The role and form of a single strategic commissioner for an Integrated Care System in Leicester, Leicestershire and Rutland

December 2019

A partnership between:

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

Introduction and executive summary 01

The NHS Long Term Plan aims to establish a health service fit for the future. Its ambition is to give everyone the best start in life, deliver world-class care for major health problems such as cancer and heart disease, and help people age well.

The plan, published by the Government in January 2019, identifies local Integrated Care Systems (ICS) as the way forward. These build upon existing Sustainability and Transformation Partnership footprints to bring together NHS organisations in collaboration with local authorities and others such as the voluntary and community sector, to take collective responsibility for managing resources, delivering NHS standards and improving the health of the population they serve.

As part of these arrangements there will be one strategic commissioning voice for each ICS, typically in the form of a single clinical commissioning group (CCG). It is expected that an ICS will be in place in Leicester, Leicestershire and Rutland (LLR) by April 2021.

The three CCGs in LLR currently have responsibility for commissioning the majority of health services for the local population. We are working with our partners to determine what an ICS looks like in LLR and a key part of this is considering how best to form a single strategic commissioner locally.

No decisions on the future form of a single strategic commissioner have yet been made but, having undertaken an initial assessment of the options, we do have a current preference to work towards the creation of a new single CCG for LLR.

We believe this is likely to be the most effective solution to help us deliver improved care and outcomes for patients across our whole area, allow for targeted resource allocation to tackle health need and inequalities, and enable the system to become financially sustainable.

This is because the system as it is currently configured naturally means that the majority of our financial resources tend to land with our acute hospitals, with an emphasis on supporting people to recover when they become unwell.

Changing the way that the system works through the creation of an ICS and the coming together of the three existing CCGs as one new strategic commissioning organisation gives us the greatest opportunity to redirect resources to others services – such as general practice and community services.

This will allow a greater focus on preventing ill health and managing long-term health conditions proactively to keep people well and out of hospital wherever possible.

Fundamentally the development of an Integrated Care System - which would operate at the three levels of system (LLR), place (existing upper tier local authorities) and neighbourhood (emerging Primary Care Network geographies) – is very different to the way in which the local NHS has worked over the last two decades.

At its heart the new system represents a move away from the competition between NHS providers, which has prevailed over the last two decades. Whilst these arrangements have helped the NHS make good progress against some key challenges such as excessive waiting times, they have often led to patients being caught between organisations and their priorities, with patients' care or experience suffering as a result.

In this context the role of the strategic commissioner will be significantly different to that of existing CCGs. No longer will the focus be on specifying the way in which services are delivered in a particular area, or procuring and monitoring individual contracts.

Instead the focus will be on taking a whole-system view of the requirements of the patient population based on known needs and health inequalities, and setting clear expected outcome improvements for those groups. It will also be responsible for allocating resources to providers, who will operate collaboratively at existing upper tier local authority levels, and in partnership with statutory Health and Wellbeing Boards, to decide upon the best approaches to delivering those desired outcomes, based on a detailed local knowledge of their populations.

The strategic commissioner will be accountable for the money we receive from Government and how we spend it, whilst monitoring delivery of outcomes across the whole system so as to ensure that our investment is making the intended difference. It will also be responsible for engaging with populations and involving them in decisions about local services and the care they receive. These are all things that we believe can be best achieved by working at scale with one organisation rather than multiple, while also enabling us to deliver operational savings that can be reinvested back into frontline services.

It is believed that working in this new way is most likely to provide the opportunity to make the most of every pound available to us. Whilst we expect spend to increase in every part of the system over the coming years, working as one single CCG would enable us to rigorously prioritise how we allocate our discretionary spend in a way that has not been possible before and has the potential to be genuinely transformative.

In doing so it would allow us to create a new type of commissioning organisation that has this commitment to addressing health inequalities and unwanted variation inscribed at its heart through its constitution, as well as being writ large into the organisation's mission, its vision for the future, and the values by which it operates.

The vision for an ICS in LLR is still under development, with plans evolving and being shaped by our current partnership arrangements under Better Care Together.

This document therefore sets out our current thinking about the LLR ICS and the benefits and opportunities presented by developing a single strategic commissioning organisation. We recognise that it does not contain all of the answers at this stage. However, it provides partners and stakeholders with an opportunity to share thoughts on the future of NHS commissioning arrangements in Leicester, Leicestershire and Rutland. These will be used to shape and finalise our proposals in advance of formal consultation on the matter during 2020.

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The proposal

02

Why do we need to change?

The NHS and our partners face significant challenges in meeting rising demand from a growing, ageing population, with increases in the number of people with complex and long-term conditions. We are also faced with increasing costs of services and challenges in effective collaborative working, when trying to manage finances without simply moving the problem around the system. These issues have put the health and care system in LLR under extreme pressure. It is clear that our current hospital-based model of care cannot meet this rising demand effectively or efficiently. This can be seen in the:

- **Health and wellbeing of local people** - early death rates in some conditions, differences in life expectancies, smoking and obesity rates, and the mixed availability of healthcare close to home.

- **Quality of care** - hospitals and community healthcare providers are struggling to keep up with demand and, as a result, the quality of care suffers. For example, waits for cancer treatment, ambulances, A&E and mental health care are too long.

- **Finance and funding** - increasing costs are exacerbated by inefficient buildings, difficulties in recruiting and retaining staff and friction between NHS organisations and local authorities. In addition, current ways of working stifle a collaborative approach to managing health and care funding. This forces the system to manage budgets on an organisation rather than system basis, culminating in commissioners and providers 'shifting' financial problems around the system rather than tackling and controlling them to deliver financial balance as a whole system.

If we do not take further action now to extend our service transformation plans, then services will decline and our service models, financial plans, workforce plans, buildings and technology will not be able to sustain services adequately for the future.

Locally we have been on a journey to tackle these issues for some time, driven by our LLR Sustainability and Transformation Partnership - Better Care Together.

The NHS Long Term Plan, published in January 2019, provides further impetus through the requirement to develop a local Integrated Care System. This emphasises the need to break down artificial barriers that have been built up between NHS organisations over many years and increasingly focus on networks of NHS and other care providers working together to proactively manage the health of the populations they serve.

These arrangements will build on existing partnership plans to deliver the changes needed locally to achieve better health, care and outcomes for local people.

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What is an integrated care system?

An integrated care system is a way of working collaboratively between a range of health and care organisations to help improve people's health and deliver local health services. In and of itself an ICS is not about creating a new organisation or organisations. Instead it is an enhanced set of partnership arrangements that allow the NHS and others to work together and share budgets, staff and resources, where appropriate, in order to best meet people's needs.

It will do this in conjunction with local authorities and others, such as the voluntary and community sector, to understand populations and their health in detail and deliver holistic services that wrap around the needs of the patient.

