MEETING OF THE LEICESTERSHIRE, LEICESTER AND RUTLAND JOINT HEALTH SCRUTINY COMMITTEE

DATE: **MONDAY, 21 JANUARY 2019**
TIME: **2:00 pm**
PLACE: **Meeting Rooms G.01 and G.02 - City Hall, 115 Charles Street, Leicester, LE1 1FZ**

Members of the Committee

Leicester City Council

Councillor Cutkelvin (Chair of the Committee)
Councillor Chaplin
Councillor Fonseca
Councillor Pantling
Councillor Cleaver
Councillor Dr Moore
Councillor Dr Sangster

Leicestershire County Council

Dr R.K.A.Feltham CC (Vice-Chair of the Committee)
Mrs A Hack CC
Dr S Hill CC
Mrs J Richards CC
Mr D Harrison CC
Mr T Barkley. CC
Mrs M Wright CC

Rutland County Council

Councillor G Conde
Councillor Miss G Waller

Members of the Committee are invited to attend the above meeting to consider the items of business listed overleaf.

For Monitoring Officer

Officer contacts:
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Leicester City Council, City Hall, 115 Charles Street, Leicester, LE1 1FZ

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- ✓ where filming, to (via the Chair of the meeting) ensure that those present are aware that they may be filmed and respect any requests to not be filmed.

Further information

If you have any queries about any of the above or the business to be discussed, please contact Julie Harget**, Democratic Support on (0116) 454 6357 or email Julie.harget@leicester.gov.uk** or call in at City Hall, 115 Charles Street, Leicester, LE1 1FZ.

For Press Enquiries - please phone the **Communications Unit on 454 4151**

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USEFUL ACRONYMS RELATING TO
LEICESTERSHIRE LEICESTER AND RUTLAND JOINT HEALTH SCRUTINY COMMITTEE

Acronym	Meaning
ACO	Accountable Care Organisation
AEDB	Accident and Emergency Delivery Board
CAMHS	Children and Adolescents Mental Health Service
CHD	Coronary Heart Disease
CVD	Cardiovascular Disease
CCG	Clinical Commissioning Group
LCCCG	Leicester City Clinical Commissioning Group
ELCCG	East Leicestershire Clinical Commissioning Group
WLCCG	West Leicestershire Clinical Commissioning Group
COPD	Chronic Obstructive Pulmonary Disease
CQC	Care Quality Commission
DTOC	Delayed Transfers of Care
ECS	Engaging Staffordshire Communities (who were awarded the HWLL contract)
ED	Emergency Department
EHC	Emergency Hormonal Contraception
ECMO	Extra Corporeal Membrane Oxygenation
EMAS	East Midlands Ambulance Service
FBC	Full Business Case
GPAU	General Practitioner Assessment Unit
HALO	Hospital Ambulance Liaison Officer
HCSW	Health Care Support Workers
HWLL	Healthwatch Leicester and Leicestershire
JSNA	Joint Strategic Needs Assessment
NHSE	NHS England
NQB	National Quality Board
OBC	Outline Business Case
PCT	Primary Care Trust
PICU	Paediatric Intensive Care Unit
PHOF	Public Health Outcomes Framework
QNIC	Quality Network for Inpatient CAHMS
RN	Registered Nurse

RSE	Relationship and Sex Education
STP	Sustainability Transformation Partnership
TASL	Thames Ambulance Service Ltd
UHL	University Hospitals of Leicester
UEC	Urgent and Emergency Care

PUBLIC SESSION

AGENDA

NOTE:

This meeting will be webcast live at the following link:-

http://www.leicester.public-i.tv

An archive copy of the webcast will normally be available on the Council's website within 48 hours of the meeting taking place at the following link:-

http://www.leicester.public-i.tv/core/portal/webcasts

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1. APOLOGIES FOR ABSENCE

2. DECLARATIONS OF INTEREST

Members are asked to declare any interests they may have in the business on the agenda.

3. MINUTES OF PREVIOUS MEETING

The minutes of the meeting held on 4 September 2018 and the Special Meeting held on 28 September 2018 have been circulated and the Committee is asked to confirm them as correct records.

4. PETITIONS

The Monitoring Officer to report on the receipt of any petitions submitted in accordance with the Council's procedures

5. QUESTIONS, REPRESENTATIONS, STATEMENTS OF CASE

The Monitoring Officer to report on the receipt of any questions, petitions, or

statements of case in accordance with the Council's procedures.

The following questions have been received in accordance with Part 4E: Scrutiny Procedure Rules (Rule 10) of the constitution.

Tom Barker

What actions will the committee be taking to scrutinise the detailed calculations underpinning UHL's decision that no additional hospital beds will be needed for the growing population of Leicester, Leicestershire and Rutland for the coming years even though we already don't have enough beds to meet patient need?

Peter Worrall

What plans have the Joint Health Scrutiny Committee for scrutinising the UHL plans for reconfiguration of acute services and how can the committee ensure UHL follows its recommendations, given that the plans have already been drawn up in detail although these details have not been shared with the public?

Katy Wheatley

Will the joint scrutiny committee be examining whether the capacity planning in UHL's acute reconfiguration proposals adequately take into consideration the growth plans across Leicester, Leicestershire and Rutland and increased numbers of dwellings and residents in the coming years?

Kathy Reynolds

How does the JHOSC plan to collect the evidence that will assure both the JHOSC and the public that STP/UHL plans for reconfiguration involving a capital bid for £367m will meet the future needs of the Leicester, Leicestershire & Rutland community? I am particularly concerned that at the recent engagement events it became clear that the UHL Plan was reliant on changes within community and primary care to allow it to deliver. However, the Community / Primary Care Plan is not available nor has the associated engagement has taken place, raising questions about the assumptions behind UHL's Plan. Does the JHOSC have a work plan or are they planning a programme of work to assure the public and can we be appraised of the arrangements?

6. UPDATE ON THE MANAGEMENT STRUCTURE ACROSS THE THREE CLINICAL COMMISSIONING GROUPS IN LEICESTER, LEICESTERSHIRE AND RUTLAND

Appendix A (Pages 1 - 24)

The Committee will be asked to consider a report that provides an update on progress with proposals to appoint a joint accountable officer and management team across the three Clinical Commissioning Groups (CCGs) in Leicester, Leicestershire and Rutland (LLR) – NHS West Leicestershire CCG, NHS East Leicestershire and Rutland CCG and NHS Leicester City CCG. The report

includes a link to an additional paper that provides background information, and that additional paper is also attached for Members' convenience.

7. BETTER CARE TOGETHER ENGAGEMENT AND INVOLVEMENT **Appendix B (Pages 25 - 30)**

The Committee will be asked to receive a report that describes the activities undertaken in October and November 2018 to engage with communities in Leicester, Leicestershire and Rutland on Better Care Together. The report also describes the ongoing activities which will take place between January and March 2019.

The Committee is asked to note the outcome of the Better Care Together engagement work and the work to be undertaken early in 2019.

8. BETTER CARE TOGETHER: COMMUNITY HEALTH SERVICES REDESIGN **Appendix C (Pages 31 - 44)**

The Committee will be asked to receive a report from the three Clinical Commissioning Groups (CCGs) in Leicester, Leicestershire and Rutland that provides an overview of the Community Services Redesign project which looks at the future model of community health.

The Committee is asked to note the progress to date in redesigning community health services and the next stage of the work.

9. WORK PROGRAMME **Appendix D (Pages 45 - 46)**

The Scrutiny Policy Officer submits a document that outlines the Leicestershire, Leicester and Rutland Health Scrutiny Committee Work Programme for 2018/19. The Committee is asked to consider the Programme and make comments and/or amendments as it considers necessary.

10. ANY OTHER URGENT BUSINESS

JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE: 21 JANUARY 2019

REPORT OF NHS WEST LEICESTERSHIRE CCG, NHS EAST LEICESTERSHIRE AND RUTLAND CCG AND NHS LEICESTER CITY CCG

UPDATE ON CCGS' MANGEMENT STRUCTURE

Purpose of report

The purpose of this report is to update the Joint Health Overview and Scrutiny Committee on progress with proposals to appoint a joint accountable officer and management team across the three Clinical Commissioning Groups (CCGs) in Leicester, Leicestershire and Rutland (LLR) – NHS West Leicestershire CCG, NHS East Leicestershire and Rutland CCG and NHS Leicester City CCG.

Background

Discussions regarding increased collaboration between the three CCGs in LLR have been ongoing for some time.

In June 2018, the three CCGs formally considered initial proposals to move to a single accountable officer and joint management structure at their respective Governing Body Meetings. However, a consensus between the three CCGs was not reached.

As set out the report provided to the Health Overview and Scrutiny Committee in August 2018, the CCGs' Governing Bodies each agreed to the continuation of conversations about the potential for a single accountable officer and management team across the organisations, including more work on the potential benefits that such a change might bring.

These discussions were extremely productive and a refreshed proposal was taken to the Governing Body meeting of each CCG on Tuesday 11 December.

Proposals

At the respective Governing Body meetings of the three clinical commissioning groups (CCGs) in Leicester, Leicestershire and Rutland (LLR) in December, the three CCGs agreed proposals to appoint a joint accountable officer and management team.

The decision represents an important milestone in the evolution of collaborative working across the combined area of more than 1.1million patients.

It is anticipated that the move will create a stronger and more consistent commissioning voice across the three CCG areas, which will focus on working together to set high level outcomes for the population as a whole and hold providers

to account for delivery. In turn it is also expected to lead to a strengthening of existing locality working, with groups of local providers given increased responsibility for designing services that improve the health of the communities they serve.

In a briefing sent to all CCG staff, the three clinical chairs commented on the proposals as follows:

- Professor Azhar Farooqi, clinical chair of Leicester City CCG, said: “We have a long history of collaboration across LLR and this represents the next logical step. It gives us the opportunity to provide more clarity to providers, while reducing duplication and freeing up people that can drive the kind of system transformation that we need.”

- Professor Mayur Lakhani, clinical chair of West Leicestershire CCG, commented: “We believe this joint approach will help us to deliver our plans for improved care for patients throughout LLR. At its heart is a commitment to thinking strategically across our three CCG areas combined with a renewed emphasis on empowering localities.”

- Dr Ursula Montgomery, clinical chair of East Leicestershire and Rutland CCG, added: “I have already seen some great examples of collaboration and innovation in practice between our CCGs. I am confident that this move will help us to build upon those as we increasingly work in a more aligned and collaborative way than ever before.”

The recruitment process for the new accountable officer will commence subject to the outcome of consultation with affected individuals. Firm proposals regarding the structure of the joint management team will be developed and consulted on in due course.

The new arrangements will see even closer working between the three CCGs although each will remain as an independent statutory body. However, the CCGs have also agreed to consider the potential benefits of a legal merger. This work is expected to begin in early 2019, with the outcome of the review expected by mid-year.

An update will be provided to the Health Overview and Scrutiny Committee in due course.

