Chair: Jon Towler
Enquiries to: ncccg.notts-committees@nhs.net

SHARED AGENDA For the Meetings in Common of:

NHS Mansfield and Ashfield CCG Governing Body
NHS Newark and Sherwood CCG Governing Body
NHS Nottingham City CCG Governing Body
NHS Nottingham North and East CCG Governing Body
NHS Nottingham West CCG Governing Body
NHS Rushcliffe CCG Governing Body

Meeting Agenda (Open Session)
Thursday 04 July 2019 9:00 – 11:50

Rooms 1-3, Birch House Ransom Wood Business Park Southwell Road West, Mansfield NG21 0HJ

Time	Item	MA	NS	NC	NNE	NW	R	Sponsor	Reference
9:00	**Introductory Items**								
1.	Welcome, introductions and apologies	✓	✓	✓	✓	✓	✓	Chair	GB 19 001 - Verbal
2.	Confirmation of quoracy	✓	✓	✓	✓	✓	✓	Chair	GB 19 002 - Verbal
3.	Declarations of interest for any item on the agenda	✓	✓	✓	✓	✓	✓	Chair	GB 19 003
4.	Management of any real or perceived conflicts of interest	✓	✓	✓	✓	✓	✓	Chair	GB 19 004
5.	Questions from the public	✓	✓	✓	✓	✓	✓	Chair	GB 19 005
6.	Consolidated action log from previous Governing Body meetings	✓	✓	✓	✓	✓	✓	Chair	GB 19 006
9:15	**Strategy and Leadership**								
7.	Establishment of a Single Strategic Commissioning Organisation	✓	✓	✓	✓	✓	✓	SCa	GB 19 007
8.	Accountable Officer's Report	✓	✓	✓	✓	✓	✓	AS	GB 19 008
9.	Mid-Nottinghamshire Patient and Public Engagement Committee – Highlight Report	✓	✓					JM	GB 19 009
10.	Greater Nottingham Patient and Public Engagement Committee – Highlight Report			✓	✓	✓	✓	SCl	GB 19 010

Time	Item	MA	NS	NC	NNE	NW	R	Sponsor	Reference
11.	360˚ Stakeholder Surveys – Summary of Results and Action Plan	✓	✓	✓	✓	✓	✓	AS	GB 19 011
10:30	**Commissioning Developments**								
12.	Primary Care Commissioning Committees – Highlight Report	✓	✓	✓	✓	✓	✓	EdG	GB 19 012
10:35	**BREAK (10 minutes)**								
10.45	**Financial Stewardship**								
13.	Finance and Turnaround Committees – Highlight Report	✓	✓	✓	✓	✓	✓	Chair	GB 19 013
14.	Finance Report	✓	✓	✓	✓	✓	✓	SP	GB 19 014
11.05	**Quality and Performance**								
15.	Quality, Safeguarding and Performance Committees – Highlight Report	✓	✓	✓	✓	✓	✓	EdG	GB 19 015
16.	Performance Report	✓	✓	✓	✓	✓	✓	SP/EM	GB 19 016
11.25	**Corporate Assurance**								
17.	Audit and Governance Committees – Highlight Report	✓	✓	✓	✓	✓	✓	SS	GB 19 017
18.	Alignment of Organisational Policies and Procedures	✓	✓	✓	✓	✓	✓	EM	GB 19 018
19.	Risk Management Arrangements	✓	✓	✓	✓	✓	✓	EM	GB 19 019
-	**Information Items** *The following items are for information and will not be individually presented. Questions will be taken by exception.*								
20.	Unratified minutes of previous Governing Body meetings:							-	GB 19 020
	a) NHS Nottingham North and East CCG – 14 May 2019				✓			-	
	b) NHS Nottingham City CCG – 15 May 2019			✓				-	
	c) NHS Rushcliffe CCG – 16 May 2019						✓	-	
	d) NHS Nottingham West CCG – 23 May 2019					✓		-	

Time	Item	MA	NS	NC	NNE	NW	R	Sponsor	Reference
	e) NHS Mansfield and Ashfield CCG and NHS Newark and Sherwood CCG (meeting in common) – 6 June 2019	✓	✓					-	
21.	Ratified Minutes of Governing Bodies' Sub-Committee's	✓	✓	✓	✓	✓	✓	-	GB 19 021
22.	Final Assurance Report from the Greater Nottingham Joint Commissioning Committee			✓	✓	✓	✓	-	GB 19 022
11:45	**Closing Items**								
23.	Any other business	✓	✓	✓	✓	✓	✓	Chair	GB 19 023 - Verbal
24.	Risks identified during the course of the meeting in common	✓	✓	✓	✓	✓	✓	Chair	GB 19 024 - Verbal
25.	Date of next meeting in common:	✓	✓	✓	✓	✓	✓	Chair	GB 19 025 - Verbal

07 August 2019 (9:00 to 12:30)

Boardroom, Standard Court, 1 Park Row, Nottingham, NG1 6GN

Confidential Motion:

The Governing Body will resolve that representatives of the press and other members of the public be excluded from the remainder of this meeting, having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest (Section 1[2] Public Bodies [Admission to Meetings] Act 1960)

Nottingham and Nottinghamshire CCGs' Governing Bodies - Members and Attendees Register of Interests as at July 2019

Name	Current position (s) held in the CCGs or external organisation(s)	Declared Interest (Name of the organisation and nature of business)	Nature of Interest	Financial Interest	Non-financial Professional Interests	Non-financial Personal Interests	Indirect Interest	Date From:	Date To:	Action taken to mitigate risk
ATKINSON, Dr Nicole	GP, Clinical Chair, Nottingham West CCG	Eastwood Primary Care Centre (provider of Primary Care Services)	GP Partner	✓				01/04/2013	Present	To be excluded from all commissioning decisions (including procurement activities and contract management arrangements) in relating to GP Services
ATKINSON, Dr Nicole	GP, Clinical Chair, Nottingham West CCG	Nottingham West PICS GP federation	Practice is a member	✓				-	Present	To be excluded from all commissioning decisions (including procurement activities and contract management arrangements) in relation to services currently provided by PICS GP federation; and Services where it is believed that PICS GP could be an interested bidder.
ATKINSON, Dr Nicole	GP, Clinical Chair, Nottingham West CCG	PICS corporate, practice management company	Partner	✓				-	Present	To be excluded from all commissioning decisions (including procurement activities and contract management arrangements) in relation to services currently provided by PICS Corporate; and Services where it is believed that PICS Corporate could be an interested bidder.
BALL, Alex	Director of Communications and Engagement Nottingham and Nottinghamshire ICS	No relevant interests declared	Not applicable					-	-	Not applicable
BARTHOLOMEUZ, Thilan	GP, Clinical Chair, Newark and Sherwood CCG	Abbey Medical Practice (provider of Primary Care Services)	GP Partner	✓					Present	To be excluded from all commissioning decisions (including procurement activities and contract management arrangements) in relating to GP Services
BARTHOLOMEUZ, Thilan	Clinical Chair, Newark and Sherwood CCG Cancer Lead	ICS Cancer Board	Cancer Lead for Mid Notts CCG's and Chair of ICS Cancer Board.		✓			-	Present	This interest will be kept under review and specific actions determined as required.
BARTHOLOMEUZ, Thilan	Clinical Chair, Newark and Sherwood CCG Cancer Lead	Macmillan UK	Macmillan GP.	✓				01/09/2013	Present	This interest will be kept under review and specific actions determined as required.
BARTHOLOMEUZ, Thilan	Clinical Chair, Newark and Sherwood CCG Cancer Lead	Sherwood Forest GP Speciality Training Programme	GP Trainer	✓				03/08/2010	Present	This interest will be kept under review and specific actions determined as required.
BARTHOLOMEUZ, Thilan	Clinical Chair, Newark and Sherwood CCG Cancer Lead	Newgate Medical Group, Worksop.	Wife, Dr Dayani Bartholomeuz is a GP Partner at Bassetlaw working for Newgate Medical Group, Worksop.	✓			✓	01/05/2018	Present	This interest will be kept under review and specific actions determined as required.
BEEBE, Shaun	Lay Member	University of Nottingham	Senior manager with the University of Nottingham, the school is in receipt of NIHR research funding.	✓				-	Present	This interest will be kept under review and specific actions determined as required.
BEEBE, Shaun	Lay Member	Nottingham University Hospitals	Patient in Ophthalmology			✓		-	Present	This interest will be kept under review and specific actions determined as required.
BRANSON, Lucy	Associate Director of Governance	St George's Medical Practice (Rushcliffe CCG)	Patient			✓		01/11/2005	Present	This interest will be kept under review and specific actions determined as required.
CARTER, Sarah	Director of Tranistion Operations	Orchid Gold Ltd Consultancy Company	The company delivers services of turnaround, transformation and OD consultancy for NHS organisations	✓				01/04/2013	Present	This interest will be kept under review and specific actions determined as required.
CHALLENGER, Alison	Director of Public Health, Nottingham City Council	Nottingham City Council	Employee	✓				01/04/2013	Present	This interest will be kept under review and specific actions determined as required.
CHALLENGER, Alison	Director of Public Health, Nottingham City Council	Nottingham University Hospitals NHS Trust	Relative is Speciality General Manager of Emergency Department	✓			✓	03/09/2018	Present	This interest will be kept under review and specific actions determined as required.
CLAGUE, Sue	Lay Member	Victoria and Mapperley Practice (Nottingham City Practice)	Registered Patient			✓		09/01/2016	Present	This interest will be kept under review and specific actions determined as required.
CLAGUE, Sue	Lay Member	Victoria and Mapperley Practice (Nottingham City Practice)	Member of Patient Participation Group			✓		10/01/2016	Present	This interest will be kept under review and specific actions determined as required.
CLAGUE, Sue	Lay Member	University Hospitals of Derby and Burton Hospitals NHS Foundation Trust	Family Member, Non Executive Director	✓			✓	31/10/2015	Present	This interest will be kept under review and specific actions determined as required.
DADGE, Lucy	Chief Commissioning Officer	Mid Nottinghamshire and Greater Nottingham Lift Co (public sector)	Director	✓				01/10/2017	Present	This interest will be kept under review and specific actions determined as required.
DADGE, Lucy	Chief Commissioning Officer	Pelham Homes Ltd – Housing provider subsidiary of Nottinghamshire Community Housing Association	Director	✓				01/01/2008	Present	This interest will be kept under review and specific actions determined as required.

DADGE, Lucy	Chief Commissioning Officer	3Sixty Care Ltd – GP Federation, Northamptonshire	Director	✓				01/01/2017	Present	This interest will be kept under review and specific actions determined as required.
DADGE, Lucy	Chief Commissioning Officer	First for Wellbeing CIC (Health and Wellbeing Company)	Director	✓				01/12/2016	Present	This interest will be kept under review and specific actions determined as required.
DADGE, Lucy	Chief Commissioning Officer	Nottingham Schools Trust	Chair and Trustee			✓		01/11/2017	Present	This interest will be kept under review and specific actions determined as required.
GRIBBIN, Jonathan	Public Health Consultant	Cornerstone Church Nottingham	Director			✓		01/04/2013	Present	This interest will be kept under review and specific actions determined as required.
GRIBBIN, Jonathan	Public Health Consultant	Nottinghamshire County Council	Public Health Consultant	✓				01/04/2013	Present	This interest will be kept under review and specific actions determined as required.
GRIBBIN, Jonathan	Public Health Consultant	Nottingham University Hospitals Trust	Spouse is Consultant in Obstetrics	✓			✓	01/04/2013	Present	This interest will be kept under review and specific actions determined as required.
DE GILBERT, Eleri	Lay Member	Middleton lodge surgery	Husband registered patient			✓	✓	-	Present	This interest will be kept under review and specific actions determined as required.
DE GILBERT, Eleri	Lay Member	Middleton Lodge Surgery	Registered patient			✓		-	Present	This interest will be kept under review and specific actions determined as required.
DE GILBERT, Eleri	Lay Member	Middleton Lodge Surgery	Son is registered patient			✓	✓	-	Present	This interest will be kept under review and specific actions determined as required.
DE GILBERT, Eleri	Lay Member	Nottingham Bench	Justice of the Peace		✓			-	Present	This interest will be kept under review and specific actions determined as required.
DE GILBERT, Eleri	Lay Member	Sherwood and Newark Citizens Advice Bureau	Trustee on the board		✓			01/03/2016	Present	This interest will be kept under review and specific actions determined as required.
DE GILBERT, Eleri	Lay Member	Major Oak Medical Practice, Edwinstowe	Son, daughter in law and grandchild are registered patients			✓	✓	-	Present	This interest will be kept under review and specific actions determined as required.
HOPKINSON, Dr James	Clinical Chair, NNE CCG	Calverton Practice (which is a provider of Primary Medical care services in NNE CCG)	GP Partner	✓				01/04/2013	Present	To be excluded from all commissioning decisions (including procurement activities and contract management arrangements) in relating to GP Services
HOPKINSON, Dr James	Clinical Chair, NNE CCG	Nottingham University Hospitals Trust	Wife is an Allergy Nurse Specialist	✓			✓	01/04/2013	Present	This interest will be kept under review and specific actions determined as required.
HOPKINSON, Dr James	Clinical Chair, NNE CCG	Faculty of Sport and Exercise Medicine (an intercollegiate faculty of the Royal College of Physicians of London and the Royal College of Surgeons of Edinburgh, which works to develop the medical specialty of Sport and Exercise Medicine).	Fellow of		✓			01/04/2013	Present	This interest will be kept under review and specific actions determined as required.
HOPKINSON, Dr James	Clinical Chair, NNE CCG	NEMS	Shareholder	✓				01/04/2013	Present	To be excluded from all commissioning decisions (including procurement activities and contract management arrangements) in relation to services currently provided by NEMS; and Services where it is believed that NEMS could be an interested bidder.
HOPKINSON, Dr James	Clinical Chair, NNE CCG	Nottingham North and East PICS GP Federation	Practice is a member of	✓				-	Present	To be excluded from all commissioning decisions (including procurement activities and contract management arrangements) in relation to services currently provided by PICS GP federation; and Services where it is believed that PICS could be an interested bidder.
KENNEDY, Dr Caitriona	GP Member	Trentside GP Practice	GP and Senior Partner			✓		14/07/2016	Present	To be excluded from all commissioning decisions (including procurement activities and contract management arrangements) in relating to GP Services
KENNEDY, Dr Caitriona	GP Member	County Health Partnerships	Part time Clinical Director for NNE Locality (*maximum of 1 day per week*).			✓		14/07/2016	Present	To be excluded from all commissioning decisions (including procurement activities and contract management arrangements) in relation to services currently provided by County Health Partnerships; and Services where it is believed that the County Health Partnerships could be an interested bidder.
KENNEDY, Dr Caitriona	GP Member	NEMS	Shareholder	✓				01/04/2013	Present	To be excluded from all commissioning decisions (including procurement activities and contract management arrangements) in relation to services currently provided by NEMS; and Services where it is believed that NEMS could be an interested bidder.

LUNN, Gavin	Clinical Chair, Mansfield and Ashfield CCG	Kirkby Community Primary Care Practice	Clinical Lead and GP. NOT a shareholder of PICS. Lead for the development of the Locality Integrated Care Partnerships.	✓				-	Present	To be excluded from all commissioning decisions (including procurement activities and contract management arrangements) in relating to GP Services
LUNN, Gavin	Clinical Chair, Mansfield and Ashfield CCG	Clinical Research Network	Member of	✓				-	Present	This interest will be kept under review and specific actions determined as required.
LUNN, Gavin	Clinical Chair, Mansfield and Ashfield CCG	Primary Care Network	Deputy Primary Care Network Director	✓				01/06/2019	Present	This interest will be kept under review and specific actions determined as required.
MCINTYRE, Julie	Lay Member	Millview Surgery	Member of PPG		✓			01/06/2011	Present	This interest will be kept under review and specific actions determined as required.
MCINTYRE, Julie	Lay Member	Primary Care Delivery Board	Lay Member		✓			01/05/2018	Present	This interest will be kept under review and specific actions determined as required.
MCINTYRE, Julie	Lay Member	EMAHSN QI Network Steering Group	Member		✓			01/03/2018	Present	This interest will be kept under review and specific actions determined as required.
MCINTYRE, Julie	Lay Member	Primary Care Network Steering Board	Lay Member		✓			01/02/2019	Present	This interest will be kept under review and specific actions determined as required.
MCINTYRE, Julie	Lay Member	QMC (cardiac ICU)	Brother-in-law senior charge nurse	✓			✓	-	Present	This interest will be kept under review and specific actions determined as required.
MCINTYRE, Julie	Lay Member	EMAS	Nephew;- Emergency Medical Dispatcher at	✓			✓	01/02/2019	Present	This interest will be kept under review and specific actions determined as required.
MCINTYRE, Julie	Lay Member	King's Mill Hospital	Niece-in-law works in Stroke Early Supported Discharge Team	✓			✓	01/01/2018	Present	This interest will be kept under review and specific actions determined as required.
MCINTYRE, Julie	Lay Member	Millview Surgery	Registered Patient			✓		01/08/2010	Present	This interest will be kept under review and specific actions determined as required.
MCINTYRE, Julie	Lay Member	St Peter & Paul's Church, Mansfield	Member			✓		01/11/2017	Present	This interest will be kept under review and specific actions determined as required.
MCINTYRE, Julie	Lay Member	Member of Parochial Church Council	Member			✓		01/05/2018	Present	This interest will be kept under review and specific actions determined as required.
MCINTYRE, Julie	Lay Member	Deanery Synod	Member			✓		01/05/2018	Present	This interest will be kept under review and specific actions determined as required.
MOSS, Elaine	Chief Nurse, Director of Quality and Governance, ICS Nurse.	No relevant interests declared	Not applicable					-	-	Not applicable
OKUBADEJO, Adedeji	Independent Secondary Care Doctor	University Hospitals Birmingham NHS Foundation Trust	Employed as Associate Medical Director and Consultant in Anaesthesia and Pain Management	✓				25/04/2016	Present	This interest will be kept under review and specific actions determined as required.
OKUBADEJO, Adedeji	Independent Secondary Care Doctor	The Hospital Medical Group Holdings	Responsible Officer	✓				17/12/2015	Present	This interest will be kept under review and specific actions determined as required.
OKUBADEJO, Adedeji	Independent Secondary Care Doctor	Spire	Independent private clinical anaesthetic practice undertaken in private hospitals in the Birmingham area	✓				17/12/2015	Present	This interest will be kept under review and specific actions determined as required.
OKUBADEJO, Adedeji	Independent Secondary Care Doctor	BMI	Independent private clinical anaesthetic practice undertaken in private hospitals in the Birmingham area	✓				17/12/2015	Present	This interest will be kept under review and specific actions determined as required.
OKUBADEJO, Adedeji	Independent Secondary Care Doctor	The Hospital Group	Independent private clinical anaesthetic practice undertaken in private hospitals in Bromsgrove	✓				17/12/2015	Present	This interest will be kept under review and specific actions determined as required.
OKUBADEJO, Adedeji	Independent Secondary Care Doctor	Carwis Consulting Ltd – Healthcare management consulting	Director	✓				01/04/2018	Present	This interest will be kept under review and specific actions determined as required.
OKUBADEJO, Adedeji	Independent Secondary Care Doctor	Transform Healthcare	Responsible Officer	✓				01/04/2018	Present	This interest will be kept under review and specific actions determined as required.
OKUBADEJO, Adedeji	Independent Secondary Care Doctor	Transform & The Hospital Group	Group Medical Director	✓				01/04/2018	Present	This interest will be kept under review and specific actions determined as required.
PORTER, Hugh	Clinical Chair of NHS Nottingham City CCG	Nottingham City GP Alliance	The University of Nottingham Health Service is a member	✓				01/04/2013	Present	To be excluded from all commissioning decisions (including procurement activities and contract management arrangements) in relation to services currently provided by the GP Alliance; and Services where it is believed that the GP Alliance could be an interested bidder.

