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BIRMINGHAM AND SOLIHULL CCGS FIND THEIR FORM

HSJ Local Briefing is our new in-depth analysis of the key issues facing the NHS's major health economies

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In brief

Issue: Clinical commissioning groups in Birmingham and Solihull primary care trust cluster are facing up to the financial challenges of the quality, innovation, productivity and prevention agenda .

Context: Three quarters of the area's CCGs were red-rated six months ago but their structure has become more viable after a series of mergers. Nearly a third of the cluster's 2011-12 QIPP savings will not be delivered until 2012-13 and just £42m of next year's £58m QIPP target has been identified.

Outcome: Moves have been made to contain activity levels at Heart of England Foundation Trust. CCGs generally back the commissioning support service being established across the cluster and the Black Country as they strive to make savings. But there are widely differing requirements on how comprehensive levels of support required from the new organisations will need to be.

Clinical commissioning groups in Birmingham and Solihull have undergone significant upheaval since three quarters were red-rated six months ago.

The five that have been formed out of the previous 12 groups are now more settled, but all have been told their plans need to focus more heavily on the quality, innovation, productivity and prevention agenda.

However, the challenges they face in making the required efficiencies are immense. Nearly a third of Birmingham and Solihull primary care trust cluster's 2011-12 QIPP savings will not be delivered until 2012-13 and just £42m of next year's £58m QIPP target has been identified. The CCGs will exist in a complex, inter-linked health system where large providers are struggling on urgent care and maternity measures, in an area with some of the most deprived wards in Europe and the worst infant mortality in the UK.

This week's HSJ Local Briefing looks at how the CCGs in Birmingham and Solihull are shaping up and their plans to tackle QIPP. The plans include restricting activity growth with their biggest acute provider to 1 per cent, stepping up demand management, restricting further "lower clinical value" treatments and redesigning clinical pathways.

Who are the main players?

There are five CCGs in Birmingham and Solihull, one of which – Sandwell and West Birmingham – also stretches into the Black Country cluster. Covering populations ranging from 136,000 to 575,312, the current five have been whittled down from the 12 that previously existed - nine of which were red-rated in a pre-authorisation test in October.

It is possible that North East Birmingham CCG could in future merge with Solihull CCG, with which it already shares management resources. There are also five GP practices from the disbanded BICC group that were considering joining the biggest CCG – Birmingham – but are now having discussions with Birmingham South Central CCG. Two other practices are unattached to a CCG but would fit geographically with South Central.

Following board-to-board meetings with the cluster, three CCGs have been told they could potentially apply early for authorisation. Of the remaining two, Sandwell and West Birmingham is to "work on a target date for authorisation" and North East Birmingham – the smallest of the five – has been told "urgent improvement" is needed. HSJ understands the concerns centre on leadership, governance arrangements and QIPP delivery.

However, all the CCGs have been told by the cluster board they need to give further thought to how they will meet QIPP targets, particularly where this will involve potentially fractious relationships with other local organisations. In addition, they have been told they should "scale up" their plans, which have been largely shaped by local medics, to provide a more strategic, multi-professional approach.

CCGs will be assessed for authorisation in four waves between October 2012 and January 2013. This will involve a "360 degree" review by organisations in the local healthcare economy, and senior West Midlands sources said it was unlikely that Birmingham and Solihull's CCGs would be in the first wave. Some well-placed GPs agreed, arguing it was better to observe and learn from others' experiences of the process before ploughing ahead.

What challenges do they face in the coming year?

Three of the four PCT areas in the cluster have entered the 2012-13 financial year with an opening deficit in their financial plans – £27.1m, in Solihull's case. Only Heart of Birmingham starts the year with an opening surplus, of £10.4m.

The combined £58m budget gap across the PCTs equates to the cluster's QIPP target for this year, which will enable it to end the year with a £4m surplus, the control total set by NHS Midlands and East. Of the £58m, £42m has been identified. There is also an underlying deficit of £17m.

With CCGs in the driving seat with budgets delegated from 1 April this year, they will have to find ways of filling this gap. The biggest burden falls proportionally on the largest group – Birmingham CCG – which will be responsible for £24.2m of QIPP this year.

While the overall QIPP target this year is considerably less than the £98m initially set for 2011-12, the latter was reduced during the year to a less ambitious £69.1m, of which only £48.6m is expected to be saved in-year. Cluster chief executive Denise McLellan said she was confident the remainder would be made in 2012-13 and pointed to the predicted surplus for 2011-12 - an improvement from the £50m deficit predicted in June 2011 - as evidence of what is possible.

However, although the cluster initiated a successful recovery plan to turn around its predicted 2011-12 deficit, its fortunes were also helped by NHS Midlands and East reducing its control total by £4m, as well as the release of contingency reserves worth £4.5m.

The main area of QIPP that the cluster is currently struggling with is planned care, forecast to bring in 36 per cent fewer savings than planned in 2011-12. Elective admissions up to January are more than 4 per cent above plan according to latest figures, with the biggest variances (6 per cent) at Heart of Birmingham Foundation Trust. Traditionally, commissioners have struggled to contain activity levels at the foundation, which is one of the largest in the country and is spread across multiple sites. It is widely acknowledged that a refreshed leadership team at the trust has improved relationships, though a strategic health authority leader acknowledged that "change [on activity levels] isn't happening quickly enough".

The SHA has also described HEFT's delivery of the four hour accident and emergency target as

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hsj.co.uk/briefing April 2012

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being "in the balance". Difficulties with the target across the NHS Midlands and East strategic health authority area triggered a letter from chief executive Sir Neil McKay on 13 March emphasising that he had given a commitment to NHS chief executive Sir David Nicholson and deputy chief executive David Flory that this would be achieved for quarter four.

