MEETING

JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

DATE AND TIME

FRIDAY 27TH SEPTEMBER, 2019

AT 10.00 AM

VENUE

COUNCIL CHAMBER, CROWNDALE CENTRE, 218 EVERSHOLT STREET, LONDON NW1 1BD

Dear Councillors,

Please find enclosed additional papers relating to the following items for the above mentioned meeting which were not available at the time of collation of the agenda.

Item No	Title of Report	Pages
1.	SUPPLEMENT	3 - 46

Sola Odusina London Borough of Camden Sola.Odusina@camden.gov.uk

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AGENDA ITEM 2

NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

FRIDAY, 27 SEPTEMBER 2019 AT 10.00 AM
THE COUNCIL CHAMBER, CROWNDALE CENTRE, 218 EVERSHOLT STREET, LONDON, NW1 1BD

Enquiries to:	**Sola Odusina, Committee Services**
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Telephone:	**020 7974 6884 (Text phone prefix 18001)**
Fax No:	**020 7974 5921**

SUPPLEMENTARY AGENDA

Wards

3. ANNOUNCEMENTS / DEPUTATIONS

(Pages 3 - 44)

SUPPLEMENTARY AGENDA ENDS

Issued on: Wednesday 25 September 2019

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Non-Emergency Patient Transport Service

Dear Mr.Odusina,

In view of the submitted papers for agenda item re: Nepts (Non-emergency patient transport) I wish to seek permission for another deputation to JHOSC on 27/9/19. In the hope that this request is accepted, I enclose some documents for consideration (albeit that they may not be in the correct order due to my ineptitude).

Document 4 is the front cover of the DoH document re: "Eligibility criteria for Patient Transport Services".

Documents 2 & 3 are pages 7 & 8 of that DoH document re: eligibility - paras 8 & 9.

Documents 1 & 5 are another DoH document re: Non-emergency patient transport services in which it should be noted that "These services provide free transport to and from hospital for :

* people whose condition means they need additional medical support during their journey

* PEOPLE WHO FIND IT DIFFICULT TO WALK

* parents or guardians of children who are being transported

Also it is necessary to refer to the NL Partners documents re: eligibility :-

page 115 - "Equity of access" - "This will make sure residents and patients who really need transport and have no other options are receiving the support they need"

page 116 - "Other benefits" * "The programme will deliver year-on-year efficiency savings.....through identifying patients who are not eligible"

page 117 - "Eligibility and assessment centre" - "The criteria makes patient transport available to patients whose clinical condition means that travelling by any other means would be detrimental to their recovery or existing condition, such as but not limited to :

patients who need to be transported on a stretcher some wheelchair patients some patients receiving oxygen patients who require paramedic services patients who need the support of patient transport staff during the journey "

Clearly nobody would disagree that the foregoing examples require Nepts. However in publicising those examples NLP & the Project Board (who are overseeing the new contract) hope to discourage many other vulnerable patients, who also require Nepts and meet the requirements of pages 115 and 117, from applying for it and also withhold information about the appeals and complaints process. Bearing in mind that the fore-runner of this contract was pilot-tested by the Royal Free Hospital in 2018 and caused angst to many patients who were refused a service to which they were entitled. Even Healthwatch Barnet in a report to the RFH referred to a number of rejected applications that had been overturned because of its intervention.

One such patient of the RFH is an 85 year-old woman, with multiple medical conditions which include wearing special boots provided by the RFH, who was required to undertake an assessment every time she requested Nepts to confirm that she was still eligible for the service despite her

FINDING IT DIFFICULT TO WALK. Even under the new contract she can be required to be re-assessed on a periodic but regular basis !

In despair some patients do not even challenge the flawed assessments but find ways to attend hospital i.e. a Catch 22 situation. You've managed to attend without Nepts - ergo you aren't eligible for Nepts !

Yours sincerely,
P.Richards.

NHS

(Link: /)

How do I organise transport to and from hospital?

It depends if it is an emergency or not.

In an emergency

In a medical emergency, call 999 and ask for an ambulance. You will not have to pay to be taken to hospital in an emergency.

A medical emergency is when someone is in a critical or life-threatening situation.

Read about ambulance services (Link: https://www.nhs.uk/using-the-nhs/nhs-services/urgent-and-emergency-care/when-to-call-999/).

Non-emergency hospital visits

If your reason for going to hospital is not an emergency, you'll normally be expected to make your own way there.

Hospital parking can be expensive and/or limited, and you may not be able to leave your car there overnight. So you may want to try and get a friend or relative to take you to hospital and collect you after you've been discharged.

You can search for your local hospital (Link: /servicedirectories/Pages/ServiceSearch.aspx?ServiceType=Hospital) to check its parking facilities.

Non-emergency patient transport services

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Document Purpose

1. 'Ambulance and other Patient Transport Services: Operation, Use and Performance Standards' [HSG 1991(29)] was published in 1991. This set out guidance for the NHS on the operation, use and performance standards for emergency and urgent ambulances. It also set out criteria for establishing which patients were eligible for non-emergency patient transport services (PTS).