Background papers

A paper detailing the proposals was presented at all three CCG Governing Body meetings on 11 December 2018. A copy of the paper can be viewed via the following link:

https://www.westleicestershireccg.nhs.uk/your-ccg/publications/your-ccg/west-leicestershire-ccg-board/board-meetings-and-board-papers/board-papers-2018/11-december-2018/1647-paper-c-collaborative-working-combined/file

Officer to Contact

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West Leicestershire Clinical Commissioning Group

Paper C

WEST LEICESTERSHIRE CLINICAL COMMISSIONING GROUP
BOARD MEETING

11th December 2018

Title of the report:	Next steps to greater collaboration between the CCGs in Leicester, Leicestershire and Rutland
Section:	Public
Report by:	Professor Mayur Lakhani, Dr Azar Farooki, Dr Ursula Montgomery
Presented by:	Professor Mayur Lakhani, Chair, WLCCG

Report supports the following West Leicestershire CCG's goal(s):			
Improve health outcomes		Improve the quality of health-care services	
Use our resources wisely		✓	

Equality Act 2010 – positive general duties:
1. The CCG is committed to fulfil its obligations under the Equality Act 2010, and to ensure services commissioned by the CCG are non-discriminatory on the grounds of any protected characteristics. 2. The CCG will work with providers, service users and communities of interest to ensure if any issues relating to equality of service within this report are identified and addressed.

Additional Paper details:	
Please state relevant Constitution provision	'5.1.2 a) - when exercising its functions to commission health services, consistently with the discharge by the Secretary of State and NHS England of their duty to promote a comprehensive health service and with the objectives and requirements placed on NHS England through *the mandate* published by the Secretary of State before the start of each financial year by…'
Please state relevant Scheme of Reservation and Delegation provision (SORD)	N/A
Please state relevant Financial Scheme of Delegation provision	N/A
Please state reason why this paper is being presented to the WLCCG Board	To restate approval for the proposal to appoint one Accountable Officer and a single senior management team across the three CCGs in Leicester, Leicestershire and Rutland.
Discussed by	Discussed in Confidential sessions of the Governing Body in February, March and April 2018. Discussed in Public sessions of the

	Governing Body in June and August 2018.
Alignment with other strategies	Better Care Together, STP
Environmental Implications	None identified.
Has this paper been discussed with members of the public and other stakeholders? If so, please provide details	Engagement with staff, member practices and statutory partners took place during late April and May. Consultation with affected individuals will commence if the proposal is supported by all three Governing Bodies.

EXECUTIVE SUMMARY:

1. This paper builds on previous discussions between the CCGs in Leicester, Leicestershire and Rutland (LLR) about enhancing collaborative commissioning arrangements and on the formal proposal considered by the Governing Body in June 2018 to appoint a single Accountable Officer and shared senior management team. It examines how commissioning has and will continue to change over the next two years and assesses whether existing commissioning arrangements in LLR are fit for purpose in the light of what must be achieved.

2. There is a national policy commitment to deliver Integrated Care Systems (ICS) across the country over the next few years. This will see collaborations of providers working in neighbourhoods/localities being given the freedom to allocate resources and design services to manage the health of the population that they serve. This commitment is based on evidence that this way of working can deliver real benefits for patients.

3. The move to working as an ICS has implications for commissioning. Many of the activities currently undertaken by CCGs such as designing pathways and the detail of how services are delivered (referred to as tactical commissioning) will become the responsibility of groups of providers working in neighbourhoods/localities. It necessitates a single commissioner across the ICS that can set high level outcomes for a population of 1m+ and hold the new provider collaborations to account for delivery (referred to as strategic commissioning)

4. It is not possible to establish this new system architecture unless CCGs allocate management resources to deliver the transformation needed. At the same time, CCGs must manage significant and immediate financial pressures and deliver large scale QIPP. The level of change needed means that commissioners must have a consistent voice with the authority to establish and manage new provider relationships. It will require new and scarce skills to establish population health budgets and determine what health outcomes are needed for the population.

5. These changes place considerable pressure on a CCG's management resources at a time when CCG running costs must reduce by 20% by 2020/21. This has led to many CCGs across the country optimising their limited resources by implementing joint management arrangements with a single Accountable Officer for an STP/ICS area; others have opted to merge their organisations.

6. The national policy commitment to implement ICSs over the next few years is consistent with the ambition in LLR to establish locality/neighbourhood working. LLR is also experiencing the same issues as other CCGs in the country with respect to management

resources and is struggling to deliver the transformation agenda alongside managing immediate financial pressures.

7. The additional challenge in LLR is that there is a risk that staff will be lost to other local systems that can now offer more certainty having already gone through the process to merge their management teams. This has led to the key recommendation in the paper that CCGs in LLR should move to a single Accountable Officer and shared management team. Merger is not currently being proposed as it has been agreed that this will be reviewed early in 2019 and concluded in mid-2019.

8. Moving to a single Accountable Officer and a shared management team also has implications for governance arrangements. Aligning decision-making and achieving a strong commissioner voice requires governance to be aligned through mechanisms such as delegating CCG functions to a joint committee. This has generated some concern in all three LLR CCGs about the impact on locality working, clinical engagement and CCG priorities, which are exacerbated by the need to fully embed trust.

9. The paper presents a range of mechanisms by which these concerns can be managed. The most important of these is the proposal to establish neighbourhood/locality working in shadow form as soon as possible and to do this by building on existing Integrated Locality Teams. This would be combined with working to a principle of subsidiarity which would be enshrined in the terms of reference for any joint governance arrangements and supported by a locality structure being reflected in the CCGs' combined management arrangements. Also proposed is an LLR Clinical Advisory Group which would provide a single clinical voice to support strategic commissioning decisions.

10. The mechanisms for aligned governance include joint committees and meetings in common. Joint committees can be established to make decisions on the CCGs' commissioning functions (i.e. statutory duties related to commissioning). Each CCG Governing Body retains statutory responsibility for a function; only operational responsibility can be delegated and so Governing Bodies have a key role in ensuring that the joint arrangements it puts in place are robust and that they are operating in line with expectations. The proposal is that this would be supported by all Governing Body members being involved in designing the new arrangements.

11. Corporate functions such as those overseen by remuneration committees and audit committees cannot be delegated to a joint committee. However, where relevant the committees (and Governing Bodies themselves) can all meet at the same time (referred to as meetings in common) and consider the same papers which does support joint decision-making. CCGs would also have their executive team as members in common which can be extended to other roles such as lay members.

12. Primary care commissioning cannot be delegated to a joint committee. Some CCGs across the country have moved to their Primary Care Committees (PCC) meeting in common whereas others have opted to retain a PCC for each CCG.

13. The overall conclusion is that CCGs in LLR should move to a single Accountable Officer and shared management team in order to ensure that current challenges are managed, system transformation is resourced, and the organisations remain fit for purpose as a commissioner within an Integrated Care System. It is acknowledged that this level of

change is significant and must be supported by a robust organisational development programme.

14. The recommendations encompass taking forward the proposal to appoint a single Accountable Officer and joint management team for LLR through the JESG and the arrangements for agreeing a revised governance structure through the involvement of all Governing Body members. Members are also asked to note both the importance of a robust organisational development programme and the fact that a review of the relative merits of merger will take place in early 2019 with an options appraisal to boards in mid-2019.

RECOMMENDATION:

The West Leicestershire Clinical Commissioning Group is requested to:

- **RESTATE APPROVAL** for the proposal to appoint one Accountable Officer and a single senior management team across the three CCGs in Leicester, Leicestershire and Rutland.

- **APPROVE** the proposal to require the JESG to develop a robust process for the appointment of the Accountable Officer and the senior management team across LLR, ensuring that: -
    - conflicts of interest are appropriately managed
    - there is a consistent approach to managing the implications for staff whilst ensuring that the process is in line with each CCG's management of change policy

- **APPROVE** the proposal to delegate authority to the CCG's Clinical Chair to sign off the arrangements for the appointments process referenced above, after seeking the recommendation of the Remuneration Committee in accordance with the CCG's constitutional requirement.

- **APPROVE** the proposal to charge the Joint Executive Steering Group (JESG) with overseeing the development of revised governance arrangements. The JESG must ensure that Governing Body members are engaged in the process to design the governance, through Board to Board sessions for example, prior to recommendations being formally presented back to Governing Bodies for approval.

- **NOTE** the importance of a fit for purpose organisational development programme and approve the proposal to require JESG to put this in place and produce reports as required on progress back to the Governing Body.

- **NOTE** the commitment to undertake a thorough consideration of the potential advantages and disadvantages of a full legal merger, with this work commencing in early 2019 and resulting in an options appraisal to boards in mid-2019.

NEXT STEPS TO GREATER COLLABORATION BETWEEN THE CCGs IN LEICESTER, LEICESTERSHIRE AND RUTLAND

INTRODUCTION

1. This paper follows on from a previous discussion in July 2018 about the appointment of a single Accountable Officer for the three CCGs in Leicester City, Leicestershire and Rutland (LLR).[1] It provides a refreshed case for change which centres on the need to develop an Integrated Care System (ICS).

2. The paper seeks to address concerns that have been raised about moving to aligned decision-making. It emphasises how the move will support the development of neighbourhood working in LLR which will involve collaborations of providers taking on responsibility for commissioning activities that have previously been undertaken by a CCG. There is a proposal to establish this neighbourhood working in shadow form at the earliest opportunity using Integrated Locality Teams as the building block.

3. The paper presents an outline of the governance options that can be used to support a single management team and presents an outline structure as an example of how it could work in LLR. However, the case is made that revised governance arrangements, whilst overseen by a cross- CCG strategic group, should involve all Governing Body members in the design as it is important that the arrangements are understood.

4. Throughout the paper, the need for strong organisational development is stressed and the recommendations include a requirement to develop this as a key programme of work.

BACKROUND

5. Since CCGs were first established in 2013 there has been a strong history of joint working across the three commissioning organisations in LLR. The original Commissioning Collaborative Board for example pre-dates CCG authorisation and has been integral to how the CCGs have delivered their lead commissioning portfolios around the main provider contracts.

6. Whilst these arrangements have served the CCGs well in the past, it is recognised that there is an imperative to ensure that they remain fit for purpose and that they enhance the ability of CCGs to collectively address the immediate financial challenge in LLR along with the need to transform and deliver the local and national ambition for an Integrated Care System.

7. In response to this, early in 2018/19 the CCGs in LLR initiated joint discussions about appointing a single Accountable Officer and senior management team across the patch. A cross-CCG Steering Group was established to oversee the detail of the proposal which culminated in a joint paper going to all three Governing Bodies in June 2018. This was then followed by a number of board-to-board development sessions, within which the positions of individual CCGs evolved, ultimately coming to a consensus in support of moving to a single accountable officer and management team.

[1] East Leicestershire and Rutland CCG; Leicester City CCG and West Leicestershire CCG

8. Following this, in August 2018 all three Governing Bodies agreed a proposal to conduct a piece of work over an eight to twelve-week period to jointly explore remaining issues, with a view to further enhancing the case for change. With respect to merger, it was agreed that a review of long-term configuration options for the CCGs would take place in early 2019, concluding by mid-2019.

9. In order to provide both additional capacity and independence, Dawn Smith, a former CCG Chief Officer in Nottingham City was commissioned to lead the work. Findings have been fed back to Governing Body members via two facilitated board-to-board development sessions in October and November 2018, which were also used to more fully understand the nature of any concerns.

CASE FOR CHANGE FROM A NATIONAL PERSPECTIVE

10. Any case for change with respect to the CCG's management arrangements should be set in the context of what must be delivered by commissioning organisations over the next few years and an assessment of whether the current arrangements are best placed to deliver that purpose.

11. This section considers the national imperative and what this means generally for commissioning arrangements and governance. This will be followed by an appraisal of how the national perspective applies to the local position in LLR.