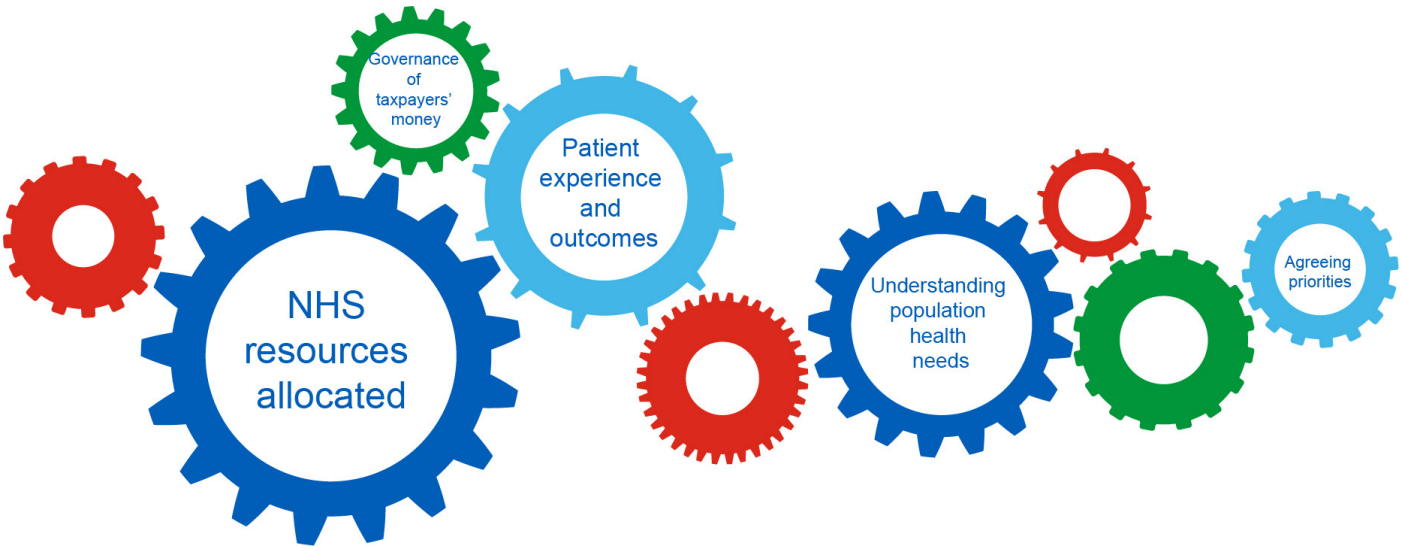
An integrated care system operates at three levels:

System [All of LLR]	A single strategic commissioner will be created to commission health and care services for the whole of LLR, ensuring agreed outcomes are delivered across the patch and within budget. Currently each of the three clinical commissioning groups (CCGs) may be involved this process
Place [Leicester City, Leicestershire & Rutland councils]	Care alliances will bring together hospitals, councils, public health and primary care to develop a complete understanding of local needs within each local authority area. Alliances will design care pathways in response to those needs to deliver better experience and outcomes, with more focus on long-term or multiple conditions
Neighbourhood [Serving 30k-50k people]	Primary care networks will develop multi-disciplinary teams to deliver more services as close to where a patient lives or works as possible, and at a time that is convenient to them. They will draw on the community, voluntary and independent sector, as well as councils to assist with housing and other services

What does this look like in LLR?

The proposals for an ICS in LLR have been developed over recent months and with involvement from NHS organisations, local authorities and representatives from local Healthwatch organisations. Their foundations lie in the learning and experience from our partnership working over a much longer period and from considering best practice elsewhere. Importantly, we have also used insights from members of the public and patients gathered under the Better Care Together programme to help shape our proposals.

System



The overall footprint for our local ICS is Leicester, Leicestershire and Rutland (LLR), which mirrors our current Sustainability and Transformation Partnership – Better Care Together. For NHS organisations it will become the level at which they will be jointly held to account. There will be collective responsibility across NHS organisational boundaries for financial delivery, via an NHS system control total for LLR, and operational performance.

The system footprint will be used as the basis on which national NHS resources will be increasingly allocated and accessed for each ICS, including allocations for NHS capital and technology funding.

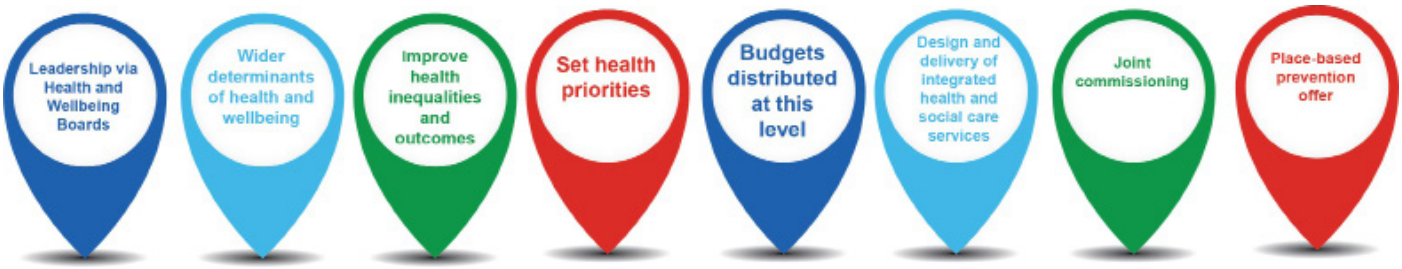
This is also the level at which strategic commissioning within the NHS will operate. In strategic commissioning the focus is on agreeing priorities, focussing on patient experience and outcomes, understanding health needs of the whole population and ensuring overarching governance of tax-payers money.

This move towards developing a single set of strategic commissioning arrangements marks a significant change to the current role and form of the CCGs. It shifts from the traditional model of commissioning as recognised and understood for the last 20 years to one with a greater focus on making shared decisions with providers on how to best use resources, design services and improve population health.

Working together with our partners, at system level, the strategic commissioner will:

- Be accountable to NHS England and NHS Improvement for the overall performance of the NHS in LLR
- Analyse and understand population health and care needs across LLR's one million-plus population, and set and measure outcomes at the LLR system level that addresses known health inequalities and unwanted variation
- Lead the response to the NHS Long Term Plan in LLR
- Lead the overall strategic direction for the Better Care Together programme
- Understand where to allocate NHS resources to 'places' or the care alliance(s) in line with need identified, for example as a result of heath inequalities
- Support local NHS providers to form a local NHS care alliance(s), and in due course commission certain services via the NHS care alliance(s)
- Take ownership and demonstrate leadership in addressing local system challenges.

Place – upper tier local authority boundaries (Leicester City Council, Leicestershire County Council, Rutland County Council)



At this level NHS providers will work with upper tier local authorities and other partners to:

- Be active partners in leadership at place level, in particular via local authority-led Health and Wellbeing Boards in LLR
- Collaborate with local authorities and other partners on the wider determinants for health and wellbeing, so that the health and wellbeing needs of local populations, including population specific health inequalities, are understood and addressed, and place-based outcomes are improved
- Ensure that the LLR-wide Better Care Together strategy, outcomes and priorities meet with expectations and priorities in each LLR place
- Design and deliver integrated health and care services within the place including the Better Care Fund services
- Develop and implement the place-based prevention offer
- Undertake joint commissioning across NHS and local authority organisations, using pooled budgets where applicable.

For NHS organisations this will also be the level at which budgets are likely to be set and distributed by the NHS strategic commissioner and at which population outcome requirements will need to be delivered.

At a place level, NHS organisations will work with upper tier local authorities and other NHS partners to improve health and wellbeing outcomes for their specific populations. Where

appropriate, they will also integrate the delivery and commissioning of health and care. Critical at this level will be the interface with the Health and Wellbeing Board, which will drive forward the localised delivery of improvements within the overall context of the Joint Health and Wellbeing Strategy for that area.

