London Borough of Hammersmith & Fulham

Health, Adult Social Care and Social Inclusion Policy and Accountability Committee

Agenda

Tuesday 12 December 2017
7.00 pm
Courtyard Room - Hammersmith Town Hall

MEMBERSHIP

Administration:	**Opposition**
Councillor Rory Vaughan (Chair) Councillor David Morton Councillor Mercy Umeh	Councillor Andrew Brown Councillor Joe Carlebach
Co-optees	
Debbie Domb, Disabilities Campaigner Jim Grealy, Save Our Hospitals Patrick McVeigh, Action on Disability Bryan Naylor, Age UK	

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Date Issued: 04 December 2017

London Borough of Hammersmith & Fulham

Health, Adult Social Care and Social Inclusion Policy and Accountability Committee

Agenda

12 December 2017

Item		Pages
1.	**MINUTES OF THE PREVIOUS MEETING**	1 - 10

(a) To approve as an accurate record and the Chair to sign the minutes of the meeting of the Health, Adult Social Care and Social Inclusion PAC held on Monday, 13th November 2018;

(b) To note the outstanding actions.

2. APOLOGIES FOR ABSENCE

3. DECLARATION OF INTEREST

If a Councillor has a disclosable pecuniary interest in a particular item, whether or not it is entered in the Authority's register of interests, or any other significant interest which they consider should be declared in the public interest, they should declare the existence and, unless it is a sensitive interest as defined in the Member Code of Conduct, the nature of the interest at the commencement of the consideration of that item or as soon as it becomes apparent.

At meetings where members of the public are allowed to be in attendance and speak, any Councillor with a disclosable pecuniary interest or other significant interest may also make representations, give evidence or answer questions about the matter. The Councillor must then withdraw immediately from the meeting before the matter is discussed and any vote taken.

Where Members of the public are not allowed to be in attendance and speak, then the Councillor with a disclosable pecuniary interest should withdraw from the meeting whilst the matter is under consideration. Councillors who have declared other significant interests should also withdraw from the meeting if they consider their continued participation in the matter would not be reasonable in the circumstances and may give rise to a perception of a conflict of interest.

Councillors are not obliged to withdraw from the meeting where a dispensation to that effect has been obtained from the Audit, Pensions and Standards Committee.

4. IMPERIAL COLLEGE HEALTHCARE NHS TRUST: INTERIM CHIEF EXECUTIVE ARRANGEMENTS AND CHARING CROSS HOSPITAL 11 - 14

The Committee is invited to note the statement issued on 29 November on behalf of Sir Richard Sykes, Chairman, Imperial College Healthcare NHS Trust, regarding interim chief executive arrangements (Appendix 1).

5. DEVELOPING FURTHER COLLABORATIVE WORKING ACROSS NW LONDON CCGS 15 - 40

The Committee is invited to review the report on 'Developing further collaborative working across NW London CCGs' presented to the Hammersmith and Fulham CCG Governing Body on 26 September and to consider its implications for local democratic accountability. The report is attached as Appendix 1.

6. UPDATE ON COMMUNITY PODIATRY SERVICES 41 - 46

The purpose of this report is to update the council on changes to the community podiatry services Hammersmith & Fulham CCG commission from Central London Community Healthcare Trust (CLCH).

7. REPORT OF THE HAMMERSMITH & FULHAM ROUGH SLEEPING COMMISSION To Follow

This report presents the findings and recommendations of the Rough Sleeping Commission.

8. WORK PROGRAMME 47 - 48

The Committee is asked to consider its work programme for the remainder of the municipal year.

9. DATES OF FUTURE MEETINGS

Tuesday, 30th January 2018
Tuesday, 13th March 2018
Tuesday, 24th April 2018

London Borough of Hammersmith & Fulham

Health, Adult Social Care and Social Inclusion Policy and Accountability Committee

Minutes

Monday 13 November 2017

PRESENT

Committee members: Councillors Rory Vaughan (Chair), Andrew Brown and Mercy Umeh

Co-opted members: Jim Grealy (Save Our Hospitals), Patrick McVeigh (Action on Disability) and Bryan Naylor (Age UK)

Other Councillors: Ben Coleman

Officers / External Guests: Helen Banham, Strategic Lead in Professional Standards & Safeguarding, WCC/RBKC/LBHF; Tara Flood, Chair, Disabled People's Commission; Mike Howard, Chair, Safeguarding Adults Executive Board, David Isaac, Commissioner, Disabled People's Commission; Eva Psychrani, Engagement Lead, Hammersmith and Fulham Healthwatch; Patricia Quigley, Commissioner, Disabled People's Commission; and Lisa Redfern, Director of Social Services

152. MINUTES OF THE PREVIOUS MEETING

The minutes of the previous meeting was agreed as an accurate record.

153. APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillors Joe Carlebach and David Morton; and Co-optee Debbie Domb.

154. DECLARATION OF INTEREST

Co-optee Patrick McVeigh declared an interest as a recently appointed of Healthwatch, Central West London.

155. REPORT OF THE HAMMERSMITH AND FULHAM DISABLED PEOPLES' COMMISSION

Councillor Rory Vaughan warmly welcomed members of the Disabled People's Commission (DPC), members of the audience and representatives from both voluntary and public-sector organisations to the meeting. Tara Flood, Chair of the DPC, led the presentation, accompanied by Patricia Quigley and David Issac.

Tara Flood began by explaining the background to the DPC report, which represented the extensive, collaborative work undertaken over the past 16 months. The structure of the report was based on information provided by disabled people and detailed key messages and findings, with the focal point being co-production and the next steps required to achieve this. The DPC had received funding and generous support from the Council but was entirely independent, with a membership drawn from people living in the borough who identified as disabled in some way. Disabled people were not one homogenous group, variable factors and differences in ability allowed for variation in experiences and co-production challenges, which should place people at the heart of the decision-making process.

Detailing the different stages of the research undertaken, Ms Flood described the three surveys undertaken with disabled people, councillors, staff, and key stakeholders. There had been three public engagement events held in August 2016, including one with young disabled people. It was explained that the while the report was currently in draft form, the final version would be in a fully accessible, easy read format. The report contained a message from the Leader of the Council, Councillor Stephen Cowan, to ensure that change cascaded from the top of the organisation. The report set out the measures for success, explaining what co-production was, outlining the economic case for supporting co-production, together with identified priority areas.

Patricia Quigley, DPC Commissioner, described how the report provided a snapshot of the range of barriers that had been reported by disabled people (page 3 of the report), ranging from physical, such as inaccessible stairs, pavement obstacles, inaccessible public transport, to multiple discrimination due to disability, gender, race, age, or LGBT. Ms Quigley reported that many disabled people felt that no one had taken the time to ask them what they wanted or what they needed. It was unacceptable that disabled people had little or no say in what services were provided and how. Worryingly, 60% of disabled people surveyed responded that their quality of life had deteriorated and that they were essentially invisible to decision-makers and 46% felt that they could not influence decision-makers. More positively, however, 86% reported that they wanted to be more involved in making the decisions affecting their lives. Of the Council staff surveyed, 94% of staff indicated that they would like to involve disabled residents and 50% felt that there was room

for improvement in how this could be achieved. While this was encouraging it was important to work together and that failure to progress this was not an option.

Ms Flood confirmed that a key message of the report was that decision-makers and service commissioners must work with disabled people, although she acknowledged that there had not been sufficient time or resources to speak to every disabled person within the borough. The report focused on social mobility, recognising the barriers to achieving aspirations, which, once removed, would level the playing field. The UN Convention on the Rights of Persons with Disabilities (CRPD, 2006) advocated the rights of disabled individuals and the title of the report, "Nothing About Disabled People Without Disabled People", reflected the need to treat disabled people equally. It was hoped that the report would extend beyond the borough boundaries, and extend further to receive national recognition. The abolition of home care charges placing a spotlight on how the London Borough of Hammersmith & Fulham progressed this.

David Issac, DPC Commissioner, referred to the implementation of changes and how this could potentially be delivered, however, this was not being proposed as something new, nor was it being presented as a unifying model. Co-production was being supported by the Council from the top down and would eventually be delivered and supported by frontline staff, but would be driven and led by disabled people. It was also important to recognise how relevant this would be to other communities and marginalised groups across the borough. They had worked with disabled residents to develop a working definition to evaluate differences and therefore formulate co-design. The DPC wanted to help with the implementation, consultation should not be an afterthought and disabled people need to be involved in decision making, from beginning to end. The recommendations were designed to be strategic, rather than issue-based, with measures included within each one. They were challenging and required political will from the very start.

Referencing Recommendation two, Mr Isaac made the point that not all the requirements of CRPD had been implemented but local authorities had a responsibility to do so. Recommendation three encouraged the development of a culture of co-production across the borough, building up the skills of residents and staff, recognising the resources required but acknowledging the long term economic cost-effectiveness. Recommendation seven highlighted the unique voice of disabled residents within the borough and the need to support and fund local groups. Highlighting the need to monitor and evaluate co-production, it was important to know that progress was being made and that services would be held to account.

A key priority was the Independent Living Fund and the move from a preventative to independent strategy, giving recognition to the need for disabled people to have care from beginning of their lives onwards. Accessible housing was another priority which presented an opportunity to co-produce a housing strategy which reflected what disabled people wanted: accessible, secure, and affordable housing. A third key issue was to develop a transitions strategy, to benefit young disabled people. The DPC would also

provide a unique perspective on the Town Hall Refurbishment plan, offering an inclusive approach to reflect best practice in accessible design. Ms Flood invited members of the Committee to endorse the report and help ensure that momentum is sustained. A two-year action plan had been drafted and it was anticipated that the DPC report would be launched in January 2018.

Victoria Brignell, Commissioner, DPC, and Chair of the Action On Disability, endorsed the report and commented that it was a great opportunity for Hammersmith and Fulham to be a beacon of good practice. Change was needed and co-production could not be a temporary solution. It should be a firmly embedded in the Town Hall structure

Mike Gannon, Commissioner, DPC, commented that the report was a key benchmark and recommended that it be supported regardless of political affiliation, allowing disabled people to be heard and not just seen.

Martin Doyle, Commissioner, DPC, and Chair of People First, was excited and proud of the report and what had been achieved, and hoped that this would continue.

Jane Wilmot, Commissioner, DPC and Hammersmith and Fulham CCG, Lay Member of Governing Body, commented that it had been a privilege to have involved in the work of the DPC, it had been an opportunity to learn and to share experiences. The DPC was not alone in promoting co-production, and the CCG had already begun to work on co-production.

Bryan Naylor, Co-optee, welcomed the report but noted the lack of any reference to the involvement of carers, many of whom were elderly and who play a significant role in providing care. He added that older people would endorse the report and all that had been stated. Ms Flood concurred and that they had tried to address the issue of how to affect the change that was required and to place this at the heart of the lives of disabled people, including parents, carers, and families. Disability crosses all groups and ethnicities and the recommendations for disabled people could be equally applied across any marginalised group. Patricia Quigley added that if they had included all groups, the process would have become overly bureaucratic and unwieldy and if co-production was done first, and correctly, then everything else would fall into place. David Isaac clarified that a ‘co-production hub’ would replicate across the board and would be more inclusive.

