

# Sessional GPs: GP Commissioning & Impact of the NHS White Paper

GPC guide to the NHS White Paper

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## Introduction

In July 2010, the Department of Health published the NHS White Paper for England, *'Equality and excellence: Liberating the NHS'* and a number of supporting consultation documents. These documents outlined significant changes to the structure of the NHS, and particularly the involvement of GPs in the commissioning of NHS services.

These changes affect **all** GPs, including salaried and locum GPs. Indeed, all GPs are already involved in commissioning; every time a GP sees a patient, they decide whether to prescribe medication or refer them to another part of the NHS, thus directing how NHS resources will be spent and which services patients will access.

However, the changes proposed in the NHS White Paper and supporting consultation documents entail a fundamental change in GPs' involvement in the commissioning process. In particular, they state that:

*"The Government will devolve power and responsibility for commissioning services to the healthcare professionals closest to patients: GPs and their practice teams working in consortia."*

Under the proposals, GP practices will be grouped into consortia, which will be statutorily responsible for commissioning the majority of NHS services. All practices will have to be part of a consortium.

The Department of Health consultation "Commissioning for Patients" outlines in general terms the services that GP-led commissioning consortia will commission on behalf of patients. It proposes that GP consortia will commission the great majority of NHS services on behalf of patients, including:

- Elective hospital care and rehabilitative care;
- Urgent and emergency care (including out of hours services);
- Most community health services;
- Mental health
- Learning disability services.

Consortia will be provided with budgets to carry out this work. They will be responsible for managing these budgets, and deciding how these resources can be used to meet the healthcare needs of patients.

A new national NHS Commissioning Board will also be established to oversee these changes at a national level. As well as holding primary medical services contracts, the Board will be given the power to authorise the establishment of consortia to ensure that they are of a sufficient size, can fulfil their statutory duties and provide comprehensive coverage of consortia across the country.

These changes are expected to be completed by 2013/14. The following indicative timetable is proposed in the NHS White Paper:

**2010/11**

- GP consortia to begin to form on a shadow basis and, where ready to do so, begin to take on some responsibilities from PCTs, supported by indicative budgets

**2011/12**

- A comprehensive system of shadow GP consortia to be in place, taking on increased responsibility from PCTs, including the leadership of the existing Quality, Innovation, Productivity and Prevention (QIPP) initiative
- NHS Commissioning Board to be established in shadow form as a Special Health Authority from April 2011 and to have a role in supporting the development of GP consortia

**2012/13**

- Formal establishment of GP consortia, together with indicative allocations
- NHS Commissioning Board to be established as an independent statutory body
- NHS Commissioning Board to announce (in the third quarter of 2012/13) the allocations that will be made directly to consortia for 2013/14

**2013/14**

- GP consortia to be fully operational, with real budgets and holding contracts with providers

## How Can Sessional GPs Become Involved In These Changes?

The specific make-up and structure of GP-Led Commissioning Consortia are not yet clear. Furthermore, central government will not be imposing a uniform structure for the consortia; this will to a large extent be determined by GPs at a local level and there will be a great deal of flexibility and variability.

Some details are emerging, however, and it is possible to glean from these how sessional GPs might become involved in the proposed changes.

When the consortia are fully established, it is likely that in each consortium, “clinical leaders” will be established to make the overall decisions regarding the commissioning of services. GPC guidance states that the leaders of consortia must have the mandate of consortium members, as well as qualities such as leadership and management skills, an understanding of the needs of the local patient population and well-developed commissioning capabilities. Although it is likely that the leadership structure will vary between different areas, it is generally envisaged that a board structure will be put in place with, for example, a Chair and Deputy Chair. It is also expected that an Accountable Officer will be appointed to run each consortium and take overall responsibility for decisions made.

The formal establishment of the GP-led commissioning consortia proposed in the White Paper is not yet taking place, however. In the meantime, the government is asking practices to form *shadow* consortia. Shadow consortia will not have full commissioning responsibilities, and it is likely that they will spend the interim period up to the formal establishment of consortia considering what functions consortia will fill once fully established. It is expected that, within each shadow consortium, a “transitional leadership” will be put in place to provide strategic leadership, and steer development to full GP Commissioning Consortium status.

The GPC has published guidance on developing and electing a transitional leadership to these consortia, which is available [here](#). The guidance discusses the different possible approaches for developing the transitional leadership.

The GPC would strongly encourage sessional GPs to consider putting themselves forward for a leadership role. In fact, sessional GPs may often be well-placed to become involved in this way. For example, locum GPs will have often worked in a large number of practices within a consortium area or across consortia, and therefore have a unique understanding of the local patient population and how different practices work. The fact that sessional GPs do not have some of the responsibilities that come with running a GP practice might also put them in a good position to take on this extra responsibility.

By the same token, the GPC believes that it is vital that the rules around who can stand for appointment or election to the transitional leadership are inclusive, and are seen to be inclusive of all GPs within the consortium’s boundaries. This would give consortia access to the widest range of

talent, thus increasing the transitional leadership's chances of success. The structures for voting in elections to the leadership should also be inclusive of all GPs within the consortium's boundaries.