2. The White Paper ('Our health, our care, our say: a new direction for community services', January 2006) made a commitment to extend eligibility for the Hospital Travel Costs Scheme (HTCS) and PTS to procedures that were traditionally provided in hospital, but are now available in a community setting. This will mean that people referred by a health care professional for treatment in a primary care setting, and who have a medical need for transport, will also receive access to PTS and HTCS.

3. This extension to PTS, as outlined in this document, is expected to come into force in 2007/08, although Primary Care Trusts (PCTs) can of course amend local eligibility criteria for PTS in line with the White Paper before that date, should they wish to do so.

4. This document therefore updates and replaces the 1991 guidance and applies to both NHS and independent service providers contracted to the NHS.

What is PTS?

5. Non-emergency patient transport services, known as PTS, are typified by the non-urgent, planned, transportation of patients with a medical need for transport to and from a premises providing NHS healthcare and between NHS healthcare providers. This can and should encompass a wide range of vehicle types and levels of care consistent with the patients' medical needs.

Who is eligible for PTS?

6. PTS should be seen as part of an integrated programme of care. A non-emergency patient is one who, whilst requiring treatment, which may or may not be of a specialist nature, does not require an immediate or urgent response.

7. Eligible patients should reach healthcare (treatment, outpatient appointment or diagnostic services i.e. procedures that were traditionally provided in hospital, but are now available in a hospital or community setting) in secondary and primary care settings in a reasonable time and in reasonable comfort, without detriment to their medical condition. Similarly, patients should be able to travel home in reasonable comfort without detriment to their medical condition. The distance to be travelled and frequency of travel should also be taken into account, as the medical need for PTS may be

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affected by these factors. Similarly, what is a "reasonable" journey time will need to be defined locally, as circumstances may vary.

8. Eligible patients are those:
   - Where the medical condition of the patient is such that they require the skills or support of PTS staff on/after the journey and/or where it would be detrimental to the patient's condition or recovery if they were to travel by other means.
   - Where the patient's medical condition impacts on their mobility to such an extent that they would be unable to access healthcare and/or it would be detrimental to the patient's condition or recovery to travel by other means.
   - Recognised as a parent or guardian where children are being conveyed.

9. PTS could also be provided to a patient's escort or carer where their particular skills and/or support are needed e.g. this might be appropriate for those accompanying a person with a physical or mental incapacity, vulnerable adults or to act as a translator. Discretionary provision such as this would need to be agreed in advance, when transport is booked.

10. A patient's eligibility for PTS should be determined either by a healthcare professional or by non-clinically qualified staff who are both:
    - clinically supervised and/or working within locally agreed protocols or guidelines, and
    - employed by the NHS or working under contract for the NHS

Who provides PTS?

11. For simplicity, the text of this guidance will refer to PCTs when discussing the role of the commissioner. There is an expectation that over time, where it is not already the case, PCTs should take on responsibility for PTS contracts and commissioning.

12. PCTs are responsible for commissioning ambulance services (which could include patient transport services) to such extent as the PCT considers necessary to meet all reasonable requirements of the area for which they are legally charged with providing services. It is for the PCT to decide who receives patient transport services in their area. PCTs should therefore apply the principles outlined in this document either to consider each case on its merits or to develop more detailed local criteria for PTS use. PCTs may lawfully ask other bodies to assist in the exercise of their commissioning functions. Yet where they make such arrangements, it is still the responsibility of the PCT to ensure that appropriate services are being provided at an appropriate cost and standard.

13. A range of different providers may provide PTS - for example the local NHS ambulance trust, independent sector providers, or a combination of providers.

14. PTS eligibility has not been extended to include patients who do not fit the criteria outlined above e.g. those who have a social need for transport. Local transport plans should address issues of access to health services to enable integrated transport provision and PCTs have been encouraged to engage in this process through accessibility planning guidance and the NHS Modernisation Agency's 'Driving Change – Good Practice Guidelines for PCTs on Commissioning Arrangements for Emergency

