HSJ LOCAL briefing

hsj.co.uk/briefing June 2012

NORTH YORKSHIRE AND YORK FINANCIAL PROBLEMS

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 NHS North Yorkshire and York has for several years overspent its budget and been bailed out, mostly by the strategic health authority. The patch is very large geographically and relies on several district general hospitals, which surround the patch, as well as numerous community hospitals, which add up to an expensive care system.

Context A major strategic change review in August 2011 proposed cutting DGH beds, a major expansion of services around community hospitals, limiting referrals, and rationalising estate. Commissioners believe change has been too slow while providers dispute the extent of the financial problem. The primary care trust last week declared it would end this year with a £19m deficit. It is an attempt to signal that there will be no more bailouts, and create momentum for faster change.

Outcome More specific and far-reaching change plans will be developed over 12-18 months, probably requiring public consultation. Hospital providers will pursue moves to share services and Harrogate and District Foundation Trust may need to merge with another organisation. The PCT's financial straits may been that the four proposed clinical commissioning groups get off to a slow start, requiring additional support organised by the NHS Commissioning Board.

Local context

North Yorkshire and York Primary Care Trust – the biggest in the country – has overspent its £1.3bn annual budget and had to be bailed out for several years.

In 2007-08 it recorded a massive £18m deficit, and since then it has recorded small surpluses only because of millions of pounds worth of support, such as the £4m payment in 2010. The pattern was repeated in 2011-12.

The PCT serves a very large, very rural patch. Although there are pockets of rural deprivation – and some poor urban areas notably Scarborough – it is generally a wealthy area, Conservative-dominated politically.

The wealthy population means that – while use of emergency care may be lower – there is relatively higher demand for expensive elective care.

Its wealth also means the allocation formula gives the PCT very low funding compared to neighbours. There is a strongly held belief, with some foundation, that it should get significantly more because its rurality makes it more expensive to provide services.

Many in the system also believe its financial problem is "historic" and if there was not a requirement to pay for past shortfalls, then it would currently be within budget.

A contributor to the problem was the sudden introduction of the payment by results system, which significantly damaged commissioners in areas such as North Yorkshire where hospital services had previously been provided at relatively lower cost.

The PCT's huge patch has a large number of providers, with several district general hospitals encircling the area.

The main DGHs are run by Harrogate and District Foundation Trust, York Hospital Foundation Trust and Scarborough and North East Yorkshire Trust (running Scarborough District General Hospital), which is to become part of York FT next month.

DGHs run by Airedale Foundation Trust and South Tees Foundation Trust (running the Friarage Hospital in Northallerton) are also providers to the patch.

More specialist and tertiary services are provided by Leeds Teaching Hospitals Trust and Hull and East Yorkshire Hospitals Trust.

The hospitals – while there are indications of quality and waiting list problems for some – generally perform strongly.

There are no signs of major financial problems for the main DGH provider foundation trusts. However, Harrogate (About £170m annual income) and Airedale (about £130m) are very small, which could leave them vulnerable as the requirement for efficiencies continues and grows.

There are a very large number of community hospitals in the patch at Ripon, Castleberg, Settle, Skipton, Richmond, Thirsk, Northallerton, York, Selby, Malton and Whitby.

These – along with the rest of community services in the area – are now all run by the hospital provider trusts in the area, having been transferred from the PCT under transforming community services.

There are also a large number of GPs per head of population.

Effects of nationally-led changes on the patch

The end of real terms funding growth for the NHS has compounded North Yorkshire's financial problem. It also makes it harder to win bailouts from elsewhere in the NHS.

At the same time, there is a national requirement in 2012-13 both to pay off historic debt, and even more pressure than usual to end the year in balance, so stable finances are passed to clinical commissioning groups, which are due to take on the majority of NHS budgets from April 2013.

The health secretary has said the new NHS will not allow bailouts or subsidies, although it is not yet clear whether this will be enforced in practice.

