

CAM HEALTH LOCAL COMMISSIONING GROUP

CONSTITUTION

Version 6, October 2013

Constitution History

Version 1 of the constitution was agreed at the first meeting of the Management Group of Cam Health on 10th June 2010, subject to changes suggested at the meeting. This resulted in Version 2 which was agreed on **8th** July 2010.

Version 3 (June 2013) reflects the changes proposed following LCG member consultation on 18th April 2013.

Version 6 (October 2013) allows the chair of the membership board a casting vote in the event of a tie.

History of Cam Health

In 2010 the Cambridge Area Cluster consisted of initially five then eight General Practices local to the Cambridge City and South Cambridgeshire Areas joining together for the purpose of sharing and managing a single commissioning health budget for the provision of community services and secondary care services and prescribing. A ninth practice joined in 2012.

The context of these arrangements initially was that Cam Health formed one of four new Commissioning Models of NHS Cambridgeshire, from 1st October 2010. A legal entity was formed for the purpose of contracting with NHS Cambridgeshire for the provision of commissioning services by the cluster. This arrangement came to an end on 31 March 2011, and the legal entity was dissolved. Cam Health became a shadow Local Commissioning Group (LCG) from 1st April 2012, remaining officially within the CATCH umbrella and linked by a concordat agreement that gave Cam Health autonomous status.

From 1st April 2012, Cam Health became an LCG in its own right, entirely distinct from CATCH, but working closely with CATCH as a sister LCG within the Cambridge Health System. Cam Health is one of eight LCGs that together make up the Cambridgeshire and Peterborough Clinical Commissioning Group (CCG).

The version 1 of the constitution launched the cluster within a democratic and transparent framework. It was recommended that the constitution be refined from time to time as the cluster developed. Changes to the constitution are by decision of the Cam Health Management Board, as constituted below.

The original aims of Cam Health were to

- to improve services to patients so they are more effective and where ever possible more cost-effective
- to deliver a balanced budget and at the same time develop services for patients
- to have high standards of clinical, financial and corporate governance

Membership

Nine practices make up Cam Health. The original members were Arbury Road Surgery ,East Barnwell Health Centre, Newnham Walk Surgery, Nuffield Road Medical Centre, The Firs House Surgery. Bottisham Medical Practice, Cherry Hinton Medical Centre and Milton joined by the end of 2010. Bridge Street medical Practice joined on 1st April 2012.

All Practices will be represented on the Cam Health Board (described below)

All members of the LCG will be committed to provide their best endeavours to support the policies of the LCG as agreed through the Board, and as stipulated in any accountability arrangements between the LCG and Cambridgeshire and Peterborough CCG, or with other organisations such as Providers of Community and Secondary Care Health Services. In the unlikely event of a practice showing insufficient commitment, they can be removed only by a unanimous vote of the other practices. There should be at least a three week notice of any such proposal.

In the event of other practices wishing to join the cluster in the future, this will be by unanimous vote of the current members. There should be at least a three week notice of any such proposal.

Cam Health Leadership

Cam Health will have a dispersed model of clinical leadership, as from 1st July 2013. This will consist of three Co-chair roles, elected by the Cam Health Board.

The co-chairs will disperse their leadership function through chairing or deputy chairing the three key governing bodies of Cam Health. These are

- Cam Health Board
- Cam Health Finance & Performance Board Sub –group
- Cam Health Health Strategy & Service Redesign Sub-group

The chair of the Board will :

- develop and coordinate the overall business of the Membership and Executive Boards (described below)
- will be the first point of contact for the CCG and
- will be the default point of contact for other organisations but such external relations to be divided up by the Co-chairs.

The LCG will have Board meetings regularly, taking the form of:

a) **A full Membership Board** meeting every two months.

The Membership Board will consist of:

- a GP representative from each member practice (the clinical lead), plus co-opted Practice Managers from each practice.
- The LCG Representative to the CCG Governing Body, (should this be a GP other than one of the member practices clinical leads)
- A Nurse representative
- A Patient Representative
- The designated CCG responsible office (i.e. Local Chief Officer for Cambridge Area)
- The LCG Manager
- The LCG Finance Manager

Each practice will have a clinical lead, as well as a deputy clinical lead. The deputy clinical lead will attend in the absence of the clinical lead or in addition.

