



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.

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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.

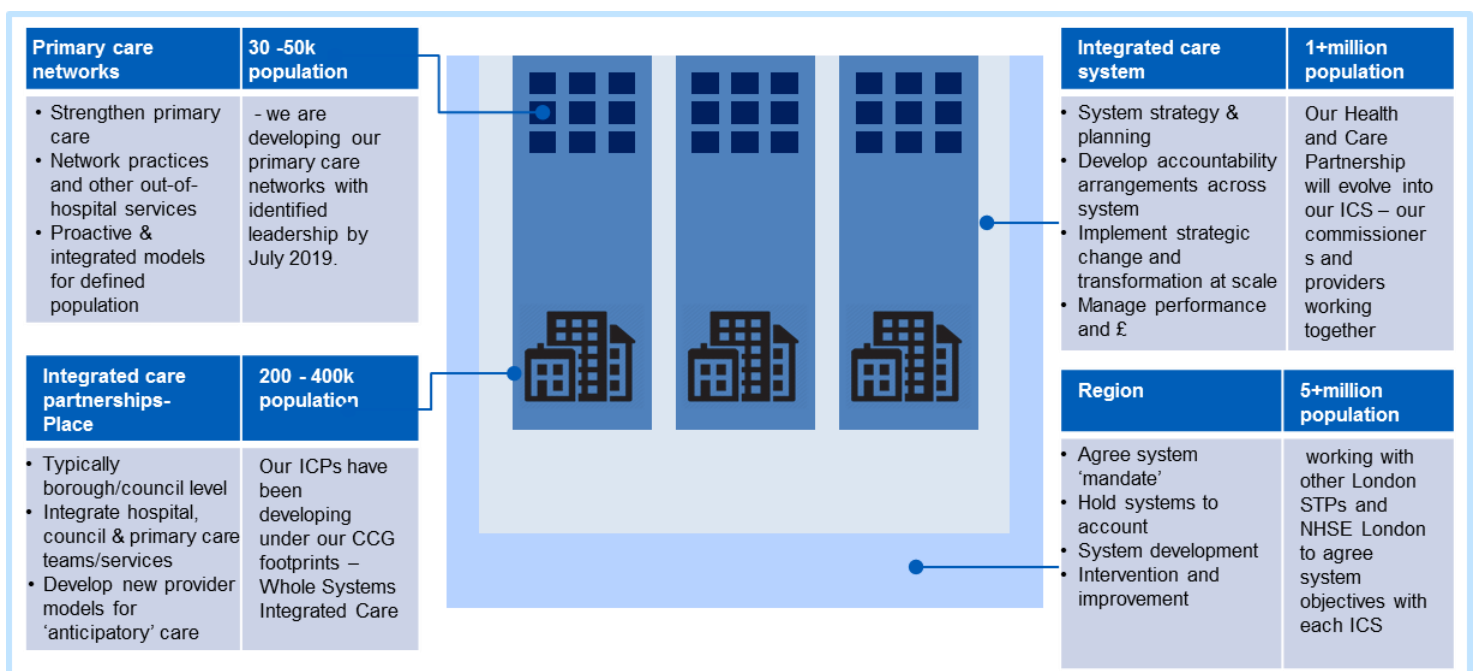


Figure 1: Integrated care as a system of systems

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.

