HSJ LOCAL briefing

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NORTH EAST REORGANISATION OF COMMISSIONING

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 The commissioning system in the North East – currently a strongly performing and closely managed system – is being completely reorganised under the government's reforms. Those involved are trying to design functional structures, fill posts and build relationships.

Context Proposed clinical commissioning groups have been formed. While they are progressing well, there is variation in the approach they are taking, and they are quite small. Commissioning support is developing well but questions remain about detail. The role of NHS Commissioning Board regional and local offices' is unclear.

Outcome There are some good leaders in place. However, many key posts remain unfilled and relationships need to be built again. There are also questions about whether structures will function together. It is likely to delay major service shifts to address the region's acute poor health and inequalities and reliance on acute care.

Context

The North East has the smallest population of any of the 10 NHS strategic health authority regions (2.6 million), although it covers a large geographical area, and the smallest budget.

Much of the population is unhealthy relative to the rest of England, with a lower life expectancy and some significantly poor outcomes, although inroads have begun to show on some issues, according to the NHS North East legacy document.

Under the prominent NHS outcomes framework indicator of people's life expectancy at 75, the North East has the worst result of all SHA regions. The region also has the largest proportion of the population reporting a "limiting long term illness". The figure is 22.1 per cent, compared to 20.1 per cent in the North West, the next highest (population health indicators).

The proposed increased focus on outcome indicators in the NHS could bring greater focus on these issues in day-to-day service management.

There is a widely held view, possibly associated with these public health issues problems, that the region is over-reliant on hospital services, with a larger number of beds per population than elsewhere.

The North East's primary care trusts are very small, which caused them to co-operate extensively and early. They effectively formed clusters in 2006 and share several key functions across groups and across the region.

Meanwhile, local acute providers are quite stable and strong (and all of them are foundation trusts), although several are quite small. Key service reconfiguration projects have often been visibly led by FTs rather than by commissioners, for example the redesign of emergency care in Northumbria and proposals for paediatrics by South Tees Hospitals Foundation Trust. Several of the providers have been asked to run the community services in their area under transforming community services.

Service and financial performance have both been very strong compared to other regions in recent years, although what has contributed to this is unclear.

The SHA has had relatively few staff – remaining leaner than others – but has had a fairly hands-on relationship with commissioners and providers in the region. It has also had a very determined focus on and control of delivery in the patch.

The relatively healthy finances of both commissioners and providers mean the consequences of the stopping of NHS budget growth from last year are not as stark as in other areas – none appear to be on the verge of going bust. However, the North East will face the same demand growth as elsewhere, possibly exacerbated by its unhealthy population, meaning the region has to dramatically reduce costs in coming years.

Financial stability may also have

North East CCGs are taking shape

CCG name	PCT cluster	Population	Estimated budget
NHS Northumberland CCG	North of Tyne	321,800	£406.8m
NHS South Tees CCG	Tees	288,800	£390.6m
NHS Durham Dales, Easington and Sedgefield CCG	County Durham and Darlington	287,400	£404.3m
NHS Hartlepool and Stockton-on-Tees CCG	Tees	287,000	£369.8m
NHS Sunderland CCG	South of Tyne and Wear	284,700	£379m
NHS North Durham CCG	County Durham and Darlington	246,300	£302.6m
NHS North Tyneside CCG	North of Tyne	215,300	
NHS Gateshead CCG	South of Tyne and Wear	205,800	£280.5m
NHS South Tyneside CCG	South of Tyne and Wear	154,900	£208.8m
NHS Newcastle North and East CCG	North of Tyne	152,200	£192.2m
NHS Newcastle West CCG	North of Tyne	130,900	£177.9m
NHS Darlington CCG	County Durham and Darlington	105,600	£128m

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been aided by organisations helping each other when necessary, something which may not be so achievable in the new system.

Emerging structure and leadership changes

Clinical commissioning group development is quite diverse, although in general the groups are small, particularly when compared with their predecessor PCT clusters which have operated in some form for six years.

In several areas there had been quite well developed practice based commissioning groups, with a strong identity. In some cases these GP commissioners have maintained small CCGs, for example in Newcastle. In others they have come together into larger groups, such as on Teesside. In Northumberland GPs agreed on a commissioning group to match the shape of the area's current care trust from an early stage.

The CCGs have begun to appoint accountable officers and these are from a mixture of clinical and managerial backgrounds. The managerial leaders, whether as accountable officers or chief operating officers, are generally experienced PCT directors.

Although the CCGs are spread throughout the authorisation waves they appear to be developing at a good pace.

It has been announced that two NHS Commissioning Board local area teams will cover the North East. They are Durham, Darlington and Tees - one of the smaller LATs covering 1.2 million population - and Cumbria, Northumberland and Tyne and Wear, which is larger with a 1.9 million population. Cumbria, Northumberland and Tyne and Wear will also commission specialised services on behalf of the whole North East, which is likely to boost its budget to around £1bn – dwarfing all the CCGs in the region (Local area team budgets).

