Working with you to make Sheffield HEALTHIER

NHS Sheffield Clinical Commissioning Group

Joint Committee of Clinical Commissioning Groups

Governing Body meeting

F

6 October 2016

Author(s)	Will Cleary-Gray, Programme Director Commissioners Working Together
Sponsor	Maddy Ruff, Accountable Officer

Is your report for Approval / Consideration / Noting

For approval

Are there any Resource Implications (including Financial, Staffing etc)?

Resource implications are subject to consultation.

Audit Requirement

CCG Objectives

Which of the CCG's objectives does this paper support?
1. To improve patient experience and access to care
2. To improve the quality and equality of healthcare in Sheffield
4. To ensure there is a sustainable, affordable healthcare system in Sheffield.

Equality impact assessment

Have you carried out an Equality Impact Assessment and is it attached?
EIA will be carried out as plans develop.

PPE Activity

How does your paper support involving patients, carers and the public?
Involving patients, carers and the public is integral to the paper.

Recommendations

Governing Body is asked to:

- Commence the necessary governance steps to establish a joint committee, specifically updating the CCG's Constitutions and Scheme of Delegation.
- Formally support the establishment of the JC CCG and its inaugural meeting in October.
- Confirm the timeline for updating constitutions to enable the above.
- Delegate to CCG Chief Officers and Clinical Chairs the action of taking forward the development of and the approach to any process for scheme of delegation for the JC CCG beyond the current terms of JC CCG reference and manual agreement.

Commissioners Working Together
Establishment of Joint Committee of CCGs (JC CCG)

Governing Body meeting

6 October 2016

1. Background

NHS Sheffield CCG has a history of collaboration with its partners in Commissioners Working Together. In September 2015 our collaborative approach was formalised in a non-binding Memorandum of Understanding between the CCGs, which set out the key objectives of the collaboration; the principles governing this approach; the governance structures to be established; and the respective roles and responsibilities that the CCGs would have during the development of the agreed collaboration areas.

The CCGs, through their respective Clinical Chairs and Accountable officers have agreed to move towards formalising joint decision-making structures, in readiness for a number of major programmes that will need to be developed and implemented. At the moment, this includes hyper acute stroke services, children's surgery and anaesthesia services, cancer and urgent and emergency care and indeed collective strategy and sharing of best practice. As future plans are agreed through the South Yorkshire and Bassetlaw Sustainability and Transformation Plan, there will likely be further need to take joint decisions.

Governing Bodies considered the collective proposal to establish a Joint Committee of Clinical Commissioning Groups (JC CCG) as the natural next step for the CCG Collaborative, Commissioners Working Together.

NHS Sheffield CCG Governing Body reviewed both the Terms of Reference and the Manual Agreement for the JC CCG at a previous meeting of the Governing Body and gave support for its establishment.

2. Feedback from Governing Bodies

The main points of feedback from member Governing Bodies were:

- Chairing of the JC CCG to be the responsibility of a CCG clinical chair
- Voting be limited to two CCG decision makers only- Chair and Accountable Officer or their nominated representative.
- A commitment to a 'no worse off' principle for increasing inequalities or negative impact on health outcomes for any populations.
- Decisions are evidenced and concerns fully addressed
- Delegated functions beyond HASU and children's surgery are agreed with CCGs and that the process for doing this is clear.

The revised terms of reference and Manual Agreement has now been updated to fully incorporate feedback from Governing Body members reflected above.

3. Next steps

NHS Sheffield CCG Constitution to be updated to include reference to the joint committee and schemes of delegation amended to set a common level of authority and to define the decisions within the remit of the joint committee as detailed in the manual Agreement and JC CCG Terms of Reference.

Amendments to CCG Constitution to be approved by Council of Members (as per Constitutional requirements) and submitted to NHS North of England for final approval.

The JC CCG will hold its inaugural meeting on 4th October 2016 which is timely for the South Yorkshire and Bassetlaw Sustainability and Transformation collaborative partnership board and formal consultation period for two major change programmes.

4. Recommendations

Governing Body is asked to:

- Commence the necessary governance steps to establish a joint committee, specifically updating the CCGs Constitutions and Scheme of Delegation.
- Formally support the establishment of the JC CCG and its inaugural meeting in October.
- Confirm the timeline for updating constitutions to enable the above.
- Delegate to CCG Chief Officers and Clinical Chairs the action of taking forward the development of and the approach to any process for scheme of delegation for the JC CCG beyond the current terms of JC CCG reference and manual agreement.

Paper prepared by: Will Cleary-Gray, Programme Director Commissioners Working Together

On behalf of: Maddy Ruff, Accountable Officer, NHS Sheffield CCG Clinical Commissioning Group

September 2016

Manual Agreement:

Joint Committee of Clinical Commissioning Groups

Commissioners Working Together

August 2016

Chapter	Content	Detail	Page
1.	Introduction and Overview	Short Introduction setting out:- • Background to creating JC CCG. • Context for decision making and purpose. • Overview of role in local health system. • Purpose of this agreement/manual.	
2.	Commissioning intentions and statutory duties	Set out:- • Regional/Local commissioning intentions. • Application of existing arrangements. • Complying with the Statutory Duties of CCGs (should include those relating to procurement and competition as well). • Governance, including provision of assurance to members, for JC CCG.	
3.	Delegation	Delegation pursuant to section 14Z3:- • State purpose of delegation, what it means and the CCGs who have made it. • Set out minute and resolution [separately drafted] of delegation. • Explain terms of delegation in context of joint commissioning approach.	
4.	Terms of reference of joint committee : setting out the role and operation of the committee	Provisions setting out:- • Role • Delegated decisions [defined list as set out in terms] • Reserved decisions [All other than defined list] • Meetings and frequency • Agenda and Minutes • Voting	

		• Electronic meetings • Resolutions [form] • Quorum • Ability to create sub-committees and further delegate (as set out in terms)	
5.	Additional terms supplementing the terms of reference	Matters to be addressed:- • Guiding Principles for JC CCG. • Definitions and interpretation [especially delegated decisions and reserved decisions] and how to deal with disputes on definitions. • Approach to Conflicts of Interest. • Liability and indemnities. • Disputes and process to be followed to resolve. [This section may also go on to consider ability for members to revoke the delegation. • Information Sharing and Data Protection protocols • Approach to FOIA requests. • Compliance with procurement and competition law obligations (to extent not dealt with in statutory duties section) • List of any other relevant protocols • Clarification and/or additional commercial terms • Process to make variations to Delegation, ToR and/or agreement/manual • Explanation of how ratification works an process to apply. • JC CCGs reporting obligations to members and form of such reports. • Set out how finance for the programme will be dealt with, including issues such as pooled funding. • Process and form for issuing Notices by JC CCG.	

		• What happens if a member leave the JC CCGs • Supporting the JC CCG and how the PMO will operate. • Implementing change through NHS Standard Contract and variations to it. • Workforce and Staffing considerations within decision making.	
6.	Appendices	Include a copy of the Delegation, ToR, statutory duties checklist and all protocols which the JC CCG need to follow.	

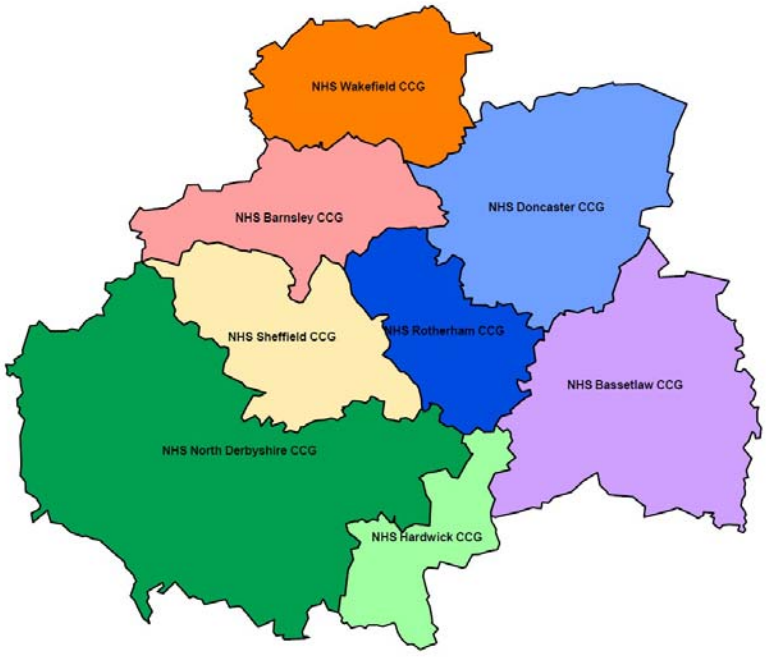
Chapter 1 - Introduction and Overview

1. Background

The purpose of the Handbook/Agreement is to set out in practical terms how the local health system will work together in both commissioning and providing health services to the public, as well as how it will interact with the delivery of social care.