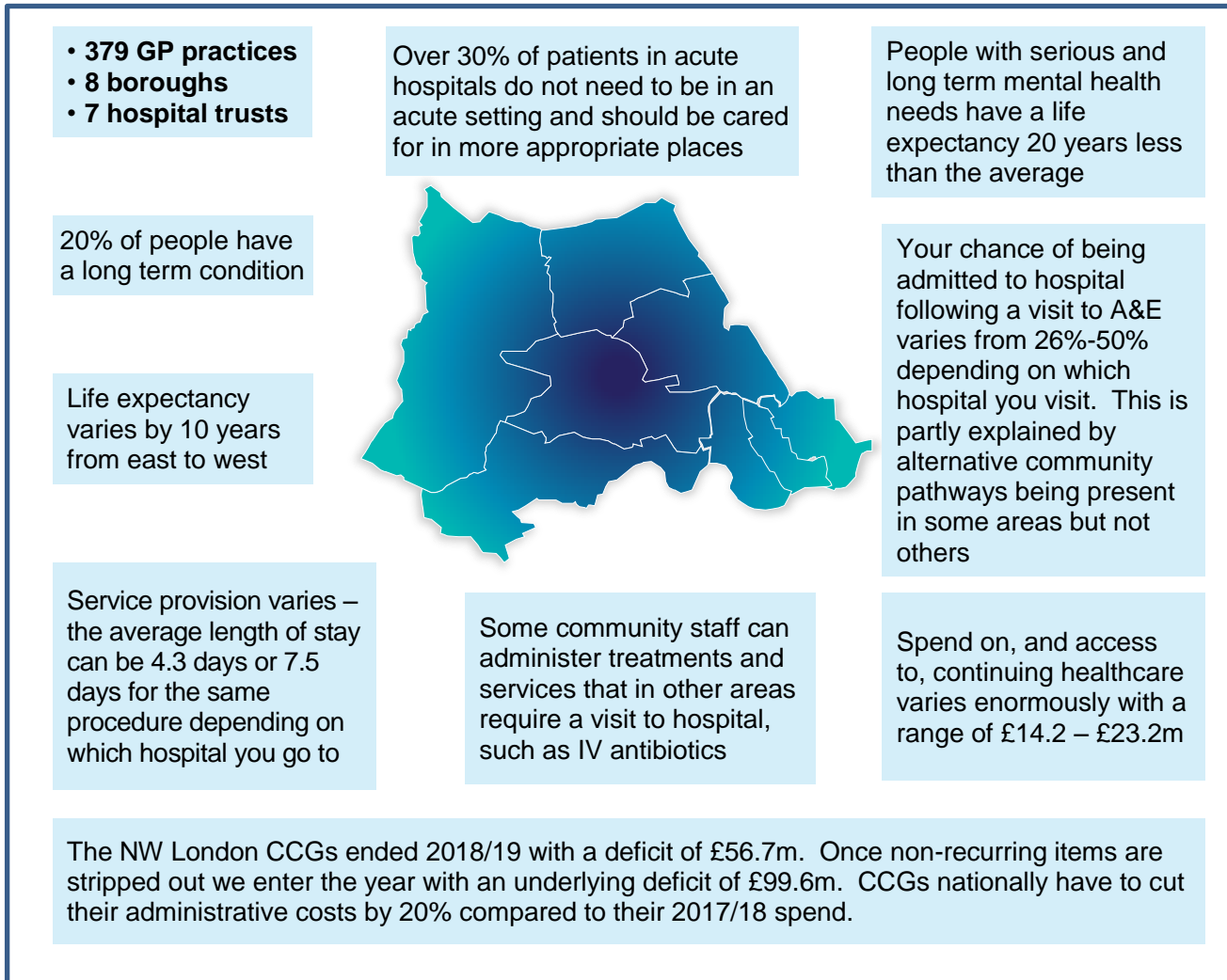


Figure 2: NW London statistics

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 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 care 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).

