Council – 13th September 2010

Notice of motion to Council – Proposals for Secretary of State for health - GP consortia

Introduction

I set out below a notice of motion from Councillors Nazir, Robertson, Burley, Sarohi, Westley and Barton to Council on 13th September 2010:

> "This Council notes :
>
> - the proposals by the Secretary of State for Health to create "shadow" GP consortia by April, 2011, with the intention to phase out current Primary Care Trusts.
> - the major and unique public health and health inequality issues facing our Borough
> - ongoing discussions amongst GP colleagues as to the best way forward
>
> and therefore supports proposals to create a single GP consortium for our Borough.
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> We believe that this would give the best opportunity within the emerging policy framework to enable joined-up and consistent work between the local NHS, Walsall Council and other agencies, and thus the best chance for health outcomes for the people of the Borough of Walsall."

Background information

1. GP Consortia

The White Paper entitled "Liberating the NHS", published in July 2010 sets out the Coalition plans for the future of the NHS. This includes "greater accountability, local autonomy and democratic legitimacy through the development of GP commissioning consortia, working in partnership at local level with local authorities".

Decisions on treatment and care will pass directly to groups of health practitioners who will be responsible for around £80 billion of NHS resources per annum. It is anticipated that there will be around 500-600 general practitioner commissioning consortia across England and all GPs will be required to join a consortium.

Each consortium will have to be of sufficient size to manage financial risk and to commission services jointly with local authorities. The NHS Commissioning Board will be responsible for holding consortia to account for their use of NHS resources. They will have the freedom to decide whether to undertake commissioning activities themselves or outsource commissioning activity to other organisations, including local authorities.

These consortia will have a duty to promote equalities, to work in partnership with local authorities and will also have a duty of patient and public involvement.

Consortia of GP practices 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, and mental health and learning disability services.

Consortia will not be responsible for commissioning primary medical services, which will be the responsibility of the NHS Commissioning Board, but consortia will become increasingly influential in driving up the quality of general practice.

The NHS Commissioning Board will calculate practice-level budgets and allocate these resources directly to consortia. Consortia will be responsible for managing these combined budgets, which will be kept separate from GP practice income, and deciding how best to use resources to meet the healthcare needs of their patients. They will have a duty to ensure that expenditure does not exceed their allocated resources.

They will enter into contracts with providers and hold providers to account for meeting their contractual duties, including required quality standards and patient outcomes.

Consortia will have a duty to promote equalities and to work in partnership with local authorities, for instance in relation to health and adult social care, early years services and public health.

Consortia will need to engage patients and the public on an ongoing basis as they undertake their commissioning responsibilities, and will have a duty of public and patient involvement.

The intention is to put GP commissioning on a statutory basis, with powers and responsibilities set out through primary and secondary legislation.

Every GP practice will be a member of a consortium, as a corollary of holding a list of registered patients. Within the new legislative framework, practices will have flexibility to form consortia in ways that they think will secure the best healthcare and health outcomes for their patients and locality. The NHS Commissioning Board will have a duty to ensure comprehensive coverage of GP consortia, and we envisage a reserve power for the Board to assign practices to consortia if necessary.

Consortia will be formed on a bottom-up basis, but will need to have sufficient geographic focus to be able to agree and monitor contracts for locality-based services (such as urgent and emergency care), to have responsibility for commissioning services for people who are not registered with a GP practice, to commission services jointly with local authorities, and to fulfil effectively their duties in areas such as safeguarding of children.

Consortia will need to work closely with the patients and local communities they serve, including through Local Involvement Networks (which will become local Health-Watch bodies) and patient participation groups, and with community partners.

The proposed new local authority health and wellbeing boards would enable consortia, alongside other partners, to contribute to effective joint action to promote the health and wellbeing of local communities, including combined action on health improvement, more integrated delivery of adult health and social care, early years' services and safeguarding of children and vulnerable adults.

2. Implementation

The proposed implementation timetable is:

In 2010/11
• GP consortia to begin to come together in shadow form (building on practice-based commissioning consortia, where they wish)

In 2011/12
• a comprehensive system of shadow GP consortia in place and the NHS Commissioning Board to be established in shadow form

In 2012/13
• formal establishment of GP consortia, together with indicative allocations and responsibility to prepare commissioning plans, and the NHS Commissioning Board to be established as an independent statutory body

In 2013/14
• GP consortia to be fully operational, with real budgets and holding contracts with providers.

3. Public Health and Health Inequality Issues for Walsall

Walsall is one of the 70 Spearhead Authorities which have been identified by the Government as requiring additional attention and resources to address its poor health profile.

There is a significant geographic divide between the health experiences of those living in the East and those in the West of the Borough. This inequality is manifest as an eight year difference in life expectancy between the most deprived and the least deprived wards, high teenage pregnancy rates, high levels of smoking, obesity and unhealthy eating, limited physical exercise and 20% of residents living with incomes only found in the poorest 10% of the nation's population. Death rates from coronary heart disease (CHD), stroke and cancer in Walsall are all higher than the National and Regional averages. Life expectancy for Walsall men is 1.5 years less than the national average and for women 0.7 years less than the national average.

The pattern of morbidity and mortality in the Borough is also differentiated by ethnicity and access rates to acute hospital provision are significantly differentiated by income (and therefore geography).

4. Tackling Health Inequalities: GP Consortia

Existing PBC clusters have identified addressing health inequalities as a priority area for action and have incorporated this into their planning processes. The changes proposed in the White Paper hugely extend the responsibility and influence that GPs will have in terms of tackling health inequalities through the commissioning of services and working with Partners through the statutory Health and Wellbeing Board. The Consortia arrangements that GPs adopt will be key to making this new model a success.

A model in which the four existing PBC clusters become four separate consortia might appear to be beneficial in terms of acting at local level. However, the ability of these existing clusters to play into major new initiatives such as the recently established six Area Partnerships is limited by a lack of coterminosity and this is unlikely to be resolved in the foreseeable future. In addition, current clusters are not clearly defined in terms of geography nor the health needs of the populations that they serve and they would lack a Borough wide strategic approach.

A single consortium that is coterminous with the Local Authority area would be highly advantageous. The Consortium would be well placed to operate on a strategic, systematic and consistent basis, working with partners to reduce health inequalities. It would also maintain the flexibility to prioritise actions in localities and community areas across the Borough.

5. Shadow Arrangements for GP Consortia in Walsall

Discussions are underway with PBC clusters regarding future arrangements.

Paul Davies
Executive Director

3rd September 2010