Patrick McVeigh, Co-optee, welcomed the report and accepted the adopted approach but suggested that it would be helpful to have a list of issues that were specific to Hammersmith and Fulham, which would help to identify priorities.

Jim Grealy, Co-optee, also welcomed the report and the strategic approach taken, detailing priorities and objectives. He enquired about the approach taken to young people and educational support. He observed that the Council did a great deal of work with schools in the Borough and the while an inclusive approach was preferable it was not always done well. The issue

was more about how to teach able people to live with disabled people, and this started in the classroom. Ms Flood explained that her day job was as Chief Executive of the Alliance for Inclusive Education and responded that there was a huge amount of work that the Borough could do and concurred that this need to begin in the classroom, with educational providers supported to welcome and include disabled people. Further encouragement was needed to build these relationships and that much of the detail of how this could be achieved was in the action plan that DPC had prepared.

Councillor Andrew Brown welcomed the report which he felt was well written and difficult to challenge. He observed that if the Conservatives were successful in the Council elections in 2018, he would welcome an opportunity to work with disabled residents on developing and delivering co-production. Referring to the title of the report and how co-production would address the way in which the Council delivered core services, Councillor Brown asked how a process could be managed that would allow an individual disabled person to make decisions about themselves. Ms Flood replied that it was a question of control and choice and that the Councillor Brown's question linked to the priority areas highlighted in the report. The recommendations in the report recognised disabled people as individuals, encouraged trust and revised aspirations. Ms Flood explained that on leaving school at 16 years of age, she had not received the support or guidance she needed. This was experienced through her contact and relationships with other disabled people. Choice and control should be valued and included as a right. It was acknowledged that the changes being sought would not take place overnight and could be a protracted process. Ms Quigley added that co-production by definition, meant working together, from the beginning.

In response to a further question from Councillor Brown, Ms Flood explained that UK had lost its global position, no longer leading on disabled rights and innovation. The UK had led the way on independent living and co-production but the commitment to this had declined in past seven years and there had been a corresponding increase in hate crime reported by disabled people. The work undertaken in the 1990's was in danger of being lost, in addition to losing the expertise. Disabled people felt that their lives were being adversely affected and this would offer an opportunity to readdress this. Economically, properly implemented co-production could save the Council a great deal of money.

A member of the public explained that he was a carer for his adult, disabled son. He posed the question: "What would be the long-term cost to disabled people if co-production was not implemented"? This was an opportunity for the Borough to be innovative.

Mike Gannon commented that most disabled people tended to seek self-employment and very few were employed. He explained that following a stroke in 2012, he had received help and support from the Council. He hoped that the support structures in place now, would be continued in the future and that everyone had a vested interest in the future of our society. Investment in people long term was invaluable and he welcomed the opportunity to be involved in projects like the Town Hall refurbishment.

A member of the public recounted her experience of the lack of disabled appropriate play equipment in a local park, how a local resident had then crowd funded play equipment for disabled children and welcomed the opportunity that it represented.

Councillor Ben Coleman, Cabinet Member for Health and Adult Social Care commended the report as an excellent piece of work. Describing the recommendations as radical, Councillor Coleman added that the DPC had done an extraordinary job and he was excited about continuing the next phase of the work required to deliver co-production. Councillor Coleman recognised that if co-production was implemented well, this would have positive and economic repercussions, for both disabled people and the Council. He affirmed that an easy read format would be provided in January, together with the drafting of an implementation plan, which would be co-produced, at the earliest opportunity. Councillor Coleman thanked the DPC for their drive, commitment, and passion, in producing an exciting and moving report.

Welcoming Councillor Coleman's commitment and support, Ms Flood hoped that there would be apolitical and non-biased support. By comparison, producing the report had been easy, with the greater challenge being to make life for disabled people easier.

Councillor Vaughan thanked the Ms Flood and her co-Commissioners for producing the report. Councillor Vaughan also thanked Kevin Caulfield, Policy and Strategy Officer, for his exceptional commitment and contribution in supporting the work of the DPC and its final report. The Committee fully endorsed the report, its findings and recommendations, together with the on-going work on the development of an action plan, which would be launched formally in January 2018. Councillor Vaughan acknowledged that this was a long-term project and hoped that the Committee's endorsement would be reflected throughout the Council.

RESOLVED

1. The Council to implement a human rights approach to its policy and service development, using the UN Convention on the Rights of Persons with Disabilities (UNCRPD) as the framework for change.

2. The Council adopts and implements a policy which commits the Council to working in co-production with Disabled residents.

3. The Council develops and implements an accessible communication strategy that promotes the development of co-production across the borough.

4. The Council with the Co-production Hub develops a co-production support strategy and resources its implementation to skill up and build the capacity of Disabled residents, local Disabled people's organisations

(DPOs), staff and councillors to participate in the co-production of policy and service development.

5. The Council to co-produce a quality assurance and social and economic value framework, which will define the values, behaviours and characteristics of all service providers and organisations funded or commissioned by the Council.

6. The Council analyses existing financial expenditure and resources on all co-production, engagement, and consultation activities with Disabled residents to identify current expenditure and then reconfigures to develop a co-production budget.

7. Recognising the unique role, values, and authentic voice of Hammersmith & Fulham's Disabled people's organisations (DPOs) and their network, the Council works with them to identify and agree a long-term funding strategy, which will ensure that local Disabled residents' rights are upheld, inclusion and equality advanced and that Disabled residents can lead on co-production.

8. Carry out monitoring and evaluation of the implementation of the recommendations and associated co-production work to evidence the impact and share learning within and beyond Hammersmith and Fulham.

156. SAFEGUARDING ADULTS EXECUTIVE BOARD ANNUAL REPORT 2016-17

Councillor Vaughan welcomed Mike Howard, Chair of the Safeguarding Adults Executive Board (SAEB), and Helen Banham, Strategic Lead Professional Standards and Safeguarding Officer. This was the fourth Annual Report and a key question was whether work of the SAEB had made a tangible difference to the quality of life experienced by people. The report contained many examples of cases, illustrating how changes had been made and implemented. It was encouraging to see the number of agencies who had contributed to the annual report, the value of their individual contributions, and the support provided that underpinned the work of the SAEB.

Two key highlights included work with the Community Champions project, on both physical and financial abuse. The Community Champions were invaluable, and positioned at the heart of the community, they sometimes faced challenging conflicts, talking to friends and neighbours. Work on hoarding was also highlighted, emphasising the need for an empathetic approach and the value of joint learnings achieved through frequent group meetings.

In response to questions from Cllr Brown, it was explained that the disaggregation of services and the impact of the Moving On initiative were not included in the report, as this had arisen outside the period covered the period up March 2017. It was confirmed that the Board in its current form would continue until June 2018. Lisa Redfern, Director for Adult Social

Services, confirmed that preparations were being made to ensure that LBHF would have its own SAEB, from June 2018.

Helen Banham responded to a query from Patrick McVeigh with regards to the Deprivation of Liberty (DoLs) reports and the new system in place. Most people in nursing care homes were deprived of liberty and in cases where there was confusion or conflict about a placement, these would be reviewed as a priority. There were approximately three per year and arose from those that were not well-placed. It was suggested that it would be helpful to have DoLs statistics reported as an appendix to the Annual Report.

Patrick McVeigh asked which agency should be contacted, in a case which fell in the remit of both mental health and trading standards colleagues. Helen Banham explained that there were few trading standards officers, with a large volume of work and few resources. They had worked with housing organisations, such as Catalyst, to find ways in which this could be addressed, concurring that more need to be done and the difficulties of working with limited resources. A recent case highlighted the plight of a lady who had unfortunately died, following a fire in her home caused by a burning candle and large volumes of newspapers.

Jim Grealy welcomed the report which observed had well-sourced case studies. He commented that a key role of a GP was to listen and identify signs and suggested that this be highlighted to the CCG and that they be invited to provide and update on this and delayed, unsupported discharges. Mike Howard referred to page 17 of the Annual Report and the significant progress made by the Board on this issue. He recognised the vital role of GPs in addressing loneliness and the challenge of working with a range of organisations to raise awareness. Commenting on unsafe discharges, he explained that they received service level reports from NHS trusts (historically, Chelsea and West Middlesex and Royal Brompton hospitals), so that they were aware of the remit and work of the SAEB. Councillor Coleman added that the Health and Wellbeing Board would be considering this issue, focusing on social isolation and loneliness. Lisa Redfern commented that there was huge and increasing pressure on the NHS and ASC to address the issue of unsupported discharges.

Bryan Naylor commented that social isolation and loneliness was a huge concern, particularly for older people, in addition to the problem of unsupported or premature discharges, and called for more frequent or accurate reviews. Mike Howard responded that this was matter of resourcing and capacity, referring to the example of engagement events on hoarding and neglect which required considerable preparation. Acknowledging the value of such events and taking a multi-agency approach led by the local authorities, they had worked closely with organisations such as MIND and Genesis housing. Lisa Redfern observed that of those supported by ASC, two out of three were older people. LBHF had recently launched a resident led, Older Peoples Commission, which would be corporately supported and resourced.

Responding to a query from Councillor Umeh regarding the referral process, Mike Howard referred to a chart provided in the Annual Report. It was

important to note that cases of abuse frequently originated from family members, leading to difficulties in bringing successful prosecutions. Expanding his response, he explained that his role as Chair of the SAEB was to challenge agencies, working to achieve prevention of harm to the individual, together with the right outcome, that they desire.

A member of the public highlighted concerns regarding the monitoring of individuals, ensuring that they took care of their personal needs and medication, citing the lack of co-ordination between agencies. Helen Banham acknowledged that there was a dilemma regarding the speed at which the SAEB operated and the co-ordination of all safeguarding champions and a significant responsibility to learn from SAEB's own work, emphasising the importance strong collaboration.

Councillor Vaughan commended the work undertaken to improve the Annual Report. Councillor Vaughan thanked Mike Howard for his work as Chair of the SAEB, recognising that this would end in June 2018. He also commended Helen Banham, for her invaluable expertise, support and commitment, and wished her well for her forthcoming retirement.

RESOLVED

That the Committee note the SAEB Annual Report 2016-17.

157. HEALTHWATCH

Councillor Vaughan welcomed Eva Psychrani, who provided a brief update on the work of Healthwatch. Key issues highlighted included work on Charing Cross, out of hospital agency support, and the changes to the decision-making powers of the CCG and associated changes to its governance arrangements. Full details of these would be circulated to Committee members in due course.

158. WORK PROGRAMME

RESOLVED

That the work programme be noted.

159. DATES OF FUTURE MEETINGS

It was noted that the next meeting would take place on Tuesday, 12th December 2017.

Meeting started: 7pm
Meeting ended: 10pm

Chair .....

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London Borough of Hammersmith & Fulham **HEALTH, ADULT SOCIAL CARE & SOCIAL INCLUSION POLICY & ACCOUNTABILITY** **12 DECEMBER 2017**	
IMPERIAL COLLEGE HEALTHCARE NHS TRUST: INTERIM CHIEF EXECUTIVE ARRANGEMENTS AND CHARING CROSS HOSPITAL	
Report of the Director for Integrated Care, H&F Adult Social Care – Lisa Redfern	
Open Report	
Classification - For Policy & Accountability Review & Comment **Key Decision: No**	
Wards Affected: ALL	
Accountable Director: Lisa Redfern	
Report Author: Graham Terry, Interim Head of Partnerships, and development	**Contact Details:** E-mail: graham.terry@lbhf.gov.uk

1. EXECUTIVE SUMMARY

1.1. The Committee is invited to note two statements and consider their implications for the future of Charing Cross Hospital.

