



**Community and Wellbeing Scrutiny
Committee**
15 September 2020

**Report from the North West
London Collaboration of Clinical
Commissioning Groups**

**North West London Clinical Commissioning Group, and
Integrated Care System for North West London**

Wards Affected:	All
Key or Non-Key Decision:	Non-key
Open or Part/Fully Exempt:	Open
No. of Appendices:	3 Appendix 1 – Timeline for establishment of the single CCG Appendix 2 – Proposed Governance Structure for single CCG Governing Body Appendix 3 - Transition Governance Structure during Covid-19
Background Papers:	0
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1.0 Purpose of the Report

1.1 To set out our vision for North West London: Start well, live well, age well. This includes the plan for form a single CCG and the vision for establishing an Integrated Care System (ICS). During Covid-19, we have moved faster towards working together as a system, as it has been a necessary part of the response to the pandemic. We could not have responded as effectively as we did to Covid-19 by working in isolation, or with providers prioritising competition over collaboration.

1.1.1 Our vision for a North West London 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.

1.1.2 The main focus of the report will be the Single CCG case for change, as that is the proposal we are currently consulting with local authorities and GP member practices on.

1.1.3 We will be glad to provide further updates on the development of the North West London ICS during this process.

2.0 Recommendation(s)

2.1 We invite the Committee to acknowledge that in order to achieve our vision we need to have one organisation buying and commissioning services for all in North West London. This means moving to a single CCG. A single CCG will allow us to:

- Reduce duplication in ways of working, allowing more time and money to be put into patient services.
- 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
- React quickly and consistently to the continuing pandemic and recovery.
- Support delivery of the ICS vision.

2.2 We invite the Committee to note that we have engaged with stakeholders as a system on the first case for change, and we are now engaging for a second time due to the change in timeline.

2.3 We invite the committee to recognise that the case for change is not significantly changed since our initial period of engagement, and that this is an administrative change, with no changes to services or patient behaviours.

3.0 Detail

3.1 As set out in our Long-Term Plan, we are working in a national context where areas will work as a single ICS 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.

3.2 The NHS is moving away from a commissioning-provider split. ICSs will be partnerships between the NHS and local authorities. An ICS is not a legal entity, but a voluntary partnership.

3.3 The eight CCGs in NW London agreed in September 2019, that a single CCG was the right direction of travel. It was also agreed that 2020/21 would be a

transitional year focused on financial recovery, developing a single CCG operating model and working through financial implications.

- 3.4 Circumstances have meant that the NHS has changed rapidly since September 2019. North West 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. For example, it was essential during the pandemic that we were able to move patients from one hospital to another, and that providers were able to share information regularly about where the highest and lowest Covid-19 pressures points were in the system at any given time.
- 3.5 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.
- 3.6 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. It is agreed that this needs to be co-designed by local authorities and NHS bodies together. We have collectively agreed across health and local authorities that in the interim for each borough, we will have three NHS leads covering primary care, community care and mental health respectively. They will 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.
- 3.7 Local CCG borough teams led by dedicated Associate Director, will work with practices and local partners to deliver local responsibilities. There will a shared CCG COO working across two or three boroughs.
- 3.8 30th September is still the current timeline for our single CCG submission.
- 3.9 The North West London Single CCG Governing Body Proposed Membership is:
 - The Chair
 - Eight Primary Care Clinicians (one from each borough)
 - One independent clinical chair (from the above group of clinicians, with that borough nominating an additional member to ensure borough representation)
 - One 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 eight local authorities (non-voting)
- A Practice Nurse and Practice Manager from North West London (non-voting).

3.10 The ICS governance has developed including the following:

- A joint local authorities leaders and CEO and NHS CEOs group.
- A joint partnership board including local authority representation
- A Clinical and quality group.

4.0 Financial Implications

4.1 The operating plan we put forward for 20/21 (i.e. before Covid-19) was a commissioning budget for the 8 North West London of just under £3.5billion.