The Membership Board will co-opt the practice managers from each of the member practices. In their absence, the practice may send a deputy for the practice manager.

Decision making will mostly take place by consensus, but in the event of a vote, 66% support will be needed to carry the vote. Should the circumstances arise whereby the vote is tied for any reason, the co-chair acting as the chair for the meeting will have the casting vote.

Each practice will have a single vote through their clinical lead (or the deputy clinical if the clinical lead is absent). In the absence of a clinical lead, a practice manager will be able to cast a vote for the practice if mandated to do so by the practice clinical lead.

The Patient Representative and the Nurse representative will each have a vote.

A meeting will be deemed to be quorate if at least six practices are represented by a clinical or deputy clinical lead or practice manager. However for the purpose of making changes to the constitution all nine practices will need to be represented. Proposals for constitutional changes need to be circulated at least three weeks in advance.

Other representatives may be co-opted to attend from time to time as needed. Other clinicians from the practices may wish to attend to contribute to discussions or observe. This in general will be welcome and their role at the meeting will be established at the onset.

There will be a strong consultative element within decision making with practice leads keeping their practices informed and consulting with all practice members as appropriate including GP partners, salaried doctors, long term locums and practice nurses.

Decision made by the Membership Board will be binding on all the practices. Any practice can ask for the Board to review a decision.

b) **A smaller Executive Board** will have delegated authority from the Membership Board. It will meet monthly and consist of:

- the GP Co-Chairs,
- the LCG Representative to the CCG Governing Body, (should this be a GP other than one of the member practices clinical leads)
- a Practice Manager,
- the LCG Manager
- the Local Chief Officer

Decision making on fundamental matters such as forward business planning, governance issues, recovery plans if needed and accountability agreements will remain with the Membership Board and other matters as deemed appropriate

The Board will be responsible for:

- The Leadership and Governance of the LCG
- The Commissioning Strategy of the LCG
- The Financial Management of the LCG Management budget
- The Monitoring of Quality and Performance in Secondary Care, Community Care, Mental Health services and Prescribing Budgets, and endeavouring to achieve a balanced end of year budget
- The Operation of the LCG through a Management Office, Informatics & Contracts
- Communications and Patient Involvement
- The relationship with the CCG and other LCGs
- The relationship with local authorities and other relevant bodies
- Specific duties as a sub-committee of the CCG as outlined in the LCG Terms of Reference Framework

Each of these functions will be allocated to one or more Board members. They will provide the leadership required to make Cam Health successful.

In order to fulfil its functions, the Board will evolve a system of support subgroups which report to the Board. Each will have its Terms of Reference:

- Finance and Performance Subgroup (monthly)
- Health and Strategy Subgroup (bimonthly)
- Prescribing (currently 6 weekly)
- Patient and Public steering group (bimonthly)

Work streams will be constituted from time to time with clear mandates and project management.

LCG Representation on CCG Board

The LCG will have a representative on the CCG Governing Body.

The representative will be elected using a process agreed with the CCG Governing Body and Local Medical Committee which allows all GPs registered on the Cambridgeshire and Peterborough Performers List and working within the LCG's practices to vote.

The LCG representative to the CCG Board will sit on the LCG Board.

External Relationships

- 1) The CCG is the statutory body designate, taking over full function from the PCT by 1st April 2013. The CCG Board is constituted such that each LCG has a nominated CCG Board member.
- 2) The CCG has developed a standard Terms of Reference for its constituent LCGs. Cam Health Management Board in April 2012 agreed to these Terms of Reference, subject to being allowed to continue with its collegiate system of representation
- 3) There will be a CCG/LCG Accountability Agreement between the CCG and Cam Health
- 4) There will be a Membership and Practice Delivery Agreement between Cam Health and its member practices

Author: Dr A Fertig

Reviewed: April 2012, and amended July 2012 by R.Harrison LCGM.

Reviewed: June and amended June 2013, A.Fertig Chair /R.Harrison, LCGM

Reviewed: October and amended October 2013, Membership Board /R.Harrison, LCGM