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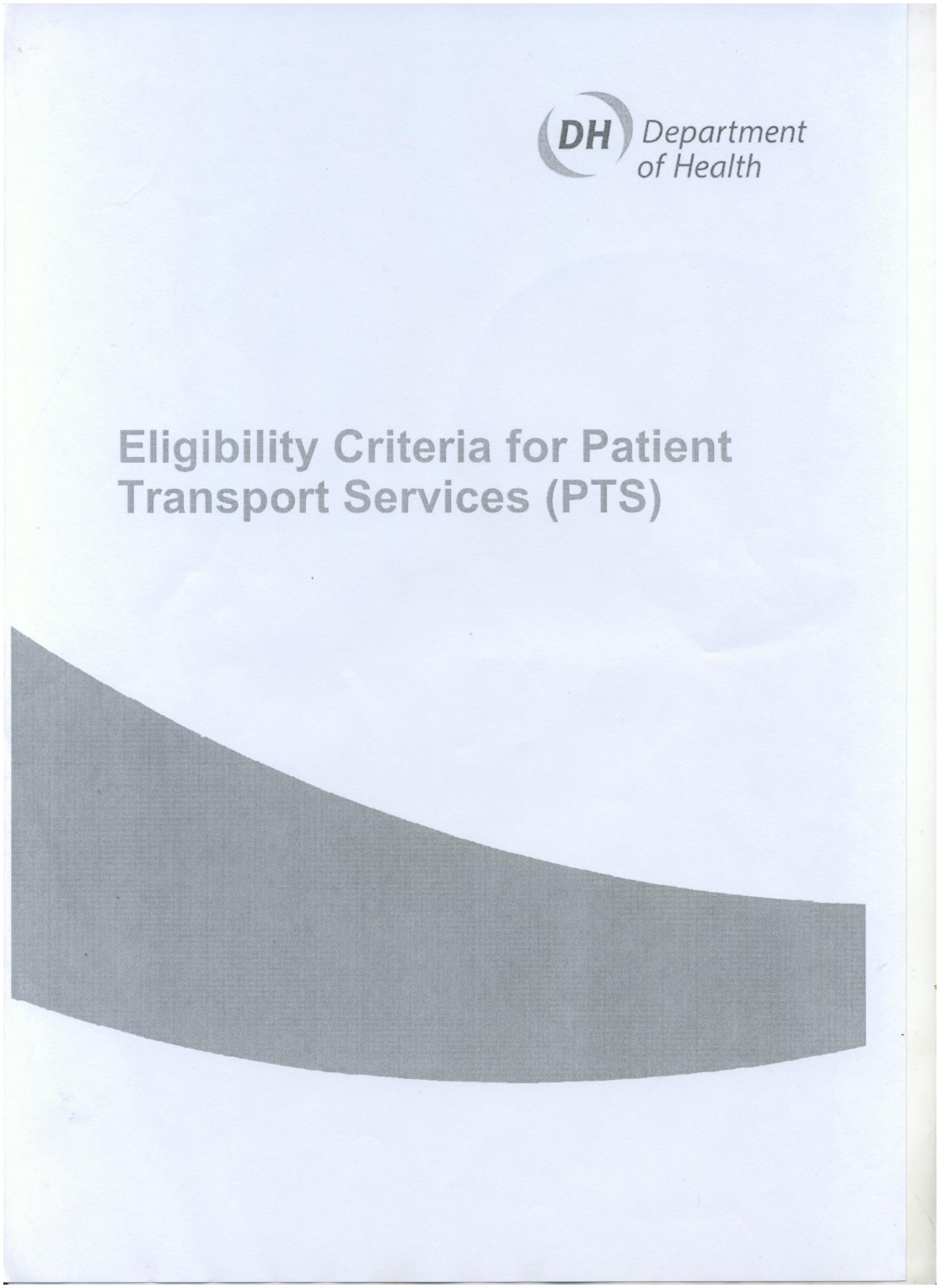
DH Department of Health
Eligibility Criteria for Patient Transport Services (PTS)

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Some people are eligible for non-emergency patient transport services (PTS). These services provide free transport to and from hospital for:

- people whose condition means they need additional medical support during their journey
- people who find it difficult to walk
- parents or guardians of children who are being transported

PTS may not be available in all areas. To find out if you are eligible for PTS and how to access it, you will need to speak to your GP or the healthcare professional who referred you to hospital.

Refunds of hospital transport costs

You may be able to claim a refund for the cost of your transport to hospital through the Healthcare Travel Costs Scheme (HTCS) if you:

- are not eligible for PTS
- cannot afford the cost of travelling to hospital
- cannot get a friend or relative to take you

Read this page on the Healthcare Travel Costs Scheme (HTCS) (Link: https://www.nhs.uk/using-the-nhs/help-with-health-costs/healthcare-travel-costs-scheme-htcs/) for more information on who is eligible, what the conditions are and how you can access the scheme.

Read the answers to more questions about NHS services and treatments (Link: /chq/pages/Category.aspx?CategoryID=68).

Further information

- Going into hospital (Link: https://www.nhs.uk/using-the-nhs/nhs-services/hospitals/going-into-hospital-as-an-inpatient-or-outpatient/)
- Can I choose where to receive treatment? (Link: /chq/Pages/902.aspx?CategoryID=68&SubCategoryID=162)
- Accidents and first aid (Link: /conditions/first-aid/)

Page last reviewed: 3 August 2017
Next review due: 3 August 2020

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From: **Alan Morton**
Date: Mon, 23 Sep 2019 at 09:50
Subject: Delegation to JHOSC 27 September
To: Kelly, Alison (Councillor) <Alison.Kelly@camden.gov.uk>
Cc: Cllr Connor Pippa <Pippa.Connor@haringey.gov.uk>, Sangarapillai, Vinothan <Vinothan.Sangarapillai@camden.gov.uk>

Dear Alison

I am writing to request that NCL NHS Watch have a delegation to the JHOSC on September 27th. We seek public consultation on the plans by North London Partners in Health to merge the 5 CCGs in NCL. If you agree, our delegation would consist of Sue Richards and myself. I attach a document outlining our case for circulation.

This email is copied to Pippa and Vinothan for their information.