As a first step, the local health commissioners have decided to create a joint committee, through which they can both consider and undertake regional wide commissioning decisions. The CCGs who are members of the joint committee ('**the JC CCG**') are:

- NHS Barnsley Clinical Commissioning Group;
- NHS Bassetlaw Clinical Commissioning Group;
- NHS Doncaster Clinical Commissioning Group;
- NHS Rotherham Clinical Commissioning Group;
- NHS Sheffield Clinical Commissioning Group;
- NHS North Derbyshire Clinical Commissioning Group;
- NHS Hardwick Clinical Commissioning Group; and
- NHS Wakefield Clinical Commissioning Group.



The eight member CCGs have a history of working together on a number of common strategic issues and change programmes under an informal memorandum of understanding between parties. Member CCGs now wish to formalise those arrangements to show the strength of their commitment to working together.

In terms of the legal basis on which the CCGs have agreed to jointly exercise a group of their functions through delegating them to the JC CCG, this has been done using their powers under section 14Z3 of the NHS Act 2006 (as amended) ('**the Act**'), which provides:

"(1) Any two or more clinical commissioning groups may make arrangements under this section.

(2) The arrangements may provide for—

(a) one of the clinical commissioning groups to exercise any of the commissioning functions of another on its behalf, or

(b) all the clinical commissioning groups to exercise any of their commissioning functions jointly.

(2A) Where any functions are, by virtue of subsection (2)(b), exercisable jointly by two or more clinical commissioning groups, they may be exercised by a joint committee of the groups….

(7) In this section, "commissioning functions" means the functions of clinical commissioning groups in arranging for the provision of services as part of the health service (including the function of making a request to the Board for the purposes of section 14Z9)."

As a result, the JC CCG has been created to exercise both commissioning functions and those related to commissioning, as has been set out in each CCGs delegation to it. The actual Delegations from each CCG are set out in Appendix 1 and the Terms of Reference are in Appendix 2. This should enable and support a more integrated regional approach to support the work of the STP as well.

2. Purpose of the JC CCG

2.1 The JC CCG has the primary purpose of enabling the CCG members to work effectively together, to collaborate and take joint decisions in the areas of work that they agree, by exercising the Joint Functions.

2.2 The Joint Functions are those set out in the Delegation, appended in Appendix 1 (*Delegation*) and summarised in Clause [add] below.

2.3 In agreement with CCG Governing Bodies the purpose of the JC CCG may expand to support implementation of Sustainability and Transformation plans.

2.4 The role of the JC CCG, as set out in Clause 3.1 of the Terms of Reference is:

2.4.1 Development of collective strategy and commissioning intentions;

2.4.2 Development of co-commissioning arrangements with NHS England;

2.4.3 Joint contracting with Foundation Trusts and other service providers;

2.4.4 System transformation, including the development and adoption of service redesign and best clinical practice across the area – which may include the continuation or establishment of clinical networks in addition to those nationally established;

2.4.5 Representation and contribution to Alliances and Networks including clinical networks nationally prescribed;

2.4.6 Work with NHS England on the outcome and implication of national or regional service reviews;

2.4.7 Work with the NHS England Area on system management and resilience;

2.4.8 Collaboration and sharing best practice on Quality Innovation Productivity and Prevention initiatives; and

2.4.9 Mutual support and aid in organisational development.

2.5 Generally, it is envisaged that the JC CCG will work across the region to develop a strategic approach to commissioning sustainable services that are patient centred. Further, it will enable the development of integrated working with social services so that the patients receive a more seamless service.

3. Role in local health system

3.1 As indicated above, it is envisaged that the JC CCG will support the development of a clear regional sustainable and transformation plan for across the footprint. In bringing commissioning leaders together, it will support strategic planning and provide an interface with both providers of health services and social care. The work which it can do with local authorities on creating better integrated health and social care services will support meeting the quality and financial challenges in the coming years.

3.2 In terms of looking at strategic issues across the STP footprint then the JC CCG will feed in to the work on such as:

- Leadership and governance and the best ways to set up joint working, taking account of the ability of providers and commissioners to set up shared governance structures. Some key issues to work through are conflicts and procurement, as well as good governance using the Handbook approach and assurance.
- Working out how best to play in your ongoing integrated care programmes and vanguards, especially in looking to implement change to benefit patients.
- Engagement and consultation strategies, both overall and when changes are needed to improve services.

- Productivity strategies, especially around joint and integrated working proposals.

4. Status of this Manual and Interpretation

This Manual sets out the arrangements that apply in relation to the exercise of the Joint Functions of the JC CCG.

If there is any conflict between the provisions of this Manual and the provisions of the Terms of Reference, the provisions of the Terms of Reference will prevail.

This Manual is to be interpreted in accordance with Schedule 1 (*Definitions and Interpretation).*

5. Term

The Manual has effect from the date of the Terms of Reference and will remain in force unless terminated in accordance with Clause 30 (*Termination of the Manual*).

Individual Member CCG(s) may terminate their membership of the JC CCG and so no longer be obliged to work in accordance with this Manual under Clause 29 (*Leaving the Joint Committee*) below.

Chapter 2- Commissioning Intentions and Statutory Duties

6. Regional/ local commissioning intentions

6.1 To be agreed

7. Any existing arrangements

8. Complying with the Statutory Duties of CCGs

The JC CCG will need to be clear that is exercising functions it meets the statutory obligations of the CCGs which are its members. A failure to do so could lead to challenge to decisions made and an inability to assure the CCG Governing Bodies that their delegated functions are being properly exercised. Such an inability would impact on a CCG's ability to assure NHS England that it was operating in accordance with the CCG Improvement and Assessment Framework.

The statutory duties which need to be taken into account are summarised in the Checklist in Appendix 3.

Further, each CCG should note that under s.14Z3(6) of the Act "*any delegation of functions to a joint committee of CCGs do not affect the liability of a clinical commissioning group for the exercise of any of its functions.*"

The result of this is that:

a) the Member CCGs need to ensure that the JC CCG is complying with the CCGs' statutory duties, as the Member CCGs continue to be responsible if there are any failings in decision making; and

b) the Member CCGs need to ensure that an appropriate reporting mechanism from the JC CCG to them is in place. This will allow the Member CCGs to maintain effective oversight of the JC CCG's processes and decision making.

In effect, the JC CCG will stand in the place of the multiple CCGs who are its members for decision making, but those individual CCGs will continue to have liability for those decisions. It is therefore essential that the JC CCG understand the statutory framework within which it will make decisions.

9. Governance

It is important that CCGs maintain effective oversight of the activities of the JC CCG.

The JC CCG will make a quarterly written report to the Member CCG governing bodies. This will cover, as a minimum summary of key decisions.

The JC CCG will also hold at least annual engagement events to review aims, objectives, strategy and progress and will publish an annual report on progress made against objectives.

As to conducting business the JC CCG will operate in accordance with the Terms of Reference approved by each CCG member when delegating functions to it. It shall also adopt the SFO and SIs of Sheffield CCG in respect to the operation of committees, with all CCG members assuring themselves that will enable their own constitution, SFIs and SOs to be met.

Regular reporting will take place with all member CCGs to include formal decisions and minutes.

Decisions and minutes will be made public and will be posted onto the Commissioners Working Together website.

Reports will be prepared by Commissioners Working Together secretariat.

Reports from any JC CCG sub-committee will be shared with CCGs by agreement or request of the JC CCG.

Chapter 3 – Delegation

10. Purpose of delegation

The Member CCGs have agreed to delegate functions to the JC CCG in order to enable the Member CCGs to work effectively together, to collaborate and to take joint decisions in those areas of work delegated.

The Member CCGs also consider that the delegation of functions will help the CCGs more easily collaborate and take integrated decisions with NHS England in respect of those services which are directly commissioned by NHS England for example specialised services.

This will also link in to the work that each STP needs to undertake to support the delivery of the Five Year Forward View under the South Yorkshire and Bassetlaw Sustainability and Transformation Plan.

The JC CCG forms a critical element of the interim governance arrangements agreed by the SYB STP executive and the mechanism by which future collective commissioning decisions can be made.

11. The delegation

The delegation of functions from each CCG to the JC CCG is set out in the delegation document at Appendix A (*Delegation*). A summary of what that means is:-

Under s.14Z3 of the NHS Act 2006 each CCG delegates a range of its commissioning functions to a joint committee, in particular to allow the joint committee to take decisions on current and future transformation programmes which involve all, or a sub-set, of the CCGs.

