Agenda pack

North West London Joint Health Overview and Scrutiny Committee

Monday 7 September 2020 at 11.00 am

Online Virtual Meeting
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London Borough of Hammersmith & Fulham

North West London Joint Health Overview & Scrutiny Committee

Agenda

Monday 7 September 2020
11.00 am
Online - Virtual Meeting

MEMBERSHIP

Chairman: Councillor Mel Collins (LB Hounslow)
Vice Chairman: Councillor Daniel Crawford (LB Ealing)

Councillor Cllr Iain Bott (Westminster City Council)
Councillor Cllr Marwan Elnaghi (Royal Borough Kensington & Chelsea)
Councillor Lucy Richardson (LB Hammersmith & Fulham)
Councillor Rekah Shah (LB Harrow)
Councillor Ketan Sheth (LB Brent)

CONTACT OFFICER: Bathsheba Mall
Committee Co-ordinator
Governance & Scrutiny
☎: 020 8753 5758 / 07776672816
E-mail: bathsheba.mall@lbhf.gov.uk

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Date Issued: 28 August 2020

London Borough of Hammersmith & Fulham

North West London Joint Health Overview & Scrutiny Committee

Agenda

7 September 2020

Item **Pages**

1. WELCOME AND INTRODUCTIONS

2. APPOINTMENT OF CHAIR AND VICE-CHAIR 2020/21

3. APOLOGIES FOR ABSENCE

4. DECLARATIONS OF INTEREST

If a Councillor has a disclosable pecuniary interest in a particular item, whether or not it is entered in the Authority's register of interests, or any other significant interest which they consider should be declared in the public interest, they should declare the existence and, unless it is a sensitive interest as defined in the Member Code of Conduct, the nature of the interest at the commencement of the consideration of that item or as soon as it becomes apparent.

At meetings where members of the public are allowed to be in attendance and speak, any Councillor with a disclosable pecuniary interest or other significant interest may also make representations, give evidence or answer questions about the matter. The Councillor must then withdraw immediately from the meeting before the matter is discussed and any vote taken.

Where Members of the public are not allowed to be in attendance and speak, then the Councillor with a disclosable pecuniary interest should withdraw from the meeting whilst the matter is under consideration.
Councillors who have declared other significant interests should also withdraw from the meeting if they consider their continued participation in the matter would not be reasonable in the circumstances and may give rise to a perception of a conflict of interest.

Councillors are not obliged to withdraw from the meeting where a dispensation to that effect has been obtained from the Audit, Pensions and Standards Committee.

5. MINUTES OF THE PREVIOUS MEETING 4 - 14

(a) To approve as an accurate record and the Chair to sign the minutes of the meeting of the Joint Health Overview Scrutiny Committee held on 9 March 2020;

(b) To approve as an accurate record and the Chair to sign the deferred minutes of the Joint Health Overview and Scrutiny Committee held on 27 January 2020; and

(c) To note the outstanding actions and matters arising.

6. NWL COLLABORATIVE: THE CASE FOR CHANGE FOR A SINGLE CCG - AUGUST 2020 15 - 28

This report sets out the latest published iteration of the North West London Collaboration of Clinical Commissioning Groups Case for Change released in August 2020. The report sets out details about the proposed merger plans and expected outcomes.

7. WORK PROGRAMME

For the Committee to consider future items and on-going work programme.

8. ANY OTHER BUSINESS

9. DATE OF NEXT MEETING

Thursday, 8 October 2020

NORTH WEST LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Minutes of the meeting held on Monday, 9 March 2020.

PRESENT: Councillor Mel Collins (Chair), Councillor Daniel Crawford (Vice-Chair), Councillor Monica Saunders and Councillor Ketan Sheth

11. WELCOME AND INTRODUCTIONS

The Chair invited Councillor Saunders as the representative member of the host borough to welcome members and officers to the meeting.

