Health and Wellbeing Board

TABLED DOCUMENTS

DATE: **Thursday 25 July 2019**

8. NW LONDON COMMISSIONING REFORM PROGRAMME: PUBLIC DRAFT CASE FOR CHANGE (Pages 3 - 40)

Report of the Accountable Officer, Harrow Clinical Commissioning Group (CCG) – tabled documents

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3

Commissioning reform in NW London
Case for change: further detail

Emerging proposals for the operating model and local engagement in our single CCG

Agenda Item 8
Pages 3 to 40

About this pack

This pack is a **discussion document** and is not a final draft – please do provide feedback. This document **builds on the detail provided in the case for change** which can be read here.

This pack has been developed following conversations with: staff, public, local authority, GPs, Governing Body members and lay partners

The **content shows the emerging direction** of travel, but has not been formally agreed.

4

We will incorporate the feedback we receive and design final proposals for **discussion with our eight governing bodies in September**, before we decide whether to make a formal application by the end of that month for the merger of NW London CCGs and the creation of a single NWL CCG.

Please send your feedback, by 24 August to: nwlccgs.commissioningreform@nhs.net

Summary

- Since we launched our **case for change for commissioning reform** on 28 May 2019, we have been engaging with our stakeholders to **shape the design of our single CCG**, and preparing for organisational change. We have attended staff meetings, governing body meetings, meetings with patient groups, meetings with GP practice members, and meetings with local government colleagues.
- We have also heard the need to give more time for feedback on our ideas and we have agreed to extend the engagement period, and **welcome comments on the developing proposals until 24 August** – please do feedback your comments to nwlccgs.commissioningreform@nhs.net.

- We said more information would be provided during the engagement process, and we have heard that stakeholders are keen to hear more on:
  - The operating model and what is commissioned at what level, including local decision making based on local intelligence
  - Governance and decision-making
  - The financial arrangements
  - How we preserve and enhance clinical leadership, benefits to patients, and patient engagement and co-production
  - Development of integrated care at place level and improving partnerships with local government
  - The arguments for and against making a change to a single CCG in 2020 or 2021.

Contents

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Clinical leadership and clinical case

A NW London CCG is underpinned by strong clinical leadership and engagement

- A single CCG allows us to set, implement and monitor a uniform of set of standards across the STP enabling us to drive down the variations in care delivery that currently exist and ensure a higher standard of care
- The clinical leadership of NW London CCGs is committed to fulfilling the requirements of the NHS long term plan and reducing the number of CCGs ideally to one CCG for our STP.
- The leadership is also committed to a smooth transition to one CCG, assuring appropriate and robust levels of clinical leadership and engagement in the new structure.
- Strong clinical leadership and involving clinicians in making healthcare decisions are essential aspects of 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.
- We believe this transformation is of value for the following clinical reasons:

1. A single CCG will enable us to reduce the unnecessary inefficiencies in the system and allow greater reinvestment into patient care
2. We can better drive quality in NW London for patients and reduce unnecessary variation by commissioning together
3. We can reduce health inequality by working stronger together, and the learning from the best can be more readily shared across the sector
4. We will be able to create partnerships of scale to represent primary care and patients, as clinicians in an ICS
5. A single CCG will allow local teams to support the development of integrated care partnerships and local system responses to local needs, allowing primary care to lead and partner with other providers, putting 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

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What are we changing to?

Draft operating model

Overview 1

- The changes to the CCGs in London need to be seen as one part of wider system change, with the establishment of integrated care systems at STP level, the creation of 'integrated care partnerships' at the level of place or borough, and primary care networks operating within the boroughs.
- The establishment of a single CCG creates a single commissioning authority for NW London, with the ability to operate at different scales simultaneously – system, borough (place) and neighbourhood (network). This is an important step towards an integrated care system (ICS) way of working. It secures the NHS long term plan commitment to ensure **'a streamlined and single set of commissioning decisions at system level' .**
- In London a common model is emerging, with the new CCGs having the ability to **delegate to local systems** of providers and commissioners (with ultimate accountability for the discharge of current CCG commissioning responsibilities continuing to reside with the CCG) at a pan-STP level or to more local systems (boroughs). Their interplay can be planned and overseen by the single CCG Governing Body.
- **This means the NW London CCG will create a series of local committees with delegated powers and budgets to drive local commissioning and the development of integrated care partnerships (ICPs). Over time, it is envisaged the ICPs may absorb the local commissioning staff and become self standing entities.**
- This allows for the commissioning of acute and specialist care at pan-STP level once (where it makes sense to do so), and the commissioning of **locally focused (health and social) care** at borough (or equivalent) level.
- It also allows for a whole system approach at a local level and provides **for local ownership**, whilst retaining scale and an equivalent **whole-system join up** and ownership where appropriate.

10

Overview 2

- 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 commissioning system by giving the north west London system and its constituent parts greater powers to:
    - standardise patient pathways which are known to be most effective (such as common frailty pathways)
    - Standardise the prices paid for similar services
    - Reduce health inequalities
    - Make decision making more straightforward
    - Give opportunities for greater integration both within the health service and with our partners in local government and other stakeholders.

11

- There will continue to be an important interface with borough democratic structures: health & well being boards and overview and scrutiny committees, via senior local NHS staff. At NW London-level we propose to have a local government representative on the governing body and to continue to work closely with the Joint Overview and Scrutiny Committee and the Health & Care Partnership Board which has council leaders and senior officers on it.
- We shall preserve, and build on, existing joint arrangements which work with local authorities.

There are significant ‘must-haves’ we will strengthen and important principles for the development of our future state

Regardless of the future arrangements for commissioning, there are a number of ‘must- haves’ and principles, that we are committed to delivering. Mostly these are examples of good practice we are already doing and form the basis of our draft proposals.