The delegated functions are referred to in this Manual as the **"Joint Functions".**

As is noted above, the JC CCG needs to also comply with statutory duties which the CCGs have. As a result, the Delegation also delegates the requirement to comply with statutory requirements relevant to the delegated functions.

12. Terms of delegation in context of joint commissioning

12.1 The JC CCG will work with NHS England on ensuring commissioning is joined up and collaborative across such as primary and specialist care under existing agreements.

Chapter 4 - Terms of reference of joint committee

[setting out the role and operation of the committee]

13. Terms of Reference of the JC CCG

The CCGs have established the JC CCG in accordance with the Terms of Reference, see Appendix 2. The JC CCG and each member will act at all times in accordance with the Terms of Reference and that means the decisions of the JC CCG will be binding on the Member CCGs.

In determining those matters on which they want to share decision making, the CCGs have also agreed a number of areas in which they are not planning to make joint decisions. The following are functions which have not been delegated to the JC CCG:

Reserved Functions

To be agreed.

It will be important for the JC CCG to be cognisant of the above Reserved Functions and to engage with member CCGs if any of those arise in the context of the functions which the JC CCG are to exercise.

14. Exercise of the Joint Functions

The JC CCG must exercise the Joint Functions in accordance with:

- the Terms of Reference;
- the terms of this Manual;
- all applicable law, see framework in Appendix 3;
- all applicable Guidance issued by health system regulators; and
- Good Practice.

Chapter 5- Additional terms supplementing the Terms of Reference

15. Key Objectives and Guiding Principles for JC CCG

15.1 The JC CCG shall work towards achieving the Key Objectives of the JC CCG and all members of the JC CCG shall act in good faith to support achievement of the Key Objectives.

15.2 The Key Objectives of the JC CCG are:

15.2.1 To achieve better patient experience, better outcomes and more efficient service delivery through the Member CCGs collaborating in the commissioning of services, by:

15.2.1.1 working together on contractual and service issues with providers several or all of the Member CCGs use, due to patient flows;

15.2.1.2 sharing clinical expertise, best practice and management resource in service redesign, enabling more focussed commissioning capacity and leadership;

15.2.1.3 leading transformation change where working together is necessary to ovate change;

15.2.1.4 achieving economies of scale through shared representation and input to clinical networks, specialised commissioning and primary care commissioning (where CCGs will wish to influence primary and tertiary commissioned pathways, and specialised and primary care commissioners will wish to influence secondary care and enhanced care pathways);

15.2.1.5 coordinate work with NHS England, particularly on specialised and primary care, where this improves experience for patients, giving consistency along pathway interfaces and avoiding duplication;

15.2.1.6 resolving cross boundary issues, where the action of one Member CCG could have an impact on a neighbour Member CCG;

15.2.1.7 providing leadership to the health system in the area covered by the Member CCGs; and

15.2.1.8 ensuring equity of access to services collaboratively commissioned; and

15.2.2 To support ongoing effective working of the Member CCGs.

15.3 The JC CCG shall adopt and follow the JC CCG Guiding Principles and all members of the JC CCG shall act in good faith to follow the Guiding Principles.

15.4 The Guiding Principles of the JC CCG are set out in the Terms of Reference and are:

15.4.1 To collaborate and co-operate. Do it once rather than repeating or duplicating actions and increasing cost across the CCGs. Establish and adhere to the governance structure set out in the Terms of Reference and in this Manual, to ensure that activities are delivered and actions taken as required;

15.4.2 To be accountable. Take on, manage and account to each other for performance of the respective roles and responsibilities set out in the Terms of Reference and in this Manual;

15.4.3 To be open. Communicate openly about major concerns, issues or opportunities relating to the functions delegated to the JC CCG, as set out in Appendix 1 (*Delegation)*;

15.4.4 To learn, develop and seek to achieve full potential. Share information, experience, materials and skills to learn from each other and develop effective working practices, work collaboratively to identify solutions, eliminate duplication of effort, mitigate risk and reduce cost whilst ensuring quality is maintained or improved across all the Member CCGs;

15.4.5 To adopt a positive outlook. Behave in a positive, proactive manner;

15.4.6 To adhere to statutory requirements and best practice. Comply with applicable laws and standards including EU procurement rules, data protection and freedom of information legislation.

15.4.7 To act in a timely manner. Recognise the time-critical nature of the functions delegated to the JC CCG as set out in Appendix 1 (*Delegation*), and respond accordingly to requests for support;

15.4.8 To manage stakeholders effectively;

15.4.9 To deploy appropriate resources. Ensure sufficient and appropriately qualified resources are available and authorised to fulfil the responsibilities set out in the Terms of Reference and in this Manual; and

15.4.10 To act in good faith to support achievement of the Key Objectives and compliance with these Principles.

16. Sub committees of the JC CCG

16.1 The JC CCG shall be able to appoint sub-committees, which shall include:

16.1.1 **Finance group**

16.1.2 **Contracting group**

17. Finances/ Pooled Funding

17.1 The Member CCGs may, for the purposes of exercising the Joint Functions under this Manual, establish and maintain a pooled fund in accordance with section 14Z3 of the NHS Act 2006.

17.2 Specifically, member CCGs may want to look at how to support the implementation of the decisions they make from service reconfiguration processes through to enabling strategic system change across the region. Pooling funds for use across the region for the overall benefit of all patients would ensure that best use of limited resources is achieved. It will also mean that implementation of decisions is less likely to stall due to financial challenges in that a pooled fund provides greater regional support options than CCGs seeking to implement change individually.

17.3 In some instances, consideration can also be given to getting better value for money by consolidating purchasing/commissioning power in a pooled fund.

18. Secretariat

18.1 Commissioners Working Together will provide the secretariat to the JC CCG

18.2 Commissioners Working Together and associated staffing resource are hosted by Sheffield CCG on Behalf of the JC CCG

18.3 Funding of Commissioners Working Together is Funded by all member CCGs of the JC CCG.

19. Staffing

19.1 See 18 above

20. Conflicts of Interest.

20.1 The Member CCGs must comply with their statutory duties set out in Chapter A2 of the NHS Act 2006, including those relating to the management of conflicts of interest as set out in section 14O of the Act.

20.2 Each member of the JC CCG must abide by NHS England's guidance *Managing conflicts of interest – statutory guidance for CCGs a*s updated from time to time (http://www.england.nhs.uk/wp-content/uploads/2014/12/man-confl-int-guid-1214.pdf) and all relevant Guidance and policies of their appointing body in relation to conflicts of interest.

20.3 In addition, the JC CCG shall operate a register of interests and has a Conflicts of Interest Policy. Members of the JC CCG shall comply with the JC CCG's conflicts of interest policy and shall disclose any potential conflict; where there is any doubt or where there is a divergence between the terms of the conflicts of interest policy of a member's appointing CCG and that of the JC CCG, the member should always err on the side of disclosure of any potential conflict.

20.4 Where any member of the JC CCG has an actual or potential conflict of interest in relation to any matter under consideration by the JC CCG, that member must not participate in meetings (or parts of meetings) in which the relevant matter is discussed, or make a recommendation in relation to the relevant matter. The relevant appointing body may send an alternative representative to take the place of the conflicted member in relation to that matter.

20.5 Any breaches of the JC CCG's conflicts of interest policy or NHS England guidance on managing conflicts of interest shall be reported to the Member CCGs promptly and in any event within 5 business days of the breach having come to light.

21. Information Sharing and Data Protection protocols

21.1 The Member CCGs shall all comply with the DPA.

21.2 The Member CCGs have entered into a Data Sharing Agreement that governs the processing of Personal Data pursuant to this Manual. A copy of this template Data Sharing Agreement is set out in Schedule 2 *(Further Information Sharing Provisions)*.

21.3 The Data Sharing Agreement:

- 21.3.1 sets out the relevant Information Law and best practice;
- 21.3.2 sets out how that law and best practice will be implemented, including responsibilities of the Member CCGs to co-operate properly and fully with each other;
- 21.3.3 identifies the information that may be processed, including what may be shared, under this Agreement;
- 21.3.4 identifies the purposes for which the information may be so processed and states the legal basis for the processing in each case;
- 21.3.5 states who is/are the Data Controller/s and, if appropriate, the Data Processor/s of Personal Data;
- 21.3.6 sets out what will happen to the Personal Data on the termination of this Agreement (with due regard to clause 29 *(Leaving the JC CCG)* of the Agreement);
- 21.3.7 explains how Member CCGs shall deal with subject access requests and other requests made under the DPA; and
- 21.3.8 sets out such other provisions as are necessary for the sharing of information to be fair, lawful and meet best practice.

