CCG mergers learning event

Wednesday 5th June 2019
Welcome to CCG mergers learning event

Dr Graham Jackson
Co-Chair, NHS Clinical Commissioners
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<th>Time</th>
<th>Session</th>
<th>Speaker(s)</th>
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<td>9.45</td>
<td>Welcome and introductions</td>
<td>Dr Graham Jackson (NHSCC)</td>
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<td></td>
<td>Background and context</td>
<td>Julie Wood (NHSCC)</td>
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<td>10.00</td>
<td>Applying to merge – an introduction</td>
<td>Keziah Halliday (NHSE&amp;I)</td>
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<td>10.20</td>
<td>An experience of merging</td>
<td>Helen Dillistone (Derby and Derbyshire CCG)</td>
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<td>Jane Chapman and Lucy Smith (NHSE&amp;I)</td>
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<td>11.00</td>
<td>Break</td>
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<td>11.15</td>
<td>Governance and legal</td>
<td>Gerard Hanratty (Browne Jacobson)</td>
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<td>Arthur Ferry (East Berkshire CCG)</td>
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<td>11.55</td>
<td>Finance</td>
<td>Darran Green (Derby and Derbyshire CCG)</td>
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<td>12.30</td>
<td>Realising the benefits</td>
<td>Helen Dillistone (Derby and Derbyshire CCG)</td>
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<td>Pardip Hundal (NHSE&amp;I)</td>
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<tr>
<td>1.00</td>
<td>Lunch</td>
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<td>Time</td>
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<tr>
<td>1.40</td>
<td>Welcome back</td>
<td>Dr Barbara Rushton (NHSCC)</td>
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<td>1.45</td>
<td><strong>Engagement: working with local authorities, GP members and communities</strong></td>
<td>Dr Paul Johnson (Devon CCG), Danny Webster (NHSE&amp;I)</td>
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<td>2.30</td>
<td><strong>The best of both worlds: working at scale, maintaining decision making in the ‘place’</strong></td>
<td>Anton Obholzer (NHSE&amp;I)</td>
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<td>2.55</td>
<td>Break</td>
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<td>3.10</td>
<td><strong>Organisational development</strong></td>
<td>Viki Wadd (East Berkshire CCG)</td>
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<td>3.35</td>
<td><strong>Q &amp; A panel</strong></td>
<td>CCG speakers</td>
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<td>3.55</td>
<td><strong>Support available</strong></td>
<td>NHSE&amp;I</td>
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<td>3.55</td>
<td><strong>Wrap up and close</strong></td>
<td>Julie Wood (NHSCC)</td>
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Background and Context

Julie Wood
Chief Executive, NHS Clinical Commissioners
• Already seen the number of CCGs reduce since 2013 through mergers – to date there have been ten mergers involving 30 CCGs. Current total = 191 CCGs.

• Many CCGs already have shared management and are working collaboratively

• Reduced running cost allocations - CCGs need to make savings and work differently

• Development of systems; closer integration

• Indications are that there are many CCGs thinking about merging in the next two years
• NHS Clinical Commissioners want to support CCGs to:

  • learn from those who have already been through the process
  • hear from NHS England and Improvement colleagues about the current assurance process and the support available
Applying to merge: an introduction

Keziah Halliday
Director of Oversight & Assessment, NHS England and Improvement
‘Every ICS will need streamlined commissioning arrangements to enable a single set of commissioning decisions at system level… This will typically involve a single CCG for each ICS area. 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.’

NHS Long Term Plan, January 2019
Chair: ‘You were clear that you did not think there would be 42. You were not going to set a number, so you do not have an optimal size.’

Simon Stevens: ‘I am not going to set a number today. This is a conversation we are going to be having with people between now and the autumn as we...sort out what their implementation framework will look like…’

‘So really the question that, pragmatically, has got to be answered by the NHS locally with its partners is “What is the biggest geography that you can have while still retaining the sense of ‘us’?”

Public Accounts Committee – 9 January 2019

NHS England & NHS Improvement
Roles and responsibilities

CCGs
- **Own** and need to **resource** the merger application and preparation processes (merger runs alongside BAU)
- **Collaborate** with each other throughout

NHS England and NHS Improvement
- **Assessment** (legal duty to approve establishment of any new CCG)
- **Support** to CCGs
Features of the application procedure

• Offers flexibility in application timing; deadline – 30 September for merger 1 April

• Supports CCGs to be prepared for change and to operate as new organisations in new health and care systems (not ‘same old, same old,’ but bigger: BUT bigger and different)

• Provides detail on what’s expected – but not be too prescriptive (flexibility)

• Builds in lessons learned from previous mergers
STATUTORY INSTRUMENTS

2012 No. 1631

NATIONAL HEALTH SERVICE, ENGLAND

The National Health Service (Clinical Commissioning Groups) Regulations 2012

Made 21st June 2012
Laid before Parliament 26th June 2012
Coming into force in accordance with regulation 1(1)

The Secretary of State for Health makes the following Regulations in exercise of the powers conferred by sections 14A(4), 14C(3), 14E(3), 14G(4), 14H(2), 14L(6), 14N and 272(7) and (8) of, and paragraph 2(2) of Schedule 1A to, the National Health Service Act 2006(a), and section 304(9) and (10) of, and paragraph 8 of Schedule 6 to, the Health and Social Care Act 2012(b).

