Lancashire and South Cumbria CCGs

Supporting Commissioning Reform and Integrated Care in Lancashire and South Cumbria

A Case for Change

Executive Summary

This paper aims to support consideration and discussion about the evolution of NHS commissioning in Lancashire and South Cumbria (L&SC) over the next two years. It sets out a case for changing the way that commissioning organisations work in order to accelerate the development of local integrated health and care partnerships. These increasingly ambitious partnerships offer a vehicle for commissioners, providers, local authorities and other partners to work very differently together, agreeing plans to improve the whole population's health, using collaboration rather than competition to improve the quality of health services and agreeing priorities to bring the system back into financial balance.

The context for the document is the work led by CCGs since 2013 to respond to a number of significant challenges in each area: poor outcomes and health inequalities, fragmented services, increasing demand compounded by workforce pressures and the need for financial sustainability [section 1]. This work has led to a broad consensus of the need for partners to work effectively together in neighbourhoods, in local places and across Lancashire and South Cumbria.

Over the next 2-3 years, CCG leaders have already stated their commitment to the continuing development of these integrated partnership models [section 2]. Clinical colleagues working in 41 Primary Care Networks are finding new ways to join up care in each neighbourhood and engage members of the public in their own health and wellbeing. As PCNs develop, they will have an increasing influence on the priorities of our evolving Integrated Care Partnerships (ICPs) in Morecambe Bay, Fylde Coast, Central Lancashire and Pennine Lancashire and a Multi-specialty Community Provider (MCP) in West Lancashire. Where there are opportunities across Lancashire and South Cumbria for collective action, learning and development, these are also being taken forwards by the wider Integrated Care System (ICS) partnership.

Looking further ahead (3-4 years) and as these partnerships continue to mature, there is further potential for them to take on more formal organisational responsibilities for improving the health of local people [section 3]. Our thinking at this stage is that a so-called "integrated care organisation" could be responsible for between 150-500,000 residents, delivering care directly and using alliances with other providers to create an effective local system of care. In doing so, we would expect this model of organisation to have demonstrated a transformational shift in its approach to population health, clinical leadership, board governance and accountability. The "integrated care organisation" would work under contract to the new single Commissioner which is charged with assuring progress of the ICP/ICO, setting consistent standards and securing improved outcomes across Lancashire and South Cumbria, achieving national policy priorities and financial value for taxpayers.

Currently, however, the 8 CCGs in Lancashire and South Cumbria are relatively small organisations. It is becoming increasingly clear that there is insufficient capacity and capability in the system as a whole to support PCNs/neighbourhoods and ICPs/MCP to

develop at the pace that is needed - and to tackle the challenges we face. This is in spite of the examples of joint decision-making and shared management arrangements which have developed over the last seven years.

In section 4, this paper begins to review the way that commissioning is currently organised and evaluates a number of potential future options against the following criteria:

- Tackle inequalities and improve outcomes for patients
- Get our resources and capacity in the right place to support our integrated place-based models in PCNs, ICPs, MCP and (where there is value in acting collectively) across the ICS
- Reduce duplication of commissioning processes, governance arrangements and the use of staff time
- Support a consistent approach to standards and outcomes
- Be affordable, reduce running costs and support longer term financial sustainability
- Offer the potential for further development of integrated commissioning between the NHS and Local Authorities
- Be deliverable
- Be congruent with the NHS Long Term Plan expectation that there will "typically" be a single CCG for each ICS area.

As a consequence of the ambitions to reform the commissioning arrangements, the option recommended is to form a new single CCG from April 2021 with aligned local commissioning teams to each Integrated Care Partnership / Multispecialty Community Provider, to support this next stage of development.

Key issues

A number of key issues have been raised by Governing Body representatives and member practices during the development work which has led to the production of this document. These issues [section 5] clarify and confirm how the process of change in commissioning arrangements would build on the existing strengths in Lancashire and South Cumbria and can be summarised as follows:

Governance, leadership and local decision-making

The single CCG will have a constitution approved by member practices across Lancashire & South Cumbria and will ensure strong local commissioning remains in each place.

It is proposed that the single CCG will have a governing body which is constituted with general practice members (Clinical Director), lay representatives, and a Managing Director who will represent each of the 5 places (Central Lancashire, Fylde Coast, Pennine Lancashire, West Lancashire and Morecambe Bay) that form the Lancashire & South Cumbria ICS.

In line with all CCG Constitutions, there will also be an Accountable Officer, Chief Finance Officer, Chief Nurse and Secondary Care Doctor.

The 5 Clinical Directors, 5 Managing Directors and 5 lay representatives who sit on the Governing body will also lead each place-based commissioning team, together with local clinical leadership and commissioning expertise. . The place based commissioning teams will retain many of the benefits member practices have indicated are important to them including responsibilities for practice engagement, primary care commissioning, population health improvement, improved service quality and financial management.

The method of appointment to the CCG governing body and place-based commissioning teams would be agreed as part of the new constitution.

The place-based commissioning teams will hold a delegated set of commissioning responsibilities through the single CCG's scheme of reservation and delegation and will act as the key NHS commissioning partner on each ICP/MCP Partnership Board. Local authority membership of local partnership boards will also drive this place-based approach.

There is a clear recognition from commissioning leaders that further development work is required in each of the local partnerships to ensure that effective leadership, decision-making and accountability arrangements are established and agreed by all partners. As local partnerships mature, it is also vital that they demonstrate how they will involve local communities and patients in decisions about their own health and wellbeing.

Clinical Leadership

It is proposed that the new single CCG Chair and the Clinical Directors will agree practical engagement arrangements with member practices in each ICP/MCP.

Place-based commissioning teams will also work closely with the PCN leaders, GP federations and LMC representatives as appropriate in each area.

The CCG also expects that PCN leaders will be formally represented within the ICP partnership arrangements.

Financial allocations for commissioning

There is a clear commitment to maintain the financial allocation for each Clinical Commissioning Group based on their "place footprint" (ICP/MCP) in line with the CCG allocations published by NHS England for the years 2021/22 until 2023/24.

Overarching financial principles would be developed and agreed as part of the engagement process, but we propose that:

- From April 2024, a single CCG could devise an allocations model which could address any remaining "distance from target" factors and top-slice specialised services commissioned across the whole of Lancashire and South Cumbria (e.g. Ambulance services.)
- From April 2024, a single CCG could also consider differential growth towards areas of higher deprivation and health inequality in Lancashire and South Cumbria, if a change to the existing allocation methodology could be evidenced as being in the best interests of the Lancashire & South Cumbria population. It is likely that a pace of change policy would be required to underpin this approach.

Commissioning general practice services

The funding for GMS/PMS contracts will continue to be nationally negotiated for all practices and will not be affected by the creation of a single CCG.

Local enhanced services contracted from General Practice by CCGs will continue to be funded until March 2022. Funding after 2022 will only change if agreed by the local place-based commissioning team as a partner on the local ICP. The exception to this principle would be if a new national DES schemes was to be introduced and duplicated an existing local incentive scheme.