21.4 The Member CCGs will share all non-Personal Data in accordance with Information Law and their statutory powers as set out in section 14Z23 of the Act.

21.5 The Member CCGs agree that, in relation to information sharing and the processing of information for the purposes of the Joint Functions, they must comply with:

21.5.1 all relevant Information Law requirements including the common law duty of confidence and other legal obligations in relation to information sharing including those set out in the NHS Act 2006 and the Human Rights Act 1998;

21.5.2 Good Practice; and

21.5.3 relevant Guidance (including guidance given by the Information Commissioner).

22. IT inter-operability

22.1 The Member CCGs will work together to ensure that, where necessary for the exercise of the Joint Functions, all relevant IT systems operated by the Member CCGs in respect of the Joint Functions will be inter-operable and that data may be transferred between systems securely, easily and efficiently.

22.2 The parties will use their respective reasonable endeavours to help develop initiatives to further this aim.

23. Confidentiality

23.1 Where information is shared with the JC CCG of a confidential or commercially sensitive nature information will be treated under the confidential policy of the host CCG

24. Freedom of Information

24.1 Each Member CCG acknowledges that the other Member CCGs are a public authority for the purposes of the Freedom of Information Act 2000 (**"FOIA"**) and the Environmental Information Regulations 2004 (**"EIR"**).

24.2 Each Member CCG may be statutorily required to disclose information about the Agreement and the information shared or generated by the Member CCGs pursuant to this Agreement and the Terms of Reference, in response to a specific request under FOIA or EIR, in which case:

24.2.1 each Member CCG shall provide the others with all reasonable assistance and co-operation to enable them to comply with their obligations under FOIA or EIR;

24.2.2 each Member CCG shall consult the others regarding the possible application of exemptions in relation to the information requested, giving them at least 5 working days within which to provide comments. Such consultation shall be effected by contacting [the CCG Representative named in Column 2 of Schedule 2 (*Member CCGs*)]; and

24.2.3 each Member CCG acknowledges that the final decision as to the form or content of the response to any request is a matter for the Member CCG to whom the request is addressed.

25. Procurement

Commissioners are required to ensure that their decisions to procure services, which actually relates to most commissioning decisions you make, comply with the National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013. Key questions are set out under each heading below to assist you when considering whether you are meeting these requirements. Commissioners are also required to comply with EU/UK general procurement law but this is not covered in the list below.

25.1 The real procurement objective is to -

'*To secure the needs of patients and improve quality and efficiency of services*'

Therefore, part of considering how robust your decision is in terms of meeting procurement obligations is to look at:

- What have you done to assess patient need and do you have evidence to support your findings?
- How are you assessing the quality of services and the performance of the current providers? How have you assessed whether the service is offering value for money?
- Have you reviewed the current service specification to ensure it is working well and whether there is scope for further improvement? In particular, it would be helpful to have a schedule of all existing contracts and relationships, including performance monitoring on contracts.
- What steps have you taken to assess equitable access to services by all patient groups?

25.2 In achieving the main objective, the regulations contain three general requirements, which are:

25.2.1 To act transparently and proportionately and in a non-discriminatory way.

- What steps have you taken to make providers and stakeholders aware of your plans? Have you provided reasons to support your decisions?
- Are you publishing details in a timely manner and have you kept records of decision making, e.g. board minutes and briefing papers?
- Do providers understand the selection criteria you are using and are they able to express an interest in providing the services? Can you show that you have not favoured one provider over the other?
- Is your approach proportionate to the nature of the services in relation to the value, complexity and clinical risk associated with the provision of the services in question?

25.2.2 To contract with providers who are most capable of meeting the objectives and provide best value for money

- How have you identified existing and potential providers and objectively evaluated their relative ability to deliver the service specification, improve quality and meet the needs of patients?
- Are you satisfied providers are capable and robust enough to deliver a safe and efficient service and provide the best value for money in doing so?

25.2.3 Consider ways of improving services through integration, competition and patient choice

- What evidence do you have to show the steps you taken to determine whether it might be better for patients if the services are integrated with other health care services?
- Have you asked providers, patients, and other stakeholders for their views?
- Does your specification or performance monitoring process incentivise delivery of care in a more integrated manner?
- Have you considered whether competition or choice would better incentivise providers to improve quality and efficiency? Do you have evidence to support your findings?

25.3 Advertisements and expressions of interest

To ensure providers are able to express an interest in in providing any services which includes the requirement to publish opportunities and awards on a website

- How have you gathered evidence about the existing and potential providers on the market?
- Have you published your intentions to the market by way of commissioning intentions or publication on a website?

25.4 Award of a new contract without a competition

A new contract may be awarded without publishing a contract notice where the commissioner is satisfied that the services in question are capable of being provided only by that provider, e.g. A&E services in a particular area or where it is not viable for providers to provide one service without also providing another service.

- What steps have you taken and what evidence are you relying on to satisfy yourself that there is only one capable provider?

25.5 Conflict of Interests

Commissioners are prohibited from awarding a contract where conflicts, or potential conflicts, between the interests of Commissioners in commissioning services and the interests involved in providing the services affect, or appear to affect, the integrity of the award of the contract.

- Have you recorded how you have managed any conflict or potential conflict?

This will be an issue over which the STP needs to be sensitive given the collaborative working between commissioners and providers. Further information and guidance is available in section 20 above.

25.6 Anti-competitive behaviour

Not to engage in anti-competitive behaviour unless to do so would be in the interests of people who use NHS services

- Are you acting in an anticompetitive manner – for instance have you prevented new providers from entering the market or caused a provider to exit the market?
- If so, is it objectively justifiable as being in the interests of users and stakeholders? What evidence do you have to support this?

Once again an issue which the STP will need to be alive and take care over.

26 Competition Issues

26.1 Requirement to Notify the Competition and Markets Authority (CMA)

The obligation to notify the CMA sits with the provider and guidance is set out below on when that duty bites. It should also be noted that if a provider has given any undertakings to the CMA or its predecessor, the Competition Commission, then they may prohibit a statutory transaction and should be checked. A brief overview of the merger regime is set out below:

26.2 Merger control rules

The merger control regime may apply to NHS service reconfigurations where two or more services are merged and the transaction meets the jurisdictional tests.

26.3 Jurisdictional Tests

The CMA has jurisdiction to examine a merger where:

26.3.1 Two or more enterprises cease to be distinct (change of control)

26.3.2 and either

- the UK turnover of the acquired enterprise exceeds £70 million; or
- the enterprises which cease to be distinct together supply or acquire at least 25% of all those particular services of that kind supplied in the UK or in a substantial part of it. The merger must also result in an increment to the share of supply, i.e. the merging providers must supply or acquire the same category of services.

[**Enterprise**: NHS foundation trusts and NHS trusts controlling hospital, ambulance services, mental health service, community services or individual services or specialities may be enterprises for the purpose of merger control.

Change in control: Two enterprises (or services) cease to be distinct if they are brought under common ownership or control. There must be a change in the level of control over the activities of one or more enterprises (or services) for merger control to apply.]

26.4 Competition test

The CMA assesses qualifying mergers to decide whether they are likely to lead to a substantial lessening of competition ('SLC'). An SLC occurs when competition is substantially less after the merger.

26.5 SLC assessment

The CMA will require detailed information about the reconfiguration. This will include:

- service overlaps;
- GP referral data / catchment area analysis; and
- Hospital share of GP practice referrals.

26.6 CMA merger assessment timetable

The process is divided into two stages:

- Phase I: an initial 40 working day investigation; and
- Phase II: a possible 24 weeks in-depth investigation, which can be extended if the CMA considers it necessary.

26. Liability and indemnities.

26.1 In accordance with section 14Z3 of the NHS Act 2006, the Member CCGs retain liability in relation to the exercise of the Joint Functions.

27. Breach of this Manual and Remedies

27.1 Any breach of this manual will be raised by the Chair and identified senior office. Disputes will be dealt with under 28 below.

28. Dispute Resolution

28.1 Where any dispute arises within the JC CCG in connection with this Manual, the relevant Member CCGs must use their best endeavours to resolve that dispute on an informal basis within the JC CCG.

28.2 Where any dispute is not resolved under clause 28.1 on an informal basis, any CCG Representative (as set out in Column 2 of Schedule 2 (*Member CCGs*) may convene a special meeting of the JC CCG to attempt to resolve the dispute.

