



Addenbrooke House Ironmasters Way Telford TF3 4NT

## JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

Date	<b>Monday, 24 June 2019</b>	Time	<b>10.30 am</b>
Venue	<b>Shrewsbury Room, Shirehall, Abbey Foregate, Shrewsbury, Shropshire, SY2 6ND</b>		

I am now able to enclose, for consideration at next Monday, 24 June 2019 meeting of the Joint Health Overview & Scrutiny Committee the following reports that were unavailable when the agenda was printed.

### AGENDA No.

	<u>Page</u>
7. <b>Merger of CCGs</b> To receive a presentation from David Evans, Chief Officer, Telford and Wrekin CCG and David Stout, Accountable Officer, Shropshire CCG.	3 - 28
8. <b>Mental Health</b> To receive an update report.	29 - 38

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**SHROPSHIRE AND TELFORD & WREKIN COUNCILS JOINT HEALTH  
OVERVIEW AND SCRUTINY COMMITTEE**

**DATE:** 24th June 2019

**REPORT TITLE:** Single Strategic Commissioner for Shropshire &  
Telford and Wrekin CCGs

**REPORT OF:** Mr David Stout, Accountable Officer, NHS Shropshire  
Clinical Commissioning Group

Mr David Evans, Accountable Officer  
NHS Telford and Wrekin Clinical Commissioning  
Group

**1. RECOMMENDATIONS**

The Joint Health Overview and Scrutiny Committee is asked to note the contents of the report.

<b>DATE:</b>	6 <sup>th</sup> June 2019
<b>TITLE OF PAPER:</b>	Single Strategic Commissioner for Shropshire and Telford and Wrekin CCGs
<b>EXECUTIVE RESPONSIBLE:</b>	David Stout, Accountable Officer, NHS Shropshire CCG David Evans, Accountable Officer, NHS Telford & Wrekin CCG
<b>Contact Details:</b>	Ext:                      Email:
<b>AUTHOR</b> (if different from above)	Alison Smith, Executive Lead Governance & Engagement, NHSTelford & Wrekin CCG
<b>Contact Details:</b>	Ext:                      Email:
<b>CCG OBJECTIVE:</b>	All CCG Objectives
<input checked="" type="checkbox"/> For Information <input type="checkbox"/> For decision <input type="checkbox"/> For performance monitoring	
<b>EXECUTIVE SUMMARY</b>	<p>The purpose of this report is to brief the Joint Health Scrutiny Committee on the recent decision by NHS Shropshire CCG and NHS Telford and Wrekin CCG to dissolve the existing two organisations, with a view to creating one single strategic commissioner across the Shropshire and Telford and Wrekin footprint.</p> <p>In November 2018 NHS England (NHSE) set a new running cost savings target of 20% for CCG's to attain by the end of the financial year 2019/20. Following this announcement in January 2019, the NHS Long Term Plan was published setting out key ambitions for the service over the next 10 years. The long term plan included the requirement to streamline commissioning organisations with typically one commissioner for each STP/Integrated Care System.</p> <p>In response to these announcements and with NHSE support, NHS Shropshire CCG and NHS Telford &amp; Wrekin CCG carried out separate facilitated sessions and then a joint session early in 2019 to begin exploring the appetite for, and mechanisms required, to support closer working. These sessions were positively received and resulted in a firm a commitment to explore the formation of a strategic commissioning organisation to cover the entire county.</p> <p>This report sets out the proposal that both CCG Governing bodies considered and agreed at their recent Board meetings regarding future working arrangements within the context of the likely changes to the NHS</p>

	landscape in the next few years and NHS England's requirements regarding running cost savings.
<b>FINANCIAL IMPLICATIONS:</b>	Future working arrangements will impact on future resources required by the CCG's
<b>EQUALITY &amp; INCLUSION:</b>	No identified impact.
<b>PATIENT &amp; PUBLIC ENGAGEMENT:</b>	Both CCGs will engage with the populations of both Shropshire and Telford and Wrekin as part of this process. The CCGs will be producing a Communications and Engagement Plan to support delivery of this project and a significant part of which, will address the delivery of engagement with the public.
<b>LEGAL IMPACT:</b>	In proposing the dissolution of the existing two statutory bodies and the creation of new statutory body across the whole footprint, the CCGs will be required by NHS England to follow a prescribed process for authorisation of a new statutory body that will ensure all legal requirements are met.
<b>CONFLICTS OF INTEREST:</b>	There are no identified conflicts of interest.
<b>RISKS/OPPORTUNITIES:</b>	Future working arrangements are a key consideration in the financial and clinical sustainability of the CCG's going forward. The project will require risks to be identified via a Risk Register.
<b>RECOMMENDATIONS:</b>	The Joint Health Overview and Scrutiny Committee is asked to note the contents of the report.

## **Joint Health Overview and Scrutiny Committee Meeting 24<sup>th</sup> June 2019**

### **Single Strategic Commissioner for Shropshire & Telford & Wrekin CCGs**

**David Stout, Accountable Officer, NHS Shropshire CCG**

**David Evans, Accountable Officer, NHS Telford & Wrekin CCG**

#### **Introduction**

1. The NHS is now in a period of transition with new emerging concepts of the role of commissioner and provider organisations. CCGs must respond flexibly to the new landscape and consider where best to focus clinical and managerial leadership and how they can adapt and interface with their local Sustainability and Transformation Partnership to transform into a commissioning organisations fit for this future. The recently published NHS Long Term Plan reinforces this direction of travel.
2. In addition CCGs have been tasked with making 20% reductions in their running costs by the end of the financial year, 2019/2020.
3. This report is to brief the Joint Health Overview and Scrutiny Committee on the recent decision by Shropshire CCG and Telford and Wrekin CCG to dissolve the existing two organisations with a view to creating one single strategic commissioner across the Shropshire and Telford and Wrekin footprint.

#### **Report**

4. With NHS England (NHSE) support, Shropshire and Telford and Wrekin CCGs carried out separate facilitated sessions and then a joint session early in 2019, to begin exploring the appetite for and mechanisms required for closer working. These sessions were positively received and resulted in a commitment to explore this further, including the formation of a new single strategic commissioning organisation.
5. In order to ensure it is fit for purpose, remains efficient and effective and can best serve their populations, NHS Shropshire CCG and NHS Telford and Wrekin CCG must consider the most appropriate organisational form for strategic commissioning going forward. Discussions have included both options of closer working; informal working using joint management and collaborative mechanisms whilst still retaining two statutory bodies and the alternative of dissolving the two CCGs and creating one new strategic commissioning organisation.

6. To meet the 20% reduction in running costs\*, the total reduction in allocations between 2018/19 and 2019/20 is £1.218m across both CCG's (£0.775m for Shropshire CCG and £0.443 for Telford and Wrekin CCG). Although the first option has some benefits, it was felt that the efficiencies both CCGs could achieve by stripping out all the duplication of effort, time and staff resource currently used to commission services and oversee contractual performance of the same providers would not be fully realised, as some duplication will still remain.
7. The conclusion of these discussions has been that the second option of dissolution of both CCGs and the creation of a new strategic commissioning organisation across the whole footprint of Shropshire, Telford and Wrekin will realise the following benefits:

- **Strategic**

It will immediately respond to the requirements set out in the NHS Long Term Plan for one strategic commissioner per STP/ICS area by allowing both CCGs to redesign a new organisation that will have the right capacity and capability to commission at a strategic level, but retain the ability to commission more local 'place' level health services building on current models; Neighbourhood working in Telford and Wrekin and Care Closer to Home in Shropshire .

