NHS
North West London
Collaboration of
Clinical Commissioning Groups

Joint Health Overview and Scrutiny Committee (JHOSC) paper: An update on the Commissioning Reform Case for Change

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Owner	Mark Easton, Accountable Officer

1. Update on emerging proposals and engagement

Since launching the Commissioning Reform Case for Change on 28 May 2019, the eight North West London CCGs have all been engaging with partners and staff to give stakeholders the opportunity to influence the design of the proposed single CCG. This has mainly been through staff meetings, governing body meetings, meetings with patient groups, meetings with GP practice members, and meetings with local government colleagues.

1a. Feedback from patients and partners to date

It is clear that many patients and partners would appreciate more time to fully consider the proposed case for change. To support our partners in providing informed, constructive scrutiny of these proposals we have agreed to **extend the engagement period until 24 August.**

In addition to formal scrutiny channels such as the JHOSC, any organisation or individual can send written feedback to the public email address (this can be found on our website and has been included in other communication materials): nwlccgs.commissioningreform@nhs.net.

The main questions raised with us so far have been:

- Clear examples of specific benefits to patients (including more detail on how we will strengthen patient engagement and co-production)
- The operating model: what could be commissioned at each level?
- What the financial arrangements and principles might look like
- Details of the proposed governance and decision-making structure
- How we will preserve and enhance clinical leadership (a fundamental principle of NHS commissioning)
- Why 2020? The case for moving to a single CCG by 2020

This paper seeks to offer greater clarity about our vision on each of these points but note that it is a discussion document intended for your feedback. The content reflects an emerging direction of travel.

We listen to all feedback we receive from our stakeholders and partners, including the Joint Health Overview and Scrutiny Committee (JHOSC). **This will happen before we decide whether to make a formal application to become a single clinical commissioning group (CCG).**

2. Must-haves and core principles

Regardless of the future arrangements for commissioning, we remain committed to a series of agreed 'must- haves' and core principles. These must-haves and principles form the basis of our draft proposals.

Must-haves

- ✓ The ability to deliver our commissioning ambitions and responsibilities effectively and as quickly as possible, both at borough-level (or equivalent) and across the entire geography we serve.
- ✓ Strong clinical leadership and involvement in the new arrangements at all levels.
- ✓ An ongoing focus on the health and care needs of local networks or specific populations, as well as a strategic focus across North West London.
- ✓ A single commissioning vision with strategic priorities and health outcome goals at system, borough (or equivalent) and primary care network levels.

- ✓ A commitment to working effectively with our partners and to delivering better integration of health and care services.

- ✓ The ability to deliver both the remaining elements of the required 20% savings in CCG running costs* by 2020/21, and support financial recovery and sustainability across the system, including protecting our primary care expenditure.

- ✓ Effective engagement with local people, clinicians, health and care partners and others to inform commissioning decision making and activities from local to pan-North West London levels.

Core principles

- ✓ We will work as one system to benefit the whole population of North West London and work together to drive health equalities. We will agree key areas to systematically focus upon as a single CCG.

- ✓ We intend to move away from the payment by results system, to place-based budgets, based on population need.

- ✓ We will drive efficiency by commissioning a standardised offer to a uniform value with consistent outcomes.

- ✓ We will work on a population health management basis, as a system, as local partnerships and as neighbourhoods or networks.

- ✓ We will retain the local patient, resident and clinical voice in the commissioning and delivery of health and care, by working effectively together at the three levels of our system.

- ✓ We will value our staff, our partners and their expertise to deliver the best health and care possible for North West London.

- ✓ We will drive forward our integration agenda, to deliver joined-up care for population.

- ✓ We will emphasise the value of subsidiarity, working as locally as is feasible whilst retaining strategic, effective commissioning for North West London.

3. Outline operating model by responsibility and influence

This section of the document sets out a draft outline to show which areas of work we might hold at a North West London level, and which areas of work we might keep at a borough and/or CCG area level. It is set out as commissioning responsibilities, and primary care responsibilities.