Our ‘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 NW London
- ✓ A single commissioning vision with strategic priorities and health outcome goals at system, borough (or equivalent) and primary care network levels
- ✓ The opportunity to work effectively with our partners and pave the way for better integration of health and care services, at borough level through integrated care partnerships and at system level through our emergent integrated care system
- ✓ 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-NW London levels

Our principles

- ✓ We will work as **one system** to benefit the whole population of NW 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/ 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 NW 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 NW London

* Running costs relate to the administration of the CCG organisations themselves, e.g. payroll, finance and procurement. They do not include patient services, which are covered by a separate budget and which will not be affected by this work.

Outline operating model by responsibility and influence

Responsibilities

NW London-wide

- ✓ Working with the Integrated Care System on:
  - NW London-wide strategy
  - Implementation of NHS Long Term Plan inc. prevention, cancer, long term conditions
  - Financial framework
  - Quality and provider regulation
  - Performance management (meeting NHS standards)
- ✓ Commissioning:
  - Acute care
  - LAS 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 NW 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

Place-based

- ✓ 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
- ✓ Commissioning:
  - Adult community services, inc. prevention and long term condition management
  - Older people's community services
  - Community services for children and young people
  - Learning disabilities in the community
  - 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
  - Medicines management
  - Local requirements of the long term plan
- ✓ Management of devolved budgets
- ✓ Management of staff and clinical teams

Interest in and influence over

NW London-wide

- ✓ Community based care
- ✓ Out of hospital planning/commissioning
- ✓ ICP development
- ✓ PCN maturity

Place-based

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

Primary care commissioning at NWL and Place

NW London	Local Integrated care partnership responsibilities
• 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 • NHSE relationships; London-wide local medical committees (LMCs) engagement	• Management and monitoring of practice-based core/enhanced contracts, PCN DES etc. • 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 BI, IT, finance and quality input to contracts • Local LMC engagement; patient and public communications

This could mean in practice:	
Central NW London team supported by locally based primary care teams	
A single primary care commissioning team, for NW London, delivered by primary care leads (from CCGs), the NHSE commissioning/finance team, Enhanced Services team etc., 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 place-level as the PCNs mature, alongside the core general practice commissioning requirements, overseen by local PCCs and/or 'Committee-in Common'. This model enables local ICPs to evolve alongside local general practice and PCN development over the 5 years of the PCN contract

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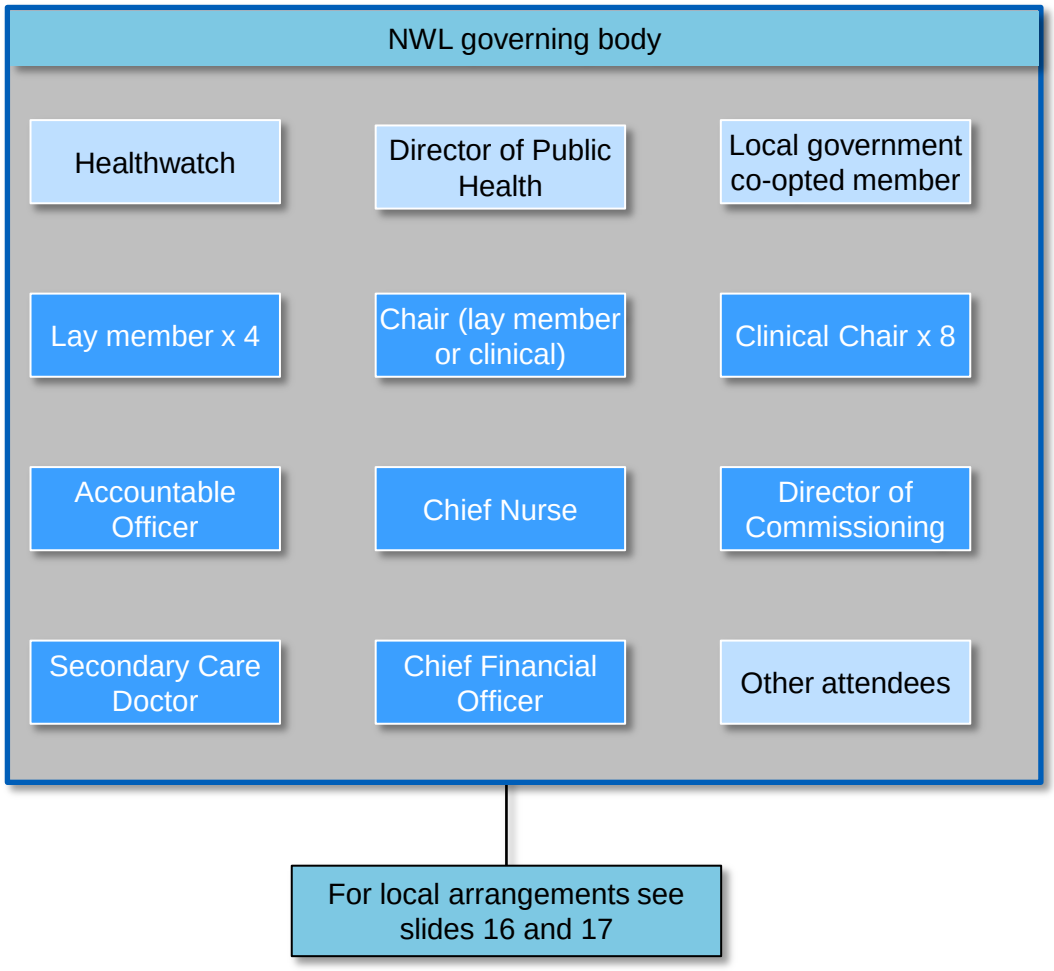
Governance proposals at NW London and place level

NW London CCG draft Governing Body arrangements: 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, the clinical members are elected by the membership, one for each borough/place.

