If you require further information about this agenda please contact: please contact: Nicola Zoumidou 020 8583 3477 or email: Nicola.Zoumidou@hounslow.gov.uk

JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE (JHOSC)

A meeting of the Joint Health Overview & Scrutiny Committee (JHOSC) will be held in the Rooms 6:06 & 6:07 - 6th Floor, Hounslow House, 7 Bath Road, Hounslow, TW3 3EB on Friday, 21 June 2019 at 2:00 pm

MEMBERSHIP

Councillor Ketan Sheth London Borough of Brent
Councillor Crawford London Borough of Ealing
Councillor Richardson London Borough of Hammersmith and Fulham
Councillor Shah London Borough of Harrow
Councillor Collins London Borough of Hounslow
Councillor Freeman Royal Borough of Kensington and Chelsea
Councillor Saunders London Borough of Richmond
Councillor Dean City of Westminster

Substitute Members: Representing:
Councillor Nerva London Borough of Brent
Councillor Morrissey London Borough of Ealing
Councillor Holder London Borough of Hammersmith and Fulham
Councillor Mithani London Borough of Harrow
Councillor Mehrban London Borough of Hounslow
Councillor Chauhan Royal Borough of Kensington and Chelsea

AGENDA

1. Welcome and Introductions
2. Election of Chair and Vice-Chair
3. Apologies for Absence
4. Declarations of Interest
5. Minutes of the meeting held on 12 March 2019 ***(Pages 1 - 7)***
6. Annual Report NWL JHOSC ***(Pages 8 - 11)***
7. Case for a single CCG and Borough arrangements and development of integrated care ***(Pages 12 - 41)***
8. Work Planning Programme ***(Pages 42 - 43)***
9. Any Other Business
10. Date of the next meeting

DECLARING INTERESTS

Committee members are reminded that if they have a pecuniary interest in any matter being discussed at the meeting they must declare the interest and not take part in any discussion or vote on the matter.

Niall Bolger, Chief Executive,
London Borough of Hounslow, Hounslow House, 7 Bath Road, Hounslow TW3 3EB

Please note that members of public can choose to record, or report in other ways, on this public meeting. If you wish to do so then please read the Council's protocol which can be found on the Council's website at:
http://democraticservices.hounslow.gov.uk/documents/s107608/Protocol%20on%20reporting%20at%20meetings.pdf .

Copies of the protocol are also available at the meeting.

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13 June 2019

NORTH WEST LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MINUTES

12 MARCH 2019

Chairman:

Councillor Mel Collins – London Borough of Hounslow

Councillors:

Councillor Daniel Crawford - London Borough of Ealing
Councillor Lorraine Dean - City of Westminster
Councillor Robert Freeman - Royal Borough of Kensington and Chelsea
Councillor Lucy Richardson - London Borough of Hammersmith and Fulham
Councillor Rekha Shah - London Borough of Harrow
Councillor Ketan Sheth – London Borough of Brent

Non-Voting Co-optee:

Councillor Alan Juriansz – London Borough of Richmond upon Thames

Officers:

Mark Easton, Accountable Officer
Dr Susan La Brooy, Medical Director
Ian Robinson, Interim Head of Continuing Healthcare
Rory Hegarty, Director of Communications and Engagement
Dr Michael Marsh, Regional Medical Director, NHS London Region
Hazel Fisher, Programme Director Cardiac and Paediatrics Specialised Commissioning, NHS England

In attendance:

Councillor Nafsika Butler-Thalassis – City of Westminster

1. Welcome and Introduction

The Chair welcomed everyone to the meeting and Councillor Rekha Shah welcomed Members, officers and members of the public to Harrow.

2. Apologies for Absence

Apologies for absence were received from Councillors Michael Borio (Harrow) and Vina Mithani (Harrow).

3. Declarations of Interest

During the course of the meeting, Councillor Mel Collins declared a non-pecuniary interest in that he had been a patient at Moorfields Eye Hospital since 1948.

Councillor Robert Freeman declared a non-pecuniary interest in that he was a governor of the Royal Marsden Hospital.

Councillor Ketan Sheth declared an interest in that he was a lead Governor at the Central North West London National Health Service Trust.

4. Minutes

RESOLVED: That the minutes of the meeting held on 4 December 2018 be taken as read and signed as a correct record.

5. Matters Arising

(a) Update: North West London Patient Transport Services (PTS) - Quality Standards:

The Committee received a report which provided an update on Patient Transport Services (PTS) implementation of PTS Quality Standards and Patient Charter in Hospital Trusts in North West London.

A Member stated that there was an inconsistency between GP assessments of patient transport needs and also challenged the time stated on page 19 of the agenda namely that patients should expect to leave within 60-90 minutes of their transport being booked, which in his view was excessive. Mark Easton, Accountable Officer, advised that it was necessary to understand the complete picture but that he understood this waiting time to be an improvement.

In terms of assessment for PTS, the Committee were advised that inequality and inconsistency needed consideration as well as a need to look at how complaints were responded to.

RESOLVED: That a report addressing the issues raised be submitted to a future meeting of the Committee.

(b) Update: Health Based Places of Safety Suites Proposal Development:

The Committee received an update on the proposal for Health Based Places of Safety Suites.

The Committee expressed concerns in relation to the provision for Section 135 and Section 136 patients, the burden placed on local authorities, the lack of risk assessment and that finance, rather than patient safety, was the main driver of the proposals.

Mark Easton, Accountable Officer, explained that both the police and NHS considered the current arrangements to be unsatisfactory but that there was not currently a preferred option. Until the impact on local government, social care, access arrangements and the ability to increase costs had been considered and worked through, there would not be a preferred option. He emphasised that that there were currently no reductions in places of safety. Dr Susan La Brooy, Medical Director, added that the aim was to improve the service for patients and that Members concerns would be addressed.

RESOLVED: That the update report be noted.

(c) Update: Joint Committee of NW London Collaboration of Clinical Commissioning Groups:

The Committee received a report which provided an update on the status of the Joint Committee of North West London Clinical Commissioning Groups.

In considering the update, the Committee raised a number of points including that an assurance be given that a representative from the relevant CCG attended borough scrutiny committees, as appropriate, and that if the report was proposing a pooling of funds, this may result in a larger deficit. Mark Easton, Accountable Officer, advised that North West London CCGs had the lowest growth and that funding would not change as it was based on population. In terms of attendance at scrutiny meetings, his expectation would be that the Chair and Managing Director of the relevant borough's CCG would attend.

RESOLVED: That the update be noted.

(d) Update: Use of Consultants by NWL CCG:

Mark Easton, Accountable Officer, provided an oral update on the use of consultants by North West London Clinical Commissioning Group. He advised that historically the NWL CCG had high spend in terms of consultants and that in 2017/18 spend had been £1.9 million. From April to October 2018, the spend had been £101,000 and this had been incurred only when there had been no alternative.

The Committee expressed concern at the use of consultants and questioned what had been done differently as a result of their work. Members were advised that the peak spend was in 2013/14 on Shaping Health for the Future.

RESOLVED: That the oral update be noted.

6. CHD standards implementation in London - NHS England

Members received a presentation from Dr Michael Marsh, Regional Medical Director and Hazel Fisher, Programme Director Cardiac and Paediatrics in relation to Congenital Heart Disease standards implementation in London.

In response to Members questions following the presentation, Dr Marsh and Hazel Fisher advised that

- NHS England would consult on all options;
- The travel times to St Thomas' Hospital in Lambeth and the impact on service users may require further consideration;
- There had been work in relation to risks and their mitigation and had been consideration of clinical risk, continuity of services and impact on services;
- It was hoped that the detailed business case would be available in the late summer but that it should be acknowledged that this was an ambitious target date;
- It was not possible at this stage to advise how services, if they were moved, would be reconfigured or how those parts of the site vacated could be used.

The Committee was pleased to note that there was to be consideration of retaining some services on the Chelsea site and commented that unique research was carried out in North West London (Imperial College and the Royal Brompton Hospitals) in terms of respiratory care. Further, the Royal Marsden Hospital was important in terms of integrated care.

The Committee expressed the view that writing to residents/ stakeholders was the best way to consult on options and Hazel Fisher invited Members to suggest further ways to engage with the community.

The Committee thanked Dr Marsh and Hazel Fisher for their attendance, presentation and responses.

RESOLVED: That Congenital Heart Disease standards implementation in London report be noted.

7. Update on Strategic Outline Case Part 1 (SOC 1) funding bid and Shaping a Healthier Future (SaHF)

Mark Easton, Accountable Officer, introduced the report which provided an update on the Strategic Outline Case Part 1 (SOC 1) and advised that formal clarification on the status of the bid for SOC 1 capital was still awaited. The report also provided an update on the Shaping a Healthier Future programme.

In response to questions from the Committee, Mark Easton advised that with an NHS Capital budget of £1.2 billion, it was inevitable that some parts of the bid might be rejected. However, officers would continue to pursue the case for capital investment in London and acknowledged the need for the backlog of maintenance on sites to be addressed. He added that, whatever the outcome of the bid, there would be no changes in configuration for 4 to 5 years but that there was a need to ensure that sites were safe. Dr Susan La Brooy stated that in addition to ensuring that hospitals were safe it was also necessary to plan for the future.

In terms of modelling, Mark Easton advised that it was now 3 to 4 years old and issues had moved on. Advice on the modelling was being sought and consideration was being given to commissioning a tool that would model different scenarios.