Best wishes

Alan

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Alan Morton

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Alan Morton

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NCL NHS Watch

We call for formal public consultation on the proposed merger of the five borough-based CCGs into one organisation, a CCG for the whole of NCL, outlined in *Delivering improved outcomes for North Central London residents: Changing the way we work together* (NLP August 2019).

A principle enshrined in law is that if an organisation in the NHS is changed in a way that might affect service to the public, there should be full public consultation with the results considered before the final decision is made – a requirement of the 2012 Health and Social Care Act.

We believe that abolishing the five statutory bodies which are co-terminous with the five boroughs will inevitably lead to changes in policy and service and therefore public consultation is required.

Few details of the proposed merger have been made public by North London Partners (NLP). But the implications are far-reaching for health policy and service for residents of North Central London. Our main arguments are about governance and privatization

Governance

If North London Partners becomes one CCG, it will decide the budget and contract for every health care provider in NCL:

a. There is no corresponding body representing local authorities and their residents. This will gravely reduce democratic oversight by Councillors and involvement of the public. (At present each Borough has a CCG with its own budget and makes decisions on healthcare for its residents).
b. If a hospital trust or a primary care network has a large deficit, the budgets for other NHS organisations in NCL could be cut to cover it

Privatization

With one CCG:

a. The Borough-based organisations replacing CCGs, the Integrated Care Partnerships, will include Primary Care Networks. These PCNs will be public limited companies. Initially these may be controlled by GPs. But in future they could be taken over by others, accelerating the large-scale privatization of health care in England and Wales
b. One CCG/Integrated Care System (ICS) will control the property portfolios of both acute hospitals and of community and primary care. North Central London has valuable NHS assets but a deficit on current spending. The new body will be under pressure to asset-strip, to sell property to fund its deficit, a deficit that's increasing as a result of deliberate Government underfunding.

We see no reason why North London Partners should rush to be in the first wave of CCG partnerships. Instead they should follow the example of their equivalent in North West London which has withdrawn from doing so.

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Sola

Please find attached the legal advice we have received from Capsticks Solicitors LLP relating specifically to public consultation and consultation with
local authorities around the proposed merger of NCL CCGs.
If you are able to circulate this advice to the JHOSC Committee members in advance of the meeting that would be very helpful.
Kind regards
Chloe

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You have asked me to advise the CCGs on whether the proposed merger require formal public consultation or a formal consultation with councils.

Dealing first with public consultation, the general duty of public involvement under s.14Z2 of the NHS Act 2006 does not apply to a proposed CCG merger because that duty only applies in respect of health services which are provided pursuant to the CCGs' "commissioning arrangements". It does not therefore apply to an organisational change of this sort. In addition, the factors relating to applications for CCG establishment or merger which are considered by NHS England on a merger application, as set out in Schedule 1 to the NHS(CCG) Regulations 2012, do not refer to public consultation.

If the merger proceeds, it will result in the dissolution of the current CCGs. Under schedule 3 to the 2012 CCG Regulations, the factors relating to applications for CCG dissolution include the extent to which the CCG to be dissolved has sought the views of individuals to whom any relevant health services are being or may be provided, what those views are, and how the CCG has taken them into account. Thus, whilst there is no requirement for formal public consultation, the extent of the CCGs' engagement with their populations will be a relevant factor for NHS England to consider.

Turning to consultation with local authorities, there is no requirement for such consultation under regulation 23 of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013, since the requirement to consult under that regulation only arises where there is a proposal for a substantial development of the health service in the area of a local authority, or for a substantial variation in the provision of such service. As with public consultation, the duty does not apply to organisational changes.

Under the 2021 CCG Regulations, one of the factors that NHS England must consider on an application for CCG merger is:

Whether any unitary local authority or upper-tier county council whose area coincides with, or includes the whole or any part of, the area specified in the CCG's constitution considers that the arrangements made by the applicants to ensure that the CCG will be able to discharge its functions are appropriate.

When considering this factor, NHS England must also take into account any observations by the applicants on the views expressed by the local authority.

In the light of this provision, whilst there is no formal requirement for consultation with local authorities, in order to satisfy NHS England that the merger should proceed the CCGs will

need to show how they sought the views of the local authorities, which could be by way of engagement.

I hope this advice is helpful but please don't hesitate to contact me if you have any further questions.