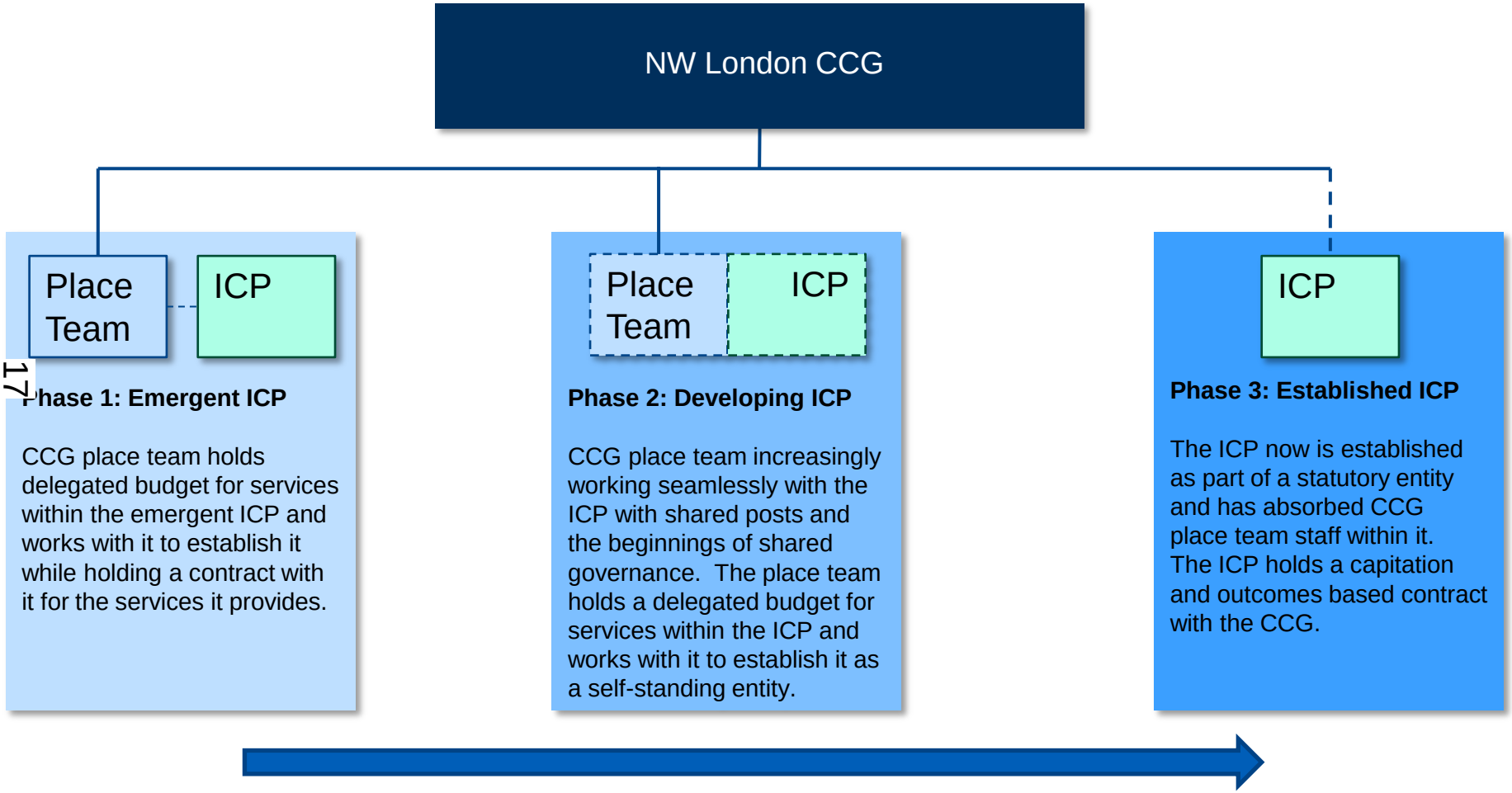
Each of the four lay members will sit on two local committees.

Key

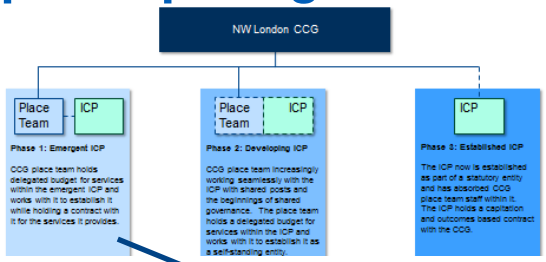
- Voting members
- Non-voting members

16

We wish to develop integrated care partnerships (ICP) in NW London, but the development of this is likely to be phased. The relationship between the local CCG team and the developing ICP will change over time



In phase one, the relationship could look something like this, with local CCG staff commissioning services from the ICP and participating in its development.



