statutory framework set up by the 2006 Act, as amended by the 2012 Act. Such contracts shall comply with:

a) the Group’s standing orders;

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

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

13.2. 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.

13.3. 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 reported to the Audit Committee.
13.4. The Accountable Officer shall nominate an individual who shall oversee and manage each contract on behalf of the Group.

14. **COMMISSIONING** (also refer to Detailed Financial Policies, paragraph 10)

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

14.1. The Group will coordinate its work with NHS England, other Clinical Commissioning Groups, local providers of services, local authorities, including through Health and 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** (also refer to Detailed Financial Policies, paragraph 11)

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

15.1. The Governing Body has a responsibility to ensure that the organisation is properly governed in accordance with best practice corporate, clinical and financial governance.

15.2. The Audit Committee will oversee the management of the assurance framework ensuring that it meets the needs of the CCG in being able to identify and reduce risk.

15.3. The Group’s risk register and the work of the Quality and Clinical Governance Committee enable the Group to have a clear view of the risks affecting each area of its activity; how those risks are being managed, the likelihood of occurrence and their potential impact on the successful achievement of the Group's objectives.

15.4. The Group’s risk register is reviewed and updated regularly at the Audit Committee, and then reported to the Governing Body on a quarterly basis.
16. **PAYROLL** (also refer to Detailed Financial Policies, paragraph 12)

**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** (also refer to Appendix 1: Detailed Financial Policies, paragraph 13)

**POLICY** – the Group will seek to obtain the best value for money goods and services received

17.1. The Commissioning, Finance and Performance Committee will approve the Financial Plan, including 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 Audit Committee 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.

17.4 The Governing Body is responsible for approving any agreement that is to be entered into by:

a) the Group and a local authority (or any other body eligible to receive funding under Section 256 of the 2006 Act); or

b) the Group and a voluntary sector organisation;

for the transfer of funding by the Group to the local authority, other body or voluntary sector organisation under Section 256 or Section 257 of the 2006 Act.
18. CAPITAL INVESTMENT, FIXED ASSET REGISTERS AND SECURITY OF ASSETS (also refer to Detailed Financial Policies, paragraph 14)

**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) 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 and ensure that these are notified to managers.

19. RETENTION OF RECORDS (also refer to Detailed Financial Policies, paragraph 16)

**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 (also refer to Detailed Financial Policies, paragraph 17)
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

THE NOLAN PRINCIPLES

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

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

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

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

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

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

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

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

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

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Available at [http://www.public-standards.gov.uk](http://www.public-standards.gov.uk)
Appendix H

THE SEVEN KEY PRINCIPLES OF THE NHS CONSTITUTION

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

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

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

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

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

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

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

7. **The NHS is accountable to the public, communities and patients that it serves** – the NHS is a national service funded through national taxation, and currently by an annual levy. 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)*

AUDIT COMMITTEE
NHS Surrey Downs Clinical Commissioning Group

Terms of Reference

1. Introduction

1.1. The Audit Committee (the Committee) is established in accordance with NHS Surrey Downs Clinical Commissioning Group’s (the 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.

1.2. The Committee - established as an assurance committee - is authorised by the Governing Body to provide assurance of the Group’s compliance with its responsibilities for the conduct of public business and stewardship of funds under its control.

1.3. The Committee is authorised to investigate any activity, within its Terms of Reference, to give the Governing Body assurance of the Group’s compliance to regulation and best practice with regards to:

- financial reporting and internal control principles;
- robust risk management; and
- ensuring an appropriate relationship with both internal and external auditors is maintained.

1.4. The Committee is charged with ensuring that an appropriate relationship with both internal and external auditors is maintained and for monitoring their performance.

1.5. The Committee is authorised to seek any information it requires from any Member, Officer or Employee of the Group - who are directed to co-operate with any request made by the Committee.

1.6. The Committee is accountable reports to the Governing Body.
2. **Membership**

2.1. The Committee shall be appointed by the Group as set out in the Group's Constitution and may include individuals who are not on the Governing Body.

2.2. The Lay Member on the Governing Body, with the lead role in overseeing key elements of governance, shall be the Chair of the Committee.

