General Practitioners Committee

NHS WHITE PAPER

GPC guide to the NHS White Paper

Legal overview and guidance on the commissioning proposals

September 2010

STANDING UP FOR DOCTORS

BMA

What is the NHS White Paper proposing?

The White Paper is currently in the consultation stage and there is no clear information on many of its broad headings. It is proposed that much health care commissioning (as well as many current PCT functions, including safeguarding) will be devolved to consortia of local GPs in given localities which they will agree. This means that consortia will carry both the responsibilities and the budgets to ensure that appropriate and necessary healthcare services are commissioned in an area to ensure that patients are supported with appropriate and necessary healthcare. Core primary medical services contracts will not be held by consortia and will probably transfer from PCTs to the NHS Commissioning Board (see below). Of course, the White Paper encompasses many other areas and while the focus in this guidance is on commissioning and consortia, it is important to be aware of the breadth of other issues covered. The BMA has produced a summary of all the issues raised in the White Paper and the accompanying consultation papers, which is available here: **http://www.bma.org.uk/healthcare_policy/nhs_white_paper/consultationpaperswp.jsp**

We are aware of various organisations who have been circulating guidance on the White Paper. In most cases, the information that is being circulated is both premature and misleading. Please note that no definite legal requirements and/or processes are as yet known, nor have they been agreed or implemented.

What are the legal implications for GPs developing consortia?

This guidance is an introduction to issues that GPs may have to consider in terms of legalities, education and training in preparation for the outcome of the current consultation on the White Paper.

The timeline is relatively short in terms of the substantial changes that may take place for GPs and practices and it is imperative that GPs consider and understand the structures and management processes that they may need to have in place to cater for any new responsibilities that commissioning will entail.

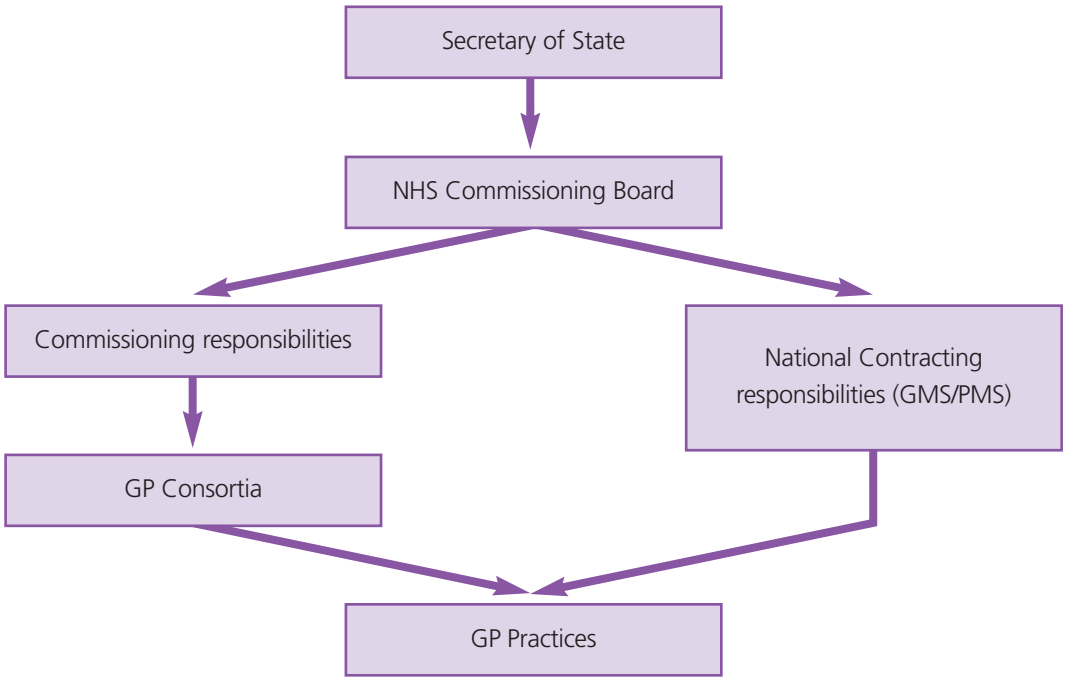
It is proposed that every GP practice will have to become a member of a consortium and the NHS Commissioning Board may have the power to allocate a practice to an existing consortium where necessary. Therefore, practices should start to consider what groups have already been set up in the area and whether these have the potential to develop into a GP consortium capable of responding to the new roles it may be expected to fulfil. If the current arrangements are not suitable or no groups exist then GPs should start talking to their LMC, their colleagues and to their PCTs to work together to agree a suitable way forward for their locality.

Whilst it is appropriate to start discussions with other practices in informal groups that have the potential to develop in to more formal consortia, we would not currently advise GPs to create consortia that do not have the flexibility to change once government expectations become clearer. It

is clear from discussions with the Government that consortia will be statutory public bodies and, therefore, the set-up and rules governing consortia will be entrenched in statute. Therefore, it is highly unlikely therefore that setting up as, for example, a company limited by way of shares or other profit making organisation will be an acceptable model at present. Practices are advised to wait until the rules and regulations around the set up of consortia have been firmly established BEFORE embarking on any formal re-structuring.

Proposed structure:

The NHS Commissioning Board will have powers devolved to it directly from the Secretary of State.