12. APOLOGIES FOR ABSENCE

Apologies were received from

- Councillor Richardson (London Borough of Hammersmith and Fulham)
- Councillor Shah (London Borough of Harrow)
- Councillor Freeman (Royal Borough of Kensington and Chelsea)
- Councillor Michael Borio (London Borough of Harrow)

It was noted that City of Westminster did not currently have a JHOSC member.

13. DECLARATIONS OF INTEREST

Councillor Sheth (London Borough of Brent) declared that he was the Lead Governor at Central & North West London NHS Foundation Trust (CNWL).

14. MINUTES OF THE LAST MEETING AND MATTERS ARISING

The meeting was not quorate so the minutes of the meeting on Monday 27 January were deferred for consideration at the next JHOSC meeting.

The Chair went through the matters arising.

The briefing on palliative care was appended to the minutes.

The health inequality assessment on palliative care was available.

The NHS Estates Strategy would be considered as part of the work programming for the forthcoming municipal year.

15. PATIENT TRANSPORT

The Director of Delivery and Performance presented the report.

The move towards a single CCG had enabled a more holistic approach to be taken. The patient transport programme would look to improve the service offer through standardisation across North West London. Key Performance Indicators (KPI)s had been established to understand the patient experience of the service. They had been collected for 18 months. There had been improvements across all the domains and had met the requirements of the Care Quality Commission (CQC).

Patients would be eligible for the service based on an equitable assessment of their needs. There was an assessment process and an appeals process. There had been few registered complaints. Patients can eat on the transport and can being food with them. If a patient was not eligible for the patient transport service they would be offered information on public transport provision.

Drivers were not aware of patient specific information such as dietary requirements due to confidentiality. Patients can make the driver aware of any concerns.

Whether patients would take a companion to their appointment would depend on the appropriate site. There are patient transport lounges where porters would collect the patient and take them to their appointment.

An Equalities Impact Assessment had been undertaken on the new assessment criteria to ensure that no groups with protected characteristics were being excluded.

Work had been undertaken with GPs so that they knew the system.

Patients were assessed on financial need. 5% of patients would lose out from the proposals.

Patients would be assessed once for their eligibility if they had a long-term condition. Those with conditions in which their symptoms could be variable would not be reassessed.

Being home before lunch of out of hospital in the morning was not a transport target. This would be a clinical decision.

There were different providers across North West London. Their service was commissioned by the host hospital. There were agreed standards and clear KPIs to ensure that standards were being met. If there was a problem with a provider this would be investigated by the Trust.

Members of patient panels were involved in the commissioning and quality assurance of the service.

There was not the capacity to commission a provider across North West London, hence commissioning was done at a more local level.

Healthwatch said that there were concerns about patient transport. Officers said there had been improvements since the beginning of the year. The patient experience was used to hold the service to account. Trusts also undertake patient surveys. PALS had not noted a rise in complaints relating

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to patient transport.

It was noted that in outer London public transport tended to be not as good as in inner London.

It was agreed that a further paper on patient transport should be brought to the JHOSC in the new municipal year. This should include the following information

- A list of providers and on-going contracts
- Engagement including with harder to reach groups
- Bedding in period
- Information on what is communicated to Heathwatch.
- Healthwatch patient experience information

ACTION: Although the meeting was not quorate, the report was noted by those members present subject to the action point discussed.

16. PATIENT AND PUBLIC ENGAGEMENT REFRESH (INCLUDING CITIZENS' PANEL AND EPIC)

The Director of Communications and Engagement presented the report.

The NHS in North West London had launched a new patient engagement programme known as the EPIC programme (Engage Participate Involve Collaborate) ahead of the development of an Integrated Care System (ICS) and a single CCG. It would be undertaken in collaboration with Healthwatch.

There would be a co-production approach with patients. This would investigate what had gone well and not so well. It would be a 12 – 15 month programme. Engagement would be with as many residents as possible. It would include a citizens' panel. It would look to engage with many different groups of residents. There was an engagement event scheduled for April 1 and 80-90 attendees were expected.