Citation, commencement and interpretation

1.—(1) These Regulations may be cited as the National Health Service (Clinical Commissioning Groups) Regulations 2012, and come into force immediately after the commencement of section 25 of the Health and Social Care Act 2012.
(2) In these Regulations—
“the 2006 Act” means the National Health Service Act 2006,
“the Board” means the National Health Service Commissioning Board.
Application criteria

1. System (ICS) alignment – mergers to enable system transformation

2. Coterminal with local authorities

3. Strategic, integrated commissioning capacity and capability

4. Clinical leadership

5. Finance – stewardship and accountability

NHS England & NHS Improvement
Application criteria

6. Joint working

7. Communication/engagement with local communities

8. Cost savings

9. CCG Governing Body approval

10. GP membership and public engagement (Healthwatch)

Application must be signed off by the AO of each of the existing CCGs to indicate that it is made in line with current governance arrangements – check your Constitution!

NHS England & NHS Improvement
Preparing to apply

• Review application procedure, template and other resources on Kahootz (NHS Future Collaboration Platform)

• Dialogue between CCGs and regional teams – expression of interest and ongoing support

• Build on existing joint working

• Engagement with stakeholders – selling the benefits of merger
# High level timeline

<table>
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<th>Step</th>
<th>Key dates</th>
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<tr>
<td>CCGs' single formal application received by Regional Director</td>
<td>By 30 September (31 October by exception)</td>
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<tr>
<td>NHS England regional review panel; decision notified ('conditional authorisation’)</td>
<td>October/early November</td>
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<td>Preparation phase e.g. apply to NHS Shared Business Services to create new ledger, apply to NHS Digital for a new organisation code, prepare a new CCG constitution, GB recruitment</td>
<td>October - March</td>
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<td>Assurance of conditions being satisfied</td>
<td>March</td>
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<td>New CCG established (old CCGs dissolved)</td>
<td>1 April</td>
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An experience of merging: a regional and CCG perspective

Helen Dillistone
Executive Director of Corporate Strategy and Delivery, NHS Derby and Derbyshire CCG

Lucy Smith
Senior Assurance & Delivery Lead, NHS England and NHS Improvement – East of England

Jane Chapman, Head of Assurance and Delivery (Derbyshire), NHS England and NHS Improvement - Midlands
The Derbyshire Experience

Helen Dillistone
Executive Director, Corporate Strategy & Delivery
The four NHS Clinical Commissioning Groups in Derbyshire were:

- NHS Erewash Clinical Commissioning Group (97,545 population);
- NHS Hardwick Clinical Commissioning Group (103,000 population);
- NHS North Derbyshire Clinical Commissioning Group (290,198 population); and
- NHS Southern Derbyshire Clinical Commissioning Group (552,000 population).

Of the above four CCGs, two were in financial deficit.
The Derbyshire STP plan in October 2016 signalled the need for improved organisational efficiencies and best use of the “Derbyshire pound.”

At that time Derbyshire consisted of four CCGs, required to deliver the same statutory responsibilities but doing it in four different ways with four sets of staff structures, governing bodies, duplication etc.

All four CCGs agreed to work more collaboratively and matrix working across functions began to develop.

NHSE provided formal approval to appoint a single AO and CFO in March 17, and advised on the submission of a formal application to merge in May 18.
Drivers for merging

• Organisations already working under one Accountable Officer and Executive Team, with staff working more collaboratively across the CCGs, but still for four separate statutory bodies. Moving to a single organisation allows more integration and focus on delivery of sustainable change.

• Single consistent commissioning focus for Derbyshire, reducing unnecessary variation but still allowing for localism via 8 places, so improving services for our patients.

• Reduce transaction costs and free up resources which can be invested in healthcare and support financial recovery.

• Improved financial management and control; single risk management process and framework.

• Ability to influence service delivery across wider footprint.

• Reduced duplication of effort for CCG and providers.
Timeline

- STP plan in October 2016 signalled the need for improved organisational efficiencies and best use of the “Derbyshire pound.”
- In March 2017 NHSE agreed to the recruitment of a single AO and single CFO for Derbyshire.
- Dr Chris Clayton commenced in post as single AO for Derbyshire in October 2017.
- Governing Body and Committees started meeting as Committees in Common from April 18.
- In May 18 NHSE advised formal application to merge should be submitted.
- Single leadership structure in place by June 2018.
- Clinical leadership is evident at all levels; at Governing Body, Executive, Place Alliance and at work stream/project level.
Timeline continued

• Engagement undertaken with membership, stakeholders and staff.
• Application submitted August 2018, together with commissioning, digital and OD strategies.
• Organisation code request form submitted Sept 2018 including new CCG name.
• Constitution approved 19\textsuperscript{th} February 2019.
• Formal appointment of new Governing Body members including statutory posts end Feb 2019.
• Grant of merger received 13\textsuperscript{th} March 2019.
• Merge date 1\textsuperscript{st} April 2019.
What went well?

- Single AO and single exec team already in place and staff prepared for reorganisation.
- Chairs were supportive, engaged, worked well together and held discussions with the four memberships.
- Dedicated PMO meeting weekly with Executive leadership; weekly updates with NHSE colleagues.
  - Useful to learn from previous CCG mergers.
  - Dedicated internal staff to carry out key tasks i.e. internal finance SBS lead rather than bringing in external resource.
  - Transition Working Group established to enable discussions and act as advisory group to governing bodies.
What were the challenges?

