Strategic Case

Strategic Case for greater alignment between Croydon CCG and Croydon Health Services NHS Trust (CHS)

May 2019

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1 Executive summary

Croydon is an Outer London borough; with more than 380,000 residents living locally, it is larger than Nottingham, Newcastle and Belfast. It is also one of London's fastest growing and most diverse boroughs.

Similar to the majority of regions across the UK, the Croydon Health and Care system is experiencing challenges. There are significant health inequalities across the borough – for example, life expectancy in the most deprived areas of the borough is up to ten years lower than the least deprived. 30% of patients treated in hospital are more suited to a community or home setting and large numbers of patients are currently leaving the borough to receive elective care elsewhere. This is occurring at the same time as financial pressures and workforce shortages.

There is a commitment and enthusiasm to address these challenges and a significant element of solving these is through the considerable collaborative work Croydon is already undertaking, through partnerships such as the One Croydon Alliance, which has resulted in a number of improvements in care to date.

However, to fully overcome these challenges, further transformative change is required. At present, the competing priorities of individual organisations risk delaying the development and implementation at pace of a sustainable place-based plan to meet the growing health and care needs of the population. It also risks slowing the pace at which we can return the local health economy to financial surplus, to be consistently high-performing and deliver continuous quality improvement.

Croydon CCG (CCCG) and Croydon Health Services (CHS) plan to initially deliver this next phase of change through greater alignment and integration, moving towards a place-based model of care. Croydon is in an ideal position for such models with a single provider of both acute and community services, a single co-terminus CCG and local authority and a commitment to integrated working at the place level. Although this next step is between two health organisations, it is expected that over time it will evolve to include all of the Partners of the One Croydon Alliance, as well as factoring in Croydon's role in the broader South West London area as the potential for the merger of CCGs across the STP area progresses.

The ultimate goal of greater alignment is to improve the health of the Croydon population, provide better quality care for patients, improve ways of working and return the system to financial balance, by a more effective and efficient use of assets and resources. We will achieve this through transforming clinical services across both primary and secondary care, but also improving organisational alignment and system performance across other areas, including shared functions and shared governance.

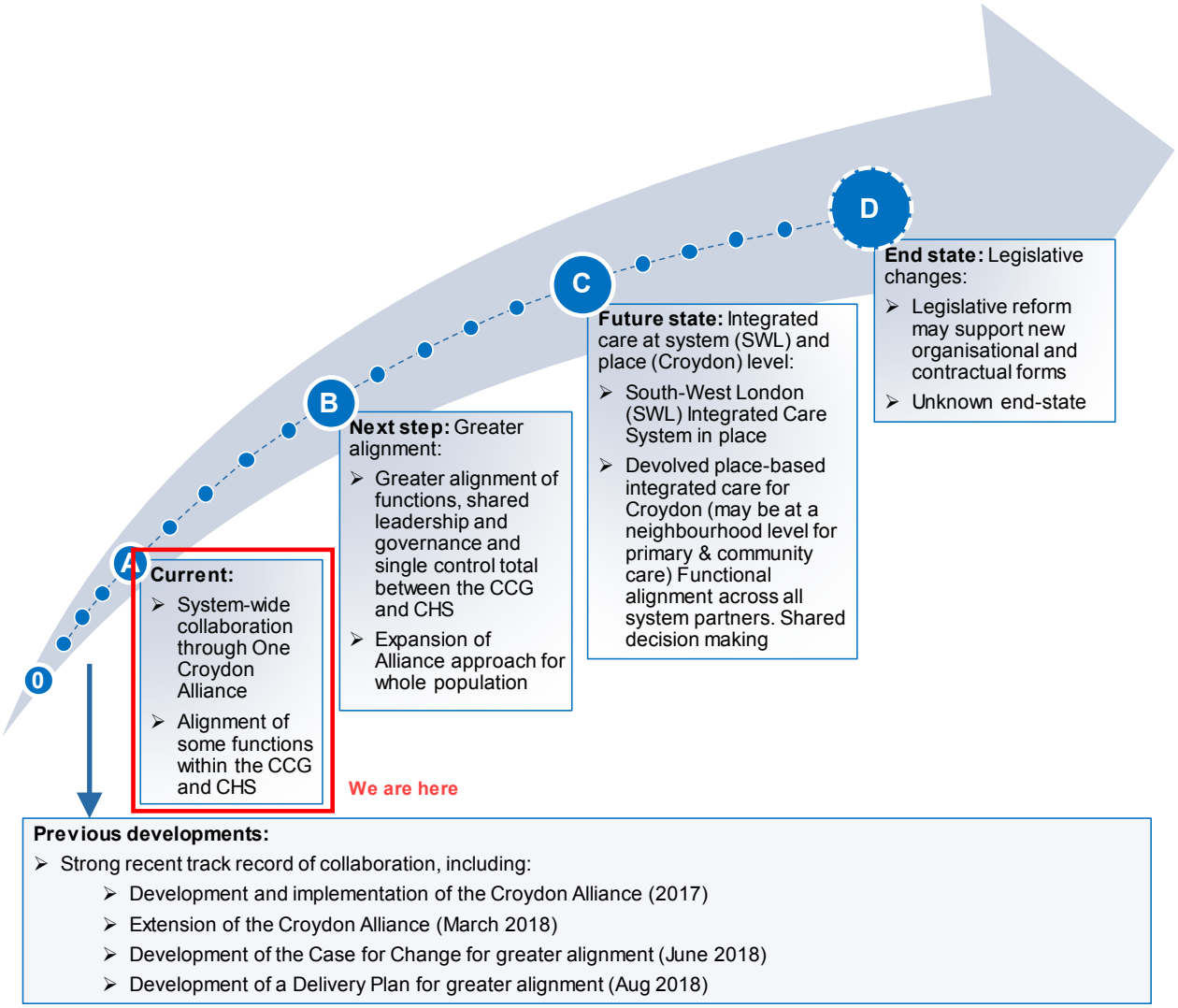
By improving organisational alignment, the Trust and CCG will be better able to deliver large-scale service and clinical transformation projects across acute, community and primary care, which benfits the whole system rather than individual care settings.
Alongside this, it will also:

- Remove duplication of function to enable resources and assets to be used more effectively;
- Reduce misalignment, divergent priorities, and conflicts, which waste unnecessary time and resources;
- Allow the Trust and CCG to share approaches, capability and best practice with one another.

Croydon's aspirations are in support of the wider direction of travel, both at a national and local level. In recent years it has been an NHS policy objective to increase integration. This is reaffirmed by the recently-published NHS Long Term Plan, which commits to every region being an Integrated Care System (ICS) by April 2021. In the event of an SW London ICS, the proposed Croydon model is expected to sit within the wider system as a place-based layer, responsible for 80-90% of resources and functions on behalf of its local population.

Developing a place-based model will be a continuous process, within which we foresee four major stages as outlined in the figure below:

Figure 1: Major stages in moving to place-based integration



Croydon is currently at stage A. System-wide collaboration is already occurring, through the One Croydon Alliance and significant progress towards greater alignment has been made between CHS and Croydon CCG. As part of greater alignment, CHS and Croydon CCG have been undertaking joint working across the key "here and now" challenges facing the organisations, establishing a joint control financial control total, stood up a shared quality committee and appointed joint roles across both organisations.

Furthermore, CHS and Croydon CCG are beginning to realise benefits of improved relationships and working together. Since July 2018, joint working together and releasing time to care has seen CHS's 62-day cancer targets improve from 78% to 80% (Nov 2018), and its RTT targets have continually remained above the 92% national targets (making it one of the top performing London boroughs). There is however much to do, and part of our current focus is addressing the system wide challenges within urgent and emergency care, which will be solved through joint working across both primary and secondary care settings.

Based on this progress and the recognition that greater benefit is available through further alignment CHS and Croydon CCG plan to move to stage B.

Stage B will see CHS and Croydon CCG effectively operating as a single organisation across many of their core responsibilities, it is only through operating at this level of alignment do the Trust and CCG believe they can deliver truly transformative care and move to a place-based model supported by a population health approach.

