Health Commissioning Transitioning from CCG to ICB

Garry Joyce

Deputy Director CYP Transformation

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Introduction

Clinical Commissioning Group (CCG)

NHS Suffolk and North East Essex CCG

- CCGs were established as part of the Health and Social Care Act in 2012, and replaced Primary Care Trusts on 1 April 2013.
- CCGs are groups of general practices (GPs) which come together in each area to commission the best services for their patients and population.
- CCGs buy services for their local community from any service provider that meets NHS standards and costs – these could be NHS hospitals, social enterprises, voluntary organisations or private sector providers. This means better care for patients, designed with knowledge of local services and commissioned in response to their needs.
- CCGs commission a wide range of services including mental health services, urgent and emergency care, elective hospital services, and community care.
- CCGs are responsible for about 60% of the NHS budget.
- The types of services commissioned by CCGs include:
    - Planned hospital care
    - Rehabilitative care
    - Urgent and emergency care (including out-of-hours and NHS 111)
    - Most community health services
    - Mental health services
    - Learning disability and/or autism services

Introduction

On 1st July 2022 CCGs will be abolished, and all responsibilities will transfer to new Integrated Care Boards.

Integrated Care Board (ICB)

NHS Suffolk and North East Essex Integrated Care Board

- An ICB is a Statutory Body.
- The ICB is responsible for developing a plan to meet the health needs of the population and allocate NHS resources accordingly.
- The ICB will receive the transfer of all CCG functions and duties.
- The ICB is able to transfer some functions and delegations to ICB Committees, Place Based Partnerships (Alliances) and Provider Collaboratives.

Integrated Care Partnership (ICP)

Suffolk and North East Essex Integrated Care Partnership

- The ICP is a Statutory Committee made up of the ICB and the Local Authority.
- The ICP will develop a local population strategy for health and care based on evidence and outcomes.
- ICP will have a Partnership Chair; across NHS, local government and community, supported by small joint secretariat

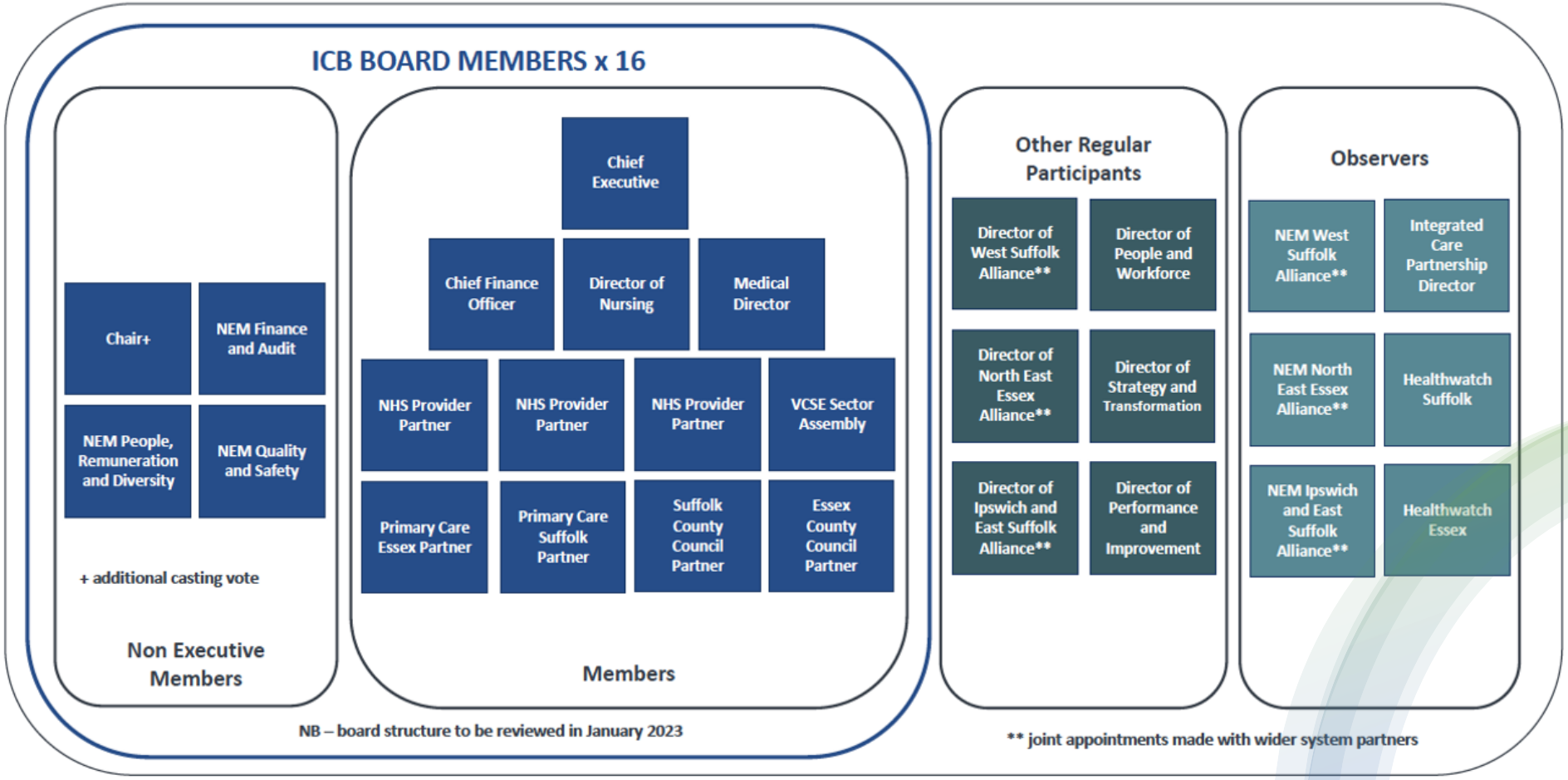
Integrated Care System (ICS)