Over time, it can be expected that the single CCG will publish a common set of primary care standards for general practice in Lancashire and South Cumbria.

In the meantime, however, there is a clear commitment to member practices that payments made by CCGs to practices for locally negotiated quality incentive schemes will be maintained until March 2022.

Engagement and Next Steps

Once this case for change has been approved, a formal process of engagement will commence with member practices, CCG staff, partner organisations, patient and public groups. [section 6] More details on the proposed timeline for this process are set out in section 7.

Contents

Introduction

This paper aims to support consideration and discussion about the evolution of NHS commissioning in Lancashire and South Cumbria (L&SC) over the next two years. It sets out the challenging context facing commissioners and communities. It also confirms the opportunities to continue a journey of integrated care which builds on the best work undertaken by CCGs and our partners in recent years. The document contains an options appraisal for future commissioning arrangements which is based on a number of criteria and recommends a preferred option for change. The paper also includes next steps and a high-level timeline for implementation of the preferred option.

This version of the Case for Change has been written for initial consideration by CCG governing bodies, member practices and the Joint Committee of CCGs. Wider engagement with commissioning staff, providers, local authorities and other partners will also be essential as this process develops.

Section 1: The Challenges We Face

As local commissioners, CCGs have been working with other partners since 2013 to respond to a range of familiar challenges:

Inequalities and Poor Health Outcomes

In Lancashire and South Cumbria, people in many of our communities experience ill health from an early age and die younger, especially in areas with higher levels of deprivation. There are high levels of physical and mental health problems, and we have seen increased levels of suicide in some of our communities. Cardiovascular disease, heart failure, hypertension (high blood pressure), asthma, dementia and depression are more common than the national average.

Persistent inequalities in health, employment, education and income are damaging the life chances of many citizens. There is increasing recognition that we need to support people and communities to help them to make changes in their own health and wellbeing. In future, therefore, commissioners will need to co-create a sustainable response from a range of public bodies to these issues, working with communities themselves.

Fragmented services and systems

There are multiple examples of fragmented pathways and services across the health and care system which leave patients uncertain as to where to access the most appropriate care or health professional.

At a systemic level in Lancashire and South Cumbria, the NHS model of commissioners and providers created nearly 30 years ago appears to have reinforced fragmentation in spite of the best efforts of many frontline professionals and leaders. Multiple contracts between several commissioners with the same provider e.g. for mental health services have created differential expectations and outcomes; competing organisational strategies have not enabled a clear focus on standards and outcomes. There are several examples e.g. improving stroke services, where decision-making on critical improvements has been painfully slow to achieve as individual organisations reconsider the proposals. These are not isolated examples: many have been discussed over the years in each Governing body and in our collective meetings across the whole of Lancashire and South Cumbria.

Our local providers are committed to working differently to repair this fragmentation: groups of general practices are working in neighbourhoods with other community and social care services to develop primary care networks. Attention will increase on these services with the

imminent publication of national standards/specifications for a range of community-based services.

Our major NHS providers are also exploring new models of collaboration, working firstly with general practice and community services to integrate care pathways in ICPs. They are also considering how "group" models of provision across Lancashire and South Cumbria can, for example, increase the sustainability of fragile services, create efficiencies in diagnostic and operating theatre services and improve the performance of cancer services.

Commissioners need to be working at the heart of these new models of delivery – but there is neither capacity nor resources to support these new approaches and maintain the infrastructure of eight separate CCGs.

Increasing Demand

Our health and care services are struggling to tackle the level of illness and poor overall health we face in Lancashire and South Cumbria. As demand for care increases, some people don't receive the quality of care they need and commissioners cannot afford to fund escalating levels of activity.

Workforce

Workforce pressures in the health and care sector are well documented – traditional multidisciplinary models of care are increasingly hard to sustain and this requires new thinking about workforce roles and support for frontline staff. The full benefits of new technology can only be realised if they are introduced into more integrated services, pathways and teams.

Financial Sustainability

In 2019/20 there is an estimated financial gap of £200m across the L&SC ICS, based on the allocations received by the 8 CCGs. Whilst funding for the NHS is set to increase over the next few years, tackling the challenges of persistent inequalities, fragmentation, increasing demand and workforce change is more urgent than ever. We need to consider every opportunity to streamline our systems and processes, and reduce duplication. Our aim has to be to make our financial position sustainable and our collaborative work on the Long Term Plan is progressing with that aim.

Over the last twelve months, all CCGs have been required to plan for a 20% reduction in running costs and this has already led to decisions to integrate management functions between CCGs and within ICPs/MCPs, hold staffing vacancies, review clinical leadership roles, reduce accommodation costs and work differently with the CSU.

The direction of travel towards 5 local place-based commissioning teams working through a single CCG will free up a proportion of running costs, particularly in relation to the costs of 8 Boards as well as taking further opportunities to consolidate or share management functions.

Some simple examples of where a single CCG would be more productive without affecting local clinical leadership and decision making include:

- We currently have to procure extrernal and internal auditors eight times and produce 8 sets of statutory accounts.
- As eight separate CCG's we hold collectively over 100 meetings per year to meet our statutory and constitutional duties. This could be vastly reduced freeing clinical time to focus on local place-based work.

- Commissioning areas like Ambulance services, cancer services and CHC would be much more effectively managed improving patient care and releasing savings and staff to reinvest locally.

It is vital to emphasise that the primary objective here is to reduce duplication of functions in order to redirect resources to support clinical leadership in PCNs and ICPs. There is a clear commitment to retain the expertise of CCG management staff in order to provide resources for population health improvement, planning and transformation activities in PCNs, ICPs and across L&SC.

The table below summarises the pattern of running costs across the 8 CCGs:

Organisations	**Population**	**No. of Practices**	**2019/20 Allocation £m**	**201/20 Running Cost Allocation £m**
NHS Blackburn with Darwen CCG	177,841	23	271.3	3.5
NHS Blackpool CCG	175,012	20	333.1	3.5
NHS Chorley and South Ribble CCG	186,154	30	287.2	3.9
NHS East Lancashire CCG	387,324	50	647.6	7.8
NHS Fylde and Wyre CCG	178,682	19	310.5	3.6
NHS Greater Preston CCG	210,857	23	311.8	4.4
NHS Morecambe Bay CCG	348,208	35	570.0	7.2
NHS West Lancashire CCG	113,532	15	177.8	2.4
TOTAL	**1,777,610**	**215**	**2,909.3**	**36.3**

In summary, maintaining the costs of eight separate statutory bodies at a total cost of £36m is difficult to justify when there is such financial pressure on health spending.

