How GP consortia will take charge

The long-awaited DoH White Paper is finally out, with a strong message for GPs: if you are not part of a consortium, you need to find one quick.

The White Paper may pose more questions than it answers, but it carries a massive amount of detail to digest.

By April 2013, each GP consortium must have an ‘accountable officer’ to take financial control of budgets from its PCT. As PCTs and SHAs are abolished, a new NHS Commissioning Board will calculate practice-level budgets, based on list size and deprivation, and allocate them directly to the consortia.

The commissioning board will hold each consortium to account against these same objectives. Unlike fundholding, GPs will not be able to profit from savings the consortium makes, nor will they be liable for financial losses. The consortium will instead receive a ‘management fee’ to pay GPs for their time (or to pay third parties for support) with a ‘premium’ available for those achieving high quality outcomes or financial performance.

Health secretary Andrew Lansley is still concerned about potential conflicts of interest however, which leads to a quirk of the policy: GP consortia will be responsible for commissioning almost all NHS services except those they know best – primary medical services.

GP contracts and services will be commissioned directly by the NHS Commissioning Board, another big job for it alongside all the other commissioning GPs will not take part in, like pharmacy and dentistry.

The White Paper also sets out plans to move to ‘a single contractual and funding model’ for practices. This new contract is likely to include aspects of the APMS contract (it pledges to ‘promote quality improvement’ and ‘remove barriers to new provision’) and may signal the end of PMS contracts.

Guy’s will still be monitored by the CQC, and despite Mr Lansley’s pledge to scrap many NHS quangos, his White Paper seems to have created new ones. The CQC will be ‘strengthened’ as a quality inspectorate, while incorporating Healthwatch England, a new body that will respond to patient and public complaints. Monitor will take over the regulation of all providers, including GP practices, as well as being the ‘economic regulator’, setting prices for the NHS services commissioners will buy.

Vast gaps in detail

Due to the vast scope of Mr Lansley’s proposals, the gaps in detail gape open like vast craters. Commissioning groups will ‘not be bailed out’: says the White Paper, but the question remains: what will the DoH do if consortia overspend or are incompetent?

Justin Cumberlege, a primary care legal expert from Carter Lemon Camerons, says the policy is ‘naïve’ and fails to address two big questions. ‘The first is how membership between partners in the consortium will be arranged, legally. And the second is termination: What happens if they fail?’

‘They might be able to fly in a new chief executive, but the members of the consortium will always be the same.’

The GP contract will be adjusted to include clauses to force practices to commission via a

**How practices will link to consortia and the wider NHS**

**Source:** DoH

**THE FACTS**

- NHS Commissioning Board allocates budgets to GP consortia and oversees commissioning.
- GP practices contractually obliged to help consortia meet their commissioning objectives.
- GP consortia purchase NHS services from non-GP providers (hospitals, etc).
- GP practice contracts and additional GP services commissioned by NHS Commissioning Board.
- GP practices regulated by CQC and licensed by Monitor.

**Any clause tying practices to risk, balancing the budget, or a potential loss of their provider contract will be a deal-breaker for the BMA**

Dr David Jenner (pictured) GMS/PMS lead, NHS Alliance

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**Key**

- Funding
- Accountability