Suffolk and North East Essex Integrated Care System

- The ICS is the ICB, the ICP and the three Alliances together.
- The ICS will work as an interlinked system not as a hierarchy.

Board Function and Membership

- The ICB Board is a unitary board.
- Board membership is set in legislation.
- The Suffolk and North East Essex Integrated Care Board (the ICB) brings together partners responsible for planning and delivering health and care across Suffolk and North East Essex to ensure shared leadership and joint action to improve the health and wellbeing of the one million people who live locally.
- It is proposed the Board functions in shadow form from 1st April 2022 with some delegated responsibilities from the three CCG Governing Bodies (TBC).
- The ICB will delegate some functions to three Alliance Committees (Ipswich and East Suffolk, West Suffolk and North East Essex, these Committees will be accountable to the ICB Board.
- The ICB Board will work with the ICP and Health and Wellbeing Boards.
- The ICB will be inspected by the CQC.
- The proposed ICB Board profile is on this slide.

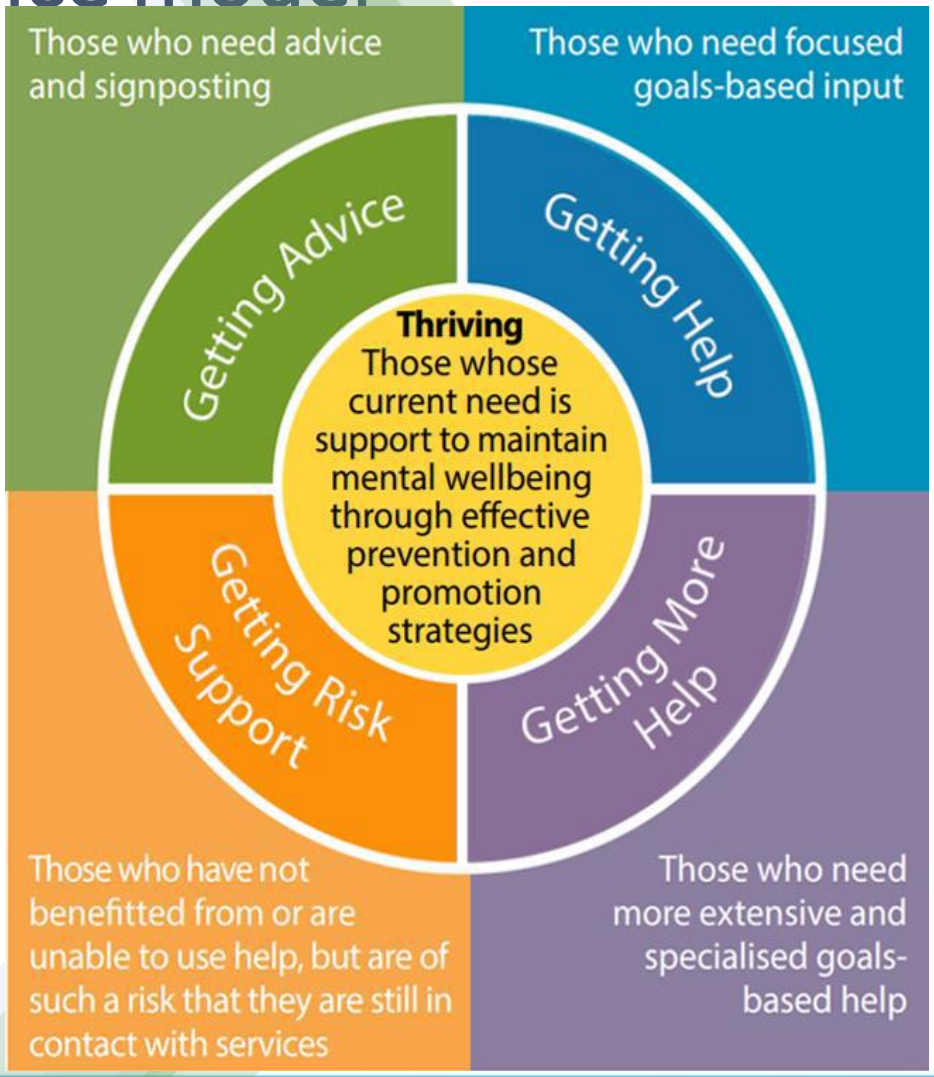


CYP Priorities - Charter

- The purpose of the Children and Young People Transformation Programme is to align local transformation with the Long Term Plan. Also taking into account the mental health and wellbeing recovery plan 21/22.
- To support the development and delivery of the wider ICS Plans, the delivery plans for each of the three alliances in the SNEE ICS and the programmes of work included within them but specifically;
    - Children's emotional health and well-being plan
    - Special Educational Needs and Disability (SEND)
    - Speech and Language Therapy and Communication
    - Neurodevelopmental and Behaviour Pathway
    - Children and Young Peoples Community Health Services
    - Agreement of Acute/Emergency Paediatric Pathway
    - Childhood Obesity
- To support the development and delivery of the Children and Young People transformation programme to manage demand differently and within localities where possible
    - To utilise localised assets based in the community to support delivery for example community hospitals, schools, libraries and other community buildings
    - To look at alternatives to managing demand to support self-care/support through dedicated support and resilience programmes
- Support system flow through embedding high impact changes
- Support the providers with integration of health and care information to manage demand and inform future capacity planning to deliver strategic aims

