

**Joint Committee of CCGs – Proposal to put in place additional arrangements for the transition to Integrated Care Boards****Governing Body meeting  
2 September 2021****D**

<b>Author(s)</b>	Brian Hughes
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<b>Purpose of Paper</b>	
<p>NHS Operational Planning Guidance for 2021/22 requires systems to start formally planning for the establishment of the statutory integrated care systems during Q1 of 2021, including setting out plans to operate in shadow form in Q4 of 2021/22. In summary this will involve the establishment of a statutory Integrated Care Board (ICB) and an Integrated Care Partnership (ICP) which together make the Integrated Care Systems (ICSs) of the future. Both statutory functions of current CCGs and some of NHS England will transfer to the ICB, along with existing non-statutory functions of ICSs, including strategic planning, transformation, and oversight. The ICB is working towards operating in full shadow form from December 2021.</p> <p>The five CCGs and ICS wish to put in place arrangements to ensure a smooth transition to the ICB in April 2022. It has been decided that the most practical way of doing this is for the Joint Committee of CCGs (“the Joint Committee”) to co-ordinate the taking of preparatory steps for the transition to the ICS on behalf of the CCGs and for the ICS to have visibility of that work.</p> <p>This paper proposes changes to the remit of the Joint Committee to enable this work to be progressed.</p> <p>The boundaries of the ICS mean that NHS Bassetlaw will be moving from the ICS into Nottinghamshire and a neighbouring integrated care system on 1<sup>st</sup> April 2022. NHS Bassetlaw will continue to have an interest in many of the transitional issues within the remit of the Joint Committee. However, it is recognised that there may also be areas in which NHS Bassetlaw does not have a direct interest, and that NHS Bassetlaw may want to be less involved in discussions on such issues. The transitional operating arrangements take account of this.</p>	
<b>Key Issues</b>	
<p>The attached Appendix A outlines a proposed addition, Schedule (3), to the Manual Agreement and Terms of Reference of the Joint Committee of CCGs, that sets out that the Joint Committee of the five CCGs is adapted for the transition to the South Yorkshire and Bassetlaw Integrated Care System by:</p> <ul style="list-style-type: none"> <li>Expanding the scope of its delegation to include transition work such as the carrying out of due diligence, development of corporate policies, development of the constitution for the new ICB and liaising with NHS England regarding the constitution.</li> </ul>	

- Inviting members of the ICB to its meetings, so that they have a full understanding of the preparatory work being done by the Joint Committee;
- Establishing a sub-committee to carry out this preparatory work; and
- Having a working arrangement with Bassetlaw CCG that the CCG may choose not to participate in parts of the meeting that are not directly relevant to Bassetlaw, following the move of Bassetlaw from South Yorkshire & Bassetlaw ICS to Nottinghamshire & Nottingham ICS on 1st April 2022.
- No changes are made to the Joint Committee's Terms of Reference. In particular, Bassetlaw CCG will continue to be a member of the Joint Committee and attendance of a representative from Bassetlaw CCG will still be required in order for meetings of the Joint Committee to be quorate. If a member from Bassetlaw CCG is in attendance at a Joint Committee meeting and decides not to actively participate in discussions on a particular topic, that will not mean that the meeting is inquorate.
- This paper has been supported by Barnsley CCG, Bassetlaw CCG, Doncaster CCG, Rotherham CCG, Sheffield CCG and Derbyshire CCG as a variation to the Manual and Delegation. If there is any difference between the provisions of this Schedule 3 and the remainder of the Manual or the Delegation, then the terms of this Paper will take precedence.
- As set out above, nothing in this Schedule 3 amends the Joint Committee Terms of Reference (the current Manual Agreement and Terms of Reference July 2019 is attached at Appendix B for reference).

**Is your report for Approval / Consideration / Noting**

**Approval**

**Recommendations / Action Required by Governing Body**

The Governing Body is asked to:

Approve that the Schedule (3) enclosed at Appendix A to be added to the JC CCG Manual Agreement / TOR (attached for reference at Appendix B) and specifically approval of the following:

- Proposed amendment to the delegation of the Joint Committee for the transition work but the Joint Committee TOR are unchanged
- Establishment of the Joint Committee sub-committee – the Change and Transition Board - to take forward the transition work between September and end March 2022

**What assurance does this report provide to the Governing Body in relation to Governing Body Assurance Framework (GBAF) objectives?**

**Which of the CCG's Objectives does this paper support?**

Strategic Objective - To ensure there is a sustainable, affordable healthcare system in Sheffield. It supports management of the CCG's principal risk 4.2 in the GB Assurance Framework.

**Description of Assurances for Governing Body**

That there are robust arrangements in place to manage the transition of functions and responsibilities from the CCG to the proposed ICS arrangements.

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

Transition will inevitably require resource, but at present this is assumed to be delivered from within existing resources.

**Have you carried out an Equality Impact Assessment and is it attached?**

*Please attach if completed. Please explain if not, why not*

Not applicable

**Have you involved patients, carers and the public in the preparation of the report?**

Not applicable

**Joint Committee Transition 2021/22  
Proposal to add as SCHEDULE 3 to  
Joint Committee of CCGs Manual / Terms of Reference**

**Background**

- 1 NHS Operational Planning Guidance for 2021/22 requires systems to start formally planning for the establishment of the statutory integrated care systems during Q1 of 2021, including setting out plans to operate in shadow form in Q4 of 2021/22. In summary this will involve the establishment of a statutory Integrated Care Board (**ICB**) and an Integrated Care Partnership (**ICP**) which together make the Integrated Care Systems (**ICSs**) of the future. Both statutory functions of current CCGs and some of NHS England will transfer to the ICB, along with existing non-statutory functions of ICSs, including strategic planning, transformation and oversight. The ICB is working towards operating in full shadow form from December 2021.
- 2 The five CCGs and ICS wish to put in place arrangements to ensure a smooth transition to the ICB in April 2022. It has been decided that the most practical way of doing this is for the Joint Committee of CCGs ("**the Joint Committee**") to co-ordinate the taking of preparatory steps for the transition to the ICS on behalf of the CCGs and for the ICS to have visibility of that work.
- 3 The boundaries of the ICS mean that NHS Bassetlaw will be moving from the ICS into Nottinghamshire and a neighbouring integrated care system from the 1<sup>st</sup> April 2022. NHS Bassetlaw will continue to have an interest in many of the transitional issues within the remit of the Joint Committee. However, it is recognised that there may also be areas in which NHS Bassetlaw does not have a direct interest, and that NHS Bassetlaw may want to be less involved in discussions on such issues. The transitional operating arrangements take account of this.
- 4 It is anticipated that these arrangements will be in place between September 2021 and 1<sup>st</sup> April 2022, when CCGs will be dissolved, and ICSs formally established under legislation.
- 5 In this paper capitalised terms have the same meaning as in the Manual, unless otherwise defined. References to the ICB, ICP and ICS include those organisations operating in shadow form, prior to their legal establishment under the Health & Care Bill.