PORTER, Hugh	Clinical Chair of NHS Nottingham City CCG	The University of Nottingham Health Service (UNHS), which provides primary care services under a GMS contract, is a hub practice for primary care research delivery for Nottingham City CCG and undertakes occasional primary care research for local, national (such as (NIHR) and private sector pharmaceutical research projects beyond that through its role as a Hub research practice for the CCG	Executive Partner,	✓				01/04/2013	Present	To be excluded from all commissioning decisions (including procurement activities and contract management arrangements) in relating to GP Services
PORTER, Hugh	Clinical Chair of NHS Nottingham City CCG	UNICOM Healthcare LLP, which provide non-GMS primary care services	Director	✓				01/04/2013	Present	To be excluded from all commissioning decisions (including procurement activities and contract management arrangements) in relating to GP Services
PORTER, Hugh	Clinical Chair of NHS Nottingham City CCG	NEMS Healthcare Ltd (provides service to NEMS CBS, current contract holder for GP Out of Hours Services)	Shareholder	✓				01/04/2013	Present	To be excluded from all commissioning decisions (including procurement activities and contract management arrangements) in relation to services currently provided by NEMS; and Services where it is believed that NEMS could be an interested bidder.
PORTER, Hugh	Clinical Chair of NHS Nottingham City CCG	University of Lincoln Health Service	Practice (Cripps) has successfully procured a contract to run the service, i.e. the GP practice that looks after the University of Lincoln	✓				01/04/2013	Present	To be excluded from all commissioning decisions (including procurement activities and contract management arrangements) in relating to GP Services
PORTER, Hugh	Clinical Chair of NHS Nottingham City CCG	NEMS	Wife is shareholder	✓			✓	01/04/2013	Present	To be excluded from all commissioning decisions (including procurement activities and contract management arrangements) in relation to services currently provided by NEMS; and Services where it is believed that NEMS could be an interested bidder.
PORTER, Hugh	Clinical Chair of NHS Nottingham City CCG	The University of Nottingham Health Service	Partner	✓					Present	To be excluded from all commissioning decisions (including procurement activities and contract management arrangements) in relating to GP Services
PORTER, Hugh	Clinical Chair of NHS Nottingham City CCG	Cripps Practice	Cripps Practice provide contraceptive and sexual health services under national agreements	✓					Present	To be excluded from all commissioning decisions (including procurement activities and contract management arrangements) in relating to GP Services
PORTER, Hugh	Clinical Chair of NHS Nottingham City CCG	Overdale and Breaston Practice in Derbyshire	Wife is GP partner	✓			✓	01/04/2013	Present	This interest will be kept under review and specific actions determined as required.
POYNOR, Stuart	Chief Finance Officer	No relevant interests declared	Not applicable					-	Present	Not applicable
SHORTT, Stephen	Clinical Chair, Rushcliffe CCG	East Leake Medical Practice	GP partner	✓				01/04/2013	Present	To be excluded from all commissioning decisions (including procurement activities and contract management arrangements) in relation to this practice.
SHORTT, Stephen	Clinical Chair, Rushcliffe CCG	PartnersHealth LLP (Gynaecological Services at Keyworth Medical Practice, Community Dermatology, Weekend Woundcare and GP Extended Access)	GP member	✓				01/10/2015	Present	To be excluded from all commissioning decisions (including procurement activities and contract management arrangements) in relation to services currently provided by Partners Health LLP; and Services where it is believed that Partners Health LLP could be an interested bidder.
SHORTT, Stephen	Clinical Chair, Rushcliffe CCG	East Leake Medical Practice	Wife is a registered patient			✓	✓	01/04/2013	Present	To be excluded from all commissioning decisions (including procurement activities and contract management arrangements) in relating to GP Services
SHORTT, Stephen	Clinical Chair, Rushcliffe CCG	Keyworth Medical Practice	Spouse is GP partner	✓			✓	01/04/2013	Present	To be excluded from all commissioning decisions (including procurement activities and contract management arrangements) in relating to GP Services
SHORTT, Stephen	Clinical Chair, Rushcliffe CCG	KMP Pharmacy	Wife is Director	✓			✓	01/04/2013	Present	This interest will be kept under review and specific actions determined as required.
SHORTT, Stephen	Clinical Chair, Rushcliffe CCG	HS Primary Care Research Network	Practice receives funding to host research studies and recruit patients	✓				01/04/2013	Present	This interest will be kept under review and specific actions determined as required.
SHORTT, Stephen	Clinical Chair, Rushcliffe CCG	PartnersHealth LLP (Gynaecological Services at Keyworth Medical Practice, Community Dermatology, Weekend Woundcare and GP Extended Access)	Wife GP member	✓			✓	01/10/2015	Present	To be excluded from all commissioning decisions (including procurement activities and contract management arrangements) in relation to services currently provided by Partners Health LLP; and Services where it is believed that Partners Health LLP could be an interested bidder.

SHORTT, Stephen	Clinical Chair, Rushcliffe CCG	Principia Multi-specialty Community Provider	Member	✓				01/10/2015	Present	To be excluded from all commissioning decisions (including procurement activities and contract management arrangements) in relation to services currently provided by Principia; and Services where it is believed that Principia could be an interested bidder.
SULLIVAN, Amanda	Accountable Officer	No relevant interests declared	Not applicable					-	Present	Not applicable
SUNDERLAND, Sue	Lay Member	Joint Audit Risk Assurance Committee, Police and Crime Commissioner (JARAC) for Derbyshire / Derbyshire Constabulary	Chair		✓			01/04/2018	Present	This interest will be kept under review and specific actions determined as required.
SUNDERLAND, Sue	Lay Member	NHS Bassetlaw CCG	Governing Body Lay Member		✓			16/12/2015	Present	This interest will be kept under review and specific actions determined as required.
SUNDERLAND, Sue	Lay Member	Inclusion Healthcare Social Enterprise CIC (Leicester City)	Non-Executive Director		✓			16/12/2015	Present	This interest will be kept under review and specific actions determined as required.
THOMPSON, Gary	Director of Special Projects	Radcliffe on Trent Health Centre	Patient			✓		01/01/2018	Present	This interest will be kept under review and specific actions determined as required.
THOMPSON, Gary	Director of Special Projects	Radcliffe on Trent Health Centre	Spouse is a patient			✓	✓	01/01/2018	Present	This interest will be kept under review and specific actions determined as required.
TOWLER, Jon	Lay Chair of the Governing Bodies/ Vice Chair ICS Board	Sherwood Medical Practice.	Registered patient			✓		-	Present	This interest will be kept under review and specific actions determined as required.
TOWLER, Jon	Lay Chair of the Governing Bodies/ Vice Chair ICS Board	Major Oak Surgery	Family members are registered patient			✓	✓	-	Present	This interest will be kept under review and specific actions determined as required.

NHS Mansfield and Ashfield Clinical Commissioning Group
NHS Newark and Sherwood Clinical Commissioning Group
NHS Nottingham City Clinical Commissioning Group
NHS Nottingham North and East Clinical Commissioning Group
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NHS Rushcliffe Clinical Commissioning Group

Managing Conflicts of Interest at Meetings

1. A “conflict of interest” is defined as a “set of circumstances by which a reasonable person would consider that an individual’s ability to apply judgement or act, in the context of delivering commissioning, or assuring taxpayer funded health and care services is, or could be, impaired or influenced by another interest they hold”.

2. An individual does not need to exploit their position or obtain an actual benefit, financial or otherwise, for a conflict of interest to occur. In fact, a perception of wrongdoing, impaired judgement, or undue influence can be as detrimental as any of them actually occurring. It is important to manage these perceived conflicts in order to maintain public trust.

3. Conflicts of interest include:
   - Financial interests: where an individual may get direct financial benefits from the consequences of a commissioning decision.
   - Non-financial professional interests: where an individual may obtain a non-financial professional benefit from the consequences of a commissioning decision, such as increasing their reputation or status or promoting their professional career.
   - Non-financial personal interests: where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit.
   - Indirect interests: where an individual has a close association with an individual who has a financial interest, a non-financial professional interest or a non-financial personal interest in a commissioning decision.

   The above categories are not exhaustive and each situation must be considered on a case by case basis.

4. In advance of any meeting of the Committee, consideration will be given as to whether conflicts of interest are likely to arise in relation to any agenda item and how they should be managed. This may include steps to be taken prior to the meeting, such as ensuring that supporting papers for a particular agenda item are not sent to conflicted individuals.

5. At the beginning of each formal meeting, Committee members and co-opted advisors will be required to declare any interests that relate specifically to a particular issue under consideration. If the existence of an interest becomes apparent during a meeting, then this must be declared at the point at which it arises. Any such declaration will be formally recorded in the minutes for the meeting.

6. The Chair of the Committee (or Deputy Chair in their absence, or where the Chair of the Committee is conflicted) will determine how declared interests should be managed, which is likely to involve one the following actions:
    - Requiring the individual to withdraw from the meeting for that part of the discussion if the conflict could be seen as detrimental to the Committee's decision-making arrangements.
    - Allowing the individual to participate in the discussion, but not the decision-making process.
    - Allowing full participation in discussion and the decision-making process, as the potential conflict is not perceived to be material or detrimental to the Committee's decision-making arrangements.

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CCG Governing Body meetings – Guidance for members of the public including media

Introduction

The Nottingham and Nottinghamshire Clinical Commissioning Groups (NHS Mansfield and Ashfield CCG, NHS Newark and Sherwood CCG, NHS Nottingham City CCG, NHS Nottingham North and East CCG, NHS Nottingham West CCG and NHS Rushcliffe CCG - hereafter referred to as "**the CCGs**") are committed to openness and transparency, and conduct as much of their business as possible in meetings that are open to members of the public to attend and observe, subject to available space.

As part of the alignment of governance arrangements across the CCGs, meetings of their Governing Bodies are held 'in common' – this means that they have common agenda items and the meetings are held at the same time and in the same venue.

The meetings, although held in public, are not public meetings and as such there is no opportunity provided for the public to ask questions at the meetings other than that offered at the discretion of the Chair. Written questions relating to items on the agenda can be submitted in advance of the meeting.

How do I find out about meetings?

Meeting dates, times and venues, which can be subject to change, are published on the CCGs' websites:

- NHS Nottingham North and East CCG - http://www.nottinghamnortheastccg.nhs.uk/our-meetings/governing-body-meetings/
- NHS Rushcliffe CCG - https://www.rushcliffeccg.nhs.uk/your-ccg/governing-body-and-meetings/
- NHS Nottingham West CCG - https://www.nottinghamwestccg.nhs.uk/about-us/governing-body/meeting-dates-papers-and-minutes/
- NHS Nottingham City CCG - https://www.nottinghamcity.nhs.uk/your-ccg/governing-body/governing-body-meetings-and-papers/
- NHS Mansfield and Ashfield CCG - https://www.mansfieldandashfieldccg.nhs.uk/about-us/meetings/governing-body/governing-body-meeting-dates/
- NHS Newark and Sherwood CCG - https://www.newarkandsherwoodccg.nhs.uk/about-us/meetings/governing-body/governing-body-meeting-dates/

Meeting agendas and supporting papers are available on the websites up to five days before each meeting.

Can members of the public ask questions during the meeting?

To assist in the management of the agenda and meeting, individuals are requested to submit written questions to the Governing Bodies' email address ncccg.committees@nhs.net at least 48 hours before the meeting.

Where possible, a response will be given to questions at the meeting, however if the matter is complex or requires the consideration of further information, a written response to questions will be provided within ten working days. If the number of questions raised exceeds the time allocated, questions will be taken on a first come, first served basis and any remaining questions subsequently addressed in writing.

We will not be able to discuss questions if:

- They relate to individual patient care or the performance of individual staff members;
- They do not relate to an item on the agenda; or
- They relate to issues which are the subject of current confidential discussions, legal action or any other matter not related to the roles and responsibilities of the CCGs.

The Chair reserves the right to move the meeting on if they judge that no further progress is likely to result from further discussion or questioning, or to ensure that the meeting can be conducted on time.

Any questions submitted may be treated as a request under the Freedom of Information Act 2000 and treated accordingly.

Attendance at meetings

If you have any particular needs with regards to access or assistance, such as wheelchair access or an induction loop please contact ncccg.committees@nhs.net and we will do our best to assist you. Please be aware that you will need to sign-in at the venue reception upon arrival, for fire safety and security reasons. A member of staff will escort everyone to the meeting room. Unfortunately, if members of the public arrive after the meeting has already started it may not be possible for them to join the meeting.

We are always interested to know who is attending our meetings and would like to encourage a wide range of organisations and individuals. To help us with this, we will ask you to sign a register when you arrive for the meeting.

At the end of meeting, all members of the public will also be escorted back to the main entrance by a member of staff.

Please note that the use of mobile phones or other electronic devices during the meeting will not be permitted if their use is deemed disruptive to the meeting. This is for the benefit of all present.

Identifying Governing Body members

The Chair will ask members to introduce themselves at the beginning of each meeting. A name plate for each member will also be displayed on the table to help you see who is speaking during the meeting.

Discussions at meetings

The members will have been provided with copies of the agenda and papers at the same time as they are published on the website and will therefore have had the opportunity to consider the papers prior to the meeting. The Governing Bodies will consider the items on the agenda in turn and each paper includes a summary cover sheet, which makes recommendations for the meeting to consider. For some items there may be a presentation whereas for others this may not be necessary. The members may not actively discuss each item in detail; this does not mean that the item has not received careful consideration but means that the members have no further questions on the matter and do not wish to challenge the recommendation(s). A formal vote will not be taken if there is a general consensus on a suggested course of action.

Minutes

A record of the issues discussed and decisions taken at the meeting will be set out in the minutes, which members will be asked to approve as a correct record at its next meeting. Please note that the minutes will not be a verbatim record of everything that was discussed at the meeting. The minutes are presented to the next meeting for approval.

Public Order

The Chair may at any time require the public or individual members of the public or media to leave the meeting or may adjourn the meeting to a private location if they consider that those present are disrupting the proper conduct of the meeting or the business of the Governing Bodies.

Will all discussion be held in open session?

The following criteria are applied in considering whether matters should be dealt with on a confidential basis.

- Material relating to a named individual;
- Information relating to contract negotiations;
- Commercially sensitive information;
- Information which may have long term legal implications or contain legal advice which, if revealed may prejudice the CCGs' position;
- Other sensitive information, which, if widely available, would detrimentally affect the standing of CCG; and
- Exceptionally, information which by reason of its nature, the Governing Bodies are satisfied should be dealt with on a confidential basis.

NHS Mansfield and Ashfield Clinical Commissioning Group
NHS Newark and Sherwood Clinical Commissioning Group
NHS Nottingham City Clinical Commissioning Group
NHS Nottingham North and East Clinical Commissioning Group
NHS Nottingham West Clinical Commissioning Group
NHS Rushcliffe Clinical Commissioning Group

Governing Body Meetings in Common

CONSOLIDATED ACTION LOG FROM PREVIOUS GOVERNING BODY MEETINGS

CCG	MEETING DATE	AGENDA REFERENCE	AGENDA ITEM	ACTION	LEAD	DATE TO BE COMPLETED	COMMENT
		ACTIONS OUTSTANDING					
				No actions outstanding			
		ACTIONS ONGOING / NOT YET DUE					
Nottingham City	15 May	GB 19 058	Aligned Governance Framework	To circulate the Patient and Public Engagement Committee terms of reference with Governing Body members once finalised	Lucy Branson	04/07/2019	The terms of reference have been drafted and will be submitted to the inaugural Patient and Public Engagement Committee for review and ratification on the 30 July 2019. They will then be made available as required.
Mansfield and Ashfield / Newark and Sherwood	4 May	GB/19/73	AO Report	To explore funding for the provision of hoists in General Practice.	Lucy Dadge	04/07/19	Verbal update to be given at the meeting

CCG	MEETING DATE	AGENDA REFERENCE	AGENDA ITEM	ACTION	LEAD	DATE TO BE COMPLETED	COMMENT
		ACTIONS COMPLETE					
Mansfield and Ashfield / Newark and Sherwood	6 June	GB/19/91	Committee Reports	To send Julie McIntyre a copy of the latest Patient Experience Report.	Elaine Moss		Report provided. Action closed.
Mansfield and Ashfield / Newark and Sherwood	6 June	GB/19/88	PPEC Report	To investigate reported delays to x-ray reporting at SFHFT.	Elaine Moss		Investigation is underway and will be reported to and reviewed by Quality Safeguarding and Performance Committee. Action closed.
Mansfield and Ashfield / Newark and Sherwood	6 June	GB/19/91	Committee Reports	To send a briefing note on GDPR to Mrs McIntyre.	Lucy Branson		Briefing note provided. Action closed.
Rushcliffe	16 May	GB 19 060	Aligned Governance Framework	To share the principles of Alliance Contracting presentation delivered to the joint City and South County Integrated Care Partnership Development Group for information.	Helen Clark		Report from Neil Moore circulated to members on 23 May 2019. Action closed.
Nottingham West	23 May	GB 19 058	Aligned Governance Framework	Clarification of the notice period for lay members will be progressed outside the meeting by Lucy Branson	Lucy Branson		CCG Constitutions have been updated. Action completed.
Nottingham City	16 January	GB 19 009	Integrated Governance Arrangements – Update	To liaise with Councillor Webster, Health and Wellbeing Board Chair, to identify which member would be an appropriate attendee at the Primary Care Commissioning Committee	Lucy Branson		Both Boards have been contacted and response awaited. Response to be overseen by the Primary Care Commissioning

CCG	MEETING DATE	AGENDA REFERENCE	AGENDA ITEM	ACTION	LEAD	DATE TO BE COMPLETED	COMMENT
				meeting in common.			Committees. Action closed.
Nottingham City	15 May	GB 19 058	Aligned Governance Framework	To share with members the GP member communication and engagement plan relating to the proposed merger.	Alex Ball		A series of communications have been circulated to member practices. Action closed.
Nottingham City	15 May	GB 19 058	Aligned Governance Framework	To set up a meeting for GP members to input on the Membership Forum terms of reference.	Lucy Branson		A meeting of the Membership Forum took place on 19 June 2019 to give members the opportunity to input into the terms of reference. Action closed.

NHS Mansfield and Ashfield Clinical Commissioning Group
NHS Newark and Sherwood Clinical Commissioning Group
NHS Nottingham City Clinical Commissioning Group
NHS Nottingham North and East Clinical Commissioning Group
NHS Nottingham West Clinical Commissioning Group
NHS Rushcliffe Clinical Commissioning Group

Meeting in Common of NHS Mansfield and Ashfield CCG, NHS Newark and Sherwood CCG, NHS Nottingham City CCG, NHS Nottingham North and East CCG, NHS Nottingham West CCG and NHS Rushcliffe CCG

Meeting Title:	Governing Bodies (Open Session)	**Date:**	04 July 2019
Paper Title:	Establishment of a Single Strategic Commissioning Organisation	**Paper Reference:**	**GB/19/007**
Sponsor:	Sarah Carter, Director of Transition	**Attachments/ Appendices:**	1. Case For Change (GB 007a) 2. Equality Impact Assessment (GB 007a) 3. Stakeholder Consultation Findings Report (GB 007b) 4. Response to Consultation Feedback (GB 007c)
Presenter:	Sarah Carter, Director of Transition		

Summary Purpose:	Approve	☒	Endorse	☐	Review	☐	Receive/Note for: • Assurance • Information	☐

Executive Summary

This paper sets out the draft case for change which will be submitted to NHSE/I for the development of a single strategic commissioning organisation for Nottingham and Nottinghamshire from 1 April 2020 and recommends that the application to merge the six Clinical Commissioning Groups (CCGs) is progressed.

During each CCG Governing Body meeting in April, members were asked to:

- Consider this case for change and agree any amendments or additions that need to be made
- Formally approve the proposal to merge
- Record any concerns or considerations that would need to be addressed as part of the development of a full merger application

All six CCG Governing Bodies agreed in April 2019 that a merger represents the best opportunity for us to improve health and wellbeing across the areas we serve. Delivering better health outcomes, reducing health inequalities, and improving the quality and consistency of local healthcare services are at the heart of our proposal.

The work undertaken in developing the merger programme has been overseen by the Merger Programme Board, as agreed by the Governing Bodies. The local NHSE/I assurance lead is a core member of the Programme Board.

The final submission of the application will take place on the 31 July 2019, prior to which a Pre- Application

assessment will be undertaken by NHSE/I chaired by Fran Steele, NHSE/I Director of Strategic Transformation, North Midlands. This will provide a significant gateway to submitting our proposal, and an opportunity to refine any areas as required

Stakeholder consultation has been undertaken as part of our process, and the support for the proposed merger has been significant. Governing Body is asked to consider the attached Stakeholder Consultation Feedback report, alongside the proposed responses and support the proposed approaches.

In progress at the time of writing the report is the individual CCG practice vote. This is being undertaken in order to secure a positive mandate for the merger proposal from our membership. A verbal update will be provided to Governing Body members at the meeting as the vote does not close until 30.06.2019. Each individual CCG must return a simple majority of votes cast in support of the merger proposal.

A Public Sector Equality Duty Impact Assessment of the proposal has been independently undertaken.

Relevant CCG priorities/objectives: *(please tick which priorities/objectives your paper relates to)*

Compliance with Statutory Duties	☒	Establishment of a Strategic Commissioner	☒
Financial Management	☐	Wider system architecture development (e.g. ICP, PCN development)	☐
Performance Management	☐	Cultural and/or Organisational Development	☐
Strategic Planning	☐	Procurement and/or Contract Management	☐

Conflicts of Interest: *(please indicate whether there are any conflicts of interest considerations in relation to the paper)*

☒ No conflict identified

☐ Conflict noted, conflicted party can participate in discussion and decision

☐ Conflict noted, conflicted party can participate in discussion, but not decision

☐ Conflict noted, conflicted party can remain, but not participate in discussion or decision

☐ Conflict noted, conflicted party to be excluded from meeting

Completion of Impact Assessments: *(please indicate whether the following impact assessments have been completed)*

Equality / Quality Impact Assessment (EQIA)	Yes ☒	No ☐	N/A ☐	If the answer is No, please explain why
Data Protection Impact Assessment (DPIA)	Yes ☐	No ☒	N/A ☐	If the answer is No, please explain why A DPIA will be completed as part of the mobilisation approach

Risk(s): *(please highlight any risks identified within the paper)*

Ineffective communication and/or engagement activities with GP Clinical Leads and GP Member Practices (including inability to demonstrate benefits of merger) may result in lack of responsiveness to merger consultation activities. The proposal to merge to a single CCG will be unable to progress if Members vote significantly against it.

Confidentiality: *(please indicate whether the information contained within the paper is confidential)*

☒No

Recommendation(s):

1. Review the Case for Change;

2. Review and endorse the PSED Equality Impact Assessment findings;

3. Review the Stakeholder Consultation Findings Report and Response to Consultation Feedback;

4. Review the outcome of the membership vote and consider the level of mandate from members.

Nottingham and Nottinghamshire Clinical Commissioning Groups

Case For Change

Proposed Merger of the Nottingham and Nottinghamshire CCGs

PLEASE NOTE: Whilst this document is largely complete, this version remains a working draft which is still being developed and written. There may be some gaps (identified with placeholders) and further editing to be undertaken. It is being shared at this stage to seek further comment and input

Nottingham and Nottinghamshire CCGs: Case for Change

Contents

This document collects the evidence as required by the KLOEs from the 'Assessment of State of Readiness' template. There is also an index at the end of the document which collates this information.

