

Berkshire West CCG Configuration: A proposal to merge the 4 CCGs into 1, with four localities (from 1 --- April 2018)

1. Introduction

The 4 CCGs in Berkshire West were established with a unique model of governance, working in a federated way. CCGs are clinically led organisations made up of member GP practices. The CCG configuration was primarily driven by the GP practices who comprise the membership and the need to engage closely with local practices. It also supported the establishment of closer working relationships with local government and the three Health and Well Being Boards in Berkshire West, especially important in view of the emerging agenda of integration between health and social care.

The CCGs share the majority of the management team and run joint committees and joint programmes of clinical transformation. The model allows for locally sensitive commissioning to meet the needs of particular populations whilst providing some opportunity to work across Berkshire West where required. The CCGs have operated this way for four years but a number of factors have now prompted them to reconsider this arrangement.

A number of key changes have taken place since the CCGs were established in 2013 which merit review of the current configuration:

- **Changing NHS landscape:** The NHS is now in a period of transition from the structures established by the Lansley Reforms to new emerging concepts of Accountable Care Systems and Primary Care Provider organisations that bring groups of practices together. Whilst no plans to make changes to statutory organisations have been announced, CCGs must respond flexibly to the new landscape and consider where best to focus clinical and managerial leadership.
- The successful Berkshire West drive to develop an **Accountable Care System (ACS)** along with the ambitious programme of reform outlined in the NHS Five Year Forward View requires a shift in focus for senior management and clinical leaders and it is felt that in this context, a proposal for a merger of 4 CCGs into 1 should now be explored.
- We are seeing the emergence of **new primary care provider organisations** across the patch and they require managerial resource and support. This can only be provided by refocusing the current management team and it is reminiscent of the period when PCTs assigned resource to shadow CCGs. The CCGs need to review their own configuration in the context of these changes.
- **Financial position.** The financial challenge facing the 4 CCGs is unprecedented with a £25m QIPP target in 17/18. In this context it is necessary to make the best use of every pound and there is a responsibility to hand on a strong financial legacy to new organisational forms. One of the duties of CCGs, where the Accountable Officer must specifically ensure compliance, is the duty regarding effectiveness and efficiency. "Each CCG must exercise its functions effectively, efficiently and economically." The CCGs have invested in a team to support primary care as part of the delegation of commissioning responsibility from NHS England without any transfer of resource. This has put pressure on the CCGs' running cost budget and a merger would alleviate that.
- The **integration of health and social care.** In the period since CCGs were established there has been good progress in joint working with our three local authority partners. In addition to strong locality working, the system also works on a Berkshire West footprint through the BW10 Delivery Group and Integration Board.

In the light of these factors a case for change to the CCG configuration was considered by the four Councils of Member Practices to whom decisions on CCG configuration are reserved. The fifty member practices of the four CCGs were asked to vote on the proposal to create a single CCG with four localities and the proposal was supported.

2. Merger Benefits

✚ **Strategic:** A merger will support the development of the Berkshire West Accountable Care System and enable sharing of commissioner and provider clinical input into pathway redesign and service transformation. As the focus of primary care leadership moves towards **primary care sustainability and delivery of the 5 Year GP View**, the merger will limit the duplicated committee work and allow some resource to be directed to supporting provider alliances and clusters.

✚ **Operational:** There is duplication of effort across the 4 CCGs e.g. servicing of 4 Governing Body meetings, production of 4 sets of plans, monitoring returns and accounts and annual reports. This is seen across many functions including those outsourced to the Commissioning Support Service e.g. IG Toolkit production. Operating 4 CCGs places a considerable additional workload on the team that work across all 4 CCGs at a time when there is an increasing workload required around ACS development and primary care sustainability.

A single CCG with four localities would enable the GP led locality teams to meet as often as they do now but to be liberated from the responsibility of organisational governance and focus instead on the development of clinical services and improving outcomes and experience for patients in their locality.