NW London Governing Body

ICP

PCN clinical directors

Clinical directors

Clinical Chair

Healthwatch

NHS borough director

Local committee

Lay representation

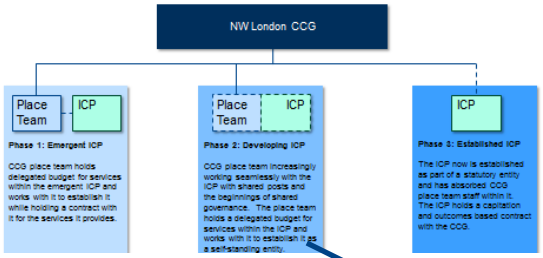
Local government/ social care (where agreed locally)

Other management staff

Other co-opted patient representation as agreed

Local team

A more developed ICP might look more like this:



NW London Governing Body

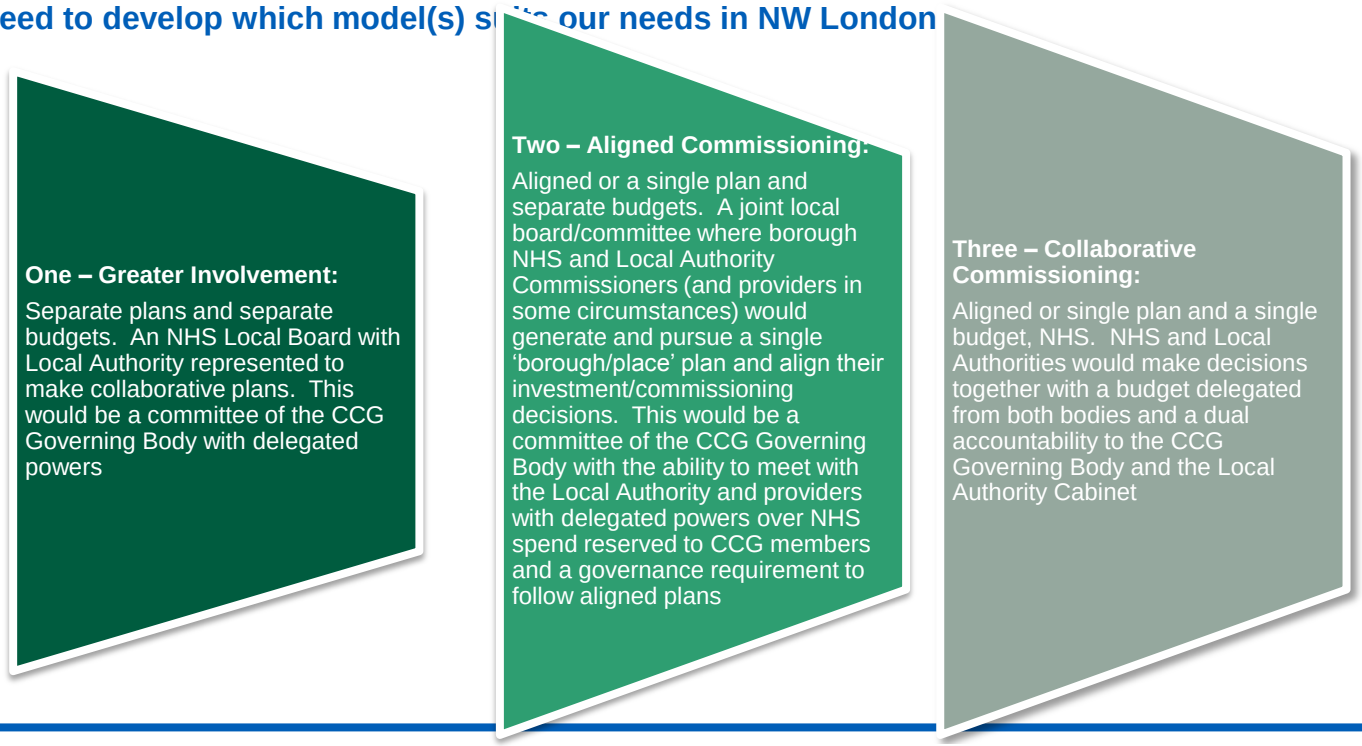
Chair

- Local government/ social care
- Provider leads
- Clinical /PCN directors
- Local management team, headed by borough director
- Lay and patient representation
- Healthwatch

Borough/local committee developing joint governance with the ICP

There are three models for working with local place/borough systems emerging from London

- Each borough system will have a different start point but **adopting one of the three models (or bits of each model as some CCGs already do)** 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(s) suits our needs in NW London**



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Local scrutiny and engagement

Patient and public involvement in NWL CCG will remain local and will feed service and standards design and review

- **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.
- We will ensure **co-production** with patients and the public, and other stakeholders.
- **Lay members and Healthwatch** will sit on the single CCG governing body.
- We will ensure that we are **reaching deep into our communities** and maintain ongoing dialogue with them. We are committed to **'continuous engagement'** with local people, rather than simply talking to people when we are planning changes to services.
- In talking to our communities, we will work with Healthwatch, the voluntary sector, local authorities and local communities, reaching and hearing from 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 within their borough/area and that that voice is heard by commissioners at local and NW London level.
- **Our Community Voices** programme will also continue to develop, ensuring that we are able to have unprompted conversations with local patients, service users and professionals about their experience of health services.
- We will meet regularly with local **HealthWatch** (who have a statutory role) and seek their insights on our work.

Patient and public involvement in NWL 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.
- Working **in partnership with patients** and local communities, we will, strengthen and deepen our shared insight in to the views and experiences of patients and service users.
- As a result, we will aim to improve our services and outcomes, working with local residents to promote behaviour change that enhances their own and wider public health, so we can develop strong, supportive and **healthy communities.**
- We will develop 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 recognise that campaigners with an interest in local health services have a role to play and we will seek to meet with such groups on a regular basis, take account of their views and keep them informed of key developments in the NHS.
- We will continue to engage through social media, taking a best practice and **responsive approach** to online dialogue.
- We will communicate and engage with people in **simple language** rather than NHS jargon. As part of this approach, we will develop a voluntary 'Readers' group' to ensure that our materials are easily understood.
- We recognise that we live in a **diverse community** and that we will sometimes need to communicate in different languages and formats. We will follow a best practice approach to making materials available in alternative formats.
- We will develop a **community-facing website** for the single CCG, providing easy access, support and information for the public about their health and wellbeing.
- We will continue to bring together patient voices and members of the public in a **Lay Partner Forum**, which we will also seek to expand to the wider voluntary sector. We will work with the Forum to co-produce and improve our approach to public engagement and involvement.

