

## Introduction

Welcome to the first Commissioning Update, which we hope you will find a valuable source of information on the changes happening in the NHS. Despite our many concerns about the Health and Social Care Bill and with the legislation not yet through Parliament, around the country things are moving at a bewildering pace. It is therefore vital that all GPs are aware of the changes that are taking place.

At a national level the BMA is working hard to make sure that developments are sensible. We are supportive of more clinician involvement in commissioning, but think this could be achieved without such radical reform. We believe the best solution would be for the Bill to be withdrawn, but we know on the ground that you need information now and that's why our experts have already prepared a number of "How to..." guides on the various components of commissioning. More are in preparation. These will enable you to keep up to date in this fast-moving area.

This update focuses on new NHS structures. No doubt, these will change in the future and the General Practitioners Committee (GPC) will keep you well informed as details emerge. We would appreciate any thoughts or feedback you may have ([info.gpc@bma.org.uk](mailto:info.gpc@bma.org.uk)) and, of course, please keep us up-to-date on developments in your area too as that enables us to help you.



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## The Health and Social Care Bill – next steps

Despite numerous changes made to the Bill and shifts in policy following the recommendations of the NHS Future Forum, the BMA still has a number of serious concerns about the legislation and NHS reform proposals in general and has been lobbying for the Bill to be withdrawn or failing that, significantly amended.

In the week of Parliament's return following the summer recess, MPs debated the Bill at its Commons Report Stage and Third Reading on 6/7 September. The Bill had previously been scrutinised by a small Committee of MPs that had been re-convened to consider parts of the Bill again following amendments the Government made to the legislation following the listening exercise (the re-convened 'Public Bill Committee').

Prior to Report Stage and Third Reading, the Government had tabled over 1000 amendments, approximately 700 of which replaced the word 'consortia' with 'clinical commissioning group'. Other amendments were tabled to take account of changes to the Bill from the re-run Public Bill Committee stage. Amendments

covered issues relating to competition, Monitor, Foundation Trusts, failure regime, duties of the Secretary of State, public health, the NHS Commissioning Board and clinical commissioning groups and various miscellaneous provisions. All the Government amendments were passed and no Opposition amendments were successful.

At the Third Reading 'summing up' debate towards the end of 7 September, there was a final vote taken on the Bill as a whole with a majority of MPs voting for the Bill.

Now that the Bill has completed its stages in the House of Commons, it will be debated for the first time in the House of Lords on 11 October where it will have its Second Reading. The BMA will continue to lobby as the Bill enters the Lords seeking further amendments to the most damaging aspects of the Bill. The deadline for the Bill to become law is spring 2012.

You can access the BMA's views on the Bill on the **BMA's NHS Reforms webpages**.

## GPC Guidance

The GPC has produced practical guidance for doctors on a whole range of issues relating to the health reforms and the proposals for commissioning. You can find it all on the **BMA website**. Recent guidance includes:

- **Leadership in clinically-led consortia;**
- **Consultant involvement in commissioning;**
- **Ensuring transparency and probity;**
- **The governance of consortia.**

Keep checking back for the latest information and advice, as we will be updating these documents in light of developments. Future guidance will cover Health and Wellbeing Boards and their relationship with CCGs, the "authorisation process" for CCGs (whereby CCGs get permission to advance their plans) and further information about the commissioning support CCGs will need and have to which they will have access.

## What's happening to the structure of the NHS

### What do we know? NHS Commissioning Board

The provisional structure of the NHS Commissioning Board (NHSCB) was published in early July ("**Developing the NHS Commissioning Board**"). The Board will be established in shadow form in October 2011 and become a statutory body in April 2012. The Chief Executive Officer will be Sir David Nicholson and further appointments are expected to be announced over the summer.

The Board, possibly to be known as "NHS England", will be accountable to the Department of Health, Ministers and Parliament, and answerable to patients and the public through an annual report.

Key roles of the Board will be to:

- Develop and oversee CCGs, including financially rewarding CCGs that achieve high standards of quality and outcomes within resources available (a proposal the BMA opposes as it risks undermining the doctor patient relationship);
- Commission certain services directly, including primary care and specialised services, and to commission services for CCGs not ready or able by April 2013.

Despite the Secretary of State's desire to cut down on "bureaucracy" and empower local decision-making, the BMA has concerns that the proposals relating to the NHSCB could lead to greater central control and have the potential to stifle local flexibility and responsiveness.

## SHAs and PCTs

	Summer 2011	October 2011	April 2012	April 2013
	The 152 Primary Care Trusts have now been reduced to 51 PCT clusters which vary in size around the country from 200,000 to 1.7 million.	The 10 Strategic Health Authorities (SHAs) to cluster from October 2011.	CCGs to be expected to be operating in full shadow mode.	SHAs and PCTs abolished.  CCGs to become statutory bodies.

