# Commissioning in Cumbria and North Lancashire – supporting delivery of the Clinical Strategies in West, North and East Cumbria, and Morecambe Bay.

## Context

The work of Cumbria CCG is increasingly being undertaken in two distinct systems: West, North and East Cumbria (WNE Cumbria), and Morecambe Bay (covering the populations of South Cumbria and North Lancashire); the latter in partnership with Lancashire North CCG.

Two clinical strategies have been developed across Cumbria and North Lancashire – the Success Regime strategy for health and care services for the WNE Cumbria population, and *Better Care Together* for the Morecambe Bay population. These strategies encompass community based services (including general practice), mental health services and hospital services. All statutory partners have been involved in developing these strategies and the three Cumbria wide organisations – Cumbria Partnership Trust, Cumbria County Council and Cumbria CCG – are full participants in both programmes of work.

Both strategies have integration of heath and care services as a core element, which is likely to lead to the development of Accountable Care Systems in the north and south (see later). The Cumbria Health and Wellbeing Board supports this direction of travel. Both Cumbria and Lancashire North CCGs support this and recognise that such developments will have significant implications for both organisations.

There are a number of reasons for this move towards greater service integration and more specifically the "two system" approach:

- The NHS' Five Year Forward View states that 'over the next five years the NHS will need to dissolve these traditional boundaries', referring to boundaries between general practice, hospitals, mental health services and social care. It goes on to describe mechanisms for achieving this – one of which is the creation of Primary and Acute Care Systems (PACS). It also states that at their most radical PACS 'would take accountability for the whole health needs of a registered list of patients, under a delegated capitated budget - similar to the Accountable Care Organisations that are emerging in Spain, the United States, Singapore, and a number of other countries'. This 'most radical' approach underpins the WNE Cumbria and Morecambe Bay strategies and will re-draw commissioning arrangements as much as it will affect service provision;
- Activity flows from hospital services in North Cumbria go across to tertiary and other specialised providers in the North East of England (particularly Newcastle); flows from Morecambe Bay go down to the North West of England (particularly to Blackpool, Preston and Manchester);
- GP Federations have formed across Cumbria and North Lancashire: with two in the WNE Cumbria area and two in the Morecambe Bay area, with no crossover of membership between the two areas.

- There are a number of wider system arrangement that create a similar north east and north west 'pull', including Clinical Senates, the Academic Health Science Networks, and Health Education England;
- Sustainability and Transformation Plan (STP) footprints have recently been set by NHSE for the Success Regime area of WNE Cumbria, and for the whole of Lancashire and South Cumbria (which includes Morecambe Bay). This provides a further 'pull' for Cumbria CCG into the two systems. The STP focus at present is on planning, but increasingly it will centre on finding system-wide solutions for the wider STP footprint areas. This is already the case for Morecambe Bay and is likely to be the way forward for WNE Cumbria as it links into the Northumberland, Tyne and Wear STP footprint;
- NHS England (NHSE) in addition to setting the STP areas as described has also decided that accountability for commissioning for the population of WNE Cumbria will sit with the Cumbria and North East Area Team, while accountability for commissioning for the Morecambe Bay population (South Cumbria and North Lancashire) will sit with the Greater Manchester and Lancashire Area Team;
- Lastly and perhaps most importantly these 'flows' and structural changes make sense to the clinicians working in Cumbria and also match many of the patterns and links that exist outside of health and social care. Communication, transport and cultural links for the North and East of Cumbria where they flow out of the County focus on Newcastle and the North East; for South Cumbria they flow to Preston and the wider North West, particularly Manchester; while many of the links in West Cumbria are to the North East, the nuclear industry looks more to the North West. Regional television reporting for WNE Cumbria is part of the North East network, and part of the North West network for South Cumbria.

## Commissioning in West, North and East Cumbria

The Clinical Strategy for West, North and east Cumbria is being developed through the Success Regime. Whilst there are a number of imperatives for improving acute services associated with the CQC inspection of North Cumbria University Hospitals Trust (NCUHT), the Strategy is a whole-system one and shares many common features with the Better Care Together strategy; particularly in relation to the Out of Hospital Model and the opportunities which the development of Integrated Care Communities can bring.