1. An Introduction from the Clinical Chairs and Accountable Officer of the Nottingham and Nottinghamshire Clinical Commissioning Groups

In April 2019, following many years of ever-closer collaboration and integration, each of our six CCG Governing Bodies formally agreed in principle the proposal to merge and create a single, strategic commissioning organisation. Since then we have undertaken consultation with GP member practices, Healthwatch, local authorities and other key stakeholders, and have confirmed widespread support for a full merger.

In July 2019, at our first joint Governing Board meeting 'in common', leaders approved the decision to submit a merger application to NHS England. The application is in accordance with CCG governance arrangements, and reflects a vote undertaken with member GP practices in June 2019 where x% of those voting expressed support for a full merger.

If approved by NHS England, the new organisation would become operational on 1 April 2020 and would be known as 'NHS Nottingham and Nottinghamshire Clinical Commissioning Group', in line with the regulations in The National Health Service (Clinical Commissioning Groups) Regulations 2012 (3) to (6).

This document sets out our case for change and explains the reasons why we believe a merger to be a logical, progressive next step for our six CCGs. In so doing, we are fully meeting our responsibilities in accordance with The National Health Service (Clinical Commissioning Groups) Regulations 2012 10 (4).

Hugh Porter, Clinical Chair, NHS Nottingham City CCG
James Hopkinson, Clinical Chair, NHS Nottingham North and East CCG
Stephen Shortt, Clinical Chair, NHS Rushcliffe CCG
Thilan Bartholomeuz, Clinical Chair, NHS Newark and Sherwood CCG
Nicole Atkinson, Clinical Chair, NHS Nottingham West CCG
Gavin Lunn, Clinical Chair, NHS Mansfield and Ashfield CCG
Amanda Sullivan, Single Accountable Officer for all six CCGs

2. Executive Summary of Our Case for Change

Local commissioners have a history of successful partnership working. Even before the inception of Clinical Commissioning Groups (CCGs) in 2013, we worked together to commission services which extended beyond our respective boundaries, and we describe our roadmap to strategic commissioning later in this document. Building on our close engagement and leadership from within our Integrated Care System, the system architecture developments which we are collectively undertaking, and the close and collaborative functionality as a group of CCGs we have developed, alongside the national direction of travel for ICS' and CCGs to operate on a coterminous footprint as described within the NHS Long Term Plan, we are moving towards operating as a single strategic commissioning organisation.

Frome 2016 when our STP was developed, there has been a collaborative effort from within the Nottingham and Nottinghamshire CCGs to ensure full engagement and system leadership, driven by a collective determination to improve services for local people and find innovative ways to continue to deliver the best care. We also know that unless we continue to focus our efforts in this way, our system will not be sustainable and affordable in the future

Fundamental changes to our system architecture are an enabler for commissioning care and transformation in more joined-up ways, working across organisational boundaries and thinking less in terms of where care is delivered and more on the outcomes it is delivering. As leaders within our own ICS, our approach has been to create the conditions for this to happen over the last 2 years.

We now operate as an Integrated Care System in Nottinghamshire, and the 6 CCGs with a single leadership team are effectively and proactively supporting and developing this approach, utilise the ICS as a framework and footprint from within which a number of clinical commissioning functions can and should operate.

We are proud of what we have achieved as a group of 6 CCGs and as key leaders within an ICS, including developing a number of innovative new ways of providing care and support in Nottinghamshire including five NHS Vanguards, one primary home care pilot, two integrated care pioneer programmes, a fast track for Transforming Care and the Nottingham Biomedical Research Centre that brought together Nottinghamshire Healthcare NHS Foundation Trust, the University of Nottingham and Nottingham University Hospitals NHS Trust world class translational research. Learning from each other across the county has been a helpful by-product of the STP and then ICS process and is something we are committed to continuing.

We know that as we move forward to meet the challenges, demands and opportunities for commissioning into 2020 and beyond that the following demands will need to be met, and that these can be most consistently met through evolving further into a single organisation, with a clear strategic direction:

- a clear and consistent but aspirational leadership which can engage in all parts of the system, and create an environment for effective change
- a fit for purpose workforce in which each individual understands their role in contributing to the CCG and systems strategic objectives
- building on ongoing organisational development in order to create high functioning teams and talent management, embed new ways of working across PCNs, ICPs and the ICS and ensure energies are harnessed in the same direction
- improve and be more effective at the movement from planning to implementation in different areas of the system (ICPs & PCNs), which will mean mobilising hundreds of our workforce (and potentially thousands in the broader system) to play their part in implementing specific changes and monitoring/improving outcomes
-

Collectively all six CCGs have achieved their financial control totals in 18/19, and have developed plans to reduce expenditure which have been agreed and developed to include all system partners in the ICS (a single system financial plan)in 19/20. The mandated 20% reduction in running cost expenditure will be enabled by a move to a single strategic commissioner as it will allow us to formally enact plans to fully reduce duplication from the CCGs, such as simplifying our governance infrastructures, and delivering our workforce restructure in full, alongside lowering non pay running costs. From our involvement with the ICS, our migration to a strategic commissioner across the ICS footprint would enable our leadership of the system to become more focussed. As a strategic commissioner we will be able to manage more effectively key questions including leading the approach to managing a system wide deficit as an integrated system and providing a conducive environment to manage change programmes of scale and complexity..

We have a system architecture evolving in Nottingham and Nottinghamshire which identifies us into 3 core footprints;

Primary Care Networks x 19
Integrated Care Providers x 3
ICS/Strategic Commissioner x 1
All PCNs have clinical leadership via a PCN Clinical Director and have roles at both ICP and ICS footprints. We have identified Locality Directors to cover clusters of PCNs under the ICP footprint, and their teams which will work with individual practices and PCNs in their development
All ICPs have an appointed ICP lead taken from the senior leadership team of the system and representing our 3 areas, City, South Notts & Mid Notts. Our ICPs are now operating ICP Boards and beginning to consider their role in the evolving system architecture. All ICPs have CCG workforce identified to fulfil roles at an ICP level in supporting commissioning for outcomes, enabling and supporting transformation, and local collaboration.

Overall, the OD plan/timeline has been developed in order to promote a new organisational culture that embraces 'system partnership thinking' and 'whole systems approach', as well as governance and leadership behaviours that support and maximises this way of working. The development of a new performance management process, competency and behavioural framework, performance reporting process, talent management process plus the fostering of effective CCG/ICS working relationships alongside improvements in knowledge, skills, behaviour and attitude will ensure the CCG is fit for purpose and can maximise its potential.

We have now moved to an integrated governance & leadership structure which will support the transition towards a single organisation. We have a comprehensive Committee in Common approach providing a single committee across all CCGs for each function. Additionally we have moved to a Governing Body in Common and appointed an interim lay Chair.

We have identified some core areas of delivery which cannot be compromised and will be delivered as part of the process of moving to a single organisation;

- The new CCG must remain a clinically-led organisation and it will demonstrate how clinicians (including GPs, nurses and AHPs) will continue to participate in decision-making and transformational change (Clinical Leadership Strategy & Plan)
- Commissioner arrangements will pave the way for integrated working across healthcare and between health and social care (Response to Stakeholder Consultation)
- The involvement and engagement of local people, GPs and stakeholder networks will continue and be continually strengthened by whichever appropriate bodies and mechanisms are set up, e.g. PCNs, ICPs and commissioning. Any move to a larger geographical footprint will not be at the expense of engaging with GPs and local communities (Communications and Engagement Strategy, Clinical Leadership Strategy)
- Commissioning support services will be considered and strengthened where necessary, and an assessment undertaken of the benefits of outsourcing vs bringing services in-house, as well as where we might make better use of local authority resources (Procurement Strategy)
- Commissioners must deliver a 20% reduction in running costs by 2020/21 (Finance Strategy, Workforce Consultation)
- It remains essential that we do not duplicate responsibilities again across the system in the move to a single organisation because of perceived risk, for example, where PCNs might lead on particular aspects of clinical engagement, the commissioner should work with these and not seek to duplicate or reinvent the wheel (Clinical Leadership Strategy and Plan)
- Commissioners operating at a more strategic level will not lose local knowledge or sight of locality- and population-based needs (Operating Model)
- We can and will effectively prioritise and ringfence certain resources in accordance with specific locality and population need (Strategic Commissioning, Financial Strategy, Workforce restructure)
- Focus can continue on maintaining existing good, or improving provider performance, as well as addressing more challenging provider performance elsewhere in the county (Outcomes Framework – in progress)
- There is an established organisational development strategy and implementation plan which will support both team and individual development, talent management and succession planning. This is accompanied by an individual appraisal system and a pre mobilisation approach to objective setting (OD Strategy, Plan)
- Roles and responsibilities between the PCNs and commissioners are now clearly defined (see below) ensuring that all the excellent progress made by CCGs in terms of clinical involvement, innovation, engagement and leadership are not only maintained but continue to strengthen (Clinical Leadership Strategy and Plan)

In summary we anticipate great benefits in becoming a single strategic commissioner across and coterminous with our ICS footprint. Benefits to patients, our workforce, partners, the system and its evolving architecture, our financial position and those with protected characteristics are all outlined in the supporting documentation to this case for change. The most compelling reason however, is that it is the natural and right next step on an evolutionary journey to develop and deliver reduced health inequalities, population health management supported by collaborative approaches to limiting the social determinants of health, greater place based care and reduction in variation, and more collaborative, sustainable and impactful primary care settings.

3. The Benefits and Opportunities of Merger to Nottingham and Nottinghamshire

Our Rationale

There are seven principal local drivers behind our proposal to merge, as follows:

1. Creating a single commissioner within Nottingham and Nottinghamshire has been the direction of travel discussed by CCGs, our ICS, local clinicians and healthcare partners for more than a year. Support was widespread at a strategic level within CCGs and partner organisations, even before the publication of the NHS Long-Term Plan. The proposal is therefore being driven locally, and not politically or nationally. Through consultation, key stakeholders have confirmed their overall support for a full merger. CCGs have also implemented significant measures in recent months to pave the way for a full integration, including joint leadership and governance arrangements. There is therefore an expectation across the system that creating a single, statutory body is the next obvious step.

2. Becoming a single entity would enable commissioners to achieve more consistency across services and agree a basic need with more equitable access. It should be easier to agree and roll out best practice models and design services across the county, using the benefit of best practice and experience from across all six CCG areas, with less risk of unhelpful competitive behaviours, e.g. ‘not invented here’. It may also enable us to strike a better balance between standardisation across the county versus tailored services

3. There is a need for a consistent, coherent approach to service planning and delivery across the whole population with a strong, strategic and consistent commissioning voice at system level. We believe that as a single, strategic commissioner, we can achieve this.

4. There is a significant system-wide deficit, and the improvements required in the financial position cannot be achieved without more radical change and transformation. The financial and operational performance of some large providers is challenging and needs focussed support from the commissioner.

5. There is constant pressure on the capacity to deliver all of our commissioning functions, yet there is significant duplication in terms of roles, responsibilities and commissioning activities. Closer integration would provide the opportunity to maximise workforce capacity and free up valuable resource, including clinical time, which could be better utilised towards the front-line where it is most needed.

6. Partners and other stakeholders can find engaging with several CCGs time-consuming, confusing and difficult, with decisions taking longer than needed with the occasional receipt of mixed messages. This has led at times to frustration, and impacts upon CCG reputation and effectiveness.

7. Becoming a larger organisation and achieving economies of scale would enable us to reduce costs and overheads, as well as attract and afford the talent and capability we need at a strategic level. This is far more challenging to achieve as smaller CCG organisations. Serving six separate organisations and governing bodies is far more time consuming, resource-hungry and expensive.

The Opportunity

Our overall commissioning aim is to enable people living across Nottingham and Nottinghamshire to have the best health and wellbeing they can. To achieve this, we must work effectively with all our partners across the entire area to provide people with consistent access to quality healthcare. At the same time, we must also respond to the needs of specific populations and neighbourhoods so that we can reduce the health inequalities that exist today.

We therefore need to be able to operate at a ‘system’ level across the entire geographical area, as well as maintain our focus on more specific, local healthcare requirements. The arrangements we put in place for commissioning

should be fit for the future and be affordable and sustainable in the longer-term, supported by both actions and functions at both ICP and PCN footprints within the system.

All six CCG Governing Bodies agreed in April 2019 that a merger represents the best opportunity for us to improve health and wellbeing across the areas we serve. Delivering better health outcomes, reducing health inequalities, and improving the quality and consistency of local healthcare services are at the heart of our proposal.

Whilst changes underway to the NHS around us are important and complement what we are proposing, they are not the primary reason why we feel a merger is the right thing to do.

Benefits of Merger to Nottingham and Nottinghamshire

There are many advantages to merging our six CCGs. These will benefit - either directly or indirectly – patients and local people, GPs and other clinicians, health and care partners and many others. Here are the top five reasons why we believe we should combine our CCGs into one single, statutory commissioning organisation. These are explained in more detail within the Appendix.

Further Benefits of Creating a Single Strategic Clinical Commissioning Group

- Meeting the NHS Long Term Plan requirements for commissioning and enables us to provide the best opportunity for emerging system arrangements to work successfully across Nottingham and Nottinghamshire, as well as across England.
- Making it easier for health and care partners at system, place and neighbourhood levels to engage and work with us
- Would help us achieve a better balance between standardisation and personalisation of care across the area, working with healthcare partners at different levels across the system
- Taking forward the best practice from individual CCGs and agreeing common approaches to increase consistency and quality of care
- More control over defining and creating the health system we need and want for the population
- Greater buying power with the ability to deliver better value for money
- Better opportunity to attract, afford and retain staff with the right talent and skills
- More affordable, so more likely to be sustainable in the longer-term

Why Staying As We Are Is Not An Option

If we do not merge, we would not be maximising our opportunity to commission healthcare services that ensure the best possible health and wellbeing for the population we serve. We would not enable the system to work in the most effective way or make it as easy as possible for health and care partners to engage with us. Furthermore, we would be missing an opportunity to work more efficiently, in turn preventing us from delivering cost savings and greater value for money. We do not believe that having six separate commissioning organisations is sustainable or affordable in the longer-term nor is it in line with the NHS Long Term Plan commitments outlined above. As a well-functioning ICS, failing to take the natural next steps an moving into a larger co terminus footprint could impact on the development of and gains made by the level and scale of collaboration and partnership. It would certainly limit the impact and influence a single strategic commissioner would have on system development and delivery.

4. The Nottingham and Nottinghamshire Roadmap to Strategic Commissioning

A History of CCG Collaboration locally

Local commissioners have a history of successful partnership working. Even before the inception of Clinical Commissioning Groups (CCGs) in 2013, we worked together to commission services which extended beyond our respective boundaries

As CCGs, Nottingham and Nottinghamshire commissioners have worked increasingly in collaboration to improve consistency and reduce unwarranted variation across our organisations and member practices, minimise duplication of effort, share a number of commissioning resources, and enable more effective working arrangements with health and care partners across the wider system. These partnerships culminated in the more formal grouping of CCGs: mid-Nottinghamshire in March 2016 (2 CCGs); and Greater Nottinghamshire in April 2018 (4 CCGs). Both groups operated under their own single leadership teams until recently, although the original CCG organisations remain as separate legal entities today.

Over the past year, and well before the publication of the NHS Long-Term Plan in January 2019, our six CCGs had already started to consider the potential for a more formal joining up of commissioning arrangements to improve efficiencies further still, pave the way for closer integration, and enable a more strategic approach to commissioning which mirrors the footprints of both the Nottinghamshire-wide health and care system, and local authorities as far as possible. To demonstrate our commitment and capability to ever-closer collaboration, we have put in place a number of shared organisational arrangements.

In November 2018, we appointed a single Accountable Officer to oversee all six CCGs and a single leadership team has since been established. Joint committees now meet 'in common' with the first joint Governing Body meeting taking place in July 2019. Transitional work is underway both to align CCG governance and bring together wider staffing structures in order to pave the way for a full merger if approved. A structure has been developed that services the current CCGs as well as being "merger-ready" anticipating a successful application. A chart showing these joint governance arrangements can be found in the Appendices.

Full merger is therefore a logical next step for our CCGs and should neither distract us from delivering our commissioning responsibilities, nor cause major organisational upheaval.

We Are An Integrated Care System

The Nottingham and Nottinghamshire Integrated Care System is one of the national 'accelerator' sites. It covers our six CCGs, and a unitary and two-tier local government structure with a city council, and a county council with seven district councils. There are two major acute trusts and two transformation partners. There is a large mental health trust (Nottinghamshire Healthcare NHS Foundation Trust) and the local authorities both commission and provide services. East Midlands Ambulance Service (EMAS) is a key system partner to the ICS. There are a myriad of smaller health and care providers across all sectors (including primary care, pharmacy, dental and care sector). There are also two well established Health and Wellbeing Boards – city and county. A population of 1 million is covered by the ICS.

Bassetlaw forms part of the South Yorkshire and Bassetlaw STP footprint. However, the district of Bassetlaw is part of the Nottinghamshire Health and Wellbeing Board footprint, is coterminous with the boundary of Nottinghamshire County Council, and is provided with mental health and community services by Nottinghamshire Healthcare FT. Bassetlaw is also within the Nottinghamshire Transforming Care Partnership.

For 2019/20 we have developed a single system operating plan which is a key part of our journey to be a fully integrated system.

As one of the national 'accelerator' ICS sites, our CCGs operating as a merged strategic commissioner within this framework are well positioned to move to an enhanced role of system leader, and further support integrated system working.

The ICS Leadership Board (comprised of commissioner and provider Chief Executives and Chairs) is chaired by an independent chair and meets on a monthly basis to consider the financial and operational performance position of the system.

We are implementing Primary Care Networks and Integrated Care Partnerships at pace

- ✓ At System level, there is an Integrated Care System Board and a Strategic Commissioner (the resulting organisation from the proposed merger of the existing six CCGs).

  The Board has oversight of the whole system, sets the strategic direction and defines the outcomes the system should deliver for patients and citizens.

  The Strategic Commissioner acts as the commissioner for the whole system, setting the commissioning strategy, managing performance and holding providers to account based on outcomes for the whole population.

- ✓ At Place level, there are 3 Integrated Care Providers (ICPs).

  These are provider-led partnerships that are responsible for organising health and social care in line with the outcomes set out by the strategic commissioner.

  ICPs are being established in Mid Notts, Nottingham City and South Notts. A Board will be established for each ICP. ICPs serve populations of 250k – 500k.

- ✓ At Neighbourhood level, there are 19 Primary Care Networks (PCNs) across Nottingham and Nottinghamshire

  These PCNs are networks of primary care practitioners who have come together to deliver integrated services around neighbourhood populations. Each PCN is led by a Clinical Director, and they will commence in full on the 1st July 2019.

We have identified our Strategic Commissioning Priorities

As a system leader within the Nottingham and Nottinghamshire Integrated Care System strategic commissioning priorities and the priorities for the system have been collaborated on for some time. As a strategic commissioner for Nottingham and Nottinghamshire, we have agreed that we would be responsible for:

- ✓ Developing a long-term system financial strategy in conjunction with partners
- ✓ Delivering financial balance across the system – a turnaround approach is required in commissioning and across the system
- ✓ Commissioning the transformation of services, designing and delivering large-scale change in conjunction with partners
- ✓ Overseeing and mitigating any quality and equality impacts of service change
- ✓ Providing professional leadership across the system (nursing, therapies, pharmacy, linking general practice with secondary care)
- ✓ Driving the personalisation agenda
- ✓ Commissioning for outcomes across places through the development of ICP contracts and PCNs
- ✓ Achieving our own control totals and QIPP targets
- ✓ Delivering a 20% reduction in commissioning running costs by 2020/21

We Are Organising For Success

Our workforce will be organised in order that they are facing all levels of the system architecture, supporting the delivery of all priorities and objectives, and very much building on the work we have been undertaking in our Alliances, in developing our Primary Care approach & engaging proactively as a system leader

What will happen in the ICS footprint

- Oversight, leadership and the development of the long-term system financial strategy alongside partners
- Oversight, leadership and delivery of financial balance across the system – turnaround approach required in commissioning and across the system, QIPP development and monitoring
- Commissioning & contracting transformation of services, designing and delivering large-scale change with partners
- Oversight and mitigation of quality and equality impacts
- Delivery of professional leadership across the system (nursing, therapies, pharmacy, linking general practice with secondary care)

- Leadership of the personalisation priorities
- Commissioning & contracting for outcomes across places through the development of ICP contracts and PCNs
- Provider & market development, procurement functionality
- Effective Governance arrangements & oversight
- Information and information governance (supporting ICPs and PCNs)
- Research and development
- Organisational development & human resources support
- Support for ICP and PCN development
- Medicines optimisation
- Safeguarding services

What will happen on an ICP footprint

Infrastructure support including;

- Information management services
- Data management
- GP IT
- Provider integration support including Locality Directors & Teams (across PCNs)
- Finance support and reporting

Delivery support including;

- Transformation and QIPP delivery and monitoring
- Urgent care management / flow & local system resilience support and management
- Clinical variation (management of)

What will happen on a PCN footprint

Infrastructure support including;

- Information provision and analysis
- Finance support & input into development
- Risk stratification implementation support
- Provider integration support – including Locality Directors & Teams working across PCNs

Delivery support including;

- QIPP delivery support
- Clinical variation management and support
- Practice facing medicines management
- Service development support linked to PCN development

5. Our Current System Architecture: Working with Health and Care Partners

Our Journey to an Integrated Care System

Nottingham and Nottinghamshire is one of the fourteen accelerator Integrated Care Systems and has been operating as such since April 2018. All relevant partners in the health economy are full members of the ICS;

- Nottingham University NHS Trust
- Sherwood Forest NHS Foundation Trust
- Nottinghamshire Healthcare Trust
- Nottingham CityCare
- The current six CCGs for Nottingham and Nottinghamshire
- East Midlands Ambulance Service
- Nottingham City Council
- Nottinghamshire County Council

The Board of the ICS has been meeting since December 2018 and these meetings have been held in public since April 2019. The representatives from the Local Authority partners are both officers and elected members – ensuring a strong connection to both the business delivery and the populations of the ICS.

