

V9 September 2013

1. North East Oxfordshire Locality Constitution Agreement

Updated September 2013 until further notice, with Annual review, or at any point where changes emerge from the legislative process.

This document forms part of the wider Oxfordshire Clinical Commissioning Group Constitution which has also been signed up to by the North East Locality Practices, and therefore only iterates the Local idiosyncratic agreements.

2. Purpose, Principles and Function of the Locality

2.1 The North East Oxfordshire Locality Group (NELG) has been established to:

- Represent the views of North East Oxfordshire practices and patients when commissioning decisions are being made.
- Actively participate in planning health services for the future.
- Develop locality plans in line with OCCG direction to change clinical care pathways.
- Work towards taking delegated responsibility for locality budgets/health planning.
- Support the Locality Clinical Director and deputy(s) to deliver their role as defined in their job description:
 - develop an effective locality structure to involve and engage all practices within the locality
 - enable the effective performance management of locality practices to ensure the locality stays within its commissioning budget
 - deliver the QIPP milestones and savings targets through a clinically led project framework
 - develop a patient and public engagement strategy within the locality
 - produce a commissioning plan for the locality which articulates the aims, ambitions and objectives of the Oxfordshire Clinical Commissioning Group
 - work to facilitate the improvement of the quality of primary care within the locality

2.2 The Locality's aim is to act in the best interests of the population it represents and to further the health and wellbeing of its population in line with the targets set by the NHS. This includes making evidence based decisions where possible, tackling health inequalities, and ensuring that the services commissioned represent value for money. This will include redesigning patient pathways to optimise the care that patients receive and provide a local focus where clinically appropriate.

2.3 North East Locality Group will attach a high priority to the sustainability of local **health** services when making decisions that affect them.

3. Powers of delegation, probity and Governance

3.1 North East Locality is not a legal entity and therefore this agreement is not enforceable in law.

3.2 The Locality will act as a Commissioner and therefore form an Advisory Group of the ten practices within its area. The Oxfordshire Clinical Commissioning Group (OCCG) is the statutory body,

3.3 The Locality agrees to retain responsibility for improving the health of its patients in a cost effective manner, however, OCCG retains accountability for the budgets overall, although some delegation for management will be the responsibility of the Locality. OCCG retains the authority to negotiate and agree Service Level Agreements and works with the Locality to increase clinical representation at these meetings.

3.4 Oxfordshire CCG will act as the paymaster both for Commissioned Service Level Agreements with Providers and for Management Costs incurred by the North East Locality as part of the Commissioning role.

3.5 The Locality agrees to work within the Investment Scheme model agreed each year with OCCG, following discussion and final approval by both the Locality members, and. Board.

The Locality Clinical Director agrees to contribute, via the Countywide Clinical Directors meeting and on behalf of the Locality practices, to any new incentive scheme proposals made by OCCG.

4. Membership

4.1 Every practice will have established a named GP Practice Commissioning Lead to be responsible for taking forward clinical commissioning within the practice acting as the main contact, both internally and externally. The named clinical representatives will attend the monthly Locality meetings to represent their practice populations. Deputies may be substituted.

Bicester Health Centre	Dr Stephen Attwood	- Chair &
------------------------	--------------------	-----------

	Clinical Director
Exeter Surgery	Dr David Finnigan
Gosford Hill Medical Centre	Dr Heidi Luckhurst
Islip Surgery	Dr Meenu Paul
Kidlington & Yarnton Medical Practice	Dr Angela Aitken
Langford Medical Practice	Dr Tom Anderson
Montgomery House Surgery	Dr Will O’Gorman - Deputy
North Bicester Surgery	Dr Brendan McDonald
Victoria House Surgery	Dr Damian Hannon
Woodstock Surgery	Dr Hassan Ali

4.2 In addition the North East Locality has approved membership to the following groups:

District Nurse representative	Helen Mayes or Jenny Hoare – representation but no voting right
Health Visitor & School Nursing representative	Sandy D’Amon — representation but no voting right
Practice Nurse representative	To be agreed – representation but no voting right
Practice Manager representative (to represent all 10 practice managers)	Varies and meetings may have more than one PM attendee although only the agreed Representative will be entitled to financial backfill – representation but no voting right
Patient representative	Mike Hobbs - (no voting right)
Social Care representative	vacant - (no voting right)
Locality Assistant Director –City & NE	Rachel Coney – (no voting right)
Locality Project Manager	Julie-Anne Howe (no voting right)

Voting Rights Decision :

The Locality Group Agreed to Weighted Voting established as follows:.