1.2. The Committee is invited to note the statement issued on 29 November on behalf of Sir Richard Sykes, Chairman, Imperial College Healthcare NHS Trust, regarding interim chief executive arrangements (Appendix 1).

1.3. The Committee is asked to note the decision of the NHS Improvement board on 28 September not to approve the Strategic Outline Case for the *Shaping a Healthier Future* programme in NW London in its current form but to request that further work be undertaken to reflect a more realistic reduction in emergency admissions (Appendix 2 extract from the minutes of that Board meeting).

2. RECOMMENDATIONS

2.1. The Committee is asked to review the statements included at Appendix 1 and 2 and consider their implications for the future of Charing Cross Hospital.

3. INTRODUCTION AND BACKGROUND

3.1. A statement issued on behalf of Sir Richard Sykes, Chairman, Imperial College Healthcare NHS Trust, reports that chief executive Ian Dalton will be moving on to take up the post of chief executive at NHS Improvement from 4 December. Medical director Professor Julian Redhead will take over as interim chief executive whilst arrangements are made to appoint a permanent chief executive in the new year. (Appendix 1)

3.2. The NHS Improvement board has not approved the application for £513 million for the Strategic Outline Case 1 (SOC1) of NW London's *Shaping a Healthier Future*. It was rejected pending further clarification of the projected reductions in "acute activity". SOC1 is the first part of the plans for hospital "reconfiguration" in NW London contained in the NW London Sustainability and Transformation Plan. (Appendix 2)

4. CONSULTATION

4.1. N/A

5. EQUALITY IMPLICATIONS

5.1. N/A

6. LEGAL IMPLICATIONS

6.1. N/A

7. FINANCIAL AND RESOURCES IMPLICATIONS

7.1. N/A

11. IMPLICATIONS FOR BUSINESS

11.1 N/A

12. RISK MANAGEMENT

12.1 N/A

13. PROCUREMENT AND IT STRATEGY IMPLICATIONS

13.1 N/A

LOCAL GOVERNMENT ACT 2000
LIST OF BACKGROUND PAPERS USED IN PREPARING THIS REPORT

Appendix 1: Message from the Chairman of Imperial College Healthcare NHS Trust: interim chief executive arrangements

Appendix 2: Extract from the Minutes of the NHS Improvement Board Meeting held on 28 September 2017

Appendix 1

Subject: Message from the Chairman of Imperial College Healthcare NHS Trust: interim chief executive arrangements

Sent: 29 November 2017, 11:01

From: FISHER, Mick (IMPERIAL COLLEGE HEALTHCARE NHS TRUST) [mailto:mick.fisher@nhs.net]

Sent on behalf of Sir Richard Sykes, Chairman, Imperial College Healthcare NHS Trust

Dear Colleague

I am writing to let you know that our chief executive Ian Dalton will be moving on to take up the post of chief executive at NHS Improvement from 4 December. I'm very sorry that Ian has only been able to be with us for a few months but pleased that someone with his skills and experience has agreed to take on this important role overseeing and supporting NHS providers nationally.

We have a very strong and capable executive leadership team at the Trust, built up during the three years of Dr Tracey Batten's leadership and continued under Ian. This is helping to create an organisational culture with strong clinical and wider staff and patient engagement and a real focus on improvement, innovation and sustainability. As such, we are putting in place interim leadership arrangements that allow us to make the most of our internal strengths and to proceed on our existing course.

Medical director Professor Julian Redhead will take over as interim chief executive. Dr William Oldfield and Professor Tim Orchard will take over the responsibilities of the medical director. Bill will act as medical director for quality, safety and strategy and Tim will act as medical director for professional development, education and research and will continue as divisional director of medicine and integrated care.

I know that Julian will be in touch – our relationships with our partners and stakeholders are extremely important. We will also keep you updated on arrangements to appoint a permanent chief executive in the new year. In the meantime, please feel free to email me any questions or comments at Richard.sykes3@nhs.net.

Best wishes

Sir Richard Sykes

Chairman

Appendix 2

Extract from the minutes of a Meeting of the NHS Improvement Board held on Thursday 28 September 2017 at 13.00 at Wellington House, 133-155 Waterloo Road, London Se18ug – subject to approval at the meeting of the Board on 24 November 2017

Shaping a Healthier Future SOC programme (BM/17/78(P)ii)

13.5. Steve Russell, Executive Regional Managing Director (London) attended the meeting for consideration of this item.

13.6. The Board considered the Strategic Outline Case for the Shaping a Healthier Future programme. The Executive Regional Managing Director provided an overview of the background and the conditions which were being proposed as part of the approval. The Board noted the key challenges faced by the North West London sector and noted that changes to primary care services and acute services were needed. It was noted that NHS England had approved the Implementation Business Case for the primary care hub component of the programme, but that the Strategic Outline Case relied on the impact of the primary care hubs and additional significant reductions in emergency admissions.

13.7. The assumptions underlying the Strategic Outline Case were discussed with particular reference to the planned total reduction in emergency admissions, which was considered to be very ambitious without sufficient underpinning evidence. Consideration was given to the process which would be followed after NHS Improvement Board approval and the costs which would be incurred in the development of the Outline Business Case.

13.8. The Board considered that it was not possible to approve the Strategic Outline Case on the basis of the assumed reduction in emergency admissions because the evidence that underpinned how this would be achieved was not clear in the Strategic Outline Case and agreed that further work was required to develop this before the Strategic Outline Case could be brought back to the Board for approval. Several Non-Executive Directors offered to work with executive colleagues in an advisory capacity as the next Board paper was being developed.

ACTION: SR

RESOLVED:

13.9. The Board resolved not to approve the Strategic Outline Case for the Shaping a Healthier Future programme in its current form, and agreed that further work should be undertaken to reflect a more realistic reduction in emergency admissions.

London Borough of Hammersmith & Fulham **HEALTH, ADULT SOCIAL CARE & SOCIAL INCLUSION POLICY & ACCOUNTABILITY** **12 DECEMBER 2017**	
Developing further collaborative working across NW London CCGs	
Report of the Director for Integrated Care, H&F Adult Social Care – Lisa Redfern	
Open Report	
Classification - For Policy & Accountability Review & Comment **Key Decision: No**	
Wards Affected: ALL	
Accountable Director: Lisa Redfern	
Report Author: Graham Terry, Interim Head of Partnerships, and development	**Contact Details:** E-mail: graham.terry@lbhf.gov.uk

1. EXECUTIVE SUMMARY

1.1. The committee is invited to review the report on 'Developing further collaborative working across NW London CCGs' presented to the Hammersmith and Fulham CCG Governing Body on 26 September and to consider its implications for local democratic accountability. The report is attached as Appendix 1.

1.2. The governing bodies of Hammersmith & Fulham CCG and the other seven CCGs in North West London approved the report's proposals to work collaboratively through a new eight-CCG Commissioning Committee.

2. RECOMMENDATIONS

2.1. The Committee is asked to review the report at Appendix 1 and consider its implications for local democratic accountability.

3. INTRODUCTION AND BACKGROUND

3.1. The report 'Developing further collaborative working across NW London CCGs' presented to the Hammersmith and Fulham CCG Governing Body on 26 September outlined the case for change for further collaboration in the way services are commissioned, and recommended specific services and functions to be organised once across NW London, along with what should continue to be done locally.

3.2. The report also included proposals for revising the leadership, governance and management arrangements of the CCGs to enable collective commissioning. This would entail the appointment of an Accountable Officer.

4. CONSULTATION

4.1. See the report at Appendix 1.

5. EQUALITY IMPLICATIONS

5.1. See the report at Appendix 1.

6. LEGAL IMPLICATIONS

6.1. N/A

7. FINANCIAL AND RESOURCES IMPLICATIONS

7.1. N/A

11. IMPLICATIONS FOR BUSINESS

11.1 N/A

12. RISK MANAGEMENT

12.1 N/A

13. PROCUREMENT AND IT STRATEGY IMPLICATIONS

13.1 N/A

LOCAL GOVERNMENT ACT 2000
LIST OF BACKGROUND PAPERS USED IN PREPARING THIS REPORT

No.	Description of Background Papers	Name/Ext of holder of file/copy	Department/ Location
1.	None.		

LIST OF APPENDICES:

Appendix 1: Paper, 'Developing further collaborative working across North West London CCGs', presented to a meeting in public of the Governing Body of North West London CCGs, 26 September 2017.

North West London CCGs' Governing Body Paper

Developing further collaborative working across North West London CCGs

1. Introduction

1.1 The purpose of CCGs is to commission services that both improve the health of our population and ensure the highest possible outcomes and patient experience within the funding available to us. To date, North West (NW) London CCGs have gained a nationally recognised reputation for collaborative working. Since 2013, the eight CCGs in NW London have chosen to collaborate as a group of five CCGs (inner NW London) and three CCGs (outer NW London) as well as coming together in a Collaboration Board at a NW London level. The rationale behind this is that we should not accept unwarranted variation in the range and quality of services available to people living in different boroughs in NWL. We also recognise that a joined up approach to the commissioning of acute and mental health services will enable us to work most effectively with our large acute and mental health providers, and therefore improve quality.

1.2 The collaborative approach that we have always brought to commissioning is now reflected in national policy, with the production of sustainability and transformation plans and the establishment of sustainability and transformation partnerships. These developments make it important for us to test whether our current arrangements are sufficient to meet the growing clinical and financial challenges we face.

1.3 NW London CCGs are considering our response to the STP requirements, in particular to identify:

- Our proposals for joined up and shared governance, systems and processes (in line with national expectations) to secure system wide delivery and transformation through the STP
- The level of agreement regarding any shared arrangement proposals amongst the eight CCG Chairs and their governing bodies
- Whether the CCGs will operate in the future with one or two Accountable Officers.

1.4 In NW London, we want to retain the initiative in determining what our future operating model needs to be in order to serve our communities by meeting our immediate challenges, deliver health and care improvements, lead the STP and be fit for purpose for future developments.

1.5 Whilst we currently collaborate across the eight CCGs at the Collaboration Board, in its present form this group functions primarily as an advisory board, with limited formal decision-making powers. This means that decisions are still being taken to each of the eight different CCG governing bodies, which can limit the pace of change.

1.6 In June and July, the governing bodies of all eight CCGs, and other stakeholders across NW London, met in a series of joint seminar sessions to debate the challenges and opportunities in our current system of collaboration. Over the course of these sessions the governing bodies agreed that further work was needed to determine how we can work more collaboratively than at present.

1.7 Five questions were identified that we need to answer in order to make progress:

1. Is there a case for changing our commissioning arrangements to better improve health and health outcomes?
2. What joint decision-making do we need to have in place to deliver the STP and our other shared objectives? (i.e. how do we make commissioning decisions once across the eight CCGs)
3. What are the services we would want to commission once across the STP?
4. What would the governance structure look like to support the above?
5. What would the management structure look like to support 2 and 3?