Accountability to local people in each area is an important facet of NWL CCG

- 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 place teams.
- **Single CCG governing body meetings will be held in public** will be rotated across the eight North West London boroughs. 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 area/borough**, based on the 'You said, we did' approach outlined above.

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Financial principles

25

Finance in the new operating model- some points for discussion

- CCGs in NW 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, NW 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 NHSE/I 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.

Work is being carried out across London on how the new financial system might work, meanwhile we have produced some initial propositions to discuss

- 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 plan 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
- Since we need to promote equality of access, and eliminate inequalities, we will need to agree a transition path which does not destabilise existing service provision. Further work is going on in this area, 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 have, via the CCG sub-committees, a delegated budget and freedom to act within a scheme of delegation.
- There is the possibility to delegate all service based budgets, including the acute budget, where this helps local accountability and integration, depending an appetite and capabilities.
- 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 and further information will be added as it is received.

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Social care and integration

28

At an NWL 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:

- **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 and across NW London as a whole (rather starting with forms and functions).

- **The future model for NW 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 NW London collaboration of CCGs, as well as joint commissioning teams in individual boroughs. This needs to be built upon.

- **There are number of service areas which are relatively uncontroversial** and where the benefits of having a NW London approach are clear (for example, in relation to standardising best-practice around specialist clinical services, or achieving consistent value for spend).

- **However, there are fewer areas which sit neatly entirely in a "NW London" or "Borough" box.** 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 need to understand in detail where current CCG commissioning functions will go, what relationships will look like between these and the ICS, and the role of local delegation, funding and governance.

- **Each borough is different.** The relationship between commissioning at NW 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.

- **We need to move away from seeing this in terms of different levels.** This is not about a hierarchical relationship between the ICS, ICPs and PCNs, but working together across these tiers to improve local health and wellbeing.

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Staff

This slide details some of the questions that have been asked by staff about their jobs inside the future organisation:

Will there be job losses?

Until we complete the organisational design, it's not possible to be definitive. However, other major consultations recently completed within the large central directorates have resulted in relatively small number of redundancies.

Our aim is to minimise any risk of compulsory redundancy. To help us do this, we have a clear change management policy and a fair and equitable process that is designed to ensure any substantive staff who are not successful in securing a role within any new structures are placed 'at risk' and have an opportunity of suitable alternative employment.

31

Why have some restructures already taken place in teams in the organisation?

We have to make reductions in our running costs, both in response to the 20% target and because of our financial challenges. As a result, all parts of the collaboration have been asked to make savings which have led to restructures.

All these savings contribute to the overall reduction we need to make by 2020/21.

When will we have some idea of internal structures?

The size of management budgets should be known before the end of the engagement process but structures will not be developed until the autumn.

Will there be a formal consultation?

There will be a formal consultation with staff when we propose new structures, the proposal to change our statutory structure is subject to engagement rather than formal public engagement as it is not a service change.

Will local CCG staff move into a single CCG or into a local ICP team?

Staff will be employed by the CCG. In some areas the ICP may eventually take on a statutory form and some CCG staff could transfer to it but this is some way off.

How will moving to a single CCG, having an ICS etc. change the day to day work for lower bands/will it change how work is allocated to them?

It is difficult to answer this question precisely at this stage. Clearly there are more significant potential changes for more senior staff, but all staff will potentially be affected by a new structure either directly or indirectly

Will staff get a vote?

Like other proposed structural changes, the proposal is subject to an engagement process. GP Member practices have to vote to change CCG constitutions and we anticipate this taking place in October.

(A full list of answers to staff questions can be found on Collabor8)

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Change management preparation

32

When to change? The benefits and drawbacks of merging in 2020 vs 2021

✓ Benefits

✗ Drawbacks

2020

Benefits

- 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 get the structural changes out of the way and minimise uncertainty for staff
- We can improve how we commission services
- We can better facilitate ICS development and long term plan implementation next year

Drawbacks

- We could miss a risk or issue that might have a detrimental impact by working to a tight timeline
- We need to ensure our stakeholders fully understand the changes, and the interdependent developments for integration
- We need to be assured that we have undertaken sufficient depth of planning to answer the key questions.
- Some stakeholders are concerned by the pace of change.