National imperative

12. Although this paper is written in advance of the forthcoming publication of the Long-Term Plan for the NHS, it is already evident that system transformation and overseeing the development of an Integrated Care System (ICS) will be integral to the future role of commissioners.

13. Furthermore, there is a documented requirement placed on CCGs to deliver their functions within the running cost budget which will be reduced by 20% from 2020/21; this is a critical consideration in the case for change.

14. This section of the paper sets out the evidence for why developing an ICS will be the main priority for commissioners and assesses what changes are required to commissioning arrangements to deliver this important agenda within a reduced running cost budget.

15. Whilst the terminology may change, there has been a consistent and long-standing message from well-respected and independent think tanks such as the Kings Fund that, in order to address the well-rehearsed challenges facing the NHS,

> *"providers of services should establish place-based 'systems of care' in which they work together to improve health and care for the populations they serve. This means organisations collaborating to manage the common resources available to them"*[2].

[2] Ham C, Alderwick H (2015). Place-based systems of care A way forward for the NHS in England London: The King's Fund. Available at: https://www.kingsfund.org.uk/publications/place-based-systems-care

16. The evidence around this comes from a variety of sources and stems from the central principle of place-based care which is about giving freedom to care-providers to allocate resources and design services that will best enable proactive management of health for the population they cover. Some examples of work which set out the evidence-base for place-based integrated care include Goodwin and Smith (2011)[3] and Dorling et al (2015)[4]

17. This place-based approach is supported by NHS England (NHSE), with the Next Steps on the Five Year Forward View for example outlining the need to *"transition to population-based integrated health systems."*[5] More recent support was provided when the boards of NHSE and NHS Improvement (NHSI) met in common in September 2018 and considered a paper about progress with the Integrated Care Systems (ICS) Programme.[6]

18. The paper described how ICSs in the national programme are building capacity at three levels (see Table 1 below) and asserted that *"ICSs will be a foundational part of the future NHS system 'architecture".* Furthermore, the paper signaled an intent to define the essential elements of an ICS in the soon to be published Long-Term Plan for the NHS, with a view to ensuring that all systems develop in this way. Whilst this is anticipated to reflect the three levels described in Table 1, it is generally recognised that there are differences in how ICSs will develop in response to local circumstances.

19. The paper was well received by the Boards of both NHSE and NHSI with members welcoming both the emphasis on enabling clinicians to find solutions and the recognition that one of the essential characteristics of an ICS is that most work takes place through providers working in collaboration in neighbourhoods, coalesced around primary care networks.

20. If more evidence were needed that there is a national policy commitment to an ICS and a single strategic commissioner within that system, it came by way of the letter to CCGs from NHSE in November concerning the planned reduction to running costs. In detailing the mechanisms by which CCGs could achieve this requirement, the letter referenced efficiency opportunities in mergers/joint working arrangements and set out that NHSE would *"…….particularly support approaches which align a single CCG area with a single ICS."*

[3] Goodwin N, Smith J (2011). The Evidence Base for Integrated Care. Slidepack. https://www.kingsfund.org.uk/sites/default/files/Evidence-base-integrated-care2.pdf.

[4] Dorling G, Fountaine T, Mckenna S, Suresh B (2015). The Evidence for Integrated Care. Health Care Practice. https://www.mckinsey.com/~/media/McKinsey/Industries/Healthcare%20Systems%20and%20Services/Our%20Insights/The%20evidence%20for%20integrated%20care/The%20evidence%20for%20integrated%20care.ashx

[5] Next Steps on the Five Year Forward View (2017) https://www.england.nhs.uk/publication/next-steps-on-the-nhs-five-year-forward-view/

[6] Meetings in Common of the Boards of NHS England and NHS Improvement (September 2018). Report on: Integrated Care Systems Programme Update https://www.england.nhs.uk/wp-content/uploads/2018/09/03-MiCIE-27-09-2018-ICS-programme-update.pdf

Table 1: Integrated Care System - building capability and improving services at three levels:	
Neighbourhoods	With networks of GP practices serving 30-50,000 patients that are responsible for strengthening primary care by developing enhanced services and increasing access. Primary care networks share primary care workforce, assets, back office functions and standardise IT systems. By collaborating and making more of non-medical staff, these networks alleviate working pressures and offer a more attractive career model. At their most mature, primary care networks proactively support people who are at risk of falling ill, drawing on NHS, local government and third sector services
Places	Which bring together GP, mental health, hospital, community and social care services serving 150-500,000 people. They will often be coterminous with boroughs or district councils. Places are the engine of integration, focused on specific groups of people for whom we could prevent illness or deterioration. They are not administrative bodies: they are alliances of providers (including GPs) that redesign and integrate services around people's needs.
Systems (the overall ICS)	Typically serve populations of 1m+. They agree overall strategy and planning for that population, manage collective financial resources (through a system control total), develop and oversee strategies for workforce, estates and digital, and design the organisation of more specialist services. They take increasing responsibility for performance across the system, operating through systems of mutual accountability

The role of commissioners in an ICS

19. Currently commissioning in CCGs involves a range of activities, from the transactional ones inherent in managing provider contracts through to a responsibility for system leadership and the role taken in the STP. Paradoxically, the strategic responsibility for system leadership has also driven commissioners to become involved in the detail of how providers manage day to day service delivery with, for example, CCGs caught between the role of performance managing the urgent care system and being performance managed themselves around the production of detailed delivery plans. Nigel Edwards, Chief Executive of the Nuffield Trust has commented that this potentially explains why NHS commissioners *"have often become too involved in defining pathways, care processes and matters of detail that they generally knew less about than the providers."*[7]

[7] Edwards N (2018) Integrated Care: What does it mean for commissioning? Blogpost https://www.nuffieldtrust.org.uk/news-item/integrated-care-what-does-it-mean-for-commissioning#nhs-commissioning-to-date-a-complex-and-imperfect-arrangement

20. Of course, it is also important to recognise that in LLR, as in many other CCGs across the country, there is a strong skill-set across commissioners with respect to these tactical commissioning activities, and GPs undertaking CCG commissioning roles provide valuable clinical expertise along with knowledge and insight into how services are delivered in their local area and how they can be improved.

21. Within an ICS, this aspect of a CCG's current 'commissioning' activity will shift to the level of neighbourhood or place and become a provider responsibility. This will enable commissioners to focus on strategic commissioning activities at the system level, such as developing a detailed understanding of the health need of the population that they serve and co-designing high-level outcomes to meet that need in conjunction with local authorities and citizens and patients.

22. As well as moving commissioning activities out to providers, strategic commissioners will also be required to work jointly with local authorities and extend existing joint commissioning activities. Additionally, joint work will be required with other systems to commission services such as the ambulance contract which cover populations beyond single system boundaries and collectively take on devolved responsibility from NHS England for some specialised commissioning.

23. Whilst there is a strong future role for commissioners in managing providers, this needs to be of a different order, such as holding providers collectively to account for delivery against agreed outcomes and within population budgets. This will require new commissioning tasks such as setting capitated budgets which calls for highly specialist and scarce skills around actuarial analysis.

24. The above outlines how commissioning activities will change once an ICS is established, however prior to that happening there is a critical role for commissioners working within an aspirant ICS area to ensure that the new system architecture is put in place – facilitating the development of provider collaborations and primary care networks; understanding how to contract with them and where necessary conducting procurement processes; and doing the appropriate engagement work to ensure that what is set up makes sense at a place and neighbourhood level.

What does this mean for future commissioning arrangements?

25. The national commissioning *'ask'* as described above represents a fundamental change for CCGs, with a blurring of the provider/commissioner split and many of a CCG's tactical commissioning activities transferring to providers, leaving commissioners to develop an enhanced strategic role. This must be considered in conjunction with the requirement placed on CCGs to reduce running costs by 20% by 2020/21.

26. It is generally recognised that this enhanced role means that in order to have enough capacity and capability**, commissioning organisations will have to come together to cover larger populations analogous with the policy direction of systems serving populations of 1m+.** The informed view is that larger-scale organisations will be more likely to address any existing and growing imbalance of power between providers/provider alliances and commissioners.[2,7] However, it will also have to be sensitive enough to pick up joint commissioning arrangements with local authorities.

27. As well as CCGs having the right resources to manage the new system, difficulties in combining the need to deliver transformation and the evolution to strategic commissioning whilst carrying out existing activities have been identified by NHS Clinical Commissioners: -

"58 per cent [of CCGs] identified that time, resource and capacity was the biggest need to deliver the evolution of the commissioning system ……44 per cent requested increased support and capacity to deliver a sustainable and transformed system…."[8]

28. The response nationally to this changing commissioning landscape has been for CCGs to bring their organisations together, either through shared management and governance arrangements or via a merger. The scale and pace of this change was highlighted in analysis conducted by the Health Service Journal in November 2018 which identified that *"Almost a third of England's population is now overseen by 13 clinical commissioning group leaders."*[9] Additionally, in 2018 alone six new CCGs were formed from the merger of eighteen constituent organisations, whereas there were only two new CCGs established following a merger process in the previous three years.

29. Feedback from the independent work that we have commissioned has identified that of the CCGs examined, most were driven to move to a single Accountable Officer and management team (with associate changes to governance) by the factors identified in this case for change. Other influences included: -

- Unlocking precious time and resource – reduce duplication
- Single leadership, consistency and focus on the things that are done collaboratively across CCGs – particularly QIPP
- Stronger management of provider performance and a single link into NHSE for assurance
- Development of common pathways for the population
- Increased confidence in CCG leadership
- Creating certainty for staff
- Some (but a minority) felt they did not have much choice about it – usually driven by finances

What does it mean for CCG governance?

30. The appointment of a single Accountable Officer and management team cannot support the delivery of an ICS or optimise the potential to remove duplication of effort in isolation. It must be accompanied by the associated decision-making related to the CCGs commissioning functions also taking place once across the organisations. Streamlining governance will also support CCGs to reduce running costs.

31. Those CCGs that moved to a single management team prior to implementing changes in governance, reported that the period of double running was time consuming and cumbersome. Whilst it is inevitable that there will be some overlap, the learning from other areas is that the management of change process and organisational development programme must address the management structure and corporate governance structure concurrently.

32. There are various mechanisms for supporting this to take place which are discussed later in this paper. It is perhaps worth stressing at this point that there is nothing to

[8] NHS Clinical Commissioners (2017) Making strategic commissioning work. Briefing paper. https://445oon4dhpii7gjvs2jih81q-wpengine.netdna-ssl.com/wp-content/uploads/2017/12/Making-strategic-commissioning-work-web-final.pdf

[9] Brennan, S (November 5 2018) Health Service Journal. Revealed: Third of population overseen by 13 CCG leaders

prevent all the CCGs commissioning functions being exercise through a joint arrangement whilst also transferring commissioning activities (such as pathway design) to place and neighbourhood, if there is assurance that appropriate capacity and capability is in place at this at this level to carry these out effectively.

Summary of the national case for change

33. There is a clear national policy commitment to move towards ICSs being established across the country which is supported by a level of evidence that suggests that this way of working offers the greatest potential to improve outcomes for patients and make the most effective use of limited resources. This policy commitment is also reflected in NHSE's letter to CCGs about running costs which indicates that unified commissioning arrangements across an ICS footprint are favoured.

34. It is envisaged that as the neighbourhood and place elements of an ICS are established, this will enable many of the tactical commissioning activities currently undertaken by the CCGs to transfer to collaborations of providers who are better placed to design and deliver services for the populations that they serve.