A key component of this level of the ICS will be care alliance(s), which will bring together hospitals, community services and primary care networks to deliver the care needed for local populations, based on assessments of local need determined and directed by Health and Wellbeing Boards, supported by public health insight, at local authority level. Social care may also choose to be part of the care alliance(s) should it so wish.

Care Alliance(s)

Within LLR we have two main local NHS providers - University Hospitals of Leicester NHS Trust, which provides acute hospital-based care, and Leicestershire Partnership NHS Trust, which provides community, mental health and learning disability services. These are supported by around 120 general practices, which are at the frontline of health provision and are usually the first point of contact for patients.

At a regional level we have two main providers in East Midlands Ambulance Service, our emergency transport provider, and DHU Health Care, a provider of primary, out-of-hours and urgent care services. The newly formed primary care networks are also provider organisations.

Although there has been a tradition to date, through our Better Care Together programme, to plan and redesign services across partners, provision has been focused on individual organisations. We believe that in order to meet our challenges a new approach is needed and more collaboration between providers is required.

To deliver this we will develop an NHS care alliance(s) across LLR. Work is ongoing to develop this, but it is likely to have a core membership of our main local NHS providers including our primary care networks. Other NHS providers, including those outside of LLR but who provide services to our patients, will need to consider whether they formally become part of the arrangement or want to be partners collaborating where it makes sense to do so. Local authorities and other providers such as the voluntary sector are likely to be organisations with which the care alliance(s) will work collaboratively to deliver some services, particularly at place and neighbourhood level. Diagrams showing how this would work are shown on page 9.

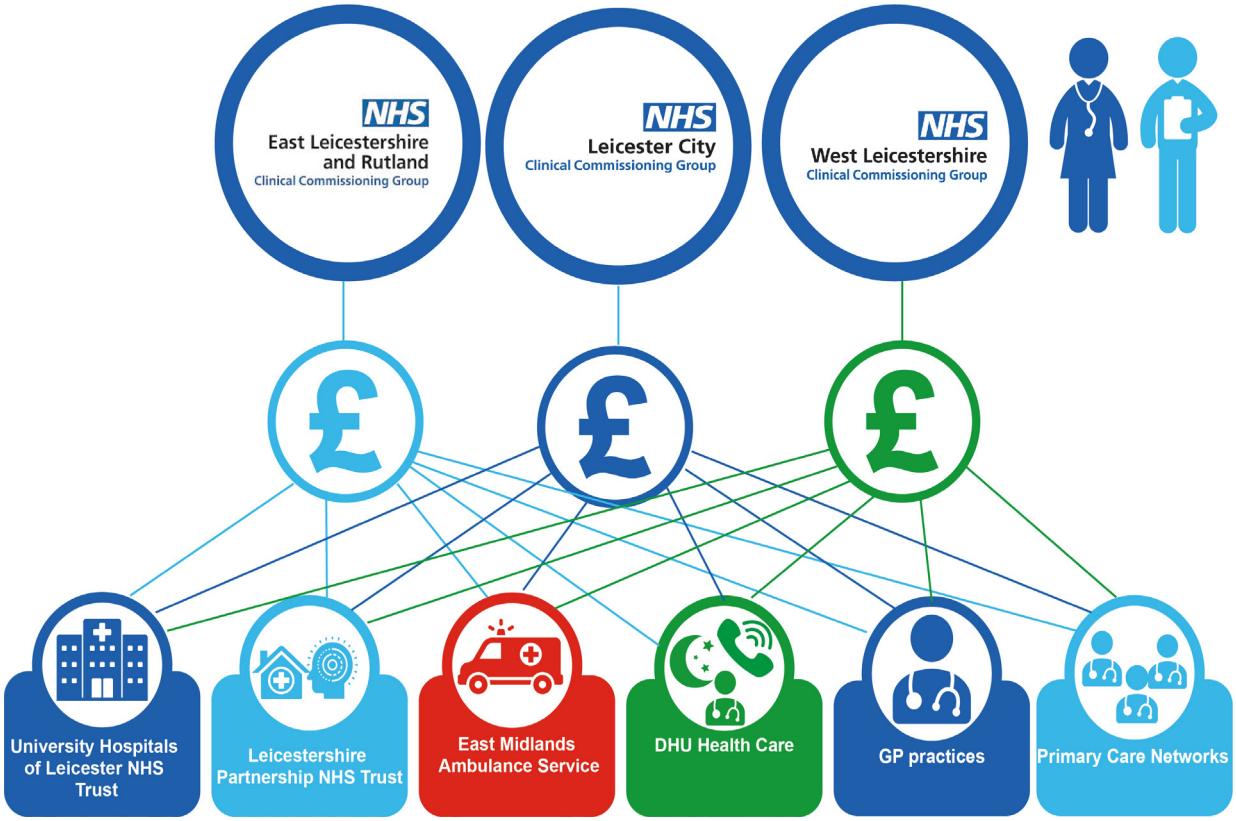
The final crucial component of care alliance(s) and the ICS, will be the primary care networks across LLR.

Neighbourhood – primary care networks

Neighbourhoods are the cornerstone of integrated care across LLR. They are based on 25 groups of GP practices, known as Primary Care Networks (PCNs). These networks, which were established on 1 July 2019, will be the focal point for delivery at the place level - working closely with social care and many other agencies to coordinate and manage care close to home for populations of 30-50,000 patients.

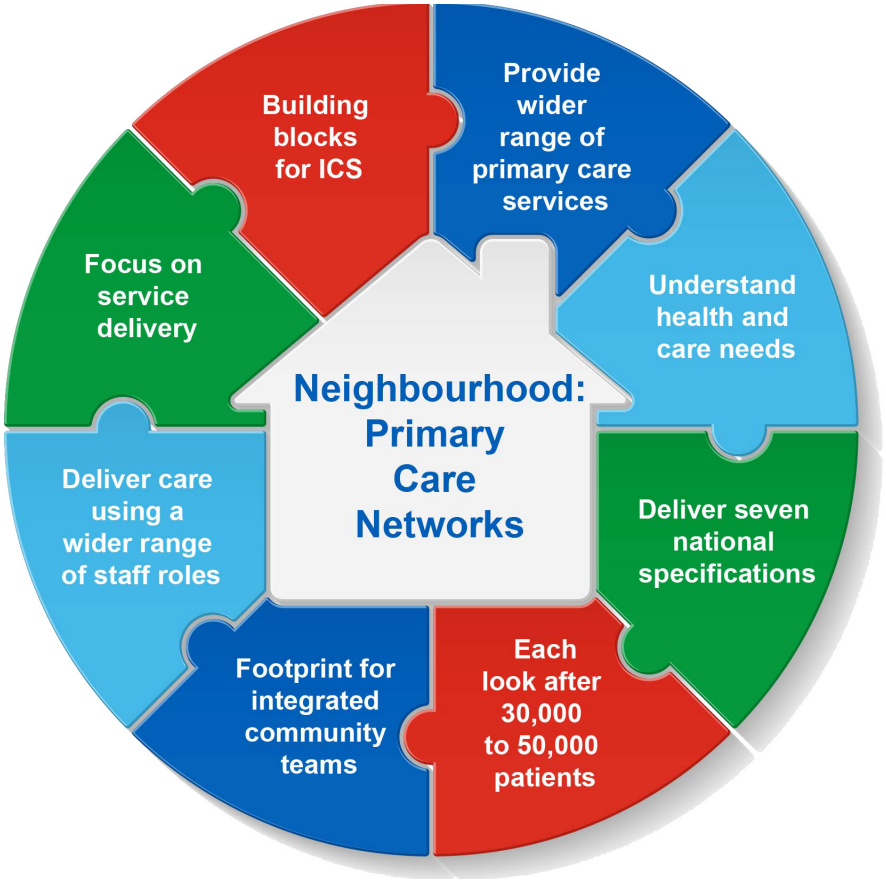
PCNs will be expected to provide a wider range of primary care services to patients, involving a wider set of staff roles than might be feasible in individual practices. They will also be the footprint around which integrated community-based teams will develop. Community and mental health services will be expected to configure their services around PCN boundaries as far as is practicably possible.