Section 2: Our Journey to Develop Integrated Health & Care in Lancashire and South Cumbria

We know that tackling the challenges set out in Section 1 is not something that any single commissioning organisation can achieve in isolation. For this reason, the CCGs in Lancashire and South Cumbria have a long history of working collaboratively together and with partners across the Integrated Care System (ICS) footprint. The publication of the NHS Five Year Forward View in 2014 achieved a new level of consensus that commissioners, providers local authorities and other partners should pursue approaches to integrating health and care – joining strategies, partnerships, resources and leadership to respond to the triple aim of better health, better care, delivered sustainably.

By 2018, this journey of integrated care development was accelerating the development of 4 maturing Integrated Care Partnerships (ICPs) in Morecambe Bay, Fylde Coast, Central Lancashire and Pennine Lancashire and a Multi-specialty Community Provider (MCP) in West Lancashire. These partnerships offer a vehicle for providers, commissioners, local authorities and other organisations to work very differently, agreeing plans to improve the whole population's health, using collaboration rather than competition to improve the quality of health services and bring the system back into financial balance.

CCGs have also begun to deploy significant resources and expectations into the early development of 41 Primary Care Networks (PCNs), building on the integrated care models which have developed in neighbourhoods. There is a clear expectation in each ICP that the clinical leadership offered by GPs and other frontline professionals should be endorsed and refocused to ensure the success of PCNs and ICPs. There is also further potential to use the development of PCNs and ICPs to encourage new approaches of integrated commissioning with our local authorities.

At the same time, a Joint Committee of CCGs was established "to carry out the functions relating to decision-making on pertinent L&SC wide commissioning issues" arising from the ICS's main change programmes. This means the CCGs across L&SC already act together as the Commissioning Board (NHS) of the ICS. The terms of reference for the Joint Committee have recently been reviewed and updated and an annual work programme has been agreed. This ensures that decision-makers and CCG Governing Bodies are clear how collective oversight and/or decisions arising from our main work programmes will take place.

The evolution of commissioning set out in this paper is not therefore a sudden jolt in our current arrangements. Our direction of travel builds on the place-based approaches being endorsed by CCGs in neighbourhoods, ICPs and across Lancashire and South Cumbria.

Recognising that the development of integrated care models would impact on the future of commissioning arrangements, in January 2018, the Joint Committee approved a Commissioning Development Framework for Lancashire and South Cumbria. The framework gave a system wide commitment to

- Listen to our communities about their priorities for health and wellbeing, connecting up the natural assets in each neighbourhood with the resources available across the public sector;
- Make shared, strategic decisions, with key partners and clinical leaders about the allocation of resources;
- Implement new, integrated models of service provision which can make significant improvements in the quality and outcomes of health and care;

- Streamline the way we do things to reduce waste and make the most efficient use of our resources.

Following approval of the Commissioning Framework, CCG commissioning colleagues across the system worked together to apply it to their workstreams and develop recommendations for place-based commissioning activity in the future. Their work addressed several examples of fragmented or variable commissioning in the current system which are leading to poor outcomes for many people. Examples include our approach to complex, individual packages of care, the availability of robust community services for people with learning disabilities and the variability of performance in cancer services. The Joint Committee agreed the recommendations and asked workstreams to develop operating and support models.

We have therefore made significant progress on our journey to develop integrated health and care for the people of L&SC and in doing so have established solid foundations for further development. ICPs/MCP and PCNs/neighbourhoods, are the fundamental foundations for a strong and effective health and care system going forward.

However, CCGs are relatively small organisations. It is becoming increasingly clear that there is insufficient capacity and capability in the system as a whole to support PCNs/neighbourhoods and ICPs/MCP to develop at the pace that is needed - and tackle the challenges, work with our communities, improve the overall quality of our health and care services and achieve better financial outcomes.

There is significant duplication in operating eight membership councils and governing bodies and the associated governance, many CCGs have similar groups to solve the same problems. Individual members of staff are trying to maintain work on several critical priorities at the same time and the work to implement new collaborative commissioning operating models across L&SC is progressing, though slowly. We therefore need to review the way we are currently organised, building on and accelerating our joint working to date, agree how best to organise ourselves to meet our challenges and deliver our vision to create a health and care system that is fit for now and the future.

Section 3: Vision

Our published vision for Lancashire and South Cumbria is that communities will be healthy and local people will have the best start in life, so they can live longer, healthier lives.

At the heart of this are the following ambitions:

- We will have healthy communities
- We will have high quality and efficient services
- We will have a health and care service that works for everyone, including our staff.

Over the next 4-5 years, we expect our system to continue its journey of integrated care, joining up the priorities of health and care organisations to achieve consistent standards of service performance and improved outcomes for patients and the public.

We are placing a premium on:

- Developing partnerships across the public sector (education, employment, housing, business, local government and NHS) in order to reduce the generational inequalities in health and life chances between our communities.
- Working with each of our communities to understand the assets available which can help people to become more engaged in their own health and well being.
- Joining up primary, community, mental health and social care services in local areas whilst at the same time ensuring that sustainable and efficient models of specialised services can be offered to the whole population.

Over the next 2-3 years, CCG leaders have already stated their commitment to the continuing development of integrated partnership models [section 2]. Clinical colleagues working in 41 Primary Care Networks are finding new ways to join up care in each neighbourhood and engage members of the public in their own health and wellbeing.

Looking further ahead (3-4 years) and as these partnerships continue to mature, there is further potential for them to take on more formal organisational responsibilities for improving the health of local people [section 3]. Our thinking at this stage is that a so-called “integrated care organisation” could be responsible for between 150-500,000 residents, delivering care directly and using alliances with other providers to create an effective local system of care. In doing so, we would expect this model of organisation to have demonstrated a transformational shift in its approach to population health, clinical leadership, board governance and accountability.

The “integrated care organisation” would work under contract to the new single Commissioner which is charged with assuring progress of the ICP/ICO, setting consistent standards and securing improved outcomes across Lancashire and South Cumbria, achieving national policy priorities and financial value for taxpayers.

In moving towards our vision, over the next 2-3 years we will continue to strengthen our partnerships in local places and across the whole Lancashire and South Cumbria system. Our priorities here are to:

- Ensure our clinical and other frontline leaders are able to lead the work to create sustainable care models in our neighbourhoods, place-based partnerships and across Lancashire and South Cumbria.

- Demonstrate to patients and communities that the ways in which we organise health and care services are leading to improved access and outcomes.
- Tackle our most difficult challenges (workforce, finance, service resilience) by agreeing clear priorities across the ICS and the decision-making arrangements we will use.
- Sustaining an open dialogue with the public about our future models of health and care.

The proposals for commissioning reform which are laid out in this document are therefore designed to help us make the next steps on this ambitious journey.

