How GP Consortia Will Work

What's known about GP consortia so far, following the publication of the 2011/12 NHS Operating Framework and the government's response to the White Paper consultation:

Size and structure
GP consortia will be free to merge, expand or change location. Not all practices in a consortium have to be physically located in the same area. Two towns could be covered by one consortium, while a rural area between them is part of a wider rural consortium.

There will be no minimum or maximum size, but the NHS Commissioning Board must be satisfied a consortium's population is appropriate. There will be no legislative requirement for lay members of consortia boards, but neither does the accountable officer have to be a clinician. Many small consortia are expected to federate into larger networks to increase their buying power and share back-office functions.

Joining a consortium
Legislation will ensure GP practices cannot operate if they do not join a consortium. Practices that have not done so by 2012 will be placed into one by the NHS Commissioning Board.
Each GP practice will nominate a clinician to represent it on the consortium board. Lawyers are currently working on model contracts to bind practices into consortia but the BMA has warned against moving into legal arrangements until legislation is finalised.

Transition
From now on, PCTs must involve emerging GP consortia in NHS contracting, with a view to transferring functions fully by April 2013. In 2011, PCTs will merge into clusters to cut costs and consolidate falling staff numbers and functions.

So far 52 consortia have been granted pathfinder status, with a second wave due to be announced this month - these sites are effectively piloting GP commissioning and will report to the DoH on their success.

The DoH admits a 'small minority' of consortia will not be ready by 2013. The NHS Commissioning Board will commission services in areas where GPs are not ready when PCTs are abolished.

Funding and PCT debt
GP consortia will be responsible for debts PCTs accrue in their final two years - 2011/12 and 2012/13.

Consortia and PCTs are expected to work closely in this period to 'reduce the risk' of deficit as they are abolished, but will not be directly responsible for deficits accrued in 2010/11 or earlier.

Beyond 2013, consortia will be paid a 'quality premium' for quality outcomes and financial stability, likely to be top-sliced from existing GP income. From April this year, consortia will receive £2 per head to fund GP involvement, on top of existing practice-based commissioning funds. By 2014/15, consortia will receive £25 to £35 per patient to cover running costs.

But the DoH has not confirmed how much they will receive in 2013/14, the first year in which they are fully operational. The GPC says consortia may be short of cash once infrastructure costs are deducted.
Work on a formula to allocate consortia budgets based on member practices' lists may take until 2013 to complete.

The NHS Commissioning Board will have powers to establish and maintain a risk pool with consortia to help manage expensive episodes of care.

Accountability

Authorised GP consortia will become statutory bodies in 2013. The NHS Commissioning Board will hold them to account on measures in a Commissioning Outcomes Framework, based on NICE advice. The board will intervene if 'there is evidence that consortia are failing or are likely to fail to fulfil their functions'.

It will also issue guidance on financial risk management.

GP consortia must also be represented on local health and wellbeing boards, which will link NHS services, local authorities and patients.

GP commissioning will also be scrutinised by local 'Healthwatch' boards, which aim to speak up for patients.

Consortia will have powers to performance manage member practices but the NHS Commissioning Board will hold GP contracts and decide if practices can be ejected from consortia.