A Member expressed the view that sufficient resources were not available within the sector and raised concerns as to whether the hospitals were fit for purpose. He stated that it was necessary to rebuild the trust of residents across a number of boroughs.

The Committee requested that the letter advising of the outcome of the bid be submitted to the JHOSC when it became available.

RESOLVED: That the update on the Strategic Outline Case Part 1 be noted.

8. Long-Term Plan and creating an integrated care system in North West London

Mark Easton, Accountable Officer, introduced the report which provided a strategic overview of the alignment between the NHS Long-Term Plan and the North West London Health and Care Partnership.

The Committee were advised that as well as working on the alignment at regional level, it was crucial that work was carried out at borough level too. There were a range of models which would vary from borough to borough. He emphasised that there was considerable work and engagement to be done over the next year. Rory Hegarty, Director of Communications and Engagement, added that in terms of public engagement, this was an opportunity for improvement by holding an outreach event in every borough and the establishment of a citizens' panel. Consideration was also being given to roadshows and consultation with local employers who could help shape the plans as well as NHS and Local Authority staff. All responses received would be recorded and feedback provided in the form of 'you said, we did'.

A Member questioned whether the need for a joint committee would be negated if the Clinical Commissioning Groups (CCG) were merged into a single group. Mark Easton advised that officers were currently determining the questions that needed to be addressed and that this was one such issue.

In response to questions from the Committee, Mark Easton advised:-

- The whole of London Borough of Richmond would be included in the South West London Region;

- Work was underway with the Local Partnership Board in relation to the role of the local authorities in the integrated care system and its' design;
- Prevention work was key and the responsibility for public health sat with local authorities.

RESOLVED: That the report on the NHS Long-term Plan and creation of an integrated care scheme in North West London be noted.

9. Continuing Healthcare (CHC) Policy Proposals

The Committee received a report which outlined proposals from the NHS North West London Clinical Commissioning Groups (CCGs) to make changes to the policy on funding community-based packages of care for people that were eligible for Continuing Health Care.

Ian Robinson, Interim Head of Continuing Healthcare, outlined the content of the report and advised that it was essentially managing the budget. He reported three case studies to highlight the difficult decisions that had to be made by professionals in determining the assessed needs of individuals. He emphasised that the involvement of an individual's family was key.

The Committee questioned the accessibility of letters to individuals in receipt of a Continuing Health Care package (CHC), some of whom would have complex learning difficulties. Members were reassured that assistance was sought for those individuals but that, given the needs of the cohort, no written information would have been comprehended.

RESOLVED: That the report be noted.

10. Annual Review of the JHOSC

Members received a report which outlined the suggested process for undertaking review of the JHOSC.

The Committee stated that

- there was currently no mechanism for public participation in the meetings and that this required consideration;
- the JHOSC was useful and as CCGs were merging it was important to continue;
- it would be helpful if the meetings of JHOSC did not clash with borough scrutiny meetings.

RESOLVED: That the process for undertaking the annual review of the JHOSC be agreed.

11. AOB and Close

The Committee's views were sought as to providing a response to the consultation on Moorfields Eye Hospital.

It was agreed that the consultation not be included on the JHOSC agenda at this time.

(Note: The meeting, having commenced at 10.30 am, closed at 12.52 pm).

(Signed) COUNCILLOR MEL COLLINS
Chairman

North West London Joint Health Overview and Scrutiny Committee

Date:	24 June 2019
Classification:	General Release
Title:	Annual Review
Report of:	Councillor Mel Collins
Policy Context:	Annual Report
Report Author and Contact Details:	Taru Jaroszynski (020 8583 2540) taru.jaroszynski@hounslow.gov.uk

1. Executive Summary

1.1. The North West London Joint Health Overview and Scrutiny Committee's (JHOSC) terms of reference requires an annual review of whether there is a need for the JHOSC to continue or whether it has fulfilled its remit.

1.2. In March 2019, the JHOSC agreed a process for undertaking the review which included looking at the key questions on the functioning of the JHOSC.

1.3. An officer workshop was held in April 2019 to consider the questions and Members also asked for and received written feedback from the North West London CCG. A Member workshop was held in May 2019 to discuss the feedback from officers and the CCG.

1.4. This report provides a summary of the activities of the JHOSC activities and outcomes from the review process.

2. Key matters for the NWL JHOSC's consideration

Members should consider:

- The activities of the NWL JHOSC as set out in the annual review; and
- If the JHOSC has fulfilled its remit and if it should continue.

3. Background

3.1. The terms of reference for the JHOSC lay out its responsibilities as follows:

- scrutinise the 'Shaping a Healthier Future' programme;
- scrutinise the Sustainability and Transformation Plan for North West London;

- review and scrutinise decisions made, or actions taken by North West London Collaboration of Clinical Commissioning Groups and/or other NHS service providers, in relation to 'Shaping a Healthier Future' reconfiguration and the Sustainability and Transformation Plan for North West London; and
- make recommendations as appropriate.

3.2. The JHOSC has met three times during the 2018/19 municipal year.

3.3. Members for 2018/19 were as set out in the table below:

London Borough	**Councillor**
Brent	Ketan Sheth Neil Nerva (alternative)
Ealing	Daniel Crawford Joy Morrissey (alternative)
Hammersmith & Fulham	Lucy Richardson
Harrow	Rekha Shah (voting member) Vina Mithani (alternative)
Hounslow	Melvin Collins Shaida Mehrban (alternative)
Kensington & Chelsea	Robert J. Freeman Max Chauhan (Alternative)
Westminster	Lorraine Dean Nafsika Butler-Thalassis (Alternative)
Richmond (co-optee)	Alan Juriansz Lesley Pollesche (alternative)

3.4. The topics discussed in the JHOSC meetings included:

- Shaping a Healthier Future (SaHF)
- Sustainability and Transformation Plan (STP)
- The proposed reconfiguration of acute hospitals (SOC 1) and the compliance with reconfiguration test
- North West London Joint Committee of CCGs
- Winter Plans
- Patient Transport Strategy
- Health-Based Places of Safety
- NWL CCG's use of consultants
- Congenital Heart Disease standards implementation in London
- Integrated Care Systems and the NHS Long-Term Plan in North West London
- Continuing Healthcare Policy.

3.5. The agreed scope of the annual review of the JHOSC was to answer the following key questions:

- Has the JHOSC scrutinised appropriate topics?
- Has the JHOSC added value to services that residents across North West London receive?
- How does the JHOSC operate?
- What is best practice?

3.6 A summary of this feedback is discussed in the table below:

Question	Discussions and Actions
Has the JHOSC scrutinised appropriate topics? *Answering this question should involve examining whether the reports the JHOSC has considered were priorities for NWL; were they within the terms of reference of the JHOSC and if not, should the terms of reference be amended?*	Members and officers noted the work on SaHF, the NWL Joint Committee, the Long-Term Plan, Continuing Healthcare and HBPoS as key and effective areas of scrutiny. Some topics could be dealt with by local health scrutiny committees. The JHOSC does not need to deal with all issues but should be strategic in its selection of topics. It was suggested the test for selecting a topic should be based on whether it impacts or affects all or most LAs in the JHOSC. The selection of topics is member driven. A work plan is useful as long as there is a flexible, agile approach to incorporate emerging issues. More work can be done to invite experts, Healthwatch or other key stakeholders to present on a specific topic to give a wider view of the issue.
Has the JHOSC added value to services residents receive across NWL? *It is important that any review identifies how the JHOSC has had a positive impact on residents in North West London. This could involve the JHOSC making recommendations that were accepted and implemented, increasing public involvement in the decisions that affect them or ensuring that the actions taken by commissioners and providers across North West London are robust.*	The key 'value add' has been to draw attention to an issue, 'keep it on the agenda' or 'keep the pressure on'. In these ways, it has acted to hold the NWL CCG and NHS England to account. The JHOSC also acts to increase the capacity of scrutiny across LAs to look at specific issues and provides direct access to the NWL CCG. As the new ICS system described in the Long-Term Plan is conceptualised and designed, there is an increasing need for joint, cross-LA working to scrutinise the proposals. It was noted that no recommendations were made this year apart from some suggestions around improving consultation processes. It was suggested that the following may assist members: • A longer pre-meeting to discuss some of the issues; • A topic champion approach where Members lead on specific topics; and • Fewer agenda items with more deep dives into topics which means items might be discussed over several meetings.
How does the JHOSC operate? *As the JHOSC holds meetings in public, and has a limited number of meetings per year, a key question for*	As mentioned above there are some suggestions to better assist the JHOSC to develop its scrutiny abilities and make recommendations. With regards to how to better facilitate public engagement, there are two options. It was suggested that

the review should be is the committee making the most of its time, and how can it work most efficiently, both inside and outside of meetings.	members of the public could email or write to the chair and this could be discussed at the meeting. It is also suggested that officer and members could publicise JHOSC more by: • Engaging RCN, Healthwatch, RCGPs and other such bodies to inform them about JHOSC; • Indicate opportunities for public engagement information on the agenda; and • Using social media or local authority's own communication channels to tell residents about the JHOSC. It was noted that Hounslow has been responsible for most of the secretariat support and communication with the NWL CCG. Hounslow has indicated that they are struggling with capacity to perform this function and the group will look at how this can be shared between officers.
What is best practice? *As there are a few JHOSCs across London, there is an opportunity to learn from their experiences to shape the future practice of the NWL JHOSC.*	Officers looked at and discussed the following JHOSC Terms of Reference, to understand how other JHOSCs work: • Inner North East London JHOSC • North Central London JHOSC • South West London JHOSC • South East London JHOSC • Kent and Medway • Bedfordshire, Luton & Milton Keynes

If you have any queries about this Report or wish to inspect any of the Background Papers please contact Report Author (020 8583 2540)
taru.jaroszynski@hounslow.gov.uk

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Joint Health Overview and Scrutiny Committee (JHOSC) paper: Integrated care and commissioning reform in North West London

13.06.2019

Summary	**This document covers:** **Development of Integrated Care Systems in North West London** - Integrated care in North West London - North West London vision and mission - Placed-based integrated care systems - Primary care networks - London region - Integrated Care Partnerships **North West London commissioning reform case for change** - North West London case for change - Commissioning reform: governance - Next steps
Date	12 June 2019
Owner	Juliet Brown, Director

1. Development of Integrated Care Systems in North West London

Integrated Care Systems are a structural mechanism through which the NHS will deliver the ambitious health and care goals set out in the **NHS Long-Term Plan** to help patients start well, live well and age well.

