London Borough of Hammersmith & Fulham

Health & Wellbeing Board

Agenda

Tuesday 25 June 2019
6pm
Courtyard Room - Hammersmith Town Hall

MEMBERSHIP

Vanessa Andreae - H&F Clinical Commissioning Group
Janet Cree - H&F Clinical Commissioning Group
Councillor Ben Coleman - Cabinet Member for Health and Adult Social Care (Chair)
Councillor Larry Culhane - Cabinet Member for Children and Education
Steve Miley - Director of Children's Services
Keith Mallinson - Healthwatch Representative
Anita Parkin - Director of Public Health
Lisa Redfern – Strategic Director of Social Care
Glendine Shepherd - Head of Housing Solutions
Dr Tim Spicer - H&F Clinical Commissioning Group
Sue Spiller - Chief Executive Officer, SOBUS

Nominated Deputy Member
Councillor Patricia Quigley – Assistant to the Cabinet Member Health and Adult Social Care
Councillor Lucy Richardson, Chair, Health, Inclusion and Social Care Policy and Accountability Committee

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http://www.lbhf.gov.uk/Directory/Council_and_Democracy

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Date Issued: 17 June 2019

London Borough of Hammersmith & Fulham

Health & Wellbeing Board
Agenda

25 June 2019

Item		Pages
1.	**APPOINTMENT OF VICE CHAIR**	
2.	**MINUTES AND ACTIONS**	4 - 10

(a) To approve as an accurate record and the Chair to sign the minutes of the meeting of the Health & Wellbeing Board held on 20 March 2019.

(b) To note the outstanding actions.

3. APOLOGIES FOR ABSENCE

4. DECLARATIONS OF INTEREST

If a Member of the Board, or any other member present in the meeting 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 Member with a disclosable pecuniary interest or other significant interest may also make representations, give evidence or answer questions about the matter. The Member 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 Member with a disclosable pecuniary interest should withdraw from the meeting whilst the matter is under consideration. Members 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.

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

5. NW LONDON COMMISSIONING REFORM PROGRAMME: PUBLIC DRAFT CASE FOR CHANGE 11 - 39

The purpose of the report is for the Board to consider implications that there will be a change to the structure of CCGs with one CCG developed to correspond to each of the proposed integrated care system areas.

6. SOCIAL ISOLATION AND LONELINESS UPDATE REPORT 40 - 42

The purpose of this report is to provide an update on the work the Council is doing to address issues of social isolation and loneliness within the Borough.

7. WORK PROGRAMME

The Board's proposed work programme for the municipal year is set out as Appendix 1 to this report.

The Board is requested to consider the items within the proposed work programme and suggest any amendments or additional topics to be included in the future.

8. ANY OTHER BUSINESS

9. DATE OF NEXT MEETING

Monday, 9 September 2019

London Borough of Hammersmith & Fulham

Health & Wellbeing Board

Minutes

Wednesday 20 March 2019

PRESENT

Committee members:
Councillor Ben Coleman (Chair)
Janet Cree, H&F CCG
Steve Miley, Director of Children's Services
Keith Mallinson, H&F Healthwatch Representative
Anita Parkin, Director of Public Health
Dr Tim Spicer
Sue Spiller, Sobus

Nominated Deputies Councillors: Lucy Richardson

Officers / guests: Martin Calleja, Head of Health Partnerships, ASC; Jim Glennon, Training and Consultancy Manager Opening Doors London; Richard Jackson, Ambassador, Opening Doors London; and Maggie Jones, Ambassador, Opening Doors London

172. MINUTES AND ACTIONS

Janet Cree clarified with reference to the comment on establishing a citizen's panel, this was in the early stages of being developed and they had not reached the point at which the panel could be established and that she would share the details when they were ready. She also clarified that the proposed change to UCC would be determined by the outcome of the consultation, which was yet to be undertaken. Finally, it was confirmed that Vanessa Andreae had discussed the idea of holding a "thinkathon" event and that the governing body were happy to support this, provided that it utilised existing collaborative networks.

NHS England had allocated funding to Central London CCG, to facilitate the work of Healthwatch on co-production, to deliver two consultation events per borough. This aligned with the Long-Term NHS Term Plan and there were many other engagement events also taking place, details of which would be shared when available.

Councillor Coleman reported that he would work more closely with other boroughs to address increased concerns regarding the combing of the CCGs and that further updates would be provided.

Discussing the changing aspects of delivering local, strategic healthcare Dr Spicer commented that local provision could in future be determined by residents and that it was important to prioritise the needs of the community. Keith Mallinson observed that it was essential that the views of residents were critical in shaping future provision.

With reference to the CCG financial deficit, Councillor Coleman found it difficult to understand how the development of new, emerging networks would be better for H&F residents. He asked whether any funds from the other CCG's could be distributed to address the H&F CCG deficit. Dr Spicer confirmed that this had been discussed but Janet Cree cautioned that seven out of eight of the CCG's were experiencing significant financial difficulties.

ACTION: The CCG to develop a piece of work around the primary configuration of the new and emerging networks, for either June or September HWB.

RESOLVED

That the minutes of the previous meeting be agreed.

173. APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillor Connell, Councillor Patricia Quigley, Lisa Redfern and Vanessa Andreae.

174. DECLARATIONS OF INTEREST

None.

175. OPENING DOORS LONDON

Councillor Coleman welcomed Jim Glennon, Richard Jackson and Maggie Jones from Opening Doors London. Explaining their interest and involvement with LGBT+ (Lesbian, Gay, Bisexual or Transgender) issues. Both Richard Jackson and Maggie Jones shared their personal stories which had eventually led to their association and work with Opening Doors London ODL. As volunteer ambassadors for ODL, they had worked with older LGBT+, people, providing support, friendship and help in navigating local health and social services. They had helped facilitate workshop events for older, LGBT+ people, fundraising and raising awareness at corporate training events.

Jim Glennon provided a detailed presentation regarding the work of ODL. Support was provided to over 2000 members, facilitating social groups across London in safe places. An outreach and befriending programme that complied with international equality standards ensured that support was

available to a generation of older LGBT+ who had previously experienced abuse and rejection, during a time when had not been possible to be open about sexuality or gender within a hostile climate. Jim Glennon outlined the extensive range of activities supported and facilitated by ODL, which offered a safe and tolerant environment in which older LGBT+ people could share experiences and support others.

Richard Jackson recounted how electro medical treatment had been intended to “cure” LGBT+ and had been developed by the Maudsley hospital. It was removed after twenty years, having been recognised as ineffective. This controversial, conversion treatment had been delivered without aesthetic and aimed to make people feel repulsed by other gay people. Homosexuality was a punishable offence, and those found guilty were given the option of imprisonment or medical treatment. Side effects included scarring and memory loss, and many people either self-harmed or were suicidal.

Maggie Jones explained that many people from the older generation were subjected to abuse, and that this impacted on those in care homes as some individuals of that generation harboured homophobic attitudes. The issue was to ensure equity for LGBT+ groups, as distinct from equality, and therefore parity in treatment. It was explained that there was evidence to indicate that people were being treated differently and that CQC inspectors where aware of the issue. Care homes had improved their awareness and better increasingly better at understanding experience of LGBT+ older people through training.

Social isolation and loneliness were key issues for many older LGBT+ people, who did not have children, or had become estranged from their families. They might have moved from away from where they once had lived and were likely to live alone. They were also more likely to have experienced mental health problems, had higher rates of suicide, alcohol or drugs abuse, compared to heterosexuals. There was no suggestion that to be LGBT+ was to be mentally ill, but that this had resulted from the impact of the pressure, abuse and treatment experienced by LGBT+ people. There was a fear of going out into the community and an individual who was not robust, would find it difficult to support themselves and became quickly isolated. The befriending service offered by ODL helped individuals build trust, confidence and helped them to engage in the community around them. This was a counter-balance to their previous experiences and lack of trust. LGBT+ often had higher medical and social needs compared to heterosexuals, as they invariably lived alone and were therefore more reliant on local health and social care services.

Keith Mallinson welcomed the presentation from ODL observing that the Council had a history of being progressive on for example, homophobia and HIV issues. He recounted his experience with one GP who had continued to refer to a trans-gender patient as ‘he’ rather than ‘she’, which had been a contributory factor when she eventually took her own life.

It was recognised that it was important for the Council to know how to support the wider, LGBT+ cohort, ensuring that staff were trained and informed about LGBT+ issues. For example, older LGBT+ people in sheltered

accommodation have sometimes experienced hostility from other residents, where training would have been helpful. Jim Grealy (Save Our Hospitals) commended the presentation and commented that it was often a matter of small things such as understanding how to sensitively ask questions about whether a person has a partner, rather than asking a gender specific question. The issue of identifying more precise numbers was complex, as sexuality remained hidden, which also made it difficult to measure. It was noted that the government action plan to address LGBT+ inequalities included the appointment of an LGBT+ tsar, and that the Care Quality Commission (CQC) had also recognised that inspections should address and develop better quality care standards for LGBT+ communities.