1.8 As a result of further work using available evidence and drawing on the views of our clinical commissioners, senior managers, lay members and other key stakeholders through interviews, surveys and workshops, we have brought this paper to the governing bodies of all eight CCGs. We have responded to those five questions and put forward recommendations that cover 'why', 'what' and 'how' we can best do more joined up working across NW London. We have also proposed a series of next steps to take this work to the next level of detail.

Purpose

1.9 The purpose of this governing body paper is to outline the case for change for further collaboration in the way services are commissioned (the 'why'), recommend specific services and functions to be organised once across NW London along with what should continue to be done locally (the 'what').

1.10 The governing body paper also identifies proposals for revising the leadership, governance and management arrangements to strengthen collective commissioning and make it a reality (the 'how').

Engagement in creating this paper

1.11 This paper has been informed by further workshops and interviews with governing body members and senior managers in the CCGs and other partners and stakeholders, including provider chief executives and local authority leaders. 44 individuals were interviewed and their responses analysed. In addition, an on-line survey was sent out to 207 CCG governing body members and senior managers. Responses were received from 119 of these individuals in the three week 'window' before the survey was analysed - a response rate of 57%. There were equal numbers of clinicians and managers who responded and there was no significant bias detected in terms of the organisation, organisational role or designation of responders. Results of the survey are available separately along with an extended case for change, which captures more exhaustively the interview feedback.

Overarching design principles

1.12 The engagement process has led to the development of three sets of design principles: overarching design principles, decision-making principles and organisational design principles. The latter two can be found later in the paper. However, the overarching design principles were devised to guide all our thinking about how to develop our collaboration. It is therefore proposed that future working arrangements need to meet the following set of principles:

- Address the case for change
- Allow governing bodies to discharge their responsibilities appropriately
- Use clinical leadership effectively
- Release clinical and managerial leadership time to focus on quality, outcomes and relationships
- Are feasible for a shared statutory accountable officer and chief finance officer to operate.

Summary of recommendations

1.13 There are seven recommendations in this paper for the governing body to consider. These are:

1. The Governing Body is asked to agree that there is a case for changing the commissioning arrangements
2. The Governing Body is asked to agree to work collaboratively and make joint decisions with the other CCGs in NW London as set out in section 3 of this paper
3. The Governing Body is asked to agree that the recommended form for joint decision-making is a joint committee, accountable to the eight CCGs via the governing bodies, and to initiate the process of constitutional change with membership to allow the establishment of such a committee
4. The Governing Body is asked to comment on the emerging operating model of the proposed joint committee and to agree that it should have an independent chair
5. The Governing Body is asked to acknowledge the implications a joint committee will have on the current operating model of the Governing Body and its sub-committees and agree to a two-month review, which will produce proposals in line with the design and decision-making principles
6. The Governing Body is asked to agree that there should be a shared Accountable Officer and a shared Chief Finance Officer appointed across all eight CCGs
7. The Governing Body is asked to acknowledge the need to design a shared management structure in support of the shared Accountable Officer and agree to a two-month process, which will produce proposals in line with the design principles.

2. The Case for Change

2.1 Since their formation the eight CCGs agreed that working closely together was important for four key reasons:

- Developing a shared clinical strategy that needs to be delivered across NW London
- Large providers that span many CCGs that we could better influence by speaking with one voice
- Around 80% of our population receives care within and by the providers in NW London – our transformation opportunity exists within this sector
- Desire to attract high quality staff across a wider geographical footprint.

2.2 Through this commitment to collaboration, the CCGs have demonstrated that closer working can bring improved outcomes for patients, staff and long-term sustainability. However, there

are also some lessons that have been learnt and progress has not always been as rapid as we have wished.

2.3 Whilst the original reasons for collaboration remain important the scale of challenges now facing the health and care system in NW London, and across the country, is unprecedented. As a result, we are reassessing the extent of our collaboration to ensure we are capable of rising to these challenges.

Responding to the patient view

2.4 All CCGs in NW London share the goal of reducing the inequality and unwarranted variation that exists in terms of access to and quality of care for the population. We have not been making sufficient progress in achieving that goal. This is because the way in which commissioning is currently organised is leading to increasing fragmentation and differential service offers to the population of NW London. Six out ten people surveyed also think that current commissioning arrangements increase the likelihood of competing strategies emerging between CCGs. The inability to speak with 'one voice' to providers has resulted in differential service offers and duplicative care pathways. The impact on patients from variability in delivery is that they are not all receiving the same access to services, or quality of care, regardless of where they live resulting in a 'postcode lottery'.

2.5 The NW London Diabetes Transformation Programme is an example of how working together with a co-ordinated focus can reduce variation and achieve significant improvements in patient care. The key components of this programme include federated working across all eight CCGs and monthly reporting dashboards to GP practices. The programme has significantly improved access to care and access to treatment. Since quarter two of 2015, an additional 46,300 patients in NW London have a collaborative care plan, an additional 5,000 are on NICE recommended statin and 20,000 more patients are being monitored for hypoglycaemia, amongst various other improvements to patient care. The impact of this is that nearly 5,000 more patients are achieving their haemoglobin targets. Reducing these targets by a small margin leads to 37% fewer patients with microvascular complications (e.g. kidney disease, blindness), 43% fewer amputations or fatal peripheral arterial disease, 14% fewer heart attacks, 12% fewer strokes and 21% fewer deaths due to diabetes.

2.6 On the other hand, Cardiology is a high spend area across NW London which brings together locally and nationally commissioned services, delivered in the community, in hospital and in specialist centres. There is significant variation throughout the pathway both between providers and between care settings, with variation being seen in referral routes, capacity and capability. An example of this variation would be the provision of Community Heart Failure nurses where there is significant difference both in capacity and acceptance criteria across the sector, ultimately the consequence of this complexity leads to avoidable in-patient stays, delayed transfers of care and impacts the quality of life for this vulnerable patient group. A more consistent approach to the cardiology pathway would target resources towards those patient groups where maximum impact can be made, both in terms of avoiding hospital admissions and maintaining quality of life.

2.7 Services users, carers and the wider community have consistently recommended a system-wide approach and commitment to come together – as equal partners – across NW London to meet the wider health and wellbeing needs of the local population. This is based on the premise that the more we commission together the better potential we have to improve experience, access and outcomes for patients. 69% of people surveyed agree that current

arrangements do not ensure commissioning is sufficiently strategic and population health driven. Local communities have therefore asked that organisations from all sectors commit together to a systemic approach rather than commission and provide services through a series of unconnected episodes of care.

2.8 While the approach needs to be co-ordinated across NW London, with standards and outcomes set once for everyone, service delivery needs to be driven by the requirements of the local population and grassroots communities so that they reflect the diverse needs of individuals and communities.

Improving patient care

2.9 Over the next five years, the growth in volume and complexity of activity will out-strip funding increases. Many services operate in silos and don't treat people holistically. Duplication, gaps and inefficiencies in services mean that patients often have poor experiences and their time isn't always being valued. The focus is on helping people to get well, yet there is not enough time spent preventing them from becoming ill in the first place. We need to improve the way services have traditionally been delivered. We need to do more and better with less and meet increased demand from people living longer with more long-term conditions.

2.10 Over 30% of patients in acute hospitals do not need to be in hospital beds as they are medically fit, and there is clear evidence that the health of frail elderly people is damaged by being in hospital. New models of integrated, out of hospital care are essential to both improve outcomes for patients and increase the efficiency and effectiveness of the system.

Benefits for patients from increased collaboration

2.11 In response to these drivers we need greater integration of services and a shift in the balance of where we are supporting people. Commissioners have a critical role in this response, coming together to stimulate new models of care; holding providers to account for outcomes; holding providers to account for streamlining the delivery of patient care; addressing the gaps between service providers and shifting the flow of money between providers.

2.12 Working together to reduce variation, and deliver more consistent quality standards and a better patient experience, will mean patients across NW London can expect the same standard of care regardless of where they live.

2.13 By reducing variation in patient outcomes and levelling up to achieve more consistent standards we have the potential to reduce the overall demand on our services. For example, if we identify more patients with atrial fibrillation in the community we can work pro-actively to reduce the incidence of strokes and thereby reduce the number of patients being admitted to hospital in the first place.

2.14 For complex patients with multiple conditions, and activity in multiple care settings, a more joined-up offering can enable more coherent management of the patient pathway regardless of where services are provided. If we commission services collaboratively across the eight CCGs with a single voice and an overall vision we can provide greater clarity for acute trusts and achieve greater influence and leverage, enhancing our ability to manage the relationships with large providers.

Supporting Primary Care Commissioning

2.15 A foundation stone in improving care in NW London and delivering the new care models so that they have the intended impact is primary care. Our primary care development agenda is significant as we support this critical part of the health care system to respond to and rise to the challenges it faces. Six of our eight CCGs have taken on delegated primary care commissioning but have received insufficient resources from NHS England to be able to contract and commission effectively. Our current arrangements mean that the resources needed to concentrate on this agenda get crowded out by other demands. Collaboration on those things better done once will reduce duplication and time expended on them, so that local resources and leadership can devote more time to primary care development and its integration with community provision.

Sharing capacity and capability

2.16 By working together more we can make better use of our total available capability and capacity. We will have more opportunities to develop the workforce together and utilise skills across NW London. We will be better able to attract the high calibre commissioning leadership needed to direct investment, manage relationships and influence the large provider organisations.

2.17 Working together we can focus on improving our digital capacity and capability to help transform current delivery models. Interviewees agreed that data on quality and performance at both NW London and the local level should be shared to help drive up standards and patient outcomes. It was also felt to be important that local intelligence on patient experience must feed up to the NW London level to ensure any service development meets the needs of individual patients or population groups at local level.

2.18 We need to be able to systematically share and interrogate our available business intelligence data so that we can identify and target our patients most in need; this will enable new, integrated models of health and social care to be built through shared digital information between care settings and a reduced emphasis on traditional face-to-face care delivery. Shared data will provide the building blocks for an integrated system. Through collaboration we can aim to improve the responsiveness and resilience of the whole system and increase our ‘fleetness of foot’ when responding to future challenges including advances in technology and delivery systems.

Enhancing clinical leadership

2.19 Currently governing body members report that they spend a disproportionate amount of time focusing on tasks that do not make best use of their particular skills (e.g. analysis and interpretation of data). This reduces the time available for identifying solutions that should be directly informed by clinical experience and knowledge of our local patients and their clinical needs. 65% of survey respondents thought current commissioning arrangements were not making best use of our capacity and capability.

2.20 The interviews have also highlighted similar frustrations and concerns from clinicians who do not feel they are making the most effective use of their time.

2.21 Going forward, collaborative working should release both clinical time and resources and encourage diversity of input into improving services. Greater input of a wider range of clinical and patient voices to achieve better quality outcomes will ensure that commissioning

recommendations are more robust, and carry significant endorsement, increasing confidence in joint commissioning decisions.

2.22 The number of meetings and governance requirements being repeated eight times is a capacity burden that can result in inconsistent decision-making without supporting, consistent methodology. More collaborative working will reduce this duplication and increase our ability to take agile, responsive and forward-looking decisions.

2.23 Effective collaboration of this form requires trust between CCGs and stakeholders. It has been reflected through the interview and workshop process that relationships across the eight organisations will need to be built, to ensure there is the trust and understanding necessary to succeed.

