Black Country and West Birmingham Governing Bodies
10 September 2019

Agenda item 8

TITLE OF REPORT:	**Outline Case for Change** Black Country and West Birmingham Clinical Commissioning Groups Merger or Continued Collaboration.
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PURPOSE OF REPORT:	As part of the journey towards a strategic commissioner, the Black Country and West Birmingham CCGs need to formally consider the options for continued collaborative work or merging. This paper sets out the options considered by the Black Country and West Birmingham Joint Commissioning Committee and the Transition Board.
ACTION REQUIRED:	☒ **Decision** ☐ **Assurance** ☐ **Information**
KEY POINTS:	• The NHS Long Term Plan indicates NHS England's preference to have one commissioner for each Integrated Care System (ICS). • This paper outlines an initial case for change in order to seek Governing Body support for stakeholder engagement and the development of a full case for change which will be required for any formal application to merger the CCGs.
RECOMMENDATION:	Governing Bodies are asked to: 1. Note the contents of the report and support the BCWB JCC and the Transition Boards recommendation to formally explore the option to merge Dudley CCG, Walsall CCG, Wolverhampton CCG, Sandwell and West Birmingham CCG CCGs. 2. Give approval to seek views of stakeholders. 3. Note the timeline outlined in section 4.4 is high level and a detailed programme plan will be developed. 4. Mandate the CCG Transitional Board to provide oversight of the consultation, development of the full case for change and the development of the merger application.

KEY IMPLICATIONS:	• Risk – a number of high level risks have been identified, • Finance – there is opportunities to achieve greater commissioner efficiency • Quality – there is greater opportunity to achieve system level improvements • Patient and Public Involvement – engagement activities are outlined • Equality and Inclusion – a full impact assessment is required • Legal - to be confirmed • HR & Organisational Development
CONFLICTS OF INTEREST MANAGEMENT:	All Governing Body members are directly conflicted.
LINK TO TRIPLE AIM OPPORTUNITIES WITHIN THE BLACK COUNTRYSTP CLINICAL STRATEGY	
1. Better Health	Consistent system level commissioning leadership, and local level integrated care. – resulting in effective population health priorities and local delivery/management.
2. Better Care	Consistent system level commissioning leadership, planning and approach to quality. Focussed on local delivery/management via local integrated care models.
3. Better Value	System and local control totals. Greater efficiency of running costs, increase in frontline care and improved quality.

Outline Case for Change
8th August 2019

Black Country and West Birmingham Clinical Commissioning Groups
Merger or Continued Collaboration

1 Introduction

1.1 The current Sustainability and Transformation Partnerships (STPs) will evolve into Integrated Care Systems (ICSs) by April 2021. By such time, NHS organisations will be expected not only to provide high-quality care and financial stewardship for their individual organisation, but also to take on responsibility for wider system objectives in relation to the use of NHS resources and population health.

1.2 The NHS Long Term Plan sets out how system level collaboration will benefit patients whilst also helping to address the challenges facing NHS, these include:

- More joined-up and coordinated care by breaking down traditional barriers between care institutions, teams and funding streams, so as to support the increasing number of people with long-term health conditions, rather than viewing each encounter with the health service as a single, unconnected 'episode' of care.

- Being more proactive in the services it provides, supplemented by a move to 'population health management', using predictive prevention (linked to new opportunities for tailored screening, case finding and early diagnosis) to better support people to stay healthy and avoid illness complications.

- Being more able to differentiate the support offered to individuals, to make further progress on prevention and on inequalities reduction. Being more responsive to population diversity. Providing the right support, to people of all ages who can and want to take more control of how they manage their physical and mental wellbeing.

1.3 ICSs are seen as the vehicle for bringing together system leadership and organisations in order to redesign care and improve population health. Together ICS leaders will create shared leadership and action to deliver the 'triple integration' of primary and specialist care, physical and mental health services, and health with social care. Whilst delivering rigorous and disciplined financial management across all NHS organisations.