It will also support the development of our Strategic Transformation Partnership into an Integrated Care System ensuring there is one strong commissioner voice with a unified approach, thus ensuring the needs of our diverse populations, particularly with regard to health and wellbeing, health inequalities, the performance of providers and financial balance can be met.

- **Quality**

For patients, the CCGs would expect to see a reduction in variation of access to services and to ensuring consistency of quality through a single set of commissioning, monitoring and decision making processes.

- **Operational**

This option would allow better use of clinical time available to the system by sharing clinical input into pathway design and reducing the duplication of clinical input into decision making processes which are often duplicated.

It will allow the duplication of CCG staff time, that is currently used to undertake the same task twice, for example contracting and overseeing performance of providers, to be focused on other commissioning priorities, i.e. health inequalities/prevention.

There will also be an efficiency saving for providers in that they do not have to deal with two commissioners, sometimes asking for different services or different ways of delivering services, which will release resource into those organisations.

\*The '20%' reduction quoted in the NHSE guidance is based on comparing 2019/20 allocations to 2017/18 outturns adjusting for pay awards , pension changes etc. and assumes that the CCGs are operating within their running cost allocations.

- Financial

Commissioners are required to deliver a 20% reduction in running costs from 2020/21. We have already begun to align teams across Shropshire Telford and Wrekin and this will contribute to the delivery of savings. However, a single organisation will maximise the opportunities to deliver these management savings to the patch through the removal of duplication and the reduction in governance processes in commissioning.

The two CCGs are working collaboratively with the STP to focus on the development of transformational solutions to address the financial pressures across Shropshire, Telford and Wrekin. A single commissioning voice will not only ensure consistency across the patch from a commissioner perspective, but will also provide stronger leadership to these transformational changes through the STP.

- Sustainability

This option would mean one single CCG, with one management team, one governing body and one set of statutory duties for the whole of Shropshire. The arrangements would be stable and permanent, aligning to existing local authority social care, health overview and scrutiny and health and wellbeing board arrangements in Shropshire Council and Telford & Wrekin Council.

Although creating uncertainty for staff in the short term, this option will provide a more sustainable future for our staff in the long term.

It offers the best use of the talent of our current staff and will help to attract high calibre staff in the future, which in turn provides more career satisfaction leading to lower turnover and more productivity.

8. It is acknowledged that it is often inevitable that some of the anticipated benefits of transformational change that were identified at the beginning of a project, may not always emerge or have the transformational impact that was first anticipated. It is for this reason that as part of the authorisation process NHS England will require both CCGs to develop a Case for Change document that seeks to outline in more detail the anticipated benefits, but also disbenefits and mitigation of undertaking the proposed dissolution of the existing CCGs and creation of a new CCG across Shropshire, Telford and Wrekin.

Feeding into this Case for Change document will be planned engagement with our CCG memberships, stakeholders and the public to help identify both additional benefits, but also the risks this change will create, in order to address these through mitigating actions.

We will also develop a Benefits Realisation Plan that will ensure the identified benefits and disbenefits are captured and key performance indicators are used to help us judge, post creation of a single strategic commissioner, whether the anticipated benefits have been realised.



9. At recent CCG Board meetings, the Governing Bodies of both CCGs have given support to the creation of a single strategic commissioner for the Shropshire, Telford and Wrekin footprint.
10. A briefing report has also been presented to Shropshire Council and Telford & Wrekin Council Health and Wellbeing Boards in May and June 2019 respectively.
11. Discussions have taken place with NHS England (NHSE) regarding the considerations for the CCG's in order to make this happen and NHSE have recently published new guidance entitled "Procedures for Clinical Commissioning Groups to apply for Constitution change, merger or dissolution" which are attached at Appendix 1.
12. In moving towards the creation of a single strategic commissioning organisation the following key elements are currently being considered:

Timeline – NHS England's new guidelines have relaxed the timescales for applications to bring commissioning organisations together. Applications must now be made by 30 September preceding the April in which the change would take effect. It is proposed that the CCG support an application by 30 September 2019 with a view to a new strategic commissioning organisation taking effect on 1 April 2020.

Whilst it is acknowledged that there is a significant amount of work involved in the planning, preparation and implementation of this, so far as it is possible, it is also considered that it would be most beneficial to all stakeholders, both internal and external, that this process is managed expeditiously, preferably to conclude for 1 April 2020.

Recruitment of a single Accountable Officer – A key step in forming a single strategic commissioning organisation will be the recruitment of a single Accountable Officer early in the process to oversee its development. This will also include the early integration of the CCGs management teams.

Resources – In line with NHSE guidance the CCGs will need to create a programme management office (PMO) to oversee what will be a significant change programme.

Updates – regular updates will be scheduled to the CCG Governing Bodies, Health and Wellbeing Boards and Joint Health Overview and Scrutiny Committee as the project timelines are developed.

12. In order to meet the challenging timescales set out in NHS England guidance, both CCGs are now focusing on actioning the following:
  - Early recruitment of a single Accountable Officer and the early integration of management teams;
  - Develop a detailed project timetable for the formation of the single strategic commissioning organisation by April 2020; and

- Create a programme management office to oversee the programme and specific work streams to undertake the work required to prepare for dissolution of the exiting CCGs and for the creation of a new statutory body that will meet the criteria outlined in the NHS England guidance on authorisation for CCGs.
- Develop a Communications and Engagement Plan to support the delivery of the project, that will include engagement with the memberships of both CCGs, stakeholders and the public.

As part of the development of a timetable for this work, we expect to schedule regular updates to the Joint Health Overview and Scrutiny Committee on the design of a single strategic commissioning organisation, the design and delivery of engagement with the public and progress against the agreed project timeline.

### **Recommendations**

The Joint Health Overview and Scrutiny Committee is asked to note the contents of the report.

# Procedures for clinical commissioning groups to apply for constitution change, merger or dissolution

NHS England and NHS Improvement

**NHS England INFORMATION READER BOX****Directorate**

Medical	<b>Operations and Information</b>	Specialised Commissioning
Nursing	Trans. & Corp. Ops.	Commissioning Strategy
Finance		

**Publishing approval number: 000441**

<b>Document Purpose</b>	Guidance
<b>Document Name</b>	Procedures for clinical commissioning groups to apply for constitution change, merger or dissolution
<b>Author</b>	NHS England, CCG Assessment team
<b>Publication Date</b>	April 2019
<b>Target Audience</b>	CCG Clinical Leaders
<b>Additional Circulation List</b>	NHS England Regional Directors, NHS England Directors of Commissioning Operations
<b>Description</b>	Policy and procedures to be followed by clinical commissioning groups (CCGs) and NHS England in the circumstances of a CCG wishing to apply to make changes to its constitution or to dissolve or two or more CCGs wishing to apply to merge
<b>Cross Reference</b>	N/A
<b>Superseded Docs (if applicable)</b>	Procedures for clinical commissioning group constitution change, merger and dissolution – Nov 2016; first published October 2015
<b>Action Required</b>	To note
<b>Timing / Deadlines (if applicable)</b>	N/A
<b>Contact Details for further information</b>	Assessment team england.ccgiaf@nhs.net

**Document Status**

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**CCG Improvement and Assessment Framework 2018/19: Technical Annex**

Version number: 0.3

First published: October 2015

Prepared by: NHS England assessment team

Classification: OFFICIAL

This document can be made available in alternative formats, such as easy read or large print, and may be available in alternative languages, upon request. Please contact 0300 311 22 33 or email [england.contactus@nhs.net](mailto:england.contactus@nhs.net)

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## 1 Preface to the revised edition – April 2019

1. This document has been revised from the previous version (November 2016) following publication of the [NHS Long Term Plan](#) in January 2019. The Long Term Plan describes how the commissioning system will continue to evolve and sets out the intention that by April 2021 all of England will be covered by an Integrated Care System, involving a CCG or CCGs working together with partners to ensure a streamlined and single set of commissioning decisions at system level. Some CCGs will want to merge to facilitate this streamlined and integrated commissioning approach, and those considering merger are encouraged to discuss their plans with their regional team, which will provide further advice and guidance.