**Transitional arrangements**

- 6 The Joint Committee is adapted for the transition to the South Yorkshire Integrated Care System ("**ICS**") by:
  - a. Expanding the scope of its delegation to include transition work such as the carrying out of due diligence, development of corporate policies, development of the constitution for the new ICB and liaising with NHS England regarding the constitution;
  - b. Inviting members of the ICB to its meetings, so that they have a full understanding of the preparatory work being done by the Joint Committee;

- c. Establishing a sub-committee to carry out this preparatory work; and
  - d. Having a working arrangement with Bassetlaw CCG that the CCG may choose not to participate in parts of the meeting that are not directly relevant to Bassetlaw, following the move of Bassetlaw from South Yorkshire & Bassetlaw ICS to Nottinghamshire & Nottingham ICS on 1<sup>st</sup> April 2022.
- 7 No changes are made to the Joint Committee's Terms of Reference. In particular, Bassetlaw CCG will continue to be a core member of the Joint Committee and attendance of a representative from Bassetlaw CCG will still be required in order for meetings of the Joint Committee to be quorate. If a member from Bassetlaw CCG is in attendance at a Joint Committee meeting and decides not to actively participate in discussions on a particular topic, that will not mean that the meeting is inquorate.
- 8 This paper has been supported by Barnsley CCG, Bassetlaw CCG, Doncaster CCG, Rotherham CCG, Sheffield CCG and Derbyshire CCG as a variation to the Manual and Delegation. If there is any difference between the provisions of this Schedule 3 and the remainder of the Manual or the Delegation, then the terms of this Paper will take precedence. As set out above, nothing in this Schedule 3 amends the Joint Committee Terms of Reference.

### Expanding the Delegation

- 9 The Delegation is expanded by adding the following paragraph to the end of section B:

*The delegated functions also relate to the preparation for the transition of commissioning responsibilities from CCGs and NHS England to Integrated Care Systems following the introduction of new legislation. The CCGs delegate these functions (regarding the preparation for the transition of commissioning responsibilities) to the Joint Committee, to enable consistent and effective decision-making. Such preparation for future commissioning to be carried out by Integrated Care Boards (ICBs) may include (but is not limited to):*

- *The development of draft corporate policies for consideration/ adoption by the ICB once it is formally established e.g. in the areas of HR, conflicts of interest, finance.*
- *Developing the ICB constitution and liaising as appropriate with NHS England to gain approval for the constitution; this may include overseeing support work carried out by the ICB, such as producing drafts of the constitution and co-ordinating engagement.*
- *Producing/ providing input into the transition schemes that will manage the move from CCGs to ICSs and liaising as appropriate with NHS England.*
- *Being the point of contact for any queries from the ICB while it operates in shadow form, including for the provision of information needed to support the ICB's work.*

*The development of any ICB plans (such as the Forward Plan and the Capital Plan) will be carried out by the ICB operating in shadow form.*

### **Developing the ICB constitution**

- 10 Under the Health & Care Bill 2021 as currently drafted the CCGs are responsible for the consultation on and submission for approval of the ICB constitution. Under the updated delegation (see section above) this responsibility has been delegated to the Joint Committee.
- 11 The ICB has offered support to the Joint Committee regarding the constitution, including through preparation of a draft constitution for consideration by the Joint Committee and the co-ordination of any engagement exercise.
- 12 The Joint Committee may request and obtain assistance from the ICB regarding its responsibilities related to the constitution, in particular regarding any engagement exercise. This may include the ICB carrying out/ co-ordinating activities to support the Joint Committee. The Joint Committee shall be responsible for overseeing any such activity by the ICB and taking any final decisions regarding the CCGs' responsibilities relating to the ICB constitution.

### **Meeting arrangements for the Joint Committee during the transition period**

- 13 The following arrangements will be put in place to ensure effective working between the Joint Committee and the ICB during the transition period.

### **Attendance**

- 14 Under its terms of reference (paragraph 5.4) the Joint Committee can invite non-voting members to join the Joint Committee. Non-voting members are invited to all Joint Committee meetings but do not count towards the quorum. The Joint Committee invites the following post holders to join the Joint Committee as non-voting members:

- ICB Chair Designate
  - Two individuals nominated by the ICB Chair Designate (the ICB Chair Designate may update these nominations from time to time through informing the Joint Committee Chair of the change)
- 15 It will be for these invitees to decide whether or not to attend the meeting, informed by the meeting agenda. If the Joint Committee particularly wants a representative from the ICB to attend, this should be highlighted to the ICB Point of Contact at the time that the agenda is circulated.
- 16 Each ICB non-voting member may nominate a deputy to attend in their place. Such nominations should be made at least three working days in advance of the meeting where possible and should be made by contacting the Joint Committee Point of Contact.
- 17 The Joint Committee may invite further post holders to join the Joint Committee. If the Joint Committee wishes further ICB officers to join, the Joint Committee Point of Contact should make a request to the ICB Point of Contact. If the ICB wishes further ICB officers to join, the ICB Point of Contact should make a request to the Joint Committee Point of Contact. The Joint Committee can then decide whether those individuals should be added as non-voting members and whether or not they are able to appoint a deputy if they are unable to attend. To keep meetings manageable, it is envisaged that the total number of non-voting members from the ICB will not exceed four.
- 18 The Joint Committee can also invite additional experts to attend its meetings on an ad hoc basis. If the Joint Committee wishes an expert from the ICB to attend, then they should make this request to the ICB Point of Contact. If the ICB wishes an ad hoc expert to attend then the ICB Point of Contact should make a request to the Joint Committee Point of Contact at least five working days prior to the meeting.

### Communications

- 19 To ensure clear lines of communication both the ICB and the Joint Committee will have a dedicated **Point of Contact**. The Chair of the Joint Committee will nominate the Joint Committee point of contact and the Chair Designate of the ICB will nominate the ICB point of contact. Nominations may be updated from time to time. At the time of writing the points of contact are:
- Joint Committee Point of Contact – Lisa Kell, Director of Commissioning at the ICS,  
[lisa.kell@nhs.net](mailto:lisa.kell@nhs.net)
- ICB Point of Contact – Will Cleary-Gray, Chief Operating Officer at the ICS,  
[will.cleary-gray@nhs.net](mailto:will.cleary-gray@nhs.net)
- 20 Communications regarding the administration of Joint Committee meetings should go through these points of contact.

### Meeting administration

- 21 Administration of the meeting shall continue to be the responsibility of the Joint Committee. It will therefore be the responsibility of the Joint Committee to ensure that:
- Meeting invitations are sent out to the appropriate people (including non-voting members from the ICB)
  - Meeting agendas and papers are circulated in advance
  - Minutes of the meeting are taken.
  - Minutes of the meeting are circulated
- 22 If the ICB wants a matter to be added to the Joint Committee meeting agenda then the ICB Point of Contact should notify the Joint Committee Point of Contact at least 5 working days before the meeting and provide any relevant papers within the timescales requested by the Joint Committee Point of Contact. The Joint Committee will then consider whether to include the item in accordance with its Terms of Reference.

### Meeting papers

- 23 The agenda and minutes for each meeting will clearly set out:
- 23.1 The voting members from the Joint Committee who are attending
  - 23.2 The non-voting members from the ICB who are attending
  - 23.3 Any other non-voting members
  - 23.4 Anyone attending as an ad hoc expert
  - 23.5 Who is leading on each agenda item
- 24 Technically, the minutes will be approved by voting members of the Joint Committee attending the following meeting. However, the voting members will take account of the views of non-voting members in attendance at the relevant meeting before approving the minutes.

### **Establishing sub-committees**

- 25 The Joint Committee establishes a sub-committee (the Change and Transition Board) to assist it with transition work.
- 26 The sub-committee will prepare proposals and carry out preparatory work for approval/adoption by the Joint Committee. The sub-committee will not itself make decisions.
- 27 The Change and Transition Board sub-committee will operate in accordance with its terms of reference, set out below.