Commissioning responsibilities: North West London level

- ✓ Working with the Integrated Care System on:

    - North West London-wide strategy

    - Implementation of NHS Long-Term Plan including prevention, cancer, long-term conditions

- Financial framework
- Quality and provider regulation
- Performance management (meeting NHS standards)

✓ Commissioning:

- Acute care
- London Ambulance Service and integrated urgent care
- Mental health care from statutory providers
- Secondary care children's services and maternity services
- Statutory obligations for primary care commissioning and development of North West London primary care strategy

✓ Providing a central and consistent framework for:

- Primary and community services
- Continuing healthcare
- Medicines management

✓ Employer of staff

✓ Statutory governance and decision-making

✓ Statutory responsibility of budgets

Interest or influence: North West London level

✓ Community based care

✓ 'Out of hospital' planning and commissioning

✓ Integrated Care Partnership development

✓ Primary Care Network maturity

Commissioning responsibilities: borough and/or CCG-area level

✓ Adult community services, including prevention and long-term condition management

✓ Older people's community services

✓ Community services for children and young people

✓ Learning disabilities in the communities

✓ Local mental health services

- ✓ Embedded interface with acute services
- ✓ Working with primary care networks
- ✓ Local development, management and organisation of primary care
- ✓ Local delivery of continuing healthcare
- ✓ Local delivery of medicines management
- ✓ Local requirements of the long term plan
- ✓ Management of devolved budgets
- ✓ Management of staff and clinical teams
- ✓ Developing the Integrated Care Partnership
  - Working with partners to agree the scope
  - Organising the contractual and governance form
  - Working in partnership with other NHS, local authority and voluntary sector partners

Interest and influence: borough and/or CCG area level

- ✓ Acute/mental health planning and commissioning
- ✓ ICS development
- ✓ Framework agreement and development

Primary care commissioning responsibilities

North West London level

- ✓ Statutory responsibility for delegated commissioning of general practice
- ✓ Agreeing sector-wide standards and service specifications
- ✓ Agreeing pricing for enhanced services, within sustainable financial envelope
- ✓ Development of digital model of primary care
- ✓ Estates and workforce planning
- ✓ Population health management via whole systems integrated care (WSIC) dashboard
- ✓ Co-ordination of BI, IT, finance and quality input to CCG contracting
- ✓ NHS England relationships and Londonwide LMCs engagement

Local Integrated Care Partnership responsibilities

- Management and monitoring of practice-based core/enhanced contracts, such Primary Care Networks, and Directed Enhanced Services.

- Negotiation of Integrated Care Partnerships (including primary and community services), with core general practice a key component, on a population health model.
- Business case development, commissioning and contract letting for new practices.
- Management of Business Intelligence, IT, finance and quality input to contracts.
- Local LMC engagement and patient and public communications.

This could mean a North West London team supported by locally-based primary care teams. For example:

A single primary care commissioning team, for North West London, delivered by primary care leads (from CCGs), the NHS England commissioning or finance team, and the Enhanced Services team, to agree service plans, outcomes and financial envelope with local integrated care partnership (ICP) teams.

Or

CCG-based teams to commission integrated care at a borough and/or CCG level as the Primary Care Networks mature, alongside the core general practice commissioning requirements, overseen by local Primary Care Commissioning Committees and/or a Committee in Common. This model enables local ICPs to evolve alongside local general practice and Primary Care Network development over the five years of the Primary Care Network contract.

4. Governance: North West London CCG proposed membership

CCGs are membership organisations. The members are GP practices. The Governing Body is a mixture of appointed and elected members.

The managers are appointed by the governing body, and the clinical members are elected by the membership (one for each borough and/or CCG area). Each of the four lay members will sit on two local committees.

The proposed membership under consideration at the moment is as follows:

- North West London CCG Governing Body Chair (lay member or clinician)
- Lay members (x4)
- Clinical chairs (x8)
- Secondary care doctor
- Director of Public Health
- Local government co-opted member
- Accountable Officer
- Director of Commissioning
- Chief Financial Officer
- Chief Nurse

5. Clinical leadership and the clinical case for change

Clinical leadership is an essential aspect of NHS commissioning. All GP practices are members of a CCG and have a say in what, and how, local NHS services are provided. **None of this will change,**

even if we become a single commissioning organisation. It is vital that, if approved, a single North West London CCG would be underpinned by strong clinical leadership and engagement.

The existing clinical leadership of North West London CCGs is committed to fulfilling the requirements of the NHS Long-Term Plan and reducing the number of CCGs. The leadership is also committed to a smooth transition as we consider the case for moving to a single CCG, assuring appropriate and robust levels of clinical leadership and engagement in the new structure.

Clinical case for change

The main clinical benefits in our case for change are:

- ✓ We can improve quality of care for all North West London patients and reduce unnecessary variation by commissioning together.
- ✓ We can reduce health inequalities by working together and sharing best practice across the sector.
- ✓ We can reduce the unnecessary inefficiencies in the system and allow greater reinvestment into patient care.
- ✓ We will be better able to establish strong partnerships of scale which will make health and social care more seamless for patients.
- ✓ A single CCG will mean that local teams can support the development of integrated care partnerships and borough or CCG-area system responses to patient needs, allowing primary care to lead and partner with other providers with patients at the core of delivery.