Section 4: Options for Commissioning System Reform

In developing and considering options for future commissioning reform, it is important that we do so in the context of the challenges we face, the progress made to integrate care and our commitment to build on the partnerships which commissioners have already developed. The following criteria have therefore been developed to support these considerations. If we are going to organise ourselves differently, any new model must:

- Tackle inequalities and improve outcomes for patients
- Get our resources and capacity in the right place to support our integrated place-based models in PCNs, ICPs, MCP and (where there is value in acting collectively) across the ICS
- Reduce duplication of commissioning processes, governance arrangements and the use of staff time
- Support a consistent approach to standards and outcomes
- Be affordable, reduce running costs and support longer term financial sustainability
- Offer the potential for further development of integrated commissioning between the NHS and Local Authorities
- Be deliverable
- Be congruent with the NHS Long Term Plan expectation that there will "typically" be a single CCG for each ICS area.

Options Appraisal

Current Arrangements

There are currently eight CCGs within the L&SC ICS footprint with a number of CCGs operating shared commissioning arrangements that are aligned to the ICP footprints:

- NHS East Lancashire CCG and NHS Blackburn with Darwen CCG have a single Accountable Officer, a newly-created single Management Team and integrated workforce. Their Governing Bodies remain separate but already have a number of common working arrangements
- NHS Blackpool CCG and NHS Fylde & Wyre CCG have a single Accountable Officer, a newly-created single Management Team and integrated workforce. Their Governing Bodies remain separate but already have a number of common working arrangements.
- West Lancashire CCG shares the same Accountable Officer as the two Fylde Coast CCGs (from January 2020).
- NHS Chorley & South Ribble CCG and NHS Greater Preston CCG have a single Accountable Officer, a single Management Team and integrated workforce. Their Governing Bodies remain separate but already have a number of common working arrangements.
- NHS Morecambe Bay CCG was formed in 2018 following a boundary change process to incorporate South Cumbria. There is a single Accountable Officer and Governing body and clinical and executives are increasingly taking "system roles" within the ICP.

Across the ICS footprint, the CCGs oversee collaborative programmes of work and are able to make joint decisions relating to L&SC-wide issues through the formally constituted Joint Committee of CCGs, in line with an agreed annual work programme. This ensures that decision-makers and CCG Governing Bodies are clear how collective oversight and/or

decisions arising from our main work programmes will take place. The work programme is also used to seek appropriate delegations from CCG Governing Bodies into the Joint Committee where appropriate. The scope of delegation to the Joint Committee is limited at the current time.

Drawing on the criteria set out above a number of options for future commissioning system reform have been generated and appraised:

Option 1	*No change to current arrangements*
Option 2	*Merger to create five CCGs aligned with ICP footprints*
Option 3	*Single Accountable Officer and Executive Team for all eight L&SC CCGs*
Option 4	*Single CCG (all functions)*
Option 5	*Single CCG which aligns commissioning functions to each Integrated Care* ***Partnership/****Multispecialty Community* ***Partnership***
Option 6	*Single CCG which discharges an agreed set of commissioning functions through a contract with each Integrated Care* ***Provider/*** *Multispecialty Community* ***Provider***

A detailed appraisal of these options is set out in Appendix A. In the light of this assessment, option 5 is recommended to commence from April 2021. The details of this option are shown below.

Our Preferred Option and Benefits

Option five is our recommended option to commence from April 2021. In advance of this, shadow arrangements would be developed during 2020/21.

Option 5: Single CCG which aligns commissioning functions to each Integrated Care Partnership/Multispecialty Community Partnership

Under this option, the eight L&SC CCGs would merge to form a single new CCG which would take responsibility for all statutory functions through a single governing body. Under this option, it is proposed that the single CCG's governing body will be constituted with general practice members (Clinical Director), lay representatives, and a Managing Director who will represent each of the 5 places (Central Lancashire, Fylde Coast, Pennine Lancashire, West Lancashire and Morecambe Bay) that form the Lancashire & South Cumbria ICS.

In line with all CCG Constitutions, there will also be an Accountable Officer, Chief Finance Officer, Chief Nurse and Secondary Care Doctor.

The 5 Clinical Directors, 5 Managing Directors and 5 lay representatives who sit on the Governing body will also lead each place-based commissioning team, together with local clinical leadership and commissioning expertise. . The place based commissioning teams will retain many of the benefits member practices have indicated are important to them

including responsibilities for practice engagement, primary care commissioning, population health improvement, improved service quality and financial management.

The place-based commissioning team will hold a delegated set of commissioning responsibilities through the single CCG's scheme of reservation and delegation and will act as the key NHS commissioning partner on each ICP/MCP Partnership Board.

The ICP Partnership Boards will support the development of PCNs/Neighbourhoods and ICPs/MCP and accelerate the progress of place-based commissioning.

Collaborative commissioning programmes at the L&SC level would be overseen and managed through the governance structures of the new CCG.

This option requires change to existing structures and organisations. It would see the majority of commissioning activity focussed on the ICP footprint, reducing duplication and maximising economies of scale. It also supports a consistent approach to setting standards and outcomes. This option ensures capacity is secured in PCNs/Neighbourhoods and ICPs/MCP to support place-based commissioning, allowing time and support for ICPs/MCP maturity to develop.

The single CCG will retain clinical commissioning capacity and resources in order to commission services for a population in excess of any one ICP/MCP (i.e. 500,000+). It will also commission those service areas in which recommendations have already been made to commission at L&SC level. Commissioners working at this level will retain specific links to local ICPs and neighbourhoods. In the context of expectations that all CCGs will achieve 20% running cost savings this option would be affordable and would be consistent with the expectations set out in the NHS LTP.

Merging into a unified, more strategic commissioning organisation with a strong local focus delivered through locality commissioning teams aligned to the five ICPs/MCP best supports our ambitions as described below:

1. Tackle inequalities and improve outcomes for patients

We know there are significant health inequalities across L&SC which create challenges for services and result in poorer outcomes for some of our most vulnerable and deprived communities. Our work to tackle health inequalities will be better supported by having Locality Commissioning Teams aligned to the five ICPs/MCP. This will enable us to:

- Maintain strong links and engagement with the local population;
- Ensure specialist analytics and population health capabilities can develop across L&SC and be available for each ICP/PCN to support local priorities
- Undertake service planning and targeted delivery to reflect the specific needs of local communities – working closely with local authorities;
- Ensure effective communication and engagement with local populations including seldom heard groups of people to enable them to share their views and concerns which will shape not just what services are provided but how they are delivered.

Only by organising ourselves differently can we begin to deliver the improvements that are needed for our patients

2. Get our resources and capacity in the right place to support our integrated place-based models in PCNs, ICPS, MCP and (where there is value in acting collectively) across the ICS

Locality commissioning teams will be aligned to the five ICPs/MCP. They will exercise an agreed set of commissioning functions on ICP/MCP and PCN footprints, working collaboratively with partners through ICP Partnership Boards to agree plans for population health improvement, improved service quality and financial recovery. The Local Partnership Boards will support the development of PCNs/Neighbourhoods and ICPs/MCP and accelerate the progress of place-based commissioning with the ultimate aim of supporting ICPs/MCP and PCNs to reach a level of maturity over the next 2-3 years whereby commissioning functions and budgets can be contracted for through an Integrated Care Provider Contract. The single CCG will retain clinical commissioning capacity and resources in order to commission services for a population in excess of any one ICP/MCP (i.e. 500,000+). It will also commission those service areas in which recommendations have already been made to commission at L&SC level. Commissioners working at this level will have specific linked roles to local ICPs and neighbourhoods.