2.3. The membership of the Committee shall consist of the independent members (both lay and clinical) and any other members co-opted under the terms of 2.1 above.

2.4. All members of the Governing Body, other than the Lay Members and Independent Members, are disqualified from being either Chair or members the Committee;

2.5. Only members of the Committee, as defined in Section 2.4 above, have the right to attend meetings of the Committee, including the right to vote on decisions. All members and employees of the Group and external advisers/service providers may be required to attend for all or part of any meeting, where the Committee deems it appropriate and necessary.

3. **Attendance**

3.1. In addition to the Committee members, the Chief Finance Officer shall generally attend meetings of the Committee.

3.1.1. Directors of the Group will periodically attend meetings of the committee to provide update and assurances on the management of risk within their directorates.

3.1.2. The Accountable Officer would normally be invited to attend and discuss, at least annually with the committee, the process for assurance that supports the Annual Governance Statement. He or she would also normally attend when the committee considers the draft internal audit plan and the annual accounts.

3.1.3. The Chair of the Governing Body may also be invited to attend one meeting each year in order to form a view on, and understanding of, the committee’s operations.

3.2. A representative of each of the internal and external auditor shall generally attend meetings of the Committee.

3.3. A representative of the Local Counter Fraud Specialist shall generally attend meetings of the Committee.

3.4. Other members of the Governing Body shall be invited to attend those meetings where the Committee will consider areas of risk or operation that are within their area of responsibility.

3.5. Regardless of attendance, external audit and internal audit providers, the external auditor, the Local Counter Fraud team and NHS Protect will have full and unrestricted rights of access to the Audit Committee.

4. **Secretary**

4.1. The Company Secretary, or equivalent, shall be the Secretary to the Committee and will provide administrative support and advice. The duties of the Secretary in this regard include but are not limited to:

4.1.1. agreement of the agenda with the chair of the Committee and attendees together with the collation and quality assurance of papers;
4.1.2. taking the minutes and keeping an accurate record of matters arising and issues to be carried forward. These must be focused on agreed actions;

4.1.3. advising the Committee as appropriate on best practice, national guidance and other relevant documentation.

4.1.4. management of the forward plan of committee business, ensuring business milestone dates are reflected and engagement expectations in pursuance of its assurance role are communicated to the wider organisation.

5. **Quorum**

5.1. A quorum shall be two voting members, as defined in Section 2.3 above

5.2. If the designated Chair is unable to attend the meeting, another member of the Committee may be nominated to fulfil the role of Chair on a temporary basis.

6. **Frequency of meetings**

6.1.1. Meetings shall be held at least four times per year, with additional meetings where necessary.

6.1.2. The external and internal auditors and the local counter fraud team shall be afforded the opportunity at least once per year to meet with the Committee without executive officers or members of the Governing Body present.

6.1.3. The Committee members shall be afforded the opportunity to meet at least once per year with no others present.

7. **Remit and responsibilities of the Committee**

7.1. The Committee shall provide assurance to the Governing Body that an appropriate system of internal control is in place to ensure that Business is conducted in accordance with the legal and regulatory framework and proper business conduct standards and public money is safeguarded and properly accounted for.

8. **Integrated governance, risk management and internal control**

8.1. The Committee shall review the establishment and maintenance of an effective system of Integrated Governance, Risk Management and Internal Control, across the whole of the Group's activities that support the achievement of the Group's objectives.

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

8.2.1. all Risk and Control related disclosure statements (in particular the governance statement), together with any appropriate independent assurances, prior to endorsement by the Governing Body;

8.2.2. the underlying assurance processes that indicate the degree of achievement of Group objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements by reviewing and scrutinising the Governing Body Assurance Framework (GBAF) and Corporate Risk Register (CRR).

8.2.3. the policies for ensuring compliance with relevant regulatory, legal, Code of Conduct and Standards of Business requirements, including related reporting and self-certification; and

8.2.4. 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 Protect.
8.3. The Committee will receive the minutes and an update from each of its sub-groups - Health & Safety; and Information Governance - reporting on all risks registered and progress against managing them, evidencing the mechanisms for effective risk identification and management within their purview.