Other benefits include:

- ✓ More control over defining and creating the health system we need and want for the population
- ✓ Greater buying power with the ability to deliver better value for money
- ✓ Better opportunity to attract, afford and retain clinical and managerial staff with the right talent and skills
- ✓ Taking forward the best practice from individual CCGs and agreeing common approaches to increase consistency and quality of care
- ✓ Making it easier for health and care partners to engage and work with us
- ✓ Meets the NHS Long Term Plan requirements

6. Local scrutiny and engagement

Patient and public involvement in the North West London CCG will remain local. As always, it will continue to feed the design and review of service standards. Patients and the public are at the heart of everything we do. In shaping, developing and improving health services, we aim to work with patients and the public rather than simply for them.

In practice this means the following local commitments:

- We are committed to co-production with patients and other stakeholders as appropriate.
- Lay members and Healthwatch will sit on the single CCG Governing Body.
- When engaging with our communities, we will work with Healthwatch (this will include regular meetings), the voluntary sector, local authorities and local communities, reaching and listening to as many people and communities as possible. This includes, for example, groups

whose interests are protected under the Equality Act 2010, carers, people experiencing social exclusion or isolation, groups that the NHS is not always successful in hearing from and people impacted by the Grenfell tragedy and others. We recognise that this will require a range of engagement tools and approaches.

- We will listen to and respond constructively to feedback from our local communities, adopting a 'You said, we did' approach to public engagement, meaning that all feedback will be recorded and responded to publicly.
- We will work with GPs and Healthwatch to enhance the role of patient participation groups, ensuring that they maintain a local voice which is heard by commissioners.
- We will continue developing Our Community Voices programme to keep unprompted conversations going with patients and service users about their experiences.

Scrutiny and engagement at a North West London level

Patient and public involvement within a single North West London CCG will be strengthened by multiple channels of engagement and input.

We will create and explore opportunities to work with the voluntary sector in each borough where possible, strengthening our shared insight into patient experiences. By getting this right there is potential to drive meaningful behaviour change and develop healthier communities.

As part of this work, we are in the process of establishing a North West London Citizens' Panel, which will be broadly representative of the local population and will be used to gather public and patient opinion on issues relating to the local health and care system. We will also set up a voluntary Readers' group to ensure that our materials are easily understood. Accessibility in general is of utmost importance and we will continue to translate materials into alternative languages where required, develop a community-facing website for the single CCG, and work to make sure all patient-facing information is in line with best practice in terms of accessibility.

Our Lay Partner Forum will continue and we will potentially expand this out to the wider voluntary sector. We will work with the Forum to co-produce and improve our approach to public engagement and involvement.

We recognise that campaigners with an interest in local health services have a role to play and we will seek to listen carefully to such groups, take account of their views and keep them informed of key developments in the NHS. This may be through meetings, calls, emails, online tools and through social media engagement, taking a best practice and responsive approach to online dialogue.

Local scrutiny and accountability

We will maintain local teams in each of the current CCG areas, operating under formally delegated responsibilities from the CCG, who will have a range of commissioning responsibilities, including maintaining and strengthening engagement with local stakeholders and communities. We will work with each of our local authorities at borough level and we expect that all local authorities will want to be a part of the North West London Integrated Care System, which brings together NHS commissioners, providers, local authorities and patients.

Each area will develop a local Integrated Care Partnership, in which will want to work with Healthwatch and patients to create a single integrated system. There will be visible partnership with local statutory stakeholders. The single CCG will continue to attend local scrutiny committees and Health and Wellbeing Boards, through its local leads, in addition to regular attendance at JHOSC for North West London wide scrutiny.

Single CCG Governing Body will be held in public, and will be rotated across the eight North West London boroughs, in a similar model to the current JHOSC. The public will have the opportunity to ask questions at these meetings. We will continue to work, as now, with local people in producing local service specifications, monitoring quality and performance and ensuring the best possible outcomes for patients and service users. We will maintain a programme of patient and public engagement in each borough and/or CCG area, based on the 'You said, we did' approach outlined above.

7. Financial principles: How finance might look in the new operating model

CCGs in North West London since their inception have had a wide variation in their distance from target allocations ranging from 19.6% above to 4.6% below. This has led to different levels of funding per head of population, and therefore different levels of investment in services.