## 2 Introduction

2. These procedures are to be followed by CCGs and NHS England. They are underpinned by the requirements of the National Health Service Act 2006 (as amended) (referred to from now on as ‘the Act’) and by relevant regulations.
3. Under the Act, NHS England has powers to make transfers of property and staff in connection with variation, merger, or dissolution. The use of these powers is included in the scope of these procedures.
4. NHS England has separate powers which allow it to vary a CCG’s area or membership without an application from the CCG. The application of this power is out of scope of the procedures outlined in this document.

## 3 Equality statement

5. NHS England has a duty to have regard to the need to reduce health inequalities in access to health services and health outcomes achieved as enshrined in the Act. NHS England is committed to ensuring equality of access and non-discrimination, irrespective of age, gender, disability (including learning disability), gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex (gender) or sexual orientation.
6. In carrying out its functions, NHS England will have due regard to the different needs of protected equality groups, in line with the Equality Act 2010. This document is compliant with the NHS Constitution and the Human Rights Act 1998. This applies to all activities for which they are responsible, including policy development, review and implementation.

## 4 Procedure to change a CCG constitution

### 4.1 Background

7. Every CCG must have a constitution. This is a key document for each CCG that sets out various matters including the arrangements that it has made to discharge its functions and those of its governing body; its key processes for decision

making, (including arrangements for ensuring openness and transparency in the decision making of the CCG and its governing body) and arrangements for managing conflicts of interest.

8. NHS England must be satisfied that the constitution complies with the requirements of the Act and is otherwise appropriate. Guidance is available to CCGs [here](#).
9. Section 14D of the Act provides that where NHS England grants an application for establishment, a CCG is established, and the proposed constitution approved under the application process has effect as the CCG's constitution. This means that it is the constitution assessed as part of CCG authorisation that is the constitution on which establishment is based. Any change to the constitution used at authorisation needs to be agreed with NHS England.
10. Section 14E of the Act provides for applications for variation of constitutions. Under section 14E, a CCG may apply to NHS England to vary its constitution (including doing so by varying its area or its list of members). If NHS England grants the application, the variation to the constitution will come into effect.
11. Under section 14J, a CCG must publish its constitution. If the constitution is varied, whether on the request of the CCG or under the powers of NHS England, the CCG must publish the revised constitution. This should be done as soon as is reasonably practical after the CCG receives the relevant approval or decision from NHS England. No requested changes to the constitution can be acted upon until formal approval has been received.
12. NHS England regional teams should be notified of any significant changes, for example, to the leadership of a governing body. Where CCGs are wishing to make significant changes, such as a replacement of the chair of the governing body, any new member, should be subject to a selection process of equivalent rigor as the original member. This will ensure that the new member has the capability to fulfil the role.
13. Section 14A(1) of the NHS Act 2006 requires each provider of primary medical services to be a member of a CCG. As new models of care are developed CCGs should therefore ensure that their membership reflects this and that any amendments this requires to their constitution are made.
14. The CCG's constitution will need to reflect any arrangements for joint and delegated commissioning arrangements. In Annex C of the document [Next steps towards primary care co-commissioning](#) there is a suggested form of words for joint commissioning constitutional amendments, which can be tailored to individual circumstances. CCGs with delegated commissioning must have a committee to manage the delegated functions and to exercise the delegated powers.

#### **4.2 Application process to be adopted**

15. Other than in the circumstances set out in paragraph 16 below, NHS England will consider applications for the variation of constitutions throughout the year. CCGs considering changes to constitutions are advised to discuss their proposed application with the relevant NHS England regional team at an early



stage in advance of submission.

16. Any application for variation which will change a CCG's boundary, or its list of members, must be made by **30 June** so that the change can be reflected in the allocations for the following financial year. Any boundary change will take effect from **1 April** of the following year.
17. Applications requiring boundary changes should list the Lower Super Output Areas (LSOA) codes, and for any proposed practice moves the application should include relevant practice codes. In addition, applications should provide the regional team with a map of proposed changes to ensure that the area remains appropriate.
18. The application should come from the CCG and changes to the constitution made in tracked changes for ease of review by the regional team. The application should already have been discussed and agreed with CCG member practices and stakeholders should have already been consulted at the point of submission of the application.
19. The application should consist of:
  - a. the reason why a variation is being sought;
  - b. the proposed varied constitution with the amended clauses clearly signposted;
  - c. assurance that member practices have agreed to the proposed change(s);
  - d. assurance that stakeholders have been consulted if required;
  - e. a self-certification by the Chair or Accountable Officer, on behalf of the CCG, that the revised constitution continues to meet the requirements of the NHS Act 2006;
  - f. assurance that the CCG has considered the need for legal advice on the implications of the proposed changes, including whether advice has been sought; and
  - g. a complete impact assessment of the changes, which should cover as a minimum the factors required to be considered by NHS England set out below.
20. A checklist of requirements for constitution changes can be found at Annex A. A list of legal requirements for a CCG constitution can be found at Annex B.
21. NHS England may seek clarification or additional information during the period when it is considering applications.

### **4.3 Consideration by NHS England of the proposed variation**

22. [\*The Act and the National Health Service \(Clinical Commissioning Groups\) Regulations 2012\*](#) set out the factors which NHS England must consider when considering an application under this procedure. They are:
  - a. that the constitution meets the requirements of legislation and is otherwise appropriate;
  - b. that each of the members of the CCG is a provider of primary medical services;
  - c. that the area is appropriate (i.e. that there are no overlapping CCGs and no gaps);

- d. that the proposed Accountable Officer is appropriate;
- e. that the CCG has made appropriate arrangements to ensure it is able to discharge its functions;
- f. that it has made arrangements to ensure that its governing body is correctly constituted and otherwise appropriate;
- g. the likely impact of the requested variation on the persons for whom the
- h. CCG has responsibility i.e. the registered and resident population of the CCG;
- i. the likely impact on financial allocations of the CCG and any other CCG affected for the financial year in which the variation would take effect;
- j. the likely impact on NHS England's functions;
- k. the extent to which the CCG has sought the views of the following, what those views are, and how the CCG has taken them into account:
  - o any unitary local authority and/or upper tier county council whose area covers the whole or any part of the CCG's area;
  - o any other CCG which would be affected; and
  - o any other person or body which in the CCG's view might be affected by the variation requested.
- l. the extent to which the CCG has sought the views of patients and the public; what those views are; and how the CCG has taken them into account; and
- m. how often the CCG has applied for variations of the kind requested.