The role of Healthwatch would be to challenge the CCG. It would also ensure that there was wider engagement with groups such as young Health watch and Black and Minority Ethnic forums. There would also be engagement with the Youth Council and Youth Parliament.

It was noted that North West London was a diverse region and that getting representation from all sections of the community could be difficult. Best practice methods from other local authorities on engaging with the wider community would be used. The JHOSC wanted to ensure that harder to reach communities were engaged with and there was demographic representation of its communities. The engagement of residents with protected characteristics would be analysed through a gap analysis, and in particular, patients with disabilities should be considered.

Questions would be asked on the patient experience and would be a standardised set of questions.

Each borough had local engagement staff. This would be brought together. It can be difficult to engage with residents whose primary language is not English. Engagement would try and ensure that those who had not previously been involved would be reached. Consultees would also be recruited by an external company.

Patient experiences would be collated. The Health and Wellbeing Boards of the participant local authorities would play a wider governance role in the programme.

ACTION: Although the meeting was not quorate, the report was noted by those members present subject to the action point discussed.

17. DEMONSTRATION OF WHOLE SYSTEMS INTEGRATED CARE DASHBOARD

The Chair of Brent CCG and Deputy Director of Business Intelligence and Data Management presented the report.

A suite of dashboards had been built to understand the patient population in North West London. There would be a focus on long term conditions. It would enable medical practitioners to be proactive rather than reactive and enable quicker integration.

There would be anonymised datasets that would enable better communication and information sharing and reduce duplication. The dashboards would enable improvement of the health and wellbeing of the general population and reduce attendance at Accident & Emergency. A co-ordinated action plan would look at the drivers of ill health and would be used as a tool to plan around local populations.

The dashboard would also enable Public Health teams in all the boroughs to look at variations in health outcomes amongst their respective population and address them.

There would be joint work with Public Health teams on areas such as air pollution. There would be analysis of where the major hotspots were, and measures implemented to look to address the issue.

ACTION: Although the meeting was not quorate, the report was noted by those members present.

18. WORK PLANNING PROGRAMME AND ANNUAL REVIEW

A work planning meeting would take place before the next municipal year. Patient transport would be revisited as part of the work programme for the forthcoming year.

The answers to the questions sent in from Councillor Richardson would be appended to the minutes.

19. ANY OTHER BUSINESS

The Chair said that as it was the end of the municipal year he would like to thank members and officers. Thanks were extended to members of the public who had sent in written questions and engaged with the Chair.

The Chair and vice-Chair also passed on their thanks to the Accountable Officer Mr Easton and gave him their best wishes. Mr Easton thanked the members of JHOSC for their contributions during his time in the post.

Vice-Chair thanked the Chair for another year of his service to the JHOSC.

20. NEXT MEETING

To be confirmed.

21. CLOSE

The Chair closed the meeting.

CHAIRMAN

The meeting, which started at 2.08pm, ended at 4.06pm.

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Joint Health Overview & Scrutiny Committee

Draft Minutes

Monday 27 January 2020
(at The Town Hall, RB Kensington & Chelsea)

PRESENT

Members Present:

Councillor Mel Collins (Chair)	London Borough of Hounslow
Councillor Daniel Crawford	London Borough of Ealing
Councillor Robert Freeman	Royal Borough of Kensington & Chelsea
Councillor Jim Glen	City of Westminster
Councillor Lucy Richardson	London Borough of Hammersmith & Fulham
Councillor Rekah Shah	London Borough of Harrow
Councillor Ketan Sheth	London Borough of Brent

NHS Representatives Present:
Juliet Brown, Health and Care Partnership Director
Dr James Cavanagh, Chair of Hammersmith & Fulham CCG
David Cox, Strategic Estates Consultant
Janet Cree, Managing Director, Hammersmith & Fulham CCG
Mark Easton, Accountable Officer, North West London Collaborative of CCGs
Rory Hegarty, Director of Communications and Engagement, North West London Collaborative of CCGs

1. WELCOME AND INTRODUCTIONS

1.1 Councillor Robert Freeman, as the representative member of the host borough, RB Kensington & Chelsea, welcomed members and officers to the meeting.