Current contracting arrangements:



Contracting under a care alliance:

Primary Care Networks will primarily be focused on service delivery, rather than on the planning and funding of services. This responsibility will remain with commissioners at a system level, supported by local authorities and the Health and Wellbeing Boards where a more localised approach is needed.



However, PCNs are expected to be the building blocks around which integrated care systems are built. The ambition is that they will be the mechanism by which primary care representation is made stronger in integrated care systems, with the clinical directors from each network being the link between general practice and the wider system.

A core role of PCNs will be to deliver against seven core national asks, which are set out as a series of service specifications.

Five will start by April 2020. These include: providing structured medication reviews for patients, delivering enhanced health in care homes, putting in place anticipatory care plans which help patients to make informed decisions about how and where they want to be treated and supported in the future, personalised care to support patients to have choice and control over the way their current care is delivered, and supporting early cancer diagnosis.

Two others will start by 2021. These include cardiovascular disease case finding and locally agreed action to tackle health inequalities (for which the Health and Wellbeing Board will take the lead role).

In summary, PCNs will:

- Understand their specific neighbourhood population health and care needs
- Deliver effective and consistent core general practice services, working collaboratively where it makes sense to do so
- Deliver enhanced primary care services either as individual practices or across a primary care network that enables patients to receive care closer to home - this may include some outpatient and diagnostics
- Design and deliver integrated health and care services with a range of partners (including social care and the NHS care alliance(s)) to meet the needs of the population
- Develop a fully functioning integrated team or network of primary and community care staff, aligned with social care and other community-based services, to support citizens with the most complex needs to stay as independent, and as close to home, for as long as possible.

What do we want to achieve through an ICS?

Ultimately we want better health, care and outcomes along with reduced health inequalities for the people of Leicester, Leicestershire and Rutland.

As part of an integrated care system, we believe there will be greater clarity of vision and purpose, and the speed of decision making and service transformation across the NHS in LLR should improve. It will also help to improve the quality and performance of the services provided, as well as the experiences of patients.

With the NHS moving away from the existing commissioner vs provider arrangements, we also believe the ICS will enable better collaboration and integration between NHS partners, and with other agencies in LLR where appropriate.

It will enable us to focus not only on outcomes associated with improved health and care service delivery, but also those outcomes that are concerned with the wider determinants of population health and wellbeing. The ICS will have a number of positive implications for population health outcomes. The diagram below outlines the benefits that an ICS will bring for our population, how this will be achieved and how our population will notice the difference.

An ICS will ensure that all partners collaborate to improve health outcomes for the entire population and utilise our available resources to tackle health inequalities. It will remove traditional organisational barriers and ensure all partners work collaboratively to deliver excellent patient care.

As a result, our patients will benefit from:

- More integrated joined up care
- New services to support improved health outcomes
- Improved access to services
- Improved joint working across health and local authorities to tackle the wider determinants of health and wellbeing
- Improved quality of care.

What is clear from our work so far is that these benefits and outcomes can only be achieved by taking a unified partnership approach, both in terms of how care is co-ordinated and delivered, and how it is commissioned. This is why the role of the single strategic commissioner will be vital in the ultimate success of an ICS in LLR.

Developing a new single strategic commissioning function for Leicester, Leicestershire and Rutland

What is a CCG and what do they do?

Clinical Commissioning Groups do not provide health services. Instead they are responsible for planning and commissioning health care services for their local area with resources delegated to them by NHS England. They are accountable to NHS England, and Parliament, for how they use these resources and the results they achieve.

Commissioning is about getting the best possible health outcomes for the local population. This involves assessing local needs, deciding priorities and strategies, and then buying services on behalf of the population from providers such as hospitals, community health providers and GPs among others.

CCGs must constantly respond and adapt to changing local circumstances. They are responsible for the health of the entire population, and measured by how much they improve outcomes for patients.

Our current arrangements and the challenges they present

The three local CCGs – Leicester City, West Leicestershire and East Leicestershire and Rutland – were formed in April 2013 taking over responsibility from former Primary Care Trusts (PCTs) for planning, paying for, and monitoring local health services. These were new organisations combining the expertise of local family doctors with NHS managers, putting local doctors and nurses at the heart of deciding which health services to provide and where and how they would be provided.

Each CCG is led by a Governing Body. All general practices in a CCG area are members of that CCG and have clinical representatives elected to their respective governing bodies. The CCG

membership retains the authority to set the strategy and direction for the organisation and to hold their governing body to account.

CCGs are responsible for commissioning services including:

- Planned hospital care
- Rehabilitative care
- Urgent and emergency care (including out-of-hours)
- Most community health services
- Mental health and learning disability services.

The CCGs also have delegated authority from NHS England for commissioning general practice primary care services.

The three CCGs in Leicester, Leicestershire and Rutland have a history of successful partnership working. The organisations have worked together to commission many services since their inception in 2013. This particularly included collaborative commissioning of contracts for our main providers – University Hospitals of Leicester NHS Trust and Leicestershire Partnership NHS Trust. These arrangements were supported by hosted teams, whereby groups of staff were employed by one of our CCGs but worked across and on behalf of all three.

However, while our CCGs have performed well against national indicators – all three were rated as 'Good' in the national Improvement and Assessment Framework for CCGs in 2018/19 – there have remained a number of significant issues.