4.2 The single CCG is expected to facilitate financial sustainability, as duplication ties up resources. We have made some savings by implementing joint arrangements across our CCGs. NHS organisations will work together to ensure that the NW London health system breaks even overall.

4.3 The savings target from the creation of a single CCG is £17m.

4.4 North West London commits to increasing 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.

4.5 North West London will level up additional primary care services across North West London over the next four years, so consistent services are offered to patients. An additional £18m will be invested in primary care across North West London. Brent will be the biggest beneficiary of this investment with an additional £8m at the end of four years.

4.6 In recognition of health inequalities across North West London London, we will make substantial progress towards fair share allocations based on population need in the next 5 years, faster than national timetable. We will also consider how best to address inequalities in boroughs within the borough allocation. (See also Section 6.0: Equalities Implication.) Brent will be the biggest beneficiary of the faster move to fair shares funding with an additional £16m at the end of five years.

5.0 Legal Implications

5.1 The eight CCGs would cease to be separate legal entities and the single CCG would be the successor legal entity.

5.2 The single CCG will be held accountable through the existing statutory processes, such as local government scrutiny committee, and Healthwatch groups and work with local borough Health and Wellbeing Bords.

- 5.3 Each local area will maintain a CCG borough committee, taking into account the needs and demographics of residents. This relation can be represented as follows:



- 5.4 We ask the Committee to note that the Single CCG Case for Change does not involve any service changes or changes in patient behaviour, and that it is an administrative reform, not a reform to patient care.

6.0 Equality Implications

- 6.1 There are two aspects to the equalities considerations regarding the single CCG case for change. The first is the impact on patients, and the second is the impact on staff.
- 6.2 It is our expectation that the single CCG would be beneficial for patient and resident health inequalities. Our vision is to reduce inequalities and achieve health outcomes on a par with the best of global cities. The single CCG as part of the ICS will focus on improving population health locally and at the level of the ICS. This will require strengthened and integrated borough-based provision.
- 6.3 By joining up our resources, we can address imbalances between the boroughs in terms of population affluence and CCG and/or Trust finances. In recognition of health inequalities across North West London, we will make substantial progress towards fair share allocations based on population need in the next five years, which is faster than national timetable.
- 6.4 Reducing inequalities is particularly important for Brent and we have committed to level up primary care services, increase the investment in community services achieving equity in access and outcomes for Brent residents.
- 6.5 Our shared clinical strategy places health inequalities at its heart – and this can only be achieved by working together as a system. For example, it would not be possible to adequately address long-term conditions such as asthma without considering air quality and housing quality.
- 6.6 Workforce equality implications are under careful consideration as part of the staff consultation, which includes an Equalities and Health Inequality Impact Assessment (EHIA). This EHIA is a review of the possible impacts that the reorganisation into a single CCG could have on staff. The key aims of the EHIA are to:

- Gather evidence on the breakdown of North West London staff through available data from the North West London Staff Survey and WRES (Workforce Race Equality Standard) data.
 - Identify potential risks where certain staff groups may be disproportionately affected by the change.
 - Implement mitigations, which will reduce any negative disproportionate impact on staff groups, and enhance any positive impacts that may arise from the move to a Single Operating Model.
- 6.7 NHS North West London is currently in the first stage of the EHIA process to identify possible staff concerns, risks, and mitigations.

7.0 Consultation with Ward Members and Stakeholders

- 7.1 We will be attending the Joint Health Overview and Scrutiny Committee (JHOSC) on 7 September 2020, as well as Brent Community and Well Being Scrutiny on 15th September.
- 7.2 A best practice approach to patient and public involvement is central to our approach. We are already working with Healthwatch, patient groups and local people to develop proposals for how this will work in practice.
- 7.3 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. The borough committee will include patient representation.
- 7.4 Our aim is to enhance patient and public involvement and engagement in the new system, ensuring that we consistently listen to patient and resident voices. This is being taken forward through our EPIC (Engage-Participate Involve-Collaborate) programme in partnership with Healthwatch.

REPORT SIGN-OFF

Jo Ohlson: Accountable Officer, NW London
Collaboration of CCGs