We have a history of better positioned CCGs making loans or transfers to support CCGs in difficulty.

Taken as a whole, North West London CCGs are slightly above target allocations. However, we enter 2019/20 with a planned CCG deficit of £50m and significant challenges to address the underlying system deficit.

Addressing the deficit is going to be central to our work over the next few years. The reform in the Case for Change is seen by NHS England and NHS Improvement as one key step in addressing our financial problems.

We are required to save 20% on our management costs from 17/18 to 20/21. We have already saved £2.5m, we still need to save £2m this year (in train) and have a further £1.3m to save next year.

The starting point for a single CCG will be the borough based allocations of funding and services they have now. Allocations covering the period to 2023/24 were published by NHSE in January. The recent guidance on the NHS Long-Term has clarified that this is the starting point for system planning and will be complemented with:

- An additional funding allocation distributed to our NWL system on an indicative, fair shares basis
- An indication of targeted funding which will be given subsequently against specific Long Term Plan commitments through regions and national programmes
- The indicative allocations will be communicated to us from NHSE in due course

As you would expect we will be keen to ensure that our transition path does not destabilise existing service provision, especially in view of our aim to promote equality of access, and eliminate inequalities. Further work is going on in this area, both locally and London-wide.

We know there are opportunities to improve value by:

- Standardising prices paid by different areas to drive value
- Standardising key pathways across NW London that are demonstrably best practice and drive value and quality e.g. rapid response, frailty pathway

We will develop a delegated model of responsibility for local commissioning (i.e. 'local teams') which have, via the CCG sub-committees, a delegated budget and freedom to act within a scheme of

delegation. This would enable local accountability and decision making, according to an agreed scheme of delegation, to support local population management and the development of integrated partnerships.

Some budgets are allocated to the CCG on a ring fenced basis; this will continue as long as ring fencing continues, e.g. primary care.

Local teams will continue to commission enhanced primary care under an agreed framework, with the starting point of current contracts with, over time, standardisation of price. There is nothing which inhibits the Better Care Fund, section 75 agreements or the development of pooled or aligned budgets. The development of these will be at ICP level.

Further technical guidance is expected shortly from NHSE on CCG finances. We are happy to share this with the JHOSC if useful when it is received.

8. Integrated care and commissioning reform

8.a North West London Integrated Care Partnership (ICP)

As well as joining up at the commissioner level, in North West London, in line with the national direction of travel we are also moving towards a more collaborative model of working more widely. This will ultimately be in the shape of an Integrated Care Partnership, and will involve integration between health and social care, as well as integration at a provider level.

The development a North West London Integrated Care Partnership (ICP) will be phased. In phase one the local CCGs would continue commissioning services from the ICP and participating in its development. In later phases, local committees could develop joint governance with the ICP.

We envisage three phases which are briefly described as follows:

Phase 1: Emergent ICP

Each CCG continues to hold a delegated budget for services within the emergent ICP. The CCG works with the emergent ICP while holding a contract with it for the services it provides.

Phase 2: Developing ICP

The CCGs work more closely with the developing ICP. For example, this stage could involve shared job roles, and the beginnings of shared governance. Each CCG still holds a delegated budget for services within the ICP, and works with the ICP to establish the latter as a self-standing entity.

Phase 3: Established ICP

The ICP exists as an established as part of a statutory entity and has absorbed CCG staff within it. The ICP holds a capitation and outcomes-based contract with the CCG.

8.b Integrated care: the three London models

Each borough system will have a different start point but adopting one of the three models in each borough of a single CCG will allow decisions to be made locally everywhere, with Local Authorities and providers with different levels of formality and governance – that will/ can become more ‘joined’ over time.

More formalised models can be achieved through Section 75s and other contractual arrangements, and be supported by committees or individuals with joint accountability to multiple bodies.

In other areas of London, Model Two appears to be the preferred option across SWL at this time. In SEL an initial mixed model approach is envisaged recognising the differing current positions across Models One to Three at an individual borough level.

We need to develop which model (or models) suits patient needs in North West London, and we encourage input from all our stakeholders, patient groups and partners on this, including scrutiny committees.

Model 1: Greater Involvement

- This model means separate plans and separate budgets.
- An NHS Local Board with Local Authority represented to make collaborative plans.
- This would be a committee of the CCG Governing Body with delegated powers.