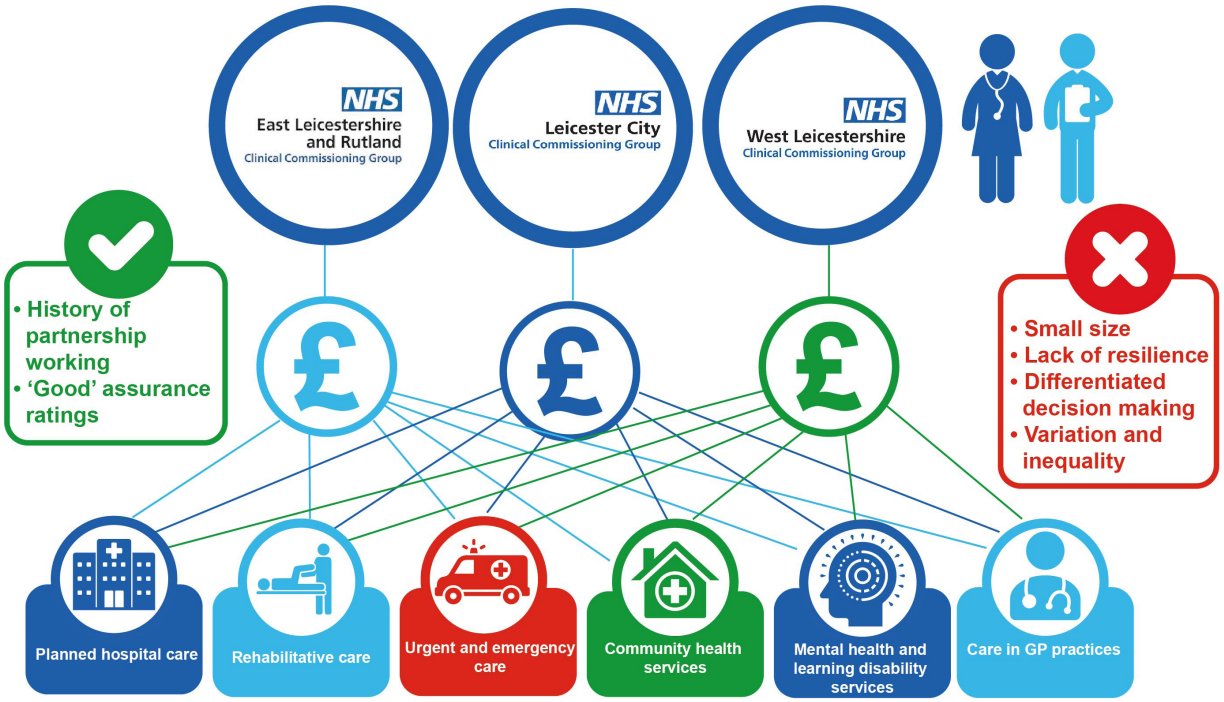
For example, the relatively small sizes of the existing CCGs mean that they can lack resilience, while progress has all-too-often been stifled by less than ideal joined-up working. This is evidenced by times when differentiated decision making by the three governing bodies has led to increased variation and inequality for patients across Leicester, Leicestershire and Rutland, rather than reduce it.

Indeed, current arrangements are confusing for patients and particularly our partners. Patients often do not understand who they should be talking to about issues affecting their care. Within LLR we have one acute provider and one major mental health and community services provider. However, under existing arrangements these organisations have often been frustrated and confused by different and sometimes competing priorities of the three existing CCGs.

Individual CCGs also means individual financial allocations. While this may be perceived by some to be a positive, spending on services across the three CCGs is variable and is often driven by the historic variation in funding per head of population. This means that our CCGs are in different financial positions.

While up until now organisations have only been held to account for delivery of their own financial performance, there is increasingly a move towards holding all NHS partners – both commissioners and providers – to account for delivery as a whole system. This means it will no longer be enough for individual organisations to take steps to manage their own financial performance to the detriment of others within the system.

Meanwhile there is still considerable duplication and sometimes triplication between organisations and there are limitations to what we can do collectively in our current form, with some statutory functions unable to be delegated.



Progress towards a single strategic commissioner

The three CCGs are currently considering the future form of the commissioning organisations, in light of the development of an LLR ICS and the need to ensure a single strategic commissioning voice.

In December 2018 we collectively took the decision to appoint a single accountable officer and management team to oversee the running of the three organisations. The new joint accountable officer has begun and work is ongoing to appoint a single team of executive directors. This is likely to be completed during early 2020.

From October 2019 enhanced joint governance arrangements have begun to be put in place across the three CCGs. These will enable more consistent and streamlined decision-making, but they still have limitations. This is because there are some functions that cannot be delegated.

We are now approaching a point where we need to finalise future organisational form to determine how strategic commissioning will be delivered within the context of the LLR ICS. Listening to our stakeholders is a crucial part of this process and we are keen to hear views on our proposals.

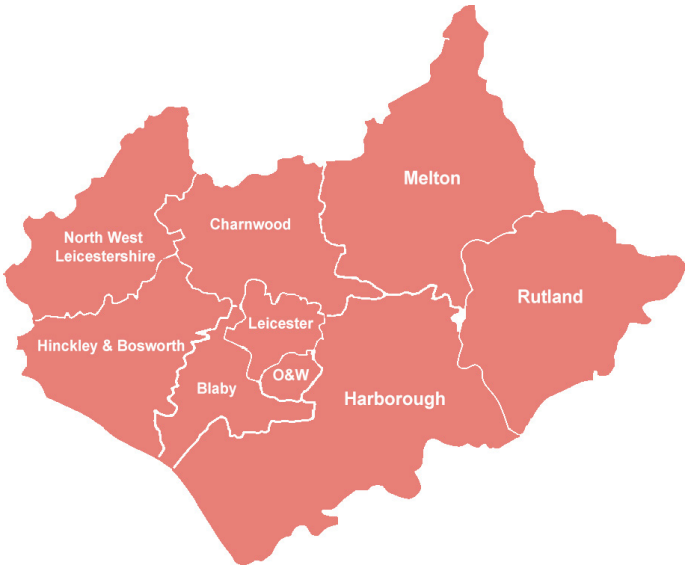
The options which have been considered for a single strategic commissioner include:

We have considered a number of key factors in appraising these options. These include:

- the ability of the option to improve health outcomes for patients, preserve and improve relationships and facilitate effective working
- give long term resilience, stability and permanence
- improve financial position and provide economies of scale
- reduce duplication and provide value for money
- maintain political oversight, improved reporting and pooling of clinical expertise.

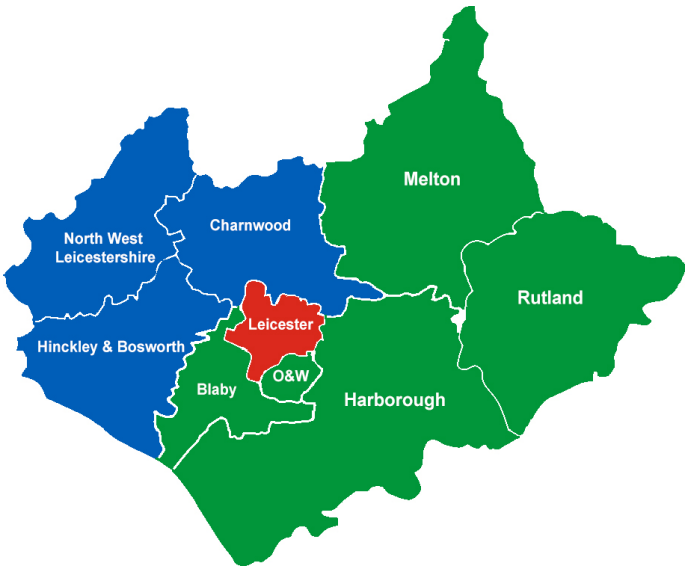
Geographical areas covered by the four options