• Timescales; length and clarity.
• Agreeing name of new organisation.
• Financial strategy still in development.
• Quoracy of committees in early stages.
• NHS Digital process.
• Time spent managing the programme.
• Uncertainty for staff.
Lessons learned

• Agree new name of organisation early on.
• Appoint a new Chair or Chair designate early on to support decision-making.
• Don’t underestimate levels of staffing required – some staff will need to work on merger full-time.
• Incorporate benefits realisation planning when starting the process.
• Plan in the time needed to consult/engage with the public.
Roles and Responsibilities - Regions

• Dual role in new regions:
  o Guiding, supporting, challenging CCGs (‘critical friend’) plus oversight of individual merger
  o Oversight and upwards assurance to national team for all mergers in a region
  o Regions require genuine assurance to ensure all necessary action has been taken to authorise establishment of the new CCG (as per merger guidance and timeline)

• Assessment of the suitability of proposed mergers
• Further to conditional authorisation provide support through the process, including working with other partners
• Post merger oversight and support

• Local context is important - each CCG response is different so each merger feels different therefore process and resources may need to be flexed
• Available regional resources and knowledge
  ✓ Local knowledge / relationships to support merging CCGs on day to day basis
  ✓ Links with wider stakeholders including national team
  ✓ Specialist skills and knowledge to support mergers, e.g. Finance / SBS; constitutions; project planning; benefits realisation
  ✓ Detail of new support offer / model emerging - to complement existing regional expertise
Phase 1: CCG Preparation - Options appraisal and engagement

(Depending on local circumstances could be as early as 12 – 24 months pre-merger application. Suggested minimum is 6 months)

• Learn from other CCG mergers – eg: contact other merged CCGs to identify lessons learned
• Identify core project team and secure Executive commitment to capacity required to deliver a new organisation
• Undertake an options appraisal on future state inc. move to single Executive team / structure (if not already in place)
• Identify benefits to the CCG, wider system (inc. STP/ICS), service users and the public for each option
• Consider requirements to address any legal directions and/or Special Measures
• Engage on options with Governing Bodies, CCG membership, local authorities and other partner organisations; LMCs; staff and public.
• Governing Body and membership vote.
• Confirmation internally of preferred option by all CCGs.
• Confirmation of intent to merge to regional office.
• Other things to consider at this stage may be practice moves (if applicable) and its never too early to think about the name of the new CCG!

* Top Tip: Communicate and engage early – you may have less time than you think!
Phase 2: Merger Preparation

• Strong Executive Leadership – CCGs establish PMO & Programme Board
  o SRO and Programme Lead
  o Work-stream leads eg: finance/SBS, HR, comms and engagement, governance, premises
  o Programme governance in place / timeline

• Oversight and assurance processes agreed with region
  o Aligned to local context / need
  o Good communication and added value

• Further benefits realisation planning
• Collating evidence against the 11 criteria
• Development of commissioning strategy, operational model, financial strategy for the proposed new organisation
• Compile evidence for removal of directions / Special Measures (if required)

* Top Tip: Don’t under estimate the level of staffing resources required to deliver the outcomes. Eg: from a finance perspective this will be at a time when involved in planning, contract negotiations and preparation for year end. Dedicated resources needed and not just an add-on to somebody’s role.
Phase 3: Merger Application

• Assure integrity of application
  o Pre-application review with CCGs to assess merger proposal / identify gaps / agree actions

• Application submission to Regional Director
  o Further development / fleshing out of application – CCGs with regional support
  o Strong and timely submission by CCGs: less is more – be succinct

• Regional assessment panel
  o Wide senior representation from CCGs (and wider stakeholders)
  o Tell the story
  o Testing of commissioning strategy, financial strategy, operational model of new organisation
  o Engagement and Consultation plan
  o Project Plan

• Authorisation in principle – subject to any conditions imposed

* Top Tip: Timescales are important - don’t wait for authorisation to progress the project plan eg: CCGs will need to make an application to NHS Shared Business Services for a business case to create a ledger for the new CCG; some things need to happen in parallel – not sequence.
  ‘Phases’ are not linear – they overlap!
Phase 4: Merger Process (i)

• Regional and CCG relationship continues; regular meeting rhythm continues to support technical requirements of merger – checking and assurance prior to submission as required. Period of high activity - regular regional oversight and support:
  o NHS Digital forms to be submitted
  o SBS process and requirements
  o Asset list
  o Staff list
  o Lifting of directions / Special Measures (if appropriate)
  o Plan for and recruitment to statutory roles of new organisation
  o HR/staff engagement & consultation/ESR
  o Design/plan website for new organisation
  o Draft new CCG Constitution (regional support available)
  o Appointment of Chair and AO to new organisation – regional involvement and national approval
  o Delegation agreements

• Risk Review: Regional Director is required to formally highlight risks to merger and mitigating actions to national assessment team
• Conditions Review: Regional Director to formally confirm (if applicable) that merger conditions have been met.

* Top Tip: the merger affects everyone – not just the project team. Be prepared to invest time chasing team members to update project plans, risk logs etc. Merger not the only priority for the majority of staff. Eg: Early dialogue and prep needed in the CCG contracts team for key actions relating to the merger.
Phase 5: Dissolution of old CCGs; new CCG

• Each outgoing CCG will receive confirmation of dissolution and ceasing of operations with a copy of the signed Grant of Merger, signed staff transfer scheme and signed property transfer scheme for said CCG.

• New CCG will receive a copy of the signed Grant of Merger to confirm establishment from 1 April and receives signed staff transfer schemes and signed property transfer schemes for each of the outgoing CCGs.