Each of the entities above will have their own responsibilities which are likely to be embedded in statute. The NHS Commissioning Board (NHS Board) is the proposed entity that will have the responsibility for holding consortia to account and for allocating and accounting for NHS resources. In essence, the NHS Board will control and support the consortia and consortia will likely be held to account in terms of outcomes, financial performance and operating in a fair and transparent manner when commissioning. The consortia will have the freedom to commission "any willing provider" which could include GP provider groups, but there are likely to be controls in place to ensure fairness and deal with conflicts of interest. There may also be arrangements in place between different consortia.

The legal framework and other detail in respect of controls and processes will become clearer after the consultation and the subsequent parliamentary process. Most of this is likely to be entrenched in either primary or secondary legislation.

Structural arrangements and responsibilities

We now know that consortia will be public bodies and therefore will be recognised and governed by statute. The detail behind this has yet to be determined and it is not known whether the structure will take the form of a committee or a public corporation. Either way, it is likely that the eventual consortium will have to manage a budget, and control and manage its own staff.

Public bodies will be subject to the Freedom of Information Act. They will also have a role of accountability, in this case, probably to the NHS Commissioning Board. Each type of public body will have different responsibilities depending on their functions and set-up.

It is likely that GP consortia will have a multitude of legal and financial responsibilities, including management of staff and commissioning issues. This will include management of finances and budgets, bidding and tendering issues and compliance with any legislation that is in place to cater for the new processes. Practices and consortia will need to understand the implications of managing and employing staff who work for a future consortium (as well as any relevant employment issues such as TUPE, redundancies, unfair dismissal etc.). This may be relevant if, for example, current PCT functions or part of a PCT's functions are transferred to GP consortia, leading to a transfer of relevant staff.

As consortia will be expected to commission services and will have the freedom to use resources to achieve cost-effective outcomes, they will need to have knowledge of how to tender for services legally. Consortia, as public bodies, will be subject to the rules of Public Procurement. Consortia will have to decide, for example, what commissioning activities they keep for themselves and what activities they choose to buy in from external organisations. The decision-making processes from within each consortium should be managed and conducted in a transparent and fair manner. Therefore, the mechanisms for establishing how decisions are made, how member practices views are taken in account and who sits on the board of a consortium, should all be envisaged by the policies and formal documents that the consortium should have in place.

Provider arms

The White Paper proposes moving a significant amount of care from hospitals into community settings, which will provide care closer to home, and also cost efficiencies. This will require an expansion of provision both in GP surgeries and in the community.

Whilst most practices will still be providing normal GMS/PMS services, many may also be involved in the provision of other services, in addition to commissioning responsibilities. GPs could for example be members of provider structures employing clinicians, including specialists. There will necessarily be some constraints in terms of ensuring that bidding and awarding of commissioning contracts are conducted in a fair and transparent manner. The NHS Board, amongst others, will ensure this happens and it is likely that processes on how this is controlled and affected will be set in legislation or guidance. In order to maintain the policy of ensuring that 'any willing provider' has an equal opportunity to provide services, it is likely that safeguards will be put in place.

Particular consideration will need to be given to the where the consortia wish to commission services from GP practices, some of whom may already be part of the consortia commissioning group. It should be noted that commissioning consortia will not be commissioning core primary care services (such as GMS/PMS/APMS). Many GPs are envisaging that in order to do this effectively, they will create a separate provider arm. There is however a difference between practice-level work, such as enhanced services, that do not require a new provider arm, and a completely new primary care provider structure.

Core GMS/PMS work will still remain separate from any other commissioned work. If a group of practices (whether they are part of a commissioning consortium or not), wishes to 'provide' services which may be commissioned from their own consortium, then keeping core work separate has the advantage of ensuring that separate terms, conditions and liabilities attached to the commissioned work remain effectively separate from 'core work'. So if, for example, diabetes work moved from a hospital to a practice, it could still be performed by trained practice staff, but within the remit of a limited liability company. Alternatively this work could be an enhanced service not requiring a limited company.

Setting up as a provider arm does have the advantage of ring-fencing services that may be considered more specialised within one entity and unlike the consortia, could be smaller, tighter outfits with smaller and, therefore, more manageable boards and members. It is important to remember that provider arms are not statutory bodies and therefore have flexibilities of structure and organisation, including being a company limited by shares. This could make for a quicker and more effective decision-making process, but will carry the responsibilities of service delivery and management in accordance with any commissioned contract. No doubt there will be some room for negotiation but this will depend on the tender process and requirements. So, even provider arms should ensure they are comfortable and familiar with bidding and the tender process and like their commissioning counterparts, are familiar with basic contractual terms and provisions, particularly in respect of meeting targets and Key Performance Indicators.

Practical steps

- **GPs should take appropriate legal/financial advice and have a basic knowledge and understanding of corporate structures and responsibilities, bidding/tendering, management of commissioning and providing entities, contract law and managing budgets – training on ALL these areas via seminars/workshops can currently be offered by the BMA through BMA Law, via any arrangements BMA Law have in place with your Local Medical Committee.**

- **More documentation and information will follow as soon as we know more detail. In the meantime, do not be pressured into making decisions to join or set up consortia groups until more is known about the structure and regulations that will govern them.**

- **The BMA will provide advice and assistance to members in all relevant areas either through GPC or BMA Law. Please note that BMA Law already provides a service that caters for structural organisation and subsidiary matters – for more information please contact Joanna Maw on 0207 383 6976 or email info.lmc@bma.org.uk**

- **The BMA will keep its website regularly updated with new information and guidance on the White Paper as it becomes available. This will be available here: http://www.bma.org.uk/healthcare_policy/nhs_white_paper/index.jsp**