8.4. The sub-groups of the Committee will escalate, through the Director of Corporate Development & Assurance, any issues it determines to be imminent in timescale and/or impact.

9. **Internal Audit**

9.1. The Committee shall ensure that there is an effective internal audit function that meets mandatory Public Sector Internal Standard or any standard that supersedes it, and provides appropriate independent assurance to the Committee, Accountable Officer and the Group.

9.2. The Committee shall achieve an effective internal audit function by:

9.2.1. consideration of the provision of the internal audit service, the cost of the audit and any questions of resignation and dismissal;

9.2.2. 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;

9.2.3. considering the major findings of internal audit work (and the senior team's response) and ensuring co-ordination between the internal and external auditors to optimise audit resources;

9.2.4. ensuring that the internal audit function is adequately resourced and has appropriate standing within the Group; and

9.2.5. an annual review of the effectiveness of internal audit.

10. **External Audit**

10.1. The Committee shall review the work and findings of the external auditors and consider the implications and the senior team's responses to their work.

10.2. The Committee shall achieve this by:

10.2.1. consideration of the performance of the external auditors, as far as the rules governing the appointment permit;

10.2.2. 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 including the NAO;

10.2.3. discussion with the external auditors of their local evaluation of audit risks and assessment of the Group and associated impact on the audit fee;

10.2.4. review of all external audit reports, including the report to those charged with governance, agreement of the annual audit letter before submission to the Group and any work undertaken outside the annual audit plan, together with the appropriateness of management responses;

10.2.5. developing and implementing a policy on the engagement of the external auditor to supply non-audit services; and
10.2.6. considering the provision of the external audit service (having regard to the requirement that the external auditors maintain their independence), the cost of the audit and any questions of resignation and dismissal.

11. Other assurance functions

11.1. The Committee shall review the findings of other significant assurance functions, both internal and external, including but will not be limited to:

11.1.1. any reviews by Department of Health arm’s length bodies or regulators/inspectors (for example, without limitation the Care Quality Commission and NHS Litigation Authority); and

11.1.2. professional bodies with responsibility for the performance of staff or functions (for example, without limitation Royal Colleges and accreditation bodies), and consider the implications for the governance of the Group.

12. Counter fraud

12.1. The Committee will seek assurance from the NHS Counter Fraud and Security Management team that effective measures are in place that meet NHS and CFSMS requirements. This will be achieved by:

12.1.1. consideration of the provision of the counter fraud and security management services, the cost of these services and any questions of resignation and dismissal;

12.1.2. review and approval of the annual Counter Fraud and Security Management plans ensuring that these are consistent with the needs of the organisation;

12.1.3. ensure management’s co-operation with counter fraud and security management services;

12.1.4. to review the undertakings of counter fraud and security management services, ensuring that effective proactive work is undertaken and any investigation outcomes are appropriately managed in line with the aims of the CCG;

12.1.5. ensuring that counter fraud and security management services are adequately resourced and have appropriate standing within the organisation; and

12.1.6. undertake an annual review of the effectiveness of counter fraud and security management services.

13. Management

13.1. The Committee shall request and review reports and positive assurances from members of the Governing Body and senior employees on the overall arrangements for governance, risk management and internal control. The Committee may also request specific reports from individual functions within the Group as they may be appropriate to the overall arrangements.

13.2. The Committee shall also seek evidence and assurance of robust mechanisms for management of Policy Development throughout the group, with a quarterly report to the Committee and an Annual Report to the Governing Body, via recommendations by this Committee. These reports will be produced by the director for Corporate Development and Assurance.

13.3. The Committee will ensure that the Group’s register of interests is regularly reviewed and monitor the effectiveness of arrangements designed to minimise the risks with conflicts of
14. **Financial reporting**

14.1. The Committee shall monitor the integrity of the financial statements of the Group and any formal announcements relating to the Group's financial performance.

14.2. The Committee shall ensure that the systems for financial reporting to the Group, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Group. This shall include monitoring cost effectiveness across the range of the Group’s activities.