The Bassetlaw area to the north of the County of Nottinghamshire is not part of the Nottingham and Nottinghamshire ICS and instead feeds into the Bassetlaw and South Yorkshire ICS. This is a well-established arrangement based on patient flow and is supported by all parties.

Roadmap to Place/ICPs

It has been agreed that there will be three Places and therefore Integrated Care Providers in Nottingham and Nottinghamshire: Mid Notts (consisting of Mansfield and Ashfield and Newark and Sherwood), South Notts (consisting of Nottingham West, Rushcliffe and Nottingham North and East) and City (for the City of Nottingham). The ICS Board undertook a considerable amount of discussion throughout 2018 and into 2019 regarding this configuration, culminating with a report from an external consultant and a decision at the February 2019 ICS Board to proceed with the three ICPs – this received overwhelming support from members of the Board.

Since this decision, the three ICPs have proceeded to set up their governance structures and started to develop their plans for the future. To support this, the ICS has conducted an open recruitment process for the executive leads for the ICPs culminating in the appointment of the following leaders into these positions;

- Mid Notts ICP: Richard Mitchell, Chief Executive of Sherwood Forest Hospitals Foundation Trust. Appointed November 2018.
- South Notts ICP: John Brewin, Chief Executive of Nottinghamshire Healthcare NHS Trust. Appointed June 2019.
- City ICP: Ian Curryer, Chief Executive of Nottingham City Council. Appointed June 2019.

Given the longer period of collaboration in the area and the earlier appointment of the lead, it is not surprising that the Mid Notts ICP have been able to move faster on their establishment, seconding key staff from Sherwood Forest Hospital into the ICP and also appointing a non-executive Chair. The other two ICPs are now rapidly following suit, including drawing on the organisational resources of the supporting organisations, to develop their plans and proposed activities.

The six CCGs, in advance of the proposed merger, but as a sign of strong progress towards it, have put in place two key elements of preparation of support the ICPs;

1. The appointment of three Locality Directors aligned to the ICPs, charged with close liaison with the ICPs to ensure, among other things, joint delivery of the financial challenge facing the system, development of the PCNs, coordination of the various partners across the geography
2. As part of the proposed staff restructure referenced above, CCG functions from the “tactical”, rather than “strategic” end of the commissioning spectrum have been identified and the resources, staff and accountability for these tactical commissioning activities will move over time to the ICPs to deliver.

Integrating with Local Authorities at ‘Place’ Level

As described above, the Local Authorities are well integrated into the governance of the ICS at a System level. In addition to this, Local Authorities are integrated into the system working at Place level in the following ways;

- City ICP: The Chief Executive of the City Council is the executive lead of the City ICP and is leading for a strong place-led approach to integration in the City. The emerging governance for the ICP includes the integration of the City’s Health and Wellbeing Board into the work of the ICP and the inclusion in the ICP Board of representatives from across the Local Authority’s service portfolio and also elected member representation.
- Mid Notts ICP: Representatives of Nottinghamshire County Council and the three District Councils (Ashfield District Council, Mansfield District Council, Newark and Sherwood District Council) are members of the ICP Board and are contributing directly to the development of the ICP’s plan.
- South Notts ICP: Representatives from the County Council are members of the ICP Development Group and as the group becomes an ICP Board there is a plan to appoint representatives from the District Councils. There is a successful track record of close collaborative working across health and local authorities in the patch, which includes appointing a joint health development worker. Over time the aim is to expand that role to cover the full ICP footprint.

As part of the strong collaboration with local authorities, the ICPs will be drawing on the expertise of Councils in involving citizens in their decision making, supporting the creation of three new patient involvement forums to serve the three ICPs.

Nineteen Primary Care Networks

Across the ICS, it has now been agreed that there will be nineteen Primary Care Networks. These PCNs will be more than just networks of General Practice and will include, at maturity, representatives from services delivered by Local Authorities, not least Social Care, but also housing, leisure, transport and other contributors to the wider determinants of health. All PCNs have an appointed PCN Clinical Director who provides the link between ICP Board, and decisions/priorities and their PCN. The PCNs commence in full at the beginning of July 2019. Our PCNs focus is very much on asset based community development, sustainability and local need.

6. Our Population: Current Health Outcomes, Health Inequalities and Our Ambitions

Our Population

A total of 1,096,640 people are registered with our GP practices across Nottingham City and Nottinghamshire. We commission the majority of healthcare services for all these people, as well as emergency services for anyone visiting the area.

Health Outcomes and Health Inequalities

Thanks to the extensive partnership work undertaken by public health, CCGs and clinicians, we have an in-depth understanding of local health needs at system, place and neighbourhood levels.

Both overall life expectancy and healthy life expectancy for Nottingham and Nottinghamshire are lower than the average for England. This is significantly worse in the City of Nottingham but performance on these indicators is poor in Nottinghamshire too.

Indicator	Nottinghamshire	Nottingham	England
Life expectancy at birth (females)	82.6	81.1	83.1
Life expectancy at birth (males)	79.5	77	79.6
Healthy Life Expectancy (females)	61.6	53.5	63.8
Healthy Life Expectancy (males)	62.5	57	63.4

On average females in Nottinghamshire and Nottingham spend 21 and 27.6 years respectively in poor health, whereas males spend 17 and 20 years respectively. In Nottingham and Nottinghamshire, the leading risks attributable to years of life lost due to premature mortality are tobacco, dietary risks and high blood pressure.

In Nottinghamshire tobacco is the highest risk impacting on years lived with disability and years of life lost due to premature mortality. Nottinghamshire has a higher rate of years lived with disability attributable to smoking and dietary risks than Nottingham (this is higher in males than females for both). Tobacco use is by far the biggest cause of preventable cancer in Nottinghamshire.

In Nottingham, alcohol is the biggest single risk factor for early death and illness in those aged 15-49. Nottingham has some of the worst outcomes for alcohol related harm in England, impacting across the wider health and social care system. In Nottingham, high BMI is the leading attributable risk to years lived with disability. High BMI increases the burden of MSK conditions which are the leading cause of disability in England. In Nottingham 72% of the MSK burden is due to low back and neck pain. Major depressive disorder and years lived with disability is higher in Nottingham than Nottinghamshire and in females versus males. Nottingham is higher than the England average.

Across Nottinghamshire and Nottingham, the move towards a smoke free generation would annually save lives (c. 1,823 early deaths due to smoking), reduce hospital admissions for smoking related and directly attributable conditions (c. 10,992), reduce health inequalities and provide societal cost savings of £153m.

Circulatory, Cancer and Respiratory are the broad causes of death contributing most to inequalities in male and female life expectancy in Nottingham and Nottinghamshire. For males, these top three causes of death contribute

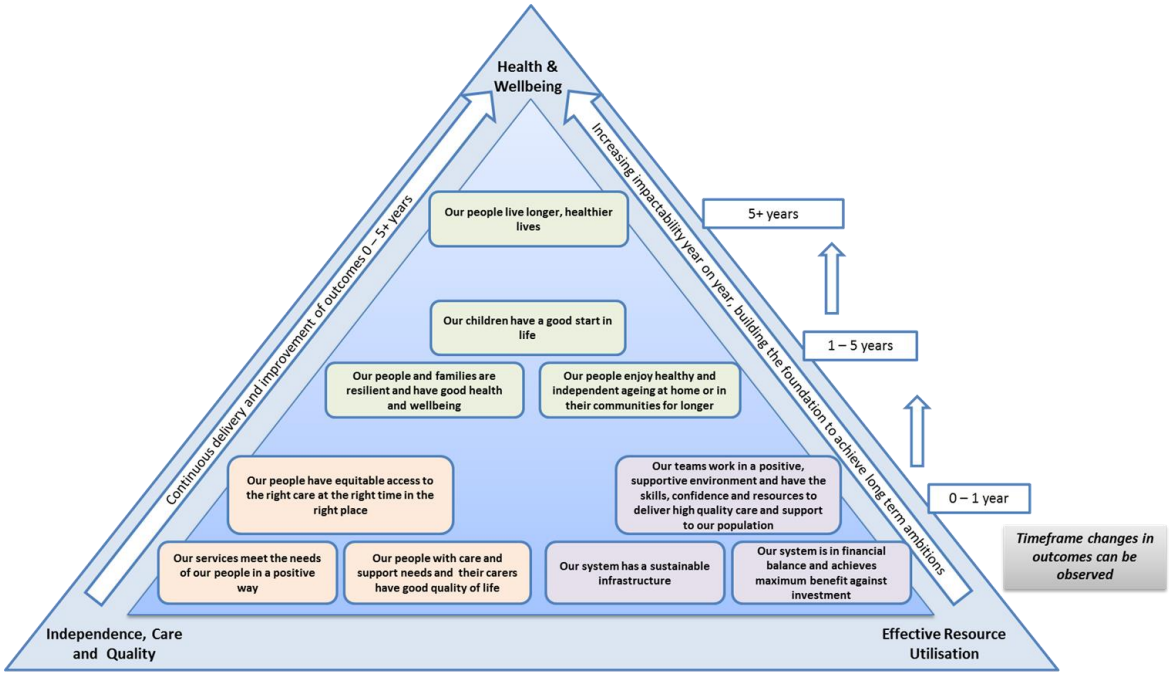
to 71% in Nottingham and 61% in Nottinghamshire of the life expectancy gap between the most and least deprived populations. For females the figures are 54% in Nottingham and 60% in Nottinghamshire.

	Nottingham City	Nottingham North & East	Nottingham West	Mansfield and Ashfield	Newark and Sherwood	Rushcliffe
Population registered with GP practices	388,378	141,257	106,542	195,710	136,229	128,524
Population key facts (compared with England average)	Significantly more young people – 1 in 8 people is a full-time university student Growing population - significant international migration particularly from Eastern Europe, and more births than deaths Adults more likely to live in ill health than elsewhere	Lower proportion of young adults aged 20 to 40 Higher proportion aged 50 and older Comparatively good health outcomes 19.5% registered disabled compared with 17.6% England average	Growing population Age profile similar to England average Health outcomes are similar or better	Growing population Age profile similar to England average Many health outcomes worse than England	Growing population Lower proportion of young adults aged 20 to 40 Higher proportion aged 50 and older Similar health outcomes to England	Lower proportion of young adults aged 20 to 40 Higher proportion aged 50 and older Health outcomes similar to, or significantly better than England
Healthy life expectancy compared with the England rate	Significantly lower		Similar	Significantly lower	Similar	Similar to, or better
Biggest health issues	Circulatory diseases, cancer, respiratory and digestive disease	Incidence rate for new cancers and mortality for all cancers higher than the England average	High number of patients with a limiting long term illness or disability (18.8% compared with 17.6% England average)	All cancers - especially lung cancer, circulatory disease and respiratory disease		
Major health determinants	Deprivation, smoking prevalence and alcohol-related harm	Lower levels of deprivation		Some of the most deprived areas in Nottinghamshire		Some of the least deprived populations in Nottinghamshire

Our Ambitions

Health and care leaders in Nottingham and Nottinghamshire are developing a Strategic Outcomes Framework for the system. This will, alongside the system's strategic plan due for publication in the autumn, enable the development of the commissioning intentions of the proposed Strategic Commissioner.

The Strategic Outcomes Framework has three pillars: Health and Wellbeing; Independence, Care and Quality and; Effective Resource Utilisation and is summarised here;



Supporting those three Pillars there are ten Ambitions for the populations of Nottingham and Nottinghamshire. These ten Ambitions are proposed to be measured by 28 Outcomes.

The Integrated Care System and Strategic Commissioning Ambitions are as follows;

Health and Wellbeing
• Our people live longer, healthier lives
• Our children have a good start in life
• Our people and families are resilient and have good health and wellbeing
• Our people will enjoy healthy and independent ageing at home or in their communities for longer
Independence, Care and Quality
• Our people will have equitable access to the right care at the right time in the right place
• Our services meet the needs of our people in a positive way
• Our people with care and support needs and their carers have good quality of life
Effective Resource Utilisation
• Our system is in financial balance and achieves maximum benefit against investment
• Our system has a sustainable infrastructure
• Our teams work in a positive, supportive environment and have the skills, confidence and resources to deliver high quality care and support to our population

7. Our Vision and Strategic Priorities

Summary

Our commissioning activities and priorities are directly informed by population and performance information, including that outlined in the section above. In terms of the national priorities for commissioning set out within the Long Term Plan, we believe that a full-merger would provide the best opportunity to meet requirements as well as enable emerging NHS arrangements across the system to work most effectively. This proposal to merge ensures that there is one single commissioner for the ICS geography, in line with the expectations of the NHS Long Term Plan.

Before April 2020 and the commencement of the proposed merged strategic commissioner, we will finalise a Commissioning Strategy for the entire population of Nottingham and Nottinghamshire. Each of the existing CCGs have well-developed strategies and plans in place and we will draw on them to create this overall Strategy.

To support this work, there are a number of goals, outcomes and priorities already in place that will directly inform a single commissioning vision and plan. These are set out below.

National Priorities

The national priorities for the commissioning system and the wider NHS are clearly set out in the NHS Long Term Plan. These priorities are guiding the development of the local system plan which is due for submission in the autumn. Many of these national priorities will be supported by and accelerated in their delivery through the creation of a strategic commissioner through the merger of the existing six CCGs.

The creation of strategic commissioner from the six merged CCGs will align with the national ambition in two ways.

Firstly, in terms of the specific patient-facing transformations in key service areas like cancer, mental health, primary care, prevention and urgent and emergency care, a merged strategic commissioner will have the ability to focus resources on the areas of highest health inequalities and need and the ability to take a strategic and system-oriented view of commissioning. This will enable faster and more strategic decisions to be made.

Secondly, the proposed merger to create a strategic commissioner will directly unlock several of the commitments or expectations in the Long Term Plan, specifically;

- ✓ "By April 2021 ICSs will cover the whole country, growing out of the current network of STPs. ICSs will have a key role in working with Local Authorities at 'place' level and through ICSs, commissioners will make shared decisions with providers on how to use resources, design services and improve population health"
- ✓ "Every ICS will need streamlined commissioning arrangements to enable a single set of commissioning decisions at system level. This will typically involve a single CCG for each ICS area. CCGs will become leaner, more strategic organisations that support providers to partner with local government and other community organisations on population health, service redesign and Long Term Plan implementation"

The proposed merger will also unlock a lower cost commissioning structure enabling a stronger focus on delivering financial balance for the NHS in Nottingham and Nottinghamshire, as set out in the following commitments from the Long Term Plan.

- ✓ "Putting the NHS back onto a sustainable financial path is a key priority in the Long Term Plan and is essential to allowing the NHS to deliver the service improvements in this Plan. This means:
  - the NHS (including providers) will return to financial balance;
  - the NHS will achieve cash-releasing productivity growth of at least 1.1% a year, with all savings reinvested in frontline care;
  - the NHS will reduce the growth in demand for care through better integration and prevention;
  - the NHS will reduce variation across the health system, improving providers' financial and operational performance;
  - the NHS will make better use of capital investment and its existing assets to drive transformation"

Regional System Priorities

The combined regional team for NHS England and NHS Improvement met on 5th June 2019 to agree priorities and ways of working for the Midlands Region. The priorities and ambitions for the region are still being developed, but in headline form they are;

1. Improve outcomes for patients in relation to quality, safety, and equity of access, by reducing unwarranted variation and developing a skilled workforce – in particular improving UEC, cancer care, mental health and learning disability services.

2. Deliver against a set of regional ambitions, for example;
    a. Talent Management
    b. Reducing health inequalities
    c. Improvements in equality, inclusion and increasing diversity

3. Work with STPs/ ICSs to develop credible transformation plans to deliver the NHS Long Term Plan, including addressing specific and immediate workforce risks.

4. Reset how NHSE/ NHSI work with and through systems to support the delivery of integrated care.

5. Ensure financial accountability and discipline and ensure that the NHS lives within its means. Develop a financial sustainability strategy for each STP and the region.

6. Deliver the integration of NHSE/ NHSI, including the development of a positive culture, in line with values of NHSE and NHSI.

This application to merge the six CCGs for Nottingham and Nottinghamshire will positive contribute to Regional priorities 1, 2b, 3, 4 and 5 in the following ways.

Regional Priority 1: By creating a single strategic commissioner, the proposed new CCG will drive out unwarranted variation and support delivery of the national standards for, in particular, UEC and Mental Health.

Regional Priority 2b: The considerable health inequalities outlined above will be able to tackled at a strategic level through the deployment of strategic commissioning capabilities across the entire population of Nottingham and Nottinghamshire on a unified basis.

Regional Priority 3: A single CCG enables these conversations about transformation to happen once rather than six times and will enable CCG staff to be focussed on key immediate challenges like workforce.

Regional Priority 4: By creating a merged CCG exactly coterminous with the ICS, the proposed new merged CCG will be able to partner in lock-step with the ICS, delivering integrated care across the geography.

Regional Priority 5: Through the accessing of back-office and administrative efficiencies, a new, merged CCG will contribute to the 20% run-cost challenge for the commissioning system in England. Furthermore, the ability to commission at a system-level will reap benefits of scale and experience that will drive down the cost of delivery of healthcare.

7. Our Financial Position, Oversight Arrangements and Operating Model

Operational Model

Background information

The Governing Bodies of the six Nottingham and Nottinghamshire CCGs (NHS Mansfield and Ashfield CCG, NHS Newark and Sherwood CCG, NHS Nottingham City CCG, NHS Nottingham North and East CCG, NHS Nottingham West CCG and NHS Rushcliffe CCG) have been discussing options to align their staffing and governance structures since November 2018, following Amanda Sullivan being jointly appointed as Accountable Officer of the six CCGs.

Since this time, a further staff consultation process to establish a single Executive and Senior Leadership Team for the six CCGs has concluded, with new arrangements operational from 1 April 2019. Work is now ongoing to integrate the remaining CCG workforce to ensure that commissioning capacity and skills are best aligned to the emerging integrated care system (ICS), integrated care partnerships (ICPs) and primary care networks (PCNs). This includes the development of required clinical leadership model for the CCGs. (see below)

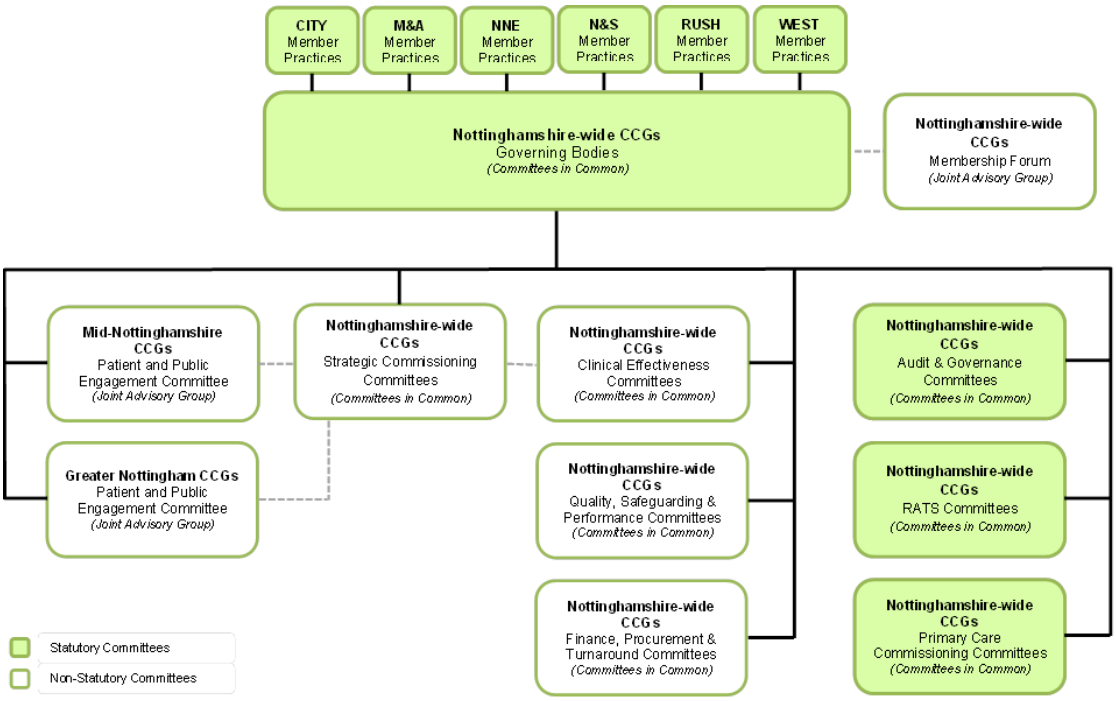
Two joint Governing Body development sessions were held in January and February 2019, which considered potential opportunities to align the governance arrangements across the six CCGs. As a result of these joint sessions, and further individual CCG discussions, all six Governing Bodies agreed in April 2019 to move to a fully aligned governance framework from June 2019 onwards.

The interim aligned governance framework

The aligned governance framework is a transitional step while the six CCGs explore the option of creating a single, strategic commissioning organisation as part of the Nottingham and Nottinghamshire Integrated Care system (ICS) development.

It has been designed to ensure that the CCGs remain statutorily compliant, while facilitating streamlined and consistent decision-making, maximising best practice, making best use of resources and reducing the burden of meetings.