• New CCG will receive formal notification of approval of the AO appointment to take effect from 1 April.

• New signed delegation agreement issued to the new CCG.

• **1st April - new CCG operational; new CCG website goes live.**

* Top Tips:

• Need to co-ordinate announcements (of new CCGs) with regional / national colleagues and other CCGs merging at the same time; ensure CCG Website and NHS England/Improvement regional pages are updated on the day of merger.

• Keep an eye on migration of accounts and utilisation of new codes etc..... regional contacts can help here.
Phase 6: Post-merger oversight and support

• Establishment of a new CCG is not the end …………………it’s a new beginning
  o New CCG will need to adopt constitution, policies etc......
  o Post merger review helpful to identify and address any issues and ensure all processes effective in new organisation

• Annual accounts and reports will need to be signed off for the former organisations – transitional period for both regions and CCGs
• Establish baseline QoL assessment for new CCG
• Benefits realisation – ensure ongoing review is embedded within CCG governance processes.

• Other CCGs will want to learn from your experience!
Regions:

- Identify the outcome / desired goal and the national deadline and work backwards...
- Keep an eye on changing regional and national guidance / timelines
- Need to take into account national deadlines and build in time for regional review / QA CCG submissions (including clarifications) – this needs to be reflected in CCG project plans
- Don’t forget Special Measures / directions if applicable – need time to collate evidence and request lifting prior to merger
- Work on tasks in parallel and/or advance as much as possible at CCG and regional level
- Need to identify and agree critical interdependencies for region and CCGs
- Critical or tricky tasks will need earlier deadlines
- Flex or bring forward deadlines where possible based on CCG response / lessons learned
- One size doesn’t fit all; we can flex how some of the assurance process works accordingly
- Regions will hold CCGs to account as they need to be genuinely assured.....but ultimately on the CCGs side – enabling and supporting, mutual respect and positive behaviours
CCGs

- CCGs need to own the merger, ensure dedicated merger resources available, and recognise the preparatory and on-going work involved
- Increased focus on benefits realisation – identify the benefits early to inform the case for change
- Don’t stop the work pending conditional or full authorisation – no time to stop!
- Engagement crucial – need to manage messages and expectations and start early
- Need to own process and documentation and allow time for checking / collating before submission to NHS England / Improvement – formal process!
- Early and appropriate escalation by CCG optimises opportunity for support
- Need to be clear on and allow time for internal decision making and sign off
- Identify critical interdependencies (e.g. Chair before AO)
- Work on tasks in parallel/advance as much as possible - buy time for pressure points toward end of process
- Usual constitution change requirements apply (e.g. AO confirmation)
- Don’t forget the smaller things or how BAU activity feeds into merger (e.g. signatories)
- BUT also detail makes people forget the bigger picture!
- Contingencies may be needed!
Break
Mergers: the legal side

Gerard Hanratty
Partner, Browne Jacobson
Reasons and Plan for Change

• What are reasons for looking at merger – is it part of evolving regional strategy for closer working?
• Have you tested/engaged views of GBs and members of CCG on closer working?
• Have you a Case for Change – be it closer working or merger?
• Does the regional system support plan?
• What is plan and how does it address hurdles to overcome?
Working more closely - Options

• Joint Committees – statutory mechanism enabling joint decision making – so 1 decision

• Committees in Common – created solution based on statutory mechanisms working together – separate decisions

• Other – delegate to another CCG, NHS England or LA

• Individuals –
  • A member of the CCG;
  • An employee of the CCG; or
  • An individual specified in the constitution
Merger - a legal view

• Plan how you will consider this option and fulfil day to day statutory functions. (JCCCG/dedicated team)

• Who will lead assessment and what are powers?

• What needs to be done:
  • Factors and Application
  • Due Diligence
  • Policy alignment

• What is allocated resource? (financial, manpower ?)
Merger - Factors (1)

- The constitution meets the requirements of legislation and is otherwise appropriate
- The area is appropriate (i.e. that there are no overlapping CCGs and no gaps, (but what adjacent relationships?))
- CCG has made appropriate arrangements to ensure it is able to discharge its functions
- CCG has made arrangements to ensure that its governing body is correctly constituted and otherwise appropriate
- Likely impact of the requested variation on the persons for whom the CCG has responsibility – so the registered and resident population of the CCG (financial, equity, quality ?)
Merger - Factors (2)

- Likely impact on financial allocations of the CCG and any other CCG affected for the financial year in which the variation would take effect;
- Likely impact on NHS England’s functions;
- 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:
  - any unitary local authority and/or upper tier county council whose area covers the whole or any part of the CCG’s area;
  - any other CCG which would be affected; and
  - any other person or body which in the CCG’s view might be affected by the variation requested.
- Extent to which the CCG has sought views of patients and the public; what those views are; how the CCG has taken them into account
Merger Application - What is needed?

• Reason why a variation is being sought
• Proposed varied constitution with the amended clauses clearly signposted
• Assurance that member practices have agreed to the proposed change(s)
• Assurance that stakeholders have been consulted if required
• 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
• 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
• A complete impact assessment of the changes, which should cover as a minimum the factors required to be considered by NHS England
Consultation

• Duty to involve and consult public (14Z2)
  • Is this a proposal that affects commissioning arrangements?