14.3. The Committee shall review the Annual Report and financial statements before submission to the Governing Body and the Council of Members, focusing particularly on:

14.3.1. the wording in the governance statement and other disclosures relevant to the terms of reference of the Committee and make recommendations to the Governing Body as necessary;

14.3.2. changes in, and compliance with, accounting policies, practices and estimation techniques;

14.3.3. unadjusted mis-statements in the financial statements;

14.3.4. significant judgements in preparing of the financial statements;

14.3.5. significant adjustments resulting from the audit;

14.3.6. letter of representation; and

14.3.7. qualitative aspects of financial reporting.

15. **Relationship with the Governing Body and Governance Committees**

15.1. The minutes of all meetings of the Committee shall be formally recorded and submitted, together with recommendations where appropriate, to the Governing Body.

15.1.1. The submission to the Governing Body shall include details of any matters in respect of which actions or improvements are needed and where assurance cannot be given. This will include details of any evidence of potential 'ultra vires', otherwise unlawful or improper transactions, acts, omissions or practices or any other important matters. To the extent that such matters arise, the chair of the Committee shall present details to a meeting of the Governing Body in addition to submission of the minutes.

15.2. The Committee will receive quarterly reports from each of the following Governance Committees: Quality; Clinical Executive; Remuneration; and Contract and Finance - reporting on the all risks registered and progress against managing them, evidencing the mechanisms for effective risk identification and management within their purview.

15.3. The Committee will submit an Annual Report to the Governing Body, having undertaken a self-assessment in respect of its performance and in fulfilment of its functions, as set out in these Terms of Reference. This Report shall include but not be limited to:

15.3.1. functions undertaken in connection with the statement of internal control; the assurance framework;

15.3.2. the effectiveness of risk management within the Group;

15.3.3. the integration of and adherence to governance arrangements.
15.3.4. its view as to whether the self-assessment against standards for better health is appropriate; and
15.3.5. any pertinent matters in respect of which the Audit Committee has been engaged.
15.4. The Group's annual report shall include a section describing the work of the Audit Committee in discharging its responsibilities.

16. Policy and best practice

16.1. The Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.

17. Conduct of the Committee

17.1. These Terms of Reference will be reviewed by the Governing Body at least once annually.

18. Meetings in Common

18.1. For clarity – the Committee may meet using the “Committees in Common” arrangement with other CCG Primary Care Commissioning Committees.

18.2. A convenor for the Meetings in Common will be selected from the chairs of the participating committees.
REMUNERATION COMMITTEE
NHS Surrey Downs Clinical Commissioning Group

Terms of Reference

1. Introduction

1.1. The Remuneration Committee (the Committee) is established in accordance with NHS Surrey Downs Clinical Commissioning Group's (the Group) Constitution, Standing Orders and Scheme of Reservation and 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 Group's Constitution and Standing Orders.

1.2. The Committee is an executive committee authorised by Governing Body to act, within these terms of reference and in accordance with its agreed Remuneration Principles (at Annex A), to advise and determine the appointments, remuneration and conditions of service for:

- members of the Governing Body;
- employees of the Group; and
- those who provide services to the Group.

1.3. All Members and employees of the Group are directed to co-operate with any request made by the Committee.

1.4. The Committee also provides assurance regarding performance and succession planning of the Governing Body.

2. Membership

2.1. The Committee shall be appointed by the Governing Body from amongst its Lay and Independent members.

2.2. The membership of the Committee shall consist of:

- the Chair of the Committee, who will be an independent member of the Governing Body.
- The independent member will elect a Chair who cannot also be a member of the Audit Committee.
2.3. Only members of the Committee have the right to attend committee meetings and the right to vote on decisions. However, other individuals such as the Accountable Officer and external advisers may be invited by the Chair to attend for all or part of any meeting, as and when appropriate and necessary.