The letter urges clusters to take whatever action is necessary to deliver the targets, including the use of contractual levers. In HEFT's case, it is widely felt to be unlikely that such action will need to be taken, thanks to extra A&E staff being brought in to help close the performance gap. However, with A&E attendances 9 per cent higher than plan according to latest figures, there are still substantial financial pressures in urgent care.

What are they going to do?

Restricting HEFT's contract growth to 1 per cent, instead of the planned 2.5 per cent, figures heavily in the plans of Birmingham and Birmingham South Central CCGs. The cluster spends about £180m more on the acute trust than any other single organisation. But with £4.5m of the £8.3m QIPP schemes on planned care in 2012-13 branded high-risk, the CCGs have a task on their hands.

In a move described as a "new departure" and "unusual" by HEFT chief executive Mark Newbold, the trust has agreed to jointly manage the financial risks by paying for anything above 2 per cent growth, including 1 per cent covered by commissioning for quality and innovation (CQUIN) payments.

This has come about from joint meetings being held between trusts, CCGs and cluster leads, leading to a "compact" setting out shared responsibilities.

Some CCGs have also been trialling the Advice and Guidance tool, whereby GPs contact hospital consultants prior to making referrals through the Choose and Book system. The consultant normally replies within 36 to 48 hours, stating whether they think the patient could be seen in primary care instead. An SHA figure told HSJ that tackling variations in referral patterns would have been difficult without the move to clinical commissioning as "PCTs would have struggled to have those peer-to-peer conversations".

Yet the £771,000 QIPP savings in 2012-13 to come from demand management (peer review) is one of the areas deemed high risk. Birmingham CCG is responsible for £588,000 of this. It has piloted Advice and Guidance at Birmingham Children's Hospital Foundation Trust and now wants to roll it out to other sites.

CCG chair Gavin Ralston said only a fifth of referrals made through the Advice and Guidance system resulted in an outpatient appointment. But he added: "You probably have to take a couple of factors into consideration; the fact that clinicians might have a slightly lower threshold for referring for A&G and therefore refer a few more cases, and of course the cost of the A&G itself." He said an audit showed they could potentially halve the number of outpatient slots.

Clinical pathway redesign is forging ahead, with the five main changes expected to save £1m in 2012-13. There has been particularly big buy-in to a project for frail patients, involving enhanced community geriatrician outreach services, a shake-up of intermediate care services and a joint bid with Age UK to create a dementia centre of excellence.

An enhanced psychological service called Rapid Assessment and Intervention in Dementia is being developed to reduce length of stay in acute trusts and repeat admissions and is hoped to save £1.3m next year. Whether savings will fall under the provider or commissioner side is still to be fully worked through.

Apparently weighing less heavily on CCGs' minds is the looming shortage of maternity care facilities. One CCG chair admitted to HSJ "to be honest it isn't on our radar at all", despite cluster chief Ms McLellan warning it needed to be a priority. Ms McLellan said: "Birmingham's a young city...with a rapidly rising birth rate. If we don't do something we won't have enough capacity." A cluster-wide review is being carried out into maternity capacity, led by Birmingham Women's Hospital Foundation Trust chief executive Ros Keeton. This is likely to build on a previous reconfiguration involving services at Solihull and Sandwell, completed last year. There is now felt to be a "window of opportunity" to expand maternity capacity at Sandwell and West Birmingham Hospitals Trust after the Department of Health approved plans for its private finance initiative rebuild.

The ever-sensitive area of lower clinical value procedures will inevitably form part of QIPP next year. An extra £1m is to be shaved off the budget by restricting access to clinical interventions, 19 of which were agreed for 2011-12 and a further four would be added in 2012-13 under a draft policy. They include hip and knee replacement, aesthetic surgery, complimentary therapies/alternative medicine and bariatric surgery.

What support will they have?

A shared commissioning support service across the Birmingham and Solihull and Black Country clusters is being developed, headed by the Black Country's chief executive Rob Bacon. Unlike neighbouring West Mercia and Arden, the CSS has released few details regarding its operations or plans into the public domain. HSJ understands KPMG was originally picked by the Black Country to help develop an outline CSS business plan and its contract has now been extended across the two clusters until the work is completed.

But CCGs' vision of the level of help they will need varies considerably. A commissioning source told HSJ the challenge will be reconciling the fact that, while one CCG in the Birmingham and Solihull wants to carry out three fifths of commissioning support internally, others want the "vast majority" to come from a CSS.

HSJ understands Birmingham and Solihull CCGs are considering sharing the bulk of commissioning support tasks between themselves, including "a significant amount of medicines management", some service redesign and contracting with the bigger trusts. This is to combat the fear that devolving too much of the work could unduly reduce the CCGs' influence. Meanwhile the much smaller North East Birmingham CCG is likely to want to lean much more heavily on the CSS.

Sandwell and West Birmingham CCG chair Nick Harding said his organisation would not be "precious" about doing work internally that could be done more effectively on a bigger scale. Business intelligence could be done "well and to scale across Birmingham and Solihull", he said. He saw the establishment of the CSS as "just as important as setting up CCGs".

He also felt there was a potential role for the CSS in helping commissioners with their safeguarding duties. "Safeguarding children has been an issue for some time in Birmingham," he said. "It's a high risk area and we have to do it exceptionally well. It's best done at something of the size of

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hsj.co.uk/briefing April 2012

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Birmingham... [with a] CSS reporting to each CGG on the changes that need to be made." Backing Dr Harding's concerns over child health and welfare, an SHA source highlighted the "very serious issue" of infant mortality in Birmingham - the worst in England according to some reports – as something CCGs needed to get on top of.

The CSS outline business plan was due to be submitted at the end of March as part of the "checkpoint two" assurance stage and, if successful, leaders will be formally appointed over May and June.