3. Reduce duplication

There will be a significant reduction in duplication both in terms of the capacity required to support the existing eight CCG governance structures and that deployed to support commissioning activity across eight CCG footprints. We know that our commissioning workforce is finding it increasingly challenging to balance the demands of collaborative commissioning activity across L&SC with ICP/MCP commissioning work to support the development of PCNs and neighbourhoods.

It is vital to emphasise that the primary objective here is to reduce duplication of functions in order to redirect resources to support clinical leadership in PCNs and ICPs. There is a clear commitment to retain the expertise of CCG management staff in order to provide resources for population health improvement, planning and transformation activities in PCNs, ICPs and across L&SC.

4. Support a consistent approach to standards and outcomes

As a strategic commissioner the CCG will focus on a key set of commissioning functions and activity related to standard setting for the whole population. It will focus on macro-level population health management and improving outcomes for patients.

Further development work is now being led by CCGs to set out the commissioning functions which will be exercised by Locality Commissioning Teams.

5. Be affordable, reduce running costs and support longer term financial sustainability

By streamlining our decision-making infrastructure and commissioning activity, doing things once where it makes sense to do so (e.g. finance, corporate services, committee meetings) we will reduce running costs. By re-focussing commissioning time and energy for those service areas in which recommendations have already been made to commission at L&SC level, we will make better use of clinical and managerial time and be better placed to deliver the financial efficiencies as required by NHS England and Improvement.

6. Offer the potential for further development of integrated commissioning between the NHS and Local Authorities

We will establish Locality Commissioning Teams to exercise key commissioning functions through ICP Partnership Boards, of which Local Authorities are key members. The new arrangements will support the continued journey towards more integrated health and social care at place level with ICP Partnership Boards being well placed to explore practical ways of integrating health and social care commissioning and delivery.

7. Be deliverable

Creating a single CCG with a combination of system-wide and locality-based leadership offers a deliverable and affordable model of commissioning in an integrated care system.

8. Be congruent with the NHS Long Term Plan expectation that there will typically be a single CCG for each ICS area

The NHS Long-Term Plan (LTP) is clear that each ICS will need streamlined commissioning arrangements to enable a consistent set of decisions to be made at system level. It talks about CCGs becoming leaner, more strategic organisations that support care providers through ICPs/MCP to partner with other local organisations to deliver population health, care transformation and implement the requirements of the LTP. It also talks about CCGs developing enhanced management capability for more specialist functions, such as estates, digital and workforce. Option five will allow us to bring together CCG clinical and managerial time to respond to the requirements of the LTP, and ensure capacity is secured in PCNs/Neighbourhoods and ICPs/MCP, to support place-based commissioning, allowing time and support for ICPs/MCP maturity to further develop.

In summary, a single CCG which operates as a strategic organisation, working with well-resourced local teams aligned to each of our local partnerships is recommended for the next stage on our journey of integrated care.

Section 5: Governance and Decision Making

As indicated above, the importance of effective governance and decision-making will be a critical success factor for this next stage of commissioning development in Lancashire and South Cumbria. This is particularly the case in order to build on the legacies of existing CCGs, move away from competition to partnership models of healthcare delivery and ensure that local organisations remain accountable to their communities.

Under the option for a single CCG, this will clearly operate as a membership organisation with a formal Constitution and scheme of reservation and delegation agreed with the members and approved by NHS England.

Membership of the Governing Body of the CCG will include the roles formally required including Accountable Officer, Chief Finance Officer, Secondary Care Doctor, Nurse and Lay members.

Locality-based decision-making

In order to emphasise the importance of place-based leadership and decision-making in Lancashire and South Cumbria, the governance of the new CCG will include a formal approach to leadership and decision-making in each locality. It is proposed that the single CCG will have a governing body which is constituted with general practice members (Clinical Director), lay representatives, and a Managing Director for each of the 5 places (Central Lancs, Fylde Coast, Pennine, West Lancs and Morecambe Bay) that form the Lancashire & South Cumbria ICS.

The 5 Clinical Directors, 5 Managing Directors and 5 lay representatives who sit on the Governing body will also lead each place-based commissioning team, together with local clinical leadership and commissioning expertise. The place based commissioning teams will retain many of the benefits member practices have indicated are important to them including responsibilities for practice engagement, primary care commissioning, population health improvement, improved service quality and financial management.

Local authority membership of ICP/MCP partnership boards will also drive this place-based approach and working relationships are expected to become increasingly close.

Given the size of the CCG, there need to be practical arrangements for ensuring member practice involvement in the accountability arrangements and governance of the organisation, particularly as many practices also want to be engaged effectively in the development of local Primary Care Networks (on the basis of 30-50000 population) as well as in their ICPs/MCP.

There is a clear recognition from commissioning leaders that further development work is required in each of the local partnerships to ensure that effective leadership, decision-making and accountability arrangements are established and agreed by all partners. As local partnerships mature, it is also vital that they demonstrate how they will involve local communities and patients in decisions about their own health and wellbeing.

Clinical Leadership

Effective clinical leadership has been at the heart of clinical commissioning in recent years. There is an explicit commitment to retain these benefits in the leadership and governance of any reformed commissioning arrangements agreed for the future.

In line with current legislation, the single CCG will remain a membership organisation with all general practices as members. We recognise that clinical leaders will continue to be involved in developing the strategy, governance and accountability of a new commissioner

(e.g. through membership of the Governing Body), as well as working with provider colleagues to drive change and improvements across the health and care system.

In the next stage of our system's development, we also know that a group of GPs and other clinicians have been asked to lead our integrated PCN models in neighbourhoods: a key driver for reorganising the resources which are currently available within CCGs. It is understood that plans are being developed in each area for PCN leads to play a full part in the governance of each ICP/MCP.

Whatever option is agreed for changes in commissioning, there will be an obligation to operate under a formal constitution with a clear model for clinical leadership which is developed and agreed with member practices.

It is proposed that the new CCG Chair and the 5 place-based Clinical Directors will agree practical engagement arrangements with member practices in each ICP/MCP. Place-based commissioning teams will also work closely with the PCN leaders, GP federations and LMC representatives as appropriate in each area.

Finance & Allocations

As indicated above, many of the NHS organisations within the ICS are currently projecting substantial deficits. These will require effective, strategic decisions to be taken if the system is to return to a stable financial base. It is recognised that existing CCGs are in different financial positions and spending on services will be variable. Much of this will be driven by historic funding variations.

It is also understood that Governing Bodies and member practices have concerns about the impact of commissioning reform on existing allocations and commitments. At this stage, therefore, it is vital therefore that the following explicit commitments are made.

