

Clinical Commissioning Group Constitutions

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NHS REFORM

Introduction

Clear and comprehensive constitutions will help Clinical Commissioning Groups ensure they have effective structures, strong governance systems and good relationships with member practices and the local profession.

This guidance highlights essential elements that should be included in a CCG constitution. This is not a comprehensive list, and each CCG should consider issues relevant to their locality and seek legal advice in drafting their constitution.

Thorough consultation and buy-in from Local Medical Committees (LMCs) will be essential. The authorisation process will require CCGs to demonstrate that they have good relationships and engagement with member practices and local GPs (principal and sessional). CCGs will be accountable to member practices for the decisions that the CCG takes on their behalf. LMCs, as statutory representatives of the profession, should work with their CCGs to ensure that the local profession is consulted in the development of their CCG.

GPC GUIDANCE ON THE AUTHORISATION PROCESS.

Contents

Introduction	Page 2
Preliminary information	Page 3
Membership of the CCG	Page 3
Structure of the CCG	Page 3
Elections and appointment processes	Page 4
The relationship between the CCG, member practices and local profession	Page 5
Governance of the CCG	Page 5
BMA Law	Page 5

Click the yellow boxes for further guidance

2. Preliminary information

The constitution should clearly state:

- The name of the CCG;
- A list of members of the CCG;
- The geographical area covered by the CCG;
- The date the constitution commences and the duration;
- How the constitution can be amended;
- Definitions of specific terms used in the constitution (e.g. 'Member', 'Observer', 'Board' and other relevant terms).

3. Membership of the CCG

The constitution should include:

- A clear definition of how membership of the CCG is defined;
- Who is eligible for membership;
- The application process by which practices can become a member of the CCG;
- The process by which membership of the CCG can be terminated (including an appeals process).

All practices will be contractually required to be a member of a CCG. CCGs will be required to cover a continuous locality i.e. their geographical footprint must include all practices in an area and not contain 'gaps' within the boundaries. Once CCG boundaries are defined and finalised, the CCG or CCGs a practice is eligible to be a member of will be dictated by geography. Whilst it would be feasible for a practice on the boundary of a CCG to change membership to a bordering CCG (thus retaining coherent geographical boundaries), practices in the centre of a CCG's locality would not have this option.

Membership of a CCG will automatically terminate where a practice ceases to hold a contract to provide primary medical services, however a CCG will not be able to 'expel' practices on any other grounds.

4. Structure of the CCG

The constitution should detail the internal structures of the CCG. For example:

- The elected board;
- The audit committee;
- The remuneration committee;
- Locality or other devolved structures;
- The governance body, if different from the elected board.

For each body, the constitution should clearly, and in detail, outline:

- Membership, distinguishing between voting members and observers;
- Election/appointment processes (see **Section 5** below);
- Roles and responsibilities;
- Operation; e.g. frequency of meetings, quorum, how decisions will be audited;
- How the body will relate to and work with external organisations such as the NHS Commissioning Board, the Health and Wellbeing Board and the Local Medical Committee.

The elected board must include:

- A chair person;
- Representatives of member practices;
- At least two lay members – one of whom will lead on patient and public involvement, and the other will oversee key governance issues such as audit, remuneration and managing conflicts of interest;
- At least one secondary care doctor and at least one registered nurse;
- An Accountable Officer;
- A nominated Clinical Lead, who could also be the chair or Accountable Officer.

GPC GUIDANCE ON POSSIBLE GOVERNANCE MODELS FOR CCGS

5. Elections and appointment processes

The constitution should clearly detail electoral and appointment processes to internal structures of the CCG, including:

- The posts for which elections will be necessary; e.g. members of the elected Board, the Clinical Lead, the Accountable Officer and the Chief Finance Officer, as well as elected positions below board level;
- The terms of office of each of these posts;
- How remuneration for elected positions will be determined;
- Electoral timetable and processes;
- Who can stand for election and how candidates will be screened prior to election for required competencies;
- Who can vote in elections;
- How elected officers of the CCG can be held accountable, and if necessary, removed from their post.

LMCs – independent bodies representing all GPs in the CCG’s geography and experienced in electoral processes - are ideally placed to run CCG elections, ensuring that the democratic structures of the CCG are inclusive and have the trust of the local profession.

All GPs (partner and sessional) should be eligible to stand and vote in CCG elections. The constitution of the CCG should explicitly state this and outline electoral processes inclusive of all GPs in the CCG area. In particular, all GPs (regardless of contractual status) should have the opportunity to stand for all elected positions (at board level or below) and vote in elections.

GPC GUIDANCE ON SESSIONAL GPs AND CCGS

6. The relationship between the CCG, member practices and local profession

The constitution should include the responsibilities of the member practices as members of the CCG, or refer to separate Terms of Engagement between practices and the CCG.

Conversely, the constitution should clearly outline what practices and local GPs can expect from their CCG, including:

- How practices and the local profession can hold their CCG to account;
- A commitment from the CCG to communicate decisions and developments to all GPs (including principals, sessional and GPs in training) in a timely fashion;
- Remuneration GPs will receive for time dedicated to CCG business – this should be equitable regardless of contractual status;
- How the CCG will seek the views of member practices and the local profession.

Whilst the constitution should outline responsibilities of practices as members of the CCG, CCGs will not have responsibility for performance management of practices. The responsibilities outlined in the constitution should relate to the practice's role as a member of a commissioning group and should not stray into general practice contract management or dictate expectations relating to performance.

7. Governance of the CCG

The constitution should describe the governance systems of a CCG. These should include:

- How member practices can hold the CCG to account;
- The roles and responsibilities of the Audit Committee and details of financial audit processes;
- Clear guidance on declaration and handling of conflicts of interest, particularly with relation to the elected officials of the CCG;
- The role and responsibilities of the Chair of the board, Accountable Officer and Chief Finance Officer;
- Details of external bodies to whom the CCG will be accountable (e.g. the NHS Commissioning Board, Health and Wellbeing Boards, HealthWatch);
- Dispute processes where a dispute arises between member practices and the CCG.

GPC GUIDANCE ON THE GOVERNANCE OF CCGS

GPC GUIDANCE ON ACCOUNTABILITY IN THE NEW STRUCTURES

BMA Law

BMA Law offers a full drafting service for CCG constitutions and already has a draft template and questionnaire to tailor to any CCG needs. BMA Law offer this in conjunction with more detailed advice on Procurement, Competition, Conflict of Interest and Accountability, in particular how to handle these types of issues on a practical basis and keep adequate audit trails. If you would like to know more about this service including any training and seminars that BMA Law offer, please call Diane Smith on 020 7383 6976 or e mail info.bmalaw@bma.org.uk