The aligned governance framework is illustrated below:



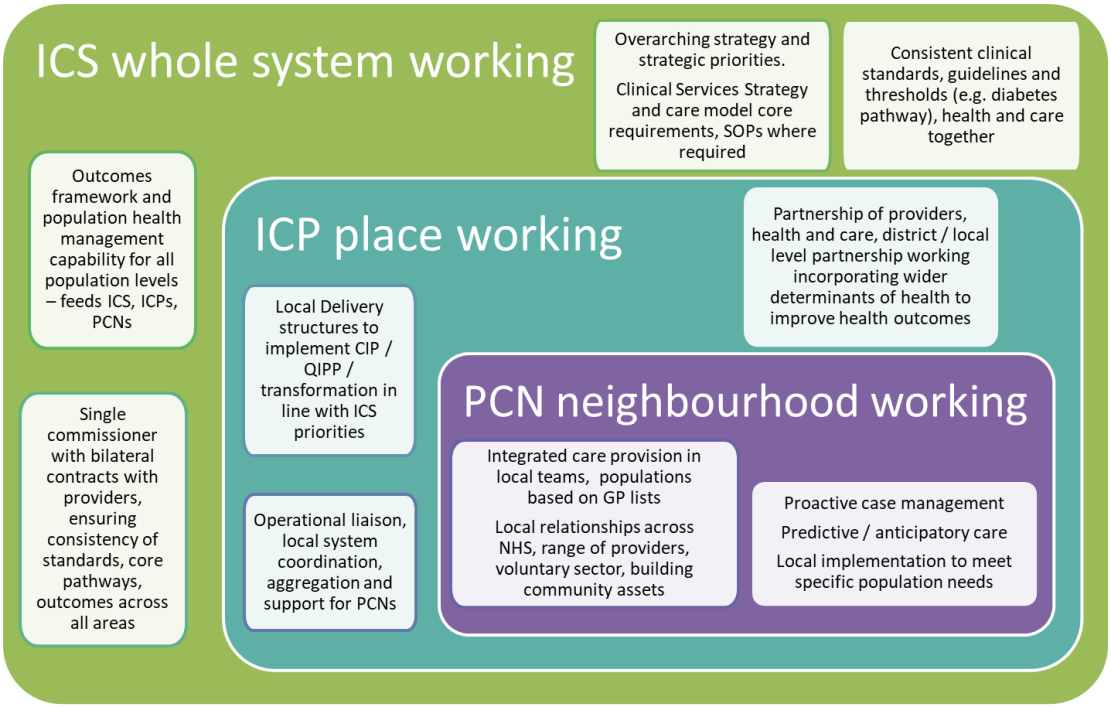
A new Membership Forum is in the process of being established to ensure that GP membership engagement, involvement and communication is effective and appropriately maintained during the transition period. These meetings will be scheduled consecutively to meetings of the Clinical Effectiveness Committees, as the memberships of the two groups will be very similar. Additionally we have a comprehensive approach articulated to support clinical leadership and engagement.

CCG Constitutions and Governance Handbooks

The CCGs Constitutions and Governance Handbooks have been reviewed and amended in line with the agreed governance framework. This has also required a move to the new national model Constitution published by NHS England during September 2018.

Model of Delivery

The model of delivery for commissioning is outlined in the table below. This is based on best practice and learning from capacity and capability reviews & emerging thinking from integrated CCGs. The distribution of work load across the executive portfolios and teams has been reviewed and the relationships with emerging place / neighbourhood working has been considered. The model of delivery is designed to support the role and function of the strategic commissioner, enhancing and building upon the integrated working delivered through the development of the ICS approach.



Clinical Leadership

General Practice Clinical Leaders from across the existing six CCGs have worked together to create a model for Clinical Leadership at all levels of the Nottingham and Nottinghamshire ICS including for the new proposed Strategic Commissioner. The thinking for this is system-wide and encompasses the following areas;

1. Clinical leadership of the ICS
2. Clinical leadership and support to CCG governance and statutory functions
3. Clinical input into CCG commissioning / contracting functions
4. Clinical leadership of clinical service developments (spans ICS / CCG / ICP / PCNs)
5. Clinical input into system enablers (spans ICS / CCG / ICP / PCNs)
6. Clinical leadership of ICPs
7. Clinical leadership of PCNs

The full detail can be found in the Appendix but in summary form, the following formal arrangements are anticipated;

- A clinical chair of the new CCG's Governing Body
- At least two other GPs on the Governing Body
- Input from an "out-of-area" GP to Primary Care Commissioning Committee

In addition to this, it is anticipated that local GP leaders will feed into specific commissioning projects and proposed pathway redesign alongside their contributions to ICP and PCN leadership.

Ensuring Effective Financial Management

Intervention Action

The two mid-Nottinghamshire CCGs – Mansfield and Ashfield, and Newark and Sherwood – have made considerable progress in addressing financial management concerns. At the end of 2017/18 they were rated as 'Requires Improvement', which reflected the improvements made since the previous year when they were rated as 'Inadequate'. Greater Notts CCGs are not subject to any intervention action.

Balanced Plans & Delivery

All 6 CCGs achieved their financial control totals in 2018/19., however this did require some non recurrent measures to be taken.

All CCGs have a significant challenge in relation to financial delivery in 2019/20 and have responded to this challenge by bringing together all financial functions in an integrated approach to achieving plans.

Collectively, all six CCGs have developed plans to reduce expenditure in accordance with the mandated 20% reduction in management costs by 2020/21. Whilst initiatives to share resources and reduce duplication have made significant headway towards achieving this target, a full merger is considered pivotal. The financial plan sets out how the CCGs will achieve the 20% target by reconfiguring staffing structures and by reducing non-pay spend across key areas such as Information Management and Technology, estates, legal and other corporate costs. A summary of these figures can be found in the Appendix XXX

Delegated Authority for Primary Medical Care Services

Since 1 April 2015, the six CCGs have had full delegated authority for commissioning primary medical care services for their populations under a formal Delegation Agreement with NHS England. In line with the Delegation Agreement, the CCG's Primary Care Commissioning Committee acts as the corporate decision-making body for the management of the delegated functions. The Committee is accountable to the Governing Body, which is fulfilled through the submission of its minutes. The new CCG will be applying for full delegation for commissioning primary medical care services as part of the mobilisation process.

8. Effective Engagement & Communications

Public Sector Equality Duty

In preparation for merger and in accordance with our Public Sector Equality Duty, CCGs commissioned an independent consultancy to undertake an Equality Impact Assessment. Conducted in June 2019, the assessment concludes that none of the issues identified in relation to the proposed merger represent significant risks that cannot be effectively mitigated. The report also notes that a merger presents many positive opportunities to promote equality, diversity and inclusion. This document is included in Appendix XXX.

Local Support for Merger: Consultation and Engagement Findings

The consultation attracted a total of 192 responses from stakeholders such as GP members, local authorities, Healthwatch, healthcare providers, local residents and patient groups.

Overall, there was strong support for the proposed merger; and notably more so than support for the alternative option of staying the same ('no change').

Significantly, the proposal to merge was supported by Healthwatch, local authority representatives and the majority of GPs, residents and patient groups. However, a caveat accompanied expressions of support from many groups, stipulating the need for CCGs to provide assurances regarding a number of matters. Most notably, this related to an ongoing focus on the needs of localities and communities as well as the need to engage with local people and clinicians to inform commissioning activities.

Whilst this was not a public consultation, the majority of responses came from local people and patient representative groups, demonstrating an eagerness to be involved in developments. Many of these respondents ask to be involved in the development of commissioning plans and activities and would like to know more about the emerging arrangements across the region with regard to the Integrated Care System (ICS), Integrated Care Providers (ICPs) and, in particular, the Primary Care Networks (PCNs).

This section addresses KLOE 56: "Includes reference to merger communications and engagement plan, including confirmation of engagement of the relevant LAs, membership of existing CCGs and local Healthwatch and consideration of their feedback" (part).

Over the past year we have been openly discussing possibilities for future commissioning arrangements with many organisations, groups and individuals, including GPs and member practices, local authorities, voluntary services, hospitals and other healthcare partners. These conversations have directly helped to shape our thinking, culminating in our decision to confirm a full merger as the preferred option in April 2019.

Our Engagement Activities

A wide ranging communications and engagement activity plan has been undertaken over the past six months including a wide-scale stakeholder consultation over a period of five weeks in May and June 2019, targeting GPs, local authorities, Healthwatch and other healthcare partners. In so doing, we have been able to confirm that our key stakeholders are, overall, supportive of a solution which paves the way for closer integration and better partnership working, enables more strategic commissioning, reduces administration costs, provides greater clinical leadership with a stronger commissioning voice across the system, and releases valuable resources to focus on services and initiatives closer to the front-line.

The Appendix contains a copy of the engagement log for these activities and an overview of the engagement responses.

Nottingham University Engagement

A research team from the University of Nottingham undertook a qualitative study with the CCGs to answer a series of questions on clinical involvement in the new CCG going forward. In each of the three ICP footprints (Mid-Nottinghamshire, City and South Nottinghamshire), 15 GPs were identified by the relevant Locality Teams to be interviewed either face-to-face or over the phone. The questions were;

1. How can we ensure ongoing clinical leadership in our future commissioning arrangements, and how can we strengthen what we do already?
2. How can we strengthen our arrangements to involve local people, GPs, other clinicians and healthcare partners in future commissioning activities?
3. What else do you think a strategic commissioner should do to ensure a continuing focus on health and care needs at a local level?
4. Are you interested in getting more involved in our commissioning activities, for example, becoming a clinical representative, getting involved in focus groups or receiving news and updates from us? If so, please give us your details.

A summary of these results can be found in the supporting documentation.

GP Practice Vote – Creating the Mandate

In June 2019, GP member practices were invited to take a formal vote on the proposal to merge on a one-practice-one-vote basis. A simple majority of practices in each current CCG area was required for the vote to support the merger to be carried. A summary of results can be found below, and the prevailing views of each GP member practice, grouped by current CCG.

Healthwatch

The proposed geography of the new merged CCG is served by Healthwatch Nottingham and Nottinghamshire. from this organisation.

Local Authorities

The proposed geography of the new merged CCG is served by two top-tier Local Authorities: Nottingham City Council and Nottinghamshire County Council. The Appendix contains copies of the record of support from both of these organisations.

Wider System Partners

At the ICS Board meeting on 13th June 2019, unanimous support for the proposed CCG merger was given and a letter confirming this can be found in the Appendix.

Members of Parliament

Three of our MPs responded and all supported the proposed merger.

Considerations Identified

Those responding to the consultation were offered the opportunity to explain their reasoning behind the response of support or opposition to the proposed merger of the 6 CCGs.

Themes relating to the reasons given for supporting a 'no change'/opposing a merger included:

1. **Local Focus-** Risk of losing focus on specific needs of localities and populations
2. **Information -** More information needed on the system architecture i.e. ICS, ICPs and PCNs. In addition clarity on how the 20% cost savings will be achieved
3. **Loss of Services -** Risk of potential loss of local services, particularly in rural areas, with funding diverted to support more deprived areas and other populations elsewhere
4. **Size -** A single organisation could be too large and unwieldy, with less accountability to local populations. It could also be harder to engage with, including geographically.

Our CCGs fully recognise the areas raised by stakeholders, as they are considerations already raised through the previous conversations with stakeholders over the past year. As such, we have been considering them for some time and plans are well underway to ensure that we not only maintain existing good practice, but continue to strengthen arrangements both within commissioning and across the emergent healthcare system.

Supporting information can be found in the Stakeholder Consultation Feedback Report

Appendices

KLOE Index

This table enables an at-a-glance view of where the KLOEs addressed in this document can be found. The Number column refers to the row number of the spreadsheet "Midlands CCG State of Readiness Assessment TEMPLATE FINAL 04062019.xlsx" as issued w/c 3rd June.

Number	Key Line of Enquiry Text	Page
41	Operational model is agreed and clear	
42	Clinical leadership arrangements are agreed and clear	
44	Describes the vision and priorities for the new CCG	
45	Includes map of new boundaries	
46	The map of new boundaries is coterminous with local authority(ies)	
47	Includes population details	
48	Includes reference to current health outcomes and health inequalities	
49	Includes reasons for the application to comply with CCG Regs 2012 10 (4) and outline description of the benefits, including the impact on the population / STP / ICS partners / other significant partners	
50	Describes ambitions on outcomes for local communities	
51	Describes the ambition for the area but also the regional and national ambitions	
52	Describes the roadmap towards ICS / ICP / Alliances	
53	Includes summary of joint working to date, including joint appointments, committees in common, lead commissioner arrangements, etc.	
54	Reflects strategic commissioning, is clear about what a strategic commissioning organisation actually is and outlines the roadmap towards strategic commissioning	
55	Describes the arrangements with LAs to support integration at place level	
56	Includes reference to merger communications and engagement plan, including confirmation of engagement of the relevant LAs, membership of existing CCGs and local Healthwatch and consideration of their feedback	
57	Includes financial position (current and high-level forecast of how 20% savings will be made)	
58	Includes reference to any intervention action for any of the existing CCGs (current or past) including legal directions and special measures	
59	Includes reference to current status regarding delegated authority for primary medical care services	
60	No longer than 15 pages (excluding appendices and evidence)	
61	Includes signatures of existing CCG	
62	Includes a declaration that application is in line with CCGs governance arrangements	
63	Includes confirmation of GB support from each of existing CCGs	
64	Includes the proposed new name (to comply with CCG Regs 2012(3) to (6)	
65	Includes reference to the PSED impact assessment for the proposed new CCG	

Future arrangements for NHS Commissioning in Nottingham and Nottinghamshire:

Equality Impact Assessment

11 June 2019

Introduction

Our approach

This short report presents the findings and recommendations of a high-level Equality Impact Assessment of the Case for Change and related documents for the proposed merger of the 6 CCGs in Nottingham and Nottinghamshire.

The assessment was conducted during June 2019 by the independent consultancy Imogen Blood & Associates (IBA).

Imogen Blood and Sarah Chalmers-Page of IBA, who have extensive expertise of Equality, Diversity and Inclusion and the NHS – reviewed the following documents:

Future arrangements for NHS commissioning across Nottingham and Nottinghamshire: consultation document

- Case for Change v.1.4 (PowerPoint)
- Benefits Realisation Worksheet
- Organisational Development Strategy & Supporting Plan, 2019 - 2021
- People Strategy v.1.2
- Communications and Engagement Strategy, 2020 - 2022
- Consultation Data (as at 6 June 2019)

Three telephone meetings were held between Sarah Carter (NHS Mansfield and Ashfield CCG), who commissioned the EIA and Imogen Blood who led the work on it. The purpose of these was to discuss questions raised by the review, to clarify current planning and mitigation by the CCGs, and to identify relevant data and documents.

Purpose and status of Equality Impact Assessment (EIA)

Under the Public Sector Equality Duty (PSED) (S.149 of the Equality Act 2010), a public authority such as a Clinical Commissioning Group, must, in the exercise of its functions, have due regard to the need to:

- Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;
- Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it; and
- Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

The following characteristics are protected under the Act:

- age;
- disability;
- gender reassignment;
- marriage and civil partnership;
- pregnancy and maternity;
- race;
- religion or belief;
- sex;
- sexual orientation.

What is an EIA and why conduct one?

An Equality Impact Assessment ("EIA") is an analysis of a proposed organisational policy, or a change to an existing one, which assesses whether the policy has a disparate impact on persons with protected characteristics.[1]

- Although not explicitly required by law, EIAs are one way in which a public authority can demonstrate its compliance with the PSED.
- They can help an authority to evidence that it has considered potential equality impacts systematically and can help it to identify the actions it can take to promote equality of opportunity.
- EIAs allow authorities to pre-empt and mitigate potential 'indirect discrimination', in which a practice, policy or rule which applies to everyone in the same way but has a worse effect on some people than others.

The proposed change

To merge the six separate CCGs currently operating within the Nottingham and Nottinghamshire Integrated Care System (ICS).

In recent months, the six CCGs have introduced a number of joint arrangements to serve all six CCGs, including a single Accountable Officer supported by a single leadership team. Joint committees and a joint Governing Body meeting will be in place by July 2019. Transitional work is underway both to align wider CCG governance and to bring together staffing structures.

The CCGs have been consulting external stakeholders and the general public during June 2019 on the option to fully merge into one organisation. This would not directly impact on service provision.

[1] p.23, House of Commons Library (2018) The Public Sector Equality Duty and Equality Impact Assessments, Briefing Paper Number 06591, 8 March 2018

Overview of key themes highlighted in the EIA

A. Patients, public and communities

Opportunities to advance equality of opportunity through the merger

Reducing inequalities through greater consistency

A single set of policies and a unified approach to commissioning (e.g. to children's or older people's preventative health services) have the potential to reduce geographic and socio-economic sources of inequality for different protected characteristic groups. There is potential to use the larger organisation to drive social value commissioning and to scrutinise and incentivise good EDI performance through procurement. There may be more scope to work with organisations such as the East Midlands Growth Engine and local hospitals to boost apprenticeships and employment opportunities for the most deprived local communities, for example by working with or encouraging partners to work with local colleges.

Reducing inequalities through stronger partnerships and joint commissioning

Having a single body should increase the potential for cross-sector working, by reducing the burden of coordination for partner organisations. Since the new organisation would align with the upper tier county council, this should improve the opportunity to work in partnership and jointly commission services with social care for key protected characteristic groups, e.g. children and young people, older people, disabled people, including people experiencing mental health conditions.

Practice learning and development

Shared learning about service delivery and best practice has the potential to improve care for all groups of patients, including those living with long-term conditions, cognitive and sensory impairments, pregnant women and new parents, trans people, etc. There should be more opportunities to commission training and development in relation to the needs of different protected characteristic groups.

Improved communication by and into the organisation

There are opportunities to improve the flow of communication both from and into the merged organisation for different protected characteristic groups. For example, having a single website may make it easier to maintain, ensure accessibility and navigate, helping patients access the information that they need without having to understand which specific CCG they are served by. The economy of scale should support more effective translation and interpretation services and can coordinate consultation and engagement for smaller minority groups by linking once into countywide groups (e.g. Nottinghamshire Deaf Society, Notts Trans Hub, Notts LGBT+ Network, etc).

Improved strategic management of Equality, Diversity & Inclusion (EDI)

Creating a new, larger organisation brings the potential to expand and develop EDI specialism across the CCG footprint, building the skills, systems, processes and culture to support the management of EDI in service delivery and policy analysis and development. These should be embedded from the outset in clear objectives, action plans and governance arrangements in accordance with EDS2.

Possible risks for equality of opportunity through the merger

NB: Mitigations and considerations moving forwards are included in italics.

Loss of relationships and knowledge

There may be a loss of location - and/or protected characteristic-specific expertise and knowledge. For example, relationships with grass roots organisations representing specific equality groups may not be replaced by the PCNs if they are medically led and have not established these relationships themselves. It will be important to ensure that the needs of people living in rural areas receive proportionate focus, especially those living in poverty and/or older and/or disabled people, who experience particular barriers accessing services. There may be barriers to engagement if people are daunted by the size of the organisation.

It will be important to ensure that existing relationships with community groups and leaders are 'handed over' to the PCN. The support of CVS and similar umbrella organisations are likely to be crucial during this transition.

Although the majority of consultation responses received and analysed up to the 6th June were in favour of the merger, there were a significant number of concerns raised about whether and how resources would be distributed, and power balanced between different geographical areas. If this is not managed well and some areas are disadvantaged, there may be a disproportionate negative impact on some equalities groups in these areas.

The Primary Care Networks (PCNs) should help to maintain a focus on local needs, and this will help where protected characteristic groups are geographically clustered, e.g. in parts of cities where there is a high proportion of people from one or more BAME community/ies, in rural areas where there is a high proportion of older people with long term conditions, in city centres where there will be people with complex needs in relation to homelessness, substance use, mental health, etc.

However, GPs' practices may not all be familiar with the challenges where areas have different profiles and needs to their own practices. The merged CCG will need to drive and lead the equalities agenda to ensure that there is strategic, systematic and evidence-based consideration of protected characteristic groups locally and centrally. This might, for example, involve the merged CCG providing place-based public health intelligence and working in partnership with PCNs to analyse and identify local priorities from it.

Reduction in number of lay members

The merger will reduce the absolute number of lay members inputting into the system, and will bring areas with different needs, demographics and health problems under a single set of rules and policies.

Any reduction in the numbers of lay members contributing to oversight and service development is balanced by rigorous consultation, at a useful stage, with groups representing a range of people, protected characteristics and EDS2 inclusion groups.

B. Workforce

Opportunities to advance equality of opportunity through the merger

The People Strategy for the proposed merged organisation already contains a number of strong and specific actions to improve the diversity of the workforce.

The merger provides an opportunity for all HR policies to be reviewed and a consistent HR offer to be rolled out. Assuming that EDI is a key criterion within this review, there is an opportunity here to

promote best practice and consistency across the footprint, e.g. in Dignity at Work, Maternity/ Paternity, Flexible Working, etc, with the benefits that should bring for advancing equality of opportunity.

The merged organisation creates an opportunity to establish, grow or link in with existing (e.g. at the county council or in provider organisations) staff networks, e.g. for BAME staff, disabled staff, LGBT+ staff and supporters, etc.

The opportunity to create a positive inclusive culture within the new organisation has already been recognised within the Organisational Development strategy.

Possible risks for equality of opportunity through the merger

Organisational change is stressful for everyone; however, this can have a disproportionate impact on a number of protected characteristic groups, e.g.:

- Those who may have concerns about whether they will be accepted by new colleagues and/or will receive the same level of support from new managers;
- Those who may have particular concerns about changes to travel due to disability, caring responsibilities or low income;
- Those who may have concerns that unconscious bias or assessment criteria (e.g. length of experience) in the selection process for new posts may disadvantage them;
- Those who may require reasonable adjustments to be made within new workplaces and may face particular access barriers within open plan/ hot desk/ dial-in working environments.

These issues are summarised by protected characteristic group in the following table, along with suggested mitigations.