The Long-Term Plan suggests that Integrated Care Systems should be in place across England by 2021. Most Integrated Care Systems will involve a single CCG, and will cover populations over one million.

"Integrated care systems are central to the delivery of the Long-Term Plan. An ICS brings together local organisations to redesign care and improve population health, creating shared leadership and action. They are a pragmatic and practical way of delivering the 'triple integration' of primary and specialist care, physical and mental health services, and health with social care. 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." – NHS Long-Term Plan

Eight NHS commissioners, providers of health and social care, and local councils are together developing our Sustainability and Transformation Partnership into an Integrated Care System called the **North West London Health and Care Partnership**, covering 2.2 million residents.

CCGs will continue to exist as statutory organisations that purchase services from providers to deliver care for a given population, and manage the contract for care delivery.

However, as we continue to fully integrate our health and care system in North West London, we will be **moving away from the distinction between provider and commissioner** as we manage care on a population health basis, working increasingly in partnership with local government and the voluntary sector.

North West London vision and mission

Our **agreed vision** is to create one integrated health and care system working together to maximise benefits to residents and staff. Our **agreed mission** is to deliver high standards of clinical and professional care to the population of North West London.

Our Health and Care Partnership clinical care strategy will underpin our operating plans. By working together across geographical and organisational boundaries, we will achieve:

- ✓ Consistency of patient outcomes
- ✓ The highest achievable quality of care, for every one of our 2 million-plus residents
- ✓ The most rewarding working conditions for the thousands of staff who serve them every day.

As part of this transition, we are **refreshing our transformation plans.**

Place-based integrated care systems (200 - 400k population)

As well as integrated care happening at a North West London level, there will also be placed-based integrated care systems (see appendix A), at a borough or CCG area level, in accordance with existing commissioning boundaries.

There will be mechanisms through which scrutiny partners, the public, and other stakeholders can hold us to account as a system as well as at a local level. We are keen to engage with JHOSC about what that might look like in practice.

- ✓ ‘Placed-based’ or borough-aligned integrated care partnerships are being established as alliances of health and care organisations in that region, responsible for the health and care of a given population.
- ✓ Hospital, council, and primary care teams will be encouraged and supported to integrate between themselves.
- ✓ As these alliances develop over the next two or three years, underpinned by the primary care networks, it is expected that they will form into integrated care providers and ultimately become a formal statutory organisation.
- ✓ These partnerships will be supported by the North West London Health and Care Partnership to ensure consistent standards and outcomes across the patch.

General practice: primary care networks (covering a 30-50k population)

The Long-Term Plan encourages ‘full engagement with primary care.’ This will involve a named accountable Clinical Director of each primary care network, and a primary care strategy to accompany each Integrated Care System’s five year plan.

This is in line with our ambitions for our local primary care plans and achievements to date.

- ✓ Strengthen primary care
- ✓ Network practices and other out-of- hospital services
- ✓ Proactive and integrated models for defined population
- ✓ We are developing our primary care networks with identified leadership by July 2019.

We have been working to improve primary care in North West London for some time, implementing the GP Forward View in order to meet the needs of our residents. Local practices have begun working together and with community, mental health, social care, pharmacy, hospital and voluntary services in their local areas in primary care networks.

The change in the way general practice is working helps teams build relationships with all other staff in their networks, and together, in partnership with patients and the public, use whole population health profiles to plan for and deliver integrated whole person care to the key groups of people.

We have also been developing our system and local population health management plans so that childhood obesity, rising numbers of long-term conditions, dementia, mental health and related health concerns can be managed by the local GP, practice nurse, community nursing staff, community pharmacists and primary care networks effectively.

Primary care networks are providers, and they are an important part of our health system. They enable greater provision of proactive, personalised, coordinated and integrated health and social care. By working in this way, practice gain more local control over the health needs of their populations. Clinicians describe this as a change from reactively providing appointments to proactively care for the people and communities they serve.

The development of these networks are a key part of the NHS Long-Term Plan, with all general practices being required to be in a network by summer 2019, and CCGs being required to commit recurrent funding to develop and maintain them. Primary care networks will be based on GP registered lists, typically serving natural communities of around 30,000 to 50,000.

Our practices will work together in our primary care networks. Our primary care networks will operate through multi-disciplinary working, delivering population health management, and support our integrated care partnerships to deliver the required health and care to our local populations. These networks will be the bedrock of borough-level arrangements.

London region

We are working with other London systems and NHS England London to agree system objectives with each Integrated Care Systems. This may include:

- ✓ An agreed Integrated Care Systems ‘mandate’
- ✓ Mechanisms through which to hold the London Integrated Care Systems to account
- ✓ System development

- ✓ Intervention, and improvement

2. Commissioning Reform: the case for change

The NHS Long-Term Plan suggested that the number of CCGs would be significantly reduced over the next two years, with each system area typically supported by a single CCG.

All eight CCG chairs and managing directors have now signed off a case for commissioning change (see appendix B). All JHOSC members were sent a copy of the case for change on 28 May, and has been made available again as an appendix.

This document will form the basis for internal and external engagement on how we should respond to the NHS Long-Term Plan. We are now starting our engagement period which lasts until the end of July. Governing bodies are discussing the case for change this month, and we will also be attending Health and Wellbeing Boards and scrutiny committees to discuss the proposal.

During the engagement period we will identify all the issues we need to address and begin to develop responses to the key issues that are raised. It is not until after the engagement period that we shall make a decision on the way forward, with the intention being that recommendations go to governing bodies in September. During the engagement period will be working on, and issuing, further information for people to consider.

North West London case for change

The case for change sets out:

- ✓ Why we believe working as one organisation will mean greater efficiency, with more resources freed up for patient care rather than administrative costs
- ✓ The importance of retaining local accountability and how this will work in practice
- ✓ Our commitment to meaningful engagement with Healthwatch and local patient groups
- ✓ Our commitment to working locally with Health and Wellbeing Boards and Overview and Scrutiny Committees

GPs will continue to play a key role in the new organisation and we will continue to work more closely with provider trusts as we move towards an integrated care system across North West London and local integrated care partnerships.

> *"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."* – NHS Long-Term Plan

Strong place based care informed by local knowledge is central to the proposal for a single CCG. However, simplifying CCG governance by reducing to one CCG Board will allow:

- ✓ Quick provision of data and information sharing

- ✓ Consistency and equity in our methods of engagement
- ✓ Simpler system-wide financial planning.

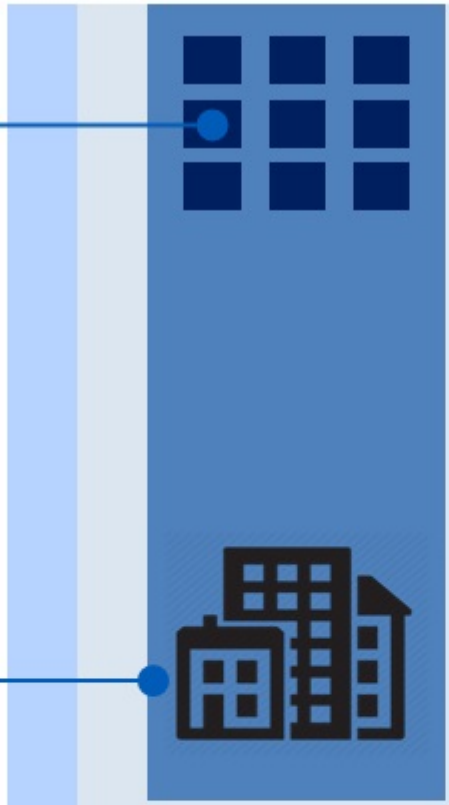
Next steps

On 24 June we have arranged a system workshop of senior officers (from health and the local councils) to develop the model for commissioning under a single CCG. This workshop will consider what needs to be owned at borough level and what is best placed at North West London level to maximise the synergies of working as a system. This will be reported back to a joint council CEO and leaders meeting on 9 July 2019.

We will continue to work collectively across our partnership to develop our integrated care system, integrated care partnerships and supportive commissioning arrangements.

Primary care networks	30 -50k population
• Strengthen primary care • Network practices and other out-of-hospital services • Proactive & integrated models for defined population	- we are developing our primary care networks with identified leadership by July 2019.