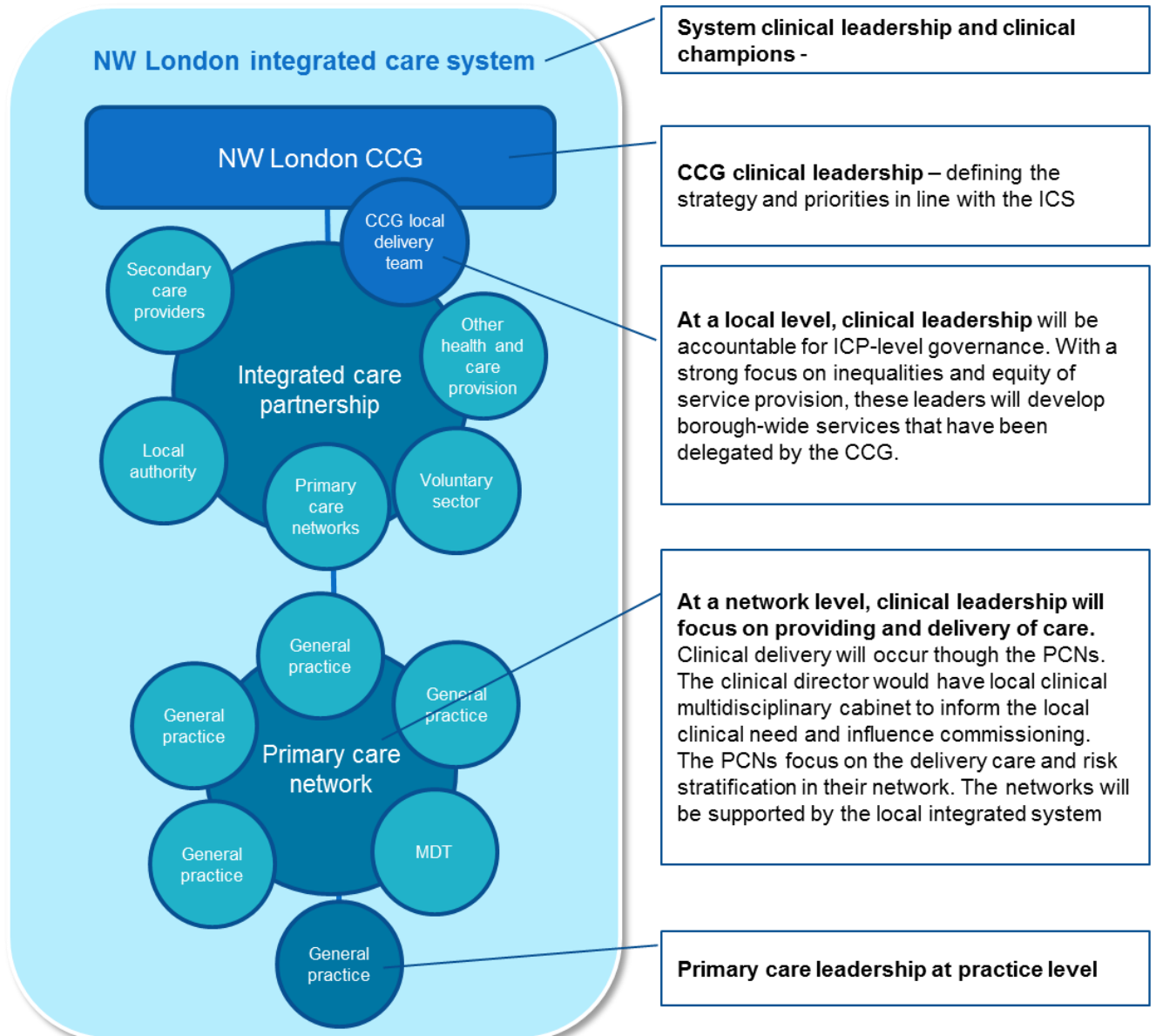


Figure 3: clinical leadership occurs at every level

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 be 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.