- Basis of weighting is on the Exeter system population as at 1.4.xx. with Annual review in April each year to reassess weightings.
- Splitting of a practice population for the purposes of weighted voting is not allowed.
- Regarding the number of principals and contracted non-principals within each practice – their vote will be a vote within their practices weighted share of the vote and each practice should include non-partners.
- For the purpose of voting in a Clinical Director or Deputy, Permanent contract doctors are eligible to vote, and the formal voting process agreed with the OCCG will be followed. If more than one candidate is eligible Locality voting will take place using the following process, with a single member being put forward for final OCCG approval.
 - A spreadsheet has been developed to enable a simple voting process for each practice, collated across into a summary position statement as the outcome.

- This will allow each permanently contracted doctor to independently cast a vote in relation to each candidate. The value of that vote will be weighted according to the practice population.
- Results will be collated by a Co-ordinator to allow abstain positions to be anonymously collected.

4.3 Other members may be invited to join – see 7 below.

5. Structure including accountability and funding

5.1 The Locality will consist of a clinical commissioning Management Group with sub-groups formed as required.

5.2 Locality Management Group

The Locality Management Group (hereafter called the Locality) shall comprise one person appointed by each member practice to represent them as per the membership table above. In addition a Practice Manager, District Nurse, Health Visitor, Practice Nurse, Patient representative and Social Care representative will represent these disciplines within the Locality. Their voice will represent their professional body not their work base.

- a) The Locality will appoint a Chair and one Deputy for 5 sessions of clinical leadership per week, subject to a 2/3 year tenure (allowing for succession planning).

Eligibility to take up a Locality Clinical Director or Deputy post is open to any GP within the Locality who is either a partner or holds a permanent contract with a member practice. Candidates will need to demonstrate that they can meet the competencies required of the post (Job description and role responsibility available).

There will be a selection process to determine eligibility to stand as a Locality Clinical Director or Deputy, which will be overseen by OCCG. Selection of eligible candidates will then be made via the voting process outlined above.

The OCCG will then formally appoint to the role.

The process of appointing a new Clinical Director will be preceded by widespread advertising of the opportunity to stand for the post to all doctors within the Locality, via the Locality main meetings and email.

- b) The Locality will have responsibility to approve and to amend this Agreement. It will require a vote in favour of at least 70% of the weighted vote membership to amend the Constitution but a system will be developed to allow those unable to attend to vote “in Absentia” by the Chair of the Management Group receiving in writing notice of their voting intentions. This will then be ratified by OCCG Governing Body.
- c) The Locality will meet monthly.

- d) It is the responsibility of the group members to articulate their own practice views, objectives and aspirations for wider discussion and agreement within the priorities of the Locality.
- e) It is the responsibility of the group members to ensure that all business of the Locality is communicated clearly within their constituent practices / disciplines.
- f) The Locality will approve the Locality Plan by a 70% majority of its members.
- g) Meetings will be quorate if 70% of the membership is present.
- h) Major decisions may be made if the attendant membership is unanimous. In the event that there is disagreement the decision will be deferred to allow voting by electronic means by representative members (or delegated deputies) as above. A decision will be carried if 70% of the members vote in favour.
- i) Where in the reasonable view of a majority of the practice representatives present there has NOT been sufficient time for practices to be consulted about a significant matter – a decision may be deferred to allow practice consultation where that consultation could influence the outcome of a vote.
- j) In a vote of censure, 80% of the Locality should be represented.

5.3 Support

The Locality will have a dedicated support Team, currently comprising:

, , :

Rachel Coney – Assistant Director – NEL & City

Julie-Anne Howe - Locality Project Manager

Jackie Bowley – NEL Support Manager

Alison Jones – Locality Support Pharmacist

Louisa Griffiths – Locality Support Pharmacist (shared with City)

Marta Gorska-Szymczyk - Locality Support Pharmacist (shared with City)

Linda Adhana – Equality & Access Manager (all shared with City) – supported by Rosita Adams, Merlyn Mistry & Nigel Carter

Expertise around finance/data/communications will be available through a network of OCCG or Clinical Support Services managers.