1.2 Prior to attending to the business of the JHOSC Councillor Mel Collins (LB Hounslow) stated that he had attended the Public Meeting on Palliative Care hosted by RB Kensington & Chelsea on 20 January. He thought that Councillor Freeman had made a fine job of chairing this meeting under difficult circumstances.

2. APOLOGIES FOR ABSENCE

2.1 Received from Councillor Monica Saunders (LB Richmond) and Councillor Lorraine Dean (City of Westminster). Councillor Jim Glen was attending as substitute for Councillor Dean.

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3. DECLARATIONS OF INTEREST

3.1 Councillor Robert Freeman (RB Kensington & Chelsea) declared he was a member of the Council of Governors of the Royal Marsden Hospital. Councillor Ketan Sheth (LB Brent) declared that he was the Lead Governor at Central & North West London NHS Foundation Trust (CNWL).

4. MINUTES OF THE PREVIOUS MEETINGS

4.1 The minutes of the 22 July 2019 meeting were agreed.

4.2 The minutes of the 30 October 2019 meeting were agreed. The following matters were noted: -

1. There was one outstanding matter (Minute 4.2 (Minutes of the Previous Meeting) point 4) – that the results of health inequality assessments carried out by the CCGs would be circulated to Members of the JHOSC as soon as they were available.

2. On Minute 5 (North West London Financial Recovery), it had been decided after discussion with Councillor Collins that it was not necessary for the CCGs to produce a map identifying QIPP (quality, innovation, productivity, and prevention) savings. The information was already regularly published.

3. On Minute 6 (NHS Long-Term Plan Submission) it was noted that the full response from North West London on Preventing Eating Disorders had been circulated.

ACTIONS:

- Circulation of the health inequality assessments by the CCGs (number 1. above).

5. UPDATE ON LONG-TERM PLAN

5.1 Juliet Brown introduced the paper that had been circulated electronically with the agenda - North West London's draft response to the NHS Long-term Plan. Over the coming months, this paper would be taken through Health and Wellbeing Boards and a number of other bodies. This was a genuinely exciting opportunity she added and notified a major workshop taking place on 19 February.

5.2 Mark Easton added that a White Paper on Health was expected. The legislation under which the health service currently operated was becoming unwieldy.

5.3 Mark Easton then referred to the ongoing arrangements leading up to merger of the CCGs in 2021. It was believed that there was scope for pooling certain functions and reducing management costs. There had been an engagement

process in respect of clusters of local councils. Consultation with staff was about to commence.

5.4 Councillor Ketan Sheth (LB Harrow) questioned Juliet Brown about the specific plans for Harrow contained in the response. She responded that the long-term plan would enable locally flexible schemes, for instance, she would shortly be meeting with Dr Melanie Smith, Director of Public Health (LB Brent) to consider innovative responses to diabetes.

5.5 In response to a question from Councillor Daniel Crawford (LB Ealing) Dr James Cavanagh stated that the aim was to keep people better for longer. People were coming together to produce more integrated and innovative services. In North West London we were responding to the long-term plan and there could be seen the early stages of recovery. Mark Easton added that exhortation to the public did not work well; within the long-term plan there was considerable scope for local innovation and the sharing of best practice.

6. BABYLON GP AT HAND AND ANY POTENTIAL IMPACT ON NW LONDON

6.1 Dr James Cavanagh (Chair of Hammersmith & Fulham CCG) together with Janet Cree (Managing Director, Hammersmith & Fulham CCG) gave a brief overview of the Babylon GP at Hand scheme. This digital first practice (originally offering services to patients within LB Hammersmith & Fulham but now with patients registered across many locations) had seen exceptional growth in its practice list size over the last two years. This was a popular service for the public offering increased ease of access. In addition, it was popular with staff, offering a better work life balance. The scheme had extended to Birmingham.