23. In addition to these factors, NHS England will consider, where appropriate, how any boundary change will fit with the local Sustainability and Transformation Partnership (STP) or Integrated Care System (ICS), and will consider the CCG's performance, as determined by its annual NHS England assessment.

24. It is for the CCG to determine what information, in addition to the requirements set out in the previous section, should be submitted to help NHS England decide on the application for constitution change. NHS England may ask for clarification or additional information it may require at any stage. Additionally, NHS England may consider any other material in making its decision which it considers relevant, not just the material submitted by the CCG. At all stages the procedure will involve communication between NHS England and the CCG.

25. NHS England will acknowledge all applications for variations within **two weeks** of receipt and will notify the CCG in writing of the outcome of its decision within **eight weeks**.

26. If NHS England thinks that its statutory duties in relation to CCGs make it preferable for it to do so, it may:

- a. where granting the application would have a significant impact on allotments to the CCG in question or other CCGs, defer determination of the application until the later of the end of the financial year in which it was received and the date six months after it was received; or
- b. defer determination until it has received all related applications for establishment or variation from other CCGs.

27. There is no appeal or review process to NHS England's decision.

## 5 Procedure to agree a CCG merger

### 5.1 Background

28. The [NHS Long Term Plan](#) describes how the commissioning environment will continue to evolve and it is in this context that CCGs will operate in future.
29. Building on the progress already made, the NHS Long Term Plan sets out an intention for Integrated Care Systems (ICSs) to cover the whole country by April 2021. It states that: *‘Every ICS will need streamlined commissioning arrangements to enable a single set of commissioning decisions at system level... CCGs will become leaner, more strategic organisations that support providers to partner with local government and other community organisations on population health, service redesign and Long Term Plan implementation.’*
30. By 2020/21, individual CCG running cost allowances will be 20% lower in real terms than in 2017/18 and CCGs may therefore wish to explore the efficiency opportunities of merging with neighbouring CCGs.
31. There are provisions under section 14G of the Act allowing for mergers of CCGs, with specific requirements set out in the [CCG Regulations 2012](#). CCGs have a legal right to apply for a merger and there are specific legal factors and further criteria that NHS England will consider when deciding whether to agree the merger. These criteria are set out in section 5.3.

### 5.2 Roles and responsibilities

32. The process to merge two or more CCGs will require the commitment and leadership of the existing CCGs’ governing bodies. The existing CCGs will need to direct sufficient resources to the merger, including establishing a programme management office (PMO), in recognition that this is a significant change programme. However, the merger should not unduly distract the existing CCGs from business as usual, including delivering core performance standards and achieving financial balance.
33. NHS England will provide information and guidance to CCGs considering merger and will assess the suitability of proposed mergers.
34. NHS England has a statutory duty to authorise any new CCG and will make reasonable requests for information and assurances from the existing CCGs to do so.
35. Following conditional authorisation, NHS England will require reasonable assurance on progress from the existing CCGs throughout the merger preparation process to ensure that all necessary action has been taken to confirm the establishment of the new CCG. NHS England will continue to provide existing CCGs with support and guidance through the merger preparation process, including working with other partners, notably NHS Shared Business Services (SBS) on financial matters and NHS Digital on informatics.

### 5.3 Criteria for merger

36. In accordance with the legal requirements and the NHS Long Term Plan, NHS England will consider the following criteria in deciding whether to approve a proposed merger:

- i. Alignment with (or within) the local STP/ICS: to provide the most logical footprint for local implementation of the NHS Long Term Plan, and to provide strategic, integrated commissioning to support population health. The merger application should briefly set out how the proposed new CCG will work with all other local STP/ICS partner organisations (including **any other CCGs**, in line with the **legal requirements**) and (where relevant) other partner organisations (including other CCGs/providers) outside the existing STP/ICS with which it has significant working relationships. Any CCG merger proposal which crosses existing STP/ICS boundaries may prompt consideration of whether the existing STP/ICS boundaries are themselves appropriate or need to be re-drawn.
- ii. Coterminosity with local authorities: there is a presumption in favour of the proposed new CCG being coterminous with one or more upper-tier county council or unitary local authority. The existing CCGs must demonstrate how the merger would be in the best interests of the population which the new CCG would cover. This is particularly important in any case where the boundary of the proposed new CCG is not coterminous with local authority boundaries. In all cases, in line with the **legal requirements**, the existing CCGs must demonstrate in their application that they have effectively consulted with the relevant local authority(ies) regarding the proposed merger, record what the local authority(ies)' views are, and what the CCGs' observations on those views are. They should also show how they have/will put in place suitable arrangements with local authorities to support integration at 'place' level (population of between 250,000 and 500,000).
- iii. Strategic, integrated commissioning capacity and capability: in line with the **legal requirements**, the existing CCGs must demonstrate that they have/will develop the leadership, capacity and capability for strategic, integrated commissioning for their population. This will include population health management, new financial and contractual approaches that encourage integration, and developing place-based partnerships. In accordance with the **legal requirements**, the application must demonstrate how any commissioning support services to be procured will be of an appropriate nature and quality.
- iv. Clinical leadership: in line with the **legal requirements**, the existing CCGs must demonstrate how the proposed new CCG will be a clinically-led organisation, and how members of the new CCG will participate in its decision-making.
- v. Financial management: in accordance with the **legal requirements**, the existing CCGs must show how the new CCG will have financial arrangements and controls for proper stewardship and accountability for public funds.
- vi. Joint working: ideally, a merger should build on collaborative working between the existing CCGs and represent a logical next step from current arrangements. The merger application should show progress on joint working to date, and must show how the existing CCGs intend to resource and manage the merger process itself.
- vii. Ability to engage with local communities: assurance is required that the move to a larger geographical footprint will not be at the expense of the proposed new CCG's ability to engage with - and consider the needs of - local communities.

- viii. Cost savings: where possible, the existing CCGs should show how collaboration and joint working **to date** has contributed to cost savings; they must also show any further cost savings projected to result from the merger, and when, and how cash released will be re-invested.
- ix. CCG Governing Body approval: the merger application must show evidence of approval for the merger by the Governing Body of each of the existing CCG governing bodies.
- x. GP members and local Healthwatch consultation: evidence is required that each of the existing CCGs have engaged with, and seriously considered the views of, their GP member practices, and local Healthwatch, in relation to the merger. The merger application must record the level of support and the prevailing views of each existing CCG's member practices and local Healthwatch, and the existing CCGs' observations on those views.