35. There is an accepted view that a single commissioner voice is required within the ICS with the capacity and capability to oversee the development of provider collaborations and ultimately to establish and manage population health budgets which those providers will manage. This requires aligned decision-making through changed governance arrangements as well as a single management team.

36. In the interim, CCGs need to address the immediate financial challenges and undertake the existing transactional and tactical commissioning responsibilities. Doing transformation at the same time as delivering immediate financial savings and detailed provider contract management is something that all CCGs across the country have struggled with and many have already concluded that there is no room for duplication of effort and have taken steps to bring together joint management teams across an STP/ICS area.

HOW DOES THE CASE FOR CHANGE APPLY TO LEICESTER, LEICESTERSHIRE AND RUTLAND?

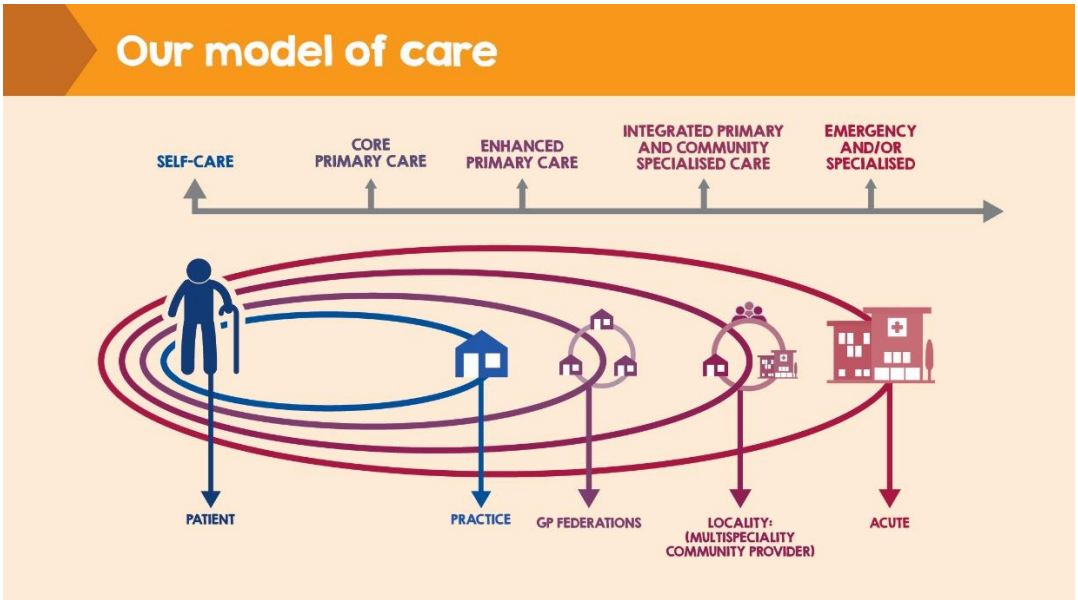
The approach to an ICS in LLR

37. As well as it being a national policy commitment, the development of an ICS also reflects the evolving model of care that LLR CCGs have committed to implement alongside other partners. This is part of the Better Care Together approach to tackling the *Triple Aim Gaps* in Health and Wellbeing; Care and Quality; and Finance (see Table 2 below).

38. This model will be built around individuals, supporting them to be as active and as independent as they can be with the aim of treating people at or close to home wherever it is clinically appropriate. As in the existing ICSs nationally which anticipate a strong role for Primary Care Networks, the LLR model is centred upon strengthening primary care and the provision of GP services, with the GP surgery and its list of registered patients being the central pillar of local care. This will see additional capacity provided through recruitment to new roles within the primary health care team, supported by integration of care for people with long-term and complex conditions. It will feature multidisciplinary teams and practices working more closely together in federations or localities to manage population health in order to improve outcomes for patients and

citizens in line with national evidence. This will create a more clinically effective and cost-efficient system which will reduce the need for emergency admissions to a hospital bed.

Table 2: Better Care Together Model of Care



Capacity and capability in LLR commissioning arrangements

39. With respect to having sufficient capacity, the independent work that we have commissioned has told us that that our senior staff who work with the current arrangements are frustrated by the time it takes them to get decisions made across three organisations and are concerned that they don't have sufficient time to do everything that needs to be done, particularly when it comes to the planning function.

40. Partners experience our commissioning decisions as being inconsistent and believe that we are distracted by discussing potential change when we should be delivering it. They are concerned that more capacity within the CCGs need to be freed up to work on transformation. The failure to do so presents a risk to progress against the *Better Care Together* plan and to the ability to access capital funding.

41. Of course, providers also have a responsibility to release their management capacity to lead transformation work and this has happened in many areas across the country. If the CCGs are able to continue to lead by example and release even more management resource to work on system issues, then this would be a powerful catalyst for change. Additionally, a single commissioner voice and strengthened role in leadership of the STP would enable CCGs to exert more authority when calling for additional provider capacity to be released.

42. It is important to note that stakeholders also report that our staff are doing a good job and that there are examples of where progress has been made which is positive. However, they believe that this is despite the arrangements we have in place as opposed to being because of them.

43. There is a now a risk that staff will be drawn to apply for roles advertised in local systems that have already implemented this level of change and that this will further impede the

ability of LLR to tackle the transformation agenda. This won't immediately be addressed by all Governing Bodies approving the proposal to move to a single Accountable Officer and senior management team, because staff will be aware that any management of change process will take time to work through. However, it would prevent any further extension to the disruption caused by the current level of uncertainty.

KEY CONCERNS TO BE ADDRESSED

44. In discussing the initial proposal and in subsequent discussions as part of the independent work that we have commissioned, there have been four broad themes which have been raised consistently. The operation of governance arrangements underpins many of these and this is discussed in a later section of the report.

Issue 1: Enhancing locality involvement

45. This overall concern stems from a worry that a single management team, and the centralised governance of commissioning functions across LLR that goes with that would lead to decision-making being separated from a real knowledge and understanding of the population. The paradox is that the driver for commissioning functions being brought together across LLR includes a need to establish neighbourhood working as part of an ICS. This in turn will enable the responsibility for commissioning activities to be transferred to providers who have a detailed understanding of the population and can manage and deliver services in response to that. This will present a real opportunity to realise the ambition in LLR to enable neighbourhood working to thrive and produce the associated benefits to patients.

46. One element of addressing locality involvement is to ensure that local authorities are involved in strategic commissioning arrangements and that joint or aligned commissioning at this level is enhanced. However, this does not bring in the clinical perspective or the anticipated involvement of all providers working on the ground at neighbourhood level. What is required in the interim whilst an ICS is established is a mechanism for ensuring that the neighbourhood and place level of the system is brought together in shadow form concurrently with the process of bringing the CCGs' commissioning functions together.

47. The building block for this initial shadow structure is the existing Integrated Locality Teams, although it is recognised that they are at an early stage of development. **In order to strengthen this level of working, this locality focus would have to be reflected in the CCGs' revised management structure.** Effective mechanisms of communication must be established between the emergent neighbourhood/place collaborations and any joint governance arrangements across the three CCGs in LLR, along with visible adherence to the principle of subsidiarity.

48. It is recognised that even moving to a place/neighbourhood structure in shadow form, with consideration of delegation of decision making as far down the chain as possible, requires a considerable amount of development work with the boundaries for place not yet having been agreed for example. **As it involves partners beyond the CCG it is suggested that this is taken forward through the STP leadership group.** This work is however already in progress which is helpful.

49. Any discussion on locality involvement should include the need to account for how the voice of patients and citizens is heard, and it would make sense to ensure that place/neighbourhoods have a key role in this. However, this will require further discussion with existing CCG patient fora and with both Healthwatch organisations in

LLR, who have expressed a keen and legitimate interest in being involved in designing patient engagement mechanisms as part of any commissioning changes.

Issue 2: Strengthening clinical involvement and engagement

50. This theme clearly relates to a worry with regards to the loss of locality working described in the previous section. However, it warrants separate consideration because clinical engagement is central to a CCG's way of working and as set out in the national case for change, is fundamental to the success of an ICS.

51. ICSs are founded on the principle of clinicians working at place and neighbourhood level being involved in designing and delivering services. The approach set out above would ensure that clinical involvement at this level would continue to take place and feed into decision-makers at the LLR commissioning system level (although ultimately the clinicians at the place/neighbourhood level would be making decisions on tactical commissioning activities themselves where it was appropriate to do so). However, it does not address the clinical involvement in discharging commissioning functions and being involved in making the decisions at the LLR system level.

52. It is proposed that strategic clinical leads are appointed to cover a range of clinical programmes across LLR. Whilst these individuals may have responsibilities at locality level as well, their role at the system level would require them to develop a strategic understanding of their lead area beyond how it relates to their own locality. They would have to have or develop a level of knowledge that would demand the respect of clinicians working across LLR such that there was confidence that they were not simply reflecting the interests of their locality.

53. The distinction between the two roles of strategic lead and locality lead could be reinforced by mechanisms such as having separate contracts for the work or clearly defined job plans. Collectively these clinicians would form a clinical advisory board and feed into the joint commissioning governance arrangements. As well as being guided by the clinical advisory group, any joint decision-making committees could have a clinical majority, in the same way that CCG Governing Bodies operate.

Issue 3: Balancing system vs local priorities

54. There are several examples that fit within this broad category. They include the following: -

- Understanding how best to recognise and address health inequalities across CCGs.
- The financial position may be worse in one of the CCGs and the improved position or savings of the other(s) may go to offset the deficit position.

55. CCG Governing Bodies are and will remain the statutory organisation responsible for setting the strategic direction of the organisation and for ensuring that the organisation achieves financial balance. It will need to be assured that joint arrangements are conducive to this taking place prior to agreeing any delegation of functions. From the point of delegation, ongoing assurance will be required via reports to the Governing Body that any delegated commissioning functions are being discharged in a way that supports the delivery of the Governing Body's strategic priorities. The single Accountable Officer and joint Chief Finance Officer will have specific statutory responsibilities relating to this as well.

56. Whilst joint arrangements can be utilised to develop each CCG's financial plan and budgets, these would be subject to the approval of each Governing Body and each CCG would retain its own ledger.

57. It is recognised that receiving assurance is one step removed from taking decisions yourself, which is a change that members may be uncomfortable with. However, it is essentially an extension of how Governing Bodies already operate in that their purpose is to offer overall direction and oversight with many decisions already delegated and operational issues managed by the senior management team, often working collectively with clinical and managerial colleagues in other CCGs. An important protective mechanism will be strengthening locality working which will ensure the involvement of a CCG's clinicians at grass roots level and reassure the Governing Body that a local response to joint decision-making will be supported. Any changes to CCG governance will need to be agreed by the respective Governing Bodies in accordance with their own processes prior to being enacted.

58. It is important that this change is supported by an organisational development programme so that members understand the mechanisms that exist to ensure that there is a continued focus on the organisation's strategic priorities and they are confident in any delegated arrangements and how the Governing Body can most effectively seek assurance. Involvement of Governing Bodies in designing the governance arrangements is integral to this process and it is recommended that this is taken forward through the organisational development programme which should encompass ongoing board- to-board sessions.