2.24 There are examples to date where collaborative commissioning in NW London has been more successful as a result of clinical input and engagement across the eight CCGs. These include the mental health and wellbeing initiative 'Like Minded' where the eight CCGs have come together to commission across a number of workstreams some of which are already being implemented. The 24/7 urgent care pathway and single point of access are now embedded, whilst the redesign of the adult pathway is taking a longer time, in part due to complex finances. The result is that NW London is ahead on mental health compared to London and the rest of the country. Communications, engagement and relationship building has worked well. What has worked less well is going to eight CCGs for the decisions that need to be made, which has been time consuming and uses significant resource. The impact of this duplication is that decisions can take a long time to be approved. Joint delegated decision-making would help reduce duplication and drive the pace of implementation.

Addressing financial risk

2.25 A single financial control total for NW London is now in place and NW London will be held to account for its shared delivery. The single control total is an aggregate of all individual organisational control totals. The performance of NW London as a sector will be managed by NHS England on the basis of our collective performance and the ability of our organisations to achieve the collective total required. As a result, two things follow. One is that there will be a pooling of risk, with organisations sharing the risk from multiple different interactions and therefore, a need for all organisations to support cost reductions where required. The second consequence is that there needs, as a minimum, to be a greater level of transparency and accountability towards each other. Both for achieving the financial control total and also for implementing the commonly agreed standards and outcomes that safeguard the longer-term sustainability of the local health system.

2.26 The single control total, the increasing management and assurance by NHS England at STP level and the worsening financial position is seen as a major driver for change requiring us to plan and manage finances more effectively across the eight CCGs and collectively with our providers.

2.27 There are deficits in most NHS providers, an increasing financial gap across health and large cuts in social care funding. Inefficiencies and duplication in the system is driven by organisational not patient focus. We need to understand the cost of delivering services and change the way we work as commissioners to align incentives, reduce duplication and take cost out of the system.

- If we 'do nothing' there will be a £1.4bn financial gap by 2021 in the health and social care system along with potential market failure in some sectors
- Local authorities face substantial financial challenges with on-going Adult Social Care budget reductions between now and 2021.

2.28 Historically there has been a significant financial disparity between the eight NW London CCGs, and income inequalities in terms of capitation. Going forward there are a number of both short and long term financial issues facing the CCGs. In the short term, the aggregated forecast outturn for the commissioners is an in-year deficit of £11.07m; largely driven by Harrow who alone have a projected deficit of £20.59m. Historically Central London, West London and Hammersmith & Fulham CCGs have been over capitated, leading to end of year surpluses, however due to changes to CCG allocation policy from 2016/17 these three commissioners will see their allocations remain flat relative to their demographic growth, resulting in less cash per head than they have been traditionally used to. By the end of the STP period the level of variation between CCG funding positions will have substantially reduced, with most CCGs being within 5% of their capitation target.

2.29 Both the BHH and CWHHE federations have to date operated financial risk sharing arrangements in order to maintain system financial balance. Given the scale of financial challenges facing the CCGs further risk sharing arrangements are likely to be needed along with further measures for cost reductions so the STP footprint can reach financial balance in aggregate.

2.30 It has been agreed that we need to develop unified governance arrangements to drive STP delivery. 74% of survey respondents said that present commissioning arrangements were not effective enough to drive delivery of the STP, echoed by 67% of survey respondents who did not think that present arrangements facilitated strong commissioning of services and effective performance management. Interviewees stated the need for greater financial transparency across the eight CCGs. Local variation in resources between CCGs can be a barrier to co-operation. Further collaboration will reinforce the commissioners' ability to manage the financial challenge and the single control total, increase collective buying and negotiating power and help to achieve sector balance across NW London - and deliver the STP.

Continued local decision-making and local delivery

2.31 Joint working across CCGs does not mean that all decisions will operate at the NW London level. There are many aspects of local commissioning (e.g. integrated commissioning with local authorities) that will need to continue to operate at a more local level. A single collaborative operating model would make clear what decisions will be made once across the eight CCGs and what would be made at the local borough level (or combination of boroughs).

2.32 Respondents to the survey and interviews identified it would be beneficial that to ensure consistent strategy should be designed at the NW London level, but delivery of that strategy should be done at the local level to take account of local circumstances and needs. There was also agreement that the benefits of strong clinical leadership and expertise need to be maintained at whatever level of commissioning they are required. Respondents also highlighted that developing trusted relationships between every stakeholder is essential at all levels but it needs to start at the NW London level.

2.33 It was also important to respondents to emphasise the sovereignty of individual CCGs and recognise that a move to further collaboration should not result in good local service provision being lost. Greater collaboration should be seen as an opportunity to learn from each other and build on the best practice.

Recommendation 1: The Governing Body is asked to agree that there is a case for changing the commissioning arrangements

3. Proposed services to be commissioned collaboratively across NW London

3.1 This section of the paper outlines proposals for the decisions we should, in the future, take jointly with the other CCGs in NW London. However, for clarity and completeness it also covers those services that we should continue to determine locally.

Rationale

3.2 As has been shown by the case for change there is a strong rationale for commissioning collaboratively across NW London. Reasons include driving more ambitious change across providers and having greater leverage to support provider performance, as well as providing more scope for productivity improvement and efficiency through a reduction in variation. There would be more clarity and simplicity in speaking with one voice and greater ability to achieve consistency of standards. Sharing scarce leadership and commissioning skills in management teams across larger populations and avoiding duplication of effort and resources would be additional benefits.

3.3 The eight CCGs in NW London have worked together to describe the areas where joint working across CCGs will ensure the best outcomes for patients by planning and commissioning across the whole system, with acknowledgement that there will be local plans for each CCG for specific areas of delivery. The aim will be to commission once where this drives efficiency or quality.

Services

3.4 Survey respondents were asked to identify the services that they thought should be commissioned once across NWL, services which should be commissioned with the local authority and those services that would be best commissioned locally by individual CCGs.

3.5 Over 80% of respondents thought there were specific services that should be commissioned once across NW London. Services recommended for joint commissioning cover all acute hospital care, including: urgent and emergency care, maternity and newborn services, planned hospital care and specialist care (not commissioned by NHS England).

3.6 There was variation in opinion with regards to how the range of community, mental health, children's and primary care out-of-hours services should be commissioned. These outcomes were shared with participants at the recent workshops. At the workshops, there was broad agreement with the results of the survey, including alignment on which services should be commissioned once and which commissioning decisions would be best taken by individual CCG governing bodies There are several services that have a long history of co-commissioning with local authorities and where a detailed understanding of the local

population is required to commission them. This proposal ensures decisions about these services will continue to be made locally.

3.7 In designing the future commissioning arrangements, NW London CCGs need to identify the remit of the joint committee and be clear about which decisions we wish to delegate to the joint committee. It needs to be clear which committee is in the lead. This doesn't prohibit agreeing different arrangements where circumstances require them.

3.8 To provide this clarity, a **proposed commissioning framework for decision-making** has been developed and applied to all services to determine which are best commissioned at a NW London level and those services best commissioned and delivered locally within each borough (see figure 1a). The framework helps to identify when commissioning decisions should be:

- jointly decided by the eight CCGs acting together across NW London
- decided locally by individual CCG governing bodies or decided with local authorities.

3.9 A similar **framework can also be applied to functions** that support decision-making to determine which functions are best carried out at local level and which functions can be delivered at the NW London level (see figure 1b). The decisions taken about the future development of services are supported by the act and process of commissioning (generally as part of a commissioning cycle). This means that the people who support the decision (i.e. our management resources) do not necessarily need to be located at the same 'level' that the decision is made at. The key criterion is who has authority for decision-making at the appropriate level, not how the management team supports that decision.

3.10 It is important to note that the separation between what is decided collaboratively versus what is decided locally is not absolute. Some of the services for which we will agree to make collaborative decisions may need to be taken back to the local level from time to time (e.g. mental health services that are provided in collaboration with local authority). We should therefore remain cognisant of the fact that the framework is dynamic and may need to be revised, in line with learning and experience.

Figure 1a. Proposed commissioning framework reflecting decision-making for services

	Primary care services	Community-based services	Mental health services	Acute hospital services	Specialist acute care
Services for which decisions are made locally/with Local Authority	*Each CCG has their own Primary Care Commissioning committee. Brent and Hounslow have level 2 delegation. Level 3 assumed by April 2018*	• NHS continuing healthcare • Rehabilitation services • Services for people with learning disabilities • Other community based services			
Services for which decisions are made once across NWL	• Out-of-hours primary medical services • Integrated urgent care including NHS 111	• Some community-based services may be shared with clusters of CCG commissioners and will benefit from decisions made at group level • Semi-specialist areas could be done collectively with a pooled budget across NWL	• Severe and Long term MH (including rehab, impatient, crisis, community teams, placement) • Common MH (including IAPT) • Perinatal • Children and Young people • Older People's MH	All acute services, including: ○ Urgent and emergency care ○ Maternity and newborn services ○ Planned hospital care ○ Service provision out of NWL	• Specialist care not commissioned by NHSE

MCP: a multispecialty, community-based, provider, which combines the delivery of primary care and community-based health and care services
PACS: Primary and Acute Care Systems (PACS), joining up GP, hospital, community and mental health services.
Notes: No changes are being proposed to the current primary care arrangement

Figure 1b. Proposed commissioning framework reflecting delivery levels for functions

	Primary care services	Community services	Mental health services	Acute hospital services	Specialist acute care	Accountable care partnerships
Functions delivered locally	Provider development					ACP development
		Contracting	Local intelligence gathering			
	Identifying needs					
	Reviewing service provision					
	Implementation of NWL Strategy (STP)					
	Evaluation: Seeking public and patient views					
Functions delivered jointly to support joint-decision making			Identifying needs			
			Reviewing service provision			
	Deciding priorities					Setting resource allocation
	Setting standards and outcomes					Establishing capitation
			Implementation of NWL Strategy (STP)			Operating payment system
			Contracting (reviewing service provision including local/CCG influences on contracting)			Contracting: ACP provider
			Provider development			Maintain accountability
	Monitoring: Managing quality & performance					Outcome measures

<u>Recommendation 2:</u> The Governing Body is asked to agree to work collaboratively and make joint decisions with the other CCGs in NW London as set out in section 3 of this paper

Accountable care

3.11 We recognise that accountable care partnerships (ACPs) will emerge in the future in NW London and there will be a need to build commissioning arrangements that will respond to the needs ACPs will place on the health and care system. For now, this need is reflected in the functions we perform, i.e. ACP development. In future, our arrangements will need to evolve so that we can commission the partnerships.

4. Proposals for joint decision-making across the NW London CCGs

4.1 To support the new commissioning arrangements, and to facilitate a more collaborative commissioning approach across NW London, the eight CCGs will need a mechanism for collective decision-making and be collectively responsible for implementing them. It is recommended that a mechanism for joint decision-making be established.

4.2 89% of survey respondents agreed that joint decision-making is the way forward to deliver collaborative commissioning and 93% of respondents agreed that effective joint commissioning requires significant changes to how organisations are currently working together.

Statutory form of the proposed committee

4.3 It is proposed that the mechanism for joint decision-making should be a joint committee. This committee will be a sub-committee of each of the CCG governing bodies, albeit one they operate jointly. Given the scale of the challenges outlined in the case for change it is proposed that a **joint committee** should be the structure we put in place to aid collaborative decision-making. When appropriate, this joint committee would meet in public.