#### 5.4 Pre-application activity and the merger application

- 37. CCGs contemplating merger should engage at the earliest possible opportunity with the relevant NHS England regional team, prior to making a formal application. NHS England will work with CCGs to minimise the risk of unnecessary work and to support their engagement with stakeholders and application preparations. The CCGs should make regional teams aware of all existing and planned joint appointments and collaborative working arrangements, e.g. committees in common, which are/will be in place prior to merger.
- 38. The relevant NHS England regional team should indicate promptly to the existing CCGs whether it is supportive in principle of the proposal to merge. If the regional team is supportive, the CCGs are strongly encouraged to start early engagement on the merger with their members, staff, local communities (including through local Healthwatch) and their local authority and provider organisation partners.
- 39. CCG merger applications may be made – and considered by NHS England - at any time of the year. However, mergers may only take effect from the beginning of a new financial year (**1 April**). If a proposal to merge is supported by the relevant regional team, a formal, written application should be made jointly by the existing CCGs to the relevant Regional Director. Formal applications should be made to the Regional Director by **30 September** for the merger to take place on 1 April the following year. *As an exception*, late applications by 31 October 2019 will be considered on a case by case basis where they support implementation of the Long Term Plan. CCGs are encouraged to make an early application to give them sufficient time post-conditional authorisation to work with NHS England and other partner organisations (notably NHS Shared Business Services (SBS) and NHS Digital) on the detailed implementation and preparatory arrangements.
- 40. The Regional Director will acknowledge receipt of the merger application in writing within two weeks of receipt.
- 41. Any application received by the Regional Director after 31 October will be considered for merger the April after next. In this case, following conditional authorisation of the merger by NHS England, the existing CCGs will default to operating (as far as possible) as a single organisation and will have longer to prepare for their formal merger.
- 42. The formal merger application must be signed off by the Accountable Officer for each of the existing CCGs and include a statement of confirmation that the decision to apply for merger has been taken in accordance with each of the existing CCGs' governance

arrangements. More details about the application requirements are shown at Annex C. The application must set out how the proposed merger will meet the criteria for merger and include selected supporting evidence (where appropriate). As part of this, there should be information about the benefits of joint working between the CCGs to date (quantified, where possible, e.g. financial savings) and an outline benefits realisation plan for the pre-merger period and post-merger. This should show the anticipated benefits of the merger, when they are expected to be realised and how they are to be measured/evaluated.

43. Leaders of the existing CCGs will be invited to present their pre-submitted merger application and supporting evidence for scrutiny by a regional panel, which may include, at the discretion of the Regional Director and, only if there is no conflict of interest, leaders from the local STP(s)/ICS(s), to offer their observations. This is an opportunity for 'check and challenge' of written information submitted. If the regional panel and Regional Director make a positive assessment of the merger application following the panel presentation, the decision to approve the application, including determining any specified actions and conditions which must be completed prior to the merger, will be made in accordance with NHS England's Scheme of Delegation. The decision on conditional authorisation will be reported to the next meeting of the Board or at an earlier opportunity.
44. The existing CCGs will be informed of the decision taken in writing by the Regional Director. The decision is final and there is no right of appeal.

## **6 Procedure to dissolve a CCG**

### **6.1 Background**

45. Section 14H of the Act, provides that a CCG may apply to NHS England for the group to be dissolved and for its members to join other CCGs.
46. Key factors set out in the Regulations that NHS England must consider in relation to an application for dissolution are:
  - a. the impact on the local population served by the dissolving CCG of proceeding with a dissolution;
  - b. the financial implications of dissolution to both the CCG in question and other affected CCGs;
  - c. the impact on NHS England's functions; and
  - d. the stakeholder engagement the CCG has undertaken and how the CCG has taken the views of stakeholders into account.

### **6.2 Application process to be adopted**

47. NHS England will consider applications for CCG dissolutions at any time in the year. This is because it needs to ensure that the entire population is always covered by a functioning CCG. Submissions should be made to the relevant regional team.
48. The application should come from the CCG wishing to dissolve. The application should already have been discussed and agreed with CCG member practices and stakeholders, including those neighbouring CCGs which will be affected by the dissolution, should have already been consulted at the point of submission of the application.

49. Applications made under section 14H of the Act must be accompanied by the following:

- a. assurance that all member practices of the CCG have plans in place to join other CCGs;
- b. confirmation that those other CCGs have been consulted and are content with the proposals for new members; and
- c. assurance that other stakeholders have been consulted.

50. CCGs receiving new practices as a result of a CCG dissolution should apply to vary their constitutions in tandem with the application for dissolution and to an agreed common timescale.

### **6.3 Consideration by NHS England of the proposed dissolution**

51. Regulation 9 applies to applications to dissolve a CCG. Schedule 3 to the Regulations sets out the factors to be taken into account. NHS England may also consider any other information which it deems relevant. The factors that must be considered are as follows:

- a. the likely impact of the dissolution on population and patients of the CCG;
- b. the likely impact of the dissolution on financial allocations;
- c. the likely impact of the dissolution on NHS England's functions;
- d. the extent to which the CCG to be dissolved has sought the views of the following, what those views are, and how the CCG has taken them into account:
  - unitary local authorities and upper tier county councils (within the meaning of paragraph 1 (2) of Schedule 1) whose area coincides with, or includes the whole or any part of, the area specified in the CCG's constitution;
  - any other CCG which in the CCG's view would be affected by the dissolution; or
  - any other person or body which in the CCG's view might be affected by the dissolution; and
- e. the extent to which the CCG to be dissolved has sought the views of individuals to whom any relevant health services are being or may be provided, what those views are, and how the CCG has taken them into account.

52. Additionally, on receipt of an application for dissolution NHS England can consider the requirement to apply the failure regime under section 14Z21, and potential need for directions to support the carrying out of the CCG's functions in the period until dissolution takes effect.

53. If only some member practices have agreed plans to move to other CCGs, NHS England will consider whether the residual practices can form a viable CCG. If necessary, NHS England will consider the use of its powers under 14F to vary the membership of a CCG. NHS England will consider this on a case by case basis and in discussion with the CCG.

54. NHS England may refuse an application for dissolution if it is not satisfied that the alternative CCGs would meet the same threshold as required for initial authorisation.

55. NHS England will also assess, where relevant, whether the CCG(s) have ensured that appropriate plans are in place to maintain good information governance

- through the transition, in consultation with local IG Lead(s) – in particular for:
- a. appropriate transfer or disposal of information assets, including manual records and electronic equipment;
  - b. physical audit of premises prior to release;
  - c. review of Data Protection Notification(s); and
  - d. revision to Fair Processing Information.

56. NHS England will acknowledge all applications for dissolution within two weeks of receipt.

57. If NHS England thinks that its statutory duties in relation to CCGs make it preferable for it to do so, it may:

- a. where granting the application would have a significant impact on allotments to the CCG in question or other CCGs, defer determination of the application until the end of the financial year in which it was received and the date six months after it was received, whichever is the later; or
- b. defer determination until it has received all related applications for establishment or variation from other CCGs.

58. In the event of dissolution, the assets and liabilities of the CCG will transfer to the organisation(s) to which the practices within that CCG become members. The dissolving CCG will need to confirm the split of assets and liabilities across practice populations. Where there is a dispute regarding the transfer of assets or liabilities, NHS England will determine the proportions to be allocated to the receiving CCGs. NHS England may make a property and/or staff transfer scheme as appropriate under section 14I of the NHS Act 2006. In the event of CCG functions being taken over by NHS England (as a result of its intervention procedures), any assets and liabilities will be transferred to NHS England proportionate to the functions being discharged.

59. There is no right of appeal to NHS England's decision.



## Annex 1: Checklist for constitution changes

For completion by CCGs – and submission to their regional teams:

CCG name	
Reason for variation	
Have the requested variations been made in tracked change(s) for ease of review by regional team?	
Have member practices agreed to the proposed change(s)?	
Have the relevant stakeholders been consulted (if required)?	
Has the Chair or Accountable Officer confirmed that the revised constitution meets the requirements of the Act on behalf of the CCG?	
Have you considered legal advice where necessary?	
Have you completed an impact assessment of the changes to be considered by NHS England?	
Have you included practice codes for any proposed practice moves if applicable?	
Have you included LSOA codes for any proposed boundary changes if applicable?	
Have you included a map as part of your submission?	