Figure 2: Characteristics of proposed Stage B model

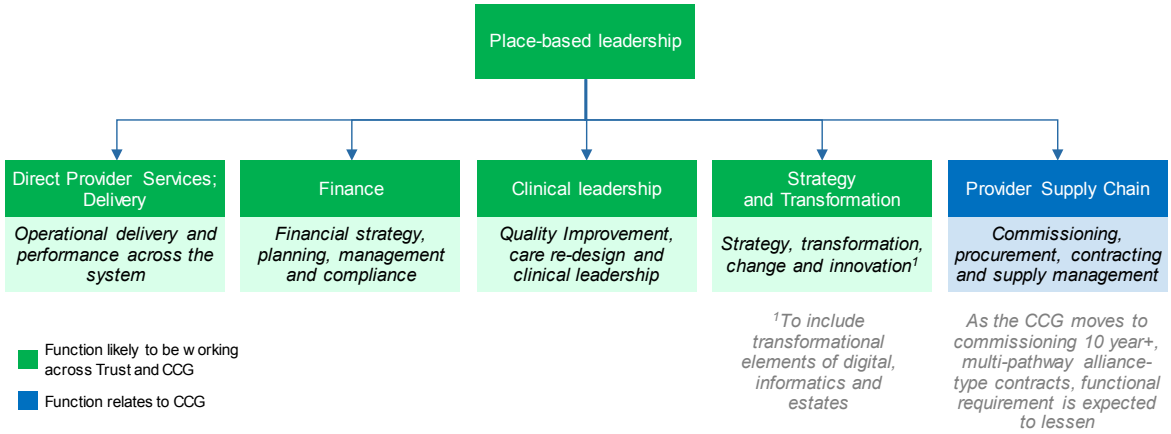
- **A number of shared forums across assurance and decision making, e.g. exec, finance and quality**
- **A set of functions and/or roles that are employed jointly and shared between CHS and the CCG**
- **Shared strategic priorities and single delivery plan across CHS and the CCG**
- **A single control total and financial plan**
- **A number of joint executive posts between the two organisations**
- **A joint place based leader**
- **A common "voice" and representation externally**

The key characteristics of stage B are:

As more details of the Long Term Plan emerge, and its potential impact on Croydon are understood, it is now expected that South West London will move towards a single CCG. Although some of the precise details of the above characteristics may change as a result (e.g. an SWL CCG will naturally need multiple delivery plans across its multiple Integrated Care Networks within the SWL region), we expect the principles will remain the same, as these are what deliver the benefits for the population of Croydon and to other local populations within SWL.

In order to deliver this model and begin to operate together across multiple functions, the Boards propose the following leadership structure and governance structure.

Figure 3: Functions within a future integrated leadership team



Proposed leadership structure:

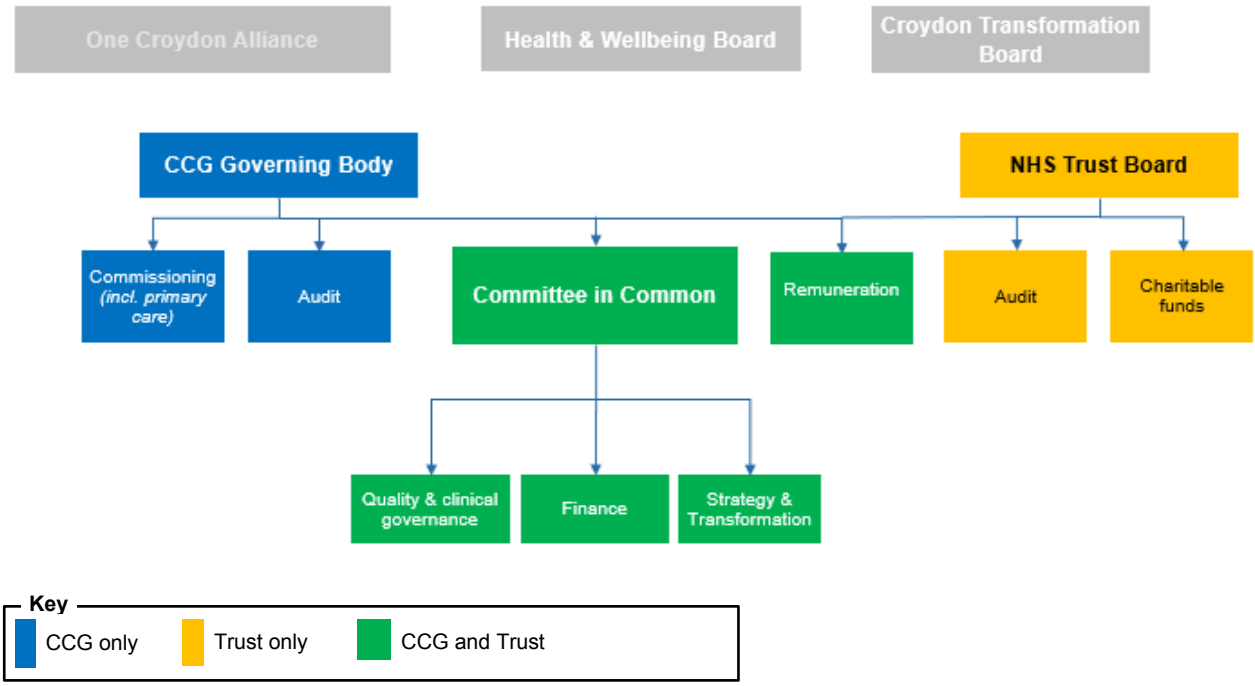
Key to this model is a single place-based leader and full alignment across provider services, finance, clinical leadership and strategy and transformation, with executives having responsibilities spanning both organisations.