Janet Cree welcomed the presentation and commented on the North West London perspective. She reported that Bethany Golding had led on a pride and practice initiative which was about to start. This was a fifteen-month long pilot working with LGBT+ groups and funded by the government equalities office, highlighting easy access to care and identifying issue that presented obstacles to care for LGBT+ communities. They would also be offering access to training and quality standards, sign-posting social prescribing. This was the optimal time in which to draw these issues together.

ACTION: Bethany Golding to link with ODL, to inform delivery of pride and practice initiative

Dr Spicer observed that the presentation went to the heart of the matter. The Long-term plan was to help people age well and to improve the standards of care in residential care homes. This presented a timely opportunity to ensure that this area of work remains on the agenda and could be included as part of the current training programme that had recently been implemented. The first tranche of training care home managers to enhance their skills had just concluded but there was an opportunity to build this into the course. It was acknowledged that there was a joint incentive for both commissioners and providers to consider how this could be influenced by developing measures that the CQC could build into the inspection's framework.

Councillor Coleman asked how ODL were able to identify people that needed help. It was explained that ODL placed adverts in the press and worked with LGBT+ networks throughout London, using venues that were recognised as "safe" places. Richard Jackson added that there was a training course for people who wanted to volunteer with ODL. Maggie Jones reported the story of a 90-year-old person with cancer, who now had a support network in place, orchestrated through coming to the coffee mornings. These events were held in over 30 various London locations, that were small, shared spaces that could be nurtured.

176. WORK PROGRAMME

None.

177. ANY OTHER BUSINESS

Consultation on Urgent Care Centres (UCC) and Extended Hours

Janet Cree provided a short update to the consultation on UCC and extended hours. The NHS Long-Term Plan indicated long-term investment in extended opening hours. It was explained that the intention was that from July 2019, extended hours would be delivered through direct enhanced services (DES) with the expectation that the CCG continued to commission that provision through the GP primary care network. The CCG will continue to commission local hours for the first quarter of 2020.

Further guidance from the NHS was expected however, the DES was expected to further develop and this had necessitated the need to change the scope of the GP contract. Janet Cree explained that it was not possible to include consultation on DES but that the consultation would still look at extended care and that this had been the reason in part for the delay to the commencement of the consultation.

Healthwatch had been very helpful in reviewing the consultation materials and work on developing this had progressed well. This had been a large, joint piece of work and following discussions, the layout and content had been refined. Final adjustments were required and then content would be available in a variety of formats online. The documents would be in plain English and included a short, A5 leaflet, a brief overview, an easy read version of the consultation document, a poster, adverts and social media activity. It was anticipated that the launch could take place the following week, once formal assurance had been provided by NHS England. The CCG had also been in contact with the Councils communications team for guidance on how best to reach residents. It was thought that it would not be possible to send text alerts or information by text message due to both potential legal and financial constraints.

Councillor Coleman enquired about the methods by which residents might be informed of the consultation. Janet Cree explained that the consultation would last approximately seven weeks and had been slightly extended due to the Easter holiday period. Details as to the location of posters could be provided but these currently included libraries, GP practices and UCCs to ensure that service users would be aware of the proposed changes.

Councillor Coleman queried the anticipated savings, that might follow the implementation of service changes. Janet Cree indicated that this could amount approximately £600,000 each, for both changes to UCCs and GP extended hours if the proposed changes were accepted, so potentially £1.2 million. Discussing the possible cost of the consultation, it was noted that this was limited to the cost of printed materials. Janet Cree explained that the CCG had taken advice on how to raise awareness with residents as well as to ensure that the consultation document was accurate.

Referring to the length and range of any consultation, Councillor Coleman highlighted two concerns. The first, was about the consultation itself and what it was nature of the consultation, with the intention to make savings, not cuts.

Secondly, the manner of the consultation. He welcomed and was encouraged by the progress of the consultation and suggested that the Board collectively undertook further work to discuss and develop a more cohesive approach to consultation for future reviews. The NHS defined what constituted a full, public consultation and he welcomed further dialogue about this. Comprehensive consultation hinged on the definition of what constituted a substantial variation in services. How a proposed change was defined influenced the level of engagement. It was important that the Council was made aware of whether a change could be regarded as substantial early on and Councillor Coleman suggested the Council's Health, Inclusion and Social Care Policy and Accountability Committee (PAC) as a potential forum through which this could be managed. Janet Cree concurred and stated that the CCG would fulfil its statutory functions.

Councillor Coleman continued and asked that in future, the scale and scope of any proposals set out whether potential service changes constituted a substantial variation, and, whether a full consultation was required. Councillor Coleman sought agreement that such decisions would be reached through collaborative work undertaken with the Council and the PAC. He acknowledged that the Council had received notice of what the CCG was consulting upon, but that there had been an absence of dialogue as to the breadth and scope of the proposed consultation. Councillor Coleman pointed out that according to NHS guidance, the determination as to whether a change a constituted substantial variation was a matter for agreement with the local authority.

Janet Cree took the view that the CCG had sought a challenge of their consultation proposals when they had presented the issue at the 4th December meeting of the PAC, considering the specific details of the proposals. Councillor Coleman felt that there had been initial discussion about consultation details but no explicit agreement as to the scope of the consultation and this should have been the conversation taking place. Janet Cree confirmed that this had been also been the CCGs intention. Addressing a comment from Keith Mallinson, Janet Cree continued that it had always been the CCGs intention to undertake a full consultation, including consultation with Healthwatch.

Jim Grealy welcomed the progress made on the consultation work and commented that it took time to undertake consultation well. He enquired if a year-long plan was being developed to address future changes. Janet Cree confirmed that there was no intention to do this and that they would be working on a case by case basis. All changes would have an equalities impact assessment.

Councillor Coleman considered that agreeing the scale of a service change and if it was a substantial variation would determine, in turn, the most appropriate level of consultation. He suggested that this was a new way of working and that it would determine the scale of change. This would be the first stage of any discussion in attempting to achieve consensus.

Sue Spillar suggested that a public engagement strategy be developed to consider the likely impact of changes in services on residents. She enquired if the CCG were consulting on a range of possible options or would these be developed with broader co-ordination. It was noted that this would be determined and shaped by the response to the consultation.

In concluding the discussion, Councillor Coleman recapped that in future, services changes would be notified to the PAC, as part of developing how consultation on such changes be undertaken.

Supported Employment

Councillor Lucy Richardson outlined her discussions with the West London Alliance regarding the development of an improved supported employment offer for local residents. There was interest in getting help with referrals and getting people into work. It was suggested that a workshop event be facilitated with health professionals and that this could be hosted at the Town Hall. It was agreed that Councillor Richardson provide further details to Janet Cree.

178. DATES OF NEXT MEETING

The date of the next meeting was noted as 25 June 2019.

Meeting started: 6pm
Meeting ended: 9pm

Chair .....

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London Borough of Hammersmith & Fulham **Health & Wellbeing Board** **25 June 2019**	
NW London Commissioning Reform Programme: Public draft case for change	
External Report	
Open Report	
For Information / Review & Comment **Key Decision: Not applicable**	
Wards Affected: All	
Accountable Lead Officer: Mark Easton, Accountable Officer, NW London Collaboration of CCGs	
Report Author: NW London Commissioning Reform Working Group	**Contact Details:** **Enquiries to Governance and Scrutiny Office** Tel: 020 87535758

1. EXECUTIVE SUMMARY

1.1. Following the publication of the NHS Long Term Plan in January 2019, one of the key changes suggested is a movement from Sustainability and Transformation Partnerships to integrated care systems or ISCs. There are also implications that there will be a change to the structure of CCGs with the suggestion that there will be one CCG developed and corresponding to each ICS area.

2. RECOMMENDATIONS

2.1. The health and well-being board members are asked to discuss the case for change to explore the implications of moving towards a single NW London CCG.

3. REASONS FOR DECISION

3.1. Not applicable.

4. INTRODUCTION AND BACKGROUND

4.1. Please refer to appendix 1.

5. PROPOSAL AND ISSUES

5.1. Please refer to appendix 1.

6. OPTIONS AND ANALYSIS OF OPTIONS

6.1. Not applicable.

7. CONSULTATION

7.1. Not applicable.

8. EQUALITY IMPLICATIONS

8.1. Not applicable

9. LEGAL IMPLICATIONS

9.1. Not applicable.

10. FINANCIAL AND RESOURCES IMPLICATIONS

10.1. Not applicable

11. IMPLICATIONS FOR BUSINESS

11.1 Not applicable.

12. RISK MANAGEMENT

12.1 Not applicable.

13. PROCUREMENT AND IT STRATEGY IMPLICATIONS

13.1 Not applicable.

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

None.