In relation to commissioning allocations:

- There is a clear commitment to maintain the financial allocation for each Clinical Commissioning Group based on their "place footprint" (ICP/MCP) in line with the CCG allocations published by NHS England for the years 2021/22 until 2023/24.
- From April 2024, a single CCG could devise an allocations model which could address any remaining "distance from target" factors and top-slice specialised services commissioned across the whole of Lancashire and South Cumbria (e.g. Ambulance services.)
- From April 2024, a single CCG could also consider differential growth towards areas of higher deprivation and health inequality in Lancashire and South Cumbria, if a change to the existing allocation methodology could be evidenced as in the best interests of the Lancashire & South Cumbria population. It is likely that a pace of change policy would be required to underpin this approach.

In relation to the commissioning of general practice services:

- The funding for GMS/PMS contracts will continue to be nationally negotiated for all practices and will not be affected by the creation of a single CCG.
- Local enhanced services contracted from General Practice by CCGs will continue to be funded until March 2022. Funding after 2022 will only change if agreed by the local place-based commissioning team as a partner on the local ICP. The exception to this principle would be if a new national DES schemes was to be introduced and duplicated an existing local incentive scheme.
- Over time, it can be expected that the single CCG will publish a common set of primary care standards for general practice in Lancashire and South Cumbria.

- In the meantime, however, there is a clear commitment to member practices that payments made by CCGs to practices for locally negotiated quality incentive schemes will be maintained until March 2022.

Section 6: Stakeholder Engagement

Since June 2019, CCG Chairs and Chief Officers have worked together with ICS colleagues to draft a roadmap and a statement of intent, setting out a direction of travel for commissioning development. These have been shared with each CCG's Governing Body and take forward a dialogue to understand concerns, answer questions and consider the options outlined in this paper. In addition, a written briefing has been cascaded to staff working in CCGs and the Midlands and Lancashire CSU which has been supported in regular staff briefings held within organisations.

It is vital that a clear approach to communication and engagement now takes place, particularly with our member practices and to ensure staff in CCGs are informed and involved at each stage. CCGs wishing to consider organisational change are also required by NHS England to demonstrate effective engagement about the plans with other key system partners and the public.

To support this process, a communications and engagement plan will be developed to deliver the following objectives:

- Demonstrate we have been able to take account of the views of key stakeholders – in particular our staff, GP membership and four local Healthwatch organisations- in developing our plans for a strategic commissioner
- Ensure key audiences are aware of our plans and in particular what this might mean for them
- Ensure stakeholders – and existing CCG staff in particular – are able to ask questions and give comments, with a robust feedback mechanism
- Ensure stakeholders – and existing CCG staff in particular – are engaged in bringing the new organisation together
- Ensure staff and members are aware of any additional roles and responsibilities they may have in helping to create the new strategic commissioner.

Our communications and engagement principles are

- The communications and engagement plan is based on clear, consistent messaging that describes both the benefits of merger and any dis-benefits
- Employing a principle of 'early communication and engagement' so there are 'no surprises' particularly amongst key stakeholders
- With effective and meaningful engagement channels to capture views, timely responses to questions and feedback and published FAQs (regularly updated)
- The plan covers both internal and external audiences across all eight CCGs, including staff, memberships and practice staff, the LMC, leaders/staff across the ICS, our regulators, Healthwatch, PPGs and engagement fora, the community/ voluntary sector, other local partners, media and wider public
- With messages and approach tailored appropriately
- Underpinned by a clear activity plan and timeline which uses existing communications/engagement channels wherever possible

Section 7: Next Steps and Timeline

This Case for Change and the Options Appraisal contained in appendix A have undergone a number of iterations during the past two months based on feedback from CCG Chairs and Chief Officers, Governing Bodies and member practices. In particular, work has been undertaken to set out a vision for the continued development of integrated care in neighbourhoods, local places and across the system. More detailed proposals have been set out relating to governance, local decision-making, clinical leadership including commitments relating to financial allocations and the commissioning of general practice services.

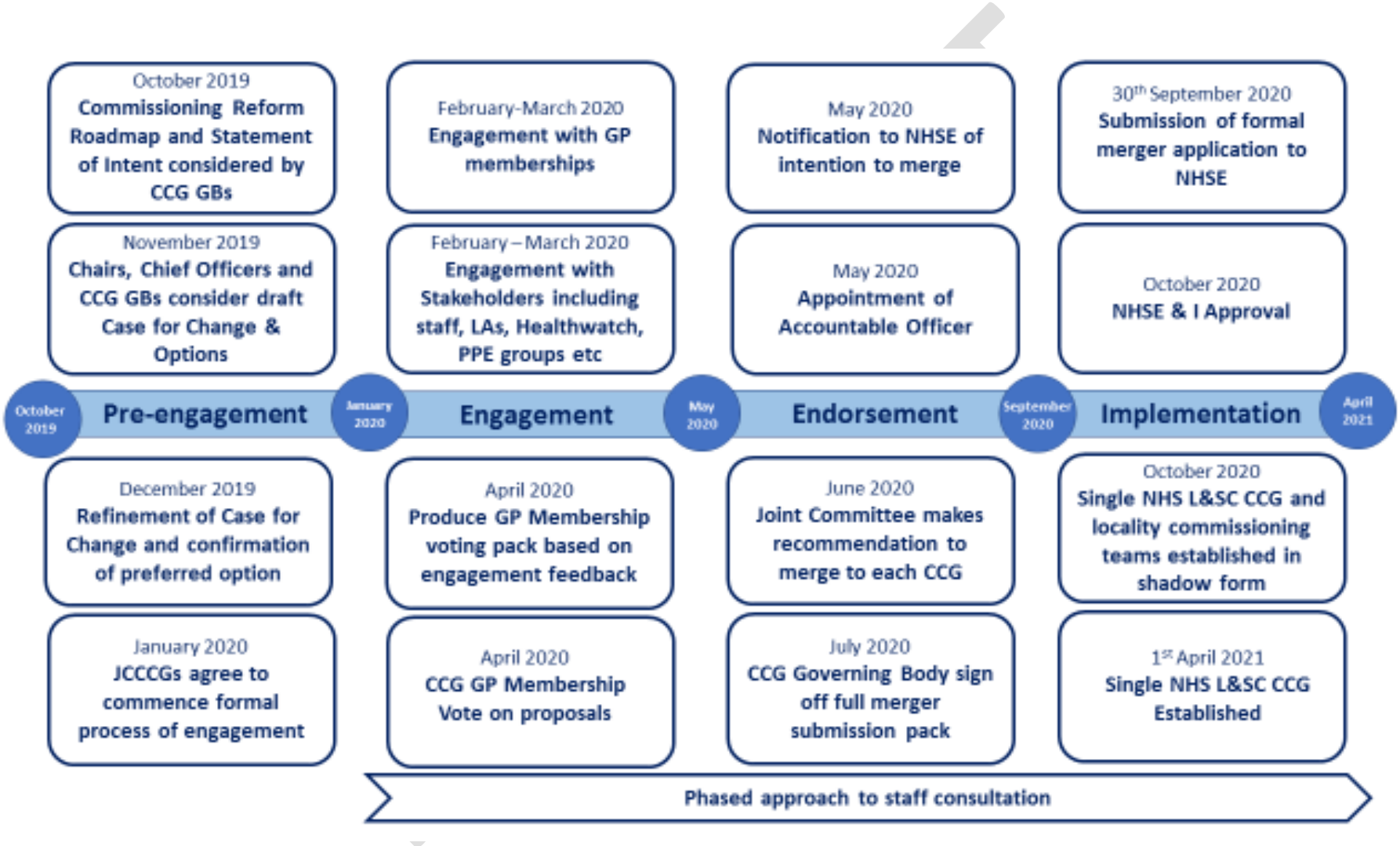
Subject to agreement by the Joint Committee at its meeting in January 2020, the next steps are to commence a period of formal engagement from February-March 2020 with member practices, CCG staff and other stakeholders including Local Authorities, Healthwatch and patient/public groups.