2021

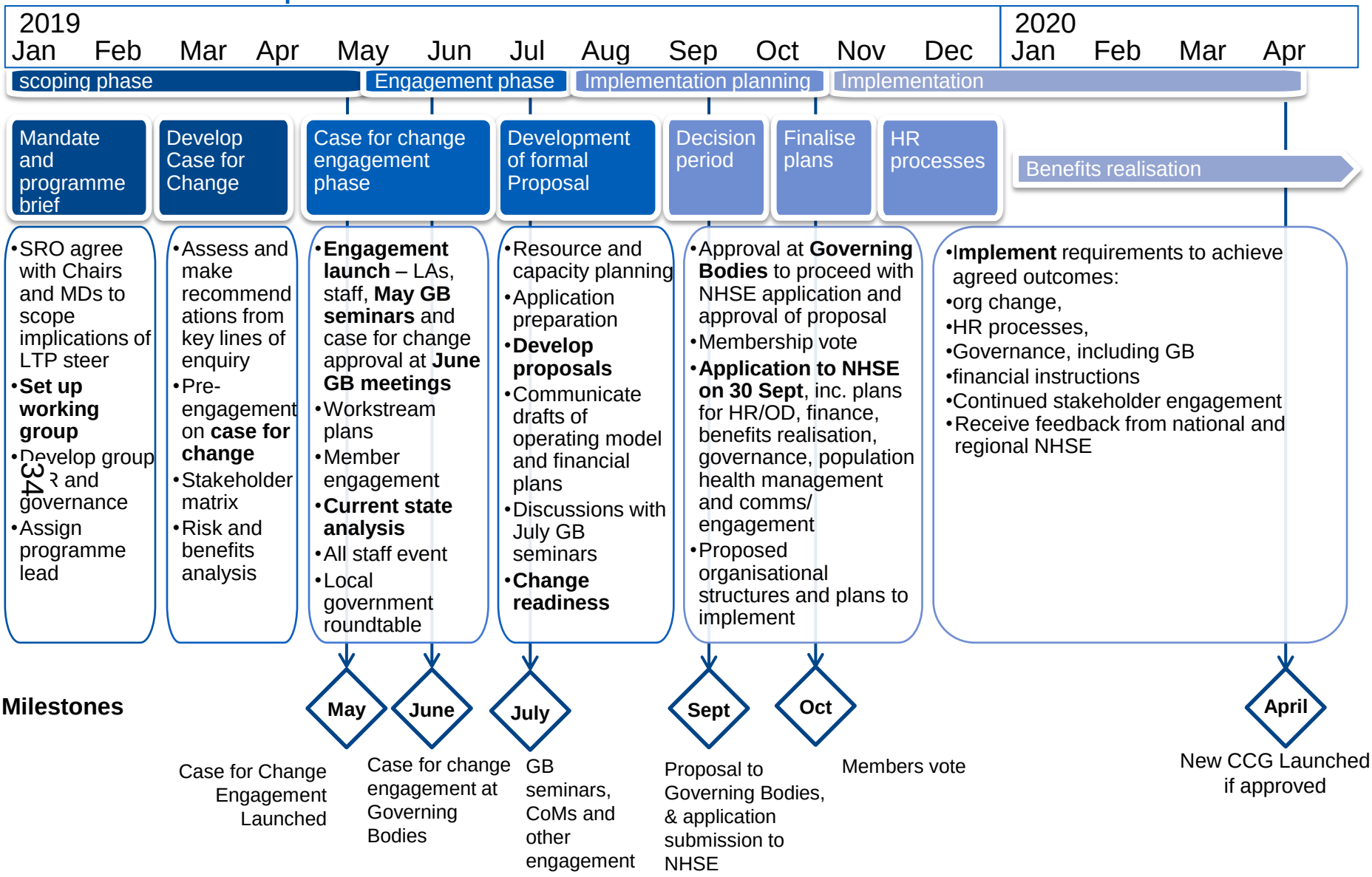
Benefits

- We can take more time and use more expertise and meeting time to develop change
- We can learn from other London mergers

Drawbacks

- Staff retention – by drawing our the change process, and uncertainty for staff, they may leave. Other areas of London will have stabilised, offering a more attractive place to work
- We will use more resource and time, thereby not utilising public fund effectively
- We risk losing regulator and stakeholder support

Outline draft plan and timeline for 2020



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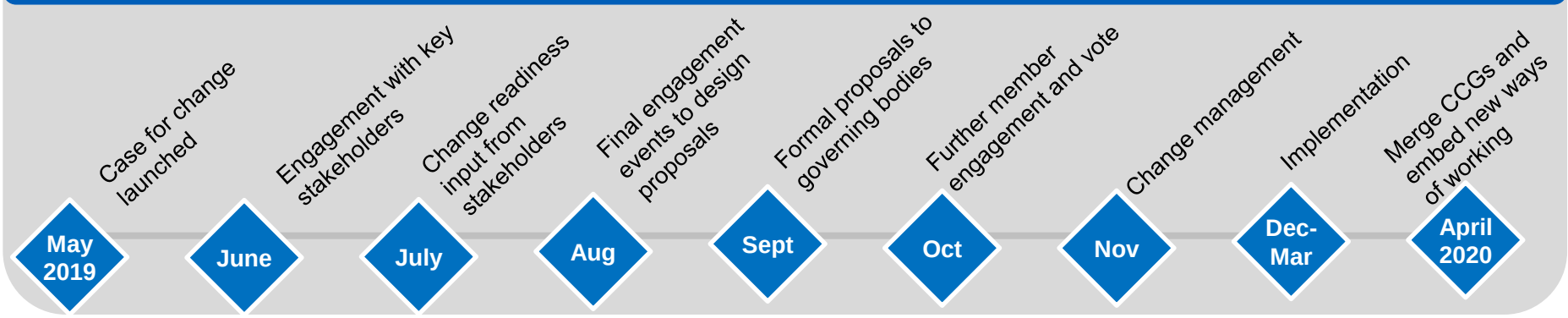
Next steps

- 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 also 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
- 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 will include our NHSE application documentation, such as our financial plans, HR/OD plans and comms and engagement plans.
- We are also 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.