Table: potential impacts and mitigations for workforce by protected characteristic group

Equality Group	Reason/Comments for Positive Impact (Why it could benefit any / all of the Equality Groups)	Reason/Comments for Negative Impact (Why it could disadvantage any / all of the Equality Groups)	Potential benefit maximisation or mitigating factors.	CCGs Initial response (– further review of actions will be undertaken throughout the mobilisation period and these responses should be considered in concert with the OD Strategy
Men		Flexible working requests: unconscious bias or assumptions about caring responsibilities may make new managers less likely to grant flexible or agile working requests from men	Ensure that requests for flexible or agile working are considered fairly, and that assumptions about caring responsibilities are not based on gender.	**The CCG will continue to embed this into practice.** **The CCGs People Strategy has incorporated the following:** - **Ensure all staff undertake Equality, Diversity and Inclusion training** - **Ensure that all CCG policies have a consistent approach in relation to equality, diversity and inclusion promoting best practice at all possible opportunities** **And will monitor according to the approach outlined in the Strategy**
Women	Increased opportunities for flexible working and for more consistent child care vouchers may be a particular benefit.	Women are more likely (although not exclusively) to have caring or childcare responsibilities that would make moving work base for an increased commuting time a barrier to the role	Encourage flexible and agile working arrangements. Consider flexible working hours.	**The CCG has included the following actions in its People Strategy:** • **Develop and implement a new approach to flexible working that recognises the employees needs to be flexible with the organisations need to deliver**
Younger People (17-25) and Children		Where multiple posts are being combined, younger people may miss out on roles to more experienced colleagues	Specific actions in talent management pathway and where people lose bands in the merger. Support team members who wish to shadow in other parts of the NHS in order to consider career moves. Provide mentorship schemes.	**The OD Strategy includes the following:** **All individuals within the CCG will have a Personal Development Plan in support of aspirations and internal talent management** **Implement talent management pipeline and opportunity**

				framework
Older People (60+)	Increased opportunities for flexible working may be a particular benefit to those wishing to 'step-down' gradually to retirement or who may be caring for a partner.	Older workers may choose to retire rather than face applications to their role. Conversely, managers may assume workers approaching retirement may not be interested in new opportunities/changing roles/applying for roles when in fact the worker is interested in new challenges.	Ensure that older workers who want to continue in their roles are assured they will be considered equally in the application process. Do not exclude older workers from training, shadowing, mentorship or other opportunities to support them in a new role.	**The OD Strategy includes the following:** **All individuals within the CCG will have a Personal Development Plan in support of aspirations and internal talent management**
Race or Ethnicity		People from ethnic minority backgrounds are under-represented in the senior management of the NHS, and if multiple people are applying for the same role and there are biases towards experience (where newly appointed managers lose out), NHS background (where people recruited outside the NHS lose out) or other biases, these may disproportionately affect people from BAME backgrounds.	Encourage mentorship, especially from leaders from BAME backgrounds in the wider NHS community in Nottingham and Nottinghamshire.	**This will be driven through the approach the offer outlined in the OD strategy for EMLA coaching and mentoring opportunities** **The CCG will also pursue opportunities for intra organisational mentoring across the system**
Learning Difficulties	A single set of predictable policies and standards may facilitate a worker with learning difficulties in transitioning between roles, either in the merger or if they seek a new role within the organisation later.	Workers with learning difficulties may be concerned that a new manager may not be able to support them or may not want to support any adjustments in place for them	Training for new managers, reassurance and transition meetings for workers.	**The CCG will develop a leadership and management programme (in modular format) to meet the learning needs of line managers, especially over the integration period as outlined in the OD Strategy**
Hearing Impairment		Where agile working is in place, people with hearing impairments may struggle to access "phoning in" to meetings – especially where this means putting a phone on speakerphone rather than specific teleconferencing arrangements at the office end.	Introduce technology that is specifically designed for "phoning in" to meeting settings, not an ordinary phone on speaker. Solutions could include using WebEx or similar technology, or specifically designed "spider" phones with larger microphone pickups.	**This will be reviewed and actions taken as part of the mobilisation approach to delivering the new organisation**
Visual Impairment		Workers may be concerned that reasonable adjustments such as where a desk is relative to a window may not be in place, especially if there is to be hotdesking	Workers with specific needs relating to desk position should not have to hot desk, and it should be clear to hot desking workers that the desk is reserved.	**This recommendation will be considered as part of the Estates approach, and actions defined to continue to support workers with specific needs**
Physical Disability	Flexible and agile working arrangements may benefit those with physical disabilities, for example chronic fatigue, by reducing the need to travel between bases and	Workers may be concerned that physical adjustments (e.g. custom desks) or other reasonable adjustments may not be in place in the new organisation, or that new managers may not be willing to make the same	Train managers in reasonable adjustments, and work to ensure that things like custom desks are in place as early as the move as possible. Workers who require specific adjustments such as raised desks may be exempt from hot desking, with it being made clear to other workers	**As above. There is a commitment in the OD strategy to undertake a subject specific TNA and offer Equality and Diversity/EIA development sessions at CCG, ICP and PCN levels (incorporate into commissioning capability development**

	reducing commuting time.	accommodations. Remote/agile/home workers may not pay adequate attention to the design of their workspace, resulting in worsening of MSK problems.	that the desk is reserved. Consider the ACAS advice on homeworking for employers and employees and advise remote workers on workspace needs	
Mental Health Need		Applying for a role or moving to an unfamiliar manager who may be unfamiliar with adjustments to working practices or supervision may be particularly stressful for a worker with mental health needs.	Train managers and manage transition sensitively and consistently, recognising that some people may need additional support through this.	**This action will be completed as part of the implementation of the actions outlined in the OD Strategy:** **Undertake a subject specific TNA and offer Equality and Diversity/EIA development sessions at CCG, ICP and PCN levels (incorporate into commissioning capability development)**
Gay/Lesbian/ Bisexual		People who have felt well accepted in their current team may have concerns about moving to a new team and having to come out again.	Ensure new managers are well trained in equality and diversity issues. This may include unconscious bias training.	**As above**
Transgender		People who have felt well accepted in their current team may have concerns about moving to a new team and having to move to a new team.	Ensure new managers are well trained. This may include unconscious bias training.	**As above**
Faith Groups (please specify)	Planning a move to a new space allows consideration to be made of whether a prayer space is needed and can be allocated. A single set of HR policies will mean that everyone requesting leave for religious festivals will be considered equally.		Ensure new managers are well trained. This may include unconscious bias training. Ensure managers and the HR policies are clear on what is reasonable when requesting time off for religious festivals and observances.	**As above**
Marriage & Civil Partnership				
Pregnancy & Maternity		There may be additional anxiety for those on maternity leave during the transitional period.	Clear information and support regarding the changes and the personal implications of them must be communicated in a timely way.	**This is included in the Communications and Engagement Strategy**
Parenthood and carers	Flexible and agile working benefit parents through allowing them to meet childcare responsibilities, avoid having to commute etc.			
Socio economic deprivation		Increased travel times and costs may disadvantage workers living in areas of socioeconomic deprivation (which are often already	Workers will have their additional mileage paid for two years under TUPE arrangements. Support workers who wish to seek NHS work closer to their homes with	**This will be considered in the approach to workforce design**

		subject to worse) and those in lower paid posts.	applications, advice and shadowing where appropriate.	

Conclusions and recommended next steps

None of the issues thrown up by this initial scoping EIA suggest that there are significant risks for equality from the proposed merger which cannot be effectively mitigated. There are also many positive opportunities to promote equality, diversity and inclusion.

Below we summarise our key recommendations to maximise these opportunities and mitigate risks:

Patient, public and communities

- Ensure that the management and governance of EDI is built into the new organisation from the outset. It will be essential that the CCG leads, challenges and provides learning and development, data and scrutiny to the PCNs in relation to EDI, and that this key role is properly resourced and has Executive level accountability.
- The merged CCG should use its scaled-up commissioning and procurement capacity to promote EDI through its supply chain.
- Ensure that the reduction in the number of lay members is balanced out by proactive engagement with less heard groups.
- Include a specific mention of Equality, Diversity and Inclusion in the Communication and Engagement Principles, and the Annual Engagement Report.

Workforce

- Equality monitor as many of the HR measures (e.g. retention, satisfaction, etc) as possible.
- Monitor the impact of the transition on equal pay and on overall workforce diversity and diversity in more senior bands, providing positive action (mentoring, shadowing, training and development) where protected characteristic groups are disadvantaged.
- Ensure that EDI is embedded in the values and modelled by leaders who have the skills to manage diverse teams from the outset
- Ensure that the potential needs of protected characteristic groups are built into the workforce transition planning

Defining the future of NHS commissioning
across Nottingham & Nottinghamshire

FINDINGS REPORT

Stakeholder consultation regarding the future of NHS commissioning across Nottingham and Nottinghamshire

FOREWORD:
Actions for Governing Body members

1. The Governing Body is asked to:
   - Review and reflect upon the views shared by stakeholders
   - Carefully consider this feedback when making decisions relating to the future of commissioning arrangements across Nottingham and Nottinghamshire
2. Agree a formal response to feedback, which will be published by 19 July 2019 together with this report
3. Note that a case for change, required to support any merger application, would need to include a specific response from CCGs to comments raised by:
   - Local Authorities
   - Healthwatch
   - GP members

Table of contents

Executive Summary

This report relates to the 2019 consultation regarding the future arrangements of NHS commissioning across Nottingham and Nottinghamshire. Two options were proposed: 1) to merge the six CCG organisations and create a single, strategic commissioner; and 2) no change, i.e. for CCG organisations to stay as they are with no further structural change.

Led by the six CCGs across Nottingham and Nottinghamshire, the consultation attracted a total of 192 responses from stakeholders such as GP members, local authorities, Healthwatch, healthcare providers, local residents and patient groups.

Overall, there was strong support for the proposed merger; and notably more so than support for the alternative option of staying the same ('no change'). Significantly, the proposal to merge was supported by Healthwatch, local authority representatives and the majority of GPs, residents and patient groups. However, a caveat accompanied expressions of support from many groups, stipulating the need for CCGs to provide assurances regarding a number of matters. Most notably, this related to an ongoing focus on the needs of localities and communities as well as the need to engage with local people and clinicians to inform commissioning activities.

As part of the stakeholder consultation many local people and patient representative groups responded requesting to be involved in the development of commissioning plans and activities going forward. They also asked for more information about the emerging arrangements across the region with regard to the Integrated Care System (ICS), Integrated Care Providers (ICPs) and, in particular, the Primary Care Networks (PCNs).

It is essential that CCG leaders take into account the feedback received during the consultation and use it to inform their decisions regarding future commissioning arrangements. Furthermore, key departments and leads would benefit from noting specific comments received as they may inform and help improve commissioning activities.

Introduction

The CCGs commissioned an independent consultant, Jo Yeaman of MIH Solutions, to carry out analysis of the consultation with the support of the CCG's Business Information Team to produce this detailed report on the results.

This report sets out the key findings following a consultation with stakeholders regarding the future possible arrangements for NHS commissioning across Nottingham and Nottinghamshire.

It is presented to the joint Governing Body for the purposes of informing a decision about whether to pursue a formal merger of the six CCGs, or to keep current arrangements as they are with no further structural change.

CCGs have committed to respond formally to these findings, and a response will be published following Governing Body discussions on 4 July 2019. This report will also be made available to stakeholders and published on CCG websites.

Consultation scope

The consultation was jointly led by the six NHS Clinical Commissioning Groups (CCGs) across Nottingham and Nottinghamshire. It ran for 31 days from 17 May to 17 June 2019.

The commissioning proposals subject to consultation were specifically about how the six CCGs might be structured in future. As proposals did not relate to patient services commissioned, this was deemed a **stakeholder consultation** and not a public one.

Outside of scope

Bassetlaw in the north of Nottinghamshire was not considered within this consultation, as it will continue to remain part of the South Yorkshire and Bassetlaw healthcare system.

The University of Nottingham is also conducting research on behalf of the CCGs, interviewing 15 GPs in each of the three localities (45 in total). This relates to wider considerations outside of the consultation, including strengthening clinical involvement and leadership, and ensuring an ongoing focus on local health needs. This work will inform commissioning strategy and activities, and is subject to a separate report.

The consultation attracted a number of comments relevant to matters beyond the subject of the consultation itself, e.g. personal experiences of NHS services. These will be shared with the appropriate departments and individuals for the purposes of continuing to improve commissioning activities. These comments are not considered within this report.

Stakeholders targeted

The following stakeholder groups were targeted:

- GPs and member GP Practices
- Healthwatch and other patient representative groups
- Local authorities (Nottingham City and Nottinghamshire County)
- CCG Staff
- Voluntary, community sector and social care
- Local clinicians and other healthcare partners
- Local decision makers and other influencers, e.g. MPs, councillors, overview and scrutiny committees

Whilst members of the public were not targeted, some patient representative groups and individuals wished to participate. The CCGs made provision for this eventuality in the consultation and welcomed views from local people. The comments shared by local people have been fully considered within this report.

Consultation questions

Respondents were asked the following:

1. In which group they categorise themselves
2. Whether views are their own or shared on behalf of others
3. Which group or organisation they represent (if applicable)
4. The extent to which they support ‘a full merger’ of the six CCGs
5. The extent to which they support ‘no further change’ to CCGs
6. An opportunity to explain their views for both options
7. Whether they have other considerations for CCGs

Respondents were able to select which questions they answered, and some chose not to answer them all

Methodology

Led by the communications and engagement team, an extensive programme of events and activities has helped to raise awareness of the consultation, engage with stakeholders and encourage feedback. This has included:

- Healthwatch, Overview and Scrutiny Committees, the Local Medical Committee and representative GPs were involved in the development of consultation material prior to launch. The Consultation Institute was also involved on an advisory basis to ensure fundamental requirements were met
- A copy of the consultation document with a link to the online questionnaire was emailed to all GP practices managers and senior leads, CCG staff, Healthwatch, local authorities (including social care, public health, scrutiny committees, Health and Wellbeing Boards) and the ICS Board. In turn, this was shared more widely by some of these stakeholders, e.g. GPs to patient participation groups
- Hard copies of the consultation and questionnaire were also sent out in the post with covering letters
- GP contact was followed up by each of the three CCG locality leads. Newly appointed Primary Care Network clinical leads have also been encouraging clinicians and others to get involved
- Face-to-face GP evening events, a webinar, Primary Care Network meetings, discussions in Protected Learning Time sessions, day-to-day contact with locality leads, clinical chairs and clinical leads
- Face-to-face meetings with CCG staff; a discussion at the Integrated Care System Board meeting; presentation and discussion at the Local Medical Committee meeting in May 2019
- Liaison with partner communications teams to promulgate messages and directly encourage involvement from key senior leads and others within their respective organisations
- Chasing up key parties who had not responded to the survey before the final week
- GPs were prompted to complete the consultation questionnaire during interviews led by the University of Nottingham when conducting research

Data cleansing

Data has been cleansed for the following reasons:

1 Some respondents have started to complete the survey by indicating the group they represent, but have exited the survey before answering any of the consultation questions.

These are known as 'false starts'. Some of the common reasons for this are that a respondent starts the survey but is not able to complete it in one go, gets 'locked out', they shut down their device or the device 'crashes', or they simply choose not to take part when they see the main questions. Typically, many respondents will return to the survey later when they have the time and opportunity to complete it fully; however, this generates two separate responses – one partial and one full.

Where respondents did not complete any questions beyond their demographics, the data has been removed. This is to prevent the risk of making inaccurate conclusions about the extent to which a particular group is represented. There were 62 of these incomplete responses.

2 A total of 14 respondents categorised themselves in the 'other' group, sharing the organisation and/or the context in which they were responding. With the exception of three, these respondents were appropriately categorised elsewhere and so this data has been transferred accordingly to the correct group: 'patient representative group' for PPG respondents (6); 'local resident' for NHS users (1); and 'other healthcare providers' for named provider Trusts (4).

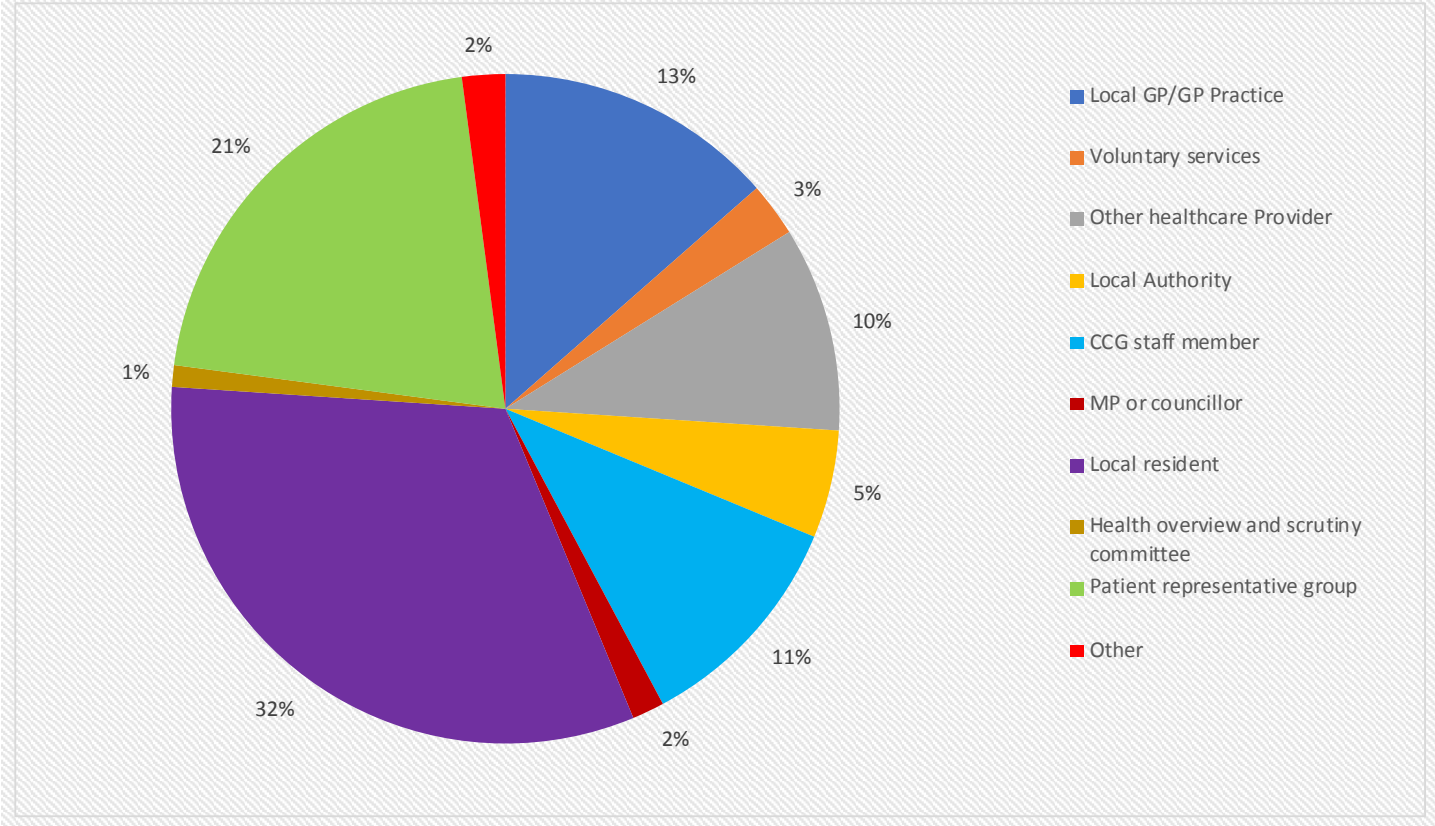
3 Some respondents did not categorise themselves in the correct group, and so these have been moved accordingly: St Luke's PPG was moved from 'GP Practice' to 'patient representative group'

4 Two completely identical 'representative' responses (including extent of support and supporting narrative) were received from Nottinghamshire County Council. One copy has therefore been removed.

CONSULTATION RESULTS

Representation by group

A total of 192 responses were received: 189 via the online survey and 3 via email. 37 respondents stated that they were representing others. A list of all organisations and groups represented within the survey can be found on pages 25-28 (an asterisk denotes where the survey has been completed on behalf of others).