Integrated care partnerships- Place	200 - 400k population
• Typically borough/council level • Integrate hospital, council & primary care teams/services • Develop new provider models for 'anticipatory' care	Our ICPs have been developing under our CCG footprints – Whole Systems Integrated Care



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Commissioning reform in North West London

The case for change

28 May 2019

Foreword

This case for change document is written in response to the NHS long term plan which suggests that the number of CCGs will be significantly reduced to align with the number of emerging integrated care system (ICSs). The long term plan raises other issues: how a NW London integrated care system would operate; how integrated care partnerships (ICPs) would develop at a more local level and the development of primary care networks.

This document focusses on the first of those issues- a proposed change that would see NW London moving from eight CCGs to a single CCG.

NW London CCGs have a long and successful history of working together, particularly over the last five years. Building upon our existing relationships, we want to strengthen our collaborative working to commission and deliver high quality, best value, and safe care for the residents of NW London. We need to continue to work to reduce inequalities for our residents, improve our staff experience and deliver the optimum value for the NHS.

We see this as an opportunity to accelerate and streamline our systems and processes, reduce duplication and improve the offer of care to NW London residents. In doing this, we will learn from the experience of previous large-scale operating models, ensuring that we maintain a strong focus on public and stakeholder engagement in each of our eight boroughs.

This document does not hold all the answers - it sets out the implications of this change for comments and feedback from staff and stakeholders to help us to develop a full proposal that we intend to take to our CCG governing bodies later in the year.

The number of CCGs will significantly reduce over the next two years. We recognise that there will be differing views on how this should happen that we will need to resolve. The key areas we need to address now in NW London are:

- Whether this change to the number of CCGs happens by April 2020 or later, in April 2021
- What functions should be delivered at a NW London level and what should be organised more locally;
- How would the finances work; and
- How the changes to our CCGs relate to: changes at NW London with the development of an NW London integrated care system, the development of integrated care partnerships (ICP), based on boroughs, current CCG footprints, or groupings of boroughs, and the development of sub-borough structures such as primary care networks (PCNs).

We believe we have set out a good starting point for discussion. We now need your help to improve the proposals further and help us implement new arrangements that better serve our patients and staff.

Mark Easton
Chief Officer
NHS North West London Collaboration of CCGs

Dr Andrew Steeden
Chair
NHS West London CCG

Dr Tim Spicer
Chair
NHS Hammersmith & Fulham CCG

Dr Mohini Parmar
Chair
NHS Ealing CCG

Dr M C Patel
Chair
NHS Brent CCG

Dr Neville Purssell
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NHS Central London CCG

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Dr Genevieve Small
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NHS Harrow CCG

Dr Nicola Burbidge
Chair
NHS Hounslow CCG

Contents

1 – Introduction

About NW London – background and our history of collaboration

NW London has a diverse population of 2.2million across eight London boroughs, served by eight Clinical Commissioning Groups (CCGs). Although the CCGs have worked together collaboratively since they began, partnership working between the eight CCGs has increased significantly over the last eighteen months.

- In June 2018 a single Accountable Officer (AO) was appointed for all eight CCGs
- We have a single Chief Financial Officer and a single Director of Nursing and Quality for all eight CCGs
- In December 2018, a Joint Committee of the CCGs was formed with delegated powers for acute and mental health commissioning, and to support delivery of the NW London clinical and care strategy and sustainability and transformation plan (STP).

During this time, the eight local CCGs have remained the statutory and accountable organisations and decision making is through their eight individual Governing Bodies.

Moving to a single CCG is the next step in our evolution to accelerate and deliver our aims and objectives.

Further partnership working is also in place beyond CCGs - with provider Trusts, other NHS bodies and our local authorities. This was formalised after the publication of the NHS Five Year Forward View which set out the requirement for areas to develop a Sustainability and Transformation Plan/Partnership (STP). The NW London STP was published in October 2016 and the NW London Health and Care Partnership, a coming together of 30 organisations across NW London, was formed.

The NW London health and care system in NW London is a partnership of 30 organisations across health and social care, with a clear objective to improve and deliver high quality, safe and best value care for the residents of NW London. Our NW London health and care partnership is comprised of eight CCGs, six local authorities, and seven NHS Trusts.

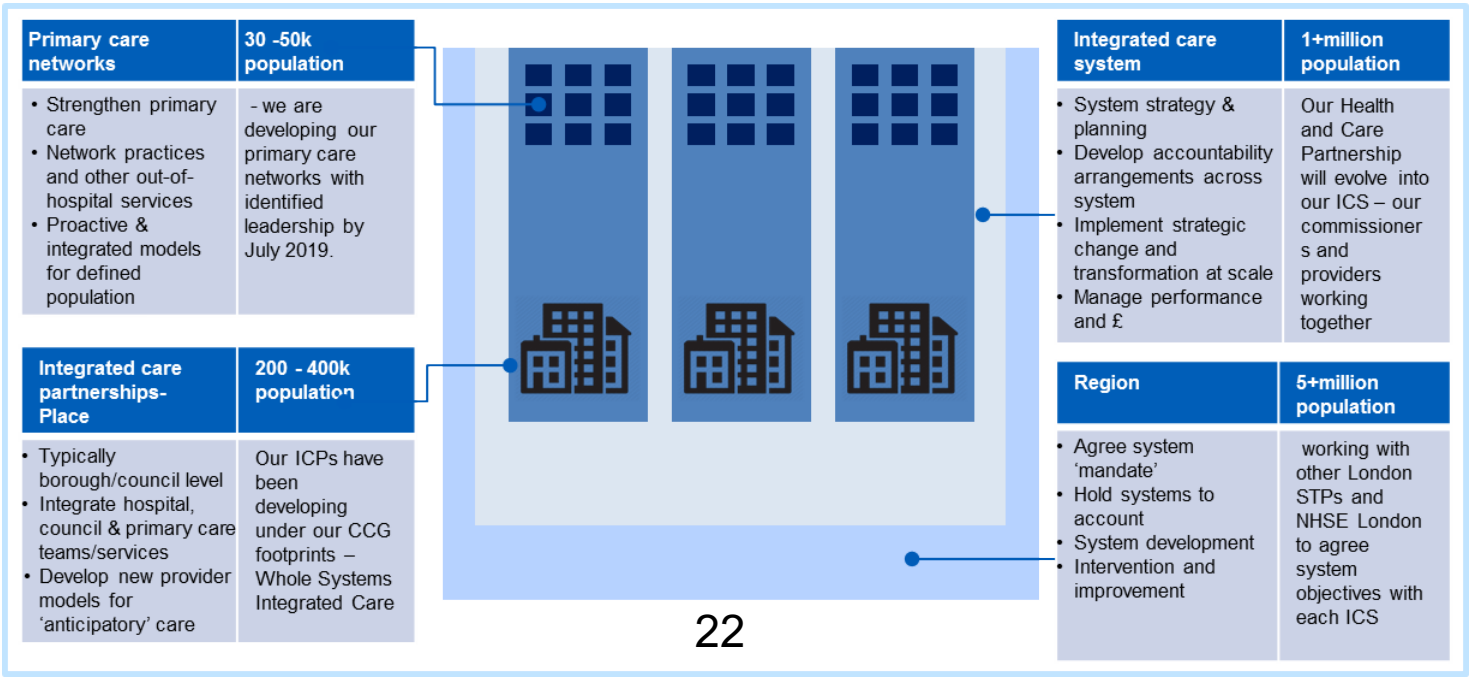


Figure 1: Integrated care as a system of systems

In early 2019 the NHS England 10 Year Long Term Plan was published. This outlines a number of goals for the NHS as a whole including the development of Integrated Care Systems (ICS) and more local Integrated Care Partnerships (ICP) which would be underpinned by Primary Care Networks (PCN). It also included a vision that each ICS would consist of just a single CCG – rather than the eight that NW London has now.

NW London is currently developing the local response to the long term plan, of which this case for change is one related element.

NW London has been working in partnership for some years and with some key successes but challenges still remain – including significant variation in care for patients - and our financial position is in deficit and deteriorating. We believe that we can address our challenges better by bringing together our eight organisations into one strategic commissioning entity to make our decision making and administration as effective and efficient as it can be, with strong borough based local integration. A move to a single CCG will also support the move away from the payment by results system towards capitated outcome- based budgeting, support consistency and equity in our methods for engagement, and simplify system wide financial planning.

We explore those challenges further within this document and set out:

- why we believe a change in commissioning arrangements in NW London is necessary
- what the change might mean and the benefits it will bring to the system
- what this means for our staff, stakeholders and residents
- areas where further discussions are required.

North West London – our challenges and ambitions

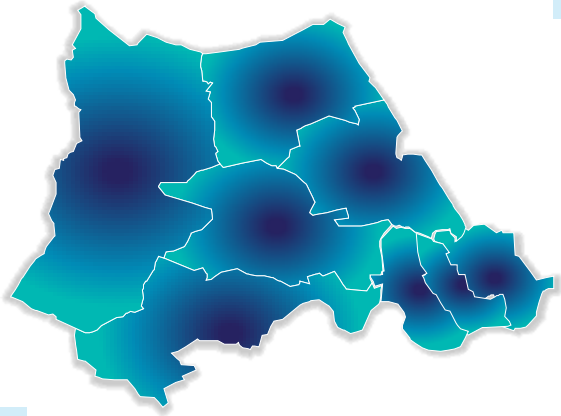
In NW London we want to deliver high quality, best value, and safe care in an environment which supports our staff and improves the experience of care for all NW London residents.