However, responsibilities related to commissioning, procurement and contracting will remain a CCG only function to manage any potential conflicts of interest.

Proposed governance structure:

Figure 4: Future near-term Governance arrangements

In order to support the joint leadership team, the boards propose the following governance structure:



As this is not a formal merger, the CCG Governing Body and the Trust Board will continue to exist and be held accountable for their statutory duties. However, all key decisions relating to strategy, transformation and finance will be delegated to a board in common made up of executives, NEDs and lay members of both organisations.

As outlined above, the CCG entity may change from a Croydon CCG to a South West London CCG in the medium-term. Again, we would expect that the above direction of travel can still be pursued, although the details (e.g. committee membership) may evolve.

Similarly, we would expect that over time we will need to consider how to reflect the One Croydon Alliance Partners in the above governance arrangements as these relationships mature – the alignment and integration of CCCG and CHS is only the first step in providing a fully joined-up approach for the people of Croydon. This will include how to involve the Croydon Health and Wellbeing Board in the above governance model.

Managing conflicts of interest:

For the most part, the current duties of CHS and CCCG organisations are able to co-exist within the leadership and governance model outlined above without giving rise to conflict or contradiction.

Where there may be areas of real or perceived contradictions or conflicts, we have built the following features into our governance structures:

- **Presence of non-conflicted decision makers on all committees where there may be a conflict**
  - *Committees to contain non-conflicted members, such as CCG lay members or CHS NEDs*
- **System-wide consultation and engagement**
  - *All processes will be open and transparent, commissioning plans will be developed at a system-wide level, with all Croydon partners engaged*
- **Escalation protocols in place for decisions where there is a potential conflict to act as an independent arbiter of the decision**
  - *Independent arbiters to approve conflicted decisions, such as the South -West London (SWL) ICS Partnership Board or the SWL CCG Governing Body (assuming these bodies exist in the future, in line with the national direction of travel), The Health Commissioning Committee or One Croydon Alliance Board*
- **Delegation of decision making**
  - *For decisions that may normally fall to an individual (e.g. the CFO), where the individual in question is conflicted, these will be delegated to another individual (e.g. a deputy) who does not have a real or perceived conflict*

Should the merging of SWL CCGs occur as currently expected, it should be noted that the potential for conflict of interest would naturally lessen.

In order to make short-term progress against the challenges facing Croydon today, CHS and Croydon CCG propose moving to the new model at pace over the next 12 months. We plan to go-live with the new model in October 2019, building up to full implementation in April 2020. Between now and October, CHS and Croydon CCG are committed to progressing the alignment, focussing on the improving the quality of care provided to the Croydon population. We are committed to working with the regulator and other partners in Croydon and South-West London to ensure that this alignment benefits our patients, the wider population in Croydon and the staff we employ, and that we are flexible in this evolution to reflect our changing relationship with our partners.

2 Strategic context

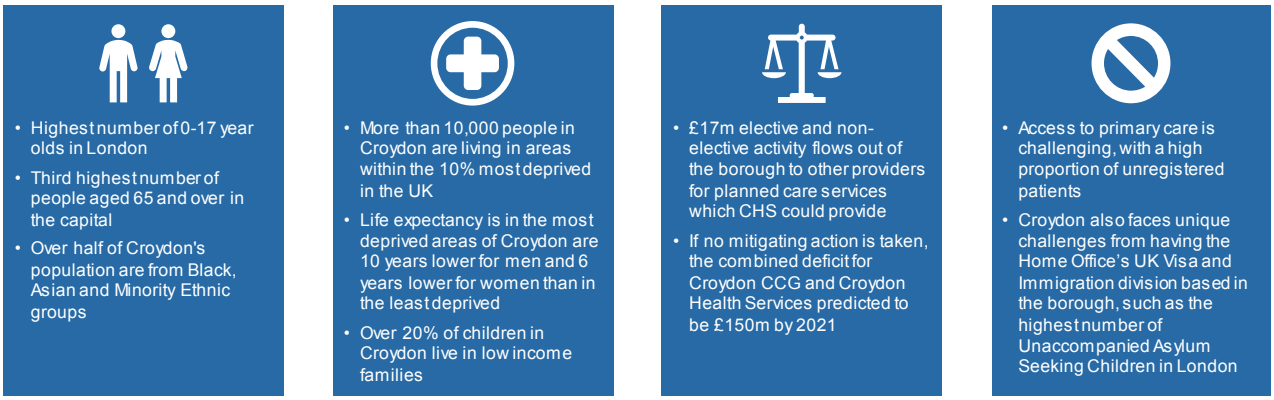
2.1 The Croydon health and care system

Croydon is an Outer London borough; with more than 380,000 residents living locally, it is larger than Nottingham, Newcastle and Belfast. It is also one of London's fastest growing and most diverse boroughs.