## Annex 2: Legal requirements of a CCG constitution

The full requirements of what a CCG must and may include in its constitution are provided in [Schedule 1A Part 1 of the 2006 Act](#) (as amended.) The essential legal requirements are listed below.

Name	
Members	
Area	
Arrangements made for discharge of functions including terms and conditions of employees	
Procedures for making decisions	
How to achieve transparency about decision making	
Arrangements to be made for discharging its functions under Section 140 of the Act, i.e., the requirement upon the CCG to maintain registers of interest, publish those registers, ensure anyone affected declares conflicts or potential conflicts of interest and have regard to any guidance issued by NHS England on <a href="#">conflicts of interest</a> .	
Effective participation by all members	
How the governing body will operate	
Arrangements for the appointment of the audit and remuneration committees	
Governing body decision making processes	
Provisions for public meetings	

## Annex 3: Merger application requirements

*The merger application should be clear and concise.*

*The application should include the following:*

1. **Summary case for change document** (no longer than 15 pages), to include:
  - signatures of the existing CCG Accountable Officer(s) and a declaration that the decision to apply for merger is made in accordance with each of the existing CCGs' governance arrangements
  - the proposed new CCG name (to comply with the CCG Regulations 2012 (3) to (6))
  - map(s) and population details; reference to current health outcomes and health inequalities
  - reference to the PSED (Public Sector Equality Duty) impact assessment for the proposed new CCG
  - the reasons for the application (to comply with the CCG Regulations 2012 10 (4)) and an outline description of benefits of merger, including the impact on the registered and resident population of the new CCG, the impact on STP/ICS partners and any other significant partner organisations
  - summary of joint working to date, including joint appointments, committees in common, lead commissioner arrangements, etc.
  - confirmation of Governing Body support for the merger from each of the existing CCGs
  - reference to the merger communications and engagement plan, including confirmation of engagement of the relevant local authorities, the membership of the existing CCGs and local Healthwatch and consideration of their feedback
  - financial position (current and high-level forecast)
  - reference to any intervention action for any of the existing CCGs (current or past) – legal directions/special measures
  - reference to current status regarding delegated authority for primary medical care services
  - **desirable – as an appendix: joint letter of support from STP leaders for the merger.**
2. **Completed application template (Excel spreadsheet – template to be supplied by NHS England – setting out the merger criteria)** – showing how the application meets the criteria for merger (including legal requirements), and signposting to the supporting evidence.
3. Outline benefits realisation plan – what benefits are expected to be realised from the merger? To include high level view on impacts on population health and financial savings. Identify baseline measures to enable evaluation of benefits post-merger.
4. Impact assessment of the proposed CCG's Public Sector Equality Duty (PSED) including the protected characteristics (Authorisation criteria, Equality Act).

**For the proposed new CCG:**

5. High level HR/OD strategy – showing how key capacity and capability requirements will be met to provide an effective integrated strategic commissioning function, and locality place-based commissioning.

6. Procurement plan for key support services.
7. Clinical commissioning strategy/population health management plan.
8. Communications and engagement strategy/plan.
9. Financial strategy/plan.

**For the merger process (prior to the new CCG being established on 1 April):**

10. High level merger programme plan, to include:

- resources (financial and staff) (to be) committed by the existing CCGs to the merger
- governance and reporting arrangements for the merger project – SRO, PMO, merger oversight group; external reporting to NHS England
- key workstreams: HR and OD (including recruitment to Governing Body and other key roles), governance for the new organisation (including plan for production of a new Constitution and Standing Financial Instructions (SFIs), finance, informatics, information governance, communications and engagement\*, estates and property (asset management)
- key milestones
- key dependencies
- risks and issues.

11. Merger communications and engagement plan\*, to include:

- stakeholder mapping (with specific reference to CCG member practices, STP leaders and local Healthwatch)
- summary of key activity to date, including any media interest, feedback received, and response to date
- summary of planned future activity.

NHS England may also request additional evidence, so this checklist should be treated as an **indicative** list only. It is also recognised that similar documents may have different titles/descriptions, so flexibility is allowed for this.

In addition, there is flexibility for CCGs to submit additional evidence in support of their application, but this should be kept to a **minimum** – and only included where it adds significant value to the case for merger.

# Agenda Item 8

**Agenda item:** Enclosure Number TBC  
**Shropshire CCG Governing Body meeting:**

Title of the report:	Update on the BeeU (0-25 year's old) Emotional Health and Wellbeing Service
Responsible Director:Melanie Please accept my apologies for this evening's meeting. steve	Fran Beck, Director of Commissioning (T&WCCG), Dr Julie Davies, Director of Performance & Delivery (SCCG)
Authors of the report:	Steve Trenchard, Programme Director Mental Health
Presenter:	Frances Sutherland, Steve Trenchard, Steph Wain
<b>Purpose of the report:</b> The purpose of this paper is to provide the Joint Overview and Scrutiny Committee with an update on progress made in relation to the required improvements following the Intensive Support Teams visit to the service leading to an action plan agreed by system leaders in October 2018.	
<b>Key issues or points to note:</b> <ul style="list-style-type: none"><li>• There is now improved system wide governance over the BeeU service (with membership from the mental health trust, both local authorities and CCGs which reports to the Clinical Quality Reporting Meeting (CQRM)).</li><li>• This group has been meeting between CQRMs to provide additional assurance to CQRM about the actions being delivered in response to the IST report.</li><li>• MPFT have delivered additional clinics for physical health screening to those children and young people (215 in total) which had not had them. There have been no concerns raised regarding the physical health of any of the children assessed to date.</li><li>• MPFT are now delivering weekly clinics for all CYP on medication and where physical health checks are required.</li><li>• A communications action plan has been agreed to articulate the Bee U 'offer' to colleagues (including GP's) across Shropshire, Telford and Wrekin.</li><li>• An independent review was undertaken by CCG medication leads and full assurance was obtained on the approach taken to by MPFT.</li><li>• A system assurance plan has been submitted to NHSE.</li><li>• There have been team and partner development days, to agree the specialist pathways and the interdependencies for successful delivery.</li><li>• MPFT have been successful in their recruitment of new staff which has seen the team strengthened in line with a psychosocial model of care commissioned.</li><li>• The CYP LTP (Local Transformation Plan) which is a document which details the system wide improvements required across the whole spectrum of children's care and support was approved by NHS England in November 2018. This is in the process of being rewritten and actions confirmed.</li><li>• An agreed stepped care service model has been proposed.</li><li>• A system application has been made to NHS England to fund two specialist Mental Health in Schools Teams (MHSTs)</li></ul>	

- A system event has been held to explore new models for meeting the needs of Looked After Children (LAC)
- Concerns remain about the numbers of children with neurodevelopmental disorders who are on waiting lists for assessment of their needs.

**Actions required by Governing Body Members:**

The Joint Overview and Scrutiny Committee are asked to note the contents of this update and receive assurance that appropriate steps have been taken, and continue to be taken, to continue to make the improvements identified.