## Terms of Reference

<b>Group or meeting</b>	<b>Change and Transition Board sub-committee, a sub-committee of the Joint Committee of CCGs (“Joint Committee”)</b>
<b>Roles and responsibilities</b>	<p>To assist the Joint Committee with the preparation for the transition of commissioning responsibilities from the CCG and NHS England to the ICS.</p> <p>The Joint Committee will ask the sub-committee to complete particular tasks on a case by case basis.</p> <p>The sub-committee will make proposals to the Joint Committee. It will then be for the Joint Committee to discuss and adopt these as appropriate. The sub-committee cannot make any decisions on behalf of the Joint Committee.</p>
<b>Membership</b>	<p><b>Voting members</b></p> <p>One individual nominated by Barnsley CCG          One individual nominated by Bassetlaw CCG          One individual nominated by Doncaster CCG          One individual nominated by Rotherham CCG          One individual nominated by Sheffield CCG</p> <p>A CCG Director of Finance from one of the core member CCGs nominated by the Chair of the Joint Committee</p> <p>Each of these members may nominate a deputy to attend in their place.</p> <p>Each CCG may update their nominations from time to time through informing the sub-committee Chair of the change.</p> <p><b>Observers</b></p> <p>Four individuals nominated by the ICB Chair Designate (the ICB Chair Designate may update these nominations from time to time through informing the sub-committee Chair of the change). It is anticipated that the initial nominees will be the ICS Lead, the ICS Deputy Lead, the ICS Chief Operating Officer and the ICS Director of HR.</p> <p>The Joint Committee Point of Contact, as described in Schedule 3 of the Manual.</p> <p>Each of these observers may nominate a deputy to attend in their place.</p> <p>The voting members may invite such other observers to join the sub-committee provided the total number of observers does not</p>

	<p>exceed 7.</p> <p>The term “<b>Members</b>” refers to both voting members and observers of the sub-committee.</p> <p><b>Other attendees</b></p> <p>The voting members may invite other individuals with subject matter expertise to join its meetings on an ad hoc basis to inform discussions</p> <p>Note that the membership of the sub-committee may flex (through the CCGs and ICB updating their nominations) according to the subject matter of the sub-committee’s work.</p>
<b>Sub-committee points of contact</b>	<p>The Point of Contact for the voting members shall be the Joint Committee Point of Contact; the Point of Contact for the observers is the ICB Point of Contact both Points of Contact as described in Schedule 3 of the Manual.</p>
<b>Chair</b>	<p>The sub-committee will be chaired jointly by two joint Chairs:</p> <p>(1)The Chair of the Joint Committee of CCGs; and</p> <p>(2)The ICB Chair Designate will select one of his nominees to be the other joint chair. It is anticipated that the ICS Lead will be the first such appointment.</p> <p>References to “Chair” in these terms of reference are to the two joint Chairs acting together.</p>
<b>Quorum</b>	<p>The sub-committee is considered quorate if there is at least one representative from Barnsley CCG, Bassetlaw CCG, Doncaster CCG, Rotherham CCG and Sheffield CCG present save that a meeting may be quorate without a representative from Bassetlaw CCG if Bassetlaw CCG has indicated that they do not want to participate in the relevant agenda item.</p> <p>If a meeting is not quorate it may continue but any work or decisions will need to be adopted by a subsequent quorate meeting before being referred to the Joint Committee.</p>
<b>Meetings</b>	<p><u>Meeting schedule</u></p> <p>The sub-committee will determine its schedule of meetings at its first meeting and may amend that schedule from time to time.</p> <p>The Chair may determine that the sub-committee needs to meet on an urgent basis, in which case the notice period shall be as specified by the Chair acting reasonably. Urgent meetings may be held virtually, using any of the means specified above.</p>

	<p><u>Participation by video-link/ phone</u></p> <p>The Chair may agree that Members may participate in meetings by means of telephone, video or computer link or other live and uninterrupted conferencing facilities provided every Member participating is able to be heard by every other Member. Participation in a meeting in this manner shall constitute presence in person at such meeting.</p> <p><u>Meetings in private</u></p> <p>Given that the sub-committee will not be making any decisions on behalf of the Joint Committee, it will meet in private.</p>
<p><b>Decision-making</b></p>	<p>Ideally, decisions made by the sub-committee should have the support of all voting members, save that the support of Bassetlaw CCG is not needed if it has stated that it does not have an interest in the matter.</p> <p>If this is not possible then decisions may be made by the majority of voting members present and voting.</p> <p>If the sub-committee refers a matter to the Joint Committee that does not have consensus support as outlined above, this should be made clear and reasons for the lack of consensus given. The Joint Committee shall also be informed of any concerns raised by observers.</p>
<p><b>Conduct of business</b></p>	<p>If a Member wishes to add an item to the agenda they must notify the Joint Committee Point of Contact. Requests for agenda items will be passed to the sub-committee Chair who will decide the content and order of the agenda.</p> <p>Circulation of the meeting agenda and papers via email will take place at least five working days prior to the meeting where possible.</p> <p>The sub-committee will have administrative support from the ICS Project Management Office to:</p> <ul style="list-style-type: none"> <li>- Collate items for the agenda</li> <li>- Circulate the agenda and any papers</li> <li>- take and circulate action points from meetings</li> <li>- maintain a record of actions and action owners</li> </ul>
<p><b>Conflicts of interest</b></p>	<p>The rules on conflicts of interest that apply to the Joint Committee shall also apply to the sub-committee.</p> <p>Observers will comply with their organisation's rules on conflicts of interest.</p> <p>Members will be transparent about any interest their organisation has in matters being discussed by the sub-committee. References to organisation include the ICB and Integrated Care</p>

	Partnership operating in shadow form.
<b>Accountability and reporting</b>	<p>The sub-committee is accountable to the Joint Committee. Action points from sub-committee meetings will be sent to Board Members within 10 working days of each meeting.</p> <p>Members are also accountable to their host organisation.</p>
<b>Review</b>	<p>It is not anticipated that these terms of reference will be reviewed as it is expected that CCGs will be dissolved in April 2022. However, the Joint Committee may review these Terms of Reference as it considers appropriate.</p>

**Manual Agreement and Terms Of  
Reference**

Of

**Joint Committee of Clinical  
Commissioning Groups**

South Yorkshire and Bassetlaw

2019/20

**Final Version**

July 2019

Start Date: 24 July 2019

Review date: 1<sup>st</sup> December 2019

## Manual/Agreement for JC CCGss

Chapter	Content	Detail	Page
1.	Introduction and Overview	<p>Short Introduction setting out:-</p> <ul style="list-style-type: none"> <li>• Background to creating Joint Commissioning of Clinical Commissioning Groups (JC CCGss).</li> <li>• Context for decision making and purpose.</li> <li>• Overview of role in local health system.</li> <li>• Purpose of this agreement/manual.</li> </ul>	
2.	Commissioning intentions and statutory duties	<p>Set out:-</p> <ul style="list-style-type: none"> <li>• Regional/Local commissioning intentions.</li> <li>• Application of existing arrangements.</li> <li>• Complying with the Statutory Duties of CCGs (should include those relating to procurement and competition as well).</li> <li>• Governance, including provision of assurance to members, for JC CCGss.</li> </ul>	
3.	Delegation	<p>Delegation pursuant to section 14Z3:-</p> <ul style="list-style-type: none"> <li>• State purpose of delegation, what it means and the CCGs who have made it.</li> <li>• Set out minute and resolution [separately drafted] of delegation.</li> <li>• Explain terms of delegation in context of joint commissioning approach.</li> </ul>	
4.	Terms of reference of joint committee : setting out the role and operation of the committee	<p>Provisions setting out:-</p> <ul style="list-style-type: none"> <li>• Role</li> <li>• Delegated decisions [defined list as set out in terms]</li> <li>• Reserved decisions [All other than defined list]</li> <li>• Meetings and frequency</li> </ul>	