Kind regards

Peter Edwards
Partner | Clinical Law - Advisory
Capsticks Solicitors LLP

peter.edwards@capsticks.com | www.capsticks.com |

Dear Sola
Further to our earlier telephone conversation, I attach herewith the NHS Procedures for Clinical Commissioning Groups to apply for constitution change, merger or dissolution, dated April 2019. I have highlighted the relevant paras for your information.
The CCGs are established by constitution and the requirements for a merger can be found in the National Health Service Act 2006 and the CCG Regulations 2012. The CCG is required to consult with its GP members and local Healthwatch. They need to have engaged with, and seriously considered the views of, their GP member practices, and local Healthwatch, in relation to the merger. They must in their merger application detail the level of support and the views of each CCG's GP practices and local Healthwatch, and their comments on those views
In terms of the LA they just need to confirm through their communications and engagement plan, that they have engaged with the relevant local authorities, and considered their feedback
With reference to the points raised by Andrew:
1. **Whether or not to accept the deputation**- perhaps if you can go back to Alan Morton, explain the position and ask him to rephrase his deputation
2. **Whether legally we can do what the deputation asks** – the answer is no
Happy to discuss further.
Regards
Ros

Ros Alexander
Principal Lawyer

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

NHS England and NHS Improvement

NHS England INFORMATION READER BOX		
Directorate		
Medical	**Operations and Information**	Specialised Commissioning
Nursing	Trans. & Corp. Ops.	Commissioning Strategy
Finance		

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

Document Status

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CCG Improvement and Assessment Framework 2018/19: Technical Annex

Version number: 0.3

First published: October 2015

Prepared by: NHS England assessment team

Classification: OFFICIAL

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

Contents

1 Preface to the revised edition – April 2019

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

2 Introduction

2. These procedures are to be followed by CCGs and NHS England. They are underpinned by the requirements of the National Health Service Act 2006 (as amended) (referred to from now on as 'the Act') and by relevant regulations.

3. Under the Act, NHS England has powers to make transfers of property and staff in connection with variation, merger, or dissolution. The use of these powers is included in the scope of these procedures.

4. NHS England has separate powers which allow it to vary a CCG's area or membership without an application from the CCG. The application of this power is out of scope of the procedures outlined in this document.

3 Equality statement

5. NHS England has a duty to have regard to the need to reduce health inequalities in access to health services and health outcomes achieved as enshrined in the Act. NHS England is committed to ensuring equality of access and non-discrimination, irrespective of age, gender, disability (including learning disability), gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex (gender) or sexual orientation.

6. In carrying out its functions, NHS England will have due regard to the different needs of protected equality groups, in line with the Equality Act 2010. This document is compliant with the NHS Constitution and the Human Rights Act 1998. This applies to all activities for which they are responsible, including policy development, review and implementation.

4 Procedure to change a CCG constitution

4.1 Background

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

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

8. NHS England must be satisfied that the constitution complies with the requirements of the Act and is otherwise appropriate. Guidance is available to CCGs here.

9. Section 14D of the Act provides that where NHS England grants an application for establishment, a CCG is established, and the proposed constitution approved under the application process has effect as the CCG's constitution. This means that it is the constitution assessed as part of CCG authorisation that is the constitution on which establishment is based. Any change to the constitution used at authorisation needs to be agreed with NHS England.

10. Section 14E of the Act provides for applications for variation of constitutions. Under section 14E, a CCG may apply to NHS England to vary its constitution (including doing so by varying its area or its list of members). If NHS England grants the application, the variation to the constitution will come into effect.

11. Under section 14J, a CCG must publish its constitution. If the constitution is varied, whether on the request of the CCG or under the powers of NHS England, the CCG must publish the revised constitution. This should be done as soon as is reasonably practical after the CCG receives the relevant approval or decision from NHS England. No requested changes to the constitution can be acted upon until formal approval has been received.

12. NHS England regional teams should be notified of any significant changes, for example, to the leadership of a governing body. Where CCGs are wishing to make significant changes, such as a replacement of the chair of the governing body, any new member, should be subject to a selection process of equivalent rigor as the original member. This will ensure that the new member has the capability to fulfil the role.

13. Section 14A(1) of the NHS Act 2006 requires each provider of primary medical services to be a member of a CCG. As new models of care are developed CCGs should therefore ensure that their membership reflects this and that any amendments this requires to their constitution are made.

14. The CCG's constitution will need to reflect any arrangements for joint and delegated commissioning arrangements. In Annex C of the document *Next steps towards primary care co-commissioning* there is a suggested form of words for joint commissioning constitutional amendments, which can be tailored to individual circumstances. CCGs with delegated commissioning must have a committee to manage the delegated functions and to exercise the delegated powers.

4.2 Application process to be adopted

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

stage in advance of submission.

16. Any application for variation which will change a CCG's boundary, or its list of members, must be made by **30 June** so that the change can be reflected in the allocations for the following financial year. Any boundary change will take effect from **1 April** of the following year.

17. Applications requiring boundary changes should list the Lower Super Output Areas (LSOA) codes, and for any proposed practice moves the application should include relevant practice codes. In addition, applications should provide the regional team with a map of proposed changes to ensure that the area remains appropriate.

18. The application should come from the CCG and changes to the constitution made in tracked changes for ease of review by the regional team. The application should already have been discussed and agreed with CCG member practices and stakeholders should have already been consulted at the point of submission of the application.

19. The application should consist of:
    a. the reason why a variation is being sought;
    b. the proposed varied constitution with the amended clauses clearly signposted;
    c. assurance that member practices have agreed to the proposed change(s);
    d. assurance that stakeholders have been consulted if required;
    e. a self-certification by the Chair or Accountable Officer, on behalf of the CCG, that the revised constitution continues to meet the requirements of the NHS Act 2006;
    f. assurance that the CCG has considered the need for legal advice on the implications of the proposed changes, including whether advice has been sought; and
    g. a complete impact assessment of the changes, which should cover as a minimum the factors required to be considered by NHS England set out below.