**Monitoring form**  
**Agenda Item:** Enclosure Number

<b>Does this report and its recommendations have implications and impact with regard to the following:</b>		
1	Additional staffing or financial resource implications	n/a
2	Health inequalities	n/a
3	Human Rights, equality and diversity requirements	n/a
4	Clinical engagement Engagement is required with colleagues across health and social care, schools and the voluntary and community sectors.	Yes
5	Patient and public engagement Ongoing engagement is required with CYP and families and health and care colleagues in relation to the development and implementation of new pathways.	Yes
6	Risk to financial and clinical sustainability	No

## Update on the BeeU (0-25 year's old) Emotional Health and Wellbeing Service

Author: Steve Trenchard, STP Programme Director Mental Health

### Background

- 1 Following the Intensive Support Team (IST) visit in the summer of 2018 a system concern was that there were a large number of children without physical health assessments who were on medication. A comprehensive clinical and medication audit of all current cases on medication was undertaken. At that time, of the 715 children remaining on caseload, 32% (215 children) had not had, or had refused to have, full physical health care checks undertaken.
- 2 Additional clinics have since been held and all children have now had full physical health checks completed. There are no concerns about the physical health of any child following assessments.
- 3 The NHS Trust (MPFT) implemented the repeat prescribing SOP (standing operating procedure) and to gain additional assurance of its implementation in May 2019 completed an audit which showed that:
  - a. Physical health testing is now available as part of BeeU pathways
  - b. Clinicians only transfer prescribing responsibility using the agreed documentation and processes.
  - c. All patients where prescribing responsibility remains with MPFT, are reviewed by an independent prescriber, at a minimum of every 6 months. This means that all amber rated children will have been reviewed since October.
- 4 An action plan to respond to all of the actions contained within the IST has been agreed, and is being reported through the Contracting Quality Reporting Meeting (CQRM).
- 5 System wide governance has been strengthened with the establishment of a Children and Young Peoples (CYP) Group which reports into the Sustainability Transformation Partnership (STP) Mental Health (MH) Group. And in addition a task and finish group has been established to provide additional assurance to the CQRM. To date, the progress against the actions in the plan have been achieved, including:
  - a. Recruitment of more staff with wider skill set such as psychology and family therapy.
  - b. Communications plan with focus on clarifying the BeeU offer and engaging with GP's in their locality meetings across Shropshire, Telford and Wrekin. All locality meetings received a presentation and BeeU to return in 6 months.
  - c. Team development days held bringing together partners to contribute to development of the service.
  - d. Continuation of service with Kooth, Healios and Children's Society.
  - e. Workforce plan in progress.
- 6 The medication leads for both CCGs are identifying the numbers of CYP that have been discharged to primary care to determine if they are on medication, and that physical health



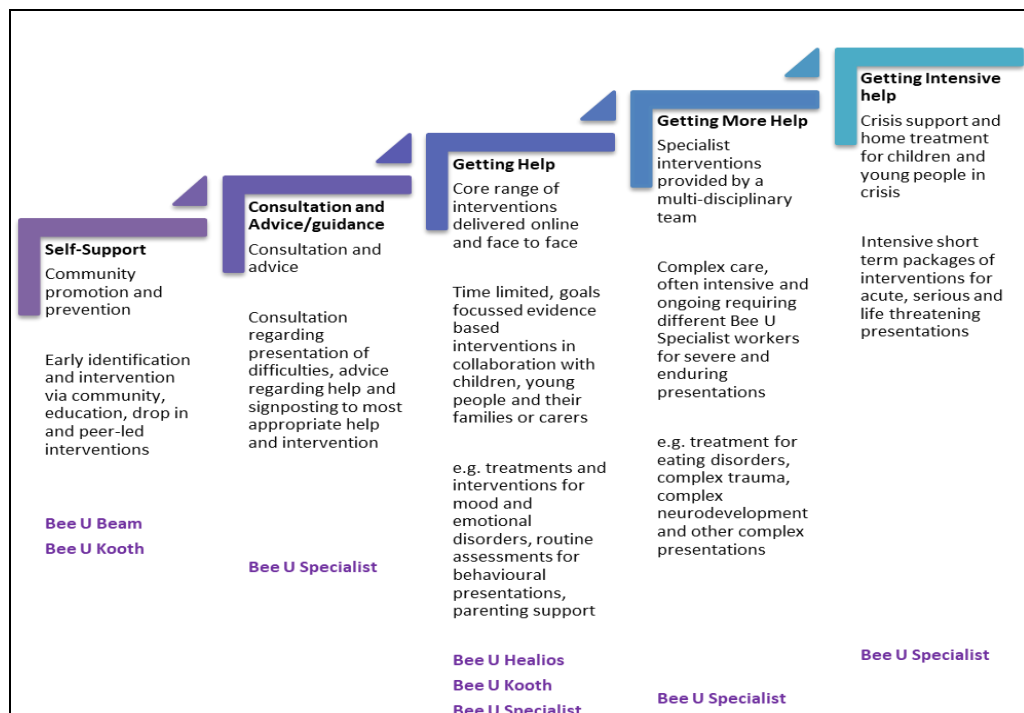
checks have been undertaken. In addition, CCG's and MPFT have renewed the current shared care agreements. This will be completed by end of July 2019.

- 7 In relation to the CYP Local Transformation Plan (CYP LTP) this has received assurance by NHSE and is available to read on both Clinical Commissioning (CCG) websites. The plan will be regularly refreshed to ensure much wider engagement with the workforce and with CYP to ensure the plan is understood, owned and actions are achievable. Additionally the workforce component of the plan needs strengthening, which is underway.
- 8 The CYP LTP follows the 'windscreen of need' which is an established model for describing children and young people's services. The table below illustrates at a high level the nine programmes. Within each of these programmes are specific actions, and it is these that require further finessing and workforce and partnership engagement.

Programme No.	Link to Windscreen of Need	Programme Title
1	Early Identification	Improving awareness and understanding of emotional health and wellbeing in CYP for all CYP, families and professionals.
2		Improved availability and consistency of family information to support children and families.
3	Targeted Prevention	Timely and visible access to appropriate practical help, and support and treatment.
4		Focussing support on vulnerable CYP and their networks
5	Treatment	Evidence-based care interventions and outcomes.
6		Develop our workforce across all services
7	Stabilise and Step Down	Ensure strong partnership working and system wide governance
8		Fully involving Children, Young People and Families
9	Crisis Resolution	Improved crisis care

- 9 An example of an area requiring immediate attention is Programme 4 and 9 where agreement has been reached to undertake a 'deep dive' into Looked after Children (LAC) across both local authorities. A workshop was held on 14<sup>th</sup> June with both CCGs, Local Authorities and MPFT involved where the scale of the challenge to ensure excellent services for LAC was explored. All parties found the event to be helpful in sharing good practice and identifying possible solutions for improved system working and agreement was reached in principle to move at pace to construct a different service offer for LAC.
- 10 The services offering 'lower level interventions' at the front end of the pathways is proving beneficial and there are satisfactory rates of access to the Healios and BEAM services.