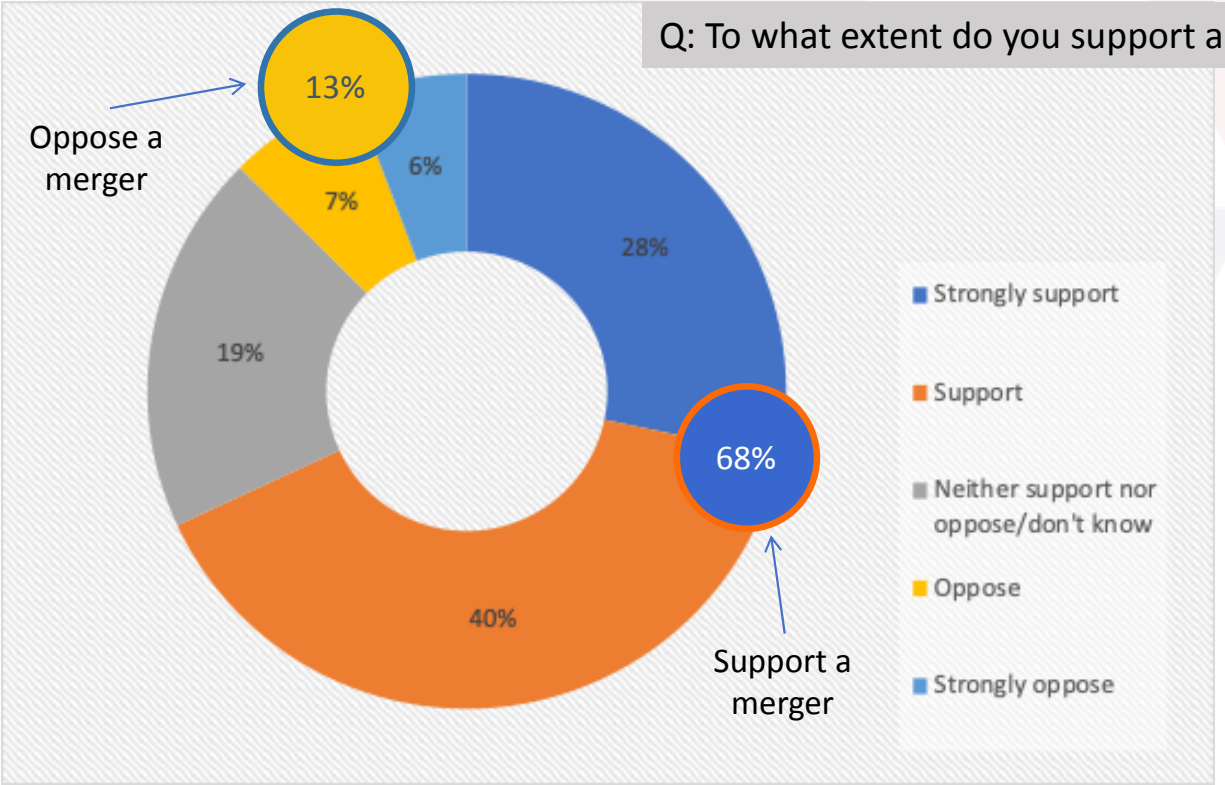


192 Responses

37 of these respondents are representing a group or organisation

Option 1 - Merge: all respondents

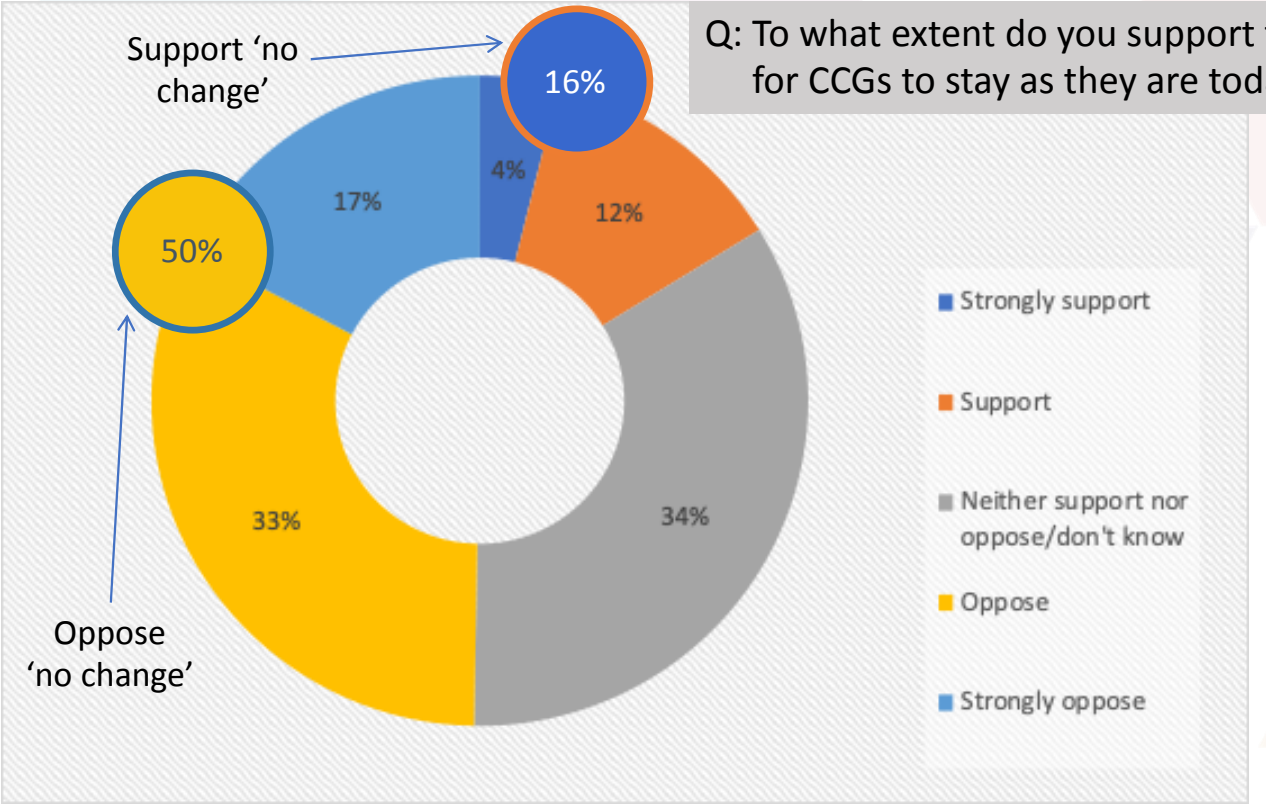
The following graph shows the extent to which respondents supported the first option: to merge the six CCGs and create a single commissioning organisation. A total of 191 respondents answered this question. One of the written responses did not refer to the extent to which its author supported a merger and so has not been counted.



191 Responses
37 of these respondents are representing a group or organisation

Option 2 - No change: all respondents

The following graph shows the extent to which respondents supported the second option: 'no change' - for CCG organisations to stay as they are with no further structural change. A total of 179 respondents answered this question.



179 Responses

37 of these respondents are representing a group or organisation

Themes

Respondents were offered the opportunity to explain their reasoning behind the response they gave as to whether they supported or opposed each of the two options. Across both options, a total of 247 comments were received from 138 respondents, ranging from just a few words to a detailed formal response. These comments were reviewed and each point raised by the respondent was noted and logged separately.

In total, 368 points were made within respondent comments: 258 relating to the advantages of merger and disadvantages of 'no change'; and 110 relating to the advantages of 'no change' and disadvantages of merger. These points were then sorted into themes.

The top themes for i) merger benefits/no change disadvantages and ii) 'no change' benefits/merger disadvantages are shown on pages 13 and 15 respectively, with a more detailed explanation of each theme on the pages that follow.

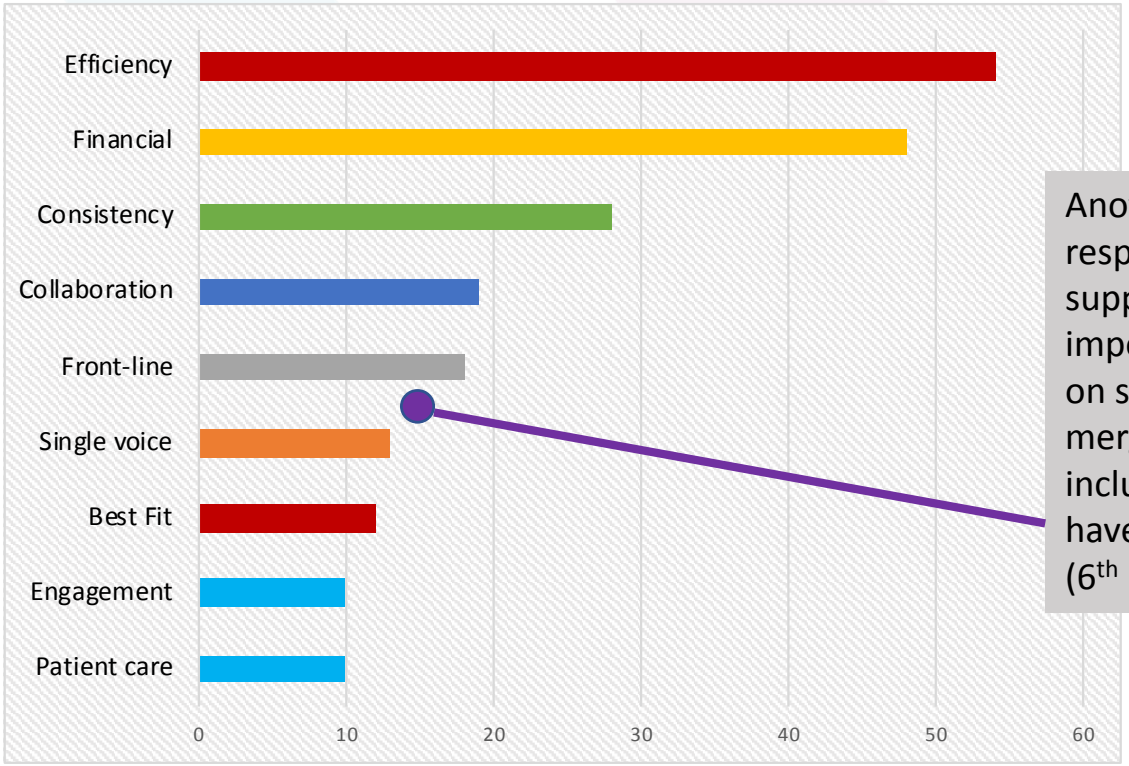
Whichever future commissioning arrangements are agreed, these themes should be taken into consideration when discussing options and making decisions. CCGs should also respond to them in their public response to consultation feedback.

Defining the future of NHS commissioning
across Nottingham & Nottinghamshire

Top Themes

Reasons given for supporting a merger

The following chart shows the top nine themes extracted from 258 individual points made within respondents' comments. Whilst more of a concern, rather than an expression of support for merger, the theme regarding the importance of ensuring an ongoing local focus was often referred to as a condition of a respondent's support for merger and, as such, should be considered alongside the level of support indicated.



Another strong theme raised by respondents (but not in direct support of merger) was the importance of ensuring a local focus on specific needs, should the CCGs merge (15 points). Had this been included within this chart, it would have been positioned here (6th place)

When added together, references to these top themes (including local focus) represent 227 out of a total of 258 relevant points made

Explanation of 'Top Themes' *(merger)*

These themes relate to the reasons given *for* supporting a merger/opposing 'no change'

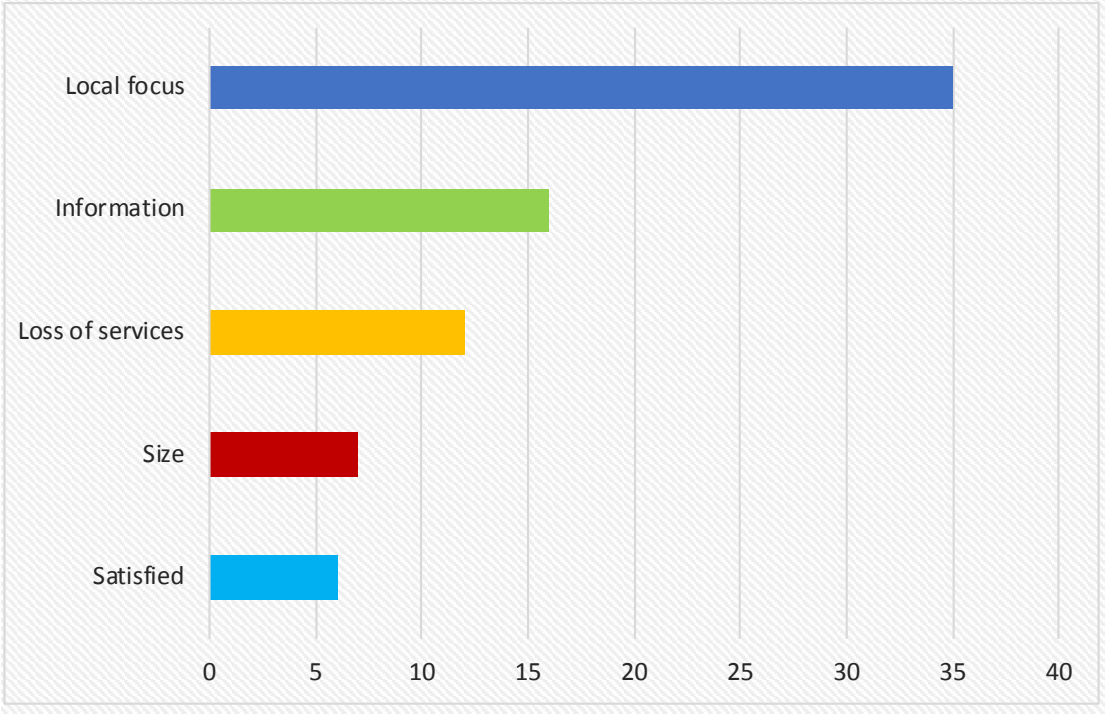
1. **EFFICIENCY:** Opportunity to reduce duplication and improve efficiencies with a more coordinated approach (54)
2. **FINANCIAL:** Opportunity to deliver cost savings and other financial benefits (48)
3. **CONSISTENCY:** Improving the consistency of: i) commissioning approach ii) patient services in terms of access to, quality and/or standardisation (28)
4. **COLLABORATION:** Best opportunity to facilitate better partnership working and integration, including the sharing of information and the ability to deliver seamless services (19)
5. **FRONT-LINE:** Redirecting resources closer to front-line patient services (18)
6. **SINGLE VOICE:** Enabling a single vision and voice across the system with the opportunity for stronger leadership (13)
7. **BEST FIT:** A single organisation would present the best fit with emerging arrangements across the system and at national level and would also reflect local authority boundaries (12)
8. **ENGAGEMENT:** Easier for organisations, groups and people to engage/'do business with' a single entity (10)
8. **PATIENT CARE:** Opportunity to improve the quality of patient care and services (10)

Themes have been noted where 10 or more points were made about the same topic. For this category, there were nine themes that met this criteria. In addition, there was the caveat expressed in 15 responses regarding the importance of focusing on local needs and voice should the CCGs merge. Had this been included in the list above, it would have taken 6th place.

Top Themes

Reasons given *for* supporting 'no change'

The following chart shows the top five themes extracted from 110 individual points made within respondents' comments. The importance of ensuring a focus on local needs and retaining local expertise was emphasised by many respondents, and was one of the main reasons for not supporting a merger or having concerns about doing so. Some respondents, typically patient representatives but not exclusively, felt more information and evidence was needed to make a decision.



When added together, references to these top themes represent 76 out of a total of 110 relevant points made

Explanation of 'Top Themes' *(no change)*

These themes relate to the reasons given for supporting a 'no change'/opposing a merger

1. **LOCAL FOCUS:** Risk of losing i) focus on specific needs of localities and populations ii) patient and clinical engagement iii) local expertise and knowledge of local population needs. The local voice of patients and groups could be marginalised and the ability to address health inequalities could be affected as a result (35)

2. **INFORMATION:** Respondents say they need more before being able to give their opinions on a merger and/or noting the unknowns relating to emergent NHS arrangements, i.e. ICS, ICPs and PCNs. Some respondents ask for evidence to support proposals and/or clarity on how the 20% cost savings will be achieved (16)

3. **LOSS OF SERVICES:** Risk of potential loss of local services, particularly in rural areas, with funding diverted to support more deprived areas and other populations elsewhere (12)

4. **SIZE:** A single organisation could be too large and unwieldy, with less accountability to local populations. It could also be harder to engage with, including geographically (7)

5. **SATISFIED:** Respondents are happy with present arrangements and do not wish to see any change (6)

Themes have been noted where 6 or more points were made about the same topic. For this category, there were only five themes that met this criteria.

Support for options by group

Group	Full merger					No Change				
	Strongly support	Support	Oppose	Strongly oppose	Neither/ Don't know	Strongly support	Support	Oppose	Strongly oppose	Neither/ Don't know
GPs/ Practices (26)	27%	42%	12%	4%	15%	0%	16%	52%	8%	24%
CCG Staff (21)	38%	43%	5%	5%	10%	0%	14%	38%	14%	33%
Local Authority (10)	30%	30%	10%	0%	30%	0%	10%	20%	30%	40%
Local residents and patient groups* (103)	25%	40%	8%	7%	20%	5%	14%	31%	18%	32%
Other healthcare providers** (24)	29%	42%	0%	8%	21%	9%	5%	23%	14%	50%
MPs (3)	33%	66%	0%	0%	0%	0%	0%	33%	33%	33%
Other (3)	67%	0%	0%	0%	33%	0%	0%	0%	67%	33%

This table shows the percentage of support from each group of respondents for both of the two options. It demonstrates that more respondents within each group support a full merger overall than oppose it. To mirror this, more respondents within each group oppose 'no change' than support it.

* *Responses from patient representative groups, local people and Health Scrutiny Committees*

** *Responses from NHS providers and voluntary services*

Themes by group

Themes can be identified within certain respondent groups, as listed below (please refer to descriptions on page 14 and 16 for more information about them). However, it is not possible to identify themes for all groups, as the number of respondents offering comments was relatively low in some and/or the points made within their comments were diverse.

Patients and patient groups
(83 respondents | 193 points)

1 Efficiency (32)

2 Local focus (29)

3 Financial (28)

4 Consistency (16)

5 Information (14)

6 Front-Line (12)

7 Collaboration (8)

Providers
(16 respondents | 49 points)

1 Financial (7)

2 Local focus (6)

3 Consistency (5)

4 Efficiency (4)

Staff
(12 respondents | 32 points)

1 Efficiency (6)

GPs
(20 respondents | 52 points)

1 Local focus (10)

2 Efficiency (7)

3 Financial (5)

4 Consistency (4)

4 Care (4)

TOP 3: 'Efficiency', 'Local focus' and 'Financial' are the most common top 3 topics

The 'respondents' number shown above for each group refers to the number of respondents submitting comments (not the overall group total)

Themes are not available for the following groups as respondent numbers were too low: MPs | Other

ESSENTIAL ORGANISATIONAL RESPONSES

Healthwatch
Local Authorities

About essential responses

Should the CCGs decide to pursue a merger, they will be required by NHS England to seek out and consider the opinions of Healthwatch and the two local authorities.

The CCGs' formal response to these must be included within the case for change accompanying the merger application. These specific stakeholders were therefore approached and encouraged to participate in the consultation regarding the future arrangements for commissioning across Nottingham and Nottinghamshire.

Responses have been received as follows:

- A response has been received on behalf of Healthwatch Nottingham and Nottinghamshire (a 'representative' response) as well as an individual response from Healthwatch Maternity Voices Partnership.
- Nottingham County Council has submitted two representative responses and there are three further responses from individuals
- A response from Nottingham City Council has been submitted and a further two individual responses (personal views only) have also been received from Nottingham City Council
- Responses have also been received from Newark and Sherwood, and Mansfield District Councils as well as Carlton on Trent Parish Council

Healthwatch Nottingham and Nottinghamshire

Healthwatch is SUPPORTIVE of a merger, owing to the opportunities to reduce duplication and costs as well as offer communities more consistent and equitable services. However, they raise some concerns and seek assurances regarding the following:

- How the 20% savings will be achieved. They would like more information to understand any adverse implications, e.g. potential reduction in resources to engage with/involve local people and so understand local needs. They ask whether partnership work with the voluntary and community sector might address this
- Ensuring that best practice across CCGs will be adopted, with learning shared and taken forward
- Making sure that CCG merger process will not impact on the ability to deliver what is expected and required
- Understanding more about key risks and CCG mitigation plans

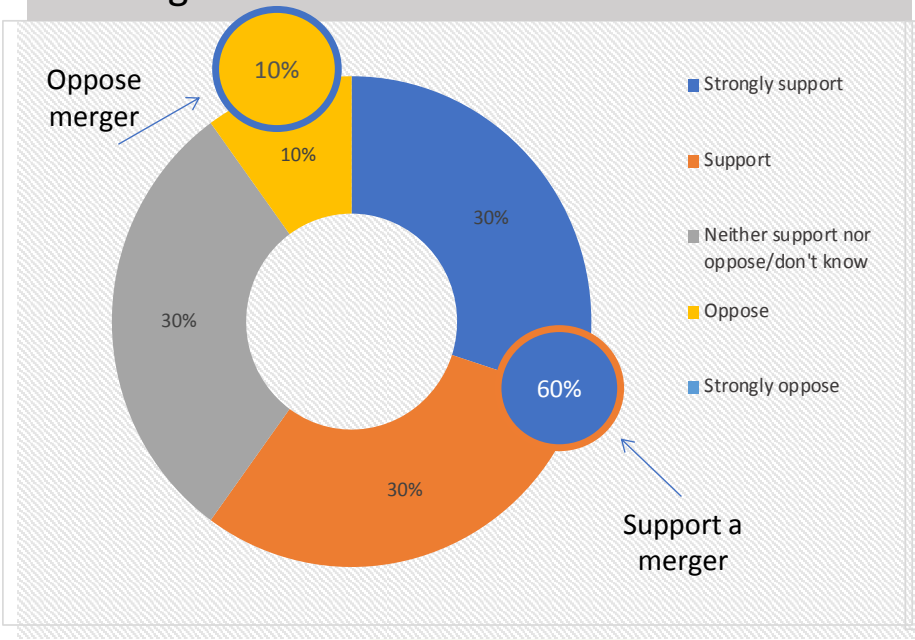
Healthwatch also stated, in their response to the consultation, that if the CCGs were to stay the same they would be supportive as the current structure enables local focus for commissioning decisions and offers an important forum for GPs to lead and inform decisions using their local knowledge.

Following the consultation Healthwatch also provided a letter of support for the merger.