3. Secretary

3.1. The Company Secretary or equivalent shall be the Secretary to the Committee and will provide administrative support and advice. The duties of the Secretary in this regard include but are not limited to:

3.1.1. agreement of the agenda with the chair of the Committee and attendees together with the collation and quality assurance of papers;

3.1.2. taking the minutes and keeping an accurate record of matters arising and issues to be carried forward. These must be focused on agreed actions;

3.1.3. advising the Committee as appropriate on best practice, national guidance and other relevant documentation.

3.1.4. management of the forward plan of committee business, ensuring business milestone dates are reflected and engagement expectations in pursuance of its assurance role are communicated to the wider organisation.

4. Quorum

4.1. A quorum shall be three voting Members of the committee, as set out in section 2.2, above.

4.2. A decision put to vote at the meeting shall be determined by a majority of the votes of members present. In the case of an equal vote, the Chair of the Committee shall have the casting vote.

5. Frequency of meetings

5.1. Meetings shall be held at least every six months and additional meetings shall be held as and when required to act as a screening panel for Governing Body appointments or in response to directives from the Department of Health or NHS England.

6. Remit and responsibilities of the Committee

6.1. The Committee shall:

6.1.1. determine remuneration and conditions of service of the members of the Governing Body, senior executives, and people who provide services to the Group including:

   a) salary, including any performance-related pay or bonus;

   b) provisions for other benefits, including pensions and cars; and

   c) other allowances.

6.1.2. consider when relevant, the severance payments of the Accountable Officer and other senior employees, seeking HM Treasury approval as appropriate and in accordance with HM Treasury guidance;
6.1.3. determine levels of remuneration that are sufficient to attract, retain and motivate members of the Governing Body and senior executives whilst remaining cost effective, adhering to all relevant laws, regulations and policy in all respects, including:
   a) national guidance;
   b) the management cost cap. Taking into account:
      i) benchmarked information of other Clinical Commissioning Groups’ costs; and
      ii) the competing earnings potential in primary care.

6.1.4. approve contractual arrangements for members of the Governing Body and senior executives, including but not limited to termination payments;

6.1.5. oversee the process by which appointment or election for members of the Governing Body are made;

6.1.6. ensure appropriate mechanisms for succession planning for key members of the Governing Body;

6.1.7. provides assurance regarding the performance review process for all members of the Governing Body including the Chair; and

6.1.8. arrange regular performance evaluation of the effectiveness of the Governing Body and provide assurance that the Governing Body has the right balance of skills, knowledge and perspectives required for members of the Governing Body and contributes to ensuring that the organisation values diversity and promotes equality and inclusivity in all aspects of its business.

6.1.9. determine the Remuneration Principles which will govern remuneration of senior managers and staff (actual awards will be determined by the Management Team acting, within these principles).

7. Relationship with the Governing Body

7.1. The Committee will submit an Annual Report to the Governing Body, having undertaken a self-assessment in respect of its performance and in fulfilment of its functions, as set out in these Terms of Reference.

7.2. Issues escalated to Governing Body for approval and/or decision will be scheduled within the confidential part of the Governing Body meeting.

7.3. The ratified minutes of meetings will be made available to Governing Body Members for viewing within the Corporate Office, through the Secretary to the Committee.

8. Policy and best practice

8.1. The Committee is authorised by the Governing Body to instruct professional advisors and request the attendance of individuals and authorities from outside the Group with relevant experience and expertise if it considers this necessary for or expedient to the exercise its functions.

8.2. The Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.

9. Conduct of the Committee
9.1. These terms of reference and the agreed Remuneration Principles of the Committee shall be reviewed by Governing Body every year.

10. **Meetings in Common**

10.1. For clarity – the Committee may meet using the “Committees in Common” arrangement with other CCG Primary Care Commissioning Committees.

10.2. A convenor for the Meetings in Common will be selected from the chairs of the participating committees.
ANNEX A

Surrey Downs CCG - Reward Policy Principles

1. National Guidance will inform reward decisions along with a wider span of relevant information (e.g. benchmark data, market pressures etc.). The principle of comply or explain will apply and be noted for audit purposes.