Most of the senior commissioning leaders in the current system appear to be leaving the system, at least in the North East, rather than moving to CCGs or the local area teams. None of the substantive PCT cluster chief executives have yet taken jobs in the new commissioning system.

Cameron Ward, an experienced and respected commissioner, has been appointed to be director of the Durham and Tees LAT. He has been leading commissioning development in the North since 2011, and has previously held several commissioning posts in the region, although he has also spent time in senior posts in London, including as NHS Barnet chief executive.

As the time of writing, no one had been appointed to lead the Cumbria, Northumberland and Tyne and Wear LAT, although an appointment is expected in the near future.

Less-senior posts in both LATs remain unfilled.

Commissioners in the North East decided at a fairly early stage in the transition process to form a single commissioning support service for the whole region. Although it will serve a larger geographic area than many CSSs, the population is smaller than several CSSs in other parts of the country.

Now it has been announced than an LAT will stretch from Tyne to Cumbria (as well as Northumberland Foundation Trust being contracted to run North Cumbria Hospitals Trust) there is potential for the CSS to also extend in some functions into Cumbria.

A strong leader was appointed earlier this year and was one of the first CSS managing directors to be confirmed on their post by the NHS Commissioning Board. Stephen Childs has previously worked as NHS Hartlepool chief executive, interim chief of the NHS Tees cluster, and managing director of Middlesbrough, Redcar and Cleveland Community Services.

The CSS has developed work on its structure and posts at lower levels, but much is still contingent on national and CCG decisions which have yet to be made.

Developing relationships and challenges

A major area of challenge identified by senior sources in the area is leadership capacity and shake-up. Only the most senior posts in any organisations in the new system have been appointed to, and even some of these have not been filled. Although many of the new postholders have worked in commissioning in the North East, they are still new to roles, and several key leaders are leaving.

The system is therefore in flux as it approaches the planning and contracting round for 2012-13, significantly limiting the ability of CCGs or others to make any major changes. It is also significantly hamstrung by the government's £25 per head management cost limit.

A second major area of challenge is collaboration. The CCGs are smaller – in some cases much smaller – than the clustered PCTs which have led commissioning in recent years. Therefore if they do not work together they will be likely to struggle in negotiations with large providers and fail in efforts to make wide-scale service changes. There is a significant risk that there is less sharing and collaboration, in both processes and functions/roles, meaning that CCGs are weak.

Some post sharing is under way at high levels in groups (for example Mark Adams is designate accountable officer for Gateshead, Newcastle North and East, and Newcastle West CCGs) and senior sources in the area believe the groups will work together, and follow similar joint contracting arrangements to those between PCTs. CCGs leaders are meeting together. However, no formal agreement or formal mechanisms are yet clear.

There is potential for LATs to aid collaboration and step in where CCGs are failing but, as elsewhere, there will be little capacity and it is not clear how they would do so in practice.

The North East CSS could support joint working across the patch, for example through contracting, and spread good practice. It could be effective, but again this is contingent on its role becoming much more developed, and on CCGs requesting this work.

It appears that CCGs will be very diverse in the amount of capacity they have in house, as opposed to that they buy from the North East CSS. For example the Teesside CCGs are intending to have very lean structures – with 10-20 staff – whereas some CCGs for example in Newcastle are planning to have more.

This has the potential to pose difficulties, such as flexing the CSS's structures to different localities, and ensuring sufficient management capacity is available to be shared across the patch.

There has been contact between providers and the emerging organisations; however some relationships appear to be at a very early stage.

Some providers realise that, as the purchaser-provider split is rammed home and as significant service reform is needed, commissioners will have to increasingly take over the lead on service change. However some sources said at present there was no

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clear idea of how relationships may operate in future.

Likely effect on service provision

The presence of the £1bn Tyne, Northumberland and Cumbria LAT may create a strong negotiator, particularly for providers of specialist services – chiefly Newcastle Upon Tyne Hospitals Foundation Trust – which could lead to some service shifts. It could also mean sharing of some services between the North East (mainly Northumberland) and Cumbria is explored more thoroughly.

In general, CCGs' main motivation and determination is likely to be to address the chronic health problems of the population and move investment from hospital services into the community and prevention.

Some of them have determined clinical leaders and their additional drive – and potentially their strength in negotiations – could see them begin to make inroads on these challenges. In particular CCGs may achieve reductions in some referrals and are likely to target bugbears such as consultant-to-consultant referrals, and follow up appointments.

In some areas CCGs have made early moves, working with PCTs, to reshape community services.

However, in their early months and possibly years, a major lack of capacity, combined with uncertainty in structures and relationships, is likely to hamper any significant shifts in service patterns.

In one view, even in the medium term, risks remain that the new system cannot properly function together because of its structural design and the damage done to capacity, relationships and previous co-operative arrangements. Hospital providers would continue to dominate and hamper primary care-led service reform. In a pessimistic scenario, the North East could lose its financial and performance records, as strong system management and co-operation disappear.

Under another view, relationships and formal cooperation will develop quickly . There could potentially be further development of structures, for example to improve joint working. This could see the strength of CCGs used to move investment away from acute care and more quickly address the region's long-standing health problems.