28.3 If any dispute is not resolved under clause 28.2, it will be referred by the [Chair] of the JC CCG to the Chief Executives of the relevant Member CCGs, who will co-operate in good faith to resolve the dispute within ten (10) days of the referral.

28.4 Where any dispute is not resolved under clauses 28.1, 28.2 or 28.3, any CCG Representative may refer the matter for mediation arranged by an independent third party to be appointed by [the Chair of the JC CCG] [CEDR], and any agreement reached through mediation must be set out in writing and signed by and the relevant Member CCGs.

29. Leaving the JC CCG

29.1 Should this joint decision making arrangement prove to be unsatisfactory, the governing body of any of the Member CCGs can decide to withdraw from the arrangement, but has to give a minimum of six months' notice to partners, with consideration by the JC CCG of the impact of a leaving partner - a maximum of 12 notice could apply.

29.2 The Member CCG who wishes to withdraw from the JC CCG will work together with the other Member CCGs to ensure that there are suitable alternative arrangements in place in relation to the exercise of the Joint Functions.

29.3 After leaving the JC CCG, that CCG shall no longer be a Member CCG but shall remain bound by Clauses 23 (*Confidentiality*), [add]

30. Termination of the Manual

30.1 This Manual shall no longer apply if the JC CCG is terminated.

30.2 Such termination shall be effective if all Member CCGs agree in writing that the JC CCG shall end and withdraw the delegation of their functions to the JC CCG.

31. Notices

31.1 Any notices given under this Manual must be in writing, must be marked for the [CCG Representative noted in Column 2 to Schedule 2 (*Member CCGs")].*

31.2 Notices sent:

31.2.1 by hand will be effective upon delivery;

31.2.2 by post will be effective upon the earlier of actual receipt or five (5) working days after mailing; or

31.2.3 by email will be effective when sent (subject to no automated response being received).

32. Variations

32.1 Any variation to the Delegation, Terms of Reference or this Manual will only be effective if it is made in writing and signed by each of the Member CCGs.

32.2 All agreed variations to the Delegation, Terms of Reference or this Manual must be appended as a Schedule to this Manual.

33. Counterparts

This Manual may be executed in any number of counterparts, each of which when executed and delivered shall constitute an original of this Manual, but all the counterparts shall together constitute the same agreement.

34. Applicable Law

This Manual shall be interpreted in accordance with the laws of England and Wales and each party to this Manual submits to the exclusive jurisdiction of the courts of England and Wales.

Schedule 1
Definitions and Interpretation

In this Manual, the following words and phrases will bear the following meanings:

Manual	means this agreement between the Member CCGs comprising the body of the Manual and its Schedules;
Data Controller	shall have the same meaning as set out in the DPA;
Data Subject	shall have the same meaning as set out in the DPA;
Delegation	means the delegation of functions set out in Appendix 1 to this Manual;
DPA	means the Data Protection Act 1998;
Good Practice	means using standards, practices, methods and procedures conforming to the law, reflecting up-to-date published evidence and exercising that degree of skill and care, diligence, prudence and foresight which would reasonably and ordinarily be expected from a skilled, efficient and experienced commissioner;
Guidance	means any applicable health and social care guidance, guidelines, direction or determination, framework, standard or requirement issued by NHS England or any other regulatory or supervisory body, including the Information Commissioner, to the extent that the same are published and publicly available;
Information Law	the DPA, the EU Data Protection Directive 95/46/EC; regulations and guidance made under section 13S and section 251 of the NHS Act; guidance made or given under sections 263 and 265 of the Health and Social Care Act 2012; the Freedom of Information Act 2000; the common law duty of confidentiality; the Human Rights Act 1998 and all other applicable laws and regulations relating to processing of Personal Data and privacy;
JC CCG	means the joint committee of the Member CCGs

established on the terms set out in the Terms of Reference;

Joint Functions means the functions jointly exercised by the Member CCGs through the decisions of the JC CCG in accordance with the Terms of Reference and as set out in detail in clause [add] of the Delegation;

Law means:

(i) any applicable statute or proclamation or any delegated or subordinate legislation or regulation;

(ii) any enforceable EU right within the meaning of section 2(1) European Communities Act 1972; or

(iii) any applicable judgment of a relevant court of law which is a binding precedent in England and Wales,

in each case in force in England and Wales;

Member CCG means the CCGs which are part of the JC CCG and are set out in the Terms of Reference and Column 1 of Schedule 2 (*Member CCGs*) to this Manual.

NHS Act 2006 means the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012 or other legislation from time to time);

NHS England means the National Health Service Commissioning Board established by section 1H of the NHS Act, also known as NHS England;

Non-Personal Data means data which is not Personal Data;

Personal Data shall have the same meaning as set out in the DPA and shall include references to Sensitive Personal Data where appropriate;

Data Sharing Agreement means the agreement governing Information Law issues completed further to Schedule 3 *(Further Information Sharing Provisions)*;

Sensitive Personal Data	shall have the same meaning as in the DPA; and
Terms of Reference	means the terms of reference for the JC CCG agreed between the CCG(s).

Schedule 2
Member CCGs

Column 1 **Clinical Commissioning Groups**	**Column 2** **CCG Representatives**
NHS Barnsley Clinical Commissioning Group;	Nick Balac, Lesley Smith
NHS Bassetlaw Clinical Commissioning Group;	Andrew Perkins, Phil Mettam
NHS Doncaster Clinical Commissioning Group;	David Crichton, Jackie Pederson
NHS Rotherham Clinical Commissioning Group;	Julie Kitlowski, Chris Edwards
NHS Sheffield Clinical Commissioning Group;	Tim Moorhead, Maddy Ruff
NHS North Derbyshire Clinical Commissioning Group;	Ben Milton, Steve Allinson
NHS Hardwick Clinical Commissioning Group; and	Steve Lloyd, Andy Gregory
NHS Wakefield Clinical Commissioning Group.	Philip Earnshaw, Jo Webster

Schedule 3
Data Sharing Agreement
[to be added]

To be added currently being reviewed.

Appendix 1- Delegation

Delegation by CCGs to JC CCGs

A. The CCG functions at B will be delegated to the JC CCGs by the member CCGs in accordance with their statutory powers under s.14Z3 of the NHS Act 2006 (as amended) (**"the NHS Act"**). Section 14Z3 allows CCGs to make arrangements in respect of the exercise of their commissioning functions and includes the ability for two or more CCGs to create a Joint Committee to exercise functions.

B. The delegated functions relate to the health services provided to the member CCGs by all providers they commission services from in the exercise of their functions. The CCGs delegate their commissioning functions so far as such functions are required for the Joint Committee to carry out the following roles, as set out in the Terms of Reference:

- Development of collective strategy and commissioning intentions;
- Development of co-commissioning arrangements with NHS England;
- Joint contracting with Foundation Trusts and other service providers;
- System transformation, including the development and adoption of service redesign and best clinical practice across the area – which may include the continuation or establishment of clinical networks in addition to those nationally established;
- Representation and contribution to Alliances and Networks including clinical networks nationally prescribed;
- Work with NHS England on the outcome and implication of national or regional service reviews;
- Work with the NHS England on system management and resilience;
- Collaboration and sharing best practice on Quality Innovation Productivity and Prevention initiatives; and
- Mutual support and aid in organisational development.

In particular, the CCGs delegate the above functions to enable the Joint Committee to take decisions around future transformation projects, including proposed transformation and redesign of stroke services and children's services.

C. Each member CCG shall also delegate the following functions to the JC CCGs so that it can achieve the purpose set out in (B) above:

1. Acting with a view to securing continuous improvement to the quality of commissioned services. This will include outcomes for patients with regard to clinical effectiveness, safety and patient experience to contribute to improved patient outcomes across the NHS Outcomes Framework

2. Promoting innovation, seeking out and adopting best practice, by supporting research and adopting and diffusing transformative, innovative ideas, products,

services and clinical practice within its commissioned services, which add value in relation to quality and productivity.

3. The requirement to comply with various statutory obligations, including making arrangements for public involvement and consultation throughout the process. That includes any determination on the viability of models of care pre-consultation and during formal consultation processes, as set out in s.13Q, s.14Z2 and s.242 of the NHS Act.

4. The requirement to ensure process and decisions comply with the four key tests for service change introduced by the last Secretary of State for Health, which are:

   Support from GP commissioners;
   Strengthened public and patient engagement;
   Clarity on the clinical evidence base; and
   Consistency with current and prospective patient choice.

5. The requirement to comply with the statutory duty under s.149 of the Equality Act 2010 i.e. the public sector equality duty.