CYP Priorities – Mental Health new service model

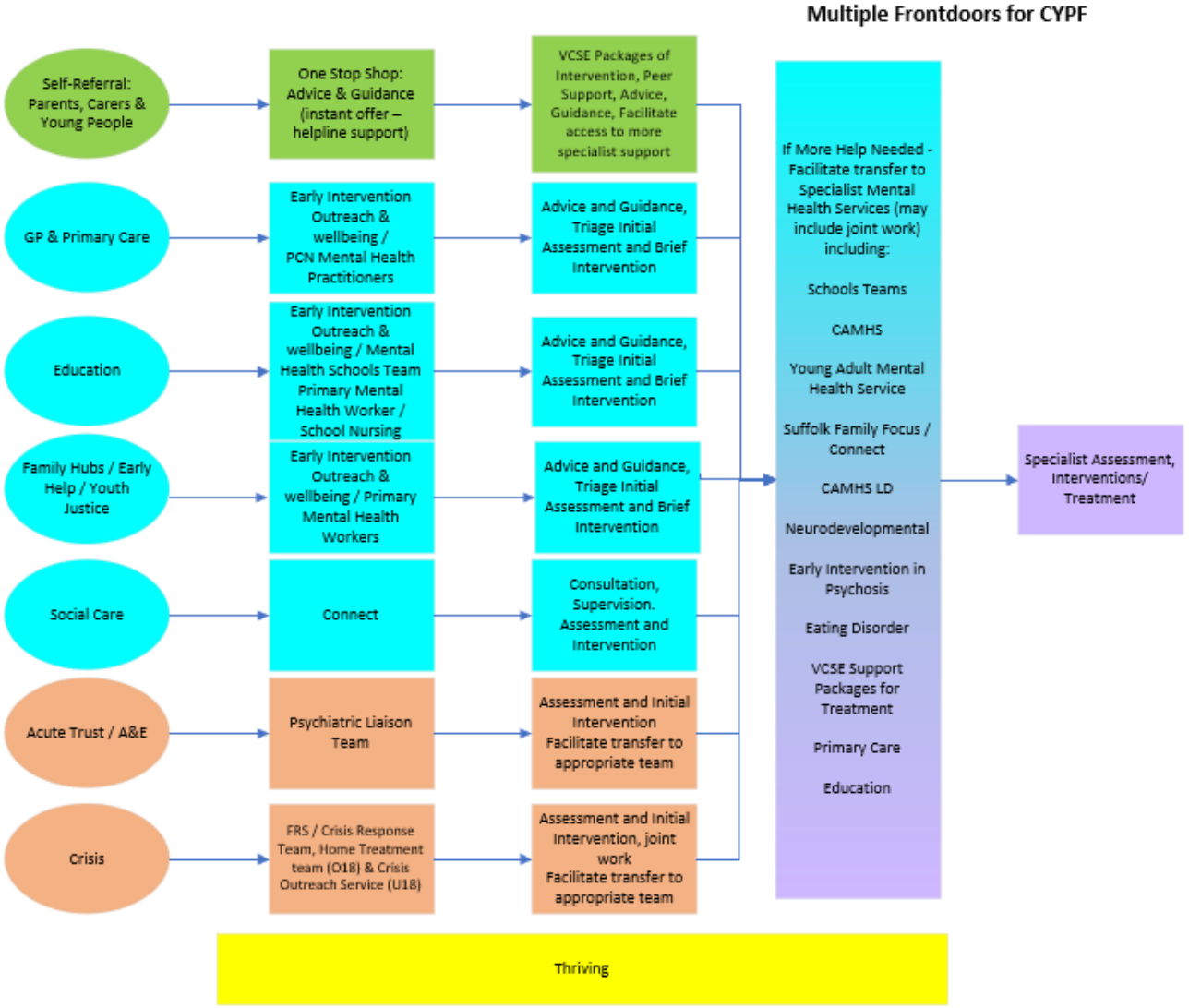
- Advice and Guidance Helpline for Parents/Carers and Young People
- Early Intervention and Wellbeing Service including
  - Mental Health Support Teams in Schools
  - Early Intervention and Wellbeing Team including PCN MH Practitioners
  - Suffolk Family Focus
  - **Psychiatric Liaison / Specialist MH clinicians embedded in Crisis Help Risk Intervention Service (CHRIS)**
- Child and Adolescent Mental Health Service (CAMHS) 0-16/18 yrs (needs based) including targeted pathway teams
  - Connect, Clinicians in Youth Justice Teams
  - CAMHS LD
  - ADHD part of Neuropathway
- Young Adult Mental Health Service (YAMHS) 16/18 – 25 years (needs based)
- Specialist Pathway Teams
  - Eating Disorders



Mental Health new service model – outcomes so far…

- New Pathways and Service Specifications co-produced for CYP MH provision 0-25 across CAMHS, YAMHS, Early Intervention and Wellbeing, specialist teams (ED, LD&A)
- New Crisis Outreach service developed and due to be implemented in Feb 22 for CYP. This is along side the all age FRS service which will move to 111.
- Improving digital resource for CYP and families and promoted digital support for 11-25 years olds via Kooth – Kooth provides an online emotional wellbeing service for young people aged 11 to 25, across the whole of Suffolk. **Over 11,000 CYP registered and accessing Kooth between April and Sept 2021.**
  - Kooth provide Free, safe anonymous counselling about anything through virtual online chat sessions and text messaging.
  - Live forums for peer-to-peer support.
  - Self-help articles.
  - Their website has journals and goal trackers to reflect their thoughts and feelings.
- Extensive business case agreed for an all age eating disorder pathway across Suffolk. With additional investment allocated to the VCSE to work in partnership with specialist teams to provide support and signposting. Investment also provided for Intensive Home Support. **Access and waiting times still below national standards this is part due to 65% increase in demand in this service during Covid.**
- Mental Health Support Teams – delivery of **24% coverage** of support in Suffolk (in line with national targets) Targeting areas of identified need in Suffolk. Ensuring PMHWs and school nursing are aligned with new teams and providing support in areas with no MHST in place. **50% of coverage of MHSTs** will be achieved by 2024.
- Full demand and capacity review of core MH service provision in Suffolk to ensure funding can support the right staff, providing the right support, in the right place.
- Thrive model embedded in pathways and service specifications for all CYP MH provision.