6.2 In response to a number of detailed financial questions from Councillor Lucy Richardson (LB Hammersmith & Fulham) Ms Cree sought to assure her that there would be full cost mitigation for the current year. The full costs for 2019/20 were expected to be £24 million; £17.4 million had already been received. This was an ongoing situation but there was not expected to be any deficit in 2019/20. Mark Easton confirmed that there was a historical deficit in place.

6.3 Councillor Collins asked about Babylon's accountability. Dr Cavanagh responded that the CQC had inspected Babylon and rated it Good. A Patients' Panel was in existence. Councillor Crawford added his concern about the administrative and financial implications on this CCG.

6.4 Dr Cavanagh sought to restate that this scheme offered better access to GP services and should be encouraged. There would be a long-term beneficial impact he believed and the financial effects were being mitigated.

6.5 Councillor Sheth asked about quality assurance and was assured by Ms Cree that an additional quality assurance process had been added. Currently the system operated under General Medical Services (GMS) contracts. This was changing to Alternative Provider Medical Services (APMS) contracts.

7. NHS ESTATES STRATEGY FOR NORTH WEST LONDON

7.1 David Cox (Strategic Estates Consultant) introduced the report. The condition of the estate across NHS North West London was varied with some buildings being very aged. Overall, we were currently in a process of reflection and review. Under the HIP bids North West London had applied for funding to improve the estates at Imperial (St Mary's, Hammersmith, and Charing Cross) and Hillingdon Hospitals.

7.2 Councillor Jim Glen (City of Westminster) asked for more details about the replacement structure likely at St Mary's. Beyond saying that it would be a steel frame, Mr Cox could not add any further details at present.

7.3 Councillor Richardson was interested in seeing a breakdown of the maintenance backlog and was referred by Mark Easton to the Education Resources Information Centre (ERIC) Database accessible online. Councillor Richardson also asked about hubs and it was agreed that Mark Easton would provide a current listing of the hubs across North West London and their state of development. He reminded that Hubs were not something new, they were part of an aim to renew primary care estate across North West London and many of them were overdue.

7.4 The Committee noted that Integrated Delivery Plans were borough specific and could be obtained from their authority's planning department. Mr Cox also added the important contextual point about the importance of housing and homes and the Greater London Authority's requirement to build more homes.

7.5 Councillor Sheth asked about Northwick Park, which Mr Cox confirmed was part of the Outer North West London Estate Plan.

ACTIONS:

- To provide the Committee with further information regarding the hubs and their state of development.

8. WORK PLANNING PROGRAMME

8.1 Councillor Collins informed the meeting that the work plan for the last meeting of the current year had been reviewed prior to this meeting.

9. ANY OTHER BUSINESS

9.1 Questions concerning Palliative Care – Cllr Collins reported that he had received a number of questions from members of the public concerning Pembridge Hospice. The response from the CCGs received to these questions **would be appended to these minutes.**

9.2 Participation of LB Hillingdon – Cllr Collins reported vigorous efforts had been made to try to get Hillingdon to join and participate in this JHOSC but without success.

9.3 JHOSC Meeting Agenda Planning Arrangements – Cllr Collins suggested, and Mark Easton agreed, that these needed to be improved for subsequent meetings.

9.4 It was noted (from a member of the public present) that there was a meeting of the North Central London JHOSC on 31 January (at 10am at Haringey Civic Centre). This meeting would consider the proposed move of Moorfields Eye Hospital. Individual boroughs had been notified of this matter. (Councillor Collins declared that he was a long-term user of this facility).

ACTIONS:

- Palliative care responses to be appended to these minutes.
- Agenda Planning Arrangements to be improved.

10. NEXT MEETING

9 March 2020 at LB Richmond upon Thames.

Meeting started: 3pm
Meeting ended: 5.05pm

Chair .....