1.4 Clinical Commissioning Groups will continue to play a prominent role within the future ICSs. The NHS Long Term Plan confirms the direction of travel for CCG configurations:

"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".

1.5 STPs are increasingly the conduit by which NHS England communicates, seek assurance and release new funding into health care systems. Significantly, individual CCGs are no longer required to produce individual planning submissions (where there are multiple CCGs in the same STP), instead STPs are collating and submitting system plans currently in the form of the Long Term Plan

1.6 As members of the Black Country and West Birmingham STP; Dudley CCG, Walsall CCG, Wolverhampton CCG, and Sandwell and West Birmingham CCG have been working closely together through the Black Country and West Birmingham Joint Commissioning Committee (BCWB JCC) and specific system level work programmes, such as, the development of the STP primary care strategy, the delivery of the local maternity system plan, the development of the joint clinical strategy, the mental health and the transforming care programmes.

1.7 As the CCGs plan for the implementation phase of the Long Term Plan the need to work collaboratively becomes even more apparent.

1.8 As a natural progression the CCGs have recently agreed the appointment of a single Accountable Officer and where it will add value, the development of committees "in common".

1.9 As part of the journey towards a strategic commissioning voice for the Black Country and West Birmingham, the CCGs need to formally consider the options, benefits and dis-benefits associated with either continuing to work collaboratively or formally merging.

2 Options

2.1 The Black Country and West Birmingham Joint Commissioning Committee (BCWB JCC) and the CCG Transition Board have considered a range of options for how the four CCGs can work together in the future. The options are outlined in table 1 below;

Table 1 **Developing a Single Commissioner Voice.**

Option	Description	Points Considered
1	No change to current status: Individual CCGs retaining Governing Bodies with separate management and governance structures. BCWB JCC formed with no	• The NHS Long Term Plan clearly articulates the aspiration to have one commissioner for the STP/ICS. • Sustaining four CCGs, requires sustaining four administrative processes - Governing Bodies, Committee Structures and Directorate Structures etc. • The CCGs have agreed the appointment of a single Accountable Officer and are actively exploring the formation of committees "in common".

	delegated authority and no joint commissioning decisions	• The new Accountable Officer will need to design an operational structure that will enable them to deliver their duties in the most effective and efficient way, this may include a review of the executive team structure. • The BCWB JCC currently has limited delegation for mental health and learning disabilities, but it oversees the commissioner involvement and the required commissioner actions to support the STP work streams. • The majority of decisions for shared programmes continue to be made by the individual CCG governing bodies; this requires shared papers to be presented to four governing bodies. There remains a risk that one or more CCGs may disagree with at BCWB JCC recommendation, resulting in a protracted decision making and delays in implementation. • The CCGs are duplicating clinical and managerial leadership for a range of work streams. • Increasingly the CCGs are working together but pace has been slow and there are differences in individual CCG approach. • The BCWB JCC would continue to support the development of local models taking into account local partnership and aspirations.
2	Black Country and West Birmingham Joint Commissioning Committee with delegated responsibilities and decisions making at a system level. CCGs retain their individual management teams and structure.	• The NHS Long Term Plan clearly articulates the aspiration to have one commissioner for the STP/ICS. • The CCGs have agreed the appointment of a single Accountable Officer and are actively exploring the formation of committees “in common”. • The new Accountable Officer will need to design an operational structure that will enable them to deliver their duties in the most effective and efficient way, this may include a review of the executive team structure. • The BCWB JCC could have delegated duties for the CCGs statutory commissioning duties but some areas cannot be double delegated i.e. primary care. • The CCGs would need to continue to resource the membership and functioning of the 4 Governing Bodies and associated subcommittees. • The CCGs would continue to consume the resources required to manage the accounts of the organisation, including holding an annual AGM. • The BCWB JCC would continue to support the development of local models taking into account local partnership and aspirations.
3	Form a shared Executive Management Team but Not a Joint Committee i.e. each CCG maintains separate governance structures	• The NHS Long Term Plan clearly articulates the aspiration to have one commissioner for the STP/ICS. • The CCGs have agreed the appointment of a single Accountable Officer and are actively exploring the formation of committees “in common”. • This option would involve dissolving the current BCWB JCC. Without the BCWB JCC the CCGs would find it difficult to co-ordinate shared decision making and agree shared system communication.
4	Joint Committee with delegated responsibilities from all CCGs with a shared Senior Management Team.	• The NHS Long Term Plan clearly articulates the aspiration to have one commissioner for the STP/ICS. • The CCGs have agreed the appointment of a single Accountable Officer and are actively exploring the formation of committees “in common”.