Mental Health new service model – access…



- Whole System Approach wrapping Services around the service users and professionals
- Multiple front doors where Children and Young People present.
- Experienced mental health clinicians to support referrers and practitioners.
- Systemwide use of signs of safety to identify need.
- Provision of Advice, Guidance and Specialist Consultation and Training

- Triage, assessment and brief intervention
- Trusted Assessment (5 Ps) – building the story
- Facilitation of referral to more specialist Clinicians and Teams where more help or risk support is needed
- Increased VCSE offer in relation to support whilst waiting, part of a treatment package and step down
- Specialist Services providing consultation and support to VCSE and universal services

Mental Health new service model – locality model…

Each locality which will be aligned to CYP current working boundaries will include:

- New Early Intervention& Wellbeing Team
- PCN MH Practitioners
- MHSTs
- CAMHS Team (0 – 16/18 yrs)
- YAMHS Team (16/18 – 25 yrs)

Staff working in locality teams will be aligned to system professionals across each areas to ensure joint working and delivery of support to CYPF.

Countywide offer

- Parent/Carer, CYP Helpline
- Eating Disorders
- ADHD, CAMHS LD, Connect
- Crisis: Psych Liaison / Crisis Outreach

Mental Health new service model – what next…

- Continue to drive forward the Eating Disorder programme to ensure access and waiting times can be met. Developing intensive home treatment support to prevent avoidable admissions. Implement ARFID pathway. 2022
- Continue to deliver the new early intervention and wellbeing model within a locality base. Early 2022
- Fully implement and monitor the new crisis outreach service and ensure pathways into all areas of crisis are fully accessible and supporting CYP effectively. Feb 2022
- Continue to work closely with our schools and colleges to embed mental health and wellbeing support.
- Continue the roll out of the MHST programme to meet 50% coverage in Suffolk - 2024
- Develop stronger working relationships with the VCSE and making best use of their skills, experience and knowledge supporting CYP. Develop collaborative provision of support bringing VCSE organisations together.
- Develop more collaborative working arrangements with the Local Authority and providers across Suffolk.
- Continue to embed Thrive across all services supporting CYP with mental health and emotional wellbeing needs. 2022
- Develop new seminar and Workforce Development plan for all professionals to ensure MH and EW is embedded in local learning
- Work with Districts and Boroughs to develop youth support programs in schools alongside our MHSTs and PMHWs
- Share the new co-produced communication plan for MH early 2022
- Recruit and embed CYP PCN workers across Suffolk
- Work with the provider collaborative on tier 4 support options in Suffolk
- Continue to support NSFT with recovery plans in place

Neurodevelopmental Pathway (NDD) - Background…

- The work arose from recognised need based upon the following key areas:
  - Historic long waiting times for a diagnosis
  - Area of concern raised within the SEND inspection (December 2016) and re-visit (January 2019)
  - Support only available with successful diagnosis
- A multi-agency NDD Steering Group was established in 2018 with the objective of reviewing the current universal and specialist offer and co-producing an inclusive NDD model - fit for purpose and meeting the needs of CYP and their families in Suffolk. The draft high-level model was agreed in July 2019 at the CYP board. It is a new way of working rather than a new service delivery
- To turn the model into reality the overarching project was in 3 distinct parts:
  - Support services procurement
  - Coordination function
  - Clinical diagnostic pathways