• Duty to consult local authority (s.244 and The Local Authority (Public Health, HWBs and Health Scrutiny) Regulations 2013) on substantial development (Reg.23)
  • Reg 24 – obligation in reg.23 does not apply to proposal to establish or dissolve a CCG
  • But see merger factors and application
New Model Constitution

• Update and create flexibility for new system

• The Products
  • A model constitution that defines the minimum requirements for CCGs
  • A set of supporting notes that provides explanation, guidance, advice and additional model wording for each section of the new model
  • A new FAQ that replaces the original with updated answers and new questions relevant to current circumstances
Issues to consider

• Clear arrangements for the membership vote which fit with each CCG’s constitution – (Bsol)
• Single Executive team and when to appoint (Derby)
• Working together arrangements (Central Sussex)
• Role and value of lay members
  • Chairing merger committee (BSol)
  • Challenging governance and local input (SYB)
• Preparation to avoid surprises
Key Legal Issues

• Mechanisms for closer working and taking forward merger assessments need to be based in legal framework
• Day to day statutory functions must be exercised
• To consult or not consult – that is the question?
• Due diligence is a necessary evil – no surprises!
• Workforce
• New Constitution flexibility
• Avoid postcode lottery – policy alignment
Any questions?

Gerard Hanratty
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T: +44 (0)7921 685815
Mergers: Governance

Arthur Ferry
Lay Member for Governance, East Berkshire CCG
Experience from East Berkshire merger - Governance

Arthur Ferry – Lay Member (Governance), Audit Chair

Working together to deliver excellent and sustainable healthcare
East Berkshire

- 3 Unitary Authorities
- Population 470,000
- 47 practices
- Diverse populations
- Total Budget £586m
History

- Long standing collaboration across East Berkshire
- 2013 – 3 CCGs formed after Berkshire PCT
  - Individual Governing Bodies and teams
  - Joint Executive Team and some joint support posts
- 2016 – Single management team
- 2017 – Single Governing Body and sub-committees
- 2018 – Formal merger
- 2019 onwards ???
Approach to formal merger

• Internal project group which met weekly
• Financial workstream
  • Continued to meet to transfer closing balances from the legacy ledgers after the merger

Working together to deliver excellent and sustainable healthcare
Governance considerations

- Leadership
- New organisation code – NHS Digital
- New CCG Constitution
- Staff consultation
- Application process for Governing Body members
- Issues related to contract and change letters
- Move all staff to new Payroll
- Policy ratification
- Notification to all Creditors (incl providers) and debtors of organisation code change
- Novation of contracts

Working together to deliver excellent and sustainable healthcare
Finance considerations

- Create new ledger - SBS
- Revenue Resource Limit Issued
- VAT registration
- Bank set up and mandates
- Fixed assets – physical verification
- Payroll, Expenses system, ESR, Pension Auto enrolment and Apprenticeship scheme set up
- Advising NHS BSA prescription prescribing division
- Debtors and Creditors cleansing exercise
- Review of any other periphery systems you may have

*Working together to deliver excellent and sustainable healthcare*
Lessons learned

• Project Team worked well, however it put pressure on the existing staff
• Practice manager on the project team would have helped
• Additional resource should have been allocated to take the lead for the project
• More clarity required between the responsibilities and division of tasks of SBS and CCG at commencement
• Consider cost saving initiatives with caution
Issues experienced

- **Change of Email addresses** - changed shared email boxes for some of the GP practices.
- **Staff information held on ESR** - job title information held on individuals not up to date.
- **GP contract Payment** – One practice was set up on two of the legacy CCGs with slightly different information.
- **Loading of the invoices from the old system** – all the invoices ended on the workflow of one individual
- **P60** - these had to be sent out in May rather than with April pay.
Lay Membership

• Governing Body in Common reduced to 3 lay members (all governance)
• Strengthened their interaction and teamwork but......
• ....disheartened lay members for PPI
• Placed more responsibility on remaining lay members,
  • particularly with the advent of delegated Primary Care Commissioning
So what worked in our favour?

• We had a
  o Single Executive and Management Team
  o Joint Audit Committee for the 3 CCGs
  o Joint Remuneration Committee in Common

• We had been risk sharing since inception

• We retained the locality identity within the unified CCG
  o GP representatives
  o Unitary Authority Representatives
  o Lay Members

• So Members had confidence that they would continue to have a line of sight through to the decision making GB
Questions?

Working together to deliver excellent and sustainable healthcare
Finance

Darran Green
Assistance Chief Finance Officer, Derby and Derbyshire CCG
## CCG Structure

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<th>2018/2019</th>
<th>Population</th>
<th>Total Resources £m</th>
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<tr>
<td><strong>Sourthern Derbyshire CCG</strong></td>
<td>555,378</td>
<td>803.8</td>
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<tr>
<td><strong>North Derbyshire CCG</strong></td>
<td>294,356</td>
<td>477.9</td>
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<tr>
<td><strong>Hardwick CCG</strong></td>
<td>103,783</td>
<td>171.7</td>
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<tr>
<td><strong>Erewash CCG</strong></td>
<td>98,977</td>
<td>150.0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>1,052,494</td>
<td>1,603.4</td>
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<table>
<thead>
<tr>
<th>2018/2019</th>
<th>Population</th>
<th>Total Resources £m</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Derby &amp; Derbyshire CCG</strong></td>
<td>1,053,808</td>
<td>1,622.4</td>
</tr>
</tbody>
</table>
Derbyshire Finance in numbers 2018/19

- 70,000 purchase invoices
- 3,500 sales invoices
- 14,000 journals
- 10,000 code combinations
Key Issues

