DECISION-MAKER:		PANEL B		
SUBJECT:		DEVELOPMENT OF COMMISSIONING CONSORTIA IN SOUTHAMPTON		
DATE OF DECISION:		10 FEBRUARY 2011		
AUTHOR:	Name:	Dr Stephen Townsend		
	E-mail:	steve.townsend@nhs.net		

STATEMENT OF CONFIDENTIALITY
None

SUMMARY

Following the publication of the white paper Equity and Excellence: Liberating the NHS, the general practices of Southampton have met, agreed to work together with a view to forming a Southampton City commissioning consortium, and elected a steering group. The steering group has recommended that a pathfinder consortium be established, which requires amongst other things demonstration of engagement with local authorities.

RECOMMENDATIONS:

(i) To note the progress towards forming a Southampton City commissioning consortium

REASONS FOR REPORT RECOMMENDATIONS

1. The requirement, which will probably be part of the Health and Social Care Act 2011,, for general practices to be part of a geographically based commissioning consortium
2. To engage with the Panel at an early stage on progress with commissioning consortia in Southampton City.

CONSULTATION

3. A meeting of GP practices was held on 9th December 2010 to agree to work together on the establishment of a commissioning consortium in the City.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

4. The structure, function and boundaries of a consortium will not be determined until it is formally established by the new NHS commissioning board in before April 2013.

DETAIL

5. The white paper *Equity and Excellence: Liberating the NHS,* published on 12 July 2010, heralds what is likely to be the largest reorganisation of the National Health Service in its history. Its proposals include:
    - Setting up an NHS Commissioning Board, which will replace the Strategic Health Authorities; this will be responsible for developing, establishing and monitoring GP led commissioning consortia.
    - Giving local authorities responsibility for public health, and for hosting local Health and Wellbeing Boards, which will ensure that the democratic accountability of the NHS.
    - Abolishing the Primary Care Trusts, and giving responsibility for commissioning most NHS services to consortia of general practitioners from 2013.
6. At the same time, the Quality Innovation Productivity and Prevention (QIPP) programme will continue, with the aim of achieving £15-20 billion of efficiency savings by 2014.
7. The white paper contains some details of the proposed commissioning consortia, though it states that central stipulation about their structure and function will be kept to a minimum. Consortia will be made up of GPs and their practice staff, and it will be compulsory for practices to belong to a consortium. Consortia will be geographically based, serving a population large enough to manage risk, which is reckoned to be between 100,000 and 500,000. They will be statutory bodies, and will have an Accountable Officer and Finance Officer.
8. Their budget will be determined by the NHS Commissioning Board, and they will be expected to stay within their budget; those that fail will not be bailed out. The maximum sum that they can spend on administration will be fixed, and they can use that budget to buy in services if they want to. They will have a duty to co-operate with their local authority, and to contribute to local health planning.
9. There appeared to be a consensus amongst Southampton City practices that they wanted to work together to form a local consortium. A meeting, supervised by the executive of Wessex Local Medical Committees, was held on 9 December 2010, and the practices formally agreed to work together. They elected a steering group to oversee the formation of a shadow consortium.

    The members of the steering group are:
    - Dr Phil Clarke of Weston Lane Surgery;
    - Dr Chris James of the University Health Service;
    - Dr Tony Kelpie of Cheviot Road Surgery;
    - Dr Amir Mehrkar-Asl of St Mary's Surgery;
    - Dr Dan Tongue of Victor Street Surgery; and
    - Dr Steve Townsend of Bitterne Park Surgery

10. A similar process has been going on in the rest of Hampshire, there has been some contact between our group and others, and there is a shared intention to work together.

11. Nationally, during the autumn the government announced a programme of pathfinder consortia, which would act as pilots and inform the definitive arrangements for consortia. This has expanded rapidly, and recently the Prime Minister announced that pathfinder consortia now covered 28.6 million people.

12. While there was no enthusiasm to be a first wave pathfinder, the consensus among the practices is that we should now join the programme. The requirements for this are

- GP leadership and support.
  It would appear that we have been more rigorous than most in ensuring that we have an elected GP leadership
- Evidence of engagement with the local authority.
  If these reforms are successful, then the relationship between the local authority and the consortia will be a key one. In Southampton, this is helped by the present co-terminosity between the City Council and PCT. While we are yet at an embryonic stage, we are very grateful to the Cabinet Member for Health and Adult Social care and the Directors of Adult Social Care and Public Health for their help and encouragement.
- Involvement in the Quality Innovation Productivity and Prevention programme. Local practices have risen to the challenge of the QIPP programme, and are taking a major part in the development of care pathways. There have been worthwhile reductions in the level of planned care referrals.

13. Delegated responsibility for part of the commissioning budget.
The part of the QIPP programme which is most challenging, and where we have made least progress is urgent care. We intend to request delegated responsibility for the urgent care budget as part of a concerted effort to tackle this. Perhaps surprisingly, the biggest opportunity in urgent care is reducing the rate at which patients with long term conditions are admitted to hospital, which is very much the responsibility of primary and social care.

14. It is expected that the Health and Social Care Act will include provision for Local Authorities to scrutinise commissioning consortia. As the consortium in the City develops, we are keen to engage with members and develop a constructive working relationship. We hope to work together during this period of transition to identify and overcome any issues and ensure services continue to be delivered to a high standard.

FINANCIAL/RESOURCE IMPLICATIONS

Capital

15. None.

Revenue

16. None.

Property

17. None.

Other

18. None.

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

19. The duty to undertake overview and scrutiny is set out in Section 21 of the Local Government Act 2000 and the Local Government and Public Involvement in Health Act 2007.

Other Legal Implications:

20. None.

POLICY FRAMEWORK IMPLICATIONS

21. None.

SUPPORTING DOCUMENTATION

Appendices

1.	None

Documents In Members' Rooms

1.	None

Background Documents

Title of Background Paper(s)		Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)
1.	None	

Background documents available for inspection at: N/A

KEY DECISION? No **WARDS/COMMUNITIES AFFECTED:** All