Issue 4: Increasing collaboration

59. The importance of trust is well illustrated through a quotation from a King's Fund report on establishing place-based commissioning[2]

> *"The argument of this paper is that collaboration through place-based systems of care offers the best opportunity for NHS organisations to tackle the growing challenges that they are faced with. It will, however, require organisational leaders to surrender some of their autonomy in pursuit of the greater good of the populations they collectively serve…."*[2]

60. This is of relevance to all leaders within an ICS from an acute trust chief executive to GP practice partners operating in a federation and is something that has featured as a concern in many instances of CCGs initiating joint arrangements. It is difficult to give up autonomy without trust, but it is by working collaboratively that the necessary relationships for trust can be developed.

61. The fact that we have identified trust and genuine collaboration as critical to the success of our future working arrangements is a positive first step. Strategies aimed at strengthening relationships, including working together on collective problems, can now be built into the organisational development plan and extended to cover our partnership arrangements across the STP.

62. Learning from other areas tells us that trust takes time to become fully embedded. In the meantime, documented principles such as subsidiarity can add confidence to the arrangements. Good governance is another mechanism by which leaders can be supported to let go of some of their autonomy and act in the interests of the wider system. Done properly it can offer the necessary safeguards whilst trust develops without being overly burdensome.

ORGANISATIONAL DEVELOPMENT

63. The importance of organisational development has been referenced on several occasions throughout this paper. This section provides an outline of what this would encompass.

64. The main purpose of the OD programme would be to develop and implement an *'LLR Joint CCG Working Implementation Plan'* with minimal disruption, ensuring Governing Bodies and CCG employees adopt and embed the new working arrangements. It is anticipated that OD support would be required at a senior level, utilising proven expertise in delivering successful business change combined with a good understanding of change management academic best practice. Ideally, this individual would establish a small business change PMO consisting of existing CCG employees seconded to deliver the LLR change, using established NHS OD resources. The OD support and team would be tasked to deliver the following: -

Organisational Design

- Design the new organisational structure, including functions and roles within functions.
- Provide detailed roles and responsibilities and reporting structures.
- Ensure that appropriate links are made with the planned review of long-term configuration (merger) that will take place early in 2019 and result in an options appraisal by mid-2019.
- The requirement for reducing administration costs by 20% by 2020/21 must also be taken in to account.

Organisational Development

- Develop the LLR CCG Vision, in collaboration with Governing Bodies and Joint Accountable Officer.
- Advise, coach and influence senior leaders in how to deliver successful business change effectively.
- Help to define, and support the embedding of, a new LLR culture with trust at its core.
- Identify, plan and deliver engagement activities/workshops to engage LLR staff, including the Governing Body to ensure everyone is on-board, fully trained and able to adopt the new ways of working.

HR

- Identify and implement all people-related activities moving from the 'old' structure to the 'new' structure, including managing consultation, recruitment to new roles and redeployment etc.
- Ensure compliance with NHSE and statutory employment requirements.

GOVERNANCE OPTIONS

65. As set out above and identified by CCG Governing Bodies when first considering a proposal to move to a single Accountable Officer and single management team, the aim of aligning decision-making and having a strong commissioner voice cannot be achieved in isolation through joint management arrangements; it also requires decision-making to be aligned across CCG partners. Any changes to CCG governance arrangements will

need to be agreed by the respective Governing Bodies in accordance with their own processes prior to being enacted.

Joint Committees

66. The strongest way of achieving aligned decision-making is via the statutory mechanism of a joint committee which enables CCGs working together to exercise their **commissioning** functions jointly. It requires each Governing Body to delegate functions and determine the arrangements with respect to terms of reference and membership, supported by a revised scheme of reservation and delegation.

67. Only commissioning functions can be delegated by Governing Bodies, corporate functions such as those undertaken by the remuneration committee and the audit committee remain the responsibility of the Governing Body.

68. It is up to Governing Bodies to determine what to delegate to a joint committee and most CCGs who have undertaken this process have designed the arrangements jointly and included Governing Body members in the process**. If the functions to be delegated are extensive, which given the need for a joint committee(s) to represent the single commissioning voice in the ICS is likely to be the case, then engagement with member practices is required as it would serve as a significant change to the CCG's constitution.**

69. Only operational responsibility for a function can be delegated, the CCG Governing Body retains legal responsibility and therefore will need to ensure that: -

    a. The arrangements that are put in place are robust and clear in terms of what has been delegated, with joint policies in place where appropriate.
    b. There is close oversight of joint committee decisions to ensure that statutory duties are complied with.

70. Whilst oversight of the decisions made by a joint committee is an essential role, the purpose is to ensure that the CCG is meeting its legal responsibilities and that the joint committee is operating within the terms of its delegated responsibilities. It is important that it isn't used as a rationale to unpick jointly made decisions which are compliant with delegated powers or to introduce an additional layer by discussing papers as a Governing Body prior to the matter being discussed at the joint committee. This would defeat the overall purpose of the joint committee which is to streamline decision-making as it would involve a single executive team attending multiple meetings to discuss the same issue.

71. Where there are specific concerns about the risk of a single decision-making body across LLR, there are other mechanisms for managing them. For example, some areas locally have developed principles which the joint committee is required to respect and are enshrined in the terms of reference e.g. the principle of subsidiarity or of clinical engagement.

72. There would be a clear expectation on all members of a Joint Committee to act in accordance with delivering each CCG's organisational strategic objectives and priorities. The Joint Committee would be held to account for delivering this through regular reporting to Governing Bodies and each Governing Body will have its own members represented on the Joint Committee who will be expected to have a full understanding of these issues.

73. It should be noted that the Governing Bodies of individual statutory CCGs would retain the right to revoke any delegation of authority, including to joint committees, that it had previously agreed.

74. As part of the arrangements for developing the joint committee, consideration will need to be given to how issues will be addressed when a consensus cannot be reached. This could for example involve further engagement / agreed voting arrangements or revert to the individual governing bodies for further consideration and, where appropriate, decision.

Committees in Common

75. This is the mechanism for streamlining decision-making for those commissioning functions that cannot be delegated such as remuneration committee and the primary care commissioning committee[10]. This does not have to be a one-sized solution and there can be a mixture of Governing Body corporate committees (or Governing Bodies themselves) meeting in common and the retention of individual committees. Many areas have for example retained primary care commissioning committees meeting separately in the first instance whilst moving to committees in common for audit committee and remuneration committee. Committees can also alternate between meeting in common and meeting separately.

76. Committees in common involve each CCG making their own decision on the same issue and so do not enable truly aligned decision-making. However, the advantage is that they meet collectively and listen to the same discussion. Additionally, there will be members in common to all the CCGs' committees such as the single Accountable Officer and this can be extended to other members of the Governing Body as well. For example, the lay member of a primary care committee for CCG1 can become a member of the primary care committee for CCG2.

77. Committees in common have the advantage of reducing the administrative burden on a single CCG executive team and make sense for example when the CCGs are receiving assurance on the same issue. There is nothing to prevent some items of the agenda only relating to one or two of the CCGs present at the meeting in common, but clearly if there are a significant number of single-CCG issues to be discussed, this defeats the object of all CCGs being in the room.

CONCLUSION

78. The paper has assessed the new commissioning requirements that arise from the need to establish integrated and high quality care in LLR that will deliver a locally responsive place-based system of care that in turn offers evidence-based improvements to health outcomes for the population that we serve. The overall conclusion is that, set against the need to establish an ICS, our existing collaborative arrangements are no longer fit for purpose because we lack the necessary capacity to manage the increased workload arising from system transformation whilst we continue to undertake current transactional commissioning arrangements and deal with immediate financial pressures. Neither do they enable us to establish ourselves as strategic commissioners within an ICS, where we will need to deliver a consistent and strong commissioner voice to shape and

[10] Primary Care Commissioning is not one of the CCGs statutory functions, it is the responsibility of NHS England who has delegated it to each CCG in LLR and therefore cannot be delegated by the CCG

manage the new provider collaborations that will evolve. However, this paper does not ask CCGs to change their current governance arrangements as outlined in their constitutions, but points to further work that is required.

79. In line with how other CCGs across the country have dealt with this capacity gap, there is a strong argument presented to focus our commissioning effort through a joint senior management team with leadership from a single Accountable Officer. Whilst it is recognised that merger is another route to achieving this, as CCGs we have collectively agreed to review this early in 2019 with a view to concluding the work by mid-2019. The merger process is complex and requires compliance with several tests. The paper sets out the imperative to deal with the existing level of uncertainty as soon as possible and delaying the move to a single Accountable Officer and shared management team is not conducive to that.

80. The paper has detailed the concerns that exist in all three CCGs about how a single team and the accompanying governance arrangements would impact on locality working, clinical engagement and CCG priorities, which are exacerbated by the need to fully embed trust. Mechanisms have been presented to address this which centre on establishing neighbourhood working in shadow form as soon as possible alongside our STP partners, as well as ensuring that the principle of subsidiarity is enshrined in our joint commissioning arrangements. This would form part of the recommended organisational development programme which is critical to the overall success of the proposed arrangements.

RECOMMENDATIONS

81. Restate approval for the proposal to appoint one Accountable Officer and a single senior management team across the three CCGs in Leicester, Leicestershire and Rutland.

82. Approve the proposal to require a the JESG to develop a robust process for the appointment of the Accountable Officer and the senior management team across LLR, ensuring that: -
    - conflicts of interest are appropriately managed
    - there is a consistent approach to managing the implications for staff whilst ensuring that the process is in line with each CCG's management of change policy.

83. Approve the proposal to delegate authority to the CCG's Clinical Chair to sign off the arrangements for the appointments process referenced above, after seeking the recommendation of the Remuneration Committee in accordance with the CCG's constitutional requirement.

84. Approve the proposal to charge the Joint Executive Steering Group (JESG) with overseeing the development of revised governance arrangements. The JESG must ensure that Governing Body members are engaged in the process to design the governance, through Board to Board sessions for example, prior to recommendations being formally presented back to Governing Bodies for approval.

85. Note the importance of a fit for purpose organisational development programme and approve the proposal to require JESG to put this in place and produce reports as required on progress back to the Governing Body.

86. Note the commitment to undertake a thorough consideration of the potential advantages and disadvantages of a full legal merger, with this work commencing in early 2019 and resulting in an options appraisal to boards in mid-2019.

Prof Azhar Farooqi **Clinical Chair** **Leicester City CCG**	**Prof Mayur Lakhani** **Clinical Chair** **West Leicestershire CCG**	**Dr Ursula Montgomery** **Clinical Chair** **East Leicestershire & Rutland CCG**

Better care together
Leicester, Leicestershire & Rutland health and social care

LEICESTER, LEICESTERSHIRE AND RUTLAND
JOINT HEALTH SCRUTINY COMMITTEE

21 JANUARY 2019

REPORT OF BETTER CARE TOGETHER ENGAGEMENT AND INVOLVEMENT

INTRODUCTION

1. Better Care Together (BCT) partners are committed to greater involvement of patients, the public and stakeholders in the proposed improvements to services – particularly those that are likely to result in significant changes to the way in which services are delivered.

2. This paper describes the activities undertaken in October and November 2018 to engage with communities in Leicester, Leicestershire and Rutland (LLR). It summarises the key themes emerging from the public engagement events and communications activities surrounding them including social media conversations.

3. This paper also describes the ongoing activities which will take place between January and March 2019.

4. The Joint Health Scrutiny Committee is asked to note the outcome of BCT engagement work and the work to be undertaken in the early part of this year.

ENGAGEMENT ACTIVITIES 2018

5. While the latter part of 2018 saw intensive communication and engagement around discussing the acute and maternity reconfiguration plans through the whole of the year, Better Care Together partners collectively and individually have engaged and involved patients, carers, staff and other stakeholder in the various aspects of Better Care Together work stream activities.