Engagement timeline for 2020 implementation



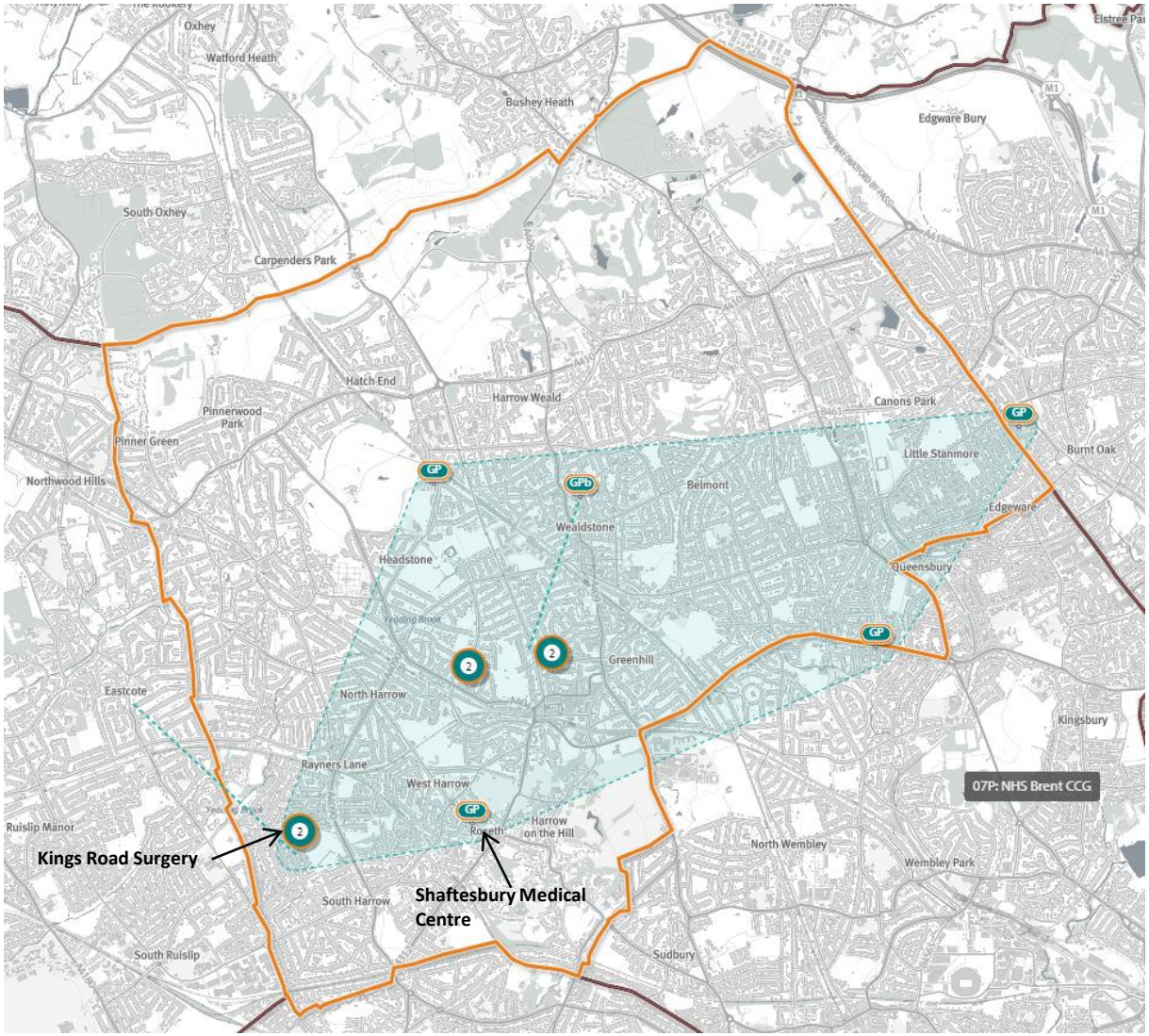
Glossary of terms

While we are developing new ways of working, we will develop clear terminology with our stakeholders. Whilst our proposals are developing, we are using some holding terms:

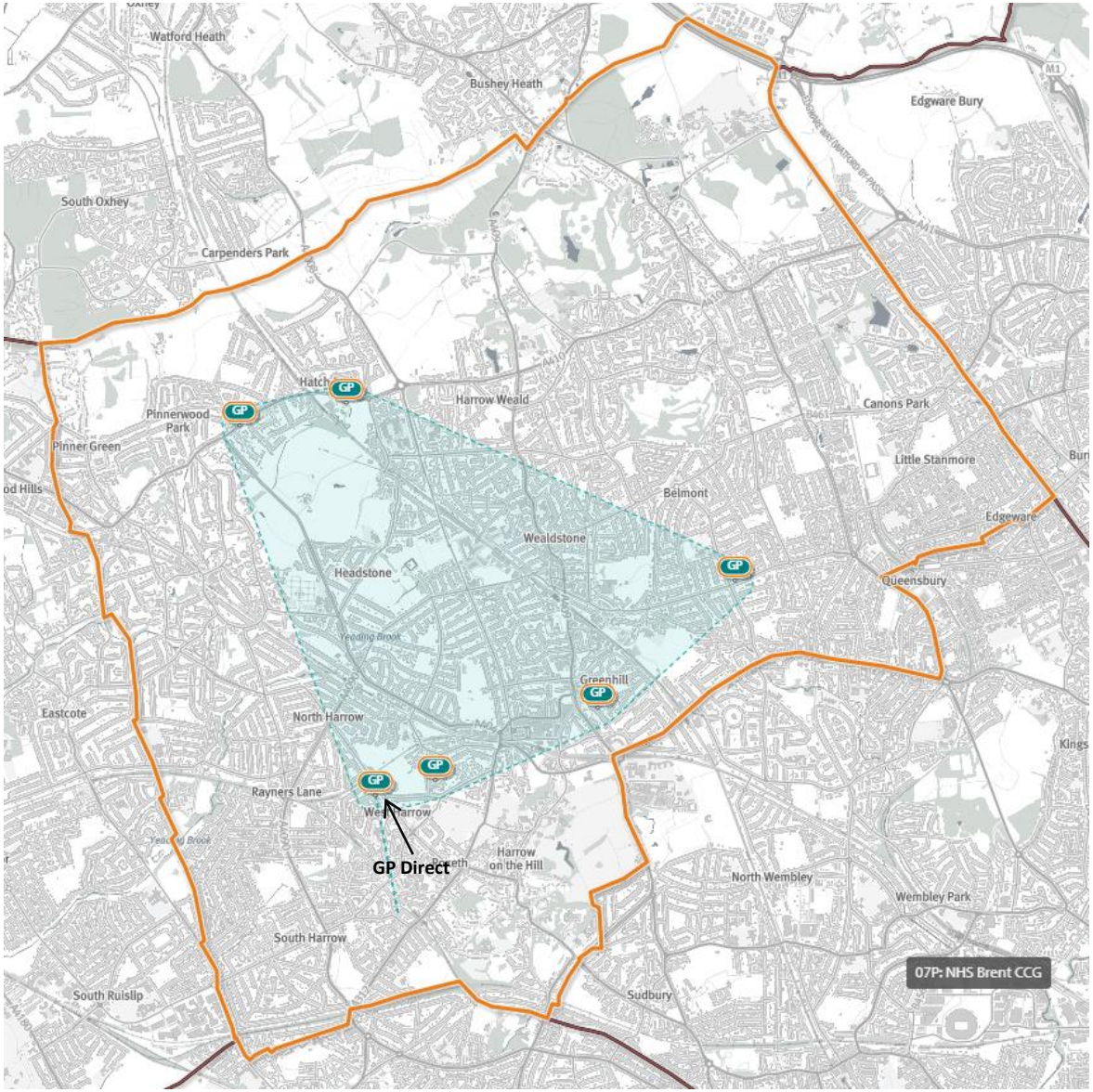
- **Operating model:** a series of slides illustrating how the organisation will work as a single entity, supported by place-based teams.
- **Place-level:** The area currently serviced by a CCG that will focus on local commissioning and the development of integrated care partnerships
- **Place team:** the local teams working at the geographical level of the current CCGs. These 'place' levels serve roughly populations 200,000-500,000 people. We expect there to be eight place teams in NW London, reflecting the emerging London model of delegation and alignment with local authority partners
- **Local committee:** The sub-committee of the CCG with delegated budget and authority for local commissioning decisions, supporting the development of the integrated care partnership in that area. The management team under this committee is the place team.
- **Clinical Chair:** We are committed to clinical leadership at all levels of our system, and want to continue with clinical leadership at place level by having a clinical Chairs of the local committee. As integrated care partnerships develop, the chairing arrangements may change.
- **Delegation:** CCGs can delegate responsibility to another person or body to carry out specific duties. The delegating person or body remains accountable for the outcome, but the receiving body is responsible for the delivery, and management of the delegated functions.
- **Primary care networks (PCNs):** We are strengthening primary care by creating 'networked' practices which will see GP practices and other out-of-hospital services join together to deliver proactive and integrated models of care for a defined population.
- **Integrated care partnerships (ICP):** ICPs are typically borough/council level and will integrate hospital, council and primary care teams/services to develop new provider models for 'anticipatory' care.
- **Integrated care systems (ICS):** Allows for whole system strategy and planning and develops accountability arrangements across a system. With ICSs we are able to implement strategic change and transformation at scale whilst managing performance and finances.
- **Region:** This is an agreed system 'mandate' which holds systems to account and allows for system development intervention and improvement.
- **Sustainability Transformation Partnership (STP):** STP stands for sustainability and transformation partnership. These are areas covering all of England, where local NHS organisations and councils drew up shared proposals to improve health and care in the areas they serve.
- **Long Term Plan (LTP):** The NHS Long Term Plan requires every STP to become an integrated care system by April 2021. The NHS Long Term Plan, also known as the NHS 10-Year Plan is a document published by NHS England on 7 January 2019, which sets out its priorities for healthcare over the next 10 years and shows how the NHS funding settlement will be used.

PCN Name	Practices Covered	Population Size (as of 1 Jan 2019) *based on raw list size*	Clinical Director
Harrow Collaborative Network	Civic Medical Centre First Choice Medical Pinner Road Surgery Pinner View Medical Centre Headstone Road Surgery Headstone Lane Medical Centre Savita Medical Centre Zain Medical Centre Kenton Clinic Shaftesbury Medical Centre Kings Road Surgery	44,972	**Dr Dilip Patel** (Civic Medical Centre)
Healthsense	Ridgeway Surgery Pinn Medical Centre Simpson House Medical Centre Enderley Road Medical Centre Roxbourne Medical Centre Kenton Bridge Medical Centre – Dr Golden Kenton Bridge Medical Centre – Dr Raja	80,779	**Dr Amol Kelshiker** (Pinn Medical Centre)
Harrow East PCN	Honeypot Medical Centre Mollison Way Surgery Bacon Lane Surgery	28,619	**Dr Meena Thakur** (Honeypot Medical Centre)
Health Alliance PCN	Aspri Medical Centre Belmont Health Centre Stanmore Medical Centre The Circle Practice The Enterprise Practice Streatfield Medical Centre	52,873	**Dr Kaushik Karia** (Aspri Medical Centre)
Sphere PCN	Elliott Hall Medical Centre Hatch End Medical Centre Northwick Surgery St Peters Medical Centre Streatfield Health Centre GP Direct	63,362	**Dr Ashok Kelshiker** (Elliott Hall Medical Centre) **Dr Varun Goel** (Streatfield Health Centre) *Job sharing the CD role*
Total	**33 Practices**	**270,605**	

Revised Map – Harrow Collaborative PCN



Revised Map – Sphere PCN



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