LIST OF APPENDICES:

Appendix 1 – North West London Collaboration of CCGs and accompanying report

NHS
North West London
Collaboration of
Clinical Commissioning Groups

Item 10

Meeting name:	Hammersmith & Fulham Health and Well Being Board
Date	Tuesday, 25 June 2019

Title of paper	NW London Commissioning Reform Programme: Public draft case for change

Presenter	Mark Easton, Accountable Officer, NW London Collaboration of CCGs				
Author/s	NW London Commissioning Reform Working Group				
Responsible Director	Mark Easton, Accountable Officer, NW London Collaboration of CCGs				
Clinical Lead	NW London CCG Chairs				
Confidential	**Yes**	☐	**No**	☑	Items are only confidential if it is in the public interest for them to be so

The Committee is asked to:
The health and well-being board members are asked to **discuss** the case for change to explore the implications of moving towards a single NW London CCG

Summary of purpose and scope of report
In response to the NHS long-term plan which suggested that all sustainability and transformation partnerships (STP) develop into an integrated care system (ICS), by April 2021 with, "typically a single CCG for each ICS area", the NW London senior leadership decided to scope the implications of moving towards a single CCG, and have begun to explore key line of enquiry. The case for change has been developed in response to these key lines of enquiry with our stakeholders to assess these implications and the impact on our patients, our staff and our system. The agreed key lines of enquiry are as follows: ○ **The benefits for patients** i.e., would the move support the efforts through the partnership to improve sustainability and quality of patient services, as set out in our strategy ○ **The financial implications** in terms of management costs, financial sustainability of the system, implications for borough-based allocations and fair distribution of funds ○ **The governance implications** and how we maintain the concept of CCGs being

clinically-led organisations with lay involvement

- The implications for **health inequalities**
- **The workforce implications** in terms of talent management and staff impacted by change
- **Relationships with stakeholders**, particularly Governing Body members and local authorities
- How **the development of a single ICS** might work in parallel with the development of borough-based integrated care
- To **monitor arrangements** that are developing across London and take these into account as appropriate
- The **implementation timeline** for any recommendations plus a consideration of implementation costs and potential disruption.

What are the benefits of this project?

Having worked together since their formation, the NW London CCGs were able to deliver many clinical priorities and were able to improve outcomes for patients and staff. Moving towards a single CCG within our STP footprint, will therefore not only put us in line with the national policy but will allow us to further develop our clinical strategies to improve the delivery of services and address our ever growing financial challenges.

Patient, staff and stakeholder engagement

Full engagement with key stakeholders launched on 28 May until 24 July 2019.

Jargon buster

Commissioning reform: the NW London programme set up to explore the effects moving to a single CCG will have on of the NW London eight CCGs

Sustainability and transformation partnership (STP): areas where local NHS organisations and councils drew up shared proposals to improve health and care in the areas they serve.

Integrated Care System (ICS): organisation to oversee the joined-up care centred around the person.

Integrated Care Partnership (ICP): borough/locality based alliance of providers to locally manage the delivery clinical services

Financial Framework: a financial structure in which our eight CCGs can manage money more effectively

Quality & Safety

Changes to patient facing services are not anticipated with this case for change. It is however predicted with the single CCG we will be able to streamline our commissioning approach, decision making process which will allow us address health inequalities across the boroughs.

Equality analysis

The thorough impact assessment is underway, the detailed report will be made available when complete.

Finance and resources
As well as improving outcomes and reducing variation, we also recognise that our financial challenges are significant and that only by working as a single CCG can we begin to address them.

Risk	**Mitigating actions**
If we do not engage sufficiently with stakeholders there is a risk that we may not realise the benefits for commissioning reform in North West London.	Full stakeholder engagement plan is underway including the 'you said, we did' document
If we do not develop an approach that is coherent across the ICS, single CCG, ICPs and Primary Care Networks then this could become just an administrative change that will not help us to address the underlying issues of financial and clinical sustainability resulting in intervention by regulators.	Commissioning reform working group in place, reporting to Chairs and managing directors Representation on the London-wide CCG merger support group
If we do not develop ideas and plans in a transparent way then staff morale will drop resulting in a loss of productivity, increased staff turnover and increased sickness absence.	Full plan with is underway and method of staff engagement is in place to manage two-way dialogue

Supporting documents
Draft case for change for commissioning reform in NW London

Conflict of interests
There are no conflicts of interest identified.

Governance, reporting and engagement		
Name	Date	Outcome and where in the report can you find out more
NW London Commissioning Reform Working Group	21/05/2019	Developed the case for change for discussion with key stakeholders
NW London Chairs & MDs meeting	23/05/2016	Approved for discussion with governing body members and other key stakeholder

NHS
North West London
Collaboration of
Clinical Commissioning Groups

Commissioning reform in North West London

The case for change

28 May 2019

Foreword

This case for change document is written in response to the NHS long term plan which suggests that the number of CCGs will be significantly reduced to align with the number of emerging integrated care system (ICSs). The long term plan raises other issues: how a NW London integrated care system would operate; how integrated care partnerships (ICPs) would develop at a more local level and the development of primary care networks.

This document focusses on the first of those issues- a proposed change that would see NW London moving from eight CCGs to a single CCG.

NW London CCGs have a long and successful history of working together, particularly over the last five years. Building upon our existing relationships, we want to strengthen our collaborative working to commission and deliver high quality, best value, and safe care for the residents of NW London. We need to continue to work to reduce inequalities for our residents, improve our staff experience and deliver the optimum value for the NHS.

We see this as an opportunity to accelerate and streamline our systems and processes, reduce duplication and improve the offer of care to NW London residents. In doing this, we will learn from the experience of previous large-scale operating models, ensuring that we maintain a strong focus on public and stakeholder engagement in each of our eight boroughs.

This document does not hold all the answers - it sets out the implications of this change for comments and feedback from staff and stakeholders to help us to develop a full proposal that we intend to take to our CCG governing bodies later in the year.

The number of CCGs will significantly reduce over the next two years. We recognise that there will be differing views on how this should happen that we will need to resolve. The key areas we need to address now in NW London are:

- Whether this change to the number of CCGs happens by April 2020 or later, in April 2021
- What functions should be delivered at a NW London level and what should be organised more locally;
- How would the finances work; and
- How the changes to our CCGs relate to: changes at NW London with the development of an NW London integrated care system, the development of integrated care partnerships (ICP), based on boroughs, current CCG footprints, or groupings of boroughs, and the development of sub-borough structures such as primary care networks (PCNs).

We believe we have set out a good starting point for discussion. We now need your help to improve the proposals further and help us implement new arrangements that better serve our patients and staff.

Mark Easton
Chief Officer
NHS North West London Collaboration of CCGs

Dr Neville Purssell
Chair
NHS Central London CCG

Dr Andrew Steeden
Chair
NHS West London CCG

Dr Ian Goodman
Chair
NHS Hillingdon CCG

Dr Tim Spicer
Chair
NHS Hammersmith & Fulham CCG

Dr Genevieve Small
Chair
NHS Harrow CCG

Dr Mohini Parmar
Chair
NHS Ealing CCG

Dr Nicola Burbidge
Chair
NHS Hounslow CCG

Dr M C Patel
Chair
NHS Brent CCG

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1 – Introduction

About NW London – background and our history of collaboration

NW London has a diverse population of 2.2million across eight London boroughs, served by eight Clinical Commissioning Groups (CCGs). Although the CCGs have worked together collaboratively since they began, partnership working between the eight CCGs has increased significantly over the last eighteen months.

- In June 2018 a single Accountable Officer (AO) was appointed for all eight CCGs
- We have a single Chief Financial Officer and a single Director of Nursing and Quality for all eight CCGs
- In December 2018, a Joint Committee of the CCGs was formed with delegated powers for acute and mental health commissioning, and to support delivery of the NW London clinical and care strategy and sustainability and transformation plan (STP).

During this time, the eight local CCGs have remained the statutory and accountable organisations and decision making is through their eight individual Governing Bodies.

Moving to a single CCG is the next step in our evolution to accelerate and deliver our aims and objectives.

Further partnership working is also in place beyond CCGs - with provider Trusts, other NHS bodies and our local authorities. This was formalised after the publication of the NHS Five Year Forward View which set out the requirement for areas to develop a Sustainability and Transformation Plan/Partnership (STP). The NW London STP was published in October 2016 and the NW London Health and Care Partnership, a coming together of 30 organisations across NW London, was formed.

The NW London health and care system in NW London is a partnership of 30 organisations across health and social care, with a clear objective to improve and deliver high quality, safe and best value care for the residents of NW London. Our NW London health and care partnership is comprised of eight CCGs, six local authorities, and seven NHS Trusts.