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		<ul style="list-style-type: none"> <li>• Agenda and Minutes</li> <li>• Voting</li> <li>• Electronic meetings</li> <li>• Resolutions [form]</li> <li>• Quorum</li> <li>• Ability to create sub-committees and further delegate (as set out in terms)</li> </ul>	
5.	Additional terms supplementing the terms of reference	<p>Matters to be addressed:-</p> <ul style="list-style-type: none"> <li>• Guiding Principles for JC CCGs.</li> <li>• Definitions and interpretation [especially delegated decisions and reserved decisions] and how to deal with disputes on definitions.</li> <li>• Approach to Conflicts of Interest.</li> <li>• Liability and indemnities.</li> <li>• Disputes and process to be followed to resolve. [This section may also go on to consider ability for members to revoke the delegation.</li> <li>• Information Sharing and General Data Protection Regulation (GDPR)</li> <li>• Approach to Freedom of Information Requests (FOIA) requests.</li> <li>• Compliance with procurement and competition law obligations (to extent not dealt with in statutory duties section)</li> <li>• List of any other relevant protocols</li> <li>• Clarification and/or additional commercial terms</li> <li>• Process to make variations to Delegation, ToR and/or agreement/manual</li> <li>• Explanation of how ratification works and process to apply.</li> <li>• JC CCGs reporting obligations to members and form of such reports.</li> <li>• Set out how finance for the programme will be dealt with, including issues such as pooled</li> </ul>	

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		<p>funding.</p> <ul style="list-style-type: none"> <li>• Process and form for issuing Notices by JC CCGss.</li> <li>• What happens if a member leaves the JC CCGss</li> <li>• Supporting the JC CCGss and how the Programme Management Office (PMO) will operate.</li> <li>• Implementing change through NHS Standard Contract and variations to it.</li> <li>• Workforce and Staffing considerations within decision making.</li> </ul>	
6.	Appendices	<ul style="list-style-type: none"> <li>• JC CCGss Terms of Reference (ToR),</li> <li>• statutory duties checklist and all protocols which the JC CCGss need to follow.</li> <li>• Clinical engagement and assurance process</li> <li>• Communications and Engagement assessment and assurance process</li> </ul>	



# Manual/Agreement for JC CCGs

## Chapter 1 - Introduction and Overview

### 1. Background

1.1 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.

1.2 The local health commissioners have created a joint committee, through which they can both consider and undertake system wide commissioning decisions.

1.3 The CCG members of the joint committee (**the JC CCGs**) 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 England Specialised Commissioning;

and Associate\* Member CCG

- NHS Derby and Derbyshire Clinical Commissioning Group;

\*Associate CCG is a partner CCG outside of the SYB footprint with commissioned patient flows into SYB for acute provider secondary and tertiary care services. Derby and Derbyshire CCG is also a member of the SYB and North Derbyshire Cancer Alliance. Our Associate CCG is involved in the commissioning arrangements, decisions and voting managed through the JC CCGs where their patients are affected by any proposed change as appropriate. Associate CCGs are non-voting members of the JC CCGs where they do not have a patient interest in a proposed change overseen by the JC CCGs.

1.4 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 CCGs, 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....*

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(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).”*

1.5 The JC CCGs exercises both commissioning functions and those related to commissioning, according to those 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 system approach to support the SYB Integrated Care System (ICS).

## 2. Purpose of the JC CCGs

2.1 The JC CCGs 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 A guiding principle for any changes to commissioning and/or joint decision making through the JC CCGs must be that it demonstrates added value, including improvement in outcomes and population health, standardisation of care, financial efficiency, better use of resources including scarce workforce and avoids unnecessary duplication. Unintended significant risks for a CCG, place or ICS should be avoided.

2.3 The Joint Functions are those set out in the Delegation, appended in Appendix 1 (*Delegation*) and summarised. below.

2.4 In agreement with CCG Governing Bodies the purpose of the JC CCGs may expand to support implementation of the ICS strategic plan in addition to the delivery of the JC CCGs priorities.

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

2.5.1 Development of collective strategy and commissioning intentions;

2.5.2 Development of co-commissioning arrangements with NHS England;

2.5.3 Joint contracting with Foundation Trusts and other service providers;

2.5.4 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;

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

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

2.5.7 Work with the NHS England on system management and resilience;

2.5.8 Collaboration and sharing best practice on Quality Innovation Productivity and Prevention (QIPP) initiatives; and Cost Improvement Plans (CIP)

2.5.9 Mutual support and aid in organisational development.

| 2.6 Generally, the JC CCGs will work across the system to develop a strategic approach to commissioning sustainable, efficient services that are patient centred and focussed on

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improving population health outcomes. Further, it will enable the development of integrated working with social care and wider community and voluntary sector partners so that the patients receive a more seamless service.

### 3. Role in local health and care system

- 3.1 As indicated above, the JC CCGs will support the development of a clear system strategic plan for the SYB ICS. 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 places and local authorities on creating better integrated health and social care services will support meeting the sustainability, quality and financial challenges in the coming years.
- 3.2 In terms of looking at strategic issues across the ICS footprint the JC CCGs 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

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

- 5.1 The Manual has effect from the date of the Terms of Reference and will remain in force unless terminated in accordance with Clause (*Termination of the Manual*).
- 5.2 Individual Member CCG(s) may terminate their membership of the JC CCGs and so no longer be obliged to work in accordance with this Manual under Clause (*Leaving the Joint Committee*).

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### Chapter 2- Commissioning Intentions and Statutory Duties

#### 6. System / local commissioning intentions

6.1 Commissioning intentions relating to Hyper Acute Stroke services and Children's Surgery and Anaesthesia and the 2019/20 JCCCG priorities requiring delegated authority set out below:

<u>2019/20 JCCCG Priorities requiring delegated authority</u>	<u>Requested delegation to the JC CCGs to:</u>
<p><b><u>System Contracting</u></b></p> <ul style="list-style-type: none"> <li>• 999 system lead contractor (YAS) for 4 SYB CCGs</li> <li>• 111 system lead contractor (YAS) for 5 SYB CCGs</li> </ul>	<ul style="list-style-type: none"> <li>• develop and agree a financial threshold of contract value against contract baseline for the lead contractor to negotiate on behalf of each CCG during 19/20 contract negotiations.</li> </ul>
<p><b><u>Outpatients</u></b></p> <ul style="list-style-type: none"> <li>• Review of outpatient follow ups across SYB by specialty, develop clinical protocols to standardise practice and reduce unwarranted variation *</li> <li>• Review of outpatient first appointments (as above) *</li> </ul>	<ul style="list-style-type: none"> <li>• identify and agree the specialities in scope of the OP review</li> <li>• develop and sign off clinical protocols developed with SYB clinical engagement from both commissioners and providers and patients/ public as necessary</li> <li>• implement clinical protocols in Providers standard NHS contracts 2019/20</li> </ul>
<p><b><u>Commissioning Outcomes</u></b></p> <ul style="list-style-type: none"> <li>• Commissioning for Outcomes – new stage 2</li> </ul>	<ul style="list-style-type: none"> <li>• identify and agree the clinical priorities in the policy</li> <li>• sign off 19/20 policy ensuring public consultation /engagement has taken place</li> <li>• implementation of protocols and included formally in standard NHS contracts 2019/20</li> </ul>
<p><b><u>IVF</u></b></p> <ul style="list-style-type: none"> <li>• Explore options for a SYB approach to the number of IVF cycles</li> </ul>	<ul style="list-style-type: none"> <li>• develop IVF options appraisal and financial modelling for consideration by CCG Governing Bodies</li> </ul>
<p><b><u>Cancer</u></b></p> <ul style="list-style-type: none"> <li>• Standard implementation of national cancer pathways across SYB tom improve outcomes and equity of access*</li> </ul>	<ul style="list-style-type: none"> <li>• implement standard cancer pathways in NHS provider contracts and across the 5 SYB places</li> </ul>