✚ **Quality:** By merging the 4 CCGs, there will be a reduced focus on assurance on small numbers of outliers against constitutional targets at individual CCG level. This will enable the CCG Quality and Operational teams to have more time to focus on the important issues for the CCG and localities with overall compliance at a Berkshire West level.

Financial: It has been estimated that the cost of the current duplication is between £150k and £200k per annum. Although only a small amount of the resource reduction would be cash releasing, there would be an opportunity to secure better value for money through the redeployment of expensive resource.

Some cash releasing savings can be made to support the CCGs' £25m QIPP target and to prepare for NHS England's plan to reduce NHSE/CCG running cost funding by £150m by 2020/21 (potentially £600k for Berkshire West). A shared back office function is already part of the ACS work programme and the CCGs have already in housed some CSU functions to increase quality and reduce cost with further in housing planned. Furthermore, the work associated with the CCG programme boards has grown significantly and these are now major transformation programmes supporting delivery of the Five Year Forward View and underpinning the ACS programme. As the CCGs move forward with the ACS and an ambitious programme of transformation, the work of the programme boards will gain further importance.

3. The proposed operating model for a single CCG:

The proposed operating model has been designed to retain the features that support close working with member practices, patients and partners in each locality whilst providing efficiency gains and supporting the emerging ACS and primary care providers.

- ✚ **A single Governing Body** with four localities: A structure that retains optimal engagement with GP practices and patients to ensure responsiveness to local health needs, whilst reducing the bureaucratic burden of being 4 separate organisations and ensures a robust separation of duties in order to avoid any Conflicts of Interest as the ACS develops.
- ✚ **Four localities based on the current CCGs:** A structure that maintains and builds on effective working relationships with local government and Health and Well Being Boards and supports the integration of health and social care
- ✚ **Four Councils:** Under the scheme of delegation they would have devolved responsibilities for local decision making and devolved budgets. This model would preserve the levels of engagement that are required for success and is one that is seen operating effectively in some neighbouring CCGs and likely to be adopted by others as CCGs review effectiveness and efficiency.
- ✚ **Retains PMS funding in the localities that will replace current CCGs:** This ensures that commitments made in 2015-2016 are met. With a merger there will be an opportunity to invest differential in the other localities to achieve **parity of primary care funding for PMS and GMS practices** across Berkshire West.
- ✚ **The shared management structure will be supported by local operational teams** as is currently the case and there will continue to be Clinical Management Team/Organisational Leadership Team meetings. It is anticipated that these meetings may have a part B focussing on primary care provider development, but it is essential that the localities continue to help meet the commissioning obligations of the CCG as they evolve over the next years. The locality groups would retain responsibility for:
 - Key decisions and financial management of agreed budgets
 - Locality strategy and vision, bearing in mind the need relate to the Berkshire West ACS
 - Local operating plans that feed into the a single Operating Plan for the CCG in line with NHSE Planning Guidance
 - Development of QIPP ideas, service redesign and quality improvement
 - Development of primary care including the implementation of the GP5YFV
 - Ensuring that services are sensitive to the needs of the local population
 - Prescribing budget and incentive schemes
 - One of the ACS programme boards e.g. urgent care
 - BCF budgets and management of associated locality projects
 - Performance reported at Locality level where it is amenable to influence by GPs e.g. immunisations, screening, GP survey, radiology, pathology, NEL referrals per 1,000, quality premium etc.
 - Actively participating in their Health and Well Being Boards and electing a representative to attend HWB meetings (likely to be the Locality Board Chair)
 - Working with their Healthwatch (they are likely to attend the statutory Board)
 - Participating in Board committees e.g. Quality, QIPP and Finance, but with a focus on avoiding duplication where it does not add value.

4.2 Councils

- There would be a statutory requirement for a single GP council but to retain engagement the proposal is to retain 4 Councils working with the relevant locality group.
- At locality level differential voting could be locally agreed to reflect practice size if required.
- The four locality Councils would come together (possibly twice a year) to share good practice, provide input to the planning process and take those decisions that are reserved to them such as signing off the Operational and Strategic Plan.