6. This work has included engagement on the Carers Strategy, the Dementia Strategy, All Age Transformation for Mental Health and Learning Disabilities and Community Health Services. We have also undertaken a formal consultation on Planned Care Policies across LLR.

7. In October and November 2018 BCT partners undertook engagement to primarily discuss the proposals for acute and maternity reconfiguration in Leicester's Hospitals.

8. Nine public events provided opportunities for patients, the public and wider stakeholders to discuss changes to the care they receive through primary and secondary care services in ways that suit them. This included talking through the rationale for the proposed changes and what it would mean in practical terms for patients using services - particularly those being provided by the three hospitals in

Leicester run by University Hospitals of Leicester NHS Trust and those provided in community settings. The events also discussed and answered questions and responded to concerns regarding changes to the Intensive Care Services in Leicester.

9. The events were held in community venues in East Leicestershire and Rutland, West Leicestershire and Leicester City. Around 350 people attended the nine events, which were held between 5pm and 7.45pm. People dropped in for the first hour to informally discuss with NHS teams the plans for improvements across all Better Care Together work streams including acute reconfiguration. This session was followed by a formal presentation and question and answer session. One event was held as an informal drop-in session only (in Eyres Monsell, Leicester).

10. While the number of people attending the events wasn't large, the reach of the promotional activities was significant. The events were promoted through the stakeholder databases of the two county councils and the city council, two provider trusts and three clinical commissioning groups. It received wide coverage, both pre and post events, on social media (BCT account: 31 tweets sent to 1482 followers - 118 retweets and 172 likes and generation of 24 comments. UHL account: 15 tweets generating 31,343 impressions and 714 comments. In addition 40 likes on Instagram), as well as in print and on broadcast media including coverage on BBC East Midlands Today and in the Leicester Mercury, Melton Times and Harborough Mail.

11. We would particularly like to acknowledge the support we also received to promote the events from voluntary and community sector groups, many of whom promoted them in their online newsletters and the wide range of public and patient groups including patient participations groups.

THEMES EMERGING FROM THE CONVERSATIONS

12. The questions raised by people at the events covered a range of topics, many of which were pertinent to local geographical areas. The feedback from the public identified a number of areas where there were concerns and the need for more information to give a better understanding of proposals and processes. Many comments were supportive of the various plans and particularly the need for investment to modify and improve Leicester's hospitals.

13. The questions and feedback were responded to on the night of each event by a panel of NHS managers and clinicians. Responses have also been made via social media and via other online mechanisms. In addition, a Question and Answer log has been created and is available on line. It is being continually updated as and when new questions arise.

14. All feedback from the events is being distributed across Better Care Together partners and work streams in order that it can influence the decision making processes within each work stream and in specific programmes of work. It is being used to refine the Pre-consultation Business Case for the Acute and

Maternity Reconfiguration and is also being fed into the current Community Services Redesign work. It is strongly influencing our communications and engagement plan for the coming months, as people told us that they wanted ongoing involvement in co-producing the proposals. Later in this document we outline what this will include.

15. The key emerging themes can be summarised as follows:

- Processes and procedures of bidding for capital resources and the unknown timeline for being permitted to commence public consultation are confusing for the public, the majority of who have a strong desire for formal consultation to take place at the earliest possible opportunity.
- In the past Leicester has been in a similar position of wishing to invest in services, but for a variety of measures has not had funds available to implement plans. There is worry that history may repeat itself.
- Broad support that investment is needed into the hospitals in Leicester and agreement that overall the plans are the right ones. However, many people still want to have a better understanding around the decision to transform Leicester General Hospital into a community hub and the plan to move acute services to Glenfield Hospital and Leicester Royal Infirmary.
- Need for continued engagement and involvement of the public in the acute and maternity services discussion to ensure that services are person-centred. Also to ensure that if national approval is given and capital funding bids are successful that we fulfil on our promise to go out to formal consultation ensuring that the LLR public have their voices heard.
- Need for transparency on what estates are being sold off, why and what will happen to the income from the sale.
- Assurance that formal consultation on acute and maternity services will be effective and that feedback from the public will influence and impact on the final proposals.
- Plans should consider the quality improvements to the infrastructure and environment including car parking, access into and around sites, sign-posting and public transport.
- Assurance, particularly from rural communities that the centralisation of acute services will benefit patients and conversations are ongoing with acute hospital trusts across the LLR borders.
- Assurance that proposals will respond to and address the current financial issues faced by NHS bodies, and will not contribute to further challenges.
- Concerns about the proposed closure of the midwifery led birthing unit at St. Mary's in Melton Mowbray and anxiety that local pre and post pregnancy support services, greatly appreciated by many, may be lost locally.
- Recognition of national staff shortages, particularly nurses and how the proposals impact on current staff and attracting and recruiting new staff.
- Importance of the role of primary care including GP federations/GP localities and the voluntary and community sector when redesigning services provided outside of hospital in the community, including in peoples' homes.
- Need for better access to primary care and GP appointments.
- Better use of information technology when integrating health and social care services to ensure systems talk to one another so that patients and their

carers do not have to repeat their story including creation of a single patient record.
- Recognition that local areas are different and there is a migration of LLR residents outside of the counties as well as a migration of residents from other counties into LLR's acute and community services.
- Enthusiasm to participate in discussion about community services including community hospitals at the earliest possible opportunity.

NEXT STEPS FOR ENGAGEMENT AND INVOLVEMENT

16. Whilst there has been merit in undertaken public engagement events to discuss the acute and maternity reconfiguration and the community services review, in the context of Better Care Together. NHS partners now wish to understand the experiences and views of people within their different communities - particularly those seldom heard groups and those people who are vulnerable and often extensively impacted by changes to NHS services. Also people told us they want to be kept informed and updated on improvements plans for the NHS.

17. This work is best done by reaching out and working within communities. Under the Equality Act 2010, we have a duty to consider potential impacts of service change on people with protected characteristics. We have extended this to include carers and other vulnerable groups. In order to help us understand these potential impacts in detail, we will reach out to these communities using their existing meetings and events. We will particularly work through voluntary and community sector agencies and local support networks to involve these communities.

Outreach work

18. From January 2019 we are undertaking a programme of outreach work using two methods:
    - Manned drop-in sessions situated in community venues where there is high footfall e.g. libraries, on days where locations are busy e.g. market days. The public will be able to view displays that explain Better Care Together and the improvement programme, and chat with NHS staff.
    - Develop relationship with key community groups attending their meetings/events and other engagement opportunities. Groups will include Council of Faiths, Youth Council Leicestershire, Leicester Action for Mental Health Projects and Leicestershire Learning Disability Partnership Board and many others.

Other engagement and communications

Staff

19. To provide further opportunities for staff to be engaged, face-to-face briefings are being held with staff. We are also using existing mechanisms available through organisations to reach staff including newsletters and online briefings.

Online communications

- We will enhance awareness of the Better Care Together programme and associated engagement activities through an increase in the range of online communications including social media channels (Twitter, Facebook and YouTube) and partner websites. This will allow people to join in the conversation and constructively feedback and share their thoughts and views.
- We will produce, on a regular basis, the BCT e-newsletter to ensure that on a monthly basis it is circulated to a wide audience both updating people of the progress of plans, as well as using it as an opportunity to seek feedback from people.
- We will also produce a brochure and video case studies and explore the production of interactive content to provide every opportunity for discussions with people.

Press and Broadcast media

20. We will continue to work with our local press and broadcast media to coordinate regular articles, updates and features utilising case studies to make important proposals resonate with patients and the public.

Existing communication mechanisms

21. There are a number of established mechanisms that BCT partners already have in place which help us to provide information and communicate with a range of stakeholders. These mechanism will be capitalised on during the engagement process;

- BCT partner websites
- Presentations at Healthwatch (Leicester and Leicestershire, Rutland), Voluntary Action Leicester and other voluntary groups
- Patients groups and members including PPG networks
- GP newsletters and locality/federation meetings

Engagement with councillors

22. We offered a series of Member Briefings with the three upper tier local authorities in Leicester, Leicestershire and Rutland. We had a good take up of this offer from members in all areas. We would like to continue this dialogue with regular and timely briefings with councillors to ensure they are updated of proposals and plans. We will also be working with all three Health Overview and Scrutiny Committees as well as the Joint Overview and Scrutiny Committee to ensure that appropriate and timely reports are presented and discussed.

Other engagement activities – community services redesign

23. In 2018 we undertook research to understand the current experiences of patients, their families and carers of receiving community services. In addition, we spoke to a range of NHS, social care and other health professionals who deliver community services. We now have a rich seam of detailed insights from this work from approximately 4,600 people, which we have used along with other research and analysis to develop a model of care for delivering high quality community services.

24. We will be discussing these insights with the public at a series of events being held early this year and through other communications. We will also discuss this two-year transformation programme for delivering care in a community setting and outline the opportunities for involvement at each stage of this work.

CONCLUSION

25. We are committed to continuous communications and engagement on all aspects of the Better Care Together programme. We are also committed to formal consultation in regard of the acute and maternity reconfiguration. This will be at the point when our plans have been approved and capital resources are available. In preparation for this we are using the feedback from the 2018 engagement to draw up a consultation plan. This plan will outline how we will undertake the consultation to ensure that we reach out to all communities in Leicester, Leicestershire and Rutland promoting the opportunity of participating in the consultation process. The plan itself will be co-designed so that it is comprehensive and enables effective public involvement and feedback, so that a robust decision on change that is the best interests of local people can be made.

RECOMMENDATION

The Joint Health Scrutiny Committee is asked to:

NOTE the outcome of BCT engagement work and the work to be undertaken in early 2019.

Appendix C

East Leicestershire and Rutland Clinical Commissioning Group
West Leicestershire Clinical Commissioning Group
Leicester City Clinical Commissioning Group

LEICESTER, LEICESTERSHIRE AND RUTLAND
JOINT HEALTH SCRUTINY COMMITTEE

21 JANUARY 2019

REPORT OF BETTER CARE TOGETHER
COMMUNITY HEALTH SERVICES REDESIGN

Introduction

1. The Community Services Redesign project (CSR) is a piece of work led by the three Clinical Commissioning Groups (CCGs) in Leicester, Leicestershire and Rutland (LLR), looking at the future model of community health. The scope of the work centres on adult community services provided by Leicestershire Partnership Trust (LPT), but also has implications for services provided in primary care, social care and other community based providers.

2. This paper provides an overview of the Community Services Redesign project. It summarises the service issues, case for change and project methodology. It also describes the work undertaken to date, in line with the methodology, to review community services including the significant engagement to support development of proposals for the future.

3. The report also outlines the principles of the proposed community health services model which is emerging from the ongoing work.

4. The Joint Health Scrutiny Committee is asked to note the progress to date in reviewing and redesigning community health services.

Background

5. Community Health Services in LLR are delivered under a block contract by LPT. District nursing teams provide a planned nursing service, largely within people's homes, concentrating on the frail and housebound population.

6. In addition, there is an Intensive Community Support (ICS) service, which was commissioned to provide enhanced nursing care to support people at home at a time of crisis, to prevent admission or facilitate rapid discharge from hospital. It was intended to provide an alternative to staying in a hospital bed – sometimes referred to as a 'virtual ward' model. The ICS service was set up as a largely nurse-led service, with limited social care and therapies within the team and delivers rapid response nursing rather than an integrated crisis

response and reablement approach, working to a 10 day length of stay, which limits reablement.