20. A checklist of requirements for constitution changes can be found at Annex A. A list of legal requirements for a CCG constitution can be found at Annex B.

21. NHS England may seek clarification or additional information during the period when it is considering applications.

4.3 Consideration by NHS England of the proposed variation

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

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

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

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

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

26. If NHS England thinks that its statutory duties in relation to CCGs make it preferable for it to do so, it may:
    a. where granting the application would have a significant impact on allotments to the CCG in question or other CCGs, defer determination of the application until the later of the end of the financial year in which it was received and the date six months after it was received; or
    b. defer determination until it has received all related applications for establishment or variation from other CCGs.

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

5 Procedure to agree a CCG merger

5.1 Background

28. The *NHS Long Term Plan* describes how the commissioning environment will continue to evolve and it is in this context that CCGs will operate in future.

29. Building on the progress already made, the NHS Long Term Plan sets out an intention for Integrated Care Systems (ICSs) to cover the whole country by April 2021. It states that: *'Every ICS will need streamlined commissioning arrangements to enable a single set of commissioning decisions at system level… CCGs will become leaner, more strategic organisations that support providers to partner with local government and other community organisations on population health, service redesign and Long Term Plan implementation.'*

30. By 2020/21, individual CCG running cost allowances will be 20% lower in real terms than in 2017/18 and CCGs may therefore wish to explore the efficiency opportunities of merging with neighbouring CCGs.

31. There are provisions under section 14G of the Act allowing for mergers of CCGs, with specific requirements set out in the *CCG Regulations 2012*. CCGs have a legal right to apply for a merger and there are specific legal factors and further criteria that NHS England will consider when deciding whether to agree the merger. These criteria are set out in section 5.3.

5.2 Roles and responsibilities

32. The process to merge two or more CCGs will require the commitment and leadership of the existing CCGs' governing bodies. The existing CCGs will need to direct sufficient resources to the merger, including establishing a programme management office (PMO), in recognition that this is a significant change programme. However, the merger should not unduly distract the existing CCGs from business as usual, including delivering core performance standards and achieving financial balance.

33. NHS England will provide information and guidance to CCGs considering merger and will assess the suitability of proposed mergers.

34. NHS England has a statutory duty to authorise any new CCG and will make reasonable requests for information and assurances from the existing CCGs to do so.

35. Following conditional authorisation, NHS England will require reasonable assurance on progress from the existing CCGs throughout the merger preparation process to ensure that all necessary action has been taken to confirm the establishment of the new CCG. NHS England will continue to provide existing CCGs with support and guidance through the merger preparation process, including working with other partners, notably NHS Shared Business Services (SBS) on financial matters and NHS Digital on informatics.

5.3 Criteria for merger

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

i. Alignment with (or within) the local STP/ICS: to provide the most logical footprint for local implementation of the NHS Long Term Plan, and to provide strategic, integrated commissioning to support population health. The merger application should briefly set out how the proposed new CCG will work with all other local STP/ICS partner organisations (including **any other CCGs**, in line with the **legal requirements**) and (where relevant) other partner organisations (including other CCGs/providers) outside the existing STP/ICS with which it has significant working relationships. Any CCG merger proposal which crosses existing STP/ICS boundaries may prompt consideration of whether the existing STP/ICS boundaries are themselves appropriate or need to be re-drawn.

ii. Coterminosity with local authorities: there is a presumption in favour of the proposed new CCG being coterminous with one or more upper-tier county council or unitary local authority. The existing CCGs must demonstrate how the merger would be in the best interests of the population which the new CCG would cover. This is particularly important in any case where the boundary of the proposed new CCG is not coterminous with local authority boundaries. In all cases, in line with the **legal requirements**, the existing CCGs must demonstrate in their application that they have effectively consulted with the relevant local authority(ies) regarding the proposed merger, record what the local authority(ies)' views are, and what the CCGs' observations on those views are. They should also show how they have/will put in place suitable arrangements with local authorities to support integration at 'place' level (population of between 250,000 and 500,000).

iii. Strategic, integrated commissioning capacity and capability: in line with the **legal requirements**, the existing CCGs must demonstrate that they have/will develop the leadership, capacity and capability for strategic, integrated commissioning for their population. This will include population health management, new financial and contractual approaches that encourage integration, and developing place-based partnerships. In accordance with the **legal requirements**, the application must demonstrate how any commissioning support services to be procured will be of an appropriate nature and quality.

iv. Clinical leadership: in line with the **legal requirements**, the existing CCGs must demonstrate how the proposed new CCG will be a clinically-led organisation, and how members of the new CCG will participate in its decision-making.

v. Financial management: in accordance with the **legal requirements**, the existing CCGs must show how the new CCG will have financial arrangements and controls for proper stewardship and accountability for public funds.

vi. Joint working: ideally, a merger should build on collaborative working between the existing CCGs and represent a logical next step from current arrangements. The merger application should show progress on joint working to date, and must show how the existing CCGs intend to resource and manage the merger process itself.

