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?

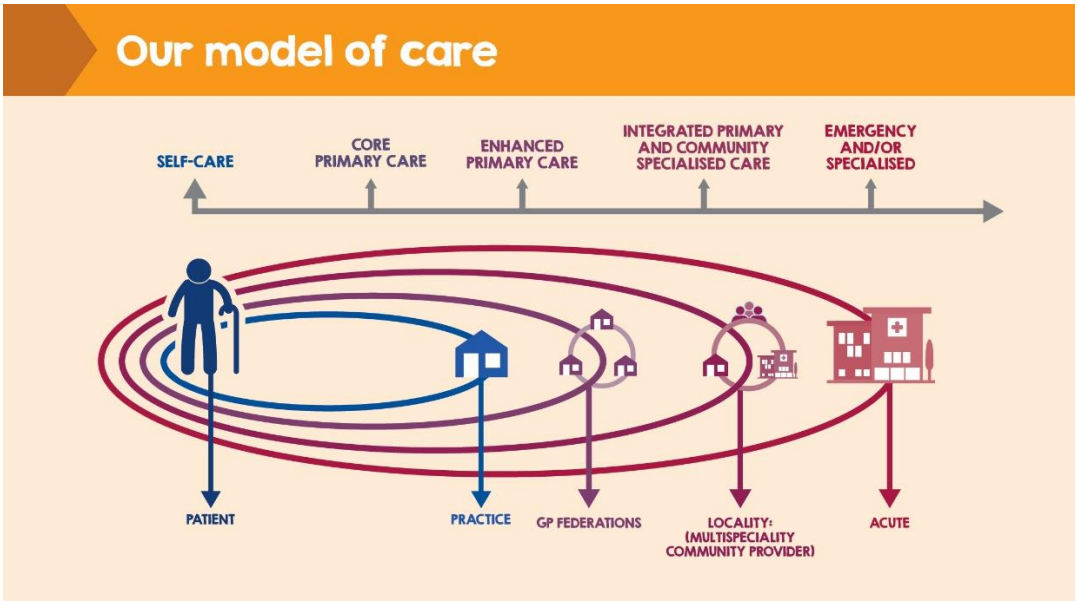
The approach to an ICS in LLR

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**