- **379 GP practices**
- **8 boroughs**
- **7 hospital trusts**

Over 30% of patients in acute hospitals do not need to be in an acute setting and should be cared for in more appropriate places

People with serious and long term mental health needs have a life expectancy 20 years less than the average

20% of people have a long term condition



Your chance of being admitted to hospital following a visit to A&E varies from 26%-50% depending on which hospital you visit. This is partly explained by alternative community pathways being present in some areas but not others

Life expectancy varies by 10 years from east to west

Service provision varies – the average length of stay can be 4.3 days or 7.5 days for the same procedure depending on which hospital you go to

Some community staff can administer treatments and services that in other areas require a visit to hospital, such as IV antibiotics

Spend on, and access to, continuing healthcare varies enormously with a range of £14.2 – £23.2m

The NW London CCGs ended 2018/19 with a deficit of £56.7m. Once non-recurring items are stripped out we enter the year with an underlying deficit of £99.6m. CCGs nationally have to cut their administrative costs by 20% compared to their 2017/18 spend.

Figure 2: NW London statistics

Quality and safety

- We will continue to drive high quality safe services, with consistent outcomes for our residents. We will reduce the variation in service provision, standardise pathways and ensure better care is delivered to our population
- We will progress our work to create a stronger, clearer and more consistent commissioning 'voice' for our area, built on the strong foundations of network-based, clinically-led commissioning, and drive forward the changes needed to deliver the resilient and sustainable NHS services that local people need
- Patient flow is often across borough/CCG boundaries, but over 80% of our residents receive care within the NW London area. North West London is a logical basis on which to commission services in order to best support our patient flow.
- By consolidating decision making, we will be able to better drive quality and focus on the important issues, working together to solve them.

Financial stability and sustainability

- We aim to make our financial situation sustainable. At the end of financial year 2018/19 the eight CCGs in NW London had collectively overspent their budgets by £56.7m – we aim to manage our spending within our budgets
- Once non-recurring items are stripped out we enter the year with an underlying deficit of £99.6m. In addition to this, CCGs nationally have to cut their administrative costs by 20% compared to their 2017/18 spend
- Maintaining eight separate statutory bodies is difficult to justify when there is so much pressure on health spending, and each statutory body costs an average of about £680k to run. In NW London we have already saved about 10% of our costs through the changes implemented last year and will endeavour to make further savings through this organisational restructure rather than only looking at changes to front line services
- We want to eliminate the administrative burden that comes from running eight statutory organisations and the transactions costs of the payment by results system. Operating a single administrative and governance function with capitated outcome-based budgets would enable us to focus more of our people and resources on delivering improved services and better patient experience.

Partnership working

- We will strengthen our individual borough relationships with local government, primary care, mental health, community services and the voluntary sector
- We will do this by building on our long history of collaboration locally and solid foundations of working as part of a wider system. Partners in NW London are committed to acting as an integrated care system. The concentration of NHS commissioning focus, through the merger of the eight CCGs in NW London, is an one essential element of these future arrangements, providing a single coherent strategic commissioning voice within an increasingly integrated care system
- We can maintain strong local relationships with our residents, staff and local government partners, without the need and cost of eight statutory bodies. We will have strong and visible local representation in each borough. Some parts of NW London are already making significant progress towards the development of integrated care partnerships which will be the focus of local health and care delivery in the future
- We will need to be clear about the strategic role of the integrated care system, operating at NW London level, and how we will work with our local authority partners in integrated care partnerships at borough level.

Workforce

- Our biggest asset is our workforce and we aim to make NW London a great place to work where staff experience is positive, and we make the best use of our skills and expertise
- We will do this by developing a talent pool and supporting our staff development more easily as one organisation.

2 – Changing at a NW London level

We want to create one integrated care system covering NW London and working together to maximise benefits to residents and staff. We want to achieve improvements in consistency of outcomes, and the highest achievable quality of care, for every one of our two million-plus residents – and the most rewarding working conditions for our thousands of staff who serve them every day.

We believe a single CCG would be an enabler for implementing an effective integrated care system and delivering on our clinical strategy – this document and the subsequent engagement will allow us to explore that and fully understand what a single CCG would enable us to do that we cannot do now with our existing partnership working.

Currently, there are unwarranted variations in case across NW London. Frailty is an example of where there is considerable variation. We have a clinical vision for improving care for the frail and older people - our geriatricians have developed a set of clinical standards for acute frailty services to promote equity of access and outcome for older people in crisis. However, expecting eight CCGs to come up with a way of solving things through eight decision making processes is unlikely to yield a consistent approach that reduces variation as effectively as working together and streamlining decision making.

A single CCG in NW London would become our statutory body for commissioning health care in NW London. The CCG's overarching focus would be commissioning the strategy and priorities of the integrated care system, focusing on patient experience and outcomes, population health management, and governance of tax payers' money

A NW London CCG would have a similar governing body to the current joint committee of CCGs, namely a combination of clinical leaders from the local teams, together with lay members, and managers. A single streamlined decision-making process would reduce decision making costs, reduce unnecessary duplication and improve consistency in service provision.

The CCG would continue to be clinically led, and would have a strong focus on partnerships, driving out variation and have a strong public voice. This public voice will need to be much more than having lay members on the governing body. We plan for to significant public engagement and involvement, so that local residents can help us shape services and provide feedback on how they are working, in a process of continuous engagement.

What we still need to explore

- What safeguards would a single CCG need to ensure it was responsive to local needs?
- What considerations should there be about a single CCG governance arrangements?
- How do we get a strong public voice into a CCG at NW London level?

3 – Changing at a local level

Strong local and visible NHS presence at the borough level remains essential. A health system as large and complex as NW London's could not be run from a single headquarters. We believe that local staff must be working to deliver needs of local populations by working in partnership with local government, primary care, community services and the voluntary sector to integrate health and social care. To achieve that, will maintain our relationships at borough level and improve our integration with local authorities. We will continue to strengthen our joint working in our Health and Wellbeing Boards to demonstrate and deliver local accountability.

There will continue to be teams of local CCG staff working with senior clinicians on local commissioning arrangements with delegated budgets. A key part of their role will be the development of integrated care partnerships.

Integrated care partnerships are vehicles for delivering seamless, integrated care to their local populations (servicing population of about 200,000- 400,000). They are usually in-line with local government boundaries and are part of an overall system of integrated care, governed at a strategic level by and integrated care system. In London, integrated care partnerships are likely to be in-line with the boundaries of boroughs or groups of boroughs, although two of our CCGs are not currently co-terminus with borough boundaries.

Where borough-based effective integrated commissioning arrangements already exist they will continue to be maintained and strengthened.

The NW London CCGs are at various stages in developing integrated care partnerships (ICPs). There is unlikely to be a single model suitable for all parts of NW London, (indeed the national guidance reproduced in appendix 1 suggests six different options) but given ICPs need to fit into a wider system it is important that arrangements do not develop in an inconsistent or contradictory fashion and north west London is developing a framework for ICP development. Our primary focus is to deliver consistent outcomes for the residents of NW London, reducing health inequalities and improve safe quality care.

Critical to each borough or place -based system will be its local general practice delivery and the development of primary care networks (PCNs). PCNs are explained in section 6.

What we still need to explore

- The operating model to determine functions which continue at local level will be developed over the summer as part of the engagement process
- We need to develop further the framework for ICP development and encourage those who are furthest ahead to make progress.

4 – Finance

To ensure effective and on-going delivery of health and care for the residents of NW London, we need to ensure the financial foundations are both stable and sustainable. We believe that this can be best achieved through a move to a single CCG as it will enable greater economies of scale, a stronger negotiating position when commissioning services and the ability to share financial skills.

Currently, our biggest challenge is finding a way to deliver the high-quality safe services for all the residents of NW London within the constraints of our budget. We can continue to improve our decision-making process to make it less fragmented, to allow for economies of scale and improve the quality of care offer for all NW London residents. The NHS long term plan asks us to make 20% savings on our management costs, coming together as a single CCG allows us to make that more easily than as eight organisations.

Becoming a single NW London commissioning entity presents a number of opportunities to maximise our current resources. Operating at-scale, we can strategically commission services, and make it easier for providers to deliver better value. This will mean that providers have more clarity in what we expect and be better able to deliver this. We will establish common standards for providers across NW London to deliver against. Furthermore; those providers who would benefit from more support will have a partner who can more easily mobilise resources to support them. The large NHS providers in NW London have fed back to us that working with a single commissioner in NW London would drive consistency in care and improve efficiency.

Although NW London CCGs as a whole are in significant deficit, individual CCGs are in very different positions, ranging from one in surplus, to others at or close to breakeven and others in significant deficit. Spending on services per CCG is highly variable, often driven by the historic variation in capitation (funding per head of population). Creating a single CCG will raise fears that better funded areas are going to be levelled down, and there will be a loss of local accountability for budgetary decisions. We will need to be sensitive to these issues and ensure that good financial management across NW London is not seen as a punishment on some. Given the sensitivity of this issue we need to be cautious that we do not de-stabilise current arrangements. There is likely to be some London guidance on this issue to ensure some consistency across the capital.

In NW London, there has been historic variation in investment priorities, now we have the opportunity to focus NW London ideas, energies and resource on achieving consistently high standard of outcomes across the ICPs and ICS.

What we still need to explore

- To what extent are there greater opportunities to work with local government from a financial perspective?
- What local level relationships and understanding need to be retained within the financial function?
- We need further understanding of the national and regional timeline on equalising financial allocations to target levels.