	Each CCG would retain their individual governance and sub-committees	• The BCWB JCC could have delegated duties for the CCGs statutory commissioning duties but some areas cannot be double delegated i.e. primary care. • The CCGs would need to continue to resource the membership and functioning of the 4 Governing Bodies and associated subcommittees. • The CCGs would continue to consume the resources required to manage the accounts of the organisation, including holding an annual AGM.
5	Form a Federation – continue with separate CCG's but establish shared management team, governance and decision making.	• Forming a Federation may or not be legally possible • This option would provide some system efficiencies but each CCG would be required to resource the membership and functioning of the 4 Governing Bodies. • The CCGs would continue to consume the resources required to manage the accounts of the organisation, including holding an annual AGM.
6	Full Merger of all CCGs and Creation of Single Black Country and West Birmingham CCG able to maintain 'Place/Localities' •	• One CCG would deliver the aspiration of the NHS Long Term Plan to ideally have one CCG per ICS. • One CCG would reduce running costs – infrastructure, workforce, leadership, administration, procurement etc. • One CCG would have the authority to deploy resources in the most efficient way to achieve the required equality, quality and performance. • The new CCG would need to sustain and deliver the local commitment to developing the four locality integrated care models and the partnerships with the five local authorities. • One CCG would be able to effectively and efficiently deploy resources across local and strategic (at scale) commissioning portfolios. • Reducing running costs in this way will allow maximum resource to be spent on front line patient care • The cost of resourcing the development of the case for change and the management of the transition will be offset by the longer term efficiencies.
7	Merger of Dudley CCG & Walsall CCG - variation of Option 6- merge the two CCG's who currently share AO and CFO	• The CCGs have agreed a single AO for the four CCGs.

3 Financial Consideration

3.1 CCGs are facing a requirement to reduce their running costs by 20% from 2020/21 which for the Black Country is a consolidated reduction of £3.5m compared to the historic level of expenditure incurred. It will not be possible to discharge the commissioning duties in the same manner with 20% less resource.

3.2 Governing Bodies have already taken a decision to appoint a single Accountable Officer, who will at some point consider a consolidation of the four senior executive teams. This would contribute some financial benefit towards the running cost reduction. However as there would remain four individual organisations, each requiring a separate Governing Body and most likely

separate teams to discharge commissioning duties, the majority of the benefit would be derived from consolidating the executive structure only. A broad estimate would be 60% of the existing cost of the four separate executive teams (this is dependent upon the actual structure developed).

3.3 A merger into a single CCG would offer additional cost saving opportunities:-

- A single executive team – similar estimate of 60%
- A single Governing Body – estimated 60% of existing governing body costs, allowing for increased volume of lay representation and clinical input (compared to existing individual CCG governing body roles)
- Merged operational teams – An estimated 15% cost saving compared to existing structures as the opportunity to carry out functions once for the whole Black Country would be greater than it would be if four individual organisations remain
- Support service contracts – There will be opportunities to reduce the costs associated with some support functions (i.e. CSU services).
- Premises costs – Whilst it is likely that each 'Place' will require a local presence, a merged CCG would likely consolidate into a single headquarters and operate smaller satellite offices in each place; the size of which would most likely be substantially smaller

3.4 Whilst a detailed plan to value the actual cost savings that would accrue from a merged CCG will need to be developed, the above opportunities are likely to deliver significant cost and operational efficiencies in order to address the required 20% reduction to running costs.