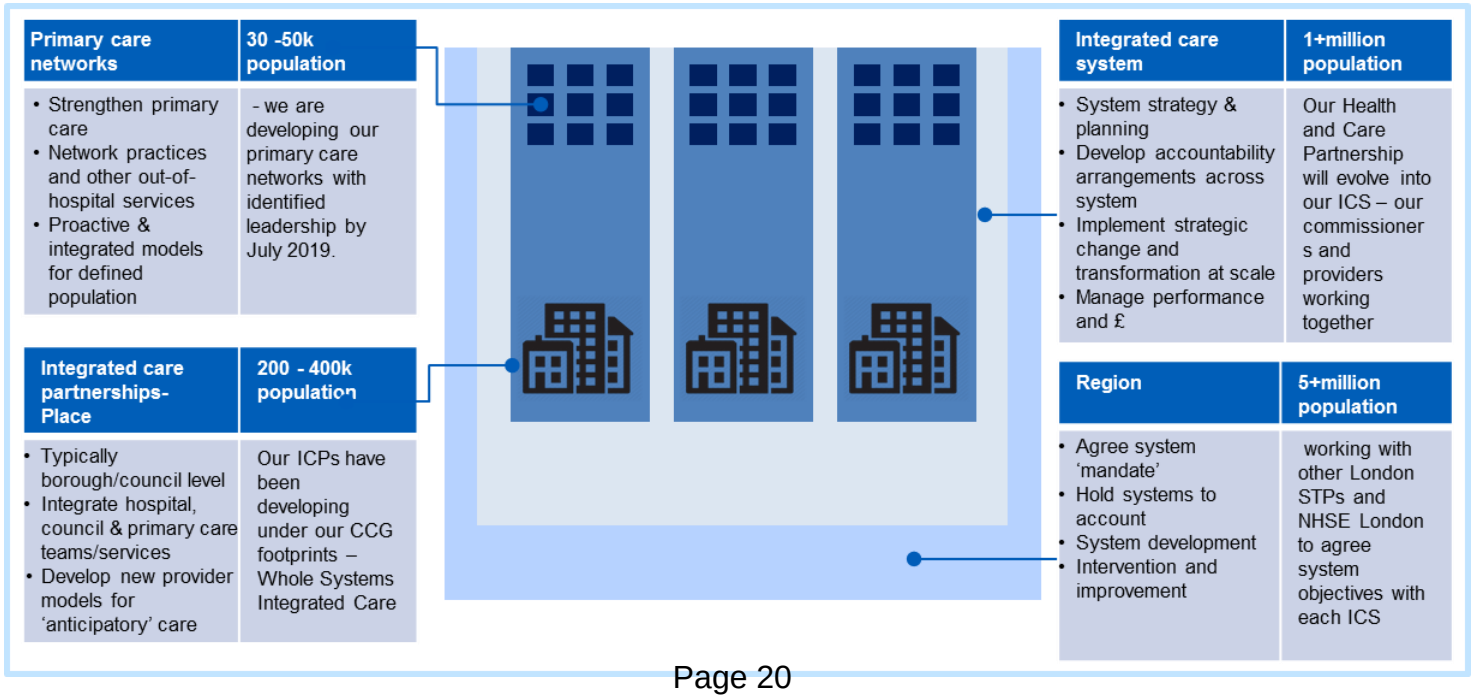


Figure 1: Integrated care as a system of systems

In early 2019 the NHS England 10 Year Long Term Plan was published. This outlines a number of goals for the NHS as a whole including the development of Integrated Care Systems (ICS) and more local Integrated Care Partnerships (ICP) which would be underpinned by Primary Care Networks (PCN). It also included a vision that each ICS would consist of just a single CCG – rather than the eight that NW London has now.

NW London is currently developing the local response to the long term plan, of which this case for change is one related element.

NW London has been working in partnership for some years and with some key successes but challenges still remain – including significant variation in care for patients - and our financial position is in deficit and deteriorating. We believe that we can address our challenges better by bringing together our eight organisations into one strategic commissioning entity to make our decision making and administration as effective and efficient as it can be, with strong borough based local integration. A move to a single CCG will also support the move away from the payment by results system towards capitated outcome- based budgeting, support consistency and equity in our methods for engagement, and simplify system wide financial planning.

We explore those challenges further within this document and set out:

- why we believe a change in commissioning arrangements in NW London is necessary
- what the change might mean and the benefits it will bring to the system
- what this means for our staff, stakeholders and residents
- areas where further discussions are required.

North West London – our challenges and ambitions

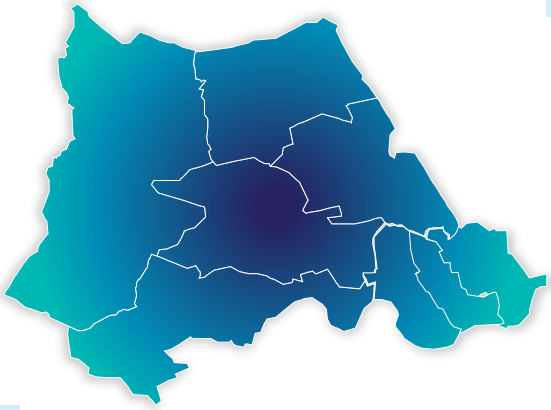
In NW London we want to deliver high quality, best value, and safe care in an environment which supports our staff and improves the experience of care for all NW London residents.

- **379 GP practices**
- **8 boroughs**
- **7 hospital trusts**

Over 30% of patients in acute hospitals do not need to be in an acute setting and should be cared for in more appropriate places

People with serious and long term mental health needs have a life expectancy 20 years less than the average

20% of people have a long term condition



Your chance of being admitted to hospital following a visit to A&E varies from 26%-50% depending on which hospital you visit. This is partly explained by alternative community pathways being present in some areas but not others

Life expectancy varies by 10 years from east to west

Service provision varies – the average length of stay can be 4.3 days or 7.5 days for the same procedure depending on which hospital you go to

Some community staff can administer treatments and services that in other areas require a visit to hospital, such as IV antibiotics

Spend on, and access to, continuing healthcare varies enormously with a range of £14.2 – £23.2m

The NW London CCGs ended 2018/19 with a deficit of £56.7m. Once non-recurring items are stripped out we enter the year with an underlying deficit of £99.6m. CCGs nationally have to cut their administrative costs by 20% compared to their 2017/18 spend.

Figure 2: NW London statistics

Quality and safety

- We will continue to drive high quality safe services, with consistent outcomes for our residents. We will reduce the variation in service provision, standardise pathways and ensure better care is delivered to our population
- We will progress our work to create a stronger, clearer and more consistent commissioning 'voice' for our area, built on the strong foundations of network-based, clinically-led commissioning, and drive forward the changes needed to deliver the resilient and sustainable NHS services that local people need
- Patient flow is often across borough/CCG boundaries, but over 80% of our residents receive care within the NW London area. North West London is a logical basis on which to commission services in order to best support our patient flow.

- By consolidating decision making, we will be able to better drive quality and focus on the important issues, working together to solve them.

Financial stability and sustainability

- We aim to make our financial situation sustainable. At the end of financial year 2018/19 the eight CCGs in NW London had collectively overspent their budgets by £56.7m – we aim to manage our spending within our budgets
- Once non-recurring items are stripped out we enter the year with an underlying deficit of £99.6m. In addition to this, CCGs nationally have to cut their administrative costs by 20% compared to their 2017/18 spend
- Maintaining eight separate statutory bodies is difficult to justify when there is so much pressure on health spending, and each statutory body costs an average of about £680k to run. In NW London we have already saved about 10% of our costs through the changes implemented last year and will endeavour to make further savings through this organisational restructure rather than only looking at changes to front line services
- We want to eliminate the administrative burden that comes from running eight statutory organisations and the transactions costs of the payment by results system. Operating a single administrative and governance function with capitated outcome-based budgets would enable us to focus more of our people and resources on delivering improved services and better patient experience.

Partnership working

- We will strengthen our individual borough relationships with local government, primary care, mental health, community services and the voluntary sector
- We will do this by building on our long history of collaboration locally and solid foundations of working as part of a wider system. Partners in NW London are committed to acting as an integrated care system. The concentration of NHS commissioning focus, through the merger of the eight CCGs in NW London, is an one essential element of these future arrangements, providing a single coherent strategic commissioning voice within an increasingly integrated care system
- We can maintain strong local relationships with our residents, staff and local government partners, without the need and cost of eight statutory bodies. We will have strong and visible local representation in each borough. Some parts of NW London are already making significant progress towards the development of integrated care partnerships which will be the focus of local health and care delivery in the future
- We will need to be clear about the strategic role of the integrated care system, operating at NW London level, and how we will work with our local authority partners in integrated care partnerships at borough level.

Workforce

- Our biggest asset is our workforce and we aim to make NW London a great place to work where staff experience is positive, and we make the best use of our skills and expertise
- We will do this by developing a talent pool and supporting our staff development more easily as one organisation.

2 – Changing at a NW London level

We want to create one integrated care system covering NW London and working together to maximise benefits to residents and staff. We want to achieve improvements in consistency of outcomes, and the highest achievable quality of care, for every one of our two million-plus residents – and the most rewarding working conditions for our thousands of staff who serve them every day.

We believe a single CCG would be an enabler for implementing an effective integrated care system and delivering on our clinical strategy – this document and the subsequent engagement will allow us to explore that and fully understand what a single CCG would enable us to do that we cannot do now with our existing partnership working.