6. Budgets, Support funding and Freed up resources

6.1 Budgets for services commissioned by OCCG are calculated by the Finance Team of the OCCG allocated on an annual basis. These are informed by both a national formula and historic spend based on a methodology.

6.2 Budgets will be calculated at a practice level. Practices will work together with the support of Locality Clinical Directors and OCCG staff to contribute to the QIPP Plan and to aim to achieve financial balance where this is possible without compromising clinical standards.

6.3 Practices will work both individually and collectively to try to achieve financial balance. There will be a collective responsibility to support practices who have financial challenges by sharing good practice and mobilising available resources within the Locality to help a practice achieve financial balance.

6.4 The Locality Budget is that which is agreed from time to time with OCCG.

It was agreed the above wording will be reviewed on an annual basis.

6.5 The Practices are responsible for the registered patient population of their area as defined below:

Practice	Population 1.4.13
Bicester Health Centre	12,012
Exeter Surgery	4,464
Gosford Hill Medical Centre	6,746
Islip Surgery	5,874
Kidlington & Yarnton Medical Practice	7,389
Langford Medical Practice	9,190
Montgomery House Surgery	12,277
North Bicester Surgery	4,416
Victoria House Surgery	7,105
Woodstock Surgery	9,400
Total	78,873

6.6 The Locality agrees to work with OCCG on the national move towards Fair Shares (capitation) based funding, or other models which may arise, such as aligning funding to the ACG Tool.

6.7 Where it can be demonstrated that an over spend could be mitigated by reasonable alterations in clinical practice that are commensurate with good medical care, the practice will undertake to work with the Locality to try to achieve financial balance.

6.8 Practices who have succeeded in making changes in clinical practice commensurate with good medical care which has reduced their spend, undertake to share their good practice for the benefit of the Locality.

6.9 Practices agree to monitor their budgets on a monthly basis via SUS+ (or another means), as the data is available, and particularly to assess areas of high cost or where activity is exceeding indicative levels.

6.10 Clinical Commissioning Management allowance to practices and the management team.

In 2013/14 OCCG has allocated the following funds to the NE Locality for management support: **£23,919.**

6.11 The Management allowance for the Locality as agreed with OCCG will be utilised in supporting the work of the Locality as agreed by its members.

6.12 Verification of invoices and payment sign off will be via the budget holder within the OCCG management team.

6.13 These funds will be held by OCCG with invoices for work signed off via the designated member of the Management Team, or nominated signatory, and processed via the Locality Project Manager using the national ISFE system.

6.14 Resourcing Locality governance structure and all other collective costs:

It is recognised there will be costs associated with running of a Locality and attendance at meetings to develop service redesign.

The funding for attending monthly Locality meetings is met from the Commissioning Local Investment Scheme.

Work on the development of business cases may be shown within the set up costs of the service, however consideration must be given to financial viability.

6.15 The agreed rates of remuneration are under review, but currently:
GP: £75 per hour (includes employer superannuation*)
Nurse: £35
Practice Manager: £35
Data check: £15
Travel may be claimed in addition.

*Specific guidance is available on GP claims via the Finance Department or Project Manager.

6.16 If in doubt discuss the claim with the Locality Clinical Director or Project Manager as both a claim form and an ISFE invoice are required to make payment.

6.17 Equipment

Any equipment purchased under the Invest to Save business case model will remain the property of the OCCG, but be held within the allocated practice(s) for the period of its useful life. The cost of any disposables, insurance, annual maintenance checks, and servicing must be built in to the business case and will be the responsibility of the Locality or practice directly.

6.18 Conflicts of interest and probity

OCCG is a commissioning organisation; members of the Locality must declare an interest and exclude themselves from decisions, but not necessarily discussions, on matters where they might benefit financially.(see 7.5)

6.19 If practices wish to form into a company which would both commission and provide services simultaneously, the issues of conflict of interest will need to be explored in more depth and advice sought from OCCG regarding corporate governance.

6.20 Each Practice Lead agrees to sign the standard Declaration of Interests and Register of Interests. Forms are available from the Locality Support Manager, who will be responsible for keeping these on record.