5 – What this means for local government

We view our local authorities as key partners within our vision of integrated care for NW London. They are pivotal both to the delivery of population health and through their democratic responsibilities for ensuring that the local voice is determining priorities. Through the development of our integrated care partnerships we want to strengthen this local accountability.

We want to build on the existing partnership arrangements and relationships and move towards greater integration with the eight local authorities in NW London. We believe doing so will enable us all to achieve more for our residents in improving health and care services within the budgets we have.

Integrated care partnerships will encourage innovation and give local freedom to determine how best to collectively work to deliver the agreed outcomes for local residents. In doing so they will build on the existing good practice, for example, in areas where we already have joint appointments and shared work programmes these arrangements should be enhanced further, in others they should provide the environment for these to be explored.

We envisage that Health and Wellbeing Boards' role of providing a strategic steer for effective local delivery of health and care outcomes would continue and the importance of the local authorities in scrutinising health services would of course continue under any reform of commissioning structures. Similarly there would be no impact on the Better Care Fund (BCF) as NW London will continue to meet BCF commitments regardless of CCG structure.

Local government would continue to work with local teams and in some areas may wish to take on more of a leadership function. Given the move to a NW London-wide organisation, these local relationships will become more important than ever in maintaining engagement and involvement at borough level. The local authorities will be key partners in local integrated care partnerships. Health and wellbeing boards in each borough will also continue to play a key role in shaping and developing local services.

What we still need to explore

- How do we ensure that the local voice is strengthened?
- The local partnership between health and local authorities will be key to delivering the outcomes the NHS Long Term Plan – how do we ensure this is most effective?
- What works really well currently that we need to develop further for the benefit of our residents?
- What level of integration is appropriate and achievable?
  Where are the opportunities to capitate and delegate budgets?

6 – What this means for GPs

CCGs are membership organisations, and a NW London CCG would be no different. Members would adopt a new constitution and elect representatives to the governing body as they do now. Commissioning of primary care would be undertaken by the CCG and managed locally with clinical input. This local input is important to ensure we continue to be fully responsive to local population health needs. It is our priority that GPs experience the same level of service, or better, from our commissioning function, we want to keep primary care management, relationships and operational support, including IT, local and will do this by maintaining local delivery teams.

Clinical leadership

Clinical leadership, the ability of clinical leaders across both commissioner and provider organisations to own and drive the local agenda, will continue to be important, irrespective of at which level commissioning operates. We want to continue the good relationships we have with our local GPs and we will not lose the understanding of local issues and needs, that has been a real benefit to our eight CCGs.

Our model is emergent and we have a triple aim for clinical leadership and engagement in development:

1. Maintain clear clinical decision making at a local level and develop system-wide speciality leadership
2. Improve quality of care and reduce health inequalities
3. Partnership working with local government, primary care, community services and the voluntary sector

We have strong clinical leadership in our system on which we will build. Clearly the role of clinical leadership will develop in the new operating model, but it is our priority that we continue to embody the ethos of clinically-led local decision making to suit local population needs, reducing health inequalities and improving patient experience. This means that we need to strengthen:

- Our system clinical commissioning leadership – moving away from traditional models of leadership to a shared leadership model; coaching and enabling collaborative decision making and building specialism. We will continue to strengthen the on-going quality assurance and clinical input to outcomes attainment and standard setting across NW London.
- Our local clinical leadership – acting as the clinical voice in borough-based systems and leading the ICP and the PCNs in the area.
- The interaction between clinical delivery at a local level in both primary and secondary care, and
- The interaction between local leadership, management and delivery with the integrated care system as a whole.

The below diagram is an illustrative example of how we may strengthen clinical leadership at all levels of our ICS. It is intended for description only as ICPs may form various models (see appendix one and two for further information).

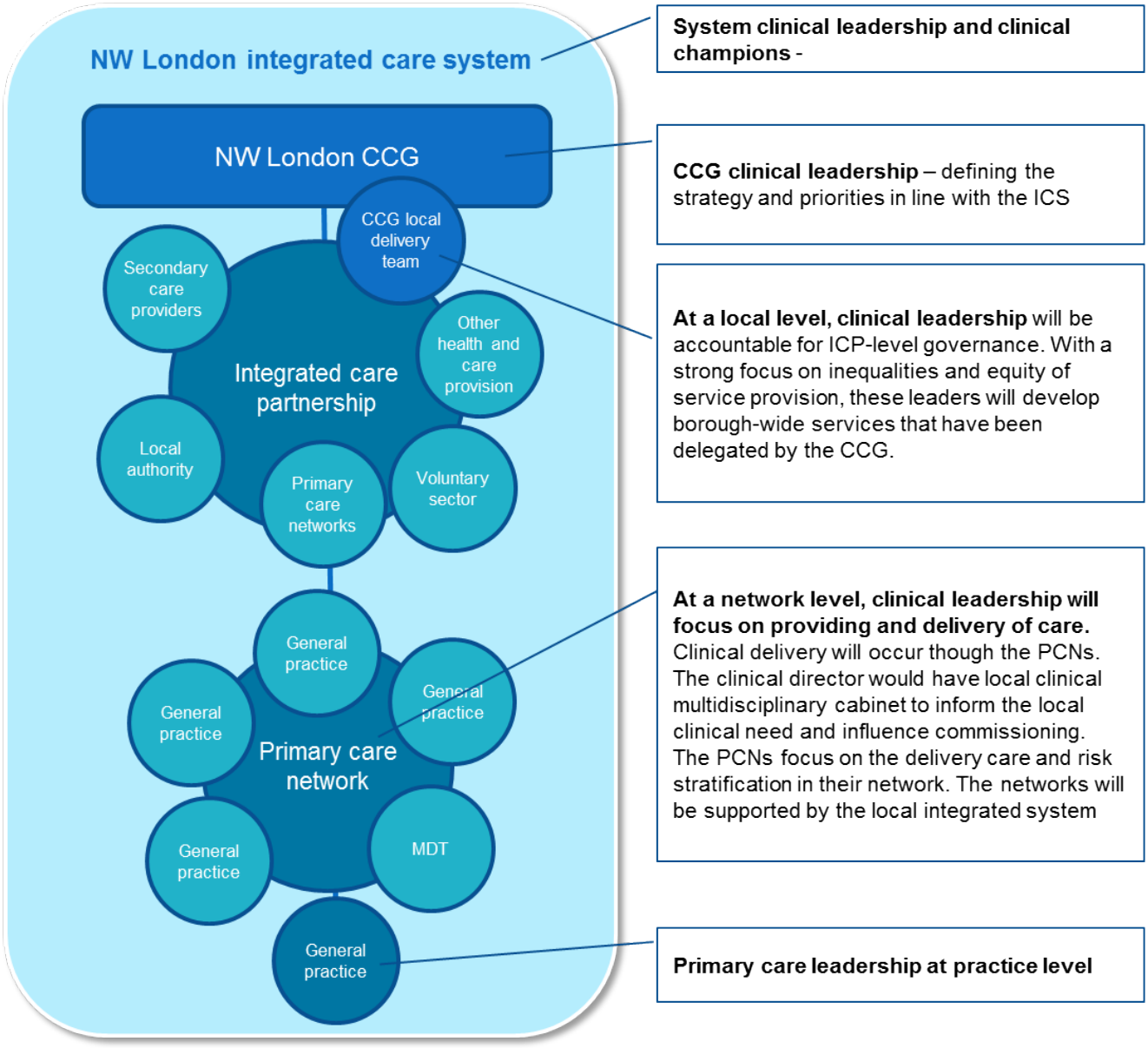


Figure 3: clinical leadership occurs at every level

What we still need to explore

- How best to hear member practices at NW London level if there is a move to a single CCG
- How we can best support transition?
- What impacts do GP practices feel this could have which hasn't been addressed?

7 - What this means for patients and the public

This case for change is about an internal structural change rather than patient facing service changes. However it is intended that the greater efficiencies gained from moving to a single CCG will enable us to be more financial sustainable, more streamlined in our decision making and ultimately lead to more opportunities to address health inequalities across the region.

The proposal for a single CCG for NW London coincides with a drive to improve our engagement with residents and patients across our eight boroughs.

We have positive relationships with our local Healthwatch partners, patient representatives and other community and voluntary sector groups. Healthwatch has always been represented in our entire governance structure and will continue to be so. Their active participation has enabled effective engagement across NW London, regular patient involvement in project development and implementation and also helped us address accessibility and access concerns when we moved to some of our decision making occurring through the Joint Committee.

As part of any changes in decision making in the region, we want to ensure we are representing the differences across NW London and that there continues to be public accessibility and involvement in our decision making. The single CCG would meet in public and rotate meetings across the region, much as the joint committee does now.

We recognise that the people of NW London are not a homogenous group and that there will be different opinions, interests and priorities among different stakeholders and communities. We also acknowledge that people identify with their local area or borough rather than 'NW London'. Most of our public engagement is currently based at borough level, where existing relationships and partnerships are vitally important these local arrangements would continue.

We have ambitious plans to transform the stakeholder engagement landscape in NW London. This will be based on a process of continuous engagement with our residents and stakeholders, offering many more opportunities for the public to feedback on how services are working to help the local voice be heard loudly at regional level. Public engagement should not be limited to proposals to change services or explaining national initiatives – our overall approach will be based on listening to and learning from what the people who use our services and work with us are saying. As part of this plan, we are putting in place a 3,000-strong Citizens' Panel across NW London – a demographically representative group from which we will regularly seek feedback.