4.4 The NHS Act 2006, was amended to allow CCGs to form joint committees. This means that two or more CCGs exercising commissioning functions jointly may form a joint committee and delegate functions to it. Joint committees are a statutory mechanism which gives CCGs an additional option for undertaking collective strategic decision-making. The joint committee can be set up with its own rules about membership and voting, and decisions made are binding on all members of the committee.

4.5 Joint committees are much more flexible and a less bureaucratic approach than a committee in common. They support implementation as decisions are made collectively and members of the group are jointly responsible for implementing them. Committees in common are particularly unwieldy as they are essentially eight governing bodies sitting together as opposed to being true joint decision-making forums. As such decisions need to be unanimous to be binding on members.

4.6 It should be noted that individual CCGs will remain accountable for meeting their statutory duties whatever statutory form is chosen.

4.7 The proposed joint committee would be accountable to the eight CCG governing bodies. As with other sub-committees of the CCG Governing Body, the Governing Body will want assurance that the proposed joint committee governance is operating effectively. The CCG governing bodies will continue to have oversight of performance and be assured that the joint committee is making progress on the matters delegated to it and that the CCG statutory duties are being satisfactorily discharged. An assurance process will be designed as part of the next steps.

Constitutional change

4.8 For a governing body to be able to establish a joint committee, the relevant paragraph of the CCG constitution should state that: 'the Governing Body of the CCG may establish or disestablish committees of the Governing Body with delegated functions as it deems fit, including, amongst other things, joint committees with other CCGs. The Governing Body will also be responsible for agreeing the terms of reference of such committees'. This is not currently in the NW London CCGs' constitutions, and so we will need to discuss a proposed change with our membership and ask for their support.

4.9 CCGs across NW London are already revising their constitutions in line with national best practice and in order to reflect new guidance and ensure governance and decision-making frameworks (enshrined in the Constitution) are fit for purpose. We should integrate the proposal to establish a joint committee into this process so that we only have one engagement process. The timing of this review of the CCG constitutions is proposed to be 24 November to 4 December.

4.10 If the amendment is agreed, the Governing Body of the CCG will need to take the following steps:

- Agree to the establishment of the Joint Committee;
- Delegate the agreed functions to the Joint Committee;
- Ideally, record in its scheme of reservation and delegation details of the delegation of the agreed functions to the Joint Committee.

Recommendation 3: The Governing Body is asked to agree that the recommended form for joint decision-making is a joint committee, accountable to the eight CCGs via the governing bodies, and to initiate the process of constitutional change with membership to allow the establishment of such a committee

Principles for joint decision making

4.11 Through the workshops we have developed a set of joint decision-making principles to inform how we should make decisions.

Principles for joint decision making

- Decisions are aligned to the vision and strategic direction
- The co-design of the decision is robust, done once, and informed by stakeholder views
- Decisions are logical and use the evidence-base as appropriate
- Decisions are efficient and have the right people around the table with the right skills to ensure quality of decision making
- Decision-making sits within a clear governance framework
- Decisions are unambiguous and avoid conflict through difference in opinion
- There is transparency around how each decision has been made
- There are clear lines of accountability to decision-making and delivery back to each local CCG and to the public
- Decisions are communicated effectively
- Delegated decisions cannot be undone locally - no factions should be allowed to join-up and sway decisions
- Decisions should be made fairly, with due regard to the impact on resources for each CCG within a single control total
- Decisions will only be valid if they follow the principles set out above.

Operating model

4.12 CCG chairs, chief officers, clinical leads and governing body lay members assessed options for the operation of the proposed joint committee at their workshop on 7 September.

Chair

4.13 It was proposed that the joint committee should be established in the first instance with an **independent chair,** with a review at 12 months. 77% of survey respondents agreed that the joint committee should have an independent chair.

4.14 The rationale behind an independent chair is that it would support the development of trusting relationships between the eight CCGs as the joint committee begins its operation. An independent chair enables others to focus on their own role and responsibilities whilst offering independent leadership, support for relationship building and management of a transition.

4.15 The next step is to develop a job specification, outlining the skills and competencies needed in a chair of this committee. The 12-month review would facilitate a discussion about whether the role should be changed and, for example, be fulfilled by a CCG Chair. However, if the independent chair structure is working effectively the joint committee may decide to keep the independent chair in post.

Membership

4.16 A discussion was held on membership and who should sit on the joint committee. There has been debate on the benefits of a small committee to keep it operating effectively in terms of contributions and discussions versus keeping membership wider with greater representation. There was agreement that a smaller committee would be ideal. Consensus was reached on an initial 17 members who are proposed to sit on the joint committee along with their proposed

voting rights (see figure 2 below). However, further discussion is required to finalise the wider membership and ensure CCGs are comfortable with the extent of governing body membership on the committee.

Figure 2. Proposed membership of the joint committee

Role	Number of members	Voting
Independent Chair	1	No
CCG Chair	8	Yes
Lay members	Minimum of 2	Yes
Other governing body members	TBD	Yes
AO	1	Yes
CFO	1	Yes
Director of Quality and Nursing	1	Yes
Independent clinician	1	Yes
Healthwatch	1	No
Public Health representative	1	No

4.17 All participants at the workshop thought that at least two lay members should be included. However, some participants thought there should be as many as two more governing body members per CCG, which would bring the total number of members at the meeting to 31. It is suggested that over the next six weeks further discussion is needed to resolve the final proposed membership of the joint committee to ensure an appropriate balance between engagement and a functional meeting of a size able to operate effectively.

4.18 It was reflected that part of the desire to have more people on the committee comes from the need to develop trust. In order for the joint committee to operate effectively, members will need to acknowledge that each organisation will be starting from a different point, both financially and culturally. Given that members of the joint committee will be required to hold each other to account, they must trust each other to work on their behalf and governing bodies need to be confident that they are operating effectively. This will require a formal assurance process. However, it also requires investment in organisational development.

4.19 Wider attendance, beyond the core membership of the committee, was also discussed. It was proposed that a Board Secretary would always be in attendance to support the committee. It was proposed that other CCG Directors will be asked to attend by the Accountable Officer as and when appropriate.

4.20 It was agreed CCG governing bodies should remain as the point of engagement with local authorities.

Proposed Voting Principles

4.21 A number of principles for voting as members of the joint committee were considered at the workshop. It is proposed that:

- There should be one vote per voting member with majority voting, but no clinical majority needed (a de facto clinical majority will most likely be a consequence of the membership).
- The proposition is that the vote is expressed as a percentage in the terms of reference of the committee. This percentage will be finalised when the membership has been agreed

but it is recommended that it is equivalent to all members from six of the eight CCGs (including the AO, CFO and Director of Quality and Nursing) needing to vote' yes'.

Recommendation 4: The Governing Body is asked to comment on the emerging operating model of the proposed joint committee and to agree that it should have an independent chair

Implications on the operation of the CCG governing body and subcommittee structure

4.22 On the basis that the governing bodies of the eight CCGs accept the recommendations for moving to establish joint decision-making, there are implications once the joint committee is formed for the operation of each CCG governing body and the sub-committee structures that currently exist. It is important to ensure that governing body meetings and sub-committees remain effective and do not drive duplication of work and resources. Consequently, these arrangements need to be reviewed over the next three months.

4.23 There are a number of specific considerations that we will need to take into account as part of this review. Decision-making will be delegated to ensure efficient and impactful decisions are made across NW London. However, at the same time, governing bodies (and the public) will need to feel appropriately assured on statutory requirements and delegated powers.

4.24 Any changes to existing committee structures should reduce the current time commitment of committee members, remove duplication and support the joint committee in making key decisions. Releasing time from meeting attendance will allow management to focus more on the act of commissioning.

Next steps on governance

4.25 It is proposed that further work is undertaken to finalise the design of the joint committee and review the current governing body and sub-committee arrangements to ensure we have an effective governance structure, which meets our decision-making design principles. We are recommending this work is overseen by a Governance Design Group, chaired by one of the two audit committee chairs.

4.26 The Governance Design Group will work in accordance with the principles for joint decision making set out in paragraph set out in paragraph 4.11 and the overarching principles set out in paragraph 1.12.

4.27 Tasks for the Governance Design Group to oversee would include:

- Finalising the proposals for the operation of the joint committee, including:
  - developing a job description and personal specification for the independent chair and independent clinician and outlining the skills and competencies needed
  - finalising wider membership of the joint committee where there is currently varied opinion
  - finalising the voting approach
  - specifying how chairs appoint and use deputies
  - specifying quoracy requirements
  - consider the impact of the joint committee on the individual CCGs as part of the next steps process, including how to manage any negative or positive impacts on each individual CCG (e.g. financial gain/loss)

  - considering the role of members and the need for delegated authority to make this work
  - developing the proposed terms of reference for the committee
  - developing an assurance process for the joint committee so that governing bodies can be confident it is operating and reporting back effectively

- A review of governing body and sub-committee arrangements, which will make recommendations for changes to complement the joint decision-making and ensure the decision-making principles are met, particularly ensuring there is no duplication of governance layers
- A review of statutory duties/obligations of CCGs to identify how governing bodies will discharge their duties in this scenario
- The development of a proposed financial framework for the management of financial targets and the delivery of the STP (in this scenario), including response to failure.

4.28 It is proposed that the governance design group has the following membership:

- Audit Chairs x 2
- Director of Compliance (or deputy) x 2
- Clinical leader x1
- Finance representative x 1
- Quality representative x 1
- COO x 1
- MD x 1

4.29 In addition, there is a need to consider how mitigation should work for areas that are disproportionately affected, how conflicts of interest should be resolved and how cabinet responsibility would work following on from decision making.

4.30 The conclusion of this work will be brought to governing bodies in December for their consideration.

Recommendation 5: The Governing Body is asked to acknowledge the implications a joint committee will have on the current operating model of the Governing Body and its sub-committees and agree to a two-month review, which will produce proposals in line with the design and decision-making principles

5. Management arrangements to support joint working

5.1 To support these proposed governance arrangements, the current senior management structures across the CCGs in NW London have been reviewed as part of the process to consider more collaborative working. As a result of the seminars and workshops over the last few months with NW London CCGs (including Accountable Officers, Chairs and Governing Body Lay members) the creation of two new shared NW London executive roles is proposed and now requires approval from the governing bodies of the eight CCGs.

Appointment of one Accountable Officer (AO) across all eight CCGs

5.2 Strong leadership both locally and across NW London will be extremely important in delivering the strategy and ambitions of the eight CCGs. More collaborative working will allow us to harness the opportunities of shared leadership for commissioning at scale with the opportunity to recruit and/or retain the highest quality commissioning leadership capability, and support the most efficient and effective management of resources.

5.3 In order to best align with key principles of sovereignty and subsidiarity, partnership, and collective responsibility, the preferred option is for a management structure led by a shared Accountable Officer. This executive leadership is best placed to both serve the proposed new NW London commissioning governance arrangements and lead the other key management roles at system and local levels under the new arrangements.

5.4 *89% of survey respondents supported the appointment of a shared CCG Accountable Officer*.

Appointment of one Chief Finance Officer (CFO) across all eight CCGs

5.5 As CCGs move toward more integrated budgets, risk-sharing arrangements and any future aspiration for capitated budgets, there is a need for financial strategy and resource allocation to be driven at the system level.