6. The requirement to have regard to the other statutory obligations set out in the new sections 13 and 14 of the NHS Act. The following are relevant but this is not an exhaustive list:

   ss.13C and 14P - Duty to promote the NHS Constitution
   ss.13D and 14Q - Duty to exercise functions effectively, efficiently and economically
   ss.13E and 14R – Duty as to improvement in quality of services
   ss.13G and 14T - Duty as to reducing inequalities
   ss.13H and 14U – Duty to promote involvement of each patient
   ss.13I and 14V - Duty as to patient choice
   ss.13J and 14W – Duty to obtain appropriate advice
   ss.13K and 14X – Duty to promote innovation
   ss.13L and 14Y – Duty in respect of research
   ss.13M and 14Z - Duty as to promoting education and training
   ss.13N and 14Z1- Duty as to promoting integration
   ss.13Q and 14Z2 - Public involvement and consultation by NHS England/CCGs
   s.13O - Duty to have regard to impact in certain areas
   s.13P - Duty as respects variations in provision of health services
   s.14O – Registers of Interests and management of conflicts of interest
   s.14S – Duty in relation to quality of primary medical services

7. The JC CCGs must also have regard to the financial duties imposed on CCGs under the NHS Act and as set out in:

   - s.223G – Means of meeting expenditure of CCGs out of public funds
   - s.223H – Financial duties of CCGs: expenditure
   - s.223I - Financial duties of CCGs: use of resources

- s.223J - Financial duties of CCGs: additional controls of resource use

8. Further, the JC CCGs must have regard to the Information Standards as set out in ss.250, 251, 251A, 251B and 251C of the Health & Social Care Act 2012 (as amended).
9. The expectation is that CCGs will ensure that clear governance arrangements are put in place so that they can assure themselves that the exercise by the JC CCGs of their functions is compliant with statute.
10. The JC CCGs will meet the requirement for CCGs to comply with the obligation to consult the relevant local authorities under s.244 of the NHS Act and the associated Regulations.
11. To continue to work in partnership with key partners e.g. the local authority and other commissioners and providers to take forward plans so that pathways of care are seamless and integrated within and across organisations.
12. The JC CCGs will be delegated the capacity to propose, consult on and agree future service configurations that will shape the medium and long terms financial plans of the constituent organisations. The JC CCGs will have no contract negotiation powers meaning that it will not be the body for formal annual contract negotiation between commissioners and providers. These processes will continue to be the responsibility of Clinical Commissioning Groups (and NHS England) under national guidance, tariffs and contracts during the pre-consultation and consultation periods.

Appendix 2 – JC CCGs Terms of Reference

1. Introduction

1.1 The NHS Act 2006 (as amended) ('**the NHS Act**'), was amended through the introduction of a Legislative Reform Order ("**LRO**") to allow CCGs to form joint committees. This means that two or more CCGs exercising commissioning functions jointly may form a joint committee as a result of the LRO amendment to s.14Z3 (CCGs working together) of the NHS Act.

1.2 Joint committees are a statutory mechanism which gives CCGs an additional option for undertaking collective strategic decision making and this can include NHS England too, who may also make decisions collaboratively with CCGs.

1.3 [Insert as relevant position regarding CCG/NHS England decision-making].

1.4 Individual CCGs and NHS England will still always remain accountable for meeting their statutory duties. The aim of creating a joint committee is to encourage the development of strong collaborative and integrated relationships and decision-making between partners.

1.5 The Joint Committee of Clinical Commissioning Groups ('**JC CCGs**') is a joint committee of:

(1) NHS Barnsley Clinical Commissioning Group;

(2) NHS Bassetlaw Clinical Commissioning Group;

(3) NHS Doncaster Clinical Commissioning Group;

(4) NHS Rotherham Clinical Commissioning Group;

(5) NHS Sheffield Clinical Commissioning Group;

(6) NHS North Derbyshire Clinical Commissioning Group;

(7) NHS Hardwick Clinical Commissioning Group; and

(8) NHS Wakefield Clinical Commissioning Group.

It has the primary purpose of enabling the CCG members to work effectively together, to collaborate and take joint decisions in the areas of work that they agree.

1.6 In addition the JC CCGs will meet collaboratively with NHS England to make integrated decisions in respect of those services which are directly commissioned by NHS England.

1.7 Guiding principles:

- Collaborate and co-operate. Do it once rather than repeating or duplicating actions and increasing cost across the CCGs. Establish and adhere to the governance structure set out in these Terms of Reference and in the JC CCGs Manual (as updated from time to time), to ensure that activities are delivered and actions taken as required;
- Be accountable. Take on, manage and account to each other for performance of the respective roles and responsibilities set out in these Terms of Reference and in the JC CCGs Manual (as updated from time to time);
- Be open. Communicate openly about major concerns, issues or opportunities relating to the functions delegated to the JC CCGs, as set out in Schedule 1; ensuring our collective decisions are based on the *best* available evidence, that these are fully articulated, heard, and understood.
- Learn, develop and seek to achieve full potential. Share information, experience, materials and skills to learn from each other and develop effective working practices, work collaboratively to identify solutions, eliminate duplication of effort, mitigate risk and reduce cost whilst ensuring quality is maintained or improved across all the CCGs;
- Adopt a positive outlook. Behave in a positive, proactive manner;
- Adhere to statutory requirements and best practice. Comply with applicable laws and standards including EU procurement rules, data protection and freedom of information legislation.
- Act in a timely manner. Recognise the time-critical nature of the functions delegated to the JC CCGs as set out in Schedule 1, and respond accordingly to requests for support;
- Manage stakeholders effectively;
- Deploy appropriate resources. Ensure sufficient and appropriately qualified resources are available and authorised to fulfil the responsibilities set out in these Terms of Reference and in the JC CCGs Manual (as updated from time to time);
- Act in good faith to support achievement of the Key Objectives as set out in the JC CCGs Manual and compliance with these Principles.

1.8 The JC CCG has a commitment to ensuring that in pursuing its Key Objectives it does not increase inequalities or worsen health outcomes for any local populations.

1.9 From time to time programmes boards may be established to oversee individual programmes of work. Where these are established under the direction of the JC CCG these will be accountable to the JC CCG.

2. Statutory Framework

2.1 The NHS Act which has been amended by LRO 2014/2436, provides at s.14Z3 that where two or more clinical commissioning groups are exercising their commissioning functions jointly, those functions may be exercised by a joint committee of the groups.

2.2 The CCGs named in paragraph 1.5 above have delegated the functions set out in Schedule 1 to the JC CCGs.

3. Role of the JC CCGs

3.1 The role of the JC CCGs shall be:

- Development of collective strategy and commissioning intentions;
- Development of co-commissioning arrangements with NHS England;
- Joint contracting with Foundation Trusts and other service providers;
- System transformation, including the development and adoption of service redesign and best clinical practice across the area – which may include the continuation or establishment of clinical networks in addition to those nationally established;
- Representation and contribution to Alliances and Networks including clinical networks nationally prescribed;
- Work with NHS England on the outcome and implication of national or regional service reviews;
- Work with the NHS England Area on system management and resilience;
- Collaboration and sharing best practice on Quality Innovation Productivity and Prevention initiatives; and
- Mutual support and aid in organisational development.

3.2 At all times, the JC CCGs, through undertaking decision making functions of each of the member CCGs, will act in accordance with the terms of their constitutions. No decision outcome shall impede any organisation in the fulfilment of its statutory duties.

4. Geographical coverage

4.1 The JC CCGs will comprise those CCGs listed above in paragraph 1.5 and cover the South Yorkshire and Bassetlaw, North Derbyshire and Hardwick and Wakefield areas.

4.2 NHS England Specialised Commissioning will also be involved through a collaborative commissioning arrangement.

5. Membership

5.1 Membership of the committee will combine both Voting and Non-voting members and will comprise of: -

5.2 Voting members:

- Two decision makers from each of the member CCGs, who will be the Clinical Chair and Accountable Officer;

5.3 Non-voting attendees:

- Two Lay Members chosen from the member CCGs.
- One Director of Finance chosen from the member CCGs.
- A representative from NHS England;
- A Healthwatch representative nominated by the local Healthwatch groups; and
- Two Local Authority representatives.

5.4 The JC CCG may invite additional non-voting members to join the JC CCG to enable it to carry out its duties.

5.4 Committee members may nominate a suitable deputy when necessary and subject to the approval of the Chair of the JC CCGs. All deputies should be fully briefed and the secretariat informed of any agreement to deputise so that quoracy can be maintained.

5.5 No person can act in more than one role on the JC CCGs, meaning that each deputy needs to be an additional person from outside the JC CCGs membership.