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<p><b><u>Medicines and Prescribing</u></b></p> <ul style="list-style-type: none"> <li>Medicines optimisation – standardisation of policies across SYB</li> </ul>	<ul style="list-style-type: none"> <li>Identify opportunities for medicines standardisation</li> <li>develop and sign off policies developed with SYB clinical engagement from clinicians, patients / public as necessary</li> </ul>
<p><b><u>Hospital Services Programme</u></b></p> <ul style="list-style-type: none"> <li>Governing Bodies agreeing next steps on the work programme of the Hospital Services Programme,</li> </ul>	<ul style="list-style-type: none"> <li>The conclusions on next steps on transformation and reconfiguration and implementation of these</li> </ul>

\* Consistent with Long Term Plan Requirements

- 6.2 A clinical engagement and assurance process has been developed by the Joint Committee Sub Group to provide assurance to the JC CCGs and Governing Bodies that the work to take forward and deliver the JC CCGs 2019/20 priorities is clinically led (appendix 4).
- 6.3 A communications and engagement Assessment Process for Section 14Z2 Duty for Public Involvement has also been agreed to provide assurance and support the work of the JC CCGs priorities (appendix 5).

### 7. Any existing arrangements

- 7.1 Commissioning intentions relating to Hyper Acute Stroke services and Children's Surgery and Anaesthesia agreed by the JCCCG in 2017.

### 8. Complying with the Statutory Duties of CCGs

- 8.1 The JC CCGs will need to be clear that in 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 and Improvement that it was operating in accordance with the CCG Improvement and Assessment Framework.
- 8.2 The statutory duties which need to be taken into account are summarised in the Checklist in Appendix 3.
- 8.3 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.*"
- 8.4 The result of this is that:
- a) the Member CCGs need to ensure that the JC CCGs 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 CCGs to them is in place. This will allow the Member CCGs to maintain effective oversight of the JC CCGs processes and decision making.
- 8.5 In effect, the JC CCGs 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

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decisions. It is therefore essential that the JC CCGs understand the statutory framework within which it will make decisions.

### 9. Governance

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

- The JC CCGs will make a quarterly written report to the Member CCG governing bodies. This will cover, as a minimum summary of key decisions.
- The JC CCGs will review aims, objectives, strategy and progress and will publish quarterly reports on progress made.
- As to conducting business the JC CCGs will operate in accordance with the Terms of Reference approved by each CCG member when delegating functions to it. It shall also adopt the Standing Financial Order (SFO) and Standing Instructions (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 SYB ICS website.
- Reports will be prepared by the SYB ICS secretariat.
- Reports from any JC CCGs sub-committee will be shared with CCGs by agreement or request of the JC CCGs as appropriate.

**Chapter 3 – Delegation**

**10. Purpose of delegation**

- 10.1 The Member CCGs have agreed to delegate functions to the JC CCGs in order to enable the Member CCGs to work effectively together, to collaborate and to take joint decisions in those areas of work delegated.
- 10.2 The Member CCGs also consider that the delegation of functions will help the CCGs more easily collaborate and take joint decisions with NHS England in respect of those services which are directly commissioned by NHS England for example specialised services.
- 10.3 This will also link in to the work that each ICS needs to undertake to support the delivery of the NHS Long Term Plan within the South Yorkshire and Bassetlaw ICS Strategic Plan.
- 10.4 The JC CCGs forms a critical element of the interim governance arrangements agreed by the SYB ICS executive and the mechanism by which future collective commissioning decisions can be made.

**11. The delegation**

- 11.1 The delegation of functions from each CCG to the JC CCGs 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.
- 11.2 The delegated functions are referred to in this Manual as the “**Joint Functions**”.
- 11.3 As is noted above, the JC CCGs 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 CCGs 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**

**13. Terms of Reference of the JC CCGs**

- 13.1 The CCGs have established the JC CCGs in accordance with the Terms of Reference, see Appendix 2. The JC CCGs and each member will act at all times in accordance with the Terms of Reference and that means the decisions of the JC CCGs will be binding on the Member CCGs.
- 13.2 The JC CCGs may at any time agree to make a decision or decisions through a common process with a CCG that is not a member of the JC CCGs. The common process would include the non-member CCG being in the same room as the JC CCGs, with the same papers and making a decision at the same time as the JC CCGs but as a separate CCG.
- 13.3 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 CCGs:

**14. Reserved Functions**

- 14.1 All functions are reserved for statutory organisations that are not specifically stated in the scheme of delegation.
- 14.2 It will be important for the JC CCGs 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 CCGs are to exercise.

**14.3 Exercise of the Joint Functions**

The JC CCGs 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 CCGs**

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

15.2 The Key Objectives of the JC CCGs 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 working together on patient and public participation in commissioning health and care, taking into account updated guidance.
- 15.2.1.4 leading transformation change where working together is necessary to ovate change;
- 15.2.1.5 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);
- 15.2.1.6 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;
- 15.2.1.7 resolving cross boundary issues, where the action of one Member CCG could have an impact on a neighbour Member CCG;
- 15.2.1.8 providing leadership to the health system in the area covered by the Member CCGs; and
- 15.2.1.9 ensuring equity of access to services collaboratively commissioned; and
- 15.2.1.10 To support ongoing effective working of the Member CCGs.

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

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

- 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;
- 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;
- To be open. Communicate openly about major concerns, issues or opportunities relating to the functions delegated to the JC CCGs, as set out in Appendix 1 (*Delegation*);
- 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;
- To adopt a positive outlook. Behave in a positive, proactive manner;
- 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.
- To act in a timely manner. Recognise the time-critical nature of the functions delegated to the JC CCGs as set out in Appendix 1 (*Delegation*), and respond accordingly to requests for support;
- To manage stakeholders effectively;
- 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
- To act in good faith to support achievement of the Key Objectives and compliance with these Principles.
- The JC CCGs has a commitment to ensuring that in pursuing its Key Objectives it does not increase inequalities or worsen health outcomes for any local populations.
- Where one of the partners voted in a different way to others on any issue the committee would take the time to discuss and understand the reasons why.

### 16. Sub committees of the JC CCGs

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

#### 16.1.1 Joint Committee Sub 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

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NHS Act 2006. 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.

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 SYB ICS will provide the secretariat to the JC CCGs

18.2 JC CCGs associated ICS staffing resource are hosted by Sheffield 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 CCGs must abide by NHS England's guidance *Managing conflicts of interest – statutory guidance for CCGs* as updated from time to time (<https://www.england.nhs.uk/commissioning/pc-co-comms/coi/>) and all relevant Guidance and policies of their appointing body in relation to conflicts of interest.