5.6 In support of this, it is proposed that there should be a shared Chief Finance Officer with executive accountability for the financial performance of the NW London CCGs and financial strategy.

5.7 84% of survey respondents supported the appointment of a shared Chief Finance Officer.

Next steps on the appointment process

5.8 If these proposals are agreed, current AO post holders will cease to be the statutory AO for their group of CCGs when an appointment to the shared AO post is made and the newly appointed post holder has commenced in post.

5.9 A move to a shared CFO role will also impact on the current CFO post holders. The process for both the AOs and CFOs will be managed with full compliance and in accordance with NW London CCGs Change Management Policy.

5.10 Next steps include developing job descriptions for the new roles, in collaboration with NHS England, which the Chairs and Remuneration Committees will be asked to consider. The Remuneration Committees will then consider remuneration for these roles. Following on from this, the appointment process will begin, in line with the NW London Change Management policy. This will ensure a fair and balanced process, including sufficient levels of engagement and consultation with any affected staff.

5.11 A wider staff communication plan will be developed and agreed with Chairs before circulation.

Recommendation 6: The Governing Body is asked to agree that there should be a shared Accountable Officer and a shared Chief Finance Officer appointed across all eight CCGs (with the next steps as outlined in 5.8 – 5.11)

Forward programme for developing the rest of the management arrangements

5.12 Whilst most people surveyed or interviewed supported the appointment of a shared accountable officer, people expressed concern that such a role should be made 'do-able'. They stressed that if the current management and governance structure remained the same then the number of direct reports and governance meetings would make the role unmanageable. The nature of the infrastructure, both at NW London level and locally, supporting the accountable officer and the chief finance officer in their roles would be an important factor in the success of future collaboration.

5.13 In addition to shared leadership there will be an ongoing need for local managerial and clinical leadership as many services will continue to be commissioned by CCGs either individually or with the local authority, and crucial functions of CCGs will continue. There is a continuing need for effective local leadership within each CCG to lead commissioning and discharge these functions.

Design principles for wider organisation design

5.14 Through the workshops we have agreed a set of design principles that outline what the new arrangements should aim to achieve. These aim to address the challenges and present difficulties identified in the case for change.

The new NW London collaborative working arrangements should:

- Address the challenges set out in the case for change
- Cost the same or less
- Provide clear accountability and responsibility i.e. clarity of mandate and authority to act
- Facilitate achievement of a sector control total
- Set common objectives across NWL which are co-designed and reduce unwarranted variation for all patients in NWL
- Allow us to improve the quality of patient care (ensuring that we treat the patient as a whole person and value their time) and deliver a sustainable service
- Make efficient use of clinical time and expertise
- Enable us to effectively manage relationships with stakeholders and other organisations
- Enable local innovation and shared learning
- Reduce duplication
- Create efficiency of decision making
- Enable the shared senior management team and governing bodies to discharge their statutory duties effectively and with appropriate assurance
- Minimise disruption to business as usual
- Retain organisational memory
- Improve staff capabilities and skillsets to ensure that workforce productivity and efficiency is maximised
- Create clear and realistic roles employed NWL wide
- Facilitate cohesion between clinical and managerial leadership
- Effectively manage the regulators
- Accelerate the pace of ensuring providers in North West London integrate care around the patient

Organisational Design and Development Group

5.15 It is proposed that an organisational design and development group be established as part of the next steps to oversee the development of the managerial and leadership infrastructure. This group will be responsible for designing core aspects of the collaborative/leadership structure, as well as defining a complimentary strategy for organisational development.

5.16 It will be difficult to change the structure of the organisation without thinking of the consequences, opportunities and challenges this presents across teams and across organisations. This group should therefore focus on developing an agreed vision and way of working amongst the Senior Management Team, to ensure that everyone is signed up to the principles and ways of working.

5.17 Any changes arising from the organisational design and development group should be well communicated to all stakeholders to minimise unnecessary anxiety amongst staff. A well thought out communications and engagement strategy will therefore be a key output of this group.

5.18 It is proposed that membership should mimic the group that was established to oversee the integration of the Commissioning Support Unit (CSU). The group would therefore include:

- Chief Officers x2
- Chief Financial Officers x2
- Director of HR x1
- Clinical leader x1
- Relevant members of the Senior Management Team.

5.19 Recommendations for the new collaborative/leadership structure will be developed in accordance with the organisational design principles (as set out in paragraph 5.14) and the overarching principles set out in paragraph 1.12. The key design steps for this work are proposed in Figure 3.

5.20 The conclusion of this work will be brought to governing bodies in December for their consideration.

Figure 3. Key steps proposed in organisation design

<u>Recommendation 7:</u> The Governing Body is asked to acknowledge the need to design a shared management structure in support of the shared Accountable Officer and agree to a two-month process, which will produce proposals in line with the design principles.

6. Conclusions and next steps

6.1 A significant amount of engagement and design work has taken place since the Governing Body seminars in June and July to bring forward the proposals outlined in this paper.

6.2 The vast majority of Governing Body members engaged in this process believe there is a case for changing the way commissioning is currently operating in NW London. They also think that responding to the case for change requires a vehicle for joint decision-making across the eight CCGs and a shared management team, operating both locally and collaboratively. However, there is wide-spread recognition that these changes are complex and further work is required to develop proposals for the future operating model for governance, organisational design and organisational development. There is a shared sense that these proposals must meet the principles outlined in this paper and respond to the issues highlighted in the case for change. For these reasons, the recommendations included in this paper cover both agreements in principle to proceed with joint arrangements across the eight CCGs alongside a series of next steps for further work. A critical next step will be getting the support of membership to joint decision-making.

6.3 For reference, the seven recommendations contained in this paper are:

1. The Governing Body is asked to agree that there is a case for changing the commissioning arrangements
2. The Governing Body is asked to agree to work collaboratively and make joint decisions with the other CCGs in NW London as set out in section 3 of this paper

3. The Governing Body is asked to agree that the recommended form for joint decision-making is a joint committee, accountable to the eight CCGs via the governing bodies, and to initiate the process of constitutional change with membership to allow the establishment of such a committee

4. The Governing Body is asked to comment on the emerging operating model of the proposed joint committee and to agree that it should have an independent chair

5. The Governing Body is asked to acknowledge the implications a joint committee will have on the current operating model of the Governing Body and its sub-committees and agree to a two-month review, which will produce proposals in line with the design and decision-making principles

6. The Governing Body is asked to agree that there should be a shared Accountable Officer and a shared Chief Finance Officer appointed across all eight CCGs

7. The Governing Body is asked to acknowledge the need to design a shared management structure in support of the shared Accountable Officer and agree to a two-month process, which will produce proposals in line with the design principles.

6.4 If these recommendations are agreed, we would move swiftly to establish two design groups; the Governance Design Group and the Organisational Design and Development Group. These groups will report to the steering group we have already established, chaired by Ethie Kong, (Brent CCG, Chair) and Mohini Parmar (Ealing CCG, Chair). A process of broader engagement will be designed, as has been the approach to date and the outputs of the work will be considered by all eight governing bodies in the Governing Body meetings to be scheduled for December 2017.

6.5 The governance design group will oversee the next steps in respect to the detailed design of the future governance arrangements as outlined in 4.24 to 4.29. The main outputs of the next phase of this work are:

- Final proposals for the operation of the joint committee, expressed in a draft terms of reference for the proposed committee
- A review of governing body and sub-committee arrangements
- A review of statutory duties/obligations of CCGs
- The development of a proposed financial framework for the management of financial targets and the delivery of the STP (in this scenario), including response to failure.

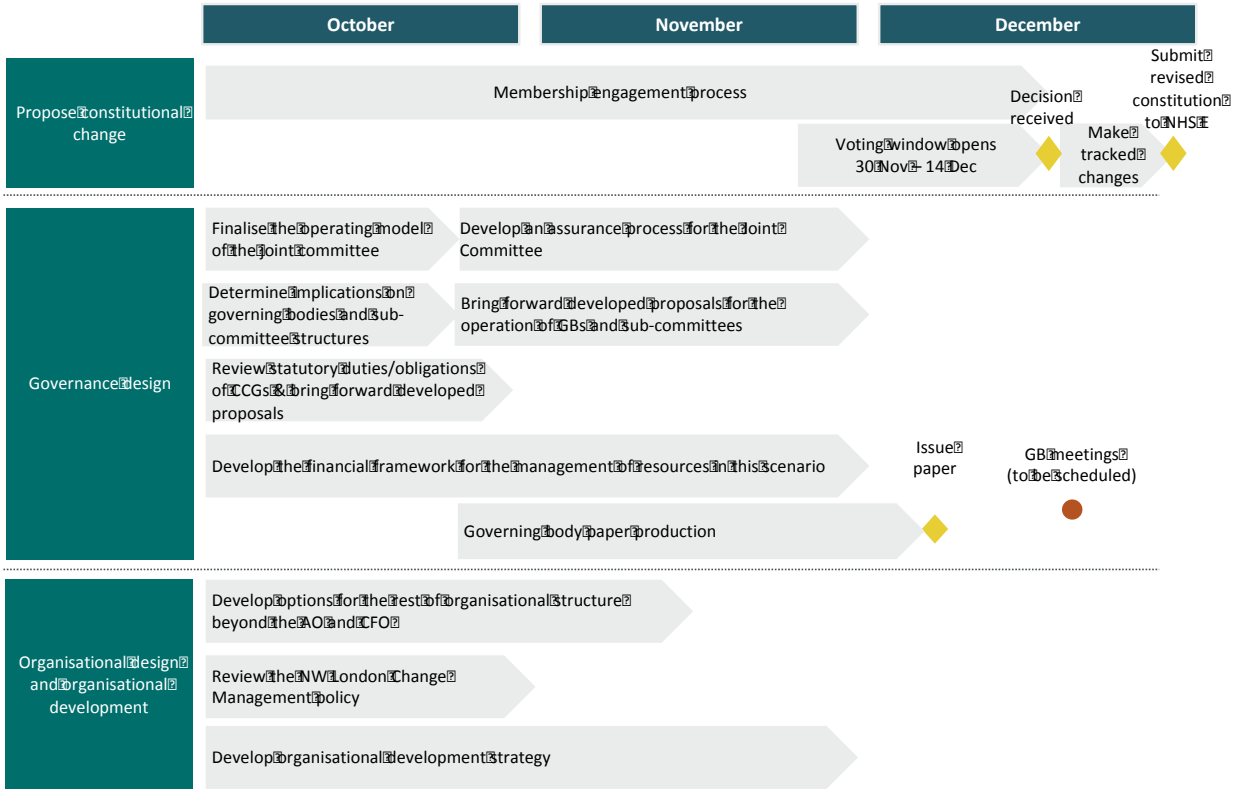
6.6 The organisational design and development group will be responsible for designing core aspects of the collaborative/leadership structure as outlined in 5.15 to 5.17. The main outputs of the next phase of this work are:

- A proposal for the rest of the shared organisational structure beyond the AO and CFO
- A complementary organisational development strategy

6.7 Next steps in respect to the appointments process will be overseen by the eight CCG Chairs, supported by the Director of HR. The process will be mindful of the interdependency with the establishment of a joint committee, which if agreed by governing bodies is subject to the proposed membership vote.