Contact officer: Gareth Ebenezer
Governance Administrator, RB Kensington & Chelsea

The case for change for a single NW London CCG – August 2020

NHS NW London Collaboration of CCGs

Why are we proposing merger of the eight CCGs?

Vision for NW London: Start well, live well, age well

Our vision for NW London Integrated Care System (ICS) is to reduce inequalities and achieve health outcomes on a par with the best global cities.

Care will be integrated within a single system, focused on the needs of the individual and unhindered by organisational boundaries.

We will combine our collective resources, clinical expertise and local knowledge to build a fair, effective and accessible health service for all.

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Key messages (single CCG)

To achieve our vision we need to have one organisation buying and commissioning services for all in NW London – this means moving to a single CCG.

A single CCG will allow us to:

1. Reduce duplication in ways of working, allowing more time and money to be put into patient services
2. Work more effectively with both NHS and local authority service providers to improve patient wellbeing and care, with improved quality and consistency of local health and care services
3. React quickly and consistently to the continuing pandemic and recovery.
4. Support delivery of the ICS vision.

In 2019 we engaged with our stakeholders on the creation of a single CCG. We want to offer further opportunity for you to comment and inform our proposals

- We are working in a **national context where areas will work as a single ICS** (Integrated Care System) setting the strategy for health and wellbeing and agreeing consistent health outcomes on behalf of our residents.
- **Each ICS is expected to have a single CCG**
- The NHS is **moving away from a commissioning/provider split** – ICSs will be partnerships between the NHS and local authorities
- **The 8 CCGs in NWLondon agreed in September 2019, that a single CCG was the right direction of travel.** It was also agreed that 20/21 would be a transitional year focused on financial recovery, developing a single CCG operating model and working through financial implications.
- Circumstances have meant that the NHS has changed rapidly since September 2019. NW London has been one of the hardest hit parts of the country in the Covid-19 pandemic and through the crisis our system and constituent boroughs have clearly demonstrated the benefits of **strong borough based partnerships delivering care to their local populations** and **working as a system to a common framework and set of standards**.
- As we continue to work towards becoming a single CCG we want to **build on previous experience and conversations**, taking our learning and experience of working across health and local government in recent months to deliver services for our residents.

Background to change/why change

Merging to create opportunity
All eight CCG Governing Bodies agreed in September 2019, that a single CCG was the right direction of travel. It was also agreed that 20/21 would be a transitional year focused on financial recovery, developing a single CCG operating model and working with providers to develop systems.

Duplication ties up resources
We have made some savings by implementing joint arrangements across our CCGs. However, each CCG is a separate legal entity and it costs significantly more to service all eight organisations than it would a single body. **Each borough will continue to have its own team to ensure the right services for local needs**

The NHS has changed rapidly around us
A lot has happened since the CCGs agreed to move to a single CCG in April 2021, with the response to the COVID19 pandemic in March 2020. NW London was one of the hardest hit parts of the country. As a result, we have worked effectively as a single CCG with the NW London system to respond to the pandemic. **We now need to build on this joint approach – wherever possible decisions about care delivery should be taken at borough or local level**

NHS Long Term Plan
The NHS Long Term Plan and the London region sets clear expectations for the a single CCG for each ICS. Both the ICS and single CCG are expected to be in place from April 2021.

Optimum balance of strategic planning NW London wide with strong clinical input and integrated care delivery at borough level
One single CCG taking strategic decisions across the whole area and smaller PCNs at local level would directly lend themselves to having an even closer local focus, whilst at the same time enabling more effective commissioning of services.

Our commitments to NW London

As part of merging the eight CCGs we are making the following six commitments:

1. Move resources across NW London and within boroughs to reduce inequalities over the next four years; we will honour commitments made on transitional periods for PMS funding at borough level

2. Increase our proportion of investment in out of hospital services, as a first step we will level up investment in primary care services outside the core contracts

3. Ensure consistency in services across NW London

4. Ensure equity of access to services, to enable our providers to improve outcomes for patients and reduce health inequalities

5. Patients and GP member practices will continue to be involved in the single CCG and at local level

6. We will devolve decision making on delivery and integration of services to neighbourhood and borough level as our integrated care partnerships develop.