7. Community hospital beds provide a ‘step down’ from acute hospitals i.e. the next phase of care before people are living independently at home. There are currently 233 community hospital beds across LLR, split across 12 wards in eight community hospital sites. Patients are admitted where they have a need for continued hospital care but not in an acute setting (approximately 40%) or rehabilitation needs (60%), although these categories are not mutually exclusive and most patients have both needs to a degree.

8. In addition to community hospital beds, ‘Pathway 3’ reablement beds provide 24/7 bed-based care in a residential or nursing home setting with in-reach therapy for patients who are not yet well enough to be cared for at home.

Why are we looking at Community Health Services?

9. In 2018 we celebrated 70 years of the NHS. Things have changed a lot in that time with perhaps the greatest success of the NHS being the dramatic change in life expectancy. In 1948 the average male died at 66 - it’s now 77.

10. However, people are living with more than one health condition and their needs are more complex. There are more of us, we are older and as we age we pick up illnesses that stay with us including heart disease, respiratory disease and diabetes.

11. With advancements in technology and knowledge, the NHS can do more than it ever could before. But people don’t want to be ill. They tell us they don’t want to have to go to hospital and have long stays in an acute or community hospital bed. They want support to stay healthy, be discharged quickly and many prefer to receive more of their care at home.

12. Clinical evidence also shows that patients achieve their maximum potential and/or recover fastest when they are in the right setting for their needs. The evidence shows that this should be the least acute setting possible and at home where appropriate.

13. In addition to this, to deliver more joined-up care for patients to aid both their outcomes and experience, greater integration is required between health and social care services. This has been the clear national and local direction for some time and significant progress has been made through close partnership working under the LLR Better Care Together (BCT) Strategic Transformation Partnership to deliver a range of improvements across a number of services.

14. Community health services in LLR however, have not been reviewed or redesigned for a number of years. The current model does not support some of the key strategic changes within the LLR Better Care Together Strategic

Transformation Partnership which aim to deliver improved care through a model which sees as much care as possible provided at home or close to home. Nor does the current model deliver the kind of care people tell us they want and which evidence shows is best for them.

15. Within the BCT plan a number of work streams were attempting to deliver more integrated community based services, most importantly the Integrated Locality Teams (ILT) work and the Home First programme. Both of these work streams have significant implications for core community health services and without a clear commissioning strategy in relation to the services provided by LPT, they have not been able to achieve the desired progress towards better integrated care models.

16. The original STP plan published in November 2016 did not have a clearly articulated community health model, which would meet current and projected demand, support the strategic shift towards more care delivered close to home, and address the issue of bed capacity requirements both within community hospitals and acute settings.

17. Staff are working really hard to deliver good care, however the current service is not configured in a way which enables it to deliver the best support to patients at home. The CCGs have therefore been working for some time to consider the improvements that are needed for reconfiguring services currently provided to people by LPT.

18. To address all of the issues described, CCGs, working with our partners, need to change the way we do things to redesign services for our needs in the 21st century, invest in the right services and provide them in the right place to match needs and improve care for local people.

Current service issues

19. Patients tell us that they want to be cared for at home where it is suitable for them. Clinical evidence shows this is better for them. Over time however, capacity within the district nursing service to deliver care at home has been reduced. A review of community nursing establishment in late 2017 demonstrated vacancy gaps. As a result, the community nursing service 'offer' is limited and district nursing teams do not have the capacity to respond fully to the needs of patients. The ICS service has absorbed much of the day to day unplanned or urgent care needs referred by GP practices, rather than delivering a 'virtual ward' model to acutely unwell patients who would otherwise be in a hospital bed. This reduces continuity of care and means that neighbourhood community nursing teams do not have the capacity to deliver the preventative and joined up care that we aspire to deliver in ILTs.

20. Reviews of the current ICS service show that it does not fulfil its intended function and is not integrated with social care crisis response and reablement services. While there are examples of excellent close working between the ICS service and social care intermediate care services, such as Intensive Crisis Response service in Leicester City, the core ICS service does not support the Home First blueprint agreed within BCT.

21. People tell us that to be as mobile as they can be is essential. Being active is important and it also supports emotional wellbeing. However, benchmarking data indicates that LLR has roughly half the number of community physio and occupational therapists compared to the national average. This leads to long waits and limitations to the input people receive at home.

22. The medical cover within the ICS service is both limited and unclear. When it was set up, the ICS service was commissioned to take clinical responsibility for patients admitted to it but does not have any dedicated medical staffing. This has led to lack of confidence in the service from acute consultants and lack of clarity and variability within GP practices about the nature of their responsibility for care when patients are being looked after.

23. An ICS service case note review (September 2017) and subsequent ICS clinical audit (November 2018) reinforce the necessity to redesign the ICS model. The audit showed that over 50% of ICS activity was actually delivering a same day core community nursing function.

24. There is significant reliance in LLR on community hospital beds to provide 'step down' from acute hospital i.e. the next phase of care before people are living independently at home. This differs from the model in other areas of the country, where there are more discharges directly home or into intermediate care services.

25. Community Hospitals are currently used as part of an LLR wide bed base with patients placed in available beds that are not always near to where they live, dependent on patient choice and system demand. For example 2017/18 data shows 45% of Leicester City patients in community hospital beds are in community hospitals outside of the city, and 32% of patients in City beds live in East and West CCG areas.

26. Community hospitals have an average 88% occupancy rate. However a number of local audits have demonstrated that patients in these settings are not in the most appropriate place.

27. In July 2017 an extensive bed audit covering 86% of UHL beds and all community hospital beds showed that 31% of UHL patients and 55% of LPT community hospital bed patients were not in the best setting of care for their needs.

28. A review of the discharge pathways in LLR has shown that we could improve access to 'Pathway 3' reablement beds (which provide 24/7 bed based care in a residential or nursing home setting with in-reach therapy for patients who are not yet well enough to be cared for at home). This would help to prevent admission and provide step down care from community hospitals.

29. The service issues described support the case for improving community health services by redesigning them to better suit patient needs, aligning them with aspirations to provide more continuity of care within locally based services, and providing better joined up crisis response services with social care (Home First).

CSR project and methodology

30. The CSR project was initiated by the CCGs in LLR in April 2018, in order to address the identified issues with core community health services and to ensure services are configured to deliver the best possible care for patients in community settings.

31. The objectives of the CSR are to:

- Develop better integrated services with better patient outcomes
- Support integrated locality services which manage the majority of patient care
- Deliver a 'Home First' approach through integrated step-up and step-down services
- Reduce use of non-elective services
- Address the future model and number of community hospital beds which could be needed in future

32. The scope of the redesign work includes the following LPT services:

- District nursing services – which provide home-based patients with ongoing nursing care for long-term conditions or end-of-life care, with treatments such as wound care and continence care
- ICS service – a 'virtual ward' providing healthcare services in a patient's own home
- Community hospital beds (including stroke beds)
- Community physiotherapy services (not including MSK physiotherapy)
- Community stroke rehabilitation service
- Primary care co-ordinators – who work in hospitals to support staff to help get patients home as quickly as possible once they are ready to leave hospital
- Single Point of Access

33. The terms of reference for the redesign recognise that, in attempting to move towards better integrated services, there will be implications for other

services, particularly primary care and social care, as well as acute hospital services.

34. The CSR work has reported into the Integrated Communities Board (ICB), one of the BCT work streams. The ICB is a system-wide group with executive membership from each of the adult social care departments, which steers the development of integrated care across LLR, through ICB members' roles linking back to their own organisations. The ICB also has representation from Healthwatch and the BCT Public and Patient Involvement group. The project has been led by the CCGs working on a co-design basis with LPT staff and other stakeholders.

35. Due to the complexity of the work, achieving significant change is being seen as a two to three year transformation programme, following a systematic process to a set methodology and has included to date:

- A review of best practice models and the evidence base for integrated community services, undertaken in July 2018
- Co-design workshops with key stakeholder and BCT work streams in June to August 2018, involving staff from social care, primary care and provider trusts among others
- Clinical Reference Group which has generated options for a clinical model, meeting August 2018 onwards
- A high level model set out in September to support further discussion and engagement with stakeholders on the clinical model
- Demand and capacity modelling supported by Deloitte UK in November 2018
- Audits of current pathways – both in 2017 and Autumn 2018
- Initial costing of potential impact for CCGs, December 2018
- Engagement to support development of the proposals, which is detailed in the next section, and which includes:
    - Review of existing engagement insights
    - In-depth structured interviews with patients, carers and staff
    - Online survey
    - Further public events to present insights and seek views are planned for early 2019
- Initial consideration of proposals by the CCGs' Collaborative Commissioning Board in December 2018, and decision making on next steps

Engagement to support development of proposals

36. Engagement was undertaken with patients, carers and staff between August and October 2018. We identified the journey of care by asking evidenced based questions and now have the stories of people experiencing community

services and those providing community services. The key question we were answering was: *"How will a new integrated model of community care change the experiences of staff, family carers, patients and people who use the services."*

37. We captured the experiences and feelings of the following groups, in relation to ten emotional touchpoints and identified what matters most to people about their care. 160 in-depth one-to-one or small group interviews were undertaken with:

- People receiving community services in their own home, in community and acute hospitals, in the ICS service and other settings
- GPs
- Acute staff referring into community services
- Social care staff
- Domiciliary care workers
- Family carers
- Care home staff

38. An online survey designed for patients, family carers and front line staff also ran between 25 September and 21 October 2018 with 66 responses in total.

39. An independent report analysing the findings from the interviews and survey was commissioned from Arden GEM Commissioning Support Unit.

40. In addition, we examined 22 existing reports relating to community services. This review of an existing knowledge base, using research undertaken by various organisations (NHS, Healthwatch, LGBT etc.) represented feedback from 4,300 people.

A summary of themes highlighted by people in a place they call home

41. In general the picture relayed by patients in their own home is mixed. Patients would prefer to stay in their own home, but their level of confidence is dependent on support from family and external agencies which can vary.

42. Relationships with services, including their GP, are important. The inability to get timely appointments and to see the same GP is a frustration. Also services not arriving on time and the lack of communication are all mentioned as issues. However, people feel that an improved relationship with health and care services would give them more confidence.

43. Falls and deteriorating health are frequently mentioned as a cause of crisis. Issues highlighted which could be improved to help service users to manage in

their own home include assistive technology and home adaptations, and timely communications from services, improved relationships with staff and a better language/cultural understanding. A range of other services including better support out of hours and in rural locations are also mentioned.

44. Patients can be left feeling stressed and social isolation is experienced by this group of people. They would like to do the things they were once able to do or at least have the best mobility it is possible to have. Socialising and involvement in external agencies are important. Mobility is everything and having support to enable people to keep busy and as physically active as they can are seen as important to improve both physical wellbeing and reduce the emotional impact on their condition. Physiotherapy and occupational therapies are seen as particularly important.

A summary of themes highlighted by people in community beds

45. The importance of good communication throughout all stages of the patient journey resounds throughout the insights. It is essential for patients to feel confident, cared for and supported.

46. The need to feel supported is also essential to recovery and wellbeing and discharge is seen as a really low point. People demonstrated their reliance on support not only while in hospital to aid successful recovery, particularly from physiotherapists and occupational therapists, other hospital staff, friends and relatives, but also when they return home. Community hospitals are seen as an important part of patients' treatment closer to home, although some patients were unsure why they were in a community hospital and what treatment they could expect.