6.8 A high-level timeline for the next phase of this work is included in Figure 4.

Figure 4. High level timeline



London Borough of Hammersmith & Fulham **HEALTH, ADULT SOCIAL CARE & SOCIAL INCLUSION POLICY & ACCOUNTABILITY** **12 DECEMBER 2017**	

UPDATE ON COMMUNITY PODIATRY SERVICES
Janet Cree, Managing Director, Hammersmith and Fulham CCG
Open Report
Classification - For Information
Wards Affected: All
Accountable Director: Janet Cree, Managing Director, Hammersmith and Fulham CCG

Report Author: **Helen Lipinski, Project Manager, Hammersmith and Fulham CCG**	**Contact Details:** E-mail: Helen.lipinski@nw.london.nhs.uk

1. EXECUTIVE SUMMARY

The purpose of this report is to update the council on changes to the community podiatry services Hammersmith & Fulham CCG commission from Central London Community Healthcare Trust (CLCH).

The community services contract with CLCH has been subject to a transformation programme that supports improvements in service quality and also ensures value for money.

As of 1st October 2017, Hammersmith and Fulham CCG no longer commission CLCH community podiatry service to provide a podiatric service for patients with low podiatry and low medical needs (for example, patients with no material medical condition with corns, calluses, or non-pathological nails). Patients with low podiatry and low medical needs are signposted to alternative podiatry providers in the community. Provision of care within the low need category remains unchanged for the following vulnerable groups: children, registered blind, housebound and the homeless.

Between 1st October 2017 and 1st March 2018 all patients on the current caseload will be seen for a review appointment and discharged from the service appropriately if they present with a low podiatric and low medical need. Information will be provided to the patient detailing self-care advice and alternative podiatry providers.

Hammersmith and Fulham CCG undertook a patient engagement programme during August and September 2017 to inform patients of the service changes and co-produce leaflets on the service changes, alternative providers, and self-care advice.

2. RECOMMENDATIONS

2.1. The Policy and Accountability Committee are asked to note the contents of this report

3. INTRODUCTION AND BACKGROUND

3.1. Service Profile

Podiatry is primarily concerned with the assessment, diagnosis and treatment of diseases and conditions affecting the feet and lower limbs. The CLCH Community Podiatry Service provides care for patients registered with a GP in Hammersmith and Fulham, West London and Central London CCGs with foot and/or lower limb pathology.

The Service operates a single point of access with clinical triage of all referrals against acceptability criteria. Following assessment, the service will diagnose and treat foot and lower limb related disease, conditions and pathologies in order to maintain mobility and independence of patients, providing expert care and treatment.

3.2. Rationale for Change

The service was experiencing a number of key challenges including:

- **Access** – There was a high demand on service and poor access performance. Users with higher levels of need were waiting longer, and may be seen less frequently than clinically appropriate.
- **Referral criteria** - Referrers (particularly GPs) advised that the referral criteria for the service were unclear. As a result, patients were not always directed to the most appropriate pathway/ tier within the service at first point of contact.
- **Discharge** - Patients who have already received appropriate levels of care are being retained within the service, rather than being discharged for self-management.
- **Finance** – The service was not considered to offer value for money.

3.3. Service Review

A joint review of the service was undertaken by the CCG and CLCH in November and December 2016. This review involved looking at the service currently commissioned, assessing the likely future demand for podiatry provision and any opportunity for greater efficiency. Following this review a number of options for service redesign were highlighted. On further consultation with CCG governance committees, it was agreed that the preferred proposal was to remove activity for patients who have a low podiatric and low medical need. These service changes came into effect from 1st October 2017.

The clinical service delivery and financial considerations for this service change included the following:

- The need to commission a community podiatry service that focuses on the treatment of medium to high needs patients with an appropriately trained and equipped workforce in a timely manner. The current spread of focus on those patients with a low and high need is resulting in higher needs user waiting longer than clinically appropriate.
- Refocusing the revised service on medium to high podiatric and medical needs patients, will reduce the current wait times, mitigating risk of delayed care and consequential increased medical and/or podiatric need for patients.
- The clinical risk of ceasing the low podiatric/low medial need provision is minimal.
- There is a range of local high street/private providers who are registered with the College of Podiatry and who already provide an equivalent service in the community.
- The provision of care will remain unchanged for vulnerable groups within the low need category: children, those registered blind, homeless people and housebound.
- Ceasing the provision of the low medical/low podiatric need element of the community podiatry service is anticipated to release £120,346 in H&F in 2017/18.
- Removal of low medical/low podiatric provision has been effectively implemented in other parts of the country e.g. Islington, Barnet, City and Hackney and Derbyshire.

3.4. Service Delivery

The Community podiatry service provides assessment and treatment to the following people:

- Patients with long term conditions such as diabetes, vascular disease, amputees, connective tissue disorders, stroke, Parkinson's disease;
- Patients with multiple and complex needs e.g. dementia, falls;
- Patients with biomechanical problems, e.g. gait / postural problems;
- Patients requiring nail / foot care advice where they have a significant underlying medical condition that puts them at high risk;
- Patients presenting with acute foot and ankle problems and conditions.

Patients with low podiatry and low medical need are no longer seen by the service. This includes patients who can provide self-care, i.e. toe nail cutting and skin care (unless clinically appropriate for high risk patients); patients with social / family support who can provide care (including private podiatry support); patients with callous and corns that have no medical presentation; patients with fungal infections of skin; patients requiring verrucae treatment; patients with minor/non-limb threatening biomechanical problems.

The exclusion criteria do not apply to patients who are eligible to receive simple foot care either due to their medical condition (such as high risk patients with diabetic or vascular pathology), or because they are considered vulnerable (defined as homeless, registered blind or housebound).

Between 1st October 2017 and 1st March 2018 all patients on the current caseload will be seen for a review appointment and discharged from the service appropriately if they present with a low podiatric and low medical need. Information will be provided to the patient detailing self-care advice and alternative podiatry providers

3.5. Engagement

A programme of stakeholder and patient engagement was carried out prior to the implementation of these changes.

On Tuesday 18th July Hammersmith and Fulham CCG and West London CCG met with representatives from Healthwatch and the community and voluntary sector to discuss the proposed Podiatry service changes and the engagement plan underpinning this work.

On Tuesday 8th August and Wednesday 9th August representatives from the CCG and CLCH clinical podiatry lead hosted two workshops to discuss with service users the proposed Podiatry service changes. The purpose of these workshops was to understand any potential risks to vulnerable groups who may be disproportionately affected by the service changes, and to work with current service users to co-design materials, such as information leaflets to communicate the service changes, provide self-care tips and information on alternative podiatry providers. The workshops were extremely well attended with more than twice as many participants than the number who registered. Councillor Coleman also attended the first workshop.

The lively sessions provided a wealth of feedback to inform future communication around the changes. Participants reported finding the session interesting, useful and reassuring. The co-produced materials designed during the workshops formed the basis for the communications sent out to service users and shared with the wider public.

Following the engagement events West London CCG and Hammersmith and Fulham CCG are producing a “You Said We Did” document.

4. CONSULTATION

4.1. See section 3.5 for details of engagement work that was undertaken.

5. EQUALITY IMPLICATIONS

An Equality Health Impact Assessment was completed, the findings of this were summarised as follows.

There is no statutory obligation to provide the service for this cohort (low podiatry and low medical need). The removal of the low podiatric low medical need service take a significant amount of patient numbers from the service. Currently, 48% of patients within the Podiatry service fall in to the low medical low podiatric need cohort. This translates to 20% of the service contacts.

The removal of this service will mean that patients who require this service will have to seek a provision elsewhere and pay a nominal cost. Therefore, we may see an effect on the more deprived populations in the area, if they are unable to fund even such a small amount of money to cover this activity. Further engagement work will be undertaken with these patients, to ensure they are aware of the service change and to support them to access voluntary and social care services where appropriate.

However, if a patient is deemed to be within the vulnerable category, such as blind or housebound, they will still have access to the low podiatric low medical need service.

Homeless people are excluded from these service changes as they are considered a vulnerable group. Therefore, they will continue to be eligible to receive podiatric care as before.

6. LEGAL IMPLICATIONS

N/A

7. FINANCIAL AND RESOURCES IMPLICATIONS

Ceasing the provision of the low medical/low podiatric need element of the community podiatry service is anticipated to release funds from the CLCH contract.

8 IMPLICATIONS FOR BUSINESS

N/A

9 RISK MANAGEMENT

Description of Risk	Controls currently in place	Additional mitigating actions required
Detrimental impact of changes to community podiatry service for patients with low podiatric and low medical need	Service user engagement events accessible to all (including vulnerable patients) Coproduced patient information pack available advising on podiatry service changes, basic foot-care advice and accessing non-NHS podiatry services. GP communications issued	On-going monitoring by CCG and CLCH

10. PROCUREMENT AND IT STRATEGY IMPLICATIONS

N/A

LOCAL GOVERNMENT ACT 2000
LIST OF BACKGROUND PAPERS USED IN PREPARING THIS REPORT

No.	Description of Background Papers	Name/Ext of holder of file/copy	Department/ Location
1.	None.		

LIST OF APPENDICES: None.

London Borough of Hammersmith & Fulham **HEALTH, ADULT SOCIAL CARE AND SOCIAL INCLUSION POLICY & ACCOUNTABILITY COMMITTEE** **12 DECEMBER 2017**	
WORK PROGRAMME 2017-18	
Report of the Chair – Councillor Rory Vaughan	
Open Report	
Classification: For review and comment **Key Decision:** No	
Wards Affected: None	
Accountable Director: Sarah Thomas, Interim Director for Delivery and Value	
Report Author: Bathsheba Mall, Committee Coordinator	**Contact Details:** Tel: 020 87535758 E-mail: bathsheba.mall@lbhf.gov.uk

1. EXECUTIVE SUMMARY

1.1 The Committee is asked to give consideration to its work programme for the municipal year 2017/18.

2. RECOMMENDATIONS

2.1 The Committee is asked to consider the proposed work programme and suggest further items for consideration.

LOCAL GOVERNMENT ACT 2000
LIST OF BACKGROUND PAPERS USED IN PREPARING THIS REPORT

None.

LIST OF APPENDICES:

Appendix 1 – Work Programme 2017/18

Appendix 1

Health, Social Care and Social Inclusion Policy and Accountability Committee

Item – Report Title	Report Author / service	Status
12th December 2017		
~~GP Prescriptions~~	H& F CCG	Rescheduled - January
Imperial – CEO Interim Arrangements	Imperial College Healthcare NHS Trust	Confirmed
Developing further collaborative working across NW London CCGs	H&F CCG	Confirmed
Podiatry Service	H&F CCG	Confirmed
Report of the Rough Sleepers Commission	Rough Sleepers Commission	Expected
30th January 2018		
Transitions Task Group – Findings	Governance and Scrutiny	Expected
GP Prescription Services	H&F CCG	Expected
Annual Budget Report	Finance LBHF	Expected
13th March 2017		

Items for future agenda planning:

- Meal Agenda
- Commissioning Strategy: Providers
- Customer Journey: Update
- Equality and Diversity Programmes and Support for Vulnerable Groups
- H&F CCG Performance
- Integration of Healthcare, Social Care and Public Health
- Listening to and Supporting Carers
- Self-directed Support: Progress Update
- Tuberculosis
- Digital Inclusion (2018)