We will need to carefully consider any impacts on groups protected under the Equality Act of changes to the way in which we structure our CCGs.

What we still need to explore

- How will we engage with patients/public at local level?
- How would patients and residents be involved in decision-making?
- How should we maintain local accountability?

8 – What this means for CCG staff

As part of a move to a single CCG, we would want to build on staff feedback and improve ways of working for staff. Previous staff engagement surveys have shown that there is limited career progression within the organisations and challenges around retaining staff. People leave one organisation to seek another role in a different organisation a few miles away or sometimes on a different floor within the same building.

The removal of organisational boundaries would allow us to create a shared talent pool. This would give staff the flexibility to progress, develop and use their skills in more challenging and interesting ways, with 'organisational friction' reduced for vertical and horizontal progression across NW London.

The significant amount of duplication which often occurs, especially when working on projects across more than one CCG, causes frustration for staff with the differing governance structures and processes in different areas proving confusing and time consuming. Working as a single CCG would enable us to establish greater consistency in standards and expectations so we can address this variation. For example, simplified governance structures would eliminate the need to pass papers through numerous committees. Common standards also ensure we have common expectations of each other, and would support shared ways of working so we can work in a truly agile manner throughout the organisation.

Any change by its nature introduces ambiguity which can have an impact on people's productivity as well as their health and wellbeing. We are also aware that there are many questions staff will have about this – especially in regard to likely structures – that will not be developed until later in the process. We are mindful of this and will be taking steps to ensure all staff are supported and involved as we develop these proposals.

Although we have to make cost savings as part of these proposals, given the number of vacancies and interim staff there are likely to be few compulsory redundancies amongst substantive NHS staff. Becoming a single CCG will not happen overnight, instead there will be a phased transitional period. During this period plans will be developed that ensure we make a smooth transition, and can realise the benefits outlined above whilst maintaining and building upon what works.

These phases will be:

- **Planning** – Human resources (HR) and operational development (OD) will provide support to map current functions and team structures in order to build a comprehensive picture that can used to develop detailed options
- **Pre-consultation** – HR&OD will carry out some early engagement around the options
- **Consultation** – All staff have an opportunity to feed into the process, raise concerns and make suggestions
- **Implementation** – Once consultation responses have been considered an outcome document will be produced detailing next steps
- **Delivery** – After the new structure becomes fully operational we would need to work together to manage any team dysfunctions, and it will take time to make new ways of working and practices part of business as usual.

Throughout the transitional period the HR&OD team will be working closely with colleagues across NW London to develop and implement plans. There will be a programme of regular

communications which will ensure all colleagues are informed of progress, and everyone will have an opportunity to feed into the decision making process.

What we still need to explore

- How to engage staff in the development of plans?
- How can we maintain staff morale and retention through this period of change?

9 – Timeline

The Case for Change will be discussed with our governing bodies 5 -26 June 2019.

Our engagement period officially begins on 24 May and we will be talking to all of our stakeholders to gather their views on the questions posed throughout this document. We request comments, input and feedback by 24 July when we will begin to develop formal proposals, should we believe it is the right thing to do following engagement. Proposals would go to governing bodies in September for agreement with submission of our intention to NHS England by 30 September.

Ratification of changes are likely to require a vote of the council of members, which would take place after the decisions of the governing bodies.

During this time, we will carry out an equality and health inequalities impact assessment.

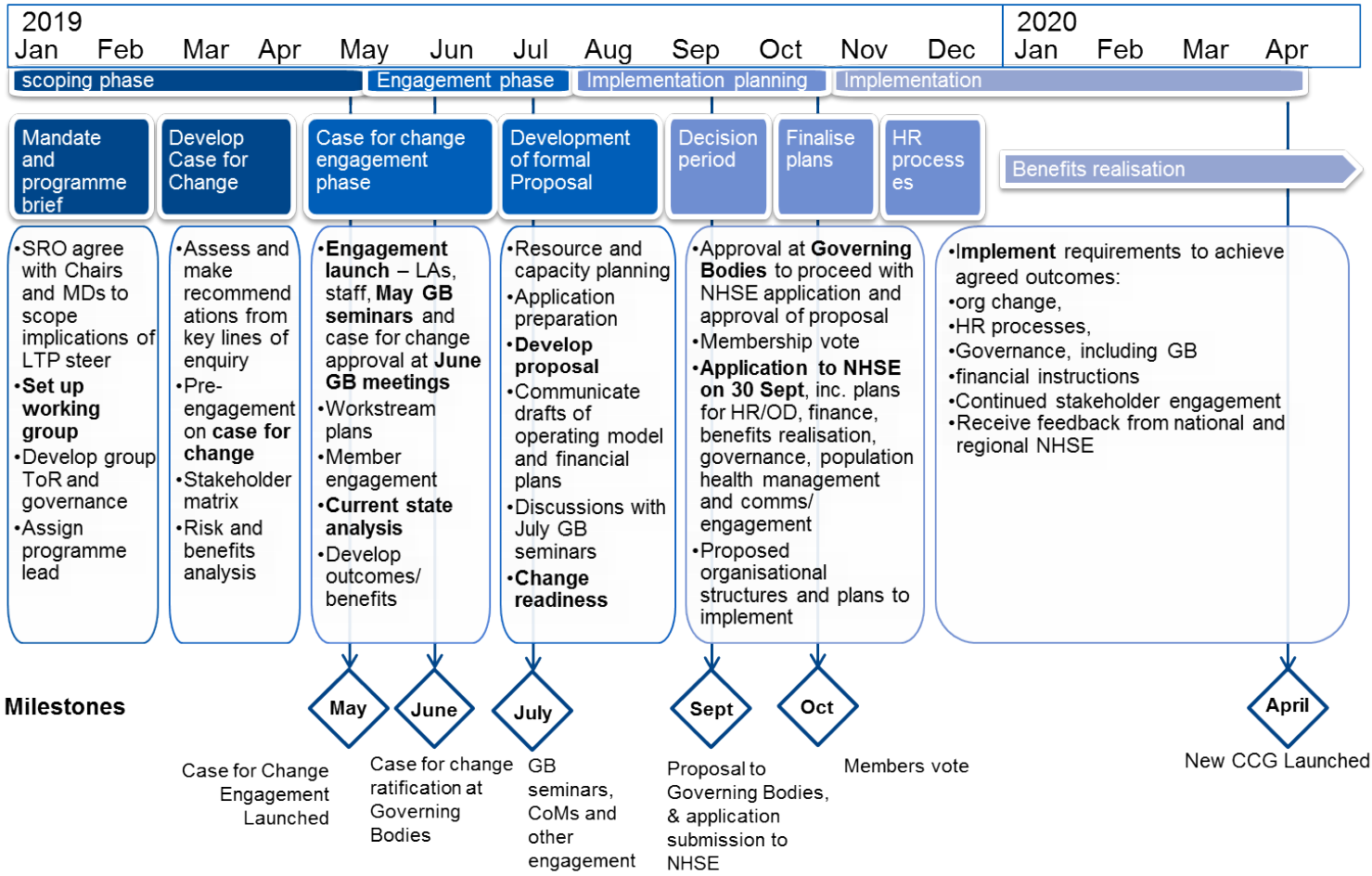


Figure 4: Illustrative high-level time line for 2020 launch

How to respond

Please send your comments by 24 July to: nwlccgs.commissioningreform@nhs.net or in writing to:

Accountable Officer's Office
NW London Collaboration of CCGs
87-91 Newman Street
London W1T 3EY

Appendix one: Our emerging integrated care system in NW London

What does an ICS mean for NW London?

The long term plan describes integrated care systems as follows:

"Integrated care systems (ICSs) are central to the delivery of the Long Term Plan. An ICS brings together local organisations to redesign care and improve population health, creating shared leadership and action. They are a pragmatic and practical way of delivering the 'triple integration' of primary and specialist care, physical and mental health services, and health with social care.

The long term plan states that 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."

Our agreed vision in NW London is to create one integrated health and care system working together to maximise benefits to residents and staff. We want to support the transition of our Health and Care Partnership into an ICS, integrating health and social care seamlessly for our residents.

We have begun this journey through our sustainability and transformation partnership – our NW London Health and Care Partnership, This partnership of over thirty organisations is working together to improve quality, patient and carer experience, staff experience, value and the reduce unwarranted variation.

