HSJ LOCAL briefing

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EAST ANGLIA FUTURE STRUCTURE OF CUMMUNITY SERVICES

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

In brief

Issue A mixed economy of aspirant foundation trusts, social enterprises and private providers has emerged for community services in the East of England.

Context Unlike other regions, the East of England has had no vertical integration between acute and community services, although it was originally mooted in some areas.

Outcome Instead, some services have been absorbed by mental health trusts. South Essex Partnership University Foundation Trust is now running community services in West Essex, South East Essex and Bedfordshire, and services in South West Essex are run by North East London Mental Health Services Foundation Trust. The future of some aspirant foundation trusts could be in doubt, with merger becoming a distinct possibility. Over the next three to five years it is likely consolidation will occur with fewer providers across the landscape.

The aspirant foundation trusts

Norfolk is a foundation trust economy and Cambridge University Hospitals Foundation Trust is the dominant player in its local health economy. So it is not surprising that commissioners look to community foundation trusts as a balance to acute power. "We need a community provider who thinks itself the equal of the big acute FTs," says Norfolk PCT chief executive Andrew Morgan. "I want a big beast striding about the patch saying 'I can look after people at home'."

But FT status is not a given: no community trust has been approved so far and none are with Monitor for assessment. They will have to satisfy Monitor over financial viability and governance while being far newer organisations than acute trusts.

Cambridgeshire Community Services Trust has been at the forefront of trusts chasing FT status since the idea was first mooted. It has hoovered up services in Peterborough and Luton, and now plans a name change to West Anglia when it gets foundation status. But does the name change signify greater ambitions?

Not according to its leaders, who are now talking of consolidation and building on what they have as they move towards authorisation (other voices talk of the trust having over-extended itself and staff unhappiness about being asked to do too much). Its application date has slipped - the Department of Heath recently agreed to a delay in submission date - as the trust has seen changes on the board and a delayed takeover of community services in Peterborough. This delay followed the county council deciding it wanted to take back control of social care (the trust already provides integrated health and social care in Cambridgeshire). It is now hoping for a 'board-to-board' with the SHA in September, submission to the DH in October and then onto Monitor in 2013.

But the trust also has some problems to overcome. It is improving staffing for its district nursing service in Cambridgeshire, where the Care Quality Commission raised concerns, and hoping to hit a troublesome chlamydia target in Luton. It made a £711,000 surplus in 2011-12 on a turnover of £156m, according to board papers.

Chief executive Matthew Winn points to effectiveness, efficiency, and aligning priorities with GPs as the way ahead. The experience of the trust in running services in different areas can lead to a lot of learning and spreading of good practice. Director of clinical delivery Alison Gilbert describes it as "a real catalyst to look at how we provide services at the front line".

But there is a sense that further expansion is off the agenda for now: Mr Winn says the trust would not be interested in taking over Milton Keynes Community Health Services, whose future is still be decided.

Norfolk Community Health and Care Trust made a small surplus in 2011-12 and is aiming for a cost improvement programme of seven per cent this year, leading to a £1m surplus on a turnover close to £130m.

The position for 2011-12, once some items such as money for foundation trust and board development are taken out, is slightly less rosy. However, the trust's financial risk rating is 3 - sufficient for authorisation, says chief executive Michael Scott.

He is preparing for a board-to-board meeting with the SHA in June to discuss progress. If the process then goes smoothly he hopes to be authorised in 2013: "Our goal is to proceed rapidly with foundation trust status because it secures our organisational form."

He believes the future will involve closer integrated working, with social care and primary care to support patients out of the acute sector, with emphasis on strengthening out-of-hours services. The trust is now structuring locality teams around CCGs and is working closely with them - the specification for some major services has been changed to reflect CCG needs, for example - and has undertaken GP satisfaction surveys.

Its FT bid is likely to be supported by commissioners who feel it has recovered after a rocky period (the running of a health centre was criticised in a SHA report - and the trust has recently published a final report). But it withdrew from the tender to run Suffolk community services, losing out to Serco.