2. Remuneration decisions will reflect the public sector obligation to achieve value for money.

3. Remuneration packages will be set at levels that secure recruitment and retention of high calibre directors.

4. Benefits will be non-negotiable

5. Any enhancements to pay will not be guaranteed

6. Changes in remuneration will be dependent on performance. Performance related bonus payments for exceptional & outstanding performance will not exceed 10% of salary as one off, non-consolidated awards that are not automatically paid each year. Any bonus payment will be dependent upon the CCG’s financial performance and ability to pay, as determined by the Remuneration Committee. Exceptional & outstanding performance is defined as:
   a. Exceptional performance – over and above the requirements of the role
   b. Exceptional complexity
   c. Exceptional circumstance

7. Only following exceptional & outstanding performance will bonus payments be paid.

8. Bonus will be considered annually at the end of the financial year and only payable to directors with more than six month’s service.

9. Directors with less than one year’s service, for whom a bonus has been agreed, will receive their bonus pro-rata to reflect months in service beyond the initial 6 months and up to the end of the financial year.

10. Bonuses are payable no more frequently than annually.

11. The pay structure for Executives will consist of two salary ranges (for the CEO and for Directors) and applied according to relative job size. The salary range for Directors will be equivalent to Agenda for Change band 9.
12. Salary ranges for all Directors will take account of the market position of like- posts/roles in in the South East of England and Home Counties.

13. A maximum addition of 10% of the basic salary will apply where recruitment is hindered by the package on offer (i.e. failed or challenging recruitment following market testing). This will be treated as a consolidated payment and form part of the spot salary.

14. A maximum addition of 10% of the basic salary will apply as a Complexity Allowance to reflect significant additional responsibilities or higher than average complexity factors. Payments will be linked to the proportion of time spent on the additional work and take account of the complexity factors. Continued payment may be contingent on delivery of those objectives. This will be treated as a consolidated payment and form part of the spot salary.

15. Experience of preferred candidates will be considered at the time of negotiating contracts although the final offer will not exceed what the Remuneration Committee has agreed as the financial limit.

16. A maximum 10% addition to basic salary will be applied for the Finance Director role only to reflect the level of commercial competence required for the role. This will be treated as a consolidated payment and form part of the spot salary.

17. Adjustments for inflation/costs of living changes will reflect that applied nationally for staff on Agenda for Change terms. This will be applied across salaries and consolidated premium payments and the remuneration of other members of the Governing Body.

18. Remuneration principles will be reviewable.
PRIMARY CARE COMMISSIONING COMMITTEE

Terms of Reference

1. Introduction

1.1. The NHS Surrey Downs Clinical Commissioning Group's (the CCG's) Governing Body hereby resolves to establish a committee of the Governing Body known as the Primary Care Commissioning Committee (known as the PCCC or 'the Committee') in accordance with Schedule 1A of the National Health Service Act 2006 (as amended) ("the NHS Act").

1.2. The Committee is established in accordance with the CCG's constitution and the delegation by NHS England (also known as 'the NHS Commissioning Board' or the 'Board' under section 13Z of the NHS Act (set out in schedule 1 to these terms of reference). These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the Committee and shall have effect as if incorporated into the CCG's constitution.

2. Statutory Framework

2.1. NHS England has delegated to the CCG authority to exercise the primary care commissioning functions set out in Schedule 2 to these terms of reference in accordance with section 13Z of the NHS Act.

2.2. Arrangements made under section 13Z may be on such terms and conditions (including terms as to payment) as may be agreed between the Board (NHS England) and the CCG.

2.3. Arrangements made under section 13Z do not affect the liability of NHS England for the exercise of any of its functions. However, the CCG acknowledges that in exercising its functions (including those delegated to it), it must comply with the statutory duties set out in Chapter A2 of the NHS Act and including:

- management of conflicts of interest (section 140);
- duty to promote the NHS Constitution (section 14P);
- duty to exercise its functions effectively, efficiently and economically (section 140);
- duty as to improvement in quality of services (section 14R);
- duty in relation to quality of primary medical services (section 14S);
- duties as to reducing inequalities (section 14T);
- duty to promote the involvement of each patient (section 14U);
- duty as to patient choice (section 14V);
- duty as to promoting integration (section 14Z1); and
- public involvement and consultation (section 14Z2).
2.4. The CCG will also need to specifically, in respect of the delegated functions from NHS England, exercise those set out below:

- duty to have regard to impact on services in certain areas (section 130);
- duty as respects variation in provision of health services (section 13P).