Under the Lansley health reforms, the PCT is set to be replaced by four CCGs as main budget holders from April next year: Hambleton, Richmondshire and Whitby; Harrogate and Rural District; Scarborough and Ryedale; and Vale of York.

The commissioning board has not yet decided how it will allocate funds to CCGs, but it is unlikely any shift will increase the area's budget significantly in the near future.

However, there could be significant knock on effects from dividing the PCT's single budget between the new budget holders - four CCGs, local authorities, and the commissioning board itself.

It is possible the CCG with a much poorer population (Scarborough and Ryedale) will find itself in a stronger funding position than at present, while the other three – with much more wealthy populations – could find themselves facing even more severe deficits.

Such a change – which may happen over several years, depending on funding policy decisions – would have a significant effect on providers. The PCT would no longer be able to shift funding around the patch and each CCG may try to protect its local provider.

There is highly likely to be one NHS Commissioning Board local area team covering North Yorkshire and York, East Riding of Yorkshire, Hull, North Lincolnshire and North East Lincolnshire. A commissioning support service is planned to cover the same area.

Local direction of change

In 2011 the then NHS Yorkshire and the Humber strategic health authority chief executive, Bill McCarthy, commissioned an

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independent review of health services in North Yorkshire and York.

Its terms of reference said: "Services have been secured beyond the means of the local health economy to afford them. For many years, this shortfall has been borne by the PCT, met by the SHA. With the abolition of the SHA [that] will end."

The review was chaired by the nationally respected medical manager Hugo Mascie-Taylor, previously medical director at Leeds Hospitals, and who has overseen service many major service changes.

The key recommendations in the final report published in August 2011 remain indicators of areas of likely service change:

- Reduce total hospital inpatient beds (a likely reduction of 200 or more) across DGHs and community hospitals
- The review rejected the option of closing all community hospitals because they are highly valued by communities, useful because of the large rural patch, and would be defended by politicians.
- Redesign community hospitals with much extended services including 'step-up' and 'step-down' care into and out of hospital. Extend other community services, including use of telecare.
- Review of health and local authority estates to co-locate services and rationalise.
- Review and set clear thresholds for elective procedures.

Separately, the main hospital providers are increasingly sharing some services. There are networks of provision of more specialised services between Harrogate and York, for example renal and some cancer services. On the fringe, there is an attempt to move paediatrics from the Friarage Hospital to Teeside.

Developing financial position

The review was not translated into costed savings plans, or into direct contracting and commissioning changes, although committees of senior leaders were established to develop the work.

The new North of England strategic health authority cluster recognised in March that progress was too slow. Minutes say: "It was felt that the SHA see the NY Review as not happening fast enough and that... level of ambitions [is] not high enough... the SHA want a vision of the plans and exposition of savings sooner rather than later."

The discussions ran into the contracting round for 2012-13, with the PCT's financial situation not addressed. One hospital provider believes it was not paid for services by the PCT in April (see p7 of report).

The financial pressures made agreeing contracts this year a difficult and drawn out process.

The leadership of the PCT was taken over, during the contracting round, by Christopher Long, the respected Humber PCT Cluster chief executive, who has been successful at Hull PCT for several years.

The PCT initially tried to negotiate deals for less activity with providers, with the aim of finishing 2012-13 in financial balance. They rejected this as unrealistic, although they are also the providers of community services, so have some capacity to control activity. The deal would have significantly risked their income.

Instead, the PCT has now reached agreement with providers for bigger contracts, but has decided to lay bare the scale of the consequent financial shortfall in public.

It last week (on 26 June 2012) announced it was planning to record a £19m deficit in 2012-13, with a financial position statement to its board. According to the board paper, the sum will be removed from the area's revenue budgets in 2013-14. That indicates it will be inherited by the area's CCGs – something PCTs have been under heavy pressure to prevent.

The paper says: "It is clear that in the past it has been more expedient to support a recurring deficit than to address the underlying causes."