Work will also be completed in early January to develop proposals for the future delivery of commissioning functions at place and system levels. The outputs from this work, alongside this Case for Change and Options Appraisal will form the basis for the formal engagement process.

Following the engagement process, and taking account of any feedback received, it is proposed that a GP membership voting pack will be developed and considered by the Joint Committee of CCGs prior to a CCG GP Membership vote in May 2020. Subject to the outcome of this vote, a full set of merger submission documents will be developed in line with NHSEI guidance. Following consideration by Joint Committee and sign off by Governing Bodies, a formal merger application will be submitted to NHSE on 30th September 2020 with the aim of a single CCG for L&SC operating in shadow form from October 2020 and being fully established on 1st April 2021.

A high-level timeline for the process described above is set out below. Work is underway to develop a detailed programme plan which will incorporate development plans for the ICPs/MCPs.

Commissioning System Reform – High Level Timeline



APPENDIX A - Commissioning System Reform Options Appraisal

Option	Number of CCG's	Pro's	Con's
1. No change to current arrangements	8	Local commissioning focus continues Minimum structural change	Continuing duplication Limits capacity to support ICP and PCN development, place-based commissioning Does not support a consistent approach to standards and outcomes across L&SC Unaffordable Holds limited potential for integrated commissioning Inconsistent with NHS LTP Reliant on JCCCG to be vehicle for strategic commissioning
2. Merger to create five CCGs aligned with ICP footprints	5	Local commissioning focus continues Some structural change Partial release of capacity and resource to support ICPs/MCP and PCN development and place-based commissioning Potential for further integration with Local Authorities based on sharing priorities and resources (rather than straightforward co-terminosity)	Continuing duplication of resource maintain five CCG governance structures Does not support a consistent approach to standards and outcomes across L&SC Unaffordable Inconsistent with NHS LTP Reliant on JCCCG to be vehicle for strategic commissioning

Option	Number of CCG's	Pro's	Con's
3. Single Accountable Officer and Executive Team for all 8 L&SC CCGs	8	Local commissioning focus continues Limited structural change May offer small efficiencies in management costs Offers potential to support a consistent approach to standards and outcomes	Continuing duplication Limits capacity to support ICP/MCP and PCN development, place-based commissioning Unaffordable Holds limited potential for integrated commissioning Inconsistent with NHS LTP Reliant on JCCCG to be vehicle for strategic commissioning Not deliverable, unworkable for a single Exec Team to relate to eight Governing bodies
4. Single CCG (all functions)	1	Reduces duplication Supports consistent approach to standards and outcomes across L&SC Economies of scale Affordable Consistent with NHS LTP Potential for further integration with Local Authorities based on sharing priorities and resources (rather than straightforward co-terminosity)	Limits capacity to support ICP/MCP and PCN development, place-based commissioning Significant structural change

Option	Number of CCG's	Pro's	Con's
5. Single CCG which aligns commissioning functions to each Integrated Care Partnership/Multispecialty Community Partnership	1	Ensures capacity is secured in each ICP/MCP and PCN to support place-based commissioning Reduces duplication Supports consistent approach to standards and outcomes across L&SC Maximises economies of scale in deployment of resources, capacity and skills for collective action across all ICPs/MCP Affordable Consistent with NHS LTP Potential for further integration with Local Authorities based on sharing priorities and resources (rather than straightforward co-terminosity)	Significant structural change
6. Single CCG which discharges an agreed set of commissioning functions through a contract with each Integrated Care **Provider/** Multispecialty Community **Provider**	1	Ensures capacity is secured in each ICP/MCP and PCN to support place-based commissioning Reduces duplication Supports consistent approach to standards and outcomes across L&SC Maximises economies of scale in deployment of resources, capacity and skills for collective action across all ICPs/MCP	Significant structural change Requires Integrated Care Providers /Multispecialty Community Provider to have reached a stage of maturity to be able to take on commissioning functions on behalf of the single CCG

Option	Number of CCG's	Pro's	Con's
		Affordable Consistent with NHS LTP Potential for further integration with Local Authorities based on sharing priorities and resources (rather than straightforward co-terminosity)	

Option 1: No Change to Current Arrangements

The eight existing CCGs continue to take individual responsibility for their statutory functions and the operation of their local system, whilst at the same time working with other CCGs and with local partners to support the further development of ICPs/MCP and PCNs/Neighbourhoods.

Collaborative commissioning programmes would continue to be overseen and collaborative decisions made through the Joint Committee, though accountability would remain with the existing CCGs

This option would mean that commissioning activity remains focussed on the local CCG footprints and would not require structural change. Duplication of governance structures and commissioning activity will continue, and we will not benefit from opportunities for greater collaboration and economies of scale offered by other options. This option also limits capacity to support the development of PCNs/neighbourhoods and ICPs/MCP and to accelerate the progress of place-based commissioning. This would hamper our ability to address current pressures, improve patient outcomes, reduce health inequalities and tackle inefficiencies. In the context of expectations that all CCGs will achieve 20% running cost savings this option is increasingly unaffordable whilst also being inconsistent with the expectations set out in the NHS LTP. This option also holds limited potential for further development of integrated commissioning with Local Authorities.

Option 2: Merger to create five CCGs aligned with ICP footprints

A number of the existing CCGs would merge to form five CCGs across the L&SC ICS footprint which are aligned with the five ICPs/MCP:

- Morecambe Bay
- Central Lancashire
- Fylde Coast
- West Lancashire
- Pennine Lancashire

The new CCGs would continue to take individual responsibility for their statutory functions and the operation of their local system, whilst working with local partners to support the further development of ICPs/MCP and PCNs/Neighbourhoods. Each CCG would retain a separate governing body and governance structure, AO and Executive Team.