6.21 Liability

Whilst practices will engage with OCCG, working as a Locality under the auspices of the local constitution and the OCCG constitution, they will have no liability either personal, financial or medico legal for their actions as part of the Locality, other than those responsibilities normally held as a GP contractor to the NHS if working within policies and procedures of the OCCG.

Liability or indemnity for decisions made as part of the Locality or OCCG will continue to be held by the OCCG as at present.

Department of Health draft guidance is available on Liability And Indemnity For Clinical Commissioning Groups - Q&A – see Appendix A

7. Joining and leaving arrangements

Configuration of the CCG

7.1. Members of the CCG will be from a defined geographical area (as specified in paragraphs 5.7 and 5.8 of the main OCCG Constitution documentation) within which a significant majority of patients are registered and the practices that make up the CCG will not be drawn from a dispersed area.

7.2. The CCG consists of 83 practices all of whom hold contracts for the provision of primary medical services. Schedule 2 of the main OCCG Constitution documentation contains a list of member practices within the CCG.

7.3. The only ground on which the CCG would terminate the membership of an individual practice is when the practice ceases to hold a contract for the provision of primary medical services.

7.4. The CCG consists of six localities:

- North East Oxfordshire Locality (10 practices)
- North Oxfordshire Locality (13 practices)
- Oxford City Locality (27 practices)
- South East Oxfordshire Locality (10 practices)
- South West Oxfordshire Locality (14 practices)
- West Oxfordshire Locality (9 practices)

7.5. All practices are required to be part of a Locality and the agreed membership is detailed in Schedule 2. A practice is not able to change Localities. If there are difficulties with engagement the Medical Director would work with the Locality Clinical Director to resolve these.

7.6. In the event of a practice wishing to leave the CCG the matter will be referred to the NHS Commissioning Board.

7.7 Duration of this agreement

Practices signing up to the Locality agree their involvement in clinical commissioning for the coming financial year and for subsequent financial years.

7.8 Representation

Should an existing Practice GP representative no longer be able to attend meetings and work on behalf of the Locality for whatever reason, the practice will provide a replacement.

7.9 For DNs, PNs and HVs, they will have the opportunity to elect a representative from amongst their constituents.

7.10 In the event a patient representative is no longer able to attend, the Locality will attempt to encourage a suitable representative to attend meetings. The OCCG will also provide support to find a suitable representative via PPI Forum and PPGs, PALS connections, Talking Health, or other means.

8. Dispute arrangements

8.1 The practices within the North East Locality agree to seek local resolution to any issues which arise. Should this not be possible the OCCG Arbitration policy will be followed, with facilitation by the Local Area Team as required. Failure to resolve the issue at this stage will lead to support from the wider National Commissioning Board.

8.2 If disputes arise from gross misconduct or failure to act appropriately, these **must** be brought to the notice of the Locality Chair who may require support by the OCCG to resolve them via the Clinical Governance Team,, an arbitration process or via HR advice.

8.3 Gross Misconduct

If a practice or a member of the Locality willingly and knowingly commits acts of dishonesty, or in the reasonable opinion of the Locality members behaves in a reckless manner putting at risk the reputation or viability of the Locality, this will constitute Gross Misconduct.

8.4 In the event that it is the unanimous view of the other Locality members that a practice or member of the Locality is guilty of gross misconduct they may be suspended from the Locality forthwith until the matter has been investigated through the dispute procedure.

9. Roles and responsibilities

9.1 The North East Clinical Director and Deputy, will be responsible to the OCCG for the efficient running of the Locality. The Locality will be responsible for developing a Locality Plan which will be informed by national and OCCG priorities.

This will encompass the Localities contribution to achieving the central QIPP plan.

9.2 It is important that all those participating in decision making do so from a position of knowledge and understanding both of the issue and of the views of those they represent.

9.3 There is a responsibility on all to ensure that documents and papers are read and understood in advance of meetings and decision making. Clarification should be sought in advance wherever possible.

9.4 It will be the responsibility of the management of the OCCG and the Locality to ensure timely and useful information is provided to enable good decision making.

9.5 It will then be the responsibility of the GP Practice Leads to work with their practice colleagues and patients to make sure their views are represented.