1. ISFE
2. Reporting
3. Planning
4. Assurance
5. Team Structure
ISFE (Integrated Single Financial Environment)

1. Resource
2. Working with SBS
3. Financial Governance
ISFE (Integrated Single Financial Environment)

Resource
1. Dedicated Resources within the CCG (CCG Project Manager)
2. This was an existing senior CCG member of finance team
3. Additional data input resource
ISFE (Integrated Single Financial Environment)

Working with SBS

1. NHSE sign off of merger required before SBS will engage
2. Weekly Project Manager meetings
3. Monthly Project Board meetings
4. Key tasks
   - Data mapping, cleansing and transfer
   - Data Cutover
   - User setup
ISFE (Integrated Single Financial Environment)

Financial Governance
1. Constitution / SFIs / SoRD
2. Budget holder process
3. Set up Bank / VAT / NI / PAYE
4. Assurance (Committee Structure)
Reporting

1. Internal Reporting
   Focused moved to new CCG structure
2. External reporting
   NHSE – Statutory bodies
3. Annual Accounts
   Single team x 4 Annual Accounts
Assurance

1. Weekly CCG wider merger meetings with a monthly Finance sub-group
2. Weekly meetings with SBS (telephone)
3. NHSE and Internal Audit involved on SBS Project Board
4. Regular reports to GB and Audit Committee
Planning

1. Single CCG Medium Term Financial Plan required for NHSE
2. Single Operational Plan (Activity and Finance)
3. Non-recurrent Merger costs
4. Single Running Cost Envelope 20% savings required in 2020/21
Team Structure

1. Merged Finance teams from 6 months before 31st March
2. Some could work as one CCG others have to retain view on statutory bodies
3. WTE stayed the same but made some senior redundancies
4. Dedicated senior Merger role
5. Dedicated senior Annual Accounts role
Conclusion

1. Bring in dedicated resources
2. Establish finance team ASAP and start to work as one CCG where possible
3. SBS have done this more than once and they are a valuable asset – use them
4. There will be an impact if wider CCG structures are not in place
5. Keep Governing Bodies, Audit Committees and NHSE assured
Any Questions
Benefits Realisation

Helen Dillistone, Executive Director of Corporate Strategy and Delivery, NHS Derby and Derbyshire CCG

Pardip Hundal, Assurance & Delivery Manager, North Midlands – Derbyshire, NHSE
What is it?

“Business change initiatives are about engaging the minds, hearts and values of people in making change happen and achieving shared business results and benefits, and not about possessing new tools, renewing legacy systems or standardising technology to reduce costs.”

Marchand and Peppard (2008)

A **benefit** is defined as:

The measurable improvement resulting from an outcome perceived as an advantage by one or more stakeholders, and which contributes towards one or more organisational objectives.

(Managing Successful Programmes, 2011)

An **outcome**, is defined as:

The result of a change, normally affecting real-world behaviour or circumstances. Outcomes are desired when a change is conceived. Outcomes are achieved as a result of the activities undertaken to effect the change. (Managing Successful Programmes, 2011)
Why do it?

• Brings clarity to the target benefits of a project
• It brings accountability for benefits
• Should be a fundamental part of the merger planning pre during and post phases
• Was it worth the time and effort – has the change really helped to improve services or improve patient health and well-being, as well as providing value for money
• Benefits and disbenefits
Roles

NHSE/I

- Set out expectations
- Provide templates and background information
- Guide and coach
- Point of contact

CCG

- Engage with stakeholders and map benefits
- Complete BR Plan
- Complete Benefits Dependency Map
- Keep the plan ‘live’
How

Engage & Plan
- Identify
- Plan
- Outcomes/ Enablers
- Measurement

Benefits Realisation Plan
- Benefit
- Enabling functionality & actions required to deliver change, realise benefit
- Benefit detail (CR, NCR, PB, Q) & Dis-benefits
- Measurement, baseline
- Stakeholders/ reporting

Benefits Dependency Map
- Vision
- Benefits & Measurement
- Outcomes
- Business Changes
- Enabling Changes
How

1. Identify benefits
2. Identify stakeholders for each benefit
3. Outcomes/enablers
4. Measurement
5. Benefit Type

NHS England and NHS Improvement
Benefits Realisation Plan

- Benefit Title
- Benefit Owner
- Change in Work practice or process/project (Who, start date, due by, Changed State)
- Benefit Type, Constraints, assumptions, risks
- Benefit Measurement (When, How, national/benchmarking data, baseline, current data, value)
- Reporting (Stakeholders, timing)
Benefits Realisation Dependency Map

Enabling Changes
- Development of a single strategic commissioning function across Derbyshire
- Single focus on financial recovery and control
- Rationalisation of estate
- Development of Place
- Development of single clinical leadership model

Business Changes
- Move to model of defining and measuring outcomes for service commissioning
- Creation of a single Governing Body and sub-Committees
- Implementation of a single Derbyshire staffing structure
- Creation of single financial plan, monitoring and management processes
- Move from three to two office bases
- 8 x Place alliances developed with clinical leads appointed
- Clinicians as members of the Governing Body and clinicians working within the CCG driving improvement

Outcomes
- More effective service delivery for patients
- Single and consistent focus on Derbyshire commissioning and increased speed of decision making
- CCG functions and responsibilities undertaken once
- CCG partners working with a single entity
- Improved financial management and control
- Improved integration of staff working for single CCG
- Focus on local patient needs retained
- Ability to influence delivery of service across wider footprint
- Assurance of total focus across all patient needs through joint work of strategic commission and Place