The social enterprises

There are three substantial social enterprises providing community services in the area - but even with incomes of £40m or £50m they are dwarfed by the aspirant FTs. Keeping management costs down is likely to be crucial for them.

Central Essex Community Services, with a turnover of around £53m, is the big daddy of them all, although smaller than originally expected as NHS South East Essex decided not to place its provider side within it. It has been in operation for just over a year.

It comes across as the most entrepreneurial of the three and has won a string of contracts outside its original geographical base, now delivering some services in Waltham Forest, Redbridge, South West, and North East Essex and Cambridgeshire and Peterborough.

Only two thirds of its income is now from its main contract with Mid Essex PCT. This diversification puts it in a good position to survive any tendering of services in the Mid Essex area - up to 50 per cent of services could be tendered over the next four years.

It is also building up relationships with CCGs and is ploughing money back into innovative community projects.

Also in Essex is Anglian Community Enterprises, which launched in January 2011 and is a Cabinet Office pathfinder. Its turnover is about £40m and it is based in Colchester and Tendring: it was born out of the North East Essex provider side.

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Director of operations Nicola Carmichael concedes the organisation is just not big enough to do some things as economically as larger ones, and is examining what functions can be done in-house and what is best outsourced. On the clinical services side, it is reconfiguring around GP practices so GPs will only have to deal with one team - a popular move.

The smallest of the three is East Coast Community Healthcare in Great Yarmouth and Waveney which was launched in October last year with a turnover of around £37m.

Its focus since launching last October has been on developing and strengthening services locally - and building up relationships with the local CCG (the two are now in the same building).

Managing director Tracy Cannell will not rule out providing some services over a larger area - it already provides sexual health services across Norfolk - but talks enthusiastically about plans for redeveloping local community hospitals, with an innovative model involving some nursing home beds and work on improving children's services with another local social enterprise. "There are advantages to being small and focused rather than trying to take over the world," she says.

With a chair, three executives and three non executives, plus two staff directors, the governance would be unrecognisable to foundation trusts, she says.

It has made significant cost improvements - without reducing staff numbers - but wants to keep staff on Agenda for Change while looking at other aspects which could improve their job satisfaction (research and development is one way, as is offering incentives - not necessarily financial - for performance). This could pay off down the line as NHS organisations look to squeeze pay and fringe benefits.

Geographical expansion may be the main way for these organisations to grow. But that would seem to offer particular challenges to social enterprises based as they are on employee engagement. Anglian talks of getting its core model right before it considers wider expansion. At Central Essex, John Niland agrees that engagement can be a challenge but believes it is possible: when Central Essex has taken on the provision of services elsewhere he has personally met each member of staff to talk through what CECS is looking for and what it is offering them.

But he says expansion has its limits: there are points beyond which he would not go, either geographically or in terms of size, although a joint venture with another social enterprise might overcome them. And restrictions on the size of organisations allowed to bid for some tenders could rule out massive expansion anyway (the Suffolk tender specified a minimum size).

Taking over another social enterprise is technically difficult - both might have to be dissolved and reformed - but he would want to offer support if one fell into difficulties, he said.

He sees offering integrated pathways as one of the ways to protect the organisation's revenue flow: it prevents cherrypicking. It is difficult for an outside organisation to offer that, if a service were tendered.

But some people argue that the social enterprises will struggle. They may be too small to really utilise economies of scale and yet may still have significant management costs. "Have they got the scale in what is going to be a very difficult market," asks one. "I find it very difficult to see how they will compete. Procuring tenders is very costly and time consuming. You need a certain amount of scale."

Suffolk: the private provider

Staff at NHS Suffolk's provider side have probably had the most difficult time, with a number of options being mooted over the last two years, including vertical integration with an acute trust, a merger with the county council, a social enterprise and, finally, going out to tender. Staff who have been hosted by a Essex mental health trust under a hosting arrangement are now expected to transfer to Serco by October.

It was chosen as preferred bidder ahead of a range of NHS organisations and other private providers who wanted to run some or all of the community services. Theoretically, the process could have led to the services being split between several bidders.