10. Relationship with OCCG

10.1 The Locality Clinical Director (or Deputy) will represent the locality on the Oxfordshire Clinical Commissioning Group Board (OCCG). The North East Locality has 1.14 vote and the Locality Clinical Director will ensure that all Board meetings are attended.

views of the North East Locality are expressed

It is clear when a personal view is expressed.

10.2 However the Locality Clinical Director has a role that is broader than representing the Locality and will be leading workstreams that will require them to present proposals and make recommendations on behalf of the county. In doing this they will need to consider the views of all localities.

10.3 It is expected that, wherever possible, those leading projects needing decisions to be made by OCCG, will have built time into the project plan to share progress and seek views of the locality before decisions are required at OCCG Governing Body. It is accepted that this could be achieved in a number of ways and that using technology to support wider engagement is encouraged.

10.4 Electronic voting via email and developing the North East Locality sections of the website and intranet will be used to support timely decision making, effective communication and access to information.

10.5 The Locality Clinical Director should always be mindful that some

decisions will require consultation within the locality before the decision is made by OCCG Governing Body. If at all possible, they will make sure that the OCCG Governing Body defer decisions until these discussions have been had. Broadly speaking any OCCG decision which would result in a significant change in health care for the North East population or has a significant impact on NHS finances should be discussed with the Locality first, making sure all appropriate information is available in time to help guide the process.

10.6 It is left to the discretion of the Locality Clinical Director to decide if these criteria have been met. However, minutes from OCCG Governing Body will be shared with GP Practice Leads who can challenge whether wider consultation was/is appropriate both before Governing Body meetings and after them.

10.7 Ideally, all decisions made at OCCG will be with a consensus of views from all Localities. However, it is accepted that this will not always be the case and that voting (as agreed in the OCCG constitution) will need to determine a majority decision at times when there is disagreement. To avoid introducing unnecessary delays and bureaucracy decisions should not routinely be deferred and the Locality Clinical Director should attend OCCG already equipped with the view from their Locality which may have been determined by a vote.

10.8 It is acknowledged that there may be occasions where a decision is made for the county that does not have the support of the North East Locality and that this majority decision should still stand and will need to be implemented.

10.9 It must also be accepted that there will be times when an immediate decision may be required at OCCG Governing Body that does not allow time for discussion at Locality level. At these times, the Locality Clinical Director will have the authority to participate in that decision on behalf of the Locality and report back to the North East practice representatives as soon as possible.

10.10 In relation to clinical commissioning the Locality will consider and support the education and training proposals of clinicians, to enhance their contribution to commissioning in the county as resources allow.

The localities will report on performance against delegated responsibilities to the Governing Body in a timely fashion, as allowed by the information provided by the OCCG. These reports will be included in Governing Body papers which are available to the public.

Once the Locality has a section within the OCCG website, it will seek to upload all information which should rightly be in the public domain.

The Locality will seek to hold at least one meeting in public per year to share their plans and intentions, and collect feedback on local issues aired.

11. Performance management and risk sharing

- 11.1 Clinical Governance: arrangements will be in place to ensure that safe clinical practice is maintained when referral management initiatives (i.e. inter practice to GP or GPSI referral) or service redesigns in the community are put in place.

To facilitate financial risk sharing the Locality will consider the pooling of an agreed portion of the budget to be retained for the use of exceptional high cost procedures which do not fall within specialist commissioning. Other financial risk sharing arrangement between practices may be agreed from time to time as voted for by the Locality.

- 11.2 Risk will also be considered in the wider health system, for example impact on other services and service providers of any changes in clinical pathways.

- 11.3 Where plans impact on secondary care services the Locality will include discussion and involvement of consultants and wider secondary care teams.

12. Involvement of stakeholders

12.1 Wider contacts

The Locality will work to build links with local authority and social care services, tertiary and secondary care, user groups, and the voluntary sector, in order to commission effectively.

12.2 Arrangements for ensuring patients/public involvement

Each practice will work with the Locality to involve patients, the public and wider stakeholders, in commissioning decisions. This will include seeking views via the Practice Commissioning Groups, or wider Patient and Public Forum. Patient representation will also be sought for each of the projects undertaken by NEL.

13. Communication

- 13.1 The Locality Clinical Director will manage communication with the member practices, OCCG and the Providers of services to North East Locality patients, supported by the NEL Team.