Currently, there are unwarranted variations in case across NW London. Frailty is an example of where there is considerable variation. We have a clinical vision for improving care for the frail and older people - our geriatricians have developed a set of clinical standards for acute frailty services to promote equity of access and outcome for older people in crisis. However, expecting eight CCGs to come up with a way of solving things through eight decision making processes is unlikely to yield a consistent approach that reduces variation as effectively as working together and streamlining decision making.

A single CCG in NW London would become our statutory body for commissioning health care in NW London. The CCG's overarching focus would be commissioning the strategy and priorities of the integrated care system, focusing on patient experience and outcomes, population health management, and governance of tax payers' money

A NW London CCG would have a similar governing body to the current joint committee of CCGs, namely a combination of clinical leaders from the local teams, together with lay members, and managers. A single streamlined decision-making process would reduce decision making costs, reduce unnecessary duplication and improve consistency in service provision.

The CCG would continue to be clinically led, and would have a strong focus on partnerships, driving out variation and have a strong public voice. This public voice will need to be much more than having lay members on the governing body. We plan for to significant public engagement and involvement, so that local residents can help us shape services and provide feedback on how they are working, in a process of continuous engagement.

What we still need to explore

- What safeguards would a single CCG need to ensure it was responsive to local needs?
- What considerations should there be about a single CCG governance arrangements?
- How do we get a strong public voice into a CCG at NW London level?

3 – Changing at a local level

Strong local and visible NHS presence at the borough level remains essential. A health system as large and complex as NW London's could not be run from a single headquarters. We believe that local staff must be working to deliver needs of local populations by working in partnership with local government, primary care, community services and the voluntary sector to integrate health and social care. To achieve that, will maintain our relationships at borough level and improve our integration with local authorities. We will continue to strengthen our joint working in our Health and Wellbeing Boards to demonstrate and deliver local accountability.

There will continue to be teams of local CCG staff working with senior clinicians on local commissioning arrangements with delegated budgets. A key part of their role will be the development of integrated care partnerships.

Integrated care partnerships are vehicles for delivering seamless, integrated care to their local populations (servicing population of about 200,000- 400,000). They are usually in-line with local government boundaries and are part of an overall system of integrated care, governed at a strategic level by and integrated care system. In London, integrated care partnerships are likely to be in-line with the boundaries of boroughs or groups of boroughs, although two of our CCGs are not currently co-terminus with borough boundaries.

Where borough-based effective integrated commissioning arrangements already exist they will continue to be maintained and strengthened.

The NW London CCGs are at various stages in developing integrated care partnerships (ICPs). There is unlikely to be a single model suitable for all parts of NW London, (indeed the national guidance reproduced in appendix 1 suggests six different options) but given ICPs need to fit into a wider system it is important that arrangements do not develop in an inconsistent or contradictory fashion and north west London is developing a framework for ICP development. Our primary focus is to deliver consistent outcomes for the residents of NW London, reducing health inequalities and improve safe quality care.

Critical to each borough or place -based system will be its local general practice delivery and the development of primary care networks (PCNs). PCNs are explained in section 6.

What we still need to explore

- The operating model to determine functions which continue at local level will be developed over the summer as part of the engagement process
- We need to develop further the framework for ICP development and encourage those who are furthest ahead to make progress.

4 – Finance

To ensure effective and on-going delivery of health and care for the residents of NW London, we need to ensure the financial foundations are both stable and sustainable. We believe that this can be best achieved through a move to a single CCG as it will enable greater economies of scale, a stronger negotiating position when commissioning services and the ability to share financial skills.

Currently, our biggest challenge is finding a way to deliver the high-quality safe services for all the residents of NW London within the constraints of our budget. We can continue to improve our decision-making process to make it less fragmented, to allow for economies of scale and improve the quality of care offer for all NW London residents. The NHS long term plan asks us to make 20% savings on our management costs, coming together as a single CCG allows us to make that more easily than as eight organisations.

Becoming a single NW London commissioning entity presents a number of opportunities to maximise our current resources. Operating at-scale, we can strategically commission services, and make it easier for providers to deliver better value. This will mean that providers have more clarity in what we expect and be better able to deliver this. We will establish common standards for providers across NW London to deliver against. Furthermore; those providers who would benefit from more support will have a partner who can more easily mobilise resources to support them. The large NHS providers in NW London have fed back to us that working with a single commissioner in NW London would drive consistency in care and improve efficiency.

Although NW London CCGs as a whole are in significant deficit, individual CCGs are in very different positions, ranging from one in surplus, to others at or close to breakeven and others in significant deficit. Spending on services per CCG is highly variable, often driven by the historic variation in capitation (funding per head of population). Creating a single CCG will raise fears that better funded areas are going to be levelled down, and there will be a loss of local accountability for budgetary decisions. We will need to be sensitive to these issues and ensure that good financial management across NW London is not seen as a punishment on some. Given the sensitivity of this issue we need to be cautious that we do not de-stabilise current arrangements. There is likely to be some London guidance on this issue to ensure some consistency across the capital.

In NW London, there has been historic variation in investment priorities, now we have the opportunity to focus NW London ideas, energies and resource on achieving consistently high standard of outcomes across the ICPs and ICS.

What we still need to explore

- To what extent are there greater opportunities to work with local government from a financial perspective?
- What local level relationships and understanding need to be retained within the financial function?
- We need further understanding of the national and regional timeline on equalising financial allocations to target levels.

5 – What this means for local government

We view our local authorities as key partners within our vision of integrated care for NW London. They are pivotal both to the delivery of population health and through their democratic responsibilities for ensuring that the local voice is determining priorities. Through the development of our integrated care partnerships we want to strengthen this local accountability.

We want to build on the existing partnership arrangements and relationships and move towards greater integration with the eight local authorities in NW London. We believe doing so will enable us all to achieve more for our residents in improving health and care services within the budgets we have.

Integrated care partnerships will encourage innovation and give local freedom to determine how best to collectively work to deliver the agreed outcomes for local residents. In doing so they will build on the existing good practice, for example, in areas where we already have joint appointments and shared work programmes these arrangements should be enhanced further, in others they should provide the environment for these to be explored.

We envisage that Health and Wellbeing Boards' role of providing a strategic steer for effective local delivery of health and care outcomes would continue and the importance of the local authorities in scrutinising health services would of course continue under any reform of commissioning structures. Similarly there would be no impact on the Better Care Fund (BCF) as NW London will continue to meet BCF commitments regardless of CCG structure.

Local government would continue to work with local teams and in some areas may wish to take on more of a leadership function. Given the move to a NW London-wide organisation, these local relationships will become more important than ever in maintaining engagement and involvement at borough level. The local authorities will be key partners in local integrated care partnerships. Health and wellbeing boards in each borough will also continue to play a key role in shaping and developing local services.

What we still need to explore

- How do we ensure that the local voice is strengthened?
- The local partnership between health and local authorities will be key to delivering the outcomes the NHS Long Term Plan – how do we ensure this is most effective?
- What works really well currently that we need to develop further for the benefit of our residents?
- What level of integration is appropriate and achievable?
  Where are the opportunities to capitate and delegate budgets?

6 – What this means for GPs

CCGs are membership organisations, and a NW London CCG would be no different. Members would adopt a new constitution and elect representatives to the governing body as they do now. Commissioning of primary care would be undertaken by the CCG and managed locally with clinical input. This local input is important to ensure we continue to be fully responsive to local population health needs. It is our priority that GPs experience the same level of service, or better, from our commissioning function, we want to keep primary care management, relationships and operational support, including IT, local and will do this by maintaining local delivery teams.

Clinical leadership

Clinical leadership, the ability of clinical leaders across both commissioner and provider organisations to own and drive the local agenda, will continue to be important, irrespective of at which level commissioning operates. We want to continue the good relationships we have with our local GPs and we will not lose the understanding of local issues and needs, that has been a real benefit to our eight CCGs.

Our model is emergent and we have a triple aim for clinical leadership and engagement in development:

1. Maintain clear clinical decision making at a local level and develop system-wide speciality leadership
2. Improve quality of care and reduce health inequalities
3. Partnership working with local government, primary care, community services and the voluntary sector

We have strong clinical leadership in our system on which we will build. Clearly the role of clinical leadership will develop in the new operating model, but it is our priority that we continue to embody the ethos of clinically-led local decision making to suit local population needs, reducing health inequalities and improving patient experience. This means that we need to strengthen:

- Our system clinical commissioning leadership – moving away from traditional models of leadership to a shared leadership model; coaching and enabling collaborative decision making and building specialism. We will continue to strengthen the on-going quality assurance and clinical input to outcomes attainment and standard setting across NW London.
- Our local clinical leadership – acting as the clinical voice in borough-based systems and leading the ICP and the PCNs in the area.
- The interaction between clinical delivery at a local level in both primary and secondary care, and
- The interaction between local leadership, management and delivery with the integrated care system as a whole.

The below diagram is an illustrative example of how we may strengthen clinical leadership at all levels of our ICS. It is intended for description only as ICPs may form various models (see appendix one and two for further information).