20.3 In addition, the JC CCGs shall operate a register of interests and has a Conflicts of Interest Policy. Members of the JC CCGs shall comply with the JC CCGs'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 CCGs, the member should always err on the side of disclosure of any potential conflict.

20.4 Where any member of the JC CCGs has an actual or potential conflict of interest in relation to any matter under consideration by the JC CCGs, 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 a suitable deputy to take the place of the conflicted member in relation to that matter.

20.5 Any breaches of the JC CCGs 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. General Data Protection Regulation (GDPR) 2018

21.1 The Member CCGs shall all comply with GDPR requirements.

21.2 The GDPR introduces a principle of ‘*accountability*’. This requires that CCGs and organisations must be able to *demonstrate compliance*. The key obligations to support this include:

- the recording of all data processing activities with their lawful justification and data retention periods
- routinely conducting and reviewing data protection impact assessments where processing is likely to pose a high risk to individuals’ rights and freedoms
- assessing the need for data protection impact assessment at an early stage, and incorporating data protection measures by default in the design and operation of information systems and processes
- ensuring demonstrable compliance with enhanced requirements for transparency and fair processing, including notification of rights
- ensuring that data subjects’ rights are respected (the provision of copies of records free of charge, rights to rectification, erasure, to restrict processing, data portability, to object, and to prevent automated decision making)
- notification of personal data security breaches to the Information Commissioner
- the appointment of a suitably qualified and experienced Data Protection Officer.

21.3 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:

- 21.3.1 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;
- 21.3.2 Good Practice; and
- 21.3.3 relevant Guidance (including guidance given by the Information Commissioner).

## 22. IT inter-operability

22.1 The Member CCGs will aim to develop inter-operable IT systems (where necessary for the exercise of the Joint Functions) in line with national Information Governance (IG) rules to enable data to be transferred between systems securely, easily and efficiently.

## 23. Confidentiality

23.1 Where information is shared with the JC CCGs 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:

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- 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

- 25.1 Commissioners are required to ensure that their decisions to procure services, which relates to many commissioning decisions, 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.

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?

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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 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 ICS 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

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- 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?

### 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

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- Phase II: a possible 24 weeks in-depth investigation, which can be extended if the CMA considers it necessary.

### **27 Liability and indemnities.**

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

### **28 Breach of this Manual and Remedies**

28.1 Any breach of this manual will be raised by the Chair and identified senior officer. Disputes will be dealt with under 29 below.

### **29 Dispute Resolution**

29.1 Where any dispute arises within the JC CCGs 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 CCGs.

29.2 Where any dispute is not resolved under clause 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 CCGs to attempt to resolve the dispute.

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

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

### **30 Leaving the JC CCGs**

30.1 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 CCGs of the impact of a leaving partner - a maximum of 12 months' notice could apply.

30.2 The Member CCG who wishes to withdraw from the JC CCGs 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.

30.3 After leaving the JC CCGs, that CCG shall no longer be a Member CCG but shall remain bound by Clauses 23 (confidentiality)

### **31 Termination of the Manual**

31.1 This Manual shall no longer apply if the JC CCGs is terminated.

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



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### 32 Notices

32.1 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*)].

32.2 Notices sent:

32.2.1 by hand will be effective upon delivery;

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

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

### 33 Variations

33.1 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.

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

### 34 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.

### 35 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.

## Manual/Agreement for JC CCGss

### Schedule 1 Definitions and Interpretation

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

<b>Manual</b>	means this agreement between the Member CCGs comprising the body of the Manual and its Schedules;
<b>Data Controller</b>	shall have the same meaning as set out in the GDPR;
<b>Delegation</b>	means the delegation of functions set out in Appendix 1 to this Manual;
<b>Good Practice</b>	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;
<b>GDPR</b>	means the General Data Protection Regulation 2018;
<b>Guidance</b>	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;
<b>Information Law</b>	The, GDPR, 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 including General Data Protection Regulation requirements;
<b>JC CCGs</b>	means the joint committee of the Member CCGs established on the terms set out in the Terms of Reference;
<b>Joint Functions</b>	means the functions jointly exercised by the Member CCGs through the decisions of the JC CCGs in accordance with the Terms of Reference and as set out in detail in clause [add] of the Delegation;

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<b>Law</b>	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;
<b>Member CCG</b>	means the CCGs which are part of the JC CCGs and are set out in the Terms of Reference and Column 1 of Schedule 2 ( <i>Member CCGs</i> ) to this Manual.
<b>NHS Act 2006</b>	means the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012 or other legislation from time to time);
<b>NHS England</b>	means the National Health Service Commissioning Board established by section 1H of the NHS Act, also known as NHS England;
<b>Non-member CCG</b>	means a CCG which is not a member of the JC CCGs
<b>Non-Personal Data</b>	means data which is not Personal Data;
<b>Personal Data</b>	shall have the same meaning as set out in the DPA and shall include references to Sensitive Personal Data where appropriate;
<b>Sensitive Personal Data</b>	shall have the same meaning as in the DPA; and
<b>Terms of Reference</b>	means the terms of reference for the JC CCGs agreed between the CCG(s).

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### Schedule 2 Member CCGs

<b>Column 1</b>
<b>Clinical Commissioning Groups</b>
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 England Specialised Commissioning
And associate CCG:
NHS Derby and Derbyshire Clinical Commissioning Group;

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### Appendix 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 its role, as set out in the Terms of Reference (appendix 2).

The CCGs delegate the functions to enable the Joint Committee to take decisions around future transformation projects, specifically and limited to transformation and redesign of Hyper Acute Stroke services and Children’s Surgery and Anaesthesia services and the specific delegation requirements for JC CCGs set out in the agreed 2019/20 JCCCG priorities which are summarised below:

<b><u>2019/20 SYB System Commissioning Priorities requiring delegated authority</u></b>	<b><u>Requested delegation to the JC CCGs to:</u></b>
<p><b>System Contracting</b></p> <ul style="list-style-type: none"> <li>• 999 system lead contractor (YAS) for 4 SYB CCGs</li> <li>• 111 system lead contractor (YAS) for 5 SYB CCGs</li> </ul>	<ul style="list-style-type: none"> <li>• develop and agree a financial threshold of contract value against contract baseline for the lead contractor to negotiate on behalf of each CCG during 19/20 contract negotiations.</li> </ul>
<p><b>Outpatients</b></p> <ul style="list-style-type: none"> <li>• Review of outpatient follow ups across SYB by specialty, develop clinical protocols to standardise practice and reduce unwarranted variation *</li> <li>• Review of outpatient first appointments (as above) *</li> </ul>	<ul style="list-style-type: none"> <li>• identify and agree the specialities in scope of the OP review</li> <li>• develop and sign off clinical protocols developed with SYB clinical engagement from both commissioners and providers and patients/ public as necessary</li> <li>• implement clinical protocols in Providers standard NHS contracts 2019/20</li> </ul>
<p><b>Commissioning Outcomes</b></p> <ul style="list-style-type: none"> <li>• Commissioning for Outcomes – new stage 2</li> </ul>	<ul style="list-style-type: none"> <li>• identify and agree the clinical priorities in the policy</li> <li>• sign off 19/20 policy ensuring public</li> </ul>