- 13.2 Each member of the Locality group accepts responsibility for communicating with their practice or professional group, and representing

their view. This will require each representative to consult their colleagues and be delegated to represent their opinion.

North East Locality Constitution Agreement
September 2013 until further notice with Annual review, or at any point where
changes emerge from the legislative process.

15. Signatories

Signed on behalf of the Practice: (please state name)

Name of signatory:

Signature:

Date:

Signed on behalf of the North East Locality

Name of signatory: Dr Stephen Attwood (Chair)

Signature:

Date:

Appendix A

**Draft - LIABILITY AND INDEMNITY FOR CLINICAL
COMMISSIONING GROUPS - Q&A**

1. Does the Health and Social Act 2012 change current arrangements for NHS indemnity and clinical negligence for providers of NHS services?

No, but it allows arrangements to be extended to new organisations. All providers of NHS services will continue to have a contractual obligation to maintain adequate and appropriate indemnity arrangements to cover claims arising directly from negligent provision that harms the patient.

Clinical commissioning groups (CCGs) and the NHS Commissioning Board would have a role, as PCTs do now, in holding providers of NHS services to account through contract management. CCGs will need to satisfy themselves

that providers have adequate and appropriate indemnity arrangements in place.

As now, we would expect both discretionary and insurance models of indemnity cover to be considered appropriate. Given the longevity of such arrangements, we would not expect commissioners or regulatory bodies to adopt a different approach unless there was evidence of failure to provide redress under either system.

2. Are clinical commissioning groups covered by NHS indemnity and clinical negligence arrangements?

Claims for damages for clinical negligence are likely to be made against the allegedly negligent provider, so we think it would be very unusual for a clinical negligence case to be brought against a commissioner. However, the Health and Social Care Act (Schedule 4, Part 2, paragraph 18) makes provision to enable regulations to be made that would allow CCGs to become members of NHS Indemnity schemes. It is our intention to lay regulations that would allow CCGs to join the variety of schemes that are available to cover clinical and non-clinical liabilities, although it will be for CCGs to determine what their indemnity requirements are and how they should be met.

Information about the different schemes that are available can be found on the NHS Litigation Authority's website.

3. Could individual members of CCGs be liable for claims against the CCG?

In the unlikely event of a claim for damages for clinical negligence against a CCG, this would need to be brought against the CCG as a body corporate. A right of action would not attach to an individual member, officer, employee or other person concerned. The Health and Social Care Act provides protection for CCG members, employees and others acting under their direction, by including a CCG within the definition of an NHS body under the terms of the NHS Act 2006.

4. Could CCGs be liable for executive decisions?

A CCG will need to use reasonable skill in carrying out its functions and would be liable for the acts or omissions of its staff in the course of their employment and of its members and officers (or a person acting under its direction).

Any claim for damages in relation to these executive decisions (for example, agreement of contracts) would need to be brought against the CCG as a body corporate rather than individual GPs or employees of the CCG. A right of action should not attach to the individual member, officer, employee or other person concerned. Similarly, a court action seeking judicial review of a policy, decision or act of the CCG made in the course of carrying out its statutory functions would need to be brought against the CCG itself, rather than the individual concerned.

As CCGs will be responsible, as statutory bodies, for the risks arising from their executive decisions, they will need to make their own arrangements to manage those risks.

5. What about members of governing bodies of clinical commissioning groups?

At present, non-executive members of NHS boards are personally liable for their actions and decisions, either as individuals or as members of a board. HSC 1999/104, *Personal Liability of Non-Executives: Amendment of Liability*,¹ recommended that for the reassurance of non-executives, Trusts and Health Authorities could provide them with an indemnity for decisions taken in the normal course of board business, in accordance with the following text:

A chairman or non-executive member or director who has acted honestly and in good faith will not have to meet out of his or her own personal resources any personal civil liability which is incurred in the execution or purported execution of his or her board function save where the person has acted recklessly.

CCGs will have a governing body, with clinicians and lay members in roles which could be regarded as sharing some similarities with those of non-executives. A CCG could provide an indemnity to these members by taking out cover to meet the costs of any potential civil liabilities, under its general power to do things incidental to its functions (Section 2 of the 2006 Act (inserted by paragraph 1(1) of Schedule 4 of the Health and Social Care Act 2012)).

Department of Health
February 2012

¹www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4011987.pdf