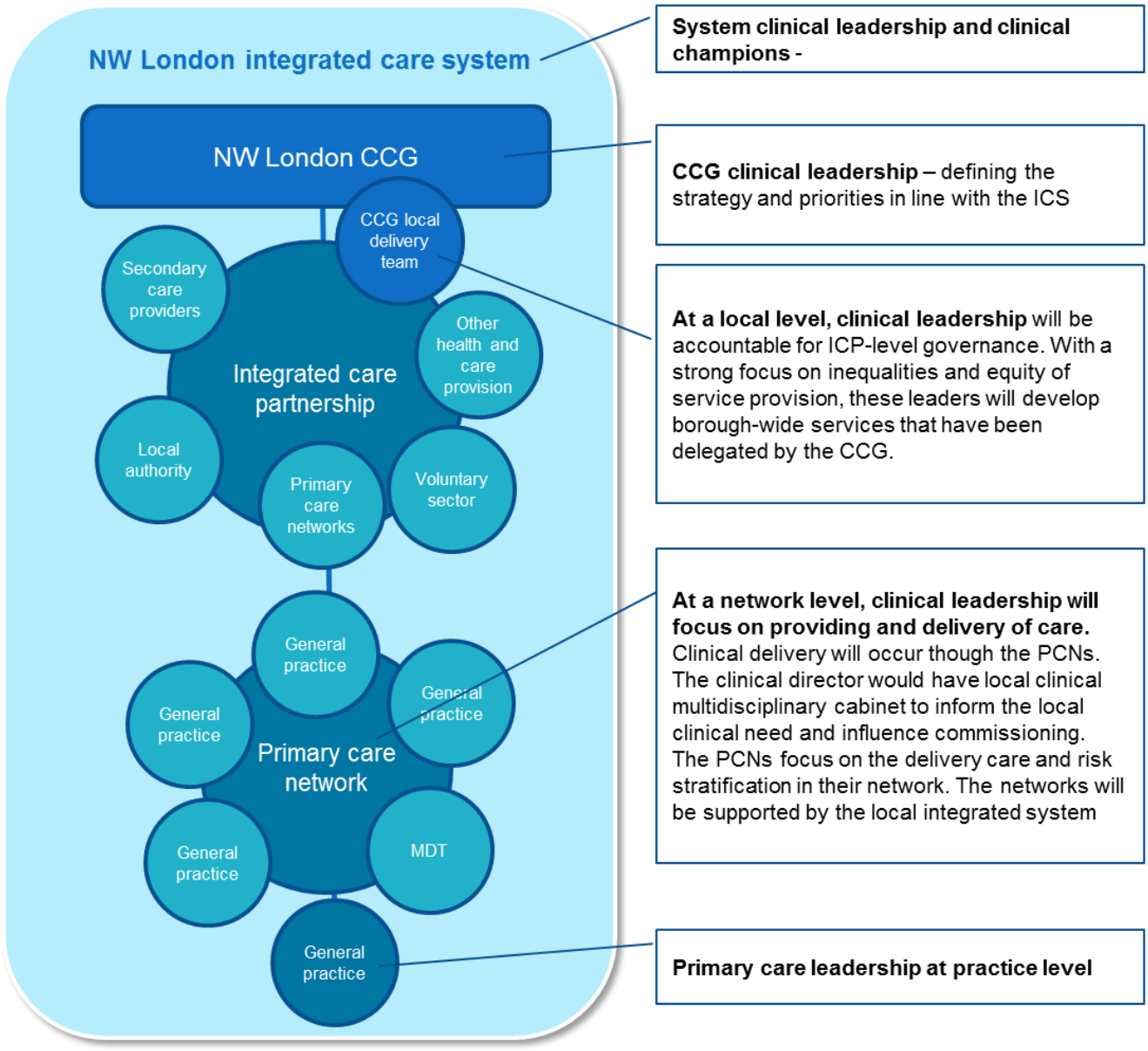


Figure 3: clinical leadership occurs at every level

What we still need to explore

- How best to hear member practices at NW London level if there is a move to a single CCG
- How we can best support transition?
- What impacts do GP practices feel this could have which hasn't been addressed?

7 - What this means for patients and the public

This case for change is about an internal structural change rather than patient facing service changes. However it is intended that the greater efficiencies gained from moving to a single CCG will enable us to be more financial sustainable, more streamlined in our decision making and ultimately lead to more opportunities to address health inequalities across the region.

The proposal for a single CCG for NW London coincides with a drive to improve our engagement with residents and patients across our eight boroughs.

We have positive relationships with our local Healthwatch partners, patient representatives and other community and voluntary sector groups. Healthwatch has always been represented in our entire governance structure and will continue to be so. Their active participation has enabled effective engagement across NW London, regular patient involvement in project development and implementation and also helped us address accessibility and access concerns when we moved to some of our decision making occurring through the Joint Committee.

As part of any changes in decision making in the region, we want to ensure we are representing the differences across NW London and that there continues to be public accessibility and involvement in our decision making. The single CCG would meet in public and rotate meetings across the region, much as the joint committee does now.

We recognise that the people of NW London are not a homogenous group and that there will be different opinions, interests and priorities among different stakeholders and communities. We also acknowledge that people identify with their local area or borough rather than 'NW London'. Most of our public engagement is currently based at borough level, where existing relationships and partnerships are vitally important these local arrangements would continue.

We have ambitious plans to transform the stakeholder engagement landscape in NW London. This will be based on a process of continuous engagement with our residents and stakeholders, offering many more opportunities for the public to feedback on how services are working to help the local voice be heard loudly at regional level. Public engagement should not be limited to proposals to change services or explaining national initiatives – our overall approach will be based on listening to and learning from what the people who use our services and work with us are saying. As part of this plan, we are putting in place a 3,000-strong Citizens' Panel across NW London – a demographically representative group from which we will regularly seek feedback.

We will need to carefully consider any impacts on groups protected under the Equality Act of changes to the way in which we structure our CCGs.

What we still need to explore

- How will we engage with patients/public at local level?
- How would patients and residents be involved in decision-making?
- How should we maintain local accountability?

8 – What this means for CCG staff

As part of a move to a single CCG, we would want to build on staff feedback and improve ways of working for staff. Previous staff engagement surveys have shown that there is limited career progression within the organisations and challenges around retaining staff. People leave one organisation to seek another role in a different organisation a few miles away or sometimes on a different floor within the same building.

The removal of organisational boundaries would allow us to create a shared talent pool. This would give staff the flexibility to progress, develop and use their skills in more challenging and interesting ways, with 'organisational friction' reduced for vertical and horizontal progression across NW London.

The significant amount of duplication which often occurs, especially when working on projects across more than one CCG, causes frustration for staff with the differing governance structures and processes in different areas proving confusing and time consuming. Working as a single CCG would enable us to establish greater consistency in standards and expectations so we can address this variation. For example, simplified governance structures would eliminate the need to pass papers through numerous committees. Common standards also ensure we have common expectations of each other, and would support shared ways of working so we can work in a truly agile manner throughout the organisation.

Any change by its nature introduces ambiguity which can have an impact on people's productivity as well as their health and wellbeing. We are also aware that there are many questions staff will have about this – especially in regard to likely structures – that will not be developed until later in the process. We are mindful of this and will be taking steps to ensure all staff are supported and involved as we develop these proposals.

Although we have to make cost savings as part of these proposals, given the number of vacancies and interim staff there are likely to be few compulsory redundancies amongst substantive NHS staff. Becoming a single CCG will not happen overnight, instead there will be a phased transitional period. During this period plans will be developed that ensure we make a smooth transition, and can realise the benefits outlined above whilst maintaining and building upon what works.

These phases will be:

- **Planning** – Human resources (HR) and operational development (OD) will provide support to map current functions and team structures in order to build a comprehensive picture that can used to develop detailed options
- **Pre-consultation** – HR&OD will carry out some early engagement around the options
- **Consultation** – All staff have an opportunity to feed into the process, raise concerns and make suggestions
- **Implementation** – Once consultation responses have been considered an outcome document will be produced detailing next steps
- **Delivery** – After the new structure becomes fully operational we would need to work together to manage any team dysfunctions, and it will take time to make new ways of working and practices part of business as usual.

Throughout the transitional period the HR&OD team will be working closely with colleagues across NW London to develop and implement plans. There will be a programme of regular communications which will ensure all colleagues are informed of progress, and everyone will have an opportunity to feed into the decision making process.

What we still need to explore

- How to engage staff in the development of plans?
- How can we maintain staff morale and retention through this period of change?

9 – Timeline

The Case for Change will be discussed with our governing bodies 5 -26 June 2019.

Our engagement period officially begins on 24 May and we will be talking to all of our stakeholders to gather their views on the questions posed throughout this document. We request comments, input and feedback by 24 July when we will begin to develop formal proposals, should we believe it is the right thing to do following engagement. Proposals would go to governing bodies in September for agreement with submission of our intention to NHS England by 30 September.