One new CCG

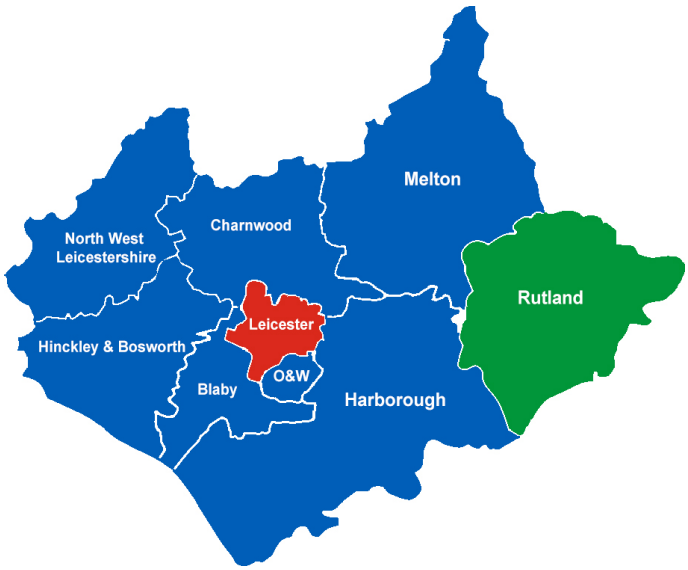


Two CCGs within a federation

Three existing CCGs within a federation



Three CCGs within a federation



Options for a single strategic commissioner in LLR

The options in more detail

	Summary of key advantages	Summary of key disadvantages
 Creation of a new single CCG for LLR, creating a unified commissioning approach and set of leadership arrangements	• Improved consistency of working, creating a single LLR approach • provides opportunity to align resources internally based on agreed priorities and population health need • allows more effective partnership work within the STP footprint, including with NHS England/Improvement, on areas outside of CCGs' current scope e.g. specialised commissioning • more sustainable and substantially reduces duplication as there would be one, rather than two or three, statutory bodies • best chance to address the financial position in LLR • single legal entity for providers and local authorities to engage with, providing a strong commissioner voice • single set of reporting and policy approaches would bring consistency for the people of the city and counties • clinical skills and expertise would be available throughout the area, including specialisms • opportunities will exist for maintained focus on local authority place level through the development of care alliance(s) and capitated place level budgets • ability to move collective resource to area of need	• move to a more consistent way of working across LLR, which could lead to a perceived loss of localism and/or focus on local 'place' • potential for arrangements to be seen as being more 'distant' from local authorities and member practices • loss of financial allocations at an individual CCG level, and potential reduction in associated flexibility to allocate resources accordingly

	Summary of key advantages	Summary of key disadvantages
 Retain the current CCG for Leicester City and create a new CCG for Leicestershire and Rutland. These two CCGs would operate as a federation with a joint management team and some shared governance and decision making	• working to existing local authority scrutiny and health and wellbeing board arrangements, thereby remaining responsive to local demographics and health needs • could reduce some duplication and provide some additional capacity and economies of scale • improved reporting and pooling of clinical expertise in Leicestershire and Rutland would potentially bring advantages for consistency of services in those parts of the STP area	• one of the CCGs could withdraw from the federation at any time - lacks long term resilience • limited advantage for system financial sustainability • does not address immediate financial challenges that we face as system • Potential remains for different decisions to be made that fails to address health inequalities and need • puts individual CCGs into competition with one another for national funding streams
 Retain the current CCGs. The three CCGs would operate as a federation with a joint management team and some shared governance and decision making	• builds upon what we already have • benefit of established structures • protects organisational and place based memory that exists within each of the three CCGs • preserves current relationships, particularly with local authorities, and maintains local patient voice	• one of the CCGs could withdraw from a federation at any time - lacks long-term resilience • possibility of differentiated decision making that further compounds existing health inequalities and unwarranted variation across the system as a whole. • risk that there may not be a genuinely unified strategic commissioning voice that speaks authoritatively and credibly on behalf of the system • puts individual CCGs into competition with one another for national funding streams • limited impact in terms of reducing overheads and management costs across the three CCGs. • existing levels of duplication would not necessarily be addressed to any great extent • does not address underlying financial issues across the three CCGs

	Summary of key advantages	Summary of key disadvantages
 Retain the current CCG for Leicester City and create two new CCGs; one for Leicestershire and one for Rutland. The three CCGs would operate as a federation with a joint management team and some shared governance and decision making This option has already been discounted on the basis that it is undeliverable	• would provide co-terminosity with existing local authority scrutiny and health and wellbeing board arrangements, providing very specific knowledge of local place • potentially improve political oversight since it matches local authority boundaries	• would not provide any additional economies of scale over and above current arrangements and could lead to further fragmentation and service variation • in turn could lead to an exacerbation of existing health inequalities • any one of the CCGs could withdraw from the federation at any time, meaning that the arrangements may lack longevity and resilience • considerable work would be required to set up two completely new CCGs and, given resource and capacity constraints, this may be a significant distraction • unlikely that this option would facilitate more collaborative or effective working at an STP level, nor would it address any concerns raised by providers and partners in relation to weaknesses within current arrangements • does not address underlying financial issues across the three CCGs • unlikely to be supported by NHS England on the basis that a CCG for Rutland would not have the critical mass of patient population to be sustainable in the medium to longer term

Our preferred option – a new single LLR CCG

Taking into account the findings of our options appraisal, we believe a single CCG is most likely to put us in the strongest position to deliver the desired improvements now and in the future.

No decisions have yet been made and the views of our stakeholders will be key in determining our final proposals. These will also be subject to formal consultation before we decide on the future form of a single strategic commissioner in LLR.

Benefits and opportunities of a new single CCG

We believe that a single strategic commissioner in the form of one CCG would have a number of benefits and opportunities for patients, member practices, partners and other stakeholders.

The most significant and compelling, in our view, is that the coming together of the three existing CCGs as one new strategic commissioning organisation - alongside the development of an ICS - provides us with the greatest opportunity to genuinely change our health and care system for the benefit of our patients.

It would allow us to begin a transformative journey that addresses the historic imbalance between in-hospital and out-of-hospital care. We would do this by working as one, in partnership with our providers, to redirect resources to support care provided by GPs and community services that focus on proactively managing the health of patients to keep them well and reduce expensive and unnecessary hospital visits and stays wherever possible.

In summary, the benefits we expect to realise as a result of coming together as one strategic commissioning organisation are:

Better healthcare and outcomes	**Align with health and care partners across the system in order to address health inequalities and ensure consistency of services where appropriate.**
Better use of resources	Redirect clinical time and resources that can be invested in to tackling system-wide health priorities.
Stronger, more consistent commissioning voice and leadership	Provide a stronger clinical voice in strategic decisions about health and care services for Leicester, Leicestershire and Rutland.
Greater support for transformation and innovation	Scale-up the most successful local clinical innovations to rapidly share best practice across a wider area.

We believe a single strategic commissioner in the form of one CCG would have a number of benefits and opportunities for our stakeholders. In summary, these include:

Patients

Benefits for Patients	
✓	Focus on agreed priorities and reducing health inequalities will improve health outcomes for those patients often overlooked or seldom heard
✓	A single commissioning organisation would bring a consistent approach to commissioning policies across LLR, ensuring that they are equitable for all patients within our area
✓	A single LLR CCG would end fragmentation of current commissioning arrangements, reducing the confusion and frustration caused by having multiple CCGs
✓	Would support the move towards becoming an Integrated Care System, which in the long term will help us focus on transformational change and delivering improved outcomes
✓	Provides enhanced opportunity to tackle health inequalities by providing flexibility to target discretionary spend from the collective budget towards those areas with the greatest needs
✓	Enables greater focus on improving service performance through increased capacity and flexibility to target our combined financial resources appropriately
✓	Would allow CCGs to invest more in front line services due to savings achieved in back office functions.