4 Exploring the opportunity

4.1 Over the last few months the executive teams of all four CCGs (at BCWB JCC Development Days and the CCG Transition Board meetings) have reached a consensus that option 6 would provide the CCGs with the best opportunity to improve commissioning efficiency and deliver the single commissioner voice for the future Black Country and West Birmingham ICS.

4.2 Having reached a consensus, it is important that this view is tested with a wide range of stakeholders before the CCGs considers formally consulting and compiling a full case for change submission to NHS England.

4.3 In addition to the clinical commissioning benefits identified above, there are a number of benefits that will be felt either directly or indirectly by patients, local people, GPs, other clinicians, health and care partners, such as alignment of harmonisation of treatment policies, equality of clinical pathways across providers, improved access for patients, better shared capacity and a locality up approach to strategic planning in the future ICS.

4.4 It is believed that a merger into a single statutory commissioning organisation that values the five distinct local communities (West Birmingham, Dudley, Sandwell, Walsall and Wolverhampton) each with their own unique histories,

strengths, challenges and approach to integration will provide the following benefits;

a. **Better healthcare and health outcomes**: The current CCGs are all rated good or outstanding, combined in one organisation the expertise will be used to ensure the new CCG continues to be managed efficiently and effectively – delivering demonstrable improvements in quality and performance, with a focus on local integration and a strategic focus on improving health outcomes and addressing health inequalities.

b. **Better use of human resource:** Merging the four CCGs into one will provide the CCG clinical and managerial leadership the opportunity to deploy human resources in an efficient and effective way, reducing duplication , thereby providing the opportunity to direct expertise towards tackling both local and strategic priorities.

c. **Greater support for transformation and local innovation:** Merging the CCGs provides the environment for scaling-up the most successful local clinical innovations to rapidly share best practice across a wider area. It provides additional buying power and resources.

d. **Provides additional investment for frontline care:** Having a single organisation would eliminate the duplication of running costs and enable the CCG to better invest in healthcare and addressing inequalities.

e. **A consistent commissioner voice:** Merging the CCGs will provide a stronger, single and more consistent commissioning vision, leadership, voice and approach within the Black Country and West Birmingham ICS. Clinical commissioning leadership will have a greater impact, with consistent decision-making and more clinical efficiency at a system-level, as well as within the locality Primary Care Networks (PCNs) and locality ICPs.

f. **Wider benefits:** Merging the CCGs will deliver additional benefits;
- Greater level of clinical leadership and a better opportunity to balance the demands of frontline care, IPC and PCN development.
- Greater buying power with the ability to deliver better value for money.
- Better opportunity to attract, afford and retain staff with the right talent and skills.
- Taking forward the best practice from individual CCGs and agreeing common approaches to increase consistency and quality of care.
- Making it easier for health and care partners in the ICS to engage and work with clinical commissioners.
- Improved affordable therefore making it more likely to be sustainable in the longer-term.
- It would enable system level standardisation where clinically indicated.
- It would improve system decision making.

4.5 The new CCG would continue to focus dedicated support towards the development of PCNs and ICPs in each of the localities. Over time, the remit of the CCG will change, giving PCNs and ICPs in each place the opportunity to

lead local service development and transformation in partnership with local authorities. The locality PCNs and ICPs will have partnership relationships with key stakeholders; voluntary sector, local authorities.

4.6 As a member of the ICS, the CCG will be able to implement a single, cohesive strategy, accompanied by speedier decision-making, thereby enhancing the pace at which transformation can be achieved.

4.7 The new CCG would continue to be an active member of local Health and Wellbeing Boards and support the aspiration to improve outcomes for local people. The locality CCG teams will work closely with local authorities to deliver shared programmes and meet statutory duties to work in partnership. Local authorities will also continue to have a lead partnership role within the ICS.