3. Purpose of Committee

3.1. The Committee has been established in accordance with the above statutory provisions to enable the members to make collective decisions on the review, planning and procurement of primary care services in Surrey Downs, under delegated authority from NHS England.

3.2. In performing its role the Committee will exercise its management of the functions in accordance with the agreement entered into between NHS England and the CCG, which will sit alongside the delegation and terms of reference.

3.3. The Committee function (as a corporate decision-making body for the management of the delegated functions and the exercise of the delegated functions set out in Schedule 2 in accordance with section 13Z of the NHS Act) shall be to carry out the functions relating to the commissioning of primary medical services under section 83 of the NHS Act.

3.4. The Committee is subject to any directions made by NHS England or by the Secretary of State.

4. Key Responsibilities

4.1. The Committee will make collective decisions on the review, planning and procurement of primary care services in Surrey Downs, under delegated authority from NHS England. This includes the following activities:

- General Medical Services (GMS), Personal Medical Services (PMS) and Alternative Provider Medical Services (APMS) contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action such as issuing branch/remedial notices, and removing contract);
- newly designed Locally Commissioned Services (This could include Locally Commissioned Services (LCS)s offered by the CCG as an alternative/addendum to Directly Enhanced Services (DESs). By definition this would be optional; it remains a practice's right to participate in a DES and to opt to do so with or without local amendments.);
- design of local incentive schemes as appropriate, including the management and administration of the Quality Outcomes Framework (QOF);
- decision making on whether to establish new GP practices in an area, including approval and management of list dispersal;
- approving practice mergers;
- making decisions on 'discretionary' payment (e.g., returner/retainer schemes).
The Committee will also carry out the following activities:

- ensuring that the work of the Committee aligns with and enables delivery of the CCG’s Strategic Commissioning Plan;
- planning, including needs assessment, primary medical care services in Surrey Downs;
- responsibility for engaging in the development and delivery of the CCG’s primary care strategy;
- undertaking reviews of primary medical care services in Surrey Downs;
- co-ordinating a common approach to the commissioning of primary care services generally;
- providing oversight of the financial planning and budget management for the commissioning of primary medical care services in Surrey Downs;
- providing oversight of the management of primary care estate in line with Surrey Downs’s Estates strategy;
- providing oversight of the GP IT Steering Group in line with the Surrey-wide Digital Roadmap.

5. **Membership**

5.1. The membership of the committee shall consist of:

5.1.1. **Voting members**

- two independent members of the governing body, one of whom will be chair and the other vice chair;
- the Accountable Officer;
- the Chief Finance Officer;
- two independent GPs from outside the CCG;
- a lay/patient representative;
- director of public health or deputy;
- Surrey and Sussex Local Medical Committee Accountable Officer (or deputy); and
- an NHS England representative.

5.1.2. **Non-Voting Members:**

- two GP representatives (one from each locality);
- one operational practice manager;
- a representative of Surrey Healthwatch;
- the County Council chair of the Health and Wellbeing Board or their nominated deputy;
- the director of strategic commissioning;
- the chair of the primary care commissioning operational group.

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Guidance indicates that a non-practising nurse member of the governing body may be chair. The secondary care doctor could not chair the committee.
5.2. The heads of locality development, primary care contracts and deputy Chief Finance Officer (or deputy) will be in attendance at all meetings.

5.3. Other representatives will be invited from time to time from:
- NHS England
- Officers of the CCG
- Other stakeholders
6. **Quorum**

6.1. A quorum shall be 5 voting members, to include one independent member, one clinician, the Accountable Officer or Chief Finance Officer, and two other voting members.\(^6\)

7. **Meetings and voting**

7.1. The Committee will operate in accordance with the CCG's Standing Orders. The Governing Body Secretary will be responsible for giving notice of meetings. This will be accompanied by an agenda and supporting papers and sent to each member representative no later than 5 days before the date of the meeting. When the Chair of the Committee deems it necessary in light of the urgent circumstances to call a meeting at short notice, the notice period shall be such as s/he shall specify.