If you are interested in becoming involved in this way, your first point of contact should be your LMC. LMCs are the local representative body for GPs, and will have up-to-date knowledge of how these plans are developing in your area and how you can become involved.

We have advised LMCs to communicate regularly with **all** GPs in their local area about how these plans are developing and to help ensure that the proposals develop in a manner that is acceptable to the local profession. It is also expected that LMCs will be publicising the appointment process for consortia leadership roles. Whether you are interested in taking on a leadership role or not, it is therefore vital that you contact your LMC to ensure that you are on their mailing list. Contact details for all English LMCs are available on the **BMA website**.

If you are a BMA member and experience problems in becoming involved in this process, please contact the BMA on 0300 123 1233 or at **[support@bma.org.uk](mailto:support@bma.org.uk)**

## Why Should Sessional GPs Become Involved?

There are a number of reasons for taking a lead role in these changes as they occur in your local area. Just some of these are outlined below:

**Sessional GPs are a significant proportion of the GP workforce:** Salaried GPs make up approximately one fifth of the GP workforce and although estimates on the number of locum GPs vary, they also make up a sizeable proportion of the workforce. It is important that this significant section of the GP workforce are represented both as these important changes occur, and once they are implemented. It is also important that the talents of such a large proportion of the GP workforce are not wasted.

**It is an opportunity to shape the local health service:** The purpose of the devolution of power to GP-led commissioning consortia is to place the responsibility for the commissioning of NHS services in the hands of clinicians who are on the frontline of the NHS and have the best understanding of the needs of the local patient population. The changes provide you with an opportunity to use your experience and knowledge to help shape the local health service for the benefit of patients. All GPs are stakeholders in the reformed NHS and this is a chance to become involved in shaping how it will eventually function.

**Many sessional GPs have the required skills:** Sessional GPs may often be well placed to become involved in these changes at a leadership or board level. Locum GPs in particular often have a unique perspective that comes with working in a variety of practices, and sessional GPs may often be in a position to undertake these additional responsibilities. Many sessional GPs have taken on a large portfolio of different roles within their careers and have acquired transferable management and leadership skills from doing so; these skills would be invaluable in taking a lead role within a consortium. Sessional GPs may also find fewer conflicts of interest than GP contractors in taking on these roles.

**The changes to the NHS require engagement across the whole profession:** the forthcoming changes to the NHS will only work if all GPs engage with them. Previous NHS commissioning initiatives have not achieved their objectives because their take-up has varied between areas or they have been led by small groups of enthusiasts. By buying into and becoming involved in these changes, you can try and help to ensure that they are successful and therefore benefit patients.

## Other effects on sessional GPs

Even if you decide not to become involved in these changes at a leadership or board level, the proposals in the White Paper will have a significant effect on the working lives of all sessional GPs. Some of these potential impacts are discussed below:

**Local decision making:** The aim of the proposed changes is to instil a “bottom up” culture in the NHS, with power being placed in the hands of local clinicians who take genuine ownership for their decisions. This culture change should affect all clinicians. If you are not interested in taking on a leadership role, there should still be local mechanisms in place for all GPs to influence the decisions made by consortia. It is important that all sessional GPs are given access to these mechanisms.

**Contractual Issues:** The obligation on GMS practices to use the salaried GP model contract is currently enshrined in the GMS regulations and contract. The GMS contract will necessarily be amended as a result of the proposals to abolish PCTs and devolve power to GP-led commissioning consortia and the proposed move to a single national contract, once negotiations have taken place with the GPC. However, we made it clear in our official response to the White Paper that we expect a continuation of the requirement for employers of salaried GPs to offer terms and conditions at least as favourable as those in the salaried GP model contract.

**Peer Review:** The government White Paper “Commissioning for Patients” proposes a role for consortia in improving the quality of primary care. It is envisaged that this will take place at least in part through an increase in peer review, both at a practice and individual level, and that all GPs will have a role in this.

**Work Opportunities:** As a result of the changes, it is likely that some services will be moved out of hospitals into the community, where GPs with a Special Interest (GPwSIs) can provide specific services. Sessional GPs with specific clinical skills may be able to provide these services, and this may provide an opportunity for sessional GPs to get involved in this newly transferred work.

**PCT Functions:** PCTs currently undertake a large number of functions which will have to be re-allocated following their abolition. Some of these, such as funding for the GP retainer scheme, specifically relate to the working lives of sessional GPs. The GPC and the sessional GPs subcommittee are currently considering how this large range of functions should be re-allocated, with the intention of making a proposal to the government and safeguarding vital support for sessional GPs.



## Further Guidance

The GPC is publishing a series of guidance notes on the NHS White Paper.  
You can find the remaining guidance notes on the BMA website here:

[http://www.bma.org.uk/healthcare\\_policy/nhs\\_white\\_paper/gpcwhitepaperguidance.jsp](http://www.bma.org.uk/healthcare_policy/nhs_white_paper/gpcwhitepaperguidance.jsp)