Member practices and other clinicians

Benefits for member practices and other clinicans	
✓	Enable greater sharing of best practiceand learning across PCNs in LLR
✓	More consistent commissioning approach will reduce variation in clinical practice and services
✓	Clinical time can be directed to transformational change – getting greatest gain from the limited clinical resources available to us across the three existing CCGs
✓	It would be easier to scale up the most successful clinical innovations to rapidly share best practice across LLR
✓	Provides a strong, more coherent clinical voice in strategic decisions about health and care, which will help to reduce duplication, and improve performance and outcomes for patients
✓	Easier to integrate with secondary care through an LLR clinical network.

Staff

Benefits for Staff	
✓	Removing organisational boundaries will allow us to create a shared talent pool, giving staff the opportunity to develop and use their skills in more challenging ways
✓	Staff would have greater capacity to support partners, through the Care Alliance(s), to deliver transformational change as duplication of roles would be removed
✓	Likely to improve retention and career progression as a result of a larger organisation with more opportunities for development
✓	Reduced duplication of work and associated frustration
✓	Greater consistency in standards and expectations.

Local authorities

Benefits for Local Authorities	
✓	Provides a single, strong and consistent commissioning vision and voice to partners, which will help to reduce duplication, and improve performance and outcomes for patients
✓	Staff would have greater capacity to support partners, through the Care Alliance(s), to deliver transformational change as duplication of roles would be removed from the system
✓	Through minimising structural barriers that exist between organisations there would be a removal of competing priorities of individual organisations and allow development of aligned objectives which will support both the system and patients
✓	The increased size and singular voice of the commissioning organisation will enable more strategic working and alignment with local and regional partners to develop and transform services
✓	Streamlining and simplification of decision making would mean shorter, more responsive processes and lead to quicker implementation of transformation and improvements.

Financial

Financial Benefits	
✓	One commissioning budget across LLR means increased flexibility to focus resources to need and sectors
✓	Economies of scale by having one instead of three organisations to run, enabling resources saved to be redirected to the front line
✓	Removal of duplication and triplication
✓	Reduces complexity of system wide financial planning and control
✓	Enables more efficient use of assets and resources
✓	Creates a stronger voice within any resource discussion and decisions taking place at a regional and/or national level
✓	More likely to achieve required reduction in CCG management and administration costs.

Developing a new single CCG for LLR

Developing a new single CCG for Leicester, Leicestershire and Rutland gives us the opportunity to create a new kind of organisation that builds upon what is good about our current arrangements while also addressing those things that have often limited progress.

The exact composition of a new Governing Body is still to be determined. However, it is expected that GP members will continue to be elected to the board to represent the views of constituent member practices within a particular place. It is also possible that at least one officer, and possibly an independent director (Independent Lay Member), will be nominally aligned to place to support the development and maintenance of relationships at that level.

However, it is important to recognise that all directors – whether managerial, clinical or independent – will be appointed to the Governing Body to act in the best interests of all 1.1million patients that the new organisation would serve.

As such, all members, regardless of background or interest, will have a collective corporate responsibility and accountability for the success of the organisation and delivery of its statutory responsibilities.

The work of any new Governing Body will be guided by its vision and values, which it will need to collectively develop and agree. This will provide the opportunity to incorporate a firm commitment to identifying and addressing health inequalities into the fabric of the new CCG in a way that is commensurate with the requirements of the NHS Long Term Plan. Governance arrangements will also need to be developed that reflect and protect this commitment.

Financial planning principles of a new single CCG

The need to act on health inequalities and unmet need is a core requirement of the NHS Long Term Plan, which sets out a requirement for strategic commissioning organisations and NHS providers to collectively have a concerted and systemic approach to reducing inequalities.

To support this, local areas have received five-year funding allocations that use a more accurate assessment of health inequalities and unmet need.

Local areas are also required to set out agreed specific, measurable goals for closing health inequalities over the next 5-10 years, including those relating to deprivation - which tends to be one of the greatest drivers of health inequalities within LLR. Working together as one organisation will allow us to take a holistic view of deprivation and unmet need across the whole of our area, with priorities and criteria for investment developed to adequately reflect this.

There is a firm commitment that any new single CCG for LLR would baseline current investment as it is currently understood by both place (e.g., Leicester, Leicestershire and Rutland) and programme. In this way there would be a clear unambiguous picture of existing non-discretionary spend, which represents a starting point for future investment.

As part of our developing financial strategy we would also set out what our long-term investment plan looks like, building in anticipated levels of financial growth over the course of the next four years. This will allow us to demonstrate expected percentage increases, which will be monitored by the Governing Body. It is expected that every part of the system will grow, although differentially in some areas based on need and health inequality.

As part of this arrangement any new single CCG would make investments jointly with local authority partners where beneficial to do so, whilst it would also make investments (and savings) in line with the shape of the LLR strategic plan. This means that there would be a clear focus on mental health, community services, and primary care networks.

As part of the new system it would be essential that the new CCG monitors both how resources are committed and how health inequalities are being improved/changed.

Planning and prioritisation

As a system we have already identified our strategic priorities for the next five years, these being the things that will help us to deliver a step change to local services and health and wellbeing during that period and beyond.

A central tenet of this approach is population health management. This will target prevention, intervention and care for those most likely to benefit. As part of this there is a clear commitment to creating detailed population profiles at place and neighbourhood level for patients in LLR– driven by public health understanding and data – that incorporates risk stratification, social care, and information on the wider determinants of health.

At a strategic level this data and insight will be used to inform the priorities and outcomes required across the system, and influence how discretionary funding may be targeted differentially at a place level to achieve these ambitions. This will be complex, but we are committed to ensuring that we are clear as a system as to what the health inequality improvements we are striving for in Leicester, Leicestershire and Rutland look like.

Critical to this will be working with public health and local authority colleagues to define in a quantifiable way what the health inequalities and contributory factors are within each place – supported by robust data and intelligence. This work is beginning, though it is still in the relatively early stages.

It is clear that we need to identify the right outcomes if we are to ensure investment is targeted to the right areas. However, it is recognised that many of the determinants of health inequalities are most likely to be impacted positively through focus on economic and social issues rather than through a focus purely on health service delivery. This includes educational attainment, employment opportunity, housing, transport, recreation, air quality, and regulations regarding food, alcohol and tobacco.

As a result it is essential that any new CCG works hand in hand – both now and in the future – with the local authority at place level, through statutory Health and Wellbeing Boards, to develop a clear understanding of the causes of health inequalities, and develop priorities that are relevant and appropriate for our places within Leicester, Leicestershire and Rutland.

Timescales and next steps

The existing CCGs and their partners need to work quickly to ensure an ICS is in place by April 2021 in line with national requirements. It is our anticipation that any new arrangements for commissioning will need to be put in place in advance of this. We also want to ensure that we make the best decisions for the future in LLR and that we are configured in the best way possible to support the development of our local ICS.