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Each local area will maintain a borough committee

- In each local area the Health and Wellbeing Board, Integrated Care Partnership and CCG Borough Committee will work together to ensure effective place-based care
- Collectively they will inform and be informed by the Single CCG and the ICS.
- The role of the CCG borough committee will be to:
  - Exercise CCG responsibility for joint commissioning with local authorities
  - Feedback between borough practices, patient groups, local authorities and the single CCG on all commissioned services
  - Local intelligence on borough health needs assessment, linking to Health and Wellbeing Board and single CCG
  - Local delivery of integrated care pathways crossing from hospital to primary care
- Membership of the CCG borough Committee is proposed to be:
  - Borough GP member on the single CCG
  - 3 borough member practice representatives (eg GP, nurse)
  - Lay partner
  - Local Authority/DPH - representation to be determined in agreement with local authority
  - Healthwatch
  - CCG team representatives

Proposed membership of the Single CCG governing

Proposed membership:

- The Chair
- 8 GPs (1 from each borough)
- 1 independent chair (from above group of GPs, with that borough nominating an additional member to ensure borough representation)
- 1 Sessional GP
- The Accountable Officer
- The Chief Finance Officer
- Secondary Care Specialist;
- A registered nurse (Chief nurse)
- Five Lay Members
- Director of Public Health representative for the 8 local authorities (non-voting)
- A Practice Nurse and Practice Manager from NWL (non-voting).

Involving local residents in the work of the single CCG

- A best practice approach to patient and public involvement is central to our approach.
- We are already working with Healthwatch and local people to develop proposals for how this will work in practice.
- The single CCG will retain a strong local presence, including responsibility to work with local people and stakeholders, to listen to their feedback and to involve them in shaping services.
- Our aim is to enhance patient and public involvement and engagement in the new system, ensuring the patient and resident voice is consistently heard and listened to.
- This is being taken forward through our EPIC (Engage-Participate-Involve-Collaborate) programme in partnership with Healthwatch.
- The borough committee will include patient representation.

Single CCG financial principles are in development; a draft financial strategy will be developed in the Autumn

- In recognition of health inequalities across NW London, we will make substantial progress towards fair share allocations based on population need in the next 5 years, faster than national timetable. Based on a draft working example, this would mean two borough allocations would reduce*.
- We will also consider how best to address inequalities in boroughs within the borough allocation
- We will increase the proportion of CCG allocation in out of hospital care, while recognising that we have a CCG deficit of £100m and system deficit of £230m.
- We will level up additional primary care services across NWL over the next 5 years, so consistent services are offered to patients. We will look at core primary care commissioned services over the next few months so we can develop plans for levelling up primary care provision across NWL over time. GMS and PMS funding is ring fenced at borough level.
- In enacting these principles, we will ensure that we have addressed any cross subsidies where one borough is contributing to costs for service in another borough and specific population characteristics for example, homelessness is considered that may not be sufficiently covered in the national formula.

* Westminster and Kensington and Chelsea

Borough based partnerships for the provision of care are a key building block for the ICS

- This requires a strong **partnership of providers at borough level** for implementation and delivery
- Needs to be **co-designed by Local Authority and health leaders**
- **We have collectively agreed across health and local authorities that in the interim - for each borough we will 3 NHS leads** – primary care, community care and mental health.
- One of these leads will assume overall responsibility as **Out of Hospital Director**
- The Out of Hospital Director will:
  - Have **local understanding** and knowledge
  - Build strong **local relationships**
  - Work jointly with the Local Authority lead to develop integrated care provision for local residents
- A lead for acute services will also link in with the borough team