Benefits
- Improved health and wellbeing of Derbyshire population
- Improved cost management in resourcing/supporting single organisation rather than four. Reduced transaction costs free up resources to invest in healthcare.
- Increased team/staff satisfaction and integration.
- Improved collaborative working and communication between staff
- Reduced financial risk, improved stewardship and control

Vision
- To continuously improve and deliver the best possible health and wellbeing for the people of Derbyshire.
Key Learning Points

Process
- Simplified original forms
- Working document not just a tick box exercise
- Measurement
- Governance

Relationship
- CCG to work closely with internal stakeholders and NHSE/I

Contribution/Impact
- Useful tool / visual for presentations to staff, member practices, public

NHS England and NHS Improvement
Questions
Lunch – please return by 1.40
Welcome back to CCG mergers learning event

Dr Barbara Rushton
Co-Chair, NHS Clinical Commissioners
<table>
<thead>
<tr>
<th>Time</th>
<th>Session Title</th>
<th>Presenter(s)</th>
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<tbody>
<tr>
<td>1.40</td>
<td>Welcome back</td>
<td>Dr Barbara Rushton (NHSCC)</td>
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<tr>
<td>1.45</td>
<td>Engagement: working with local authorities, GP members and communities</td>
<td>Dr Paul Johnson (Devon CCG) Danny Webster (NHSE&amp;I)</td>
</tr>
<tr>
<td>2.30</td>
<td>The best of both worlds: working at scale, maintaining decision making in the ‘place’</td>
<td>Anton Obholzer (NHSE&amp;I)</td>
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<tr>
<td>2.55</td>
<td>Break</td>
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<tr>
<td>3.10</td>
<td>Organisational development</td>
<td>Viki Wadd (East Berkshire CCG)</td>
</tr>
<tr>
<td>3.35</td>
<td>Q &amp; A panel</td>
<td>CCG speakers</td>
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<tr>
<td></td>
<td>Support available</td>
<td>NHSE&amp;I</td>
</tr>
<tr>
<td>3.55</td>
<td>Wrap up and close</td>
<td>Julie Wood (NHSCC)</td>
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Engagement: working with local authorities, GP members and communities

Dr Paul Johnson
Chair, Devon CCG
Maintaining localism and working with local authorities

Dr Paul Johnson, Chair - NHS Devon Clinical Commissioning Group

@PaulJohnsonCCG
Where we came from

Two CCGs:

1. Northern, Eastern and Western Devon CCG
   - Population of 900,000,
   - Annual budget of £1.1 billion
   - Three acute and community providers
   - Two mental health providers
   - Two local authorities

2. South Devon and Torbay CCG
   - Population of 250,000,
   - Annual budget of £400 million
   - One acute and community provider
   - One mental health provider
   - Two local authorities
Why merge?

CCGs had been functioning as single for 12 months
CCG would match STP footprint
Maximise economies of scale
Better placed to tackle significant issues

But:
Bigger isn’t always better
# Membership Vote

<table>
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<th>Merge</th>
<th>Don’t Merge</th>
<th>No Vote</th>
</tr>
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<tbody>
<tr>
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<td>59</td>
<td>13</td>
<td>3</td>
</tr>
<tr>
<td>SDT</td>
<td>12</td>
<td>14</td>
<td>3</td>
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<table>
<thead>
<tr>
<th></th>
<th>Merge</th>
<th>Don’t Merge</th>
<th>No Vote</th>
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</thead>
<tbody>
<tr>
<td>SDT</td>
<td>21</td>
<td>6</td>
<td>2</td>
</tr>
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</table>
Our new CCG

- On 1 April 2019, our two CCGs merged to form Devon CCG
- 5th largest CCG in the country
- 130 GP practices

Maintain Localism

- Improve working relationships to SDT level
- Operate locally unless there is a reason not to
Maintaining localism

Four localities, based on acute/community provider footprints
Maintaining localism

Four localities, based on acute/community provider footprints

Each locality is represented by an Executive Director, a local GP and a Non-Executive Director
Maintaining localism

- Four localities, based on acute/community provider footprints
- Each locality is represented by an Executive Director, a local GP and a Non-Executive Director
- Investing in place-based clinical support
Maintaining localism

- Four localities, based on acute/community provider footprints
- Each locality is represented by an Executive Director, a local GP and a Non-Executive Director
- Investing in place-based clinical support
- Develop Local Care Partnerships
System Priorities

1. Accelerating the **digital** opportunities for the system
2. Development of an **acute strategy** for Devon and Cornwall
3. Piloting the implementation of the national community models for **mental health**
4. **Addressing inequalities** by ensuring resources are deployed in line with strategic ambitions and population needs and outcomes
5. Investment in **prevention** to support people’s needs in better ways, alternative to traditional care settings, to impact on demand in 2019/20

Plus two additional areas of focus:

• Implementation of the **Integrated Care Model** (ICM) blueprint, which will also help to stabilise primary care and impact on demand
• Implementation of the **workforce strategy**
Working with local authorities

Strategic Commissioning Partners

• Integrated Commissioning Executive
• Joint Health and Wellbeing Boards
# Joint health and wellbeing strategies

### Devon
1. A focus on children young people and families
2. Living well
3. Good health and wellbeing in older age
4. Strong, safe and supportive communities
5. Lifelong mental health

### Plymouth
1. Integrated health and wellbeing, promote choice & personal responsibility
2. Addressing health inequalities
3. Best outcomes for children
4. Supporting adults with health and care needs
5. Strong and safe communities
6. Health-enabling transport system
7. Optimising natural environment health benefits
8. Accessible, excellent services