GPs were actively engaged in the decision with CCG members sitting on the board which assessed bids.

Not surprisingly, there are some concerns among staff, according to RCN policy adviser Kellie Norris. "Serco is a big international company with experience of healthcare but it's a big step for them," she says.

Serco has extensive experience in the health field but generally with running particular services such as out-of-hours GP services in Cornwall and prison healthcare. It does have a contract to run Braintree Community Hospital in Essex but has sub-contracted the provision of many clinical services at the hospital. Unions have picked up on this and have been critical of NHS Suffolk's claims that Serco has the capacity and capability to run the Suffolk services.

Serco has said it will be working in partnership with a number of NHS organisations including South Essex Partnership University Foundation Trust - and NHS Suffolk has said in a staff briefing that some jobs will transfer to SEPT and Bedford Community Dentistry. Serco says it will be in partnership to deliver services with these organisations and that this will be its approach to community services both in Suffolk and elsewhere. It also wants to invest and use new technologies to improve accessibility.

But, like all providers, it will be under intense pressure to reduce costs. "We all recognise that delivering more efficient services is a necessity and we believe that this partnership approach will deliver the required savings for commissioners as well as improved services for patients," it said.

Conclusion

So what will provision across the patch look like in a year's time? Community service providers will be looking to prove their worth - often through providing a pathway which reduces acute admissions. Realistically, this is one way of persuading commissioners to push more money in their direction or to limit the savings they will inevitably be asking for. They will be looking at new ways of delivering some of their core services - without transformation, they probably will not see costs reduce or make the efficiency savings needed - and will be acutely aware of what CCGs want.

Judging how some of these organisations are doing, both financially and in terms of service quality, will become more difficult, says the RCN's Ms Norris. Private providers and social enterprises will not have to meet in public and publish board papers the way NHS bodies do - so their finances are likely to be opaque at best. And as SHAs and PCTs give way to CCGs it

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may become harder to monitor performance against quality indicators. “It is going to be much more difficult to scrutinise,” says Ms Norris.

NHS Suffolk says: ”Local scrutiny and public input will continue through the usual channels, through the emerging HealthWatch and the health scrutiny committee and the health and wellbeing board. In addition, Serco, like all providers, will be required to carry out regular patient experience surveys to help improve and shape services.”

One challenge to all of these organisations is any qualified provider. The first services are opening up to AQP now and NHS Midlands and East has been enthusiastic about the opportunities it offers. But there are no great surprises in the services PCTs have selected as their priorities for AQP in the East and most will just nibble at the edges of the big providers at the moment.

Mr Morgan says that the future development of AQP could make it for difficult for organisations to predict income going forward - important for aspirant foundation trusts. It could also be a powerful weapon for CCGs unhappy with current provision although they are likely to try to resolve problems amicably first.

Further tendering of services could change the landscape - though this is likely to be over a longer timescale. In South East Essex, for example, Castle Point and Rochford is the lead commissioner on the contract with SEPT. It is reviewing services, looking at what progress has been made, agree re-targeting, and where duplications are emerging - for example, across acute and community providers.

A PCT cluster statement suggests that community services could change as commissioning priorities are further defined and some services may be tendered. “However, at this stage plans are not sufficiently developed to define what areas might need to be tendered,” it says.

Elsewhere, Serco will be bedding in at Suffolk and, with a £140m three-year contract, will look hard to dislodge, although it will face close scrutiny. It is likely to look closely at any other tenders which come up in the East: many people believe it would like to use the Suffolk tender as a springboard to win others.

Central Essex will be emerging as the social enterprise to watch with a wider client base which would enable it to survive any challenge to its core contract and potentially to pick up other contracts in the region and beyond. It also wants to work closer with social care.

And the aspirant foundation trusts? If they are not on the cusp of foundation status and delivering a healthy surplus, their future could be in doubt. Merger - perhaps with a mental health trust - or break-up could beckon.

Over a longer timeframe - three to five years - there could be a different landscape of fewer larger providers and local niche organisations picking up some work under AQP.