5.6 Commissioners Working Together will act as secretariat to the Committee to ensure the day to day work of the JC CCGs is proceeding satisfactorily. The membership will meet the requirements of the constitutions of the CCGs named above at paragraph 1.5.

6. Meetings

6.1 The JC CCGs shall adopt the standing orders of NHS Sheffield Clinical Commissioning Group insofar as they relate to the:

a) notice of meetings;

b) handling of meetings;

c) agendas;

d) circulation of papers; and

e) conflicts of interest.

7. Voting

7.1 The JC CCGs will aim to make decisions by consensus wherever possible. Where this is not achieved, a voting method will be used. The JC CCG has eight CCG members and sixteen voting members. The voting power of each individual present will be weighted so that each party (CCG) possesses 12.5% of total voting power.

7.2 It is proposed that recommendations can only be approved if there is approval by more than 75%.

8. Quorum

At least one full voting member from each CCG must be present for the meeting to be quorate. The Healthwatch representative must also be present.

9. Frequency of meetings

Frequency of meetings will usually be bi-monthly, on the first Tuesday of every other month but the Chair has the power to call meetings of the JC CCGs as and when they are required.

10 Meetings of the JC CCGs

10.1 Meetings of the JC CCGs shall be held in public unless the JC CCGs 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. Therefore, the JC CCGs 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.

10.2 Members of the JC CCGs have a collective responsibility for the operation of the JC CCGs. They will participate in discussion, review evidence and provide objective expert input to the best of the knowledge and ability, and endeavor to reach a collective view.

10.3 The JC CCGs may call additional experts to attend meetings on an ad hoc basis to inform discussions.

10.4 The JC CCGs has the power to establish sub groups and working groups and any such groups will be accountable directly to the JC CCGs.

10.5 Members of the JC CCGs shall respect confidentiality requirements as set out in the Standing Orders referred to above unless separate confidentiality requirements are set out for the JC CCGs, in which event these shall be observed

11. Secretariat provisions

The secretariat to the JC CCGs will:

a) Circulate the minutes and action notes of the committee within five working days of the meeting to all members; and

b) Present the minutes, decisions and action notes to the governing bodies of the CCGs set out in paragraph 1.5 above.

12. Reporting to CCGs and NHS England

The JC CCGs will make a quarterly written report to the CCG member governing bodies and NHS England and hold at least annual engagement events to review aims, objectives, strategy and progress and publish an annual report on progress made against objectives.

13. Decisions

13.1 The JC CCGs will make decisions within the bounds of the scope of the functions delegated.

13.2 The decisions of the JC CCGs shall be binding on all member CCGs.

13.3 All decisions undertaken by the JC CCGs will be published by the Clinical Commissioning Groups set out in paragraph 1.5, above.

14. Review of Terms of Reference

These terms of reference will be formally reviewed annually by Clinical Commissioning Groups set out in paragraph 1.5 and may be amended by mutual agreement between the CCGs at any time to reflect changes in circumstances as they may arise.

15. Withdrawal from the JC CCG

15.1 Should this joint commissioning arrangement prove to be unsatisfactory, the governing body of any of the member CCGs can decide to withdraw from the

arrangement, but has to give a minimum six months' notice to partners, with consideration by the JC CCG of the impact of a leaving partner - a maximum of 12 notice could apply.

16. Signatures

Schedule 1 - Delegation by CCGs to JC CCGs

A. The CCG functions at B will be delegated to the JC CCGs by the member CCGs in accordance with their statutory powers under s.14Z3 of the NHS Act 2006 (as amended) (**"the NHS Act"**). Section 14Z3 allows CCGs to make arrangements in respect of the exercise of their commissioning functions and includes the ability for two or more CCGs to create a Joint Committee to exercise functions.

B. The delegated functions relate to the health services provided to the member CCGs by all providers they commission services from in the exercise of their functions. The CCGs delegate their commissioning functions so far as such functions are required for the Joint Committee to carry out the following roles, as set out in the Terms of Reference:

- Development of collective strategy and commissioning intentions;
- Development of co-commissioning arrangements with NHS England;
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- System transformation, including the development and adoption of service redesign and best clinical practice across the area – which may include the continuation or establishment of clinical networks in addition to those nationally established;
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- Work with NHS England on the outcome and implication of national or regional service reviews;
- Work with the NHS England Area on system management and resilience;
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In particular, the CCGs delegate the above functions to enable the Joint Committee to take decisions around future transformation projects, including proposed transformation and redesign of stroke services and children's services.

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1. Acting with a view to securing continuous improvement to the quality of commissioned services. This will include outcomes for patients with regard to clinical effectiveness, safety and patient experience to contribute to improved patient outcomes across the NHS Outcomes Framework

2. Promoting innovation, seeking out and adopting best practice, by supporting research and adopting and diffusing transformative, innovative ideas, products, services and clinical practice within its commissioned services, which add value in relation to quality and productivity.

3. The requirement to comply with various statutory obligations, including making arrangements for public involvement and consultation throughout the process. That includes any determination on the viability of models of care pre-consultation and during formal consultation processes, as set out in s.13Q, s.14Z2 and s.242 of the NHS Act.

4. The requirement to ensure process and decisions comply with the four key tests for service change introduced by the last Secretary of State for Health, which are:

   Support from GP commissioners;
   Strengthened public and patient engagement;
   Clarity on the clinical evidence base; and
   Consistency with current and prospective patient choice.

5. The requirement to comply with the statutory duty under s.149 of the Equality Act 2010 i.e. the public sector equality duty.

6. The requirement to have regard to the other statutory obligations set out in the new sections 13 and 14 of the NHS Act. The following are relevant but this is not an exhaustive list:

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   ss.13G and 14T - Duty as to reducing inequalities
   ss.13H and 14U – Duty to promote involvement of each patient
   ss.13I and 14V - Duty as to patient choice
   ss.13J and 14W – Duty to obtain appropriate advice
   ss.13K and 14X – Duty to promote innovation
   ss.13L and 14Y – Duty in respect of research
   ss.13M and 14Z - Duty as to promoting education and training
   ss.13N and 14Z1- Duty as to promoting integration
   ss.13Q and 14Z2 - Public involvement and consultation by NHS England/CCGs
   s.13O - Duty to have regard to impact in certain areas
   s.13P - Duty as respects variations in provision of health services
   s.14O – Registers of Interests and management of conflicts of interest
   s.14S – Duty in relation to quality of primary medical services

7. The JC CCGs must also have regard to the financial duties imposed on CCGs under the NHS Act and as set out in:

   - s.223G – Means of meeting expenditure of CCGs out of public funds
   - s.223H – Financial duties of CCGs: expenditure
   - s.223I - Financial duties of CCGs: use of resources
   - s.223J - Financial duties of CCGs: additional controls of resource use

8. Further, the JC CCGs must have regard to the Information Standards as set out in ss.250, 251, 251A, 251B and 251C of the Health & Social Care Act 2012 (as amended).
9. The expectation is that CCGs will ensure that clear governance arrangements are put in place so that they can assure themselves that the exercise by the JC CCGs of their functions is compliant with statute.
10. The JC CCGs will meet the requirement for CCGs to comply with the obligation to consult the relevant local authorities under s.244 of the NHS Act and the associated Regulations.
11. To continue to work in partnership with key partners e.g. the local authority and other commissioners and providers to take forward plans so that pathways of care are seamless and integrated within and across organisations.
12. The JC CCGs will be delegated the capacity to propose, consult on and agree future service configurations that will shape the medium and long terms financial plans of the constituent organisations. The JC CCGs will have no contract negotiation powers meaning that it will not be the body for formal annual contract negotiation between commissioners and providers. These processes will continue to be the responsibility of Clinical Commissioning Groups (and NHS England) under national guidance, tariffs and contracts during the pre-consultation and consultation periods.

Schedule 2 - List of Members from each Constituent CCG and non-voting members

Column 1 **Organisation or nomination**	**Column 2** **Representatives**
Voting members	
NHS Barnsley Clinical Commissioning Group;	Nick Balac, Lesley Smith
NHS Bassetlaw Clinical Commissioning Group;	Andrew Perkins, Phil Mettam
NHS Doncaster Clinical Commissioning Group;	David Crichton, Jackie Pederson
NHS Rotherham Clinical Commissioning Group;	Julie Kitlowski, Chris Edwards
NHS Sheffield Clinical Commissioning Group;	Tim Moorhead, Maddy Ruff
NHS North Derbyshire Clinical Commissioning Group;	Ben Milton, Steve Allinson
NHS Hardwick Clinical Commissioning Group; and	Steve Lloyd, Andy Gregory
NHS Wakefield Clinical Commissioning Group.	Philip Earnshaw, Jo Webster
Non-voting members	
Commissioners Working Together	Will Cleary-Gray
Nominated Director of Finance	Julia Newton
Nominated lay members	John Boyington Steven Hardy
Nominated Healthwatch member	TBC
Local Authority members	TBC
SYB STP lead	Sir Andrew Cash

Appendix 3 – Checklist of Statutory Duties and Protocols

Public Law Issues (including for service change)

1. Case For Change

The starting point is to have established a clear Case for Change that both commissioners and providers agree is clinically and financially sound.