A summary of themes highlighted by family carers

47. Family carers want services which are reliable and appropriate to their situation and allow them to support their loved one. However, they report difficulties in getting the help they need and frustration around the processes, including decision making and discharge. Getting further help at times of crisis was a particular challenge for some. They report that providing care at home as simply waiting for the next crisis to happen.

48. Family carers reported mixed relationships with services and staff. They did not always receive consistent information and were not involved and kept informed.

49. The caring role resulted in emotional stress for carers, such that they sometimes did not feel that they could take holidays or have breaks.

50. Particular areas of concern were falls, getting help when their loved ones' health deteriorates and administering painkillers.

A summary of themes highlighted by frontline staff

51. Building good relations and working together with patients and families are important aspects of the role of frontline staff. They try to involve patients in their care, but this can be challenging where patients and family disagree or do not understand the care available. Staff tell us that time and workload pressures reduce their ability to develop a good relationship with patients and families. Providing emotional support can be a very rewarding aspect of the work but more guidance, training and time is needed.

52 Equally, relationships with other services significantly impact on the care given. Good working relationships with other teams are important - where teams work well together and trust each other to do their job the outcomes for patients are improved. Currently, the quality of these relationships varies but is improved where individuals know each other. There can be issues between services, particularly connections between NHS and social care around poor communication, lack of awareness and understanding of services and processes, or where referral criteria are not clear or understood.

53. Staff feedback that good IT can support closer working between services, e.g. how the community clinical IT system, SystmOne, can improve the referral process. Job satisfaction is important to staff, they want to feel that their work is valued and they have made a difference to patients and their family. However, they report feeling stressed and tired, in particular where they are short staffed and there is a high caseload. The job is made easier by supportive colleagues and leaders who work well together and good relationships with other teams.

A summary of themes highlighted by care home and domiciliary staff

54. It is apparent that staff feel very passionate about the care they deliver and the resources and support they subsequently require. Particular low points in the care pathway are around relationships with other health and social care staff and involving the person in decisions about their care.

55. In addition, co-ordination and providing physical and emotional support is an area of concern. Time pressures sometimes prevent these being considered equally.

56. Staff also find it difficult to look after their own health, wellbeing and personal resilience.

57. The importance of having integrated services, good communication and involvement and team working is widely reported.

Proposals for the future of Community Health Services

58. The work undertaken by the CSR project to date, including the insights from patients, carers, staff, clinicians and stakeholders, has enabled the CCGs to:
    - Set out a potential model for the future model of community based health services
    - Make some proposals for initial changes to how community services provided by LPT are organised to improve care for patients
    - Recommend some next steps to further develop the model

59. The proposed new model is based around the following main services:
    Neighbourhood community nursing as part of integrated locality teams, which would manage the majority of care of patients in the community, working closely with social care and primary care neighbourhoods (groups of GP practices with between 30,00 – 50,000 patients).
    Home First services - integrated health and social care crisis response and reablement services, which would deliver intensive, short term care for up to six weeks. Home First services would be accessed via Locality Decision Units, with health and social care services working on the basis of trusted assessment and delivering co-ordinated packages of care.
    Community bed based care - delivered either in community hospitals for patients requiring medical rehabilitation needing significant 24/7 nursing care and on-site therapies, and in 'Pathway 3' reablement beds for patients with lower medical needs requiring reablement and a degree of 24/7 support.

60. Key features of the model include improvements in:
    - Co-ordinated Care
    - Integrated team working
    - Preventative care, support for self-care
    - Pro-active approach to identifying patients who need co-ordinated care
    - Focus on the frail and 'multi-morbid' patients
    - Trusted assessment – where agencies trust the assessments made by those outside their organisation reducing duplication in assessment
    - 'Discharge to Assess' – ensuring people leave hospital when medically fit
    - Delivery of the 'Home First' principles
    - Capactity in community nursing and development of a sustainable workforce

61. It is important to note, that the evidence review suggests if the community model described were further developed, and had sufficient capacity in the home based teams and reablement beds, there could be reduced utilisation of community hospital inpatient beds in future. This could create a shift towards using community hospital beds predominantly for patients who on discharge from an acute hospital and continue to need 24 hour care with on-site therapies.

CCG discussions to date

62. In December 2018, a summary report outlining the work done to date, and considering the benefits and implications of moving towards the future potential model was considered by the CCGs' Collaborative Commissioning Board (CCB).

63. The CCB supported in principle a move towards the model outlined in this paper, but recognised that to fully deliver the vision of improved services, further work needed to be done, including:

- Continued and wider engagement with the public and partners on the potential future community health model and its implications to further develop test and strengthen plans
- Testing some initial operational changes to provide proof of concept for future changes including a move towards more integrated services and the potential to support more patients to be cared for at home. Also a more a robust process to explore the costs and activity implications of the future model
-

64. This work will commence in January 2019 with ongoing engagement with partners and a series of public engagement events across LLR planned from February.

65. In the meantime, to deliver the improvements in ICS services for the benefit of patients, carers, staff and clinicians, the CCB also supported the reorganisation of the current LPT nursing teams and specifically redeploying the capacity in the ICS service into enlarged community nursing teams at a locality level.

66. This reorganisation means the treatment delivered by the ICS service will continue to be delivered, with care still provided to patients at home in the way that it is now. There are however anticipated improvements in patient outcomes and experience through improved effectiveness and efficiency and greater capacity in locally based teams to deliver continuity of care. The CCGs will work with LPT to enact this change in the course of 2019/20.

67. To support these initial improvements to ICS services, the CCB also gave approval in principle to:
    - providing dedicated medical support to patients being looked after by Home First services, conditional on approval of further work on costs and proposals for how the medical cover would be organised and employed
    - the creation of care co-ordinator posts in West Leicestershire CCG, in line with the agreed model for ILTs, again conditional on approval of the costs and employment arrangements in January/February.

68. The CCGs believe the changes proposed to the way in which ICS services are organised will have benefits for patients, carers, staff and clinicians. It is important to note, that once enacted, the changes would not preclude or prevent changes to proposals for the future configuration of community health services following further engagement.

Next steps

69. Due to the complexity of the work, achieving significant change to community health services is being seen as a two to three year transformation programme, following a systematic process.

70. In recognition of the importance of the work, and the possible implications for the wider provision of care in community settings, as well as the implications on utilisation of other health services, including inpatient beds, the CCGs will embark on a second phase of work towards a full business case to redesign community health services. This work will include:

    - Further engagement with local people on the future vision and options for community health based services
    - Further engagement with clinicans, staff and partners on the proposals for the future
    - Further work to define how community health services could work with social care crisis response and reablement services to deliver Home First
    - Testing the impact of more redesigned community health services and more integrated care model on patient outcomes and demand for care in different settings
    - Generation of options for further changes to community health services, including assessing the impact of increasing capacity in home based care and reablement beds, which could increase the number of people who can be cared for in their own home
    - Depending on the options being put forward, the CCGs will consider their legal duties in respect of formal consultation on future services changes, particularly if there are proposals to make any significant changes to the community hospital configuration. It should be noted

that in any case there will be ongoing co-design with the public on the proposals.

71. The CCGs are working with local authorities and Adult Social Care departments to discuss how they wish to be further engaged in the development and implementation of the overall model. In parallel with this, the CCGs will continue to work with social care teams and other stakeholders to develop the model of integrated care taking into account the recent publication of the NHS 10 Year plan as we do so. This will include work via the project team engaging with lead council members, leadership teams and, where appropriate Council Cabinets/ Executive Teams and scrutiny functions.

72. Further work will be undertaken to set out the milestones and governance processes for future decision making. This will be done in discussion with Adult Social Care teams and with the System Leadership Team of BCT.

73. The CCGs will continue to engage with the Joint Health Overview and Scrutiny Committee and an update will be brought in due course.

RECOMMENDATION

The Joint Health Scrutiny Committee is asked to:

NOTE the progress to date in redesigning community health services and the next stage of the work.

Leicestershire, Leicester and Rutland Joint Health Scrutiny Committee

Work Programme 2018 – 2019

Meeting Date	Topic	Actions arising
4 Sept 18	1) Consolidation of Level 3 Intensive Care 2) Update on Non-Emergency Transport (TASL – Thames Ambulance Services Ltd) 3) Update on EMAS's direction of travel 4) CCGs Engagement on Planned Care Pathways 5) Update on the STP	1) Further meeting to be arranged to convene this item. 2) A further report on the progress of EMAS come back to the committee. 3) A further report including performance data, and information relating to contractual obligations and conditions be brought back in six months' time and that a representative from TASL comes to the meeting. 4) The committee asked for the wording in the Gynaecology Policy be rectified. The committee asked that the numerous different planned care policies be broken down during engagement to make it more meaningful for service users. The committee expressed concerns relating to the continuity of care and the application of policies across different postcodes. It was requested to see the full EIA, including impacts on mental health. The CCG were asked to ensure that GPs and locums are fully trained and where treatments cannot be provided in the settings where they are, that primary care provide the treatment, particularly in relation to patients who require ear wax removal prior to having a hearing aid fitted. Questions from Members be submitted separately, outside of the meeting. 5) Questions from Members be submitted separately, outside of the meeting.
28 Sept 18	1) Consolidation of Level 3 Intensive Care	1) Despite all the information provided to the committee by the CCGs and UHL, the committee were not convinced that any of the reasons given preclude their responsibility to carry out public consultation. As such, in the interests of openness and transparency, the committee recommended that the CCGs and UHL undertake public consultation before continuing with the proposals.

21 Jan 19	1) Update on CCG Management Structure 2) Better Care Together Engagement Update 3) Better Care Together – Community Health Services Redesign	
March – TBC	1) Leicestershire Partnership Trust - Update 2) Better Care Together Update	

Previous Meetings

Meeting Date	Topic	Actions arising
14 Dec 16	1) Sustainability and Transformation Plan	All three council scrutiny committees agreed to consider elements of the STP separately based on local concerns. Another joint meeting will convene when each council has had separate consideration.
14 Mar 17	1) NHS England's Proposals for Congenital Heart Disease Services at UHL NHS Trust	It was agreed to have a further meeting of the committee before the consultation ends to hear views from Members of the public and other stakeholders.
27 Jun 17	1) NHS England's Proposals for Congenital Heart Disease Services at UHL NHS Trust	It was agreed for the committee response to be collated following information heard at the meeting and submitted to NHS England. It was also agreed to write to the Secretary of State to request he looks at the process and reconsiders the review and drop proposals to close the CHD centre at Glenfield Hospital.
27 Apr 18	1) Update on LPT NHS Trust Improvement Plan following their CQC Inspection 2) Update on CHD Services in East Midlands and the NHS England review into PICU and ECMO services nationally 3) Update from UHL NHS Trust following their CQC Inspection 4) Update on EMAS Quality Improvement Plan	1) A further update from the LPT to come back in a years' time. 2) Continue to monitor performance against the targets set by NHS England and an update be brought to the committee in a year's time, and to include targets, issues around winter pressures and the numbers of referrals. Also a letter to be sent to Nottingham City Council to request that they encourage the University Hospitals of Nottingham to refer their congenital heart patients to UHL and to share with them the minutes of the meeting. 3) Further CQC inspection reports of UHL, along with the resulting action plans, are brought to future meetings of the committee. 4) A further update from EMAS is brought back to the committee in a years' time.