Through this pre-consultation engagement process, we would like to hear your views on our proposals for a single strategic commissioner in the context of an integrated care system and specifically:

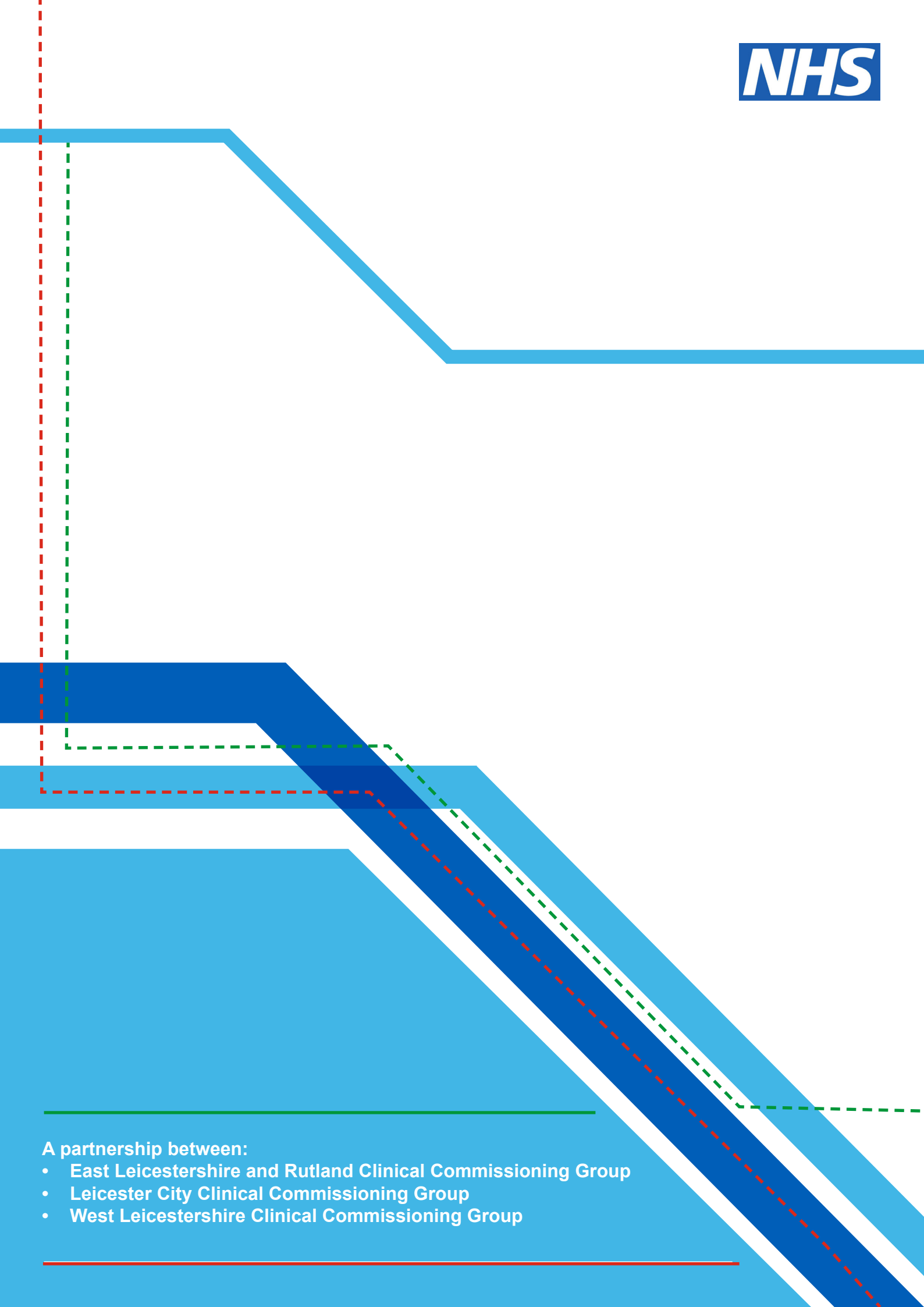
- whether there are things that are important to you that you don't feel we have considered
- the benefits and disbenefits of the proposals from your point of view
- what you think are the most significant issues that will affect successful implementation of a single commissioning organisation
- what you think works well in the current commissioning/provider structure and what you would like to be retained in the future
- what frustrates you about the current commissioning/provider structure and what would you like to see addressed in the future
- your thoughts on how to ensure a single strategic commissioner can be responsive to patients, practices, providers and local authorities

We will use your feedback to shape our plans before undertaking wider consultation. You can let us know your views online, by visiting www.surveymonkey.co.uk/r/SSCICS2019

Glossary

Term	Description
Better Care Together	The partnership of local health and social care organisations working together to improve care.
Care Alliance	Health and social care providers working together to deliver health care in the best way.
Care Plan	A plan that describes the care a person should receive, their medication and what to do if their condition gets worse. It is developed after an assessment of a person's health and wellbeing needs.
Clinical Commissioning Group	Plans and buys most health services for a local population.
Commissioning	Planning, agreeing, buying and monitoring healthcare provision in order to meet the needs of patients.
Constitution	A formal document that describes how an organisation will operate.
Federation	A group of organisations that have joined together to form a larger organisation.
Health and Wellbeing Boards (HWBs)	A statutory forum where political, clinical, professional and community leaders from health and care organisations come together to improve the health and wellbeing of their local population and reduce health inequalities.
Health Inequalities	The unjust and avoidable differences in people's health across the population and between specific population groups.
Healthwatch	An organisation set up by Government to represent the views of users of health and social care services and members of the public.
Holistic Services	Services that treat the whole person, taking into account mental and social factors, rather than just the symptoms of a disease.
Integrated Care Systems or Pathways	Health and social care organisations working together in a local area to provide good quality care for patients. It consists of a strategic commissioner (plan and buy services), a care alliance (organisations that provide care) and primary care networks (groups of GP practices).
Joint Health and Wellbeing Strategy	A document produced by Health and Wellbeing Boards that describes how the health and wellbeing of the local population will be improved.

Term	Description
LLR	Leicester, Leicestershire and Rutland.
Local Authority	Local Government – for example Leicester City Council, Leicestershire County Council, Rutland Borough Council.
Local Authority Scrutiny	Also known as the Health Overview and Scrutiny Committee. It is a meeting of local councillors who review the plans of health organisations to ensure they are fit for purpose and represent the needs of local people.
Medication Review	An examination of a person's medicines by a health professional, such as a GP or a pharmacist, to check they are still working for the patient and are still needed.
NHS Long Term Plan	The NHS Long Term Plan is a ten year plan that describes how health care will be provided and improved. It aims to give everyone the best start in life; deliver world-class care for major health problems, such as cancer and heart disease, and help people age well.
Pathway	The process that patients follow through the NHS to receive treatment for a condition.
Primary Care Network	Groups of GP practices working together with other health and social care professionals, such as nurses, dietitians and pharmacists, to provide excellent health care for patients.
Primary Care Network boundaries	The areas covered by the practices in a Primary Care Network.
Provider	Organisation delivering health care services. For example, a hospital, GP practice, local authority (social care) or community organisation.
Service Specifications	Describes in detail the care that a service will deliver.
Single Control Total	Financial targets to be met by NHS organisations.
Strategic Commissioner	One single organisation, or a group of organisations working together, to plan and buy healthcare for the local area. In this case, for Leicester, Leicestershire and Rutland.
System	The collective group of health and social care organisations that provide care for local people.
Sustainability and Transformation Partnership	The partnership of local health and social care organisations working together to improve care.
Voluntary Sector	Organisations whose primary purpose is to create social impact rather than profit. It is often called the third sector.



A partnership between:

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