As stated earlier due to the North Cumbria system being part of the Success Regime, at the moment it sits on its own as an STP area, which covers by some degree the smallest population in England within an STP area. Cumbria CCG is the only CCG within this STP area meaning it has to take on all the STP responsibilities relating to commissioning; in contrast the average number of CCGs in each STP area in the north of England in 7.4. Whether WNE Cumbria will remain as an STP area in its own right remains to be seen. Given that the proposed solutions for hospital and specialist services in WNE Cumbria require networks to

be built with the North East – particularly into the Northumberland Tyne and Wear STP area – it is likely WNE Cumbria will in time become part of this STP area.

The partners in the Success Regime have begun discussions on creating an Accountable Care System (ACS) and possibly a single Accountable Care Organisation (ACO). The lack of any firm proposals now for the acquisition of NCUHT, whilst having some disadvantages does lead to opportunities for developing an ACS/ACO approach. Discussions are still at an early stage with no firm conclusions, but it seems likely that an Accountable Care System would bring benefits to the area given the need to integrate care in order to deliver the new clinical models and improved clinical and financial outcomes that are desperately needed.

## Commissioning in South Cumbria and North Lancashire

Cumbria CCG and Lancashire North CCG have worked closely with partners in the Morecambe Bay system in developing the Better Care Together strategy and associated clinical models. The two CCGs are also working closely on commissioning services from UHMBFT, but not as yet from other providers. In order to create real service coherence across the Bay the two CCGs have committed to develop a common approach to commissioning all other services for the Bay population.

This collaborative approach is important for a number of reasons:

- It makes best use of scarce commissioning resources: at a time of constrained resources it should avoid the need to 'double up' the commissioning effort;
- It makes more effective use of provider resources: responding to a common commissioning approach, rather than a single provider having to respond to different contract meetings, quality meetings etc;
- It provides a more consistent approach to service developments, commissioning policies etc particularly when seeking to reach a common approach to the population within a defined geographical area.

Currently we have significant duplication of effort across the two CCGs when commissioning for the two CCG populations. Cumbria CCG also has to do things twice for the two systems it covers. Rationalising our effort across the two CCGs would mean we could create two teams – one focusing on the WNE Cumbria and the other on Morecambe Bay.

Although significant improvements have occurred due to our informal approach to collaborative commissioning there are still some significant anomalies that exist. For example the two CCGs have different approaches to commissioning procedures of limited value (one using the North East policies and the other the North West's). Given that these impact on UHMBFT alone it causes confusion for Trust clinicians and for patients.

Integration across the system by 'dissolving traditional boundaries' is also hindered at times by different approaches; for example Lancashire North has joint arrangements with other Lancashire CCGs for the commissioning of mental health services, whereas Cumbria does this alone.

Partners working together in the Morecambe Bay system are on a journey to create an Accountable Care System. This will see organisations in the Bay area working together and over time ceding some individual sovereignty for their current responsibilities into a joint endeavour. Ultimately, this will include the following:

- Working to a common purpose, vision and values
- A single system plan, objectives, initiatives and metrics
- A single capitated budget for the Bay population
- Common leadership teams
- A common platform covering ICT, shared support for improvement and learning, estates
- Common regulation and governance.

Creating a single approach to commissioning for the Morecambe Bay system is an essential enabler for the evolution of an Accountable Care System for the Bay.

## Implications for Future Commissioning

If we accept the proposition that we are moving to some form of integrated Accountable Care System (ACS) in both Morecambe Bay and WNE Cumbria, then there are significant implications for health care commissioning in Cumbria, and to a lesser extent in North Lancashire. In WNE Cumbria in order to deliver the Success Regime strategy it is likely Cumbria CCG will need to develop closer links with the CCGs in the Northumberland Tyne and Wear STP area. For South Cumbria it is important commissioning is brought together with Lancashire North CCG to support progress towards establishing a Morecambe Bay Accountable Care System.