7.2. The aim of the Committee is to achieve consensus decision-making wherever possible. Each voting member of the Committee shall have one vote. The Committee shall reach decisions by a simple majority of members present, but with the Chair having a second and deciding vote if necessary.

7.3. In an emergency or for an urgent decision, the chair (or in their absence the vice chair) may take action in agreement with the Accountable Officer or the Chief Finance Officer together with one clinical member of the committee (i.e. three members of the committee representing a majority of a quorate committee). This action will be reported as soon as possible to the full committee along with the reason for chair’s action. The action and the reasons for the action will be formally reported to the next formal meeting of the committee and recorded in the minutes.

8. **Reporting**

8.1. The minutes of this Committee shall be formally recorded and received by the Governing Body at its meetings in public.

8.2. Approved minutes of public part 1 meetings will be made available to the public. Minutes or sections of minutes which are of a confidential nature which would not be disclosed under the Freedom of Information Act will not be made available on the Group’s website.

8.3. The Committee will present its minutes to NHS England South (South East) for information, including the minutes of any sub-committees to which responsibilities are delegated.

8.4. There will also be a quarterly report from the PCCC to the Governing Body and NHS England South (South East).

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\(^6\) The clinician may be an independent GP member or the LMC representative.
9. **Administration**

9.1. The Board Secretary shall provide secretarial and administrative services to the Committee.

10. **Frequency**

10.1. Meetings shall be held not less than six times a year and more frequently as required.

11. **Conduct of Committee**

11.1. The Committee shall conduct its business in public (subject to paragraph 11.3) in accordance with national guidance and relevant codes of practice including the Nolan Principles and the CCG’s Conflict of Interests policy. Members of the Committee shall respect confidentiality requirements as set out in the CCG's Constitution and relevant policies.

11.2. In respect of potential conflicts, the minutes of the meeting will record:

- the name of the person noting the interest;
- the nature of the interest and why it gives rise to the conflict;
- the item of the agenda to which the interest related;
- how it was agreed that the conflict should be managed;
- evidence that the conflict was managed as intended.
11.3. The Committee may resolve to exclude the public from a meeting that is open to the public (whether during the whole or part of the proceedings) whenever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time.

11.4. Non-voting members may be asked to withdraw from the confidential part of the meeting.

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

11.6. The Committee may delegate tasks to such individuals, sub-committees or individual members as it shall see fit, provided that any such delegations are consistent with the parties’ relevant governance arrangements, are recorded in a scheme of delegation, are governed by terms of reference as appropriate and reflect appropriate arrangements for the management of conflicts of interest.

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

11.8. If a practice considers that the Committee has not followed due procedure in its decision, it may appeal against the decision to NHS England in accordance with such procedures as NHS England may set out.

12. Review

12.1. These terms of reference will be reviewed on an annual basis or sooner if required with recommendations made to the CCG’s Governing Body and NHS England South (South East) for approval.

13. Accountability of Committee

13.1. For the avoidance of doubt, in the event of any conflict between the terms of the Scheme of Delegation, these Terms of Reference and the Standing Orders or Standing Financial Instructions, the latter will prevail.

14. Procurement of Agreed Services

14.1. The detailed arrangements regarding services to be procured will be set out in the delegation agreement.

15. Decisions

15.1. The Committee will make decisions within the bounds of its remit and such decisions shall be binding on NHS England and the CCG.
15.2. All decisions taken in good faith at a meeting of the Committee shall be valid even if there is any vacancy in its membership or it is discovered subsequently that there was a defect in the calling of the meeting, or the appointment of a member attending the meeting.

16. Meetings in Common

16.1. For clarity – the Committee may meet using the “Committees in Common” arrangement with other CCG Primary Care Commissioning Committees.

16.2. A convenor for the Meetings in Common will be selected from the chairs of the participating committees.
Schedule 1

Full Delegation Agreement (available as separate PDF)