We want to continue to develop integrated working at three levels, aligned with national strategy; system, place and network:

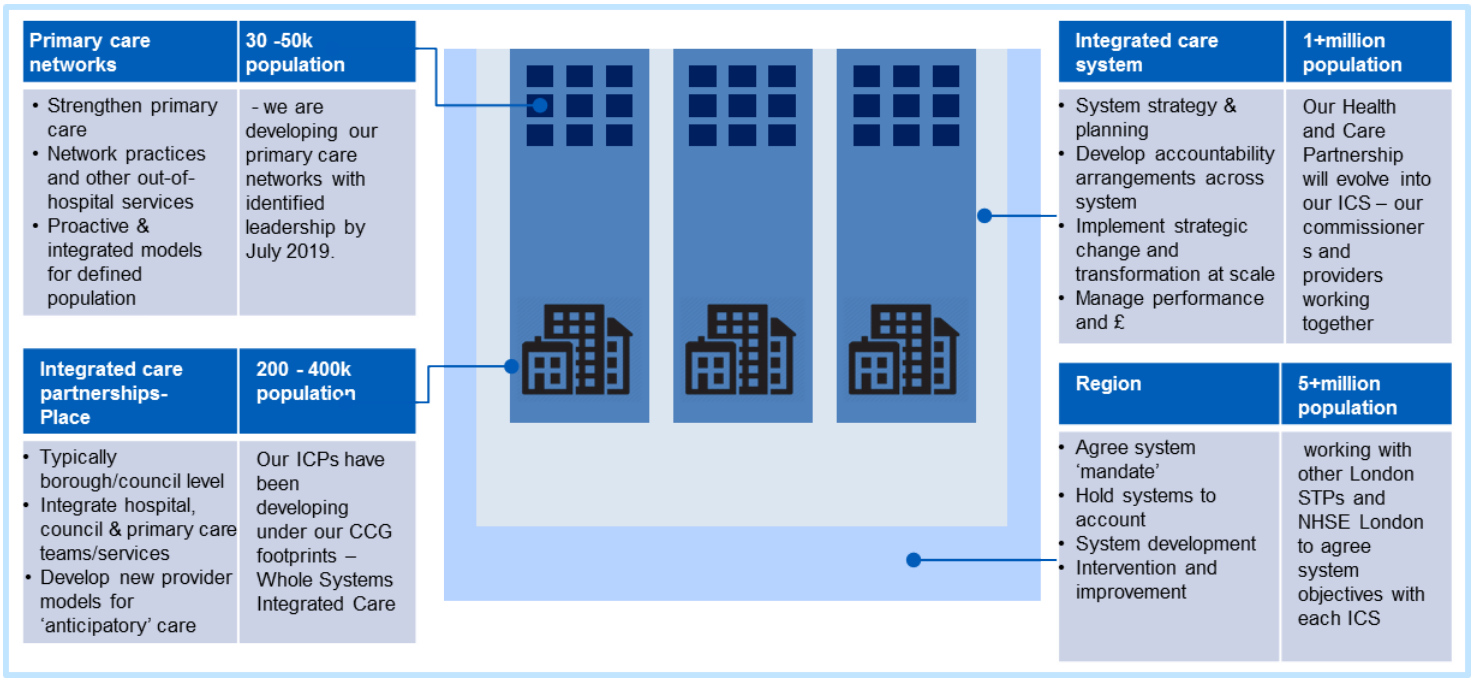


Figure 5: Integrated care as a system of systems

How does moving to a single CCG support our integration agenda?

The NHS long term plan states that "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."

In order to support true integration of our system of health and care in NW London, we need to strengthen several aspects of our strategic and operational functions:

Figure 6: features of integration

At the moment, we operate with eight statutory accountability arrangements for our governance in commissioning, supported by our Joint Committee. Although we have made progress is simplifying our governance, we can go further to streamline decision making – by reducing our statutory boards to one.

This will also support the quick provision of data and information sharing, support consistency and equity in our methods of engagement, and simplify system wide financial planning.

How is an ICP different from a CCG?

An ICP is focused on care provision and delivery for a given population, most commonly, 200,000-400,000 people. A CCG is a statutory organisation that purchases services from providers to deliver care for a given population, and manages the contract for care delivery.

As we continue to fully integrate our health and care system in NW London, we will be moving away from the distinction between provider and commissioner as we manage care on a population health basis, working increasingly in partnership with local government and the voluntary sector.

Our CCG would be responsible for the commissioning of the ICP contract. In the future, it is possible that mature ICPs may form statutory bodies themselves, as their alliance working with partners is strengthened. Our ICPs will be underpinned by local delivery teams from our CCG.

Why are we developing primary care networks?

Primary care is the bedrock of care provision to our residents. We need to ensure GPs are supported to manage the health and care of their registered lists. As part of national policy GPs are coming together in primary care networks with a range of local providers to offer more personalised, coordinated health and social care to their local populations. This multidisciplinary working, led by clinicians, will be the heart of our integration to offer the best care to our residents in NW London.

How are we developing primary care?

We have been working to improve primary care in NW London for some time, implementing the GP forward view in order to meet the needs of our residents. To meet these needs, local practices have begun working together and with community, mental health, social care, pharmacy, hospital and voluntary services in their local areas in primary care networks (PCNs). The change in the way general practice is working helps teams build relationships with all other staff in their networks, and together, in partnership with patients and the public, use whole population health profiles to plan for and deliver integrated whole person care to the key groups of people

The local and NWL primary care strategies have consistently focused on improving the experience of working in primary care; streamlining workloads and improving our track record in retaining and recruiting staff; developing digital solutions; investing accordingly to achieve the standards in accessible, co-ordinated and pro-active care set out in London's Strategic Commissioning Framework.

Our next step is general practice 'working at scale'; with GPs supported by Primary care networks in partnership with local community services, mental health and social care. Ability to make that work for local patients will be enhanced by better working relationships between organisations across the system; consistent and inter-operable IT systems; and better data-sharing.

We have also been developing our system and local population health management plans so that childhood obesity, rising numbers of long-term conditions, dementia, mental health and related health concerns can be managed by the local GP, practice nurse, community nursing staff, community pharmacists and PCN effectively

Primary care networks (PCNs), although provider functions are important part of our health system and are described in this document for completeness. PCNs build on the core of current primary care services and enable greater provision of proactive, personalised, coordinated and more integrated health and social care. By working in this way, practice gain more local control over the health needs of their populations. Clinicians describe this as a change from reactively providing appointments to proactively care for the people and communities they serve.

The development of these networks are a key part of the NHS long term plan, with all general practices being required to be in a network by June 2019, and CCGs being required to commit recurrent funding to develop and maintain them. Primary care networks will be based on GP registered lists, typically serving natural communities of around 30,000 to 50,000.

Our practices will work together in our PCNs. Our PCNs will operate through multi-disciplinary working, delivering population health management, and support our ICPs to deliver the required health and care to our local populations. These networks will be the bedrock of local/borough-level arrangements.

Appendix two: Options for integrated care partnerships (ICPs)

How different commissioning structures can commission different configurations of services – draft

The draft ICP contract pack[1] sets out the following six scenarios:

Services to be commissioned	Mechanism under current legislation	Comments
1. A new care model providing primary medical services, community health services and acute car	The CCG would need to establish aligned budgets for the ICP (which can have a single contract), to ensure that primary medical care funding remains ring-fenced within the ICP's total budget	Primary medical care funding is currently ring-fenced under the delegation agreement
2. A new care model providing primary medical services, community health services, acute care, social care and LA commissioned public health	Under a s75 Partnership Arrangement; an aligned budget within the ICP contract for those service that cannot be included in a s75 arrangement but can be under a single contract	Exceptions as above plus: • surgery, radiotherapy, termination of pregnancies, endoscopy, the use of Class 4 laser treatments and other invasive treatments • s7a public health services • primary dental services • pharmaceutical services • primary ophthalmic services • emergency ambulance service
3. A new care model providing community health services, social care and LA commissioned public health with more than one LA	As above	Exceptions as above
4. A new care model providing community health services, acute care, social care and LA commissioned public health	As above	Exceptions as above
5. A new care model providing primary medical services, community health services, acute care, , social care, LA commissioned public health and s7A (**NHSE**) public health services	As above	Exceptions as above plus need regional agreement for NHSE to be a party to the contract and S7a functions cannot be given to more than one CCG jointly
6. A new care model providing primary medical services, community health services, acute care, social care, LA commissioned public health and specialised services	As above	Exceptions as above plus need regional agreement for NHSE to be a party to the contract and S7a functions cannot be given to more than one CCG jointly

[1] CCG roles where ICPs are established Draft Integrated Care Provider (ICP) Contract - consultation package August 2018

North West London Joint Health Overview and Scrutiny Committee

Date:	21 June 2019
Classification:	General Release
Title:	Work Programme
Report of:	Officers for the NWL JHOSC
Report Author and Contact Details:	Taru Jaroszynski (020 8583 2540) taru.jaroszynski@hounslow.gov.uk

1. Executive Summary

1.1. The NWL JHOSC met in May 2019 to discuss the work programme for the 2019/20 municipal year. meeting in March 2018 that the newly constituted JHOSC set out their work plan for the next year. This plan is meant to be flexible and can be adjusted to address emerging issues. It provides a guide to enable officers and the CCG to prepare accordingly.

1.2. The process to develop this long list involved

- Members, NWL CCG officers and local authorities officers proposed a 'long list' of topics for consideration
- A workshop in May 2019 to prioritise and select topics.

1.3. The proposed work programme is set out below

2. Key matters for the NWL JHOSC's consideration

Members should

- Adopt the work programme for 2019/20

3. Background

Members used the following questions to help prioritise topics

- Is it relevant?
- Does it affect a number of people?
- Does it affect all JHOSC boroughs?
- Can JHOSC have meaningful impact?

The proposed work programme for 2019/20 is set out below:

Date and Time	Host	Activity
24 May 2019	Brent	**Members Workshop:** Annual Review and work programme
21 June 2019	Hounslow	• Case for a single CCG and borough arrangements • Development of integrated care
September 2019 *TBC*	Hammersmith & Fulham	• North West London Finance Committee and GP at hand funding issues • North West London Financial recovery
10 December 2019 11:30-13:30	Kensington & Chelsea	• Long-Term Plan submission • Estate Strategy for NHS London
February 2020	Richmond	• Patient Transport and the CQC report

If you have any queries about this Report or wish to inspect any of the Background Papers please contact Report Author (020 8583 2540)
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