In a fully functioning ACS many of the two CCGs' current responsibilities will be transferred to such a system (such as support for GP practice development, medicines management support, clinical pathway development, informatics development, commissioning of third sector and other services from providers outside an ACS). With a strategic commissioning function (strategic planning, setting outcomes, agreeing a budget for the ACS, and monitoring system performance) being retained by a slimmed down commissioner(s).

The Vanguard programme, for which Morecambe Bay's Better Care Together is a first wave site, was established to accelerate progress towards such new models of care. However, it is now clear that issues such as primary legislation stand in the way of the rapid implementation of an ACS. The 2012 Act does not allow CCGs to delegate commissioning functions to a provider organisation. We are exploring opportunities to move forward on this with NHSE as part of the Vanguard work; but despite national support it does not

appear that a formal resolution to the restrictions of the Act will occur in the near future. This will have implications for north and south systems. It is unlikely that an ACS can be established before April 2018 at the very earliest, so the option of a single leap from our current position into two ACSs from next April is not possible, even if all the due diligence could be completed.

This leaves us with some very practical challenges. Cumbria CCG is facing a significant raft of system and provider challenges across the whole of the County. Having the capacity and capability to provide commissioning leadership and focus to address these issues is vital. The number of CCG clinicians and managers who move between Better Care Together and the Success Regime is causing confusion, a dilution of effort and effectiveness, and causes frustration for both the CCG and its partners. Both are vital programmes of work which provide a real opportunity to deliver answers for our system challenges. However, we must ensure that we can deliver both equally successfully, and at present we risk stretching our limited resources (in terms of capacity) across the two programmes and failing to support either properly. While in the south as already described Cumbria CCG also often duplicates the commissioning efforts of colleagues in Lancashire North CCG. These risks have started to become reality as evidenced in Cumbria CCG's staff and stakeholder surveys as well as in the recent NHSE review of capacity and capability.

Lancashire North CCG faces a similar but different set of challenges. It is the smaller but lead commissioning partner in the Morecambe Bay system. It is working in partnership with Cumbria but often finds it difficult to access the support needed from Cumbria to deliver a joined up approach to commissioning, recognising there is significant pull on Cumbria CCG due to the challenges in the north of the county. Arrangements for representation of the Morecambe Bay system in the Lancashire and South Cumbria STP are also not clear.

We recognise that commissioning arrangements need to change to support rather than hinder the development of the two ACSs. We believe that across the two CCGs we have the capacity to deliver on all our responsibilities and to support the two systems effectively but only if we use our resources, especially our people, effectively. So what is the best way of achieving this?

There are a number of options for how we could move forward. Some involve varying degrees of organisational change. To be clear no one would seek organisational change for changes sake. However, in order to provide the clarity we and our providers need and also to make best use of our workforce we believe change is needed.

We also recognise that all too often we end up focusing on structural change to the detriment of the 'day job', which is commissioning high quality, safe and sustainable services for the people of Cumbria and North Lancashire. However, it is the view of both CCG Executive Teams that doing nothing puts the delivery of our overarching purpose at significant risk.

## Options for Change

The following options do not include a 'do nothing' option as this is not a sustainable option.

1. **More focused informal arrangements**: This involves creating teams at both clinical leader/executive level and below which will focus on the two systems. For the Morecambe Bay system this will involve the continuation of the informal partnership committee between the two CCGs, but with greater clarity especially from Cumbria, regarding which individuals are focused on the south system. For Cumbria CCG some individuals will retain a Cumbria wide focus for county wide issues.

   There is a real question as to whether Cumbria CCG has the capacity to service this way of working. It will still require senior leadership to span two systems and be formally accountable to two NHSE area teams. It could be argued that this approach would be less unsettling for staff, but there is a very real risk it will leave staff with the lack of clarity they already experience.

   Cumbria and Lancashire North CCG would still have their own financial and quality responsibilities although we would try to align these where possible/desirable. Despite this it will still mean there is a significant degree of duplication of effort across the two CCGs and potential confusion for our providers.