Short and longer term changes

The PCT board paper indicates there will be measures to reduce 2012-13 spend to prevent it overshooting the £19m deficit plan and to try to reduce it. The PCT is appointing a turnaround director.

This is likely to mean a range of relatively short term moves, for example stricter referral management; and tougher enforcement of contract mechanisms.

More importantly, there will be a concerted effort to accelerate implementation of longer-term proposals from last year's Mascie-Taylor review.

In Hull, Mr Long has overseen successful major service change, shifting from hospital care into community services, in recent years. Pressure on North Yorkshire's providers to deliver this shift is now likely to increase.

Declaring the £19m shortfall, and saying it will pass to CCGs, is intended to create a "burning platform" for change.

It is understood that changes will largely be based on last year's review and the PCT has committed to new plans protecting quality and accessibility of services in the rural community, as well as financial sustainability.

Areas which will be aggressively pursued include reducing hospital stays in the DGHs; significantly developing services in community hospitals – particularly step-up/step-down and diagnostics; and rationalising estate across local organisations.

For some major changes there is likely to be public consultation beginning over the next 12-18 months. Together the moves may increase the financial pressure on the main providers.

Hospital providers believe changes will be a development of ongoing work networking clinical services between York and Harrogate. Following the acquisition of Scarborough trust by York– to be formally completed on 1 July - there will be a review of links between the two. It is likely to lead to integration of support services such as pathology, and probably networking of some clinical services.

Some in the system believe some providers will be tipped into high-risk unsustainable positions, and have to look to further mergers. Finances may be a particular problem for Harrogate District Foundation Trust, which is small, significantly reliant on North Yorkshire and, unlike York FT, is not already merging with another provider. It could too be a problem for Airedale, which is also small.

Under this view providers will ultimately have to seek closer alliances or later mergers, potentially grouping Airedale Foundation Trust with either Bradford Teaching Hospitals Foundation Trust or Harrogate. Another potential partner for Harrogate is Leeds Hospitals.

However, there is an alternative view that the providers – while they must reform services – are reasonably stable. They are running community services including community hospitals so – while they need to make major changes to methods of provision – can remain sustainable as organisations.

Organisations are very far apart, it is argued, so the potential benefits of mergers are even more dubious

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than in urban areas.

There is also a view – supporting the current pattern of providers – that the financial gap in North Yorkshire is not as severe as is being claimed. There is a belief that a "historic" overhead of debt can be paid off over a number of years, and that current provision is affordable and in balance.

There is a tendency to believe additional funding or bailout will be found. There is also a reiteration - supported by providers and emerging CCGs as well as local politicians – of pleas for a larger funding allocation for the patch, despite this appearing very unlikely in the short term.

The range of views reflects the fact that, while most in the system believe service change is needed, there will be clashes over how dramatic it must be and how quickly it needs to come.

Future commissioning system

There are outstanding questions about the functioning of the new commissioning system in North Yorkshire and York.

Regardless of the success of cost-cutting efforts and work to change services, its financial problems will persist this year and inevitably stretch beyond April 2013.

Firstly, during the commissioning board's authorisation process for CCGs in coming months they will be required to demonstrate they have a "detailed financial plan that delivers financial balance". It is unclear how that could be achieved for the North Yorkshire CCGs.

It is also unclear how the commissioning board will respond to that, but it is possible the regional sector and local area team of the board – which will have very limited staffing and capacity – may unwillingly emerge with an extensive role in overseeing CCGs' decisions and managing the system in this troubled patch.

At the same time, the acceleration of service change will fuel a political debate, and probably a row, locally. MPs are already seeking meetings with the health secretary over possible changes.

It will test the CCGs' ability and appetite for making unpopular changes and dealing with a budget and financial system which they believe is unfair.

Reactions to the situation will test and shape the roles of CCGs, the commissioning support service, and the commissioning board's regional and local teams. It is possible the commissioning board will be looked to for system management and handling of high-level political concern.