2. Engagement with Public and Patients

You must comply with various statutory obligations to engage with and consult the public and patients throughout the process. That includes any determination on the viability of models of care pre-consultation and during formal consultation processes. – see s.13Q, s.14Z2 and s.242 of the NHS Act 2006 (as amended) ('the Act')

3. Four Key Tests

It is important throughout the reconfiguration process to have in mind the four key tests introduced by the last Secretary of State for Health, which are:

(i) strong public and patient engagement;

(ii) consistency with current and prospective need for patient choice;

(iii) a clear clinical evidence base; and

(iv) support for proposals from clinical commissioners.

Decision makers will need to show compliance when making a final decision on service change.

4. Equality

All NHS statutory bodies must also ensure compliance with their duty under s.149 of the Equality Act 2010 that is their public sector equality duty.

5. Statutory obligations

Commissioners must also have regard to the other statutory obligations set out in the new sections 13 and 14 of the Act. In looking at CCG duties the following, amongst others, are relevant:

- 14P – Duty to promote NHS Constitution
- 14Q – Duty as to effectiveness, efficiency etc
- 14R – Duty as to improvement in quality of services
- 14T – Duty as to reducing inequalities

- 14V – Duty as to patient choice
- 14X - Duty to promote innovation
- 14Z1 – Duty as to promoting integration
- 14Z2 – Public involvement and consultation by CCGs (see above)

6. Cabinet Office

All consulting NHS bodies should consider and comply with Cabinet Office Guidance on Consultation. This sets out what the CO recommends needs to be done to undertake a lawful public consultation exercise.

7. Seven criteria for consultation

- When to consult – that is when you have all relevant information available for consultees to give informed responses.
- Duration of consultation exercises – CO guidance is at least 2 weeks but no more than 12 weeks.
- Clarity of scope and impact – you should clearly set out what is proposed and how that may impact on patients within any consultation document.
- Accessibility of consultation exercises – you should make sure that you obtain the views of all relevant people and run an open consultation process.
- The burden of consultation – that is you should not over burden the public with consultations.
- Responsiveness of consultation exercises – your process should operate so that appropriate consideration is given to all responses from the consultation exercise.
- Capacity to consult – you should make sure you devote sufficient resources so that a lawful exercise is undertaken

8. Governance

As to decision making it is important that clear governance arrangements are put in place that are compliant with statute.

9. Local authorities

Equally you must comply with your obligation to consult the relevant local authorities under s.244 of the Act and the associated Regulations.

10. Clear plan

As to consulting you need to have a clear plan in place which ensures that you give the public sufficient information for them to provide informed responses.

11. Analysis and report

Once the public consultation is complete, you must be able to collate and analyse responses for the decision makers to consider, often in the form of a consolidated report. Equally, you

need a clear analysis of compliance with your obligations under the public sector equality duty.

12. Compliance with statutory obligations and four Key Tests

Commissioners will also want to ensure that decisions comply with their other statutory obligations and the four Key Tests, as set out above.

13. IRP

Consideration should be given to those issues which the IRP have indicated in annual reviews cause the most concern to the public an patients. (See separate note for a list of the issues).

Procurement Issues

Commissioners are required to ensure that their decisions to procure services comply with the National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013. Key questions are set out under each heading below to assist you when considering whether you are meeting these requirements. Commissioners are also required to comply with EU/UK general procurement law but this is not covered in the list below.

1. Procurement objective

'To secure the needs of patients and improve quality and efficiency of services'.

- What have you done to assess patient need and do you have evidence to support your findings?
- How are you assessing the quality of services and the performance of the current providers? How have you assessed whether the service is offering value for money?
- Have you reviewed the current service specification to ensure it is working well and whether there is scope for further improvement? In particular, it would be helpful to have a schedule of all existing contracts and relationships, including performance monitoring on contracts.
- What steps have you taken to assess equitable access to services by all patient groups?

2. Three general requirements

I. To act transparently and proportionately and in a non-discriminatory way.

- What steps have you taken to make providers and stakeholders aware of your plans? Have you provided reasons to support your decisions?
- Are you publishing details in a timely manner and have you kept records of decision making, e.g. board minutes and briefing papers?
- Do providers understand the selection criteria you are using and are they able to express an interest in providing the services? Can you show that you have not favoured one provider over the other?

- Is your approach proportionate to the nature of the services in relation to the value, complexity and clinical risk associated with the provision of the services in question?

II. To contract with providers who are most capable of meeting the objectives and provide best value for money

- How have you identified existing and potential providers and objectively evaluated their relative ability to deliver the service specification, improve quality and meet the needs of patients?
- Are you satisfied providers are capable and robust enough to deliver a safe and efficient service and provide the best value for money in doing so?

III. Consider ways of improving services through integration, competition and patient choice

- What evidence do you have to show the steps you taken to determine whether it might be better for patients if the services are integrated with other health care services?
- Have you asked providers, patients, and other stakeholders for their views?
- Does your specification or performance monitoring process incentivise delivery of care in a more integrated manner?
- Have you considered whether competition or choice would better incentivise providers to improve quality and efficiency? Do you have evidence to support your findings?

3. Advertisements and expressions of interest

To ensure providers are able to express an interest in in providing any services which includes the requirement to publish opportunities and awards on a website

- How have you gathered evidence about the existing and potential providers on the market?
- Have you published your intentions to the market by way of commissioning intentions or publication on a website?

4. Award of a new contract without a competition

A new contract may be awarded without publishing a contract notice where the commissioner is satisfied that the services in question are capable of being provided only by that provider, e.g. A&E services in a particular area or where it is not viable for providers to provide one service without also providing another service.

- What steps have you taken and what evidence are you relying on to satisfy yourself that there is only one capable provider?

5. Conflict of Interests

Commissioners are prohibited from awarding a contract where conflicts, or potential conflicts, between the interests of Commissioners in commissioning services and the

interests involved in providing the services affect, or appear to affect, the integrity of the award of the contract.

- Have you recorded how you have managed any conflict or potential conflict?

6. Anti-competitive behaviour

Not to engage in anti-competitive behaviour unless to do so would be in the interests of people who use NHS services

- Are you acting in an anticompetitive manner – for instance have you prevented new providers from entering the market or caused a provider to exit the market?

- If so, is it objectively justifiable as being in the interests of users and stakeholders? What evidence do you have to support this?

Competition Issues

1. Requirement to Notify to the Competition and Markets Authority (CMA)

Any undertakings given to the CMA or its predecessor, the Competition Commission, may prohibit a statutory transaction and should be checked. They may not apply to a merger by reconfiguration but the merger regime set out below will still apply.

2. Merger control rules

The merger control regime may apply to NHS service reconfigurations where two or more services are merged and the transaction meets the jurisdictional tests.

3. Jurisdictional Tests

The CMA has jurisdiction to examine a merger where:

1. two or more enterprises cease to be distinct (change of control)

2. and either

- the UK turnover of the acquired enterprise exceeds £70 million; or
- the enterprises which cease to be distinct together supply or acquire at least 25% of all those particular services of that kind supplied in the UK or in a substantial part of it. The merger must also result in an increment to the share of supply, i.e. the merging providers must supply or acquire the same category of services.

[**Enterprise**: NHS foundation trusts and NHS trusts controlling hospital, ambulance services, mental health service, community services or individual services or specialities may be enterprises for the purpose of merger control.

Change in control: Two enterprises (or services) cease to be distinct if they are brought under common ownership or control. There must be a change in the level of control over the activities of one or more enterprises (or services) for merger control to apply.]

4. Competition test

The CMA assesses qualifying mergers to decide whether they are likely to lead to a substantial lessening of competition ('SLC'). An SLC occurs when competition is substantially less after the merger.

5. SLC assessment

The CMA will require detailed information about the reconfiguration. This will include:

- service overlaps;
- GP referral data / catchment area analysis; and
- Hospital share of GP practice referrals.

6. CMA merger assessment timetable

The process is divided into two stages:

- Phase I: an initial 40 working day investigation; and
- Phase II: a possible 24 weeks in-depth investigation, which can be extended if the CMA considers it necessary.