MILLS & REEVE

briefing

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GP commissioning

The Government announced its proposals for radical changes to the structure of the NHS on Monday 12 July. One of the key proposals is to transfer responsibility for commissioning many health services from PCTs to GPs, who will group together as GP consortia to carry out their new commissioning role.

The White Paper, *Equity and excellence: liberating the NHS*, has given us more information about the Government's proposals, although a lot more detail is required in order to understand fully the proposed arrangements for GP commissioning. What is clear is that much of the statutory and contractual framework within which the NHS operates will have to change to accommodate these major reforms.

At this initial stage, we have identified the following key legal issues arising from the GP commissioning proposals:

1. Organisational structure of GP consortia - will these be statutory bodies or private entities? The White Paper is not clear on this point and it remains to be seen what leeway consortia will actually have within the legal framework to decide their structure.

2. Accountability and assurance framework - how will GP consortia be held to account for the management of large amounts of public funds? The White Paper states that this will happen but gives no detailed indication of how it will work. A robust accountability framework will, however, be central to GP Consortia being acceptable to parliament.

3. Sharing of risk and reward - many GPs anticipate being able to benefit financially from the model but will they be prepared, and to what extent should they be expected, to take on any responsibility for risk? One of the challenges will be to strike the right balance between implementing robust accountability and providing incentives for achieving outcomes and innovation.

4. Will staff transfer under the TUPE Regulations from PCTs to GP consortia? If so what obligations would arise and what liabilities might GP consortia be exposed to?

5. Will staff of GP consortia have access to the NHS Pension Scheme?

6. The extent to which GP consortia will be bound by public sector duties is currently unclear. On the face of it, many such duties may not automatically apply but this will depend on the ultimate structure of consortia. The government may also choose to extend some such duties via legislation or policy. For example, will GP consortia be brought within the public sector duty to consult? The White Paper does mention the need for patient and public involvement by GP consortia but they would not be caught by the current legislation.

7. The handling of patient sensitive information, along with ensuring data security, will carry different obligations for GP consortia from use of patient data by their constituent GP practices, as the consortia will be separate legal entities. To what extent will GP consortia handle patient sensitive data in carrying out commissioning functions? In addition, GP consortia may not expect to be bound by NHS guidance, codes of confidentiality or the requirement to have a Caldicott Guardian. As with other NHS-specific rules and policy, it seems likely that

the government will wish to extend such requirements so that they do apply to GP commissioners. The resource implications of complying with data requirements are therefore likely to be significant.

8. GP consortia are likely to be subject to procurement regulations, as they will be spending large amounts of public money and carrying out public functions. How will the consortia source the expertise for compliance with procurement requirements? Will the government also extend NHS policy requirements to GP consortia, along the lines of the current PCT Procurement Guide? The White Paper also suggests that contestability rules will be extended to consortia.

9. Could the shift to GP commissioning exaggerate the postcode lottery, in that different commissioning decisions may be made on a narrower locality basis than at present? With an increased number of commissioning bodies, this increases the likelihood of different approaches to prioritisation of treatments and funding decisions. Will the ability of patients to register with GPs away from where they live help to address this issue? Or will it just mean that those who are able to go further afield will have access to more treatment options than those who cannot?

10. How will management of contracts with providers of NHS funded services be organised to ensure providers are not being held to account by more than one organisation?

11. TCS policy made it clear that those responsible for commissioning should retain responsibility for estate ownership. What will happen to NHS property when PCTs are abolished? What requirements will GP consortia have for accommodation? Who will take over PCT management of leases with providers? What will happen to any PCT share in LIFT companies, particularly when the main occupier of properties owned by LIFT companies are GPs?

12. Will there be sufficient skill base within GP consortia, or will they rely more on involvement of the private sector? Will this bring about cost benefits?

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