vii. Ability to engage with local communities: assurance is required that the move to a larger geographical footprint will not be at the expense of the proposed new CCG's ability to engage with - and consider the needs of - local communities.

viii. Cost savings: where possible, the existing CCGs should show how collaboration and joint working **to date** has contributed to cost savings; they must also show any further cost savings projected to result from the merger, and when, and how cash released will be re-invested.

ix. CCG Governing Body approval: the merger application must show evidence of approval for the merger by the Governing Body of each of the existing CCG governing bodies.

x. GP members and local Healthwatch consultation: evidence is required that each of the existing CCGs have engaged with, and seriously considered the views of, their GP member practices, and local Healthwatch, in relation to the merger. The merger application must record the level of support and the prevailing views of each existing CCG's member practices and local Healthwatch, and the existing CCGs' observations on those views.

5.4 Pre-application activity and the merger application

37. CCGs contemplating merger should engage at the earliest possible opportunity with the relevant NHS England regional team, prior to making a formal application. NHS England will work with CCGs to minimise the risk of unnecessary work and to support their engagement with stakeholders and application preparations. The CCGs should make regional teams aware of all existing and planned joint appointments and collaborative working arrangements, e.g. committees in common, which are/will be in place prior to merger.

38. The relevant NHS England regional team should indicate promptly to the existing CCGs whether it is supportive in principle of the proposal to merge. If the regional team is supportive, the CCGs are strongly encouraged to start early engagement on the merger with their members, staff, local communities (including through local Healthwatch) and their local authority and provider organisation partners.

39. CCG merger applications may be made – and considered by NHS England - at any time of the year. However, mergers may only take effect from the beginning of a new financial year (**1 April**). If a proposal to merge is supported by the relevant regional team, a formal, written application should be made jointly by the existing CCGs to the relevant Regional Director. Formal applications should be made to the Regional Director by **30 September** for the merger to take place on 1 April the following year. *As an exception*, late applications by 31 October 2019 will be considered on a case by case basis where they support implementation of the Long Term Plan. CCGs are encouraged to make an early application to give them sufficient time post-conditional authorisation to work with NHS England and other partner organisations (notably NHS Shared Business Services (SBS) and NHS Digital) on the detailed implementation and preparatory arrangements.

40. The Regional Director will acknowledge receipt of the merger application in writing within two weeks of receipt.

41. Any application received by the Regional Director after 31 October will be considered for merger the April after next. In this case, following conditional authorisation of the merger by NHS England, the existing CCGs will default to operating (as far as possible) as a single organisation and will have longer to prepare for their formal merger.

42. The formal merger application must be signed off by the Accountable Officer for each of the existing CCGs and include a statement of confirmation that the decision to apply for merger has been taken in accordance with each of the existing CCGs' governance

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

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

44. The existing CCGs will be informed of the decision taken in writing by the Regional Director. The decision is final and there is no right of appeal.

6 Procedure to dissolve a CCG

6.1 Background

45. Section 14H of the Act, provides that a CCG may apply to NHS England for the group to be dissolved and for its members to join other CCGs.

46. Key factors set out in the Regulations that NHS England must consider in relation to an application for dissolution are:
    a. the impact on the local population served by the dissolving CCG of proceeding with a dissolution;
    b. the financial implications of dissolution to both the CCG in question and other affected CCGs;
    c. the impact on NHS England's functions; and
    d. the stakeholder engagement the CCG has undertaken and how the CCG has taken the views of stakeholders into account.

6.2 Application process to be adopted

47. NHS England will consider applications for CCG dissolutions at any time in the year. This is because it needs to ensure that the entire population is always covered by a functioning CCG. Submissions should be made to the relevant regional team.

48. The application should come from the CCG wishing to dissolve. The application should already have been discussed and agreed with CCG member practices and stakeholders, including those neighbouring CCGs which will be affected by the dissolution, should have already been consulted at the point of submission of the application.

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

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

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

6.3 Consideration by NHS England of the proposed dissolution

51. Regulation 9 applies to applications to dissolve a CCG. Schedule 3 to the Regulations sets out the factors to be taken into account. NHS England may also consider any other information which it deems relevant. The factors that must be considered are as follows:
    a. the likely impact of the dissolution on population and patients of the CCG;
    b. the likely impact of the dissolution on financial allocations;
    c. the likely impact of the dissolution on NHS England's functions;
    d. the extent to which the CCG to be dissolved has sought the views of the following, what those views are, and how the CCG has taken them into account:
        - unitary local authorities and upper tier county councils (within the meaning of paragraph 1 (2) of Schedule 1) whose area coincides with, or includes the whole or any part of, the area specified in the CCG's constitution;
        - any other CCG which in the CCG's view would be affected by the dissolution; or
        - any other person or body which in the CCG's view might be affected by the dissolution; and
    e. the extent to which the CCG to be dissolved has sought the views of individuals to whom any relevant health services are being or may be provided, what those views are, and how the CCG has taken them into account.