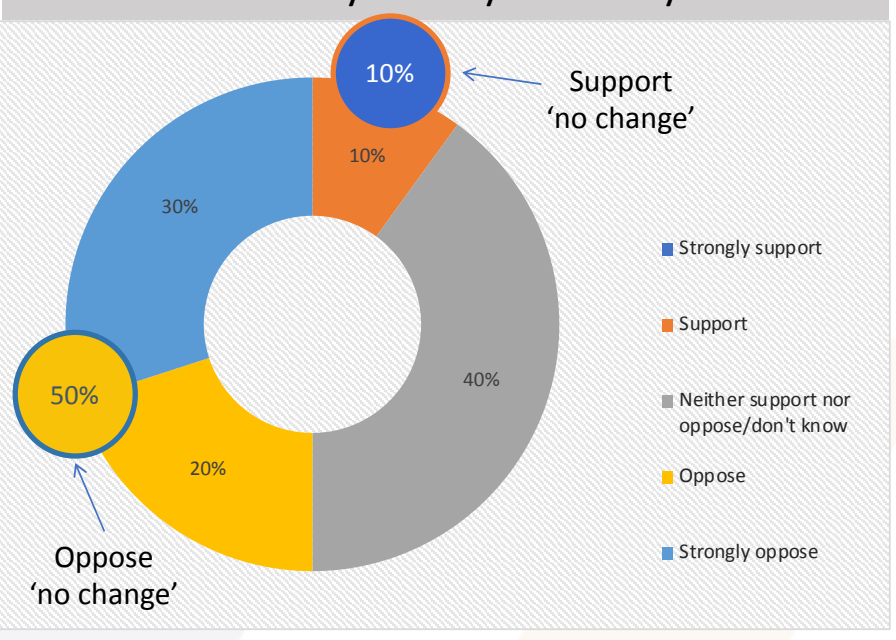
Healthwatch comment from the consultation response : “We would like to see a more consistent approach to commissioning, while making sure that small scale providers who know and operate effectively with communities are not excluded by larger scale commissioning. We would like to see a greater transparency across all commissioning decisions, so that we and the public are informed on how decisions are made, what those decisions are and how these could impact on local people. We feel that in bringing the CCGs together, there is an opportunity to begin a new approach to communicating with our communities with openness, honesty and transparency. The public know that difficult decisions have to be made and enabling them to understand and in turn meaningfully engage in decisions should be the focus.”

Local Authorities: overview

Q: To what extent do you support a full merger?



Q: To what extent do you support the proposal for CCGs to stay as they are today?



A total of 10 responses were received under the category 'local authority'. Five of these were submitted on behalf of the organisation concerned; the remainder were responses from individuals. Of those representing local authority bodies, three were supportive of a merger (Notts County Council x 2 and Newark and Sherwood District Council). Nottingham City Council stated it did not support the 'no change' option but did not give a specific answer with regard to the level of support for a merger; however, its written response indicated that a proposal to merge might be supported if assurances can be met (this response has been classified as 'neither support nor oppose'). The fifth (Carlton on Trent Parish Council) was not supportive of a merger owing to concerns relating to the potential loss of local services and the risk of funds being diverted elsewhere. More detail can be found on page 23 overleaf.

Local Authorities: summary of responses

Local Authority		Response type	Extent of support: merger	Extent of support: no change	Key concerns/assurances needed
1	Carlton on Trent Parish Council	Representative	Oppose	Support	Reorganisation would lead to reduced services in Newark and Sherwood; funds could get diverted to deprived areas and denser populations. Limited merger may work, but not all CCGs
2	Notts County Council	Representative	Strongly support	Strongly oppose	Importance of strategic partnerships in aligning priorities with Bassetlaw
3	Notts County Council	Representative	Strongly support	Strongly oppose	No narrative provided
4	Newark and Sherwood District Council	Representative	Support	Neither/nor	How 20% savings affects services; must continue to collaborate at a local level with council and partners; ensure focus on local need – even mid-Nottinghamshire is not considered local enough; Council keen to engage with new CCG on strategic planning of service and infrastructure provision; health services in top 5 most important as rated by residents
5	Nottingham City Council	Representative	Not stated	Oppose	That citizens are not detrimented by a merger, e.g. 'Nottingham pound' identified and accounted for; commissioning to reflect distinct needs of City; specific engagement with Nottingham communities/respond to diversity
6	Mansfield District Council	Individual	Support	Oppose	Need to maintain local focus and allocate resources across communities
7	Nottingham City Council	Individual	Support	Neither/nor	Ensure needs of smaller areas not lost
8	Nottingham City Council	Individual	Neither/nor	Neither/nor	No narrative provided
9	Notts County Council	Individual	Strongly support	Strongly oppose	Shortage of doctors and nurses; need for CCGs and social care to commission together; duplication of services between CCGs, public health, social care
10	Notts County Council	Individual	Neither/nor	Neither/nor	Stability and sustainability – constant re-organisation is costly and affects jobs

Local Authorities: feedback summary

Reasons given behind support for a merger included:

- Supporting NHS long-term plan and mirroring local authority boundaries
- The need to enable equality of provision and access across the whole of Nottinghamshire
- Opportunities for more integrated working
- Becoming more efficient and delivering savings in NHS administration and management costs
- The opportunity for CCGs to reduce duplication, including with social care and the voluntary sector

Reasons for supporting no change revolved around the risk of potential reduction in local services with funding being diverted away to deprived areas or denser populations; also that re-organisation and rebranding is costly and affects jobs

Assurances were requested regarding:

- No impact on patient services as a result of delivering the 20% savings target
- Continuing to collaborate at local level with councils and partners, including in addressing health inequalities
- Commissioning must respond to diversity and needs at a local level with funding for specific areas accounted for
- No shifting in emphasis away from existing area boundaries towards other areas in the County and/or City
- Ensuring sufficient staff to deliver services, including patient engagement and involvement, focus on local needs and addressing the shortage of nurses and doctors
- Not becoming distracted from responsibilities owing to merger activities
- Validity of the consultation given the steps already taken to align CCG arrangements

It was noted that:

- Good practice needs to be standardised across the whole county to improve services (all should be rated as 'Good')
- Various respondents expressed their desire to work with PCN, ICPs and the ICS to ensure equity of provision as well as address local inequalities
- Need to maximise opportunities to improve outcomes as a partnership (and system)
- Narrowing health inequalities is a council priority
- Relationships need to be developed between councils and new clinical and locality directors
- Mid-Nottinghamshire as an area is not considered local enough to address community needs
- Social care and CCGs must commission together; case for joint commissioning and closer integration should be scoped asap
- Duplication should be reduced further by working more closely with social care and public health

ORGANISATIONS AND GROUPS REPRESENTED

Organisations/groups represented (1)

GPs and GP practice Teams (26 responses)

- Abbey Medical Centre*
- Belvoir health group
- BPMC
- Churchside Medical Practice
- Churchside Medical Practice*
- Collingham Medical Centre*
- Derby Road Health centre
- Family Medical Centre
- Family Medical Centre
- Middleton Lodge Practice
- Millview Surgery
- Millview Surgery
- NEMS Platform One Practice
- Nottingham West CCG
- Roundwood Surgery*
- Roundwood Surgery*
- Sherwood Medical Partnership
- Southwell Medical Centre
- St. George's Medical Practice*
- The Forest Practice*
- Torkard Hill Medical Centre
- Victoria & Mapperley Practice*
- Victoria & Mapperley Practice; Nottingham City GP Alliance*
- WBMC
- Woodlands Medical Practice
- Unnamed GP Practice

*** Response submitted on behalf of the group or organisation**

Organisations/groups represented (2)

Patient representative groups (40)

- Belvoir Health Group, PPG x 2
- Bingham PPG
- Blf support groups*
- Carers in Hucknall self help group*
- Castle Healthcare PPG
- Castle PPG
- Deer Park PPG
- Derby Road Health Centre PPG x 2*
- East Leake Medical Practice PPG x 2
- East Midlands PPI Senate
- Forum for Public Involvement
- Gamston Medical Centre PPG*
- Healthwatch Maternity Voices Partnership (MVP)
- Healthwatch Nottingham and Nottinghamshire*
- Millview Surgery PPG x 2
- Nottingham University Hospitals
- Opportunity Nottingham. Expert Citizen Group*
- Orchard Kegworth PPG*
- Patient Cabinet
- POhWER
- Roundwood Patients Group*
- Rushcliffe PPG Cropwell Bishop Practice
- Saxon Cross Surgery
- Southwell PPG
- Southwell PPG*
- St Georges PPG, Healthwatch
- St Luke's practice PPG*
- Versus Arthritis
- West Bridgford Medical Centre x 2
- Whyburn Surgery
- Woodlands Medical Practice PPG
- Unnamed x 4

*** Response submitted on behalf of the group or organisation**

Organisations/groups represented (3)

Voluntary Services (5)

- Ashfield Voluntary Action
- Citizens Advice Broxtowe
- Mansfield Community and Voluntary Service
- Unnamed voluntary group x 2

Other healthcare providers (19)

- East Midlands Ambulance Service*
- East Midlands Ambulance Service
- Nottingham CityCare
- Nottingham University Hospitals NHS Trust x 3
- Nottinghamshire Healthcare NHS Foundation Trust x 6
- Nottinghamshire Healthcare NHS Foundation Trust x 2*
- NHS
- Unnamed (x4)

Nottingham and Nottinghamshire CCGs (staff) (21)

*** Response submitted on behalf of the group or organisation**

Local Authorities (10)

- Carlton on Trent Parish Council*
- Mansfield District Council
- Newark and Sherwood District Council *
- Nottingham City Council x2
- Nottinghamshire County Council x3*
- Nottinghamshire County Council x2

Health Overview Committees (2)

- Nottinghamshire Health Scrutiny Committee
- Nottingham City Council (Chair of Health Scrutiny Committee)*

Other (4)

- BBO – Building Better Opportunities
- Mid-Nottinghamshire Prescribing Group
- NUBS
- Nottinghamshire Safeguarding Children Partnership

Contents

Background

This report responds to the consultation held during May and June 2019 on future Commissioning arrangements across Nottingham and Nottinghamshire. In that consultation two options were proposed: 1) to merge the six CCG organisations and create a single, strategic commissioner; and 2) to make no change, i.e. for the six CCG organisations to stay as they are with no further structural change.

Led by the six CCGs across Nottingham and Nottinghamshire, the consultation attracted a total of 192 responses from stakeholders such as GP members, local authorities, Healthwatch, healthcare providers, local residents and patient groups. The responses to the consultation have been summarised by an independent external consultant and this document should be read alongside that report.

Summary of Consultation Responses

Overall, there was strong support for the proposal with 68% of respondents indicating that they were in favour of the merger to create a single strategic commissioner. In addition, only 16% of respondents were in favour of there being no change to the current commissioning arrangements. This is therefore a clear and strong indication of support for the proposal.

Reasons for Supporting the Proposal

Within the strong indication of support for the proposed merger to create a single strategic commissioner, a number of common themes underpinning that support emerged. The top five themes were;

1. Efficiency – respondents were attracted to the potential in the new organisation to reduce duplication and improve efficiencies with a more coordinated approach. The removal of the need to run six separate statutory organisations with associated administrative burden was also part of this strong positive feedback.
2. Financial – it was clear from many responses that interested parties saw the proposed merger and creation of a strategic commissioner as a way to unlock cost savings and other financial efficiencies.
3. Consistency – given the population size of the proposed single commissioning organisation, respondents felt that the proposed merged organisation was strongly positioned to standardise and ensure consistency of patient access across the whole of Nottingham and Nottinghamshire.
4. Collaboration – similarly, a single organisation was seen to be ideally positioned to act as a strong, collaborative partner with the Integrated Care System and other system partners. This feedback included the ability to more easily share clinical information where appropriate.
5. Front Line – finally in these top themes, respondents were attracted to the idea that a single merged organisation would be able to more strongly direct clinical resources to the front line to more directly serve patients.

<u>Supporting Actions</u>

These strong indications of support from respondents to the consultation give confidence that the merger is the right approach to take. However in order to deliver on the underlying rationale that respondents used to indicate their support for the proposed merger, the following supporting actions are proposed to be put in place. It should be noted that these actions are already part of the merger programme plan and benefits realisation plan which can be viewed as part of the merger application process.

- Complete the CCG staff restructure to deliver an integrated and streamlined management approach to the work of the merged organisation and also unlock the savings represented by removing back-office duplication.
- Roll out a complete Organisational Design process including an enhanced employee benefit offer, a leadership development programme, refreshed vision and values – all to support the alignment of the single CCG's staff to a clear set of strategic priorities and operating model.

- Reap the benefits of the merged organisation by streamlining the financial reporting required and the controls in place – unlocking internal resource to focus on financial support to strategic commissioning and reducing external costs on (eg) Audit.
- Along with the considerable reduction in leadership and management time attending duplicated governance meetings, the creation of a single strategic commissioner will enable a stronger voice for commissioning in system level conversations with other ICS partners. This opportunity must be grasped.
- There is already a proposed approach to clinical involvement at all levels within the Nottingham and Nottinghamshire system – ensuring the voice of General Practice is heard through commissioning decisions. This proposal will need to be taken forward, including ensuring that the potential for reduction in the burden on clinical time is unlocked.

Concerns Expressed by Respondents

Whilst there was an overwhelming level of support for the merger, there were also, within the limited number of respondents not supportive of the proposal, a number of concerns that will need to be addressed. These concerns have been grouped into five overall themes;

1. Local Focus – risk of losing i) focus on specific needs of localities and populations ii) patient and clinical engagement iii) local expertise and knowledge of local population needs. The local voice of patients and groups could be marginalised and the ability to address health inequalities could be affected as a result.
2. Information – respondents said they needed more information before being able to give their opinions on a merger and/or noting the unknowns relating to emergent NHS arrangements, i.e. ICS, ICPs and PCNs. Some respondents ask for evidence to support proposals and/or clarity on how the 20% cost savings will be achieved.
3. Loss of Services – risk of potential loss of local services, particularly in rural areas, with funding diverted to support more deprived areas and other populations elsewhere.
4. Size – a single organisation could be too large and unwieldy, with less accountability to local populations. It could also be harder to engage with, including geographically.
5. Satisfied – respondents are happy with present arrangements and do not wish to see any change.

It should be noted that only concerns expressed by more than five (5) respondents are included in the above themes – so other concerns expressed had very limited currency amongst the respondents.

<u>Mitigating Actions</u>

Despite the overall strong level of support for the proposed merger, the minority views against the merger represent important feedback that needs to be considered carefully. The following mitigating actions are proposed against each of the five themes.

Local Focus

i. As a single commissioning organisation we would ensure that we are able to work more consistently and make our resources go further while delivering fair and equitable outcomes for patients, however this would not be at the cost of addressing local healthcare priorities. The new system architecture which incorporates Primary Care Networks at a locality level, and Integrated Care Providers at a Place levels, and our approach to clinical leadership and engagement being embedded at every footprint of the system architecture will ensure effective connection and balance in our approach to specific and local focus on needs, and active engagement in commissioning decisions. We would also look to prioritise and ring- fence certain resources in accordance with specific locality and population needs.

ii. Ensuring ongoing clinical leadership and involvement in commissioning activities remains an absolute priority for us. Clinical time is valuable, and with a national shortage of clinicians to provide patient care it is essential that clinical resources are used wisely. Our proposals aim to free-up clinicians to support the development and delivery of care services, instead of being tied up in CCG administration or duplicated activity. The

existing Clinical Directors for the CCGs have worked together to agree a set of proposals for how clinicians will be at the heart of the future proposed arrangements. These include the following elements;

a. Clinicians will have key roles to play in Primary Care Networks and Integrated Care Providers. Working at neighbourhood and wider 'place' levels, these new networks and alliances will assume responsibility from the existing CCGs for the development of pathways and many other clinically-led initiatives. At a local level, clinicians will therefore be able to have the greatest impact on improving the quality of care and services for the populations they serve.
b. Regardless of what our future organisational arrangements look like, we remain committed to engaging and involving our key stakeholders in our commissioning activities.
c. As happens now, the Governing Body of a single CCG would include patient representatives (lay members) and clinical leads including a GP Clinical Chair, other GPs, a nurse and a secondary care doctor. We would also continue to strengthen and build upon our arrangements for involving and engaging local people, clinicians, CCG staff, partners and others in our everyday activity, which include patient participation groups, patient and public engagement committees, lay member representation and other events and activities.

iii. Primary Care Networks will bring together local expertise from across the system and the community to work on understanding local population needs. PCNs will be fundamental in ensuring that individual places health care needs are understood and met through appropriate methods for that community. PCNs are under development and it is now a good time to get involved. To find out more about PCNs visit: https://www.england.nhs.uk/wp- content/uploads/2019/06/designing-integrated-care-systems-in-england.pdf

Information

i. It is right that much of the work going on across England to create Integrated Care Systems (and Strategic Commissioning organisations as part of that) is being developed as it is being delivered. This ambiguity is one of the challenges that system leaders in Nottingham and Nottinghamshire are having to deal with as one of the first wave 'accelerator' systems.

ii. Through national publications such as the NHS Long Term Plan (January 2019), the Implementation Framework for the Long Term Plan (June 2019) and the various supporting documents, including the document referenced in the above section, more and more clarity is emerging on the future commissioning arrangements for England. We will continue to ensure that patients and members of the public are keep informed about these changes, including through the new Patient and Public Engagement Committees that are included in the "merger-ready" governance structure already in place. Keeping the public informed about these national changes and ensuring that they are able to be involved in their development is a critical activity for the proposed merged organisation – details of this can be seen in the Communications and Engagement Strategy which will be available as part of the merger application process.

iii. Collectively, all six CCGs have developed plans to reduce expenditure in accordance with the nationally mandated 20% reduction in management costs by 2020/21. This is the CCG contribution to the overall £700m national administrative savings requirement for commissioners and providers by 2023/24. To ensure that full, recurrent savings can be made from the beginning of 2020/21, CCGs are asked to ensure that they are planning for and taking actions to achieve these reductions during 2019/20. One of the benefits of working on a larger scale is that we have more control where the money goes. By taking away perverse incentives in healthcare we will save millions across Nottingham and Nottinghamshire. But at the same time we need to cut our CCG operating costs by 20%.

iv. The CCGs running costs allowance will reduce by £2.4m to £19.7m by 2021.The largest element of running costs is pay to staff, clinicians and independent lay members. This element accounts for 80% of the total running cost spend. The other 20% covers everything else and includes estate costs, IMT, corporate costs such as audit fees, legal and professional services, stationery and office costs.

v. Delivery against this running cost reduction requirement will be delivered through reduction of duplication, reduced workforce costs and driving efficiency through reduction of non-pay running costs. More detailed information will be available by October 2019 when the impacts of plans are known. This efficiency will not be delivered through reduction in clinical commissioning spend.

vi. How and on what the CCGs spend money on will continue to subject to scrutiny from various parties. We will still be clinically led by our GPs and the new Governing Body and will continue to have Lay Members. Regulators will need to be assured that our plans continue to address the needs of all our patients, across the previous CCG areas. Our independent auditors scrutinise the CCG and give a public assessment as to the how we operate against “value for money” criteria.

Loss of Services

i. The new Primary Care Networks and Integrated Care Providers will take on our existing responsibility to develop personalised care services which meet the needs at neighbourhood level. The work of the PCNs will directly inform the commissioning plans and activities of the CCG.

ii. The new arrangements of the one single CCG taking strategic decisions across the whole area and smaller PCNs at local level will directly lend themselves to having an even closer local focus, whilst at the same time enabling more effective commissioning of services across the entire geography.

iii. By supporting and working with these networks we have an opportunity to strengthen our existing approach to commissioning for specific populations and communities across Nottingham and Nottinghamshire.

iv. As a single clinical commissioning group our duty to promote the involvement of patients and carers in decisions which relate to their care or treatment would remain. As one CCG we would still be required to ensure that we work with our stakeholders and involve people in any service change. As we potentially move into one organisation we would retain the two locality based Patient and Public Engagement Committees.

v. Our commissioning plans are scrutinised by regulators and our partners in Health Scrutiny Committees at the local councils to ensure they are aligned to areas of priority and need.

Size

i. There are pros and cons to whatever size organisation we choose. We believe the proposed merged CCG will provide the advantages of scale with a focus on local relationships working to population needs.

ii. We believe if we stay as we are, we would not be maximising our opportunity to commission healthcare services that ensure the best possible health and wellbeing for the population we serve. We would be using public money to fund avoidable duplication of administrative services, tying up clinical time that could be freed up to focus on front-line services and healthcare improvements.

iii. At the same time as merging into one strategic commissioning organisation we are also breaking down the organisation into smaller neighbourhood units with the introduction of Primary Care Networks and ICPs. This will offer the best of both worlds.

iv. As outlined in the Communications and Engagement Strategy for the proposed merged organisation, there will be a variety of ways for patients and the public to get involved in the shaping of health services – including both commissioning and system transformation activities – at all levels of the population from their local GP practice's Patient Participation Group up to the 1m+ Nottingham and Nottinghamshire level – and all stages in-between.

Satisfied

i. Whilst the current commissioning arrangements have served the people of Nottingham and Nottinghamshire well since 2013, the political and external context for the NHS in England has changed significantly since then. The NHS Long Term Plan sets clear expectations for the next generation of commissioning organisations. These include typically having a single commissioner within each healthcare system and one set of commissioning decisions. Staying as we are would not directly align with the national direction for the NHS.

ii. In order to maximise the voice of strategic commissioning within the Nottingham and Nottinghamshire ICS, there needs to be one single commissioning organisation operating on a system-wide basis, with more tactical commissioning activities taking place at the ICP (Place) and PCN (Neighbourhood) levels.

iii. Furthermore, whilst we have made some financial savings by implementing joint arrangements across our CCGs, given the reductions in management cost budget allocations, we need to find ways to unlock further savings. Each current CCG is a separate legal entity and it costs significantly more to service all six organisations than it would a single body. If we continue to run multiple CCGs the costs incurred on back-office activities will be much higher than having one streamlined organisation.

Summary and Recommendation

It is clear that the overwhelming majority of respondents to the stakeholder consultation are in favour of the proposed merger of the six CCGs in Nottingham and Nottinghamshire to create a single, strategic commissioner operating across the whole system.

However, this was not a unanimous position and so it is important that the minority views of respondents are carefully considered and taken into account going forward.

The five themes identified and the mitigating actions laid out above are important considerations as system leaders and the CCG's management team consider the next steps with the proposed merger. It is recommended that the proposed supporting and mitigating actions are carefully tracked throughout the next stages of the merger application process and any implementation activities.