4.8 The CCG would continue to meet its statutory duties to effectively engage, consult and co-produce with patients and the public via an engagement model that supported both strategic and locality level engagement. At some point in the future, it is envisaged that the ICPs will lead the majority of local engagement and co-design.

4.9 The CCGs need to engage with patients, their carers, their communities, members of the public, CCG General Practice members and wider stakeholders regarding the potential merger of the CCGs. The outputs and insights gained from the engagement will be included in a full case for change which will be submitted to Governing Bodies in due course. Should the CCGs decide to submit an application to merger with NHS England, the full case for change and the outputs of the engagement will be required.

5 NHS England Requirements

5.1 When applying to merge CCGs are required to provide the following evidence to NHS England:

- 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 current status regarding delegated authority for primary medical care services
- Desirable – as an appendix: joint letter of support from STP leaders for the merger.
- A high level HR/OD strategy for the new CCG
- Procurement plan for key support services.
- Clinical commissioning strategy/population health management plan.
- The new CCG Engagement Strategy/Plan

5.2 To deliver the above requirements, a significant amount of work will need to be undertaken and the CCGs will need to ensure the sufficient resource is available.

5.3 The CCG Transitional Board would be ideally placed to oversee the development of the full case for change and the associated transition plan (as outlined in section 5.1).

5.4 The following milestones would need to be achieved in order to meet the NHS England merger application deadline for an April 2021 launch.

September	Governing Bodies, support the recommendation to pursue a formal merger of Dudley CCG, Walsall CCG, Wolverhampton CCG, Sandwell and West Birmingham CCG. Give approval to seek views of stakeholders (separate paper). Mandate the CCG Transitional Board to continue to oversee the delivery of the engagement plan and the requirements outlined in 5.1.
September	Engagement Teams commence pre engagement period, 4 public events, a survey to stakeholders and 4 members events, presentations to Healthwatch, Scrutiny Committees and Governing Bodies including sharing the full engagement plan. Transition Director commences EQIA and Quality Impact Assessment process.
November	Governing bodies receive progress paper, outlining the result of the pre-engagement exercise and the proposed formal consultation documents.
December	Formal consultation for 6 weeks period.

February	Governing Bodies receive the analysis of consultation and impact assessments and full chase for change. Commence GP Member ballot (based on individual CCG constitution).
March	Report to Governing Bodies.
March/May	Collation of the evidence for formal merger application.
May	Governing Bodies sign off the formal application. Application submitted to NHSE.

6 Risk and Mitigation

6.1 The capture and management of risks will be a fundamental component of the full business case development and the subsequent transition planning process. Risks will be reported and managed in accordance with CCG policy. The following table identifies high level risks;

Table 2 **Risks and Mitigation**

Risk	Mitigation
NHS West Midlands may not agree with the new CCG footprint	Ensure the full case for change clearly articulates the patient flows within the Black Country and West Birmingham STP/ICS, identifying the benefits to wider regeneration and economic stability of the health and care system.
Partners may not support the argument for the merger of the four CCGs	Clearly articulate the continued role and leadership of localities. Clearly set out the case for change, complete a pre-engagement phase to ascertain the views of partners/stakeholders and the potential questions that will need answering. Design the consultation phase to address the concerns and questions of partners and wider stakeholders.
Higher than expected attrition of staff due to uncertainty and/or the potential reduction in workforce due to efficiencies and organisational restructure	A robust and transparent engagement and communication plan. An organisational development plan to support staff during transition phase. A plan to sustain corporate memory.

7 Recommendation

Governing Bodies are asked to:

1. Note the contents of the report and support the BCWB JCC and the Transition Boards recommendation to formally explore the option to merge Dudley CCG, Walsall CCG, Wolverhampton CCG, Sandwell and West Birmingham CCG CCGs.

2. Give approval to seek initial views of stakeholders prior to full consultation.

3. Note the timeline outlined in section 4.4 is high level and a detailed programme plan will be developed.

4. Mandate the CCG Transitional Board to provide oversight of the consultation, development of the full case for change and the development of the merger application.