- The four SHA clusters will be: London; the North (North West, Yorkshire and Humber and North East); the Midlands (West Midlands, East Midlands and East of England) and the South (South Central, South West and South East Coast).
- The Department of Health have released an **operating model** for PCT clusters, outlining key responsibilities throughout the transition period and a timescale for the transfer of functions.
- Clearly, this timescale is very tight (for instance, guidance stipulates that by August 2011, PCT clusters will have “begun ensuring that a clear percentage of budgets are delegated to CCG pathfinders”) and GPC will continue to raise concerns that rushed implementation, particularly before the proposals reach the statute book, risks destabilising fledgling CCGs.

## Clinical Commissioning Groups

More details are emerging of the Authorisation Process, with more prescriptive requirements for CCGs to have clear geographical boundaries that do not cross upper tier local authority boundaries unless with good reason. It is expected that many CCGs may need to reconsider their membership to ensure comprehensive and cohesive coverage across regions and populations. It is also important that CCGs are sufficiently large to be able to fulfil their statutory functions without becoming dependent on an external organisation for commissioning support, and this is where close liaison with PCT clusters will help to ensure a smooth transition and the best use of resources available.

The BMA has concerns that there is too much variability in the quality of support being given by PCT clusters to shadow CCGs. Ideally, PCT clusters should not only support the process of clinically led commissioning but also enable the development of a sustainable commissioning support unit (CSU). The BMA believes that CSUs should remain part of the NHS. They should support CCGs and could even be hosted by them. CCGs should not become dependent on external commissioning bodies from outside the NHS.

Each CCG will have a Governance

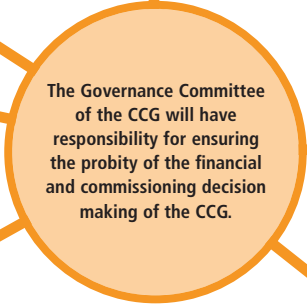
### THE GOVERNANCE COMMITTEE

The Governance Committee will **hold its meetings in public** (as opposed to the commissioning decision-making board).

The Governance Committee will need to include at least **one secondary care consultant** and **one nurse** (neither of whom should work for a local provider),

For further guidance on the governance of consortia please visit the GPC's **NHS Reform webpages**.

At least **two lay members** will sit on the Governance Committee. One lay member will lead on **patient and public involvement**, and the other will oversee **key governance issues** such as audit, remuneration and managing conflicts of interest.



One of the **lay members** of the Governance Committee will be appointed **Deputy Chair or Chair** of the Governance Committee.

The GPC has asked the Secretary of State for clarification as to how **lines of accountability** will operate in practice, given the diversity of membership of the consortia decision-making bodies.

Committee, performing an audit function, and a decision-making body, who will be responsible for taking commissioning decisions and determining commissioning strategy.

## The decision-making body of the CCG

• Although the terminology has changed (from GP Commissioning Consortia to Clinical Commissioning Groups), CCGs will still have a majority of GPs sitting on the decision-making body (if the practices wish this to be the case). The support and engagement of all constituent GP practices will be vital to the successful functioning of a CCG.

• In addition to the expert involvement of other medical and health colleagues, including public health doctors, the GPC has emphasised that all GPs, regardless of whether partner, salaried or freelance, should have equal opportunity to play an active role in their CCG if they wish.

• Further guidance on the role of sessional GPs and CCGs can be found [here](#).

## Clinical Senates and Clinical Networks

Clinical Networks and Clinical Senates are some of the new proposals that came out of the Listening Exercise, in response to stakeholder concerns that CCGs should have access to a broad range of clinical expertise to support their commissioning decisions. The BMA has written to the Secretary of State stating strongly that Clinical Senates should be hosted by CCGs in order to ensure that the valuable support and advice they will provide is tailored to local needs and not rendered distant by unnecessary bureaucracy.

The NHS Commissioning Board will establish and fund both Clinical Networks and Clinical Senates. Clinical Networks will be organised around clinical conditions or client groups, however much of the detail of their constitution and role is yet to be determined. Until more detail is known about these proposals, the value these bodies will bring to the NHS, patients or the profession, remains uncertain.

A little more is known about Clinical Senates:

- There will be 14 Clinical Senates in England, largely geographically determined. These will cover an average population of approximately 4,000,000, although it is likely that London will have one Clinical Senate covering a population of closer to 10,000,000.
- The Clinical Senates will provide population level clinical advice to CCGs. They will be purely advisory and have no power to compel CCGs to take any particular line of action.

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Commissioning in the news...



LINKS

Links to recent BMA News stories:

- **Call to revoke Health Bill intensifies**
- **DH releases pro-choice schedule**
- **Commissioning staff to be halved**
- **Integration trumps competition**



Check out the **Tavistock blog** for insider views on the latest developments with the Health and Social Care Bill.



If you have comments about this update, about the Health and Social Care Bill or what the GPC is doing to support you, please email [info.gpc@bma.org.uk](mailto:info.gpc@bma.org.uk).