4.3 CCG Governing Body

The proposed Governing Body structure ensures that a clinical majority is maintained and is suggested below but this is not yet finalised:

- Accountable Officer
- Chief Finance Officer
- Nurse Director
- Secondary Care Consultant
- 3 or 4 lay members (one for each locality, with one non-voting)
- 1 GP for each of the 4 localities (one being the Chair)
- 1 Operational Director for each of the localities (non-voting)
- Director of Strategy (non-voting)
- Director of Joint Commissioning (non-voting)

The member practices have made a number of proposals with regard to the constitution of the new CCG and the CCGs will work them through a period of co-production to develop the new constitution.

Our key stakeholders should not notice any change in the way we do business but the statutory entity will change to reduce the bureaucratic burden and maximise managerial and clinical capacity

4. Process

The CCGs must obtain approval from NHS England to change their configuration.

The CCGs submission will need to demonstrate that member practices support this change and show that the views of Health and Well Being Boards have been taken into account. Due to the tight timelines some of these processes will need to happen in parallel.

5. Timeline

The proposed timeline for the merger is as follows

Action	Date
Review of draft business case by Clinical Commissioning Committee	April 2017
Council of Member Practices to be briefed on the Merger Option	May 2017
Approval of the final business case by Clinical Commissioning Committee	May 2017
Practices to vote on the Merger proposal	27 July 2017
Submission of expression of interest to NHS England	31 July 2017
Engagement with partners	31 July – 18 th August 2017
Submission to NHSE	18 th August 2017
NHSE Commissioning Committee decision	27 th September 2017
Berkshire West CCG to operate in shadow form	1 October 2017
Merged CCG fully operational	1 April 2018

Annex 1: The Five Legal Factors

Whilst there are provisions under section 14G of the NHS Act 2006 (as amended) allowing for mergers of CCGs, there are specific legal factors that NHS England must consider when deciding whether or not to agree the merger. Each of the five factors has been considered below:

1. Coterminosity with local authorities

There will be no changes to the overall boundary, with the merged CCG having coterminosity with the 3 Local Authorities in Berkshire West.

2. Clinically-led: the new CCG should demonstrate that it will remain a clinically-led organisation, and that members of the new CCG will participate in decision-making in the new CCG.

Strong clinical leadership has been an important feature of the CCGs during the 4 years to date and will have even greater importance over years ahead given the levels of transformational change required across the health and social care system in Berkshire West. The Accountable Care System and the development of sustainable primary care providers involves change supported by high levels of leadership and engagement at all levels throughout the organisations involved. It is proposed that the only reduction in clinician time is as a result of reducing the number of governing body meetings and committees that clinical leads attend and in fact some of the time saved will be reinvested in the transformation programme.

3. Financial management: NHS England will consider whether the new CCG will have financial arrangements and controls for proper stewardship and accountability for public funds.

The individual CCGs currently maintain separate ledgers. However, the overall financial position is managed on a Berkshire West basis with risk sharing agreements in place between the CCGs. The controls and procedures operate in the same way across all CCGs and consolidated reports are produced for key meetings e.g. QIPP and Finance Committee. A move to a single ledger and set of reports should not result in any significant change to the control environment and it will facilitate the management of the position across Berkshire West. It is anticipated that finance resource will be released to support key developments. However, an important piece of work to undertake quickly is to ensure that reports are available at locality level, something that is achieved by local CCGs that operate multiple localities.

4. Arrangements with other CCGs: the new CCG will have appropriate arrangements with others, for example lead commissioning arrangements.

None of the current arrangements will be changed as a result of the merger. It is anticipated that arrangements will develop further under the STP arrangements.

5. Commissioning support: NHS England can take into account whether the new CCG has good arrangements for commissioning support services.

The CCGs share their CSU support and are currently procuring jointly their future support services through the Lead Provider Framework. It is anticipated that the merger would significantly reduce duplication of tasks and the CCG would expect to see a reduced price for support.