2. **Creating a Joint Committee with Lancashire North for Morecambe Bay and a separate "team" for WNE Cumbria**: The two Governing Bodies have agreed in principle to support the Joint Committee approach, pending final agreement on governance arrangements, terms of reference etc. This approach would create two commissioning teams with the two CCGs pooling much of their current management resource, then allocating this so that each 'system population' had a fair share of this resource, while recognising that there are still statutory functions and committees that both CCGs have to provide.

   One Accountable Officer (from Lancashire North) would take the lead for the Morecambe Bay area, working to the Joint Committee; this individual would lead the commissioning management resource allocated to the Morecambe Bay population. Staff would still be employed by their 'home' CCG. The Joint Committee would operate with a budget set by the two Governing Bodies in line with the agreed scope of commissioning responsibilities; financial responsibility and risk would continue to rest with each CCG. Final accountability for commissioning actions would also rest with each CCG, although NHSE have made it clear they would expect the Greater Manchester and Lancashire area team to relate to the Morecambe Bay Accountable Officer and his/her senior commissioning team for routine assurance processes, including quarterly review meetings.

Cumbria CCG would create a separate commissioning team led by the CCG's Accountable Officer to focus on the challenges faced in WNE Cumbria. This would avoid much of the duplication of effort that currently occurs across both systems. Some responsibilities may still remain at a Cumbria wide level, but the proposal would be to keep these to as small a number as possible.

This approach would have the effect of creating another tier of governance within both CCGs, which could prove to be unwieldy. The Joint Committee would have membership drawn from each CCG's Governing Bodies, along with representation from member practices. Each CCG Governing Body in agreeing the committee's terms of reference would need to decide what level of reporting it would require, and whether it would want attendance at its meetings by the 'Morecambe Bay' Accountable Officer. For some Governing Body members there would be a significant increase in the number of meetings they attend.

This option would also require a formal restructure of Cumbria CCG with appropriate staff consultation. It would also require a joint approach by the two commissioning support organisations that currently support our two CCGs. It could also lead to some difficulty for Cumbria County Council, as it would have to relate to two different commissioning teams and Accountable Officers, although to some degree it is already experiencing that through the Better Care Together programme.

3. **CCG boundary change**: This option would alter the boundary of Lancashire North CCG to take on the practices in South Cumbria (ie the practices in the CCG localities of Furness and South Lakes) creating a Morecambe Bay CCG; the practices in the localities of Allerdale, Carlisle, Copeland and Eden would remain in Cumbria CCG. There are a very small number of practices sitting on the border that do not obviously fall one way or the other.

   Clearly, commissioning resources and commissioning budgets would need to move with the practices. This approach would also require a consultation process with member practices in South Cumbria, our stakeholders and a consultation with both CCG's staff. It would also require support from each CCG's Council of Members, Governing Bodies and from NHSE.

   Boundary change would avoid the complex governance arrangements of the Joint Committee approach. It would also provide complete clarity about where accountability and financial risk sits, and clarity about commissioning responsibility – ie for two clearly defined populations. There would be a new challenge for the expanded south CCG in that it would have to relate to two County Councils, but this is not new, as this situation

existed for Morecambe Bay Health Authority and PCT up until 2006. Cumbria Health and Wellbeing Board would now have a membership drawn from two CCGs.

This option would require significant work, at a time when both CCGs are facing a number of other challenges. The question is whether the short term time and energy involved will deliver sufficient benefits in the medium term, to justify this, through more effective commissioning for the two populations.

A further boundary change option would be to alter the boundary of Cumbria CCG to take on the practices of Lancashire North CCG (ie in effect to create a Cumbria and North Lancashire CCG). However, both CCGs do not consider this is a viable option as it does not address the 'two system' issues, and the pull of the south system towards the North West. It is also not supported by NHSE.

It is recognised that both options 2 and 3 bring with them a workload associated with change in governance systems and the need for staff consultation on restructuring, and that this can be a distraction from our already challenging commissioning agenda. No one should enter into significant restructuring lightly. Option 3 also brings other significant workload associated with a formal separation of part of Cumbria CCG.

A decision on boundary change could only be in principle at this stage. There are two routes to boundary change and a very simple note of a preliminary discussion with Capsticks outlining these is contained in Appendix 1. With either route there are significant issues to address before approval including engagement with member practices, local authorities and other key stakeholders as well as formal agreement with Lancashire North CCG and NHSE.