Neurodevelopmental Pathway (NDD) - Background…

- The high level model that was agreed:
  - Makes support for families a priority
  - Is not diagnosis driven. The focus is on what support the CYP needs rather than on what condition they have.
  - Provides support at the point of need
  - Provides support through 3rd sector
  - Introduces a Coordination Function
  - Reviews clinical pathways
- An NDD Steering Group provided oversight of task and finish (working) groups, for the following areas:
  - NDD Procurement
  - NDD Coordination Function
  - NDD Triage Panel
  - NDD Clinical Pathways

  The primary focus of the group was to deliver a high-level neurodevelopment pathway model, to involve outlining and changing current pathways and ways of working, seeking out and developing support for children, young people and families and improving advice and guidance. To optimise pathways between providers in a way that puts children, young people and families first.

Neurodevelopmental Pathway (NDD) – Key points…

- The pathway is being tested from January 2022, to develop the outputs from the development stage. Launch of the pathway is scheduled for April 2022.
- Nothing will be excluded in assessment. This will be an NDD service but accepted that majority of referrals will be ASD/ADHD, but not exclusively.
- 0 -18 to start but at ‘go live’ will start to plan for 18 – 25’s. And support offer procurement will cover 0 – 25. Evaluation will inform progress. Panel will look different for 18 – 25
- Language is key. Trying to move away from ‘we think it may be ADHD’. Towards addressing a need…. What does the child need. And accept that it will probably be ongoing.

Neurodevelopmental Pathway (NDD) – Key points…

Support Services Procurement (in addition to existing available support)

- Support offers will be open to all (they do not require a diagnosis or referral from a specialist to access), and will provide support at any stage of the NDD journey, from pre referral to post diagnosis
- A procurement process resulted in 7 VCSE providers being offered contracts.
- The focus on early intervention will provide help to develop the skills of the family thus reducing the need for referrals to specialist services.
- Referrals to support services will be via the coordination function (CF) when it becomes operational. In the interim, the services are working with the Emotional Wellbeing Hub and others to progress inward referrals until the CF is up and running. Discussions continue with Hub staff to ensure that Barnardo's, who provide the CF are allocated cases from the Hub that indicate NDD issues
- All providers are now mobilized
- Successful bidders meet together regularly as a group to enable partnership working and information sharing.

Neurodevelopmental Pathway (NDD) – Key points…

Coordination Function

- The coordination function needs will hold and provide help and support around support services that are available and also assist in guiding families through the clinical diagnostic pathways.
- The coordination function is a key link for CYP, families and services to ensure that consistency of support and information, and a single point of access to the NDD pathway.
- Following a procurement process Barnardo's, as a well-established children's charity have been confirmed as providers of the NDD CF, bringing with them experience of:
    - A person-centred approach – Providing support along the child's journey using a strengths-based approach.
    - Child and family voice – A strong partner for advocacy for children and families ensuring their voice is heard.
    - Community outreach – Barnardo's can play a critical role in engaging the wider community using an asset-based approach.
- Barnardo's are providing integral support to the mobilisation process

Neurodevelopmental Pathway (NDD) – Key points…

Triage Panel

- The new triage panel will ensure that all referrals to the new pathway help identify any early interventions that may be needed as well as ensuring that the most appropriate assessments are undertaken, removing the existing processes where a child may be assessed under one pathway before being directed to another.
- Triage will be front loaded, - experienced clinicians to decide on assessments to avoid unnecessary use of clinical time
- No conditions to be excluded (and to include behaviours that challenge)
- Evaluation of panel to be undertaken (initial internal and after 12 months externally)
- Referral form drafted.

Neurodevelopmental Pathway (NDD) – What next…

- Currently testing the processes and procedures that have been developed at working groups. It is expected that this will take 3 months
- Comms strategy being worked up to coincide with full launch of the new way of working.
  - To include internal and external briefings (e.g. to GPs, SENCO's, headteachers)
  - A dedicated NDD area on the local offer website to be in place
  - Myth busting help sheet to be cascaded
  - Use of language to be an integral part of comms, to move away from diagnosis to needs, to recognise and accept NDD as a difference rather than disorder
- Draft MOU/SOPs to develop more collaborative working arrangements with the Local Authority and providers across Suffolk, particularly at professional meetings
- Close alignment with the development of locality working

Thank you