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

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

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

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

through the transition, in consultation with local IG Lead(s) – in particular for:

a. appropriate transfer or disposal of information assets, including manual records and electronic equipment;
b. physical audit of premises prior to release;
c. review of Data Protection Notification(s); and
d. revision to Fair Processing Information.

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

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

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

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

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

Annex 1: Checklist for constitution changes

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

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

Annex 2: Legal requirements of a CCG constitution

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

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

Annex 3: Merger application requirements

The merger application should be clear and concise.

The application should include the following:

1. **Summary case for change document** (no longer than 15 pages), to include:
   - signatures of the existing CCG Accountable Officer(s) and a declaration that the decision to apply for merger is made in accordance with each of the existing CCGs' governance arrangements
   - the proposed new CCG name (to comply with the CCG Regulations 2012 (3) to (6))
   - map(s) and population details; reference to current health outcomes and health inequalities
   - reference to the PSED (Public Sector Equality Duty) impact assessment for the proposed new CCG
   - the reasons for the application (to comply with the CCG Regulations 2012 10 (4)) and an outline description of benefits of merger, including the impact on the registered and resident population of the new CCG, the impact on STP/ICS partners and any other significant partner organisations
   - summary of joint working to date, including joint appointments, committees in common, lead commissioner arrangements, etc.
   - confirmation of Governing Body support for the merger from each of the existing CCGs
   - reference to the merger communications and engagement plan, including confirmation of engagement of the relevant local authorities, the membership of the existing CCGs and local Healthwatch and consideration of their feedback
   - financial position (current and high-level forecast)
   - reference to any intervention action for any of the existing CCGs (current or past) – legal directions/special measures
   - reference to current status regarding delegated authority for primary medical care services
   - **desirable – as an appendix: joint letter of support from STP leaders for the merger.**

2. **Completed application template (Excel spreadsheet – template to be supplied by NHS England – setting out the merger criteria)** – showing how the application meets the criteria for merger (including legal requirements), and signposting to the supporting evidence.

3. Outline benefits realisation plan – what benefits are expected to be realised from the merger? To include high level view on impacts on population health and financial savings. Identify baseline measures to enable evaluation of benefits post-merger.

4. Impact assessment of the proposed CCG's Public Sector Equality Duty (PSED) including the protected characteristics (Authorisation criteria, Equality Act).

For the proposed new CCG:

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

6. Procurement plan for key support services.

7. Clinical commissioning strategy/population health management plan.

8. Communications and engagement strategy/plan.

9. Financial strategy/plan.

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

10. High level merger programme plan, to include:

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

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

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

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

Dear Sola Odusina
Thank you for forwarding the legal advice you have received. We will rephrase our document in the light of that advice. I expect to get the revised document to you later this afternoon.
Many thanks
Alan Morton

On Tue, 24 Sep 2019 at 14:47, Odusina, Sola <Sola.Odusina@camden.gov.uk> wrote:

Dear Mr Morton
Thank you for your email and deputation.
I referred your deputation to Camden's legal section for advice on the issues you raised and I have been advised that the NCL JHOSC cannot legally do what the deputation asks for – to call for a public consultation into the proposed mergers of the CCG.
The CCGs are established by constitution and the requirements for a merger can be found in the National Health Service Act 2006 and the CCG Regulations 2012. I have been advised that, the general duty of public involvement under s.14Z2 of the NHS Act 2006 does not apply to a proposed CCG merger because that duty only applies in respect of health services which are provided pursuant to the CCGs' "commissioning arrangements". It does not therefore apply to an organisational change of this sort. In addition, the factors relating to applications for CCG establishment or merger which are considered by NHS England on a merger application, as set out in Schedule 1 to the NHS(CCG) Regulations 2012, do not refer to public consultation.
If the merger proceeds, it will result in the dissolution of the current CCGs. Under schedule 3 to the 2012 CCG Regulations, the factors relating to applications for CCG dissolution include the extent to which the CCG to be dissolved has sought the views of individuals to whom any relevant health services are being or may be provided, what those views are, and how the CCG has taken them into account.
The CCG is required to consult with its GP members and local Healthwatch. They need to have engaged with, and seriously considered the views of, their GP member practices, and local Healthwatch, in relation to the merger. They must in their merger application detail the level of support and the views of each CCG's GP practices and local Healthwatch, and their comments on those views.
Thus, whilst there is no requirement for formal public consultation, the extent of the CCGs' engagement with their populations will be a relevant factor for NHS England to consider.
Turning to consultation with local authorities, there is no requirement for such consultation under regulation 23 of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013, since the requirement to consult under that regulation only arises where there is a proposal for a substantial development of the health service in the area of a local authority, or for a substantial variation in the provision of such service. As with public consultation, the duty does not apply to organisational changes.
The CCG just need to confirm through their communications and engagement

plan, that they have engaged with the relevant local authorities, and considered their feedback.
Therefore you might want to rephrase your deputation and ask if the CCG have engaged with the relevant local authorities and considered their feedback.
Hopefully this is a bit clearer.
Could you please let me know as soon as possible, what you want to do?
Kind regards
Sola