- 11 The five year contract for these services included a percentage of the contract values for outcomes and how these are monitored. The work underway on various specialist pathways within a stepped care model is identifying which outcomes will be routinely collated.
- 12 The IST report identified the BeeU service delivery model as a key area of concern, and the action plan focus was to develop and agree a model of delivery for the service going forward, that described a fully integrated BeeU offer and wider engagement with CYP services. The detailed work has produced a draft service delivery model that incorporates the THRIVE principles and a stepped care approach to delivery in terms of expected interventions quality and outcome. This model implements a genuine single point of access, ensures CYP can move seamlessly across pathways without the need for multiple assessments. The stepped care model is shown below:



- 13 The Thrive model is a nationally recognised model of good practice which has been approved by national policy teams. The purpose of the stepped care approach is to provide effective leadership to the whole system (i.e. GP's, schools, community groups, young people and families, etc) that there is a lot that CYP can do to help themselves, and that moving up the steps is a dynamic process starting with consultation and formulation of needs and the next approach to take. Emotional difficulties in CYP should not lead to an automatic referral to specialist Bee U. The move nationally for Child and Adolescent Services (CAMHs) is to enable effective interventions to be available to CYP as close to their homes and schools as possible, without referral into specialist services.
- 14 Further work is required to ensure that the specialist interventions delivered within the stepped model are appropriately described and shared with stakeholders CYP parents and Carers.
- 15 The current draft specialisms need to be standardized, provide a consistent description of service offer, detail the interrelations/dependencies between steps and suggested duration and outcomes.

- 16 The principles of the Thrive Framework, underpinned the workforce modelling along with the opportunity for staff to work across the model. This would increase the skill set of the workforce, allow for more flexibility and reduce rigidity in staff only having a very specific set of skills. This approach is believed to be in the best interests of providing care to young people.
- 17 When considering the proposed model compared to the existing workforce, it can be seen that there are more psychological posts, in line with the Thrive Framework and the necessary move towards a more biopsychosocial model of care. There are more posts at a lower banding to undertake tasks that can be performed at that level but that are currently being undertaken by staff at a more senior level. These posts will be supervised by more senior staff.

### **CYP IAPT (Improving Access to Psychological Therapies) framework principles**

- 18 0-25 BeeU service has signed up to become part of the nationally approved CYP IAPT collaborative. The framework and principles that the collaborative provides offers a clear structure under which to continue to develop the BeeU service providing wider access to good practice and support via Collaborative Board meetings. As part of the collaborative there needs to be a local CYP IAPT Steering Group, Project Plan for CYP IAPT. Support has been offered via the regional support team to provide Transformation workshop – ½ days on the CYP IAPT Transformation principles for the wider workforce.
- 19 The offer also includes Thrive workshop- to focus on the prevention and getting help elements of Thrive particularly with the wider workforce. Plus support to implement Routine Outcome Measures (RoMs) and develop quarterly reporting. Utilizing this framework would support the continuation of the focus that has been developed and provide the assurance that the work still required is completed. There is significant synergy between the CYP IAPT framework and the areas of work that have been undertaken so far, work that now needs to continue to be developed further to see the quality interventions and effective outcomes for CYP.

### **System Learning Event**

- 20 Held on 21st March 2019 the event enabled honest and open discussion to take place reflecting on procurement, contracting, performance management and relationships. The event also had the benefit of hearing from a senior independent researcher who had undertaken evaluation into the service from April 2017.
- 21 The meeting reflected on how together the 'system leadership' had failed to really listen to the issues facing this service which had been 'known' for a number of years. When the issues were named in detail the commissioning response was to increase its focus on assurance and scrutiny, where perhaps an appreciative approach might have been more appropriate to gain a deeper understanding of the issues. The findings from the independent evaluation highlighted that this is a very difficult and complex area of healthcare. The experience of a similar service in Birmingham was that it had also struggled and has taken nearly five years to achieve the 0-25 years model – it is very different to traditional CAMHS. It requires mature and balanced leadership for the required changes to be made.

- 22 The learning event highlighted the following:

- a. Procurement - Generally a good co-produced process leading up to procurement but last minute changes to the model of delivery saw provider status change with little time for the necessary full due diligence to be undertaken. Aspiration for new model became diluted as continuing issues with long waiting list continue and other quality issues emerged.
- b. Contracting - Outcomes based contract still not realized and original contract not supported by detailed modelling of need against JSNA. Contract mobilisation was not clearly established in transformation plan with clear milestones. Therefore contract management function lacked focus and became transactional – same system behaviours produced continuation of long standing problems.
- c. Performance Management - The expectations held by commissioners for the transformation of the existing service into the new model were very high and in hindsight, unrealistic. The decision to move to one provider over the prime model resulted in processes that were carried out in haste, with the result that business as usual continued, reinforced through transactional contract management arrangements.
- d. Innovation - There were aspects of the new service which demonstrated the innovation sought such as the new partnership between Kooth, Healios and Beam to meet emotional needs of CYP. However, the longstanding service issues within the service stifled innovation which resulted in:
  - i. The new model not being shared or communication.
  - ii. Loss of important features of the model in order to stabilize
  - iii. Little or no innovation up to time of IST visit

23 From October 2018 to now the following has occurred:

- i. New model of care agreed – MDT with evidence based interventions
- ii. New clinical information system
- iii. Joint training with LA staff
- iv. Improved ESCA's, reduced locums, more psychologists
- v. Major organizational development (OD) support for BeeU team
- vi. Workforce modelling
- vii. Waiting list down apart from for those CYP with neurodevelopmental needs

24 In relation to the last bullet point above, there is within the service an unacceptable waiting list for children with possible neurodevelopmental disorders (such as autism spectrum disorders) awaiting assessment. The commissioners are aware of this, and are in discussion with MPFT to consider a number of potential solutions. The waiting list was transferred when the service was recommissioned and has since grown. The main challenge relates to recruiting the right staff to undertake the required assessments in line with NICE Guidance.

## **Relationships**

25 In the mobilisation period the relationships between commissioners and the provider became strained. The impetus to continue with business as usual (especially waiting list reduction) outweighed the capacity to undertake the transformation envisaged. The expectations for change were seen as unrealistic in light of the new information that came to MPFT regarding systems, culture, workforce morale and the requirement to undertake TUPE at pace. There was loss of memory and knowledge to the system.

- 26 The challenge now facing the 'system team' is how to move from leadership behaviours characterized as 'transactional' to 'transformational' within a refreshed governance and assurance process. This is likely to require changes for individuals, teams and processes to enable the dialogue and commitment we heard during the event to become a reality. The recommendations have been shared with Shropshire CCG Quality Committee and the Executive Team and NHS England Assurance Team.
- 27 The findings concurred with an internal audit which highlighted issues around key personnel changes had resulted in loss of organizational memory, poor contractual grip following the contract transfer and slow mobilisation by the provider.

## **Summary**

- The Overview and Scrutiny Committee is asked to note the progress made following the IST visit.
- Whilst progress has been achieved in relation to waiting lists there are still too many children where there are unacceptable waiting times in the neurodevelopment pathways. This is a national problem given the very specialist teams required, the changes to the pathways since the service was commissioned, and a business case to understand this more fully has been developed.
- Prescribing for children and young people is being reviewed on an individual basis and where appropriate reduced or stopped. The BeeU core team have systems in place that alert the team when appointments are missed and when medication needs to be reviewed.
- All pathways have been developed and written and an implementation plan considered at the June contracts meeting.
- The service has agreed to link to the CYP IAPT
- The workforce plan has been developed and will be refreshed in line with Health Education England guidelines..
- All pathways will be subject to capacity and demand analysis to determine the current whole service demand and ongoing sustainability.

## **Recommendations**

- 28 The Joint Health Overview and Scrutiny Committee is asked to note the contents of this update and note the progress that has been made to date.

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