Ratification of changes are likely to require a vote of the council of members, which would take place after the decisions of the governing bodies.

During this time, we will carry out an equality and health inequalities impact assessment.

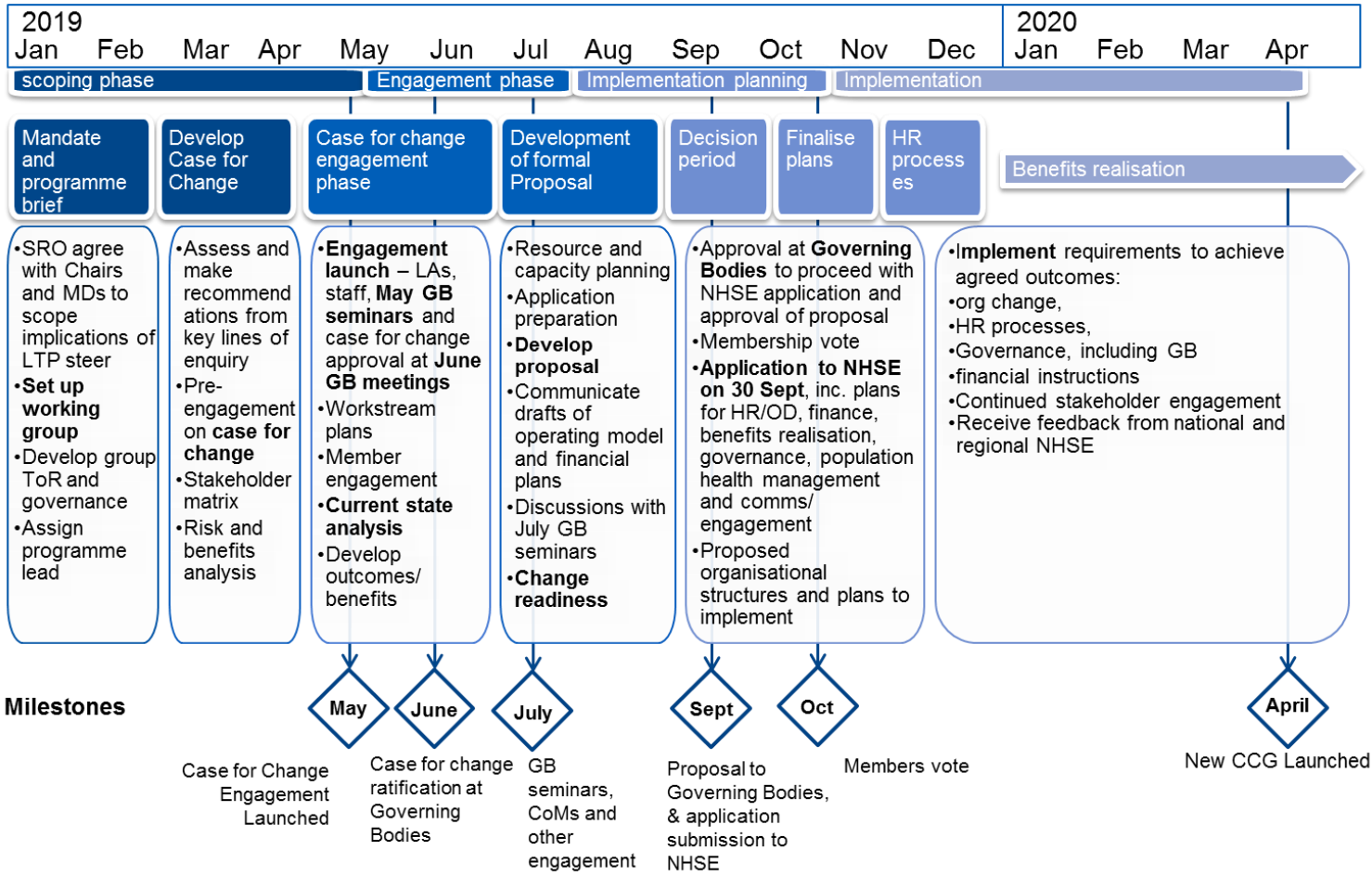


Figure 4: Illustrative high-level time line for 2020 launch

How to respond

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

Accountable Officer's Office
NW London Collaboration of CCGs
87-91 Newman Street
London W1T 3EY

Appendix one: Our emerging integrated care system in NW London

What does an ICS mean for NW London?

The long term plan describes integrated care systems as follows:

"Integrated care systems (ICSs) are central to the delivery of the Long Term Plan. An ICS brings together local organisations to redesign care and improve population health, creating shared leadership and action. They are a pragmatic and practical way of delivering the 'triple integration' of primary and specialist care, physical and mental health services, and health with social care.

The long term plan states that ICSs will have a key role in working with Local Authorities at 'place' level and through ICSs, commissioners will make shared decisions with providers on how to use resources, design services and improve population health."

Our agreed vision in NW London is to create one integrated health and care system working together to maximise benefits to residents and staff. We want to support the transition of our Health and Care Partnership into an ICS, integrating health and social care seamlessly for our residents.

We have begun this journey through our sustainability and transformation partnership – our NW London Health and Care Partnership, This partnership of over thirty organisations is working together to improve quality, patient and carer experience, staff experience, value and the reduce unwarranted variation.

We want to continue to develop integrated working at three levels, aligned with national strategy; system, place and network:

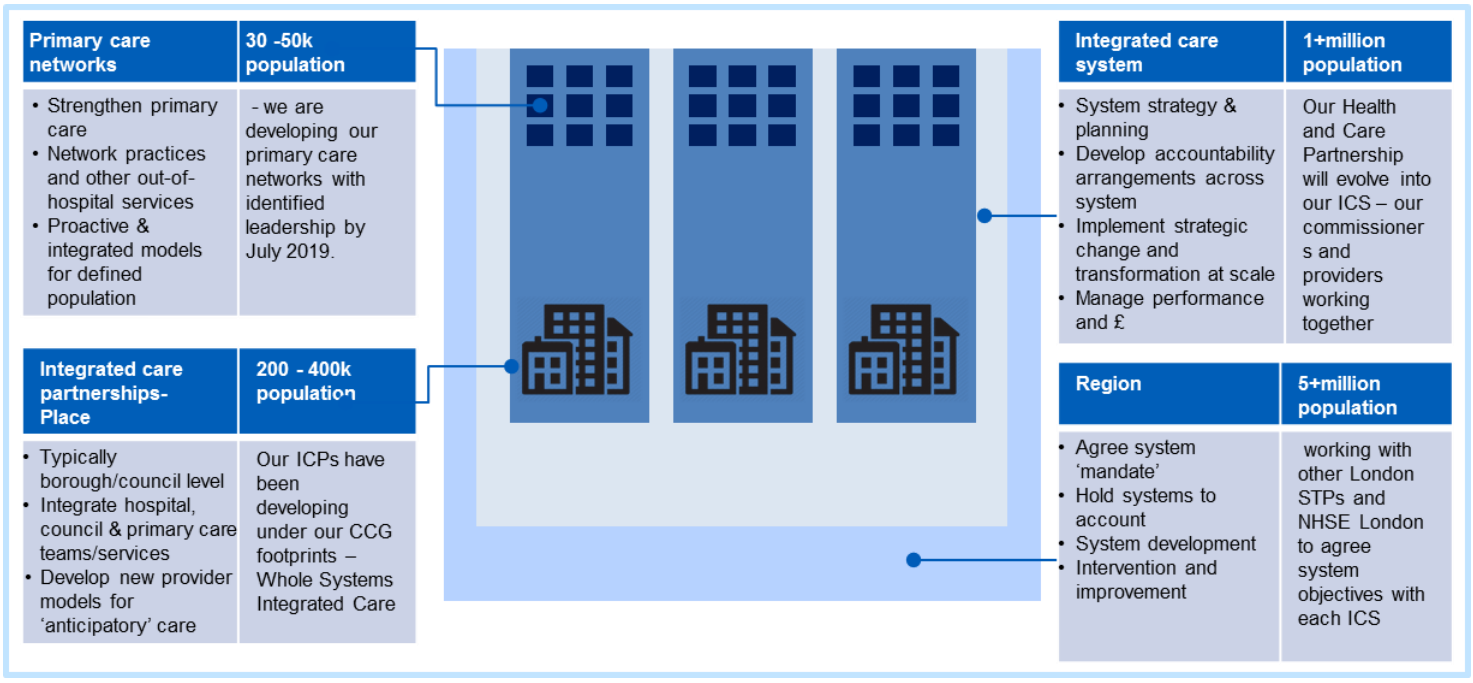


Figure 5: Integrated care as a system of systems

How does moving to a single CCG support our integration agenda?

The NHS long term plan states that "every ICS will need streamlined commissioning arrangements to enable a single set of commissioning decisions at system level. This will typically involve a single CCG for each ICS area. CCGs will become leaner, more strategic organisations that support providers to partner with local government and other community organisations on population health, service redesign and long term plan implementation."