### Torbay
1. Working together to promote good health and prevent illness
2. Best start in life
3. Emotional resilience in young people
4. Create healthy places
5. Support the vulnerable
6. Enable people to age well
7. Promote good mental health

### Common areas of priority between the strategies:
1. Common vision around **reducing health inequalities** and addressing **wider determinants** of health
2. **Mental health** across the life course
3. A focus on **communities**, **housing** and the built environment
4. Giving **children** the best start in life
5. A focus on **living well**, encouraging **health lifestyles** and **prevention**
6. Maintaining **independence** and good health into older age
Working with local authorities

Place based implementation of HWB Strategy

Need for different ‘place’ approach for:
- Joined up health and care commissioning
- Developing joint roles
- Options for pooling budgets
- Opportunities with BCF
Working with Primary Care Networks

• Likely to be 31 PCNs that *almost* fit within our four localities
Working together for Devon

Dr Paul Johnson, Chair - NHS Devon Clinical Commissioning Group

@PaulJohnsonCCG
Engagement

Danny Webster
Senior Manager, System Partnerships, NHS England and Improvement
Best of both worlds: working at scale, maintaining decision making in the “place”

Anton Obholzer
Primary Care and System Transformation Group, NHS England and Improvement
ICSs carry out tasks at the appropriate geographical scale

<table>
<thead>
<tr>
<th>Level</th>
<th>Population size</th>
<th>Purpose</th>
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<tbody>
<tr>
<td>Neighbourhood</td>
<td>~50k</td>
<td>• Integrated multi-disciplinary teams</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Strengthened primary care through Primary Care Networks – working</td>
</tr>
<tr>
<td></td>
<td></td>
<td>across practices and health and social care enabled by Network</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Contract DES</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Proactive role in population health and prevention</td>
</tr>
<tr>
<td>Place</td>
<td>~250-500k</td>
<td>• Typically council / borough level</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Integrate hospital, council &amp; primary care teams/services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Develop new provider models for ‘anticipatory’ care</td>
</tr>
<tr>
<td>System</td>
<td>1+m</td>
<td>• System strategy &amp; planning</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Develop governance and accountability</td>
</tr>
<tr>
<td></td>
<td></td>
<td>arrangements across system</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Implement strategic change</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Manage performance and collective financial resources</td>
</tr>
<tr>
<td>Region</td>
<td>5-10m</td>
<td>• Agree system objectives</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Hold systems to account</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Support system development</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Intervention and improvement</td>
</tr>
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</table>

Each level performs specific functions under the following common headings:
1. Leadership, engagement and workforce
2. Population health management
3. Accountability and performance management
4. Strategy and planning
5. Managing collective resources
Place is the engine room of an ICS (except in the smallest systems)

• Current ICSs report **80% of the work is to be done at the place level** (including neighbourhoods)

• Typically the **system level will focus on** setting system wide outcomes, **holding the ring on system control total and oversight** delivery, and **horizontal acute integration** for service sustainability

• And the **place will typically determine** how **integrated population health and care models** will be delivered

NHS England and NHS Improvement
Decision making at place reflects a move away from traditional NHS commissioning and care models

1. The **traditional NHS commissioning model is being replaced** by health and care commissioners and providers (including VCS) coming together using an MoU/alliance agreement to decide on how to align all the resources of the place

2. This **increasingly includes joint teams being established across commissioners and providers**, e.g. a single transformation team, BI team, quality meeting

3. A **commitment to decision making at place** on the deployment of resources is often **a reassurance sought by LA partners**

NHS England and NHS Improvement
Questions
Break
Organisational Development

Viki Wadd
Associate Director – Organisational Development, Communications and Engagement, East Berkshire CCG
Reflections from the East Berkshire - Organisational development

Viki Wadd
Associate Director – Organisational Development, Communications and Engagement

Working together to deliver excellent and sustainable healthcare
East Berkshire

- 3 Unitary Authorities
- Population 470,000
- 47 practices
- Diverse populations

Working together to deliver excellent and sustainable healthcare
Approach

• Engagement in developing vision and values
• Developing an identity
• Developing networks and understanding
• Co-creation of plan with staff
Governing Bodies

- Development of vision and values
- Principles for working together
- Engagement in the development of common Operating Plan
- Governing Bodies in Common and sub-committees led to a natural conclusion
Member practices/ Clinical leadership

- Engagement in
  - Vision and values
  - Changes to Constitution
- Development of clinical leads forum and lead areas
- Identification of future leaders and support through leadership development
- Collaborative events
- Sharing local learning and demonstrating commonality

Working together to deliver excellent and sustainable healthcare
Staff

- Developing the culture
- Appreciating a local approach and building on collaborative working
- Designing our values

Working together to deliver excellent and sustainable healthcare
ICS leadership development

• Underpinning organisational change
• Collaborative leadership development
• Clinical Forum
• Sharing approach to OD opportunities
Questions?
Q&A
Further support and information

- NHS Future Collaboration Platform – lessons learned reports, templates, ‘chat’ facility

- NHS E & I regional teams

- Access to subject matter experts

- Other CCGs (peer support)

- Further learning and sharing events and webinars

- NHS Clinical Commissioners support
Additional resources: Merger preparation

- CCG mergers guidance and templates
- Separate finance guidance
- High level timeline
- Detailed checklist
Thank you!

@nhsccpress

office@nhscc.org