Model 2: Aligned Commissioning

- This model means aligned plans or a single plan and separate budgets.
- A joint local board or committee where borough NHS and Local Authority Commissioners (and providers in some circumstances) would generate and pursue a single 'borough/CCG-area' plan and align their investment/commissioning decisions.
- This would be a committee of the CCG Governing Body with the ability to meet with the Local Authority and providers with delegated powers over NHS spend reserved to CCG members and a governance requirement to follow aligned plans.

Model 3: Collaborative Commissioning

- This model means aligned plans or single plan and a single budget.
- NHS and Local Authorities would make decisions together with a budget delegated from both bodies and a dual accountability to the CCG Governing Body and the Local Authority Cabinet.

8.c Local authority partners and integration

At a North West London workshop on 24 June with local council chief executives, directors of adult social services, CCG managing directors and chairs, we discussed the development of our future operating model from an integration perspective. A summary of the feedback is detailed below:

It is agreed that there should not and will not be a hierarchical relationship between Integrated Care Systems, the Integrated Care Partnership, and the Primary Care Networks. All of these groups will work together improve local health and wellbeing for patients and residents.

We need to protect what is working well and develop future shared priorities building on the outcomes and priorities that are important to local areas. The future model for North West London and borough-working should build from what we have today and should go further and deeper. There are already a number of areas of joint-working across local authorities and through the North West London collaboration of CCGs, as well as joint commissioning teams in individual boroughs. This needs to be built upon.

There are some service for which the benefits of having a North West London-wide approach are already clear. For example, standardising best practice for specialist clinical services, or achieving consistent value for spend.

In areas such as urgent and emergency care, and acute mental health services, there is a desire to develop more integrated pathways of care which will require commissioners and providers to work together within and across borough boundaries. We will look carefully at where each CCG

commissioning function will go, what relationships will look like between these functions and the Integrated Care System, and the role of local delegation, funding and governance in this model.

We recognise that with social care as with health, each borough is different. The relationship between commissioning at North West London and borough level will need to reflect these differences, whilst accepting the need to fit within common frameworks. This process needs to engage both commissioners and providers of care including local acute trusts and primary care, as well as community and social care providers.

9. Timeline and next steps

9.a Why April 2020?

Our proposed deadline is that we become a single CCG by April 2020. This timeline would be beneficial for patients and for the NHS in the following ways:

- We will be aligned to three of the four other STP areas in London, ensuring we are making staffing and structural changes at the same time as most other parts of London.
- Our regulators and NHS partners see the single CCG as a key step in the development of integrated care, new ways of working and financial recovery.
- We can focus on what is important: improving care for our patients, reducing health inequalities, and financial recovery.
- We can better enable financial recovery by moving away from payment by results more quickly.
- We can minimise uncertainty for staff by moving ahead with any structural changes.
- We can improve how we commission services sooner.
- We can better facilitate ICS development and implementation of the NHS Long-Term Plan this year.

Alternative deadlines are still open to consideration but we would face the following risks:

- Staff retention is likely to be affected if we draw out the change process, with ongoing uncertainty for staff. Other areas of London will have stabilised, offering a more attractive place to work.
- The longer the time period, the more resources will be used.
- We risk losing regulator and stakeholder support.

9.b Proposed milestones

Our proposed timeline is:

- June 2019: Commissioning Reform Case for Change launched and discussed at CCG Governing Bodies
- July 2019: Ongoing engagement through CCG Governing Body seminars and Council of Members' meetings. Attendance at various stakeholder meetings including JHOSC, H&WB Boards and scrutiny committees

- September 2019: Finalised proposal presented to CCG Governing Bodies, and application submitted to NHS England. Governing Bodies make decision.
- October 2019: Depending on governing bodies decisions, CCG members vote on whether to become a single CCG
- Autumn 2019 NHS Assurance
- April 2020: If approved, the new North West London CCG will launch.

Next steps

- We will continue to engage with our stakeholders throughout the process, but we welcome comments on proposals until 24 August.
- We will be developing the delegated budgets and management cost allowance at place level over the next month.
- We are preparing for organisational change by developing our values and behaviours and our organisational development strategy.
- We will continue to develop our integrated care partnerships with stakeholders including the JHOSC.
- By the time we are ready to take proposals to Governing Bodies in September, we aim to have the budgets and outline structures ready.
- Our proposals to Governing Bodies include our NHS England application documentation, such as our financial plans, HR and Organisational Development plans, and communications and engagement plans.
- We are developing the draft constitution and financial framework required to operate as one. We are working with colleagues across London for consistency.
- As we develop new staffing structures, we will use our change management process as set out in our policies. We aim to do this through late autumn when we enter the implementation phase.