In order to support true integration of our system of health and care in NW London, we need to strengthen several aspects of our strategic and operational functions:

Figure 6: features of integration

At the moment, we operate with eight statutory accountability arrangements for our governance in commissioning, supported by our Joint Committee. Although we have made progress is simplifying our governance, we can go further to streamline decision making – by reducing our statutory boards to one.

This will also support the quick provision of data and information sharing, support consistency and equity in our methods of engagement, and simplify system wide financial planning.

How is an ICP different from a CCG?

An ICP is focused on care provision and delivery for a given population, most commonly, 200,000-400,000 people. A CCG is a statutory organisation that purchases services from providers to deliver care for a given population, and manages the contract for care delivery.

As we continue to fully integrate our health and care system in NW London, we will be moving away from the distinction between provider and commissioner as we manage care on a population health basis, working increasingly in partnership with local government and the voluntary sector.

Our CCG would be responsible for the commissioning of the ICP contract. In the future, it is possible that mature ICPs may form statutory bodies themselves, as their alliance working with partners is strengthened. Our ICPs will be underpinned by local delivery teams from our CCG.

Why are we developing primary care networks?

Primary care is the bedrock of care provision to our residents. We need to ensure GPs are supported to manage the health and care of their registered lists. As part of national policy GPs are coming together in primary care networks with a range of local providers to offer more personalised, coordinated health and social care to their local populations. This multidisciplinary working, led by clinicians, will be the heart of our integration to offer the best care to our residents in NW London.

How are we developing primary care?

We have been working to improve primary care in NW London for some time, implementing the GP forward view in order to meet the needs of our residents. To meet these needs, local practices have begun working together and with community, mental health, social care, pharmacy, hospital and voluntary services in their local areas in primary care networks (PCNs). The change in the way general practice is working helps teams build relationships with all other staff in their networks, and together, in partnership with patients and the public, use whole population health profiles to plan for and deliver integrated whole person care to the key groups of people

The local and NWL primary care strategies have consistently focused on improving the experience of working in primary care; streamlining workloads and improving our track record in retaining and recruiting staff; developing digital solutions; investing accordingly to achieve the standards in accessible, co-ordinated and pro-active care set out in London's Strategic Commissioning Framework.

Our next step is general practice 'working at scale'; with GPs supported by Primary care networks in partnership with local community services, mental health and social care. Ability to make that work for local patients will be enhanced by better working relationships between organisations across the system; consistent and inter-operable IT systems; and better data-sharing.

We have also been developing our system and local population health management plans so that childhood obesity, rising numbers of long-term conditions, dementia, mental health and related health concerns can be managed by the local GP, practice nurse, community nursing staff, community pharmacists and PCN effectively

Primary care networks (PCNs), although provider functions are important part of our health system and are described in this document for completeness. PCNs build on the core of current primary care services and enable greater provision of proactive, personalised, coordinated and more integrated health and social care. By working in this way, practice gain more local control over the health needs of their populations. Clinicians describe this as a change from reactively providing appointments to proactively care for the people and communities they serve.

The development of these networks are a key part of the NHS long term plan, with all general practices being required to be in a network by June 2019, and CCGs being required to commit recurrent funding to develop and maintain them. Primary care networks will be based on GP registered lists, typically serving natural communities of around 30,000 to 50,000.

Our practices will work together in our PCNs. Our PCNs will operate through multi-disciplinary working, delivering population health management, and support our ICPs to deliver the required health and care to our local populations. These networks will be the bedrock of local/borough-level arrangements.

Appendix two: Options for integrated care partnerships (ICPs)

How different commissioning structures can commission different configurations of services – draft

The draft ICP contract pack[1] sets out the following six scenarios:

Services to be commissioned	Mechanism under current legislation	Comments
1. A new care model providing primary medical services, community health services and acute car	The CCG would need to establish aligned budgets for the ICP (which can have a single contract), to ensure that primary medical care funding remains ring-fenced within the ICP's total budget	Primary medical care funding is currently ring-fenced under the delegation agreement
2. A new care model providing primary medical services, community health services, acute care, social care and LA commissioned public health	Under a s75 Partnership Arrangement; an aligned budget within the ICP contract for those service that cannot be included in a s75 arrangement but can be under a single contract	Exceptions as above plus: • surgery, radiotherapy, termination of pregnancies, endoscopy, the use of Class 4 laser treatments and other invasive treatments • s7a public health services • primary dental services • pharmaceutical services • primary ophthalmic services • emergency ambulance service
3. A new care model providing community health services, social care and LA commissioned public health with more than one LA	As above	Exceptions as above
4. A new care model providing community health services, acute care, social care and LA commissioned public health	As above	Exceptions as above
5. A new care model providing primary medical services, community health services, acute care, , social care, LA commissioned public health and s7A (**NHSE**) public health services	As above	Exceptions as above plus need regional agreement for NHSE to be a party to the contract and S7a functions cannot be given to more than one CCG jointly
6. A new care model providing primary medical services, community health services, acute care, social care, LA commissioned public health and specialised services	As above	Exceptions as above plus need regional agreement for NHSE to be a party to the contract and S7a functions cannot be given to more than one CCG jointly

[1] CCG roles where ICPs are established Draft Integrated Care Provider (ICP) Contract - consultation package August 2018

London Borough of Hammersmith & Fulham **HEALTH AND WELLBEING BOARD** **25 June 2019**	
Social Isolation and Loneliness Update Report	
Open Report	
Classification: For Discussion **Key Decision:** No	
Accountable Director: **Report of Lisa Redfern, Strategic Director of Social Care**	
Update Author: Fraser Serle, Public Health Commissioner	**Contact Details:** Email: fraser.serle@lbhf.gov.uk

1. EXECUTIVE SUMMARY

1.1 This paper is a follow-up to the Draft Social Isolation and Loneliness Action Plan that was presented to the Health and Wellbeing Board (HWB) in March 2019.

1.2 It provides a brief summary of a series of actions that aim to reduce isolation and loneliness in Hammersmith & Fulham (H&F).

2. RECOMMENDATIONS

2.1 Health and Wellbeing Board members are asked to review and note the report.

3. INTRODUCTION AND BACKGROUND

3.1 Combating social isolation and loneliness is one of the top priorities of H&F council, the HWB, Older People's Commission, Social Inclusion Board, Youth Council and Integrated Care Partnership, as well as many health and third sector partners.

3.2 Anyone can experience social isolation and loneliness. There are clear links between

health and social inequality and loneliness. Those at increased risk include people living on lower incomes, people with poor physical and mental health or a disability, people living alone and people from black and minority ethnic or LGBT+ communities.

3.3 A draft action plan was presented to the HWB in March 2019. It outlined initial actions to address social isolation and loneliness. The approach to addressing social isolation and loneliness needs a stepped approach that links all the actions outlined.

4. INITIAL SIX ACTIONS

4.1 **Social isolation and loneliness plan**
This was presented to the HWB in March for information/comment and subsequently sent to stakeholders such as the members of the Integrated Care Partnership. Comments have been received and an updated delivery plan is now being developed. Some of the actions are outlined in this report.

4.2 **Partnership working - participatory culture**
The H&F Communities team has convened a small multi-agency task group to explore actions that everyone in the borough can do to address social isolation and loneliness based on the Cities of Service model (https://www.nesta.org.uk/project/cities-service-uk/).

The working group comprises of the Young Hammersmith & Fulham Foundation, St Andrew's Church Fulham Fields, Hammersmith & Fulham Volunteer Centre, Hammersmith Bid and representatives from Public Health and Corporate Services in H&F. A bid to the National Lottery to fund this campaign is being developed.

4.3 **Partnership working - emergency services**
H&F is convening a meeting of the three emergency services to link with the participatory culture campaign. We will explore how we can work collaboratively to link socially isolated and lonely people they come into contact with to activities in the community.

4.4 **Partnership working - social prescribing**
We are working with partners in the NHS and voluntary sector to link up the various social prescribing programmes that are being developed with already established initiatives. This includes the MacMillan Cancer Care social prescribing project in the north of the borough.

4.5 **Embedding actions to address social isolation and loneliness within services provided through H&F**
H&F is intending to address social isolation and loneliness through the implementation of social value within contracts and service specifications issued by the council. This element is currently being developed by Procurement with input from Public Health.

A Social Isolation and Loneliness Board is being convened by Anita Parkin, DPH. It will have representation from all council departments to facilitate the identification of actions their staff can take to address isolation and loneliness and inform the delivery of this. Officers are currently in the process of drafting terms of reference. Date for first meeting to be scheduled.

4.6 **Preventative services and interventions**

Whole life / adults social care commissioning is looking at the services that they commission to see if there is a way to connect the offer to enable people to remain connected to and play an active role in their community. The SAIL model is being looked at as one potential system to introduce. A meeting was recently held with commissioning AD Jon Lillistone on how this might happen.

The Economy Department are looking at a service model to engage and link up with anyone who lives in council housing regardless of tenure. Working with the London Fire Brigade and Tenants Residents Associations, it will be a further route to identify isolated and lonely people.