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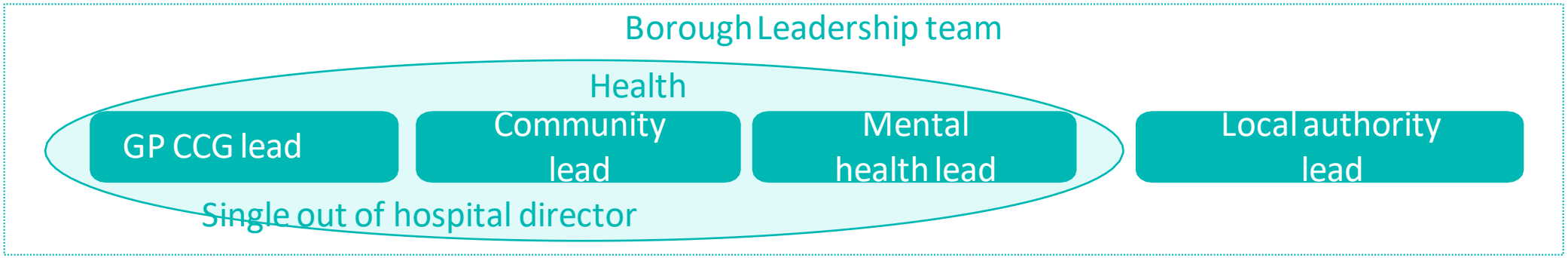

- Local **CCG staff will work on behalf of this quartet** developing strong, integrated borough-based care

Local CCG borough teams will work within the overall CCG to deliver local responsibilities

- The table summarises what responsibilities will be undertaken by the CCG Borough team and what will be undertaken by the single CCG at system level
- CCG Borough team structures will reflect the functions and priorities within them; NHS borough leadership will be provided by the single Out of Hospital Borough Director, a shared CCG COO working across 2 or 3 boroughs and a CCG Associate Director for each borough

Borough	NW London Single CCG
Equalities and engagement	Communications & engagement
Primary care delivery including PCN development, practice support, personalisation	Primary care contracting Primary care and personalisation strategy & transformation Primary care standardisation
Integration and delivery supporting borough partnerships	Out of hospital strategy & transformation Standardisation of services ICS delivery programmes (quality improvement, strategic & programme delivery)
Joint commissioning Complex care teams Safeguarding	Contracting CHC Safeguarding
Medicines management delivery	Medicines management strategy and programme design
System resilience and delayed discharges	Clinical leadership
Clinical leadership	Quality: patient safety, complaints, infection prevention and control, clinical effectiveness
Business administration	Performance and planning
	ICT & WISC/ BI with identified borough support PMO,
	governance and secretariat

Involving local residents in the work of the single CCG

- A best practice approach to patient and public involvement will be central to our approach.
- We are already working with Healthwatch and local people to develop proposals for how this will work in practice.
- The single CCG retain a strong local presence, including responsibility to work with local people and stakeholders, to listen to their feedback and to involve them in shaping services.
- Our aim is to enhance patient and public involvement and engagement in the new system, ensuring the patient and resident voice is consistently heard and listened to.
- This is being taken forward through our EPIC (Engage-Participate-Involve-Collaborate) programme in partnership with Healthwatch

Summary

- All eight CCGs in NW London – Brent, Central London, Ealing, Hammersmith and Fulham, Harrow, Hillingdon, Hounslow and West London – would become a single CCG, as a single statutory body
- NW London CCG would work within the NWL Integrated Care system (ICS) to set strategy and priorities, resource allocation and monitor quality/performance (mutual accountability)
- All GP practices are currently members of their local CCG and would become members of NW London CCG instead
- Governing bodies and GP members will vote on the proposal in September.
- If members and Governing Bodies support the proposal to merge in September, an application will be submitted to NHS England (NHSE) in line with the national deadline of 30th September
- If approved by NHSE, the single CCG would be established in shadow form by March 2021

Your feedback, comments and questions

Please send any feedback, comments or questions on this case for change to:

nwlccgs.communications.nwl@nhs.net

by midday on Friday, 11 September