Collaborative commissioning programmes would continue to be overseen and collaborative decisions made through the Joint Committee in line with an agreed work programme, though accountability would remain with the existing CCGs

This option would mean that commissioning activity is focussed on the local ICP footprints and offers the partial release of capacity to support ICPs/MCP and PCN/Neighbourhood development and place-based commissioning. The potential for further integration with Local Authorities would be based on sharing priorities and resources (rather than straightforward co-terminosity). This option does not support a more consistent approach to standards and outcomes across the ICS footprint and would see duplication of governance structures and commissioning activity continue. This option does not benefit from opportunities for greater collaboration and economies of scale offered by other options. In the context of expectations that all CCGs will achieve 20% running cost savings this option

would also be unaffordable and would be inconsistent with the expectations set out in the NHS LTP.

Option 3: Single Accountable Officer and Executive Team for all L&SC CCGs

The eight existing CCGs appoint a single Accountable Officer and Executive Team for the whole Lancashire and South Cumbria footprint. Individual CCGs would retain responsibility for the delivery of statutory functions but Accountable Officer (AO) decision making would be held at the Lancashire and South Cumbria level. The AO and Executive Team would be responsible for working with their local partners to support the further development of ICPs/MCP and PCNs/Neighbourhoods. The single AO would be responsible for providing assurance to each governing body for statutory functions that continue within the CCG and for appropriate adherence to standards, targets and performance expectations.

Collaborative commissioning programmes would continue to be overseen and collaborative decisions make through the Joint Committee, though accountability would remain with the existing CCGs

This option would mean that commissioning activity remains focussed on the local CCG footprints and would require limited structural change. It also offers the potential to support a more consistent approach to standards and outcomes across the ICS footprint and may offer small efficiencies in management costs. Duplication of governance structures and commissioning activity will continue, and we will not benefit from opportunities for greater collaboration and economies of scale offered by other options. This option also limits capacity to support the development of PCNs/neighbourhoods and ICPs/MCP and to accelerate the progress of place-based commissioning. This would hamper our ability to address current pressures, improve patient outcomes, reduce health inequalities and tackle inefficiencies. In the context of expectations that all CCGs will achieve 20% running cost savings this option would also be unaffordable and would be inconsistent with the expectations set out in the NHS LTP.

The key issue with this option is that it would be undeliverable in practical terms for a single AO and Executive Team to relate to eight Governing bodies.

Option 4: Merger of CCGs to form a single NHS L&SC CCG (all functions)

The eight L&SC CCGS would merge to form a single new CCG which would take responsibility for all the statutory functions of the current eight CCGs and the operation of the system across L&SC working with local partners to support the further development of ICPs/MCP and PCNs/Neighbourhoods.

Collaborative commissioning programmes would be subsumed within the governance arrangements of the single CCG.

This option would see all commissioning activity focussed on the ICS footprint and would benefit from economies of scale. In the context of expectations that all CCGs will achieve 20% running cost savings this option would be affordable and would be consistent with the expectations set out in the NHS LTP. However, with all commissioning functions focussed on ICS level activity this would limit the extent to which capacity and resource could be redirected to better support the development of PCNs/Neighbourhoods and ICPs/MCP and to accelerate the progress of place-based commissioning. This would hamper our ability to

address current pressures, improve patient outcomes, reduce health inequalities and tackle inefficiencies. It would also require significant structural change.

Option 5: Single CCG which aligns commissioning functions to each Integrated Care Partnership/Multispecialty Community Partnership

Under this option, the eight L&SC CCGs would merge to form a single new CCG which would take responsibility for all statutory functions through a single governing body. Under this option, it is proposed that the single CCG's governing body will be constituted with general practice members (Clinical Director), lay representatives, and a Managing Director who will represent each of the 5 places (Central Lancashire, Fylde Coast, Pennine Lancashire, West Lancashire and Morecambe Bay) that form the Lancashire & South Cumbria ICS.

In line with all CCG Constitutions, there will also be an Accountable Officer, Chief Finance Officer, Chief Nurse and Secondary Care Doctor.

The 5 Clinical Directors, 5 Managing Directors and 5 lay representatives who sit on the Governing body will also lead each place-based commissioning team, together with local clinical leadership and commissioning expertise. . The place based commissioning teams will retain many of the benefits member practices have indicated are important to them including responsibilities for practice engagement, primary care commissioning, population health improvement, improved service quality and financial management.

The place-based commissioning team will hold a delegated set of commissioning responsibilities through the single CCG's scheme of reservation and delegation and will act as the key NHS commissioning partner on each ICP/MCP Partnership Board.

The ICP Partnership Boards will support the development of PCNs/Neighbourhoods and ICPs/MCP and accelerate the progress of place-based commissioning.

Collaborative commissioning programmes at the L&SC level would be overseen and managed through the governance structures of the new CCG.

This option requires change to existing structures and organisations. It would see the majority of commissioning activity focussed on the ICP footprint, reducing duplication and maximising economies of scale. It also supports a consistent approach to setting standards and outcomes. This option ensures capacity is secured in PCNs/Neighbourhoods and ICPs/MCP to support place-based commissioning, allowing time and support for ICPs/MCP maturity to develop.

The single CCG will retain clinical commissioning capacity and resources in order to commission services for a population in excess of any one ICP/MCP (i.e. 500,000+). It will also commission those service areas in which recommendations have already been made to commission at L&SC level. Commissioners working at this level will retain specific links to local ICPs and neighbourhoods. In the context of expectations that all CCGs will achieve 20% running cost savings this option would be affordable and would be consistent with the expectations set out in the NHS LTP.

Option 6: Single CCG which discharges an agreed set of commissioning functions through a contract with each Integrated Care Provider/ Multispecialty Community Provider

The eight L&SC CCGs would merge to form a single new CCG which would initially take responsibility for all the statutory functions of the current eight CCGs. An agreed set of commissioning functions, which it makes sense to undertake on ICP and PCN footprints, would be contracted for, alongside a capitated budget with each IC Provider/MC Provider through an Integrated Care Provider contract.

Collaborative commissioning programmes would be overseen and managed through the governance structures of the new CCG.

This option would require significant structural change. It would see the majority of commissioning activity focussed on the ICP footprint, would reduce duplication and would maximise economies of scale. It would also support a consistent approach to standards and outcomes. This option would ensure capacity is secured in PCNs/Neighbourhoods and ICPs/MCP to support place-based commissioning, allowing time and support for ICPs/MCP maturity to develop.

The single CCG will retain clinical commissioning capacity and resources in order to commission services for a population in excess of any one ICP/MCP (i.e. 500,000+). It will also commission those service areas in which recommendations have already been made to commission at L&SC level. Commissioners working at the Lancashire and South Cumbria level will retain links with local ICPs and neighbourhoods. In the context of expectations that all CCGs will achieve 20% running cost savings this option would be affordable and would be consistent with the expectations set out in the NHS LTP.

This option requires ICPs/MCP to have reached a level of maturity whereby integrated care provider contracts could be established and budgets delegated. At this point in time, it is proposed that further development of local partnerships is required to reach this stage of maturity.