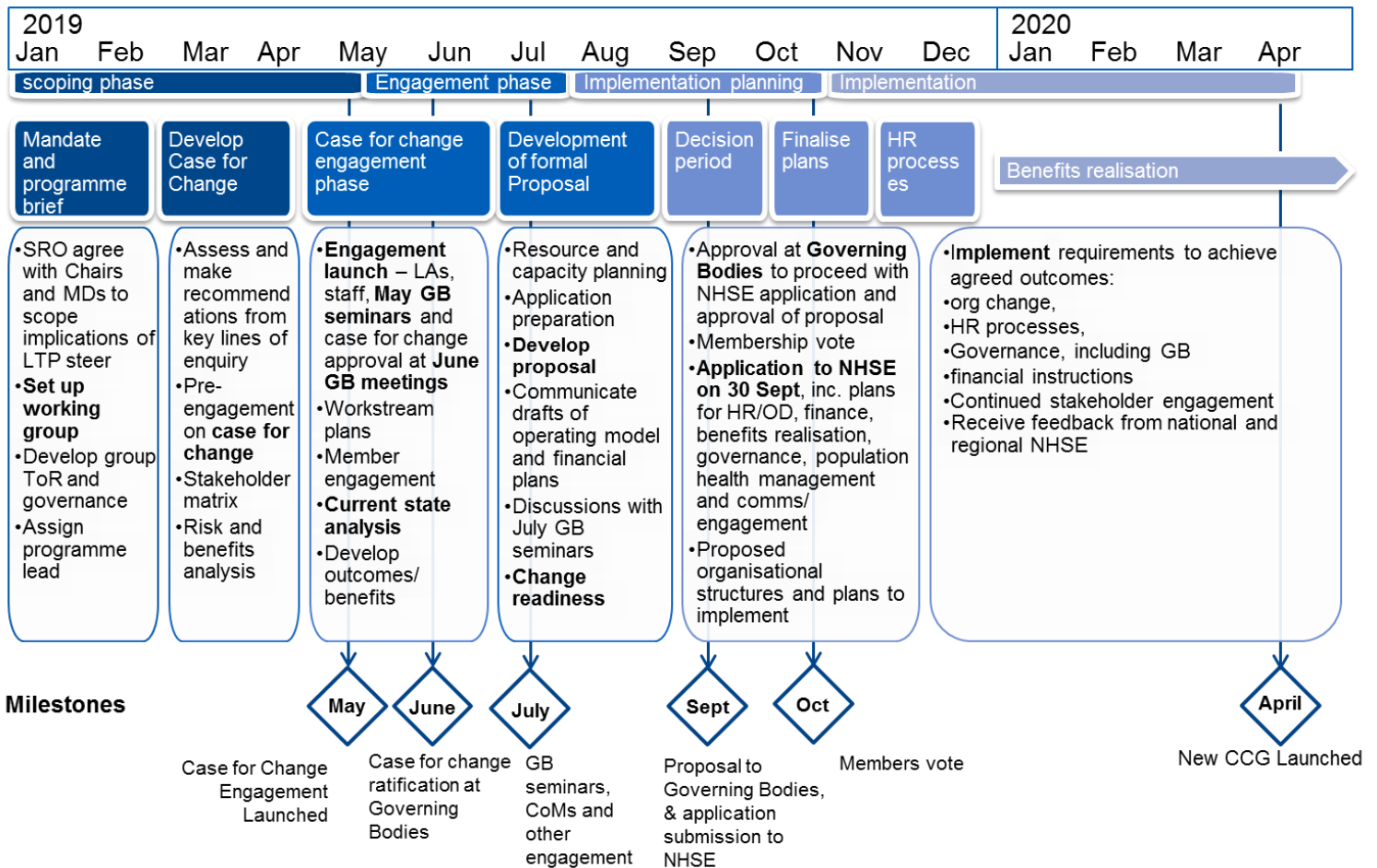


Figure 4: Illustrative high-level time line for 2020 launch



North West London
Collaboration of
Clinical Commissioning Groups

How to respond

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

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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:

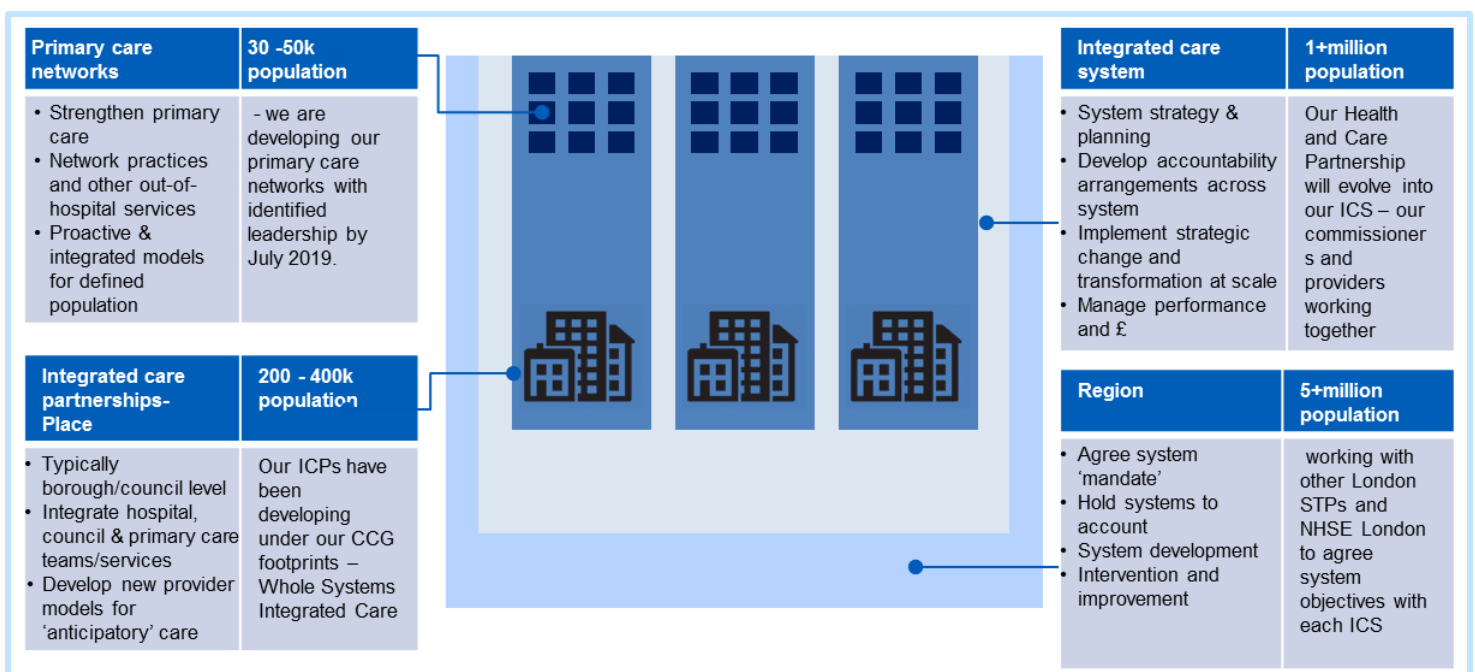


Figure 5: Integrated care as a system of systems

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 in 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 pack¹ 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 care	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 services that cannot be included in a s75 arrangement but can be under a single contract	Exceptions as above plus: <ul style="list-style-type: none"> • 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