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	<p>consultation /engagement has taken place</p> <ul style="list-style-type: none"> <li>• implementation of protocols and included formally in standard NHS contracts 2019/20</li> </ul>
<p><b>IVF</b></p> <ul style="list-style-type: none"> <li>• Explore options for a SYB approach to the number of IVF cycles</li> </ul>	<ul style="list-style-type: none"> <li>• develop IVF options appraisal and financial modelling for consideration by CCG Governing Bodies</li> </ul>
<p><b>Cancer</b></p> <ul style="list-style-type: none"> <li>• Standard implementation of national cancer pathways across SYB to improve outcomes and equity of access*</li> </ul>	<ul style="list-style-type: none"> <li>• implement standard cancer pathways in NHS provider contracts and across the 5 SYB places</li> </ul>
<p><b>Medicines and Prescribing</b></p> <ul style="list-style-type: none"> <li>• Medicines optimisation – standardisation of policies across SYB</li> </ul>	<ul style="list-style-type: none"> <li>• Identify opportunities for medicines standardisation</li> <li>• develop and sign off policies developed with SYB clinical engagement from clinicians, patients / public as necessary</li> </ul>
<p><b>Hospital Services Programme</b></p> <ul style="list-style-type: none"> <li>• Governing Bodies to agree next steps on the work programme of the Hospital Services Programme,</li> </ul>	<ul style="list-style-type: none"> <li>• The conclusions on next steps on transformation and reconfiguration and implementation of these</li> </ul>

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 and taking into account updated guidance on patient and public participation in commissioning health and care. 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 Secretary of State for Health, which are:
  - Support from GP commissioners;
  - Strengthened public and patient engagement;
  - Clarity on the clinical evidence base; and

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- 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.

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## 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 can include NHS England, who may also make decisions collaboratively with CCGs.
- 1.3 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.
- 1.4 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 England Specialised Commissioning; Non voting

And \*Associate CCG members:

- (6) NHS Derby and Derbyshire Clinical Commissioning Group;

**\*Associate CCG** is a partner CCG outside of the SYB footprint with commissioned patient flows into SYB for acute provider secondary and tertiary care services. Derby and Derbyshire CCG is also a member of the SYB and North Derbyshire Cancer Alliance. Our Associate CCG is involved in the commissioning arrangements and decisions managed through the JC CCGs where their patients are affected by any proposed change as appropriate. Associate CCGs are non-voting members of the JC CCGs where they do not have a patient interest in a proposed change overseen by the JC CCGs. The involvement of the associate CCG in the JC CCGs work (where voting rights would be appropriate for that specific priority) is clarified on the list of JC CCGs work priorities.

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.



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1.5 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.

1.6 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 Agreement (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.
- The JC CCGs has a commitment to ensuring that in pursuing its Key Objectives it does not increase inequalities or worsen health outcomes for any local populations.
- 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 CCGs these will be accountable to the JC CCGs.
- Where one of the partners voted in a different way to others on any issue the committee would take the time to discuss and understand the reasons why.

## 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.

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### 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 and Improvement 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, NHSE/I specialised commissioning covering the South Yorkshire and Bassetlaw, Derby and Derbyshire areas (associate members).

### 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 five SYB member CCGs: the Clinical Chair and Accountable Officer. Each CCG has one vote.

5.3 Non-voting attendees:

- Two Lay Members
- One Director of Finance chosen from the member CCGs.
- A Healthwatch representative nominated by the local Healthwatch groups
- SYB ICS Chief Executive or deputy
- SYB ICS Director of Commissioning
- SYB ICS Communications and Engagement lead
- NHSE Specialised Commissioning lead
- Associate CCG member (where no or minimal patient interest in proposed changes, see para 1.4)

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- 5.4 The JC CCGs may invite additional non-voting members to join the JC CCGs to enable it to carry out its duties
- 5.5 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 quorum can be maintained.
- 5.6 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.
- 5.7 The SYB ICS will act as secretariat to the JC CCGs 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 1.4.
- 5.8 The JC CCGs will be Chaired by a respective CCG Clinical Chair and vice clinical Chair. For 2019/20 the chair is Doncaster CCG Clinical Chair, Deputy Chair is Rotherham CCG Clinical chair. The tenure of the role is 12 months.

### **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 CCGs has five CCG members and 1 vote for each CCG. The voting power of each individual present will be weighted so that each party (CCG) possesses 20% of total voting power.
- 7.2 It is proposed that recommendations can only be approved if there is approval by more than 80%.

### **8. Quorum**

- 8.1 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**

- 9.1 Frequency of meetings will usually be monthly, but the Chair has the power to call meetings of the JC CCGs as and when they are required.

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- 9.2 Meetings may be held by telephone or video conference, JC CCGs members can participate and included as quorum in a face to face meeting, by telephone or by video link.

### 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 The Chair shall set the agenda and arrange papers to be circulated 5 working days prior to the JC CCGs meeting
- 10.3 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 endeavour to reach a collective view.
- 10.4 The JC CCGs may call additional experts to attend meetings on an ad hoc basis to inform discussions.
- 10.5 Each JCCCCG member must abide by all policies in relation to conflicts of interests. Where any JC CCGs member has an actual or potential conflict of interest in relation to any matter under consideration at any meeting, the Chair (in their discretion) shall decide, having regard to the nature of the potential or actual conflict of interest, whether or not that member of the JC CCGs can participate / vote in the meeting or part of the meeting where the item is discussed
- 10.6 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.
- 10.7 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.
- 10.8 The right of attendance at meetings by members of the public as referred to in paragraph 10.1 does not give the right to such members of the public to ask questions or participate in that meeting, unless invited to do so by the Chair.
- 10.9 Members of the public or press may not record proceedings in any manner whatsoever, other than in writing, or make any oral report of the proceedings as they take place, without the prior written agreement of the Chair.
- 10.10 Questions must be submitted in writing to the JC CCGs secretariat by noon on the Monday before the meeting.

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10.11 Answers to submitted questions relating to the agenda received in advance of the meeting will be published on the JCCCG section of the South Yorkshire and Bassetlaw Integrated Care System website prior to the meeting. Up to 15 minutes will be set aside at the beginning of the meeting in public for questions and/or statements to be made by members of the public. The chair reserves the right to not answer questions or statements that are not deemed appropriate to the JC CCGs agenda.

10.12 Confidential items will be considered in a closed private meeting of the JC CCGs.

10.13 The Chair may exclude any member of the public from a meeting of the JC CCGs if they are interfering with or preventing the proper or reasonable conduct of that meeting.

### 11. Secretariat provisions

The secretariat to the JC CCGs will:

- a) Take and circulate the minutes, conflicts, matters arising action notes and decisions of the JC CCGs meeting to all members; and
- b) Present the minutes, conflicts, matters arising, action notes and decisions to the governing bodies of the CCGs set out in paragraph 1.4 above.

### 12. Reporting to CCGs

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

### 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 1.4 above.

13.4 The JC CCGs agrees to make decisions by a common process for decision making with a non-member CCG. This process will apply where a non-member CCG has delegated the functions within the scope of the JC CCGs to an individual or member or employee of the non-member CCG.

### 15. Attendance

14.1 Voting members of the JC CCGs shall attend a minimum of at least 75% of meetings during the financial year.

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### 15. Review of Terms of Reference

These terms of reference will be formally reviewed in **6 months** by Clinical Commissioning Groups set out in paragraph 1.4 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 CCGs

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 CCGs of the impact of a leaving partner - a maximum of 12 months notice could apply.

