NHS
North West London
Collaboration of
Clinical Commissioning Groups

Commissioning reform in NW London

Summary of emerging proposals for operating model and local engagement in our single CCG

Published on behalf of the Accountable Officer and the CCG Chairs

In May 2019, we published a 'case for change for commissioning reform', setting out a proposed merger of the eight North West London clinical commissioning groups, to form a single CCG. This proposal aligns with the NHS England Long Term Plan, which calls for a reduction in the number of CCGs, with typically one per STP area', meaning a single CCG for North West London.

Since then, we have been talking to local organisations and stakeholders to shape the design of the single CCG. The initial period of engagement has been extended to 24th August, to allow people more time to comment.

We said we would publish more information during the engagement period on how the single CCG might work. We are now in a position to do so. Our new publication, *Commissioning Reform in North West London: emerging proposals for operating model and engagement in our single CCG,* aims to provide more clarity about potential future arrangements.

While we have made considerable progress we should be clear that at this stage, there is further work to do on a number of questions including future staffing structures and the detail of how the finances will work. We are, however, on schedule to have completed all the necessary work in time for the September governing bodies, where CCGs will be asked to decide on the proposal, including the question of when the change should take place.

We are still in an engagement process, so if people have other ideas about how a single CCG might work, or how a different future arrangement of commissioning in NW London might be better, we would be happy to consider them and give them due regard.

What does the document say?

1. **It sets the proposal in the context of wider system change.** We are working towards establishing an '**integrated care system' (ICS)** between all NHS commissioners and provider trusts in NW London, working with our local authority partners, patients and the public, Healthwatch and the voluntary sector. At place or borough level, the ICS would be supported by '**integrated care partnerships'** (made up of local trusts and commissioners working with local authority partners and other stakeholders) and **primary care networks** in each borough.

2. **It sets out the proposed balance between local and NW London systems.** The NW London CCG would set up a series of local committees with delegated powers and the budgets to drive local commissioning and the development of integrated care partnerships (ICPs) in each current CCG area. The paper provides further information on what would need to be delivered locally and what would be done at NW London level (see table on slide 9 of the document). Acute and specialist care would be commissioned once, at NW London level (where it makes sense to do so), while locally-focused health (and social care if agreed) would be commissioned at local level.

3. **It clarifies further the underlying rationale for change and the interface with local government** (slide 9)**.** The management changes to the CCGs will make a modest financial contribution, but their main purpose is to create a more effective and better value system by giving the north west London system and its constituent parts greater powers to standardise care, standardise what we pay for services, reduce health inequalities, make decision making more straightforward and support closer working between health services and between the NHS and local councils.

   We will maintain and build on relationships with local government, including health & well being boards and overview and scrutiny committees, via senior local NHS staff.

4. **It describes potential future governance and decision-making arrangements** (slides 14-17). This includes the proposed membership of the **NW London GGC Governing Body.** This recognises that CCGs are membership organisations made up of GP practices. The proposed governing body is a mix of elected and appointed members. The governing body would appoint managers and clinical members would be elected by members, with one per borough/area. There would be four lay members and a local government representative.

5. **It explains that the development of integrated care partnerships in each borough/place will be phased** (slide 18). Initially, the local (currently CCG) team in each borough/place will hold a delegated budget for services covered by the ICP. In phase two, the local team will increasingly work as one with the ICP, including shared posts and moves towards joint governance. In a further phase, which depends on legislation, the ICP could be established as part of a statutory integrated body, absorbing the local CCG/place team.

6. **It sets out the clinical reasons why a single CGG would be beneficial** (slide 6). These include: greater investment in patient care by reducing inefficiencies; better ability to drive high quality care and reduce variation; reducing health inequalities by working together and learning from the best; leaner, more focused teams to support the development of integrated care; greater buying power and value for money; more control over creating the health system we want for our residents.

7. **It sets out our proposed future approach to patient and public involvement and engagement** (slides 20-21). In proposals jointly designed with lay members and partners, we set out our commitment to co-production and working with patients and the public, who are at the heart of everything we do. We will listen to and respond constructively to feedback, adopting a 'you said we did' model, aiming to reach deep into our communities and hear from as many people as possible. We will work in partnership with providers, local authorities, Healthwatch, the voluntary sector and our local communities, including groups we do not always successfully reach. We will establish a broadly representative Citizens' Panel to test and monitor local opinion on issues relating to local health services.

8. **It sets out how we will strengthen our accountability to local people in each area** (slide 22). We will maintain teams in each area and public and stakeholder engagement will remain local. We will work with each of our local authorities at borough level and expect that most local councils will want to be part of the North West London Integrated Care System. Local CCG teams will continue to attend local meetings such as Scrutiny Committees and Health and Wellbeing Boards. Single CCG governing body meetings will be held in public and rotated across the eight areas. We will continue to work with local people to co-produce local service specifications, monitor quality and ensure the best outcomes for patients and service users.

9. **It provides more information on the principles underpinning our approach to finances** (slides 24-25). Borough-based funding has varied depending on funding per head of population. We have a history of better positioned CCGs supporting CCGs in difficulty and we expect this to continue between areas in a single CCG. We enter 2019/20 with a deficit of £50m and tackling our financial challenge is likely to be central to our work over the next few years. This programme of Commissioning Reform is one key step towards resolving our financial problems.

10. **It sets out initial feedback from local authorities on a more integrated approach between health and social care** (slide 27). There is a shared view that we need to protect what we have and develop share future priorities, building on what is in place but going further and deeper. While the benefits of a NW London approach are clear in some service areas, such as achieving consistency in terms of clinical best practice and what we pay for services, others do not sit neatly in a 'NW London' or 'local' box – commissioners and providers will need to work both within and across borough boundaries. This is not about a hierarchical relationship, but working together as one system across the ICS, ICPs and primary care networks. We need to recognise that all boroughs are different and commissioning relationships should reflect that.

11. **It responds to some of the questions our staff have been asking** (slide 29). These include questions about potential job losses and changes, internal staffing structures and consultation.

12. **It sets out the pros and cons of making the change in 2020 or 2021** (slide 31). Benefits of changing in 2020 include minimising uncertainty for staff, progressing a

key step in the development of integrated care, alignment to most other parts of London and being able to focus on what matters: improving care, reducing health inequalities and getting our finances in better shape. Drawbacks include the risk of moving too quickly to ensure that everything is in place and we do not miss key issues. 2021 would allow us more time and the ability to learn from other London mergers, but may also adversely affect staff retention, cause staff uncertainty, use more resources and time and risk losing the support of regulators and stakeholders.

Feedback on this latest communication is very welcome. We will continue to meet with our staff and key stakeholders to discuss the issues raised, working to a new deadline of 24th August for the engagement period. Written feedback or questions can be sent to nwlccgs.commissioningreform@nhs.net

The document (slides 32-33) sets out our current timeline and the next steps.