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Chairman of the General Practitioners Committee

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Dear Colleague

NHS Reforms

Many of you will be aware that BMA Council at its recent meeting hardened its position on the Health and Social Care Bill and now opposes it in its entirety. The BMA and the GPC have always had many concerns about the Bill, but the decision to strengthen opposition arises from the increasing alarm felt by many doctors, particularly following the publication of the government's draft plans for supporting Clinical Commissioning Groups (CCGs), '*Developing Commissioning Support: Towards Service Excellence*'. The government intends to encourage outsourcing of commissioning support after 2016, introducing commercially focused procurement criteria that would make it very difficult for CCGs to have any real choice other than to obtain this support from large commercial organisations. Even though we agree that CCGs should be able to decide for themselves where they get this support, this broad policy direction causes us deeper concerns about the risks to the NHS, given the potential for the vast majority of commissioning functions to be delivered by large multinational companies. We believe they will lack accountability and local sensitivity and that this is not in the best interests of practices, CCGs or patients; it would disempower doctors, and risk losing experienced NHS managers.

The government has been made fully aware of the strength of our views on this issue and we are still working to change this policy – which is not yet final - as much as we can.

The way forward for Clinical Commissioning Groups
We know that GPs on the ground are facing real, practical issues as CCGs are established. The timescale for establishment is tremendously challenging and GPs are being compelled to develop CCGs very quickly, with authorisation on the horizon in summer 2012. There is now a small but critical window of opportunity for GPs to seize the initiative to influence and determine what is evolving locally.

I urge all GPs to make sure they are involved in and have input into their emerging CCG, and make themselves fully aware of what is happening in their locality to protect themselves and NHS services.

There are a number of key conditions that we believe are vital to the positive development of CCGs:

- The government is currently proposing that practices should be the constituent bodies of CCGs. We do not believe that this model is appropriate. The CCG needs to be as inclusive as possible - engaging with all those working in the CCG area, including salaried and locum GPs, not just practices as single units - and this is more likely to lead to the CCG becoming a successful organisation.

- **All** GPs, irrespective of contractual status, must have an equal opportunity for involvement in their CCG. Elections for board members should be conducted on the basis of one GP, one vote, and all GPs should be eligible to stand for positions on the board.

- Apart from being one of a number of sources of information available to the NHS Commissioning Board, CCGs should have no role in the performance management of the GP contract.

- Involvement of secondary care colleagues, public health doctors and other clinical colleagues, as appropriate, is essential.

- CCGs should be working in partnership with their LMCs. LMCs play an important role in facilitating and advising on elections to the CCG, observing CCGs to advise on probity issues, acting as a mediator to resolve conflicts of all sorts, and representing the views of all GPs in the area. CCGs' constitutions should detail how they will interact with the LMC and other bodies.

- The CCG should be undertaking meaningful engagement with patients and the public and seeking patients' views, without placing an unnecessary bureaucratic burden on CCGs.

- Robust governance structures are essential, coupled with a transparent way of working, to guarantee the probity of the decisions made.

- Adequate funding is essential to allow the CCG to be able to function effectively. We do not consider the proposed £25 per head to be sufficient and will be seeking a substantial increase in that sum.

- CCGs should not need to be dependent on external commissioning support, and should be able to employ an infrastructure of commissioning managers and staff. Where required for specific tasks, commissioning support should be coming from within the NHS as far as possible. Commissioning support organisations will be best able to provide cohesive and patient-focused support if they remain within NHS bodies.

We have previously advised that CCGs should have a minimum population of 500,000, but with strong local structures to ensure they can be truly representative and sensitive to local needs. However, in the light of the current proposals, we are now recommending that CCGs should be proactive and come together to form a CCG of PCT or even PCT cluster size. It would be big enough to employ its own staff with the necessary skills and expertise to be an effective commissioning body. Staff would work for the smaller sub-groups, (the current CCGs), ensuring they were both protected and empowered within the devolved federation of the larger group. They could continue to work in the way GPs are telling us they want, but without the need to create unaffordable and duplicate governance structures. This would not be re-creating a PCT, but would be a group led by clinicians who would ensure the smaller sub-groups were really empowered and enabled to take account of local needs.

We support GPs who want to remain in smaller groups to ensure genuine practice engagement. We believe the way to achieve this is for current CCGs to work together in this federated structure within one statutory body. This would mitigate the risk of smaller CCGs becoming dependent on external support, and almost certainly losing the power to commission independently in an effective way.

We are at a very worrying point in the transformation of the NHS and many GPs have serious misgivings about the way developments are occurring. We do understand that playing a full part in these changes is a daunting task, given what GPs are struggling with at a local level. The GPC will continue to produce guidance and provide support and advice to GPs to help empower you to influence local developments.

However, we firmly believe that the balance is tipping against clinicians having any real influence over commissioning, and that the direction of travel now risks more than we thought we stood to gain from clinically-led commissioning. Doctors' concerns about the reforms have also continued to grow rather than

diminish because of what is actually already happening on the ground. There is a genuine and widespread perception that the positive vision of clinically-led, patient-focused, locally sensitive and accountable commissioning is being lost in the huge amount of often chaotic change taking place right now. On top of this, vast amounts of guidance on how the system will work in detail are being rapidly developed which appear to be constraining clinically-led commissioning within a bureaucratic straightjacket. GPs must now radically reassess the current situation in their locality and ensure they are fully involved to retain any degree of control in their local area and over the future of the NHS.

Yours sincerely

Chairman
General Practitioners Committee