### 16. List of Members from each CCG and non-voting members

Column 1 Organisation or nomination	Column 2 Representatives
<b>Voting members</b>	
NHS Barnsley Clinical Commissioning Group;	The Clinical Chair, The Accountable Officer
NHS Bassetlaw Clinical Commissioning Group;	The Clinical Chair, The Accountable Officer
NHS Doncaster Clinical Commissioning Group;	The Clinical Chair, The Accountable Officer
NHS Rotherham Clinical Commissioning Group;	The Clinical Chair, The Accountable Officer
NHS Sheffield Clinical Commissioning Group;	The Clinical Chair, The Accountable Officer
<b>Non-voting members</b>	
JC CCGs Lay Members	Lay members X2
Nominated Director of Finance	NHS Sheffield CCG Director of Finance
Nominated Healthwatch member	Healthwatch Doncaster
South Yorkshire and Bassetlaw ICS	ICS Chief Executive or Deputy ICS Director of Commissioning ICS Communications & Engagement Lead
NHS England	Specialised Commissioning
Associate CCG member	NHS Derby and Derbyshire CCG

## 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') and statutory guidance for CCGs and NHS England (May 2017).

##### 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

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- 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. Government Consultation Principles Updated 2018

All consulting NHS bodies should consider and comply with government principles on Consultation on what needs to be done to undertake a lawful public consultation exercise.

### 7. Principles for consultation (2018)

- **Consultations should be clear and concise**

Use plain English and avoid acronyms. Be clear what questions you are asking and limit the number of questions to those that are necessary. Make them easy to understand and easy to answer. Avoid lengthy documents when possible and consider merging those on related topics.

- **Consultations should have a purpose**

Do not consult for the sake of it. Ask departmental lawyers whether you have a legal duty to consult. Take consultation responses into account when taking policy forward. Consult about policies or implementation plans when the development of the policies or plans is at a formative stage. Do not ask questions about issues on which you already have a final view.

- **Consultations should be informative**

Give enough information to ensure that those consulted understand the issues and can give informed responses. Include validated impact assessments of the costs and benefits of the options being considered when possible; this might be required where proposals have an impact on business or the voluntary sector.

- **Consultations are only part of a process of engagement**

Consider whether informal iterative consultation is appropriate, using new digital tools and open, collaborative approaches. Consultation is not just about formal documents and responses. It is an on-going process.

- **Consultations should last for a proportionate amount of time**

Judge the length of the consultation on the basis of legal advice and taking into account the nature and impact of the proposal. Consulting for too long will unnecessarily delay policy development. Consulting too quickly will not give enough time for consideration and will reduce the quality of responses.

- **Consultations should be targeted**

Consider the full range of people, business and voluntary bodies affected by the policy, and whether representative groups exist. Consider targeting specific groups if appropriate. Ensure they are aware of the consultation and can access it. Consider how to tailor consultation to the needs and preferences of particular groups, such as older people, younger people or people with disabilities that may not respond to traditional consultation methods.

- **Consultations should take account of the groups being consulted**

Consult stakeholders in a way that suits them. Charities may need more time to respond than businesses, for example. When the consultation spans all or part of a holiday period, consider how this may affect consultation and take appropriate mitigating action, such as prior discussion with key interested parties or extension of the consultation deadline beyond the holiday period.



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- **Consultations should be agreed before publication**  
Seek collective agreement before publishing a written consultation, particularly when consulting on new policy proposals. Consultations should be published on gov.uk.
- **Consultation should facilitate scrutiny**  
Publish any response on the same page on gov.uk as the original consultation, and ensure it is clear when the government has responded to the consultation. Explain the responses that have been received from consultees and how these have informed the policy. State how many responses have been received.
- **Government responses to consultations should be published in a timely fashion**  
Publish responses within 12 weeks of the consultation or provide an explanation why this is not possible. Where consultation concerns a statutory instrument publish responses before or at the same time as the instrument is laid, except in very exceptional circumstances (and even then publish responses as soon as possible). Allow appropriate time between closing the consultation and implementing policy or legislation.
- **Consultation exercises should not generally be launched during local or national election periods.**  
If exceptional circumstances make a consultation absolutely essential (for example, for safeguarding public health), departments should seek advice from the Propriety and Ethics team in the Cabinet Office. This document does not have legal force and is subject to statutory and other legal requirements.

### 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 and patients. (See separate note for a list of the issues).

## Procurement Issues

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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 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

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- 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.

### Appendix 4

#### South Yorkshire and Bassetlaw JC CCGs Clinical Engagement and Assurance Process

The SY&B system commissioning priorities for 2019/20 have been developed by the JC CCGs, members of SYB CCG Governing Bodies and Directors of Commissioning. Individual CCGs will be responsible for leading specific priorities of work to be adopted across the ICS in order to standardise access, improve outcomes and quality of care for patients across SY&B.

It is important that JC CCGs priorities are clinically developed using best practice and evidence based and are locally clinically led to ensure an agreed SYB consensus to pathways, policies and protocols. Assurance will be sought through the JC CCGs that all SYB priorities being developed are underpinned by a robust locally managed process in each place for clinicians to engage, influence, develop and agree the work and is supported by CCG memberships.

Wider involvement of clinicians and professionals from across the system including; primary and community care, secondary care, tertiary care, mental health, cancer and specialised services will be engaged in the relevant work priorities as appropriate to inform the clinical consensus. The lead CCG will ensure that wider SYB clinical engagement has been undertaken as required.

Each CCG currently has a forum to ensure this clinical assurance takes place locally through their place:

- Doncaster CCG – Clinical Reference Group
- Barnsley – Clinical Forum
- Sheffield CCG – Clinical Reference Group
- Rotherham CCG – Clinical Referral Management Committee
- Bassetlaw CCG – Service Delivery Committee

These respective groups all have the remit to ensure clinical debate and assurance is undertaken at place enabling a clinical consensus in each place for SYB system commissioning priorities throughout the work that cover the following requirements:

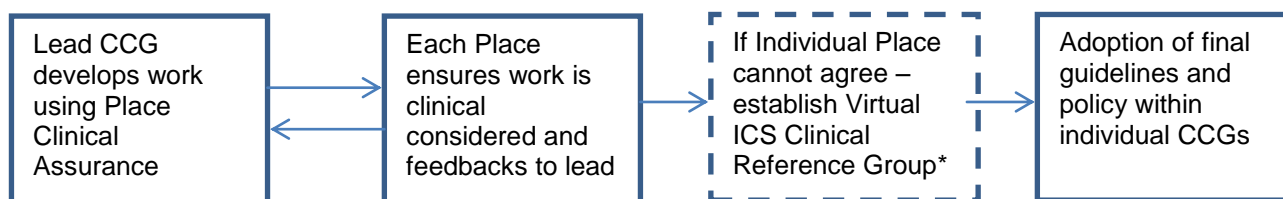
- Patient centred and quality driven decision making
- Local ownership and implementation of recommendations

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- Consistency of guidelines and clinical pathways across the ICS
- Timely decision making to ensure implementation within agreed timeframes

### SYB Clinical Engagement and Assurance Process:

Lead CCG liaises with individual places to ensure clinical reference and agreement takes place during development of work:



\*A virtual ICS Clinical Reference Group would be created to debate and reconcile clinical opinion and confirm final clinical sign off in each place. This group would be clinically tailored to the priority subject matter and have authority of clinical decision making from the ICS and place.

Appendix 5

**South Yorkshire and Bassetlaw ICS Assessment Process for Section 14Z2 Duty for Public Involvement**