It is also recognised that for option 3 in particular further detailed analysis would be needed in terms of the financial impact (eg levels of spend vs allocation; impact on running cost allowance etc) and quality impact etc. Critically, any decision must have a clear pathway for maintaining and improving patient care for all the populations involved.

## NHS England View

NHS England has a role to play in assessing the ability of a CCG to discharge its statutory functions. They undertake an assurance process for all CCGs and where appropriate can also provide further support, such as through capacity and capability reviews. Ultimately, NHSE can intervene if there is a CCG is failing to discharge its statutory functions or if there is a risk of failure.

NHSE has made it clear informally that its preference is to see the two CCGs change their boundaries, to create a North Cumbria CCG and a Morecambe Bay CCG, but at this point in time are not intending to direct us to do this. The two Directors of Commissioning Operations, who together cover our geographic area, have also indicated that if we choose to explore this option in more detail they will identify resources to support this.

## Conclusion

The destination set by the leaders across the health and care systems in both WNE Cumbria and Morecambe Bay is towards creating two Accountable Care Systems. However, given the restrictions of the 2012 Act this is not an option that can be implemented rapidly and may take some time for a national resolution as this involves primary legislation.

Given this direction of travel, the increasing 'pull' into two distinct systems, the significant improvement and transformation agendas facing both CCGs, and the obvious risk posed to our ability to deliver, we believe that changes in local commissioning arrangements are needed.

Structural change will not in itself solve the challenges we face, but failing to act when we are facing capacity challenges, when both staff and stakeholders are confused by the current approaches is also not the answer. Ineffective commissioning is not good for the health of our residents.

It is our view that the first option of more focused informal arrangements (ie very limited change) will not deliver the clarity either CCG needs, and will not address the capacity issues being experienced particularly in Cumbria.

It is our view that the second option of creating a Joint Committee of both CCGs, while initially appearing attractive, is also not the route to provide the clarity and focus needed by commissioners. This approach would bring with it a complex set of governance arrangements that have the potential to confuse, and also to create significant work for the senior leaders across the two CCGs in servicing these arrangements.

This has brought us to believe that the boundary change option is the one that should be pursued. It is the only option that will bring real clarity in terms of organisational focus along with clear lines of accountability. It also works with, rather than against, the increasing 'pull' by both the regional and national NHS structures to create two new health systems – although some would argue it is just recognising that these systems have always existed and is a return to the natural order. Finally, and most importantly, it is the logical and essential next step for commissioners in preparing for the creation of two Accountable Care Systems. We believe we should seek to achieve this change by 1 April 2017.

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## Appendix 1

**Note of discussion with Gerard Hanratty (Partner, Capsticks) Andrew Bennett and Anthony Gardner – 17th May 2016**

Scope of discussion was linked to potential for CCGs to consider boundary changes under current H&SC Act 2012.

1. Gerard noted that Capsticks had helped NHSE to clarify its thinking on this topic as part of preparations for H&SC Act.

2. He appeared to suggest there are 2 main routes through which a boundary change could take place:
    a) Cumbria CCG initiates a proposal for boundary change and offers practices within South Cumbria to Lancashire North CCG. LNCCG then makes a decision as to whether to accept.
    b) NHSE makes a direction under section 14z21 of the act. GH suggested the drafting of this section had been to respond to significant organisational failure or significant risk of failure. However, he went on to indicate that a direction under this part of the legislation could be presented as consensual rather than punitive. Ie that NHSE and CCGs might agree to use the law to get an improved outcome and avoid risk of failure.

3. Under scenario a) GH suggested that support from both memberships and governing bodies was required. He was explicit that a public consultation would be required to comply with the Act.

4. Under scenario b) a paper with clear evidence/rationale would need to be considered by the NHSE Commissioning Committee and a direction would then be issued. There would still be an expectation of local engagement/agreement but not the level of consultation expected in scenario a).

NB This is simply a note of discussion and should not be relied on as advice from Capsticks.