Croydon's health service provision is relatively self-contained, it is served by a single CCG – Croydon CCG (CCCG) – and one NHS Trust – Croydon Health Services NHS Trust (CHS) – who provides ~80% of all acute hospital services and community health services in the borough. It is also served by a single mental health trust, South London and Maudsley NHS Foundation Trust (SLAM), who provides both secondary and community mental health services.

However, the Croydon system is facing a number of challenges. There are significant health inequalities across the borough – for example life expectancy in the most deprived areas of the borough is ten years lower for men and six years lower for women when compared to the least deprived areas. Furthermore, Croydon has the largest number of young people in the capital and a rapidly growing number of older people.

Figure 5: Challenges facing the Croydon system



These dynamics put pressure on a system that is already under strain. The CCG until recently was in Financial Special Measures and although has set a balanced budget for 2018/19 it has an extensive QIPP programme to deliver. The Trust was also placed in Financial Special Measures in 2016, successfully exiting in 2017 but has a financial target to deliver £19m of savings in 2018/19, and £5m of additional net income.

At the same time, the Croydon system recognises it is facing quality challenges; 30% of patients treated in hospital are more suited to a community or home setting, while large numbers of patients are currently leaving the borough to receive elective care elsewhere. There are workforce shortages across multiple professional groups, making it harder for the system to meet its quality targets and driving up costs, as providers rely on agency and locum staff to cover gaps in provision.

It is recognised that organisational barriers and siloed working within care settings are compounding these challenges. The competing priorities of individual organisations risk delaying the development and implementation of a sustainable place-based plan to meet the growing health and care needs of the population.

To overcome these barriers, Croydon is already undertaking considerable collaborative working across the Croydon system, which has resulted in a number of improvements in care to date. For example, since Croydon CCG and CHS started the process towards greater alignment in July 2018, CHS has seen its 62-day cancer targets improve from 78% to 80% (Nov 2018), its RTT targets have continually remained above the 92% national targets (making it one of the top performing London boroughs) and the number of patients currently waiting on a waiting list has decreased by 12%. These improvements are driven by a joint focus across the two organisations to support the 'here and now' challenges facing Croydon. Furthermore, wider system collaboration as part of the One Croydon Alliance (see section 2.3) has seen unplanned admissions

amongst the over-65s fall by 15%, at a time when unplanned admissions across the total population has risen. The One Croydon Alliance has also supported an increase in the number of elderly patients returning to independent living after time in hospital.

However, given the context of health inequality in the area and the scale of the challenge, further alignment and greater collaboration is still required.

2.2 Why is change needed?

The 2012 Health and Social Care Act and the creation of the NHS internal market has resulted in a system where there are incentives that have unintended consequences, and individuals are encouraged to act in the interests of their own organisation rather than the whole system. As a result, collaboration is deprioritised, and neighbouring NHS organisations often have a combative relationship and a culture of distrust.

Further, the lack of a common goal or purpose often creates a dichotomy between what organisations would like to achieve, and what tools they have to get there. These organisational barriers make it difficult to affect holistic service improvement for the benefit of patients and the system.

In Croydon this challenge is highlighted in the problems currently facing urgent care, where poor access to primary care, and underfunding of out-of-hospital care has led to significant non-elective overspend in hospitals. Taking a system wide approach will see some of these challenges resolved.

Croydon has taken a number of steps to overcome these barriers – such as the creation of the One Croydon Alliance and the establishment of integrated care networks – and the relationship between CHS, Croydon CCG and Croydon Council is significantly stronger today than it has been in previous years. However, there is a need to go further and faster in order to address the health inequalities in Croydon and to ensure smooth financial recovery for the system.

In 2017, Croydon CCG and CHS commissioned an independent review to provide an in-depth understanding of the challenges faced in delivering health and care to people in the borough. The review concluded that the Trust and CCG must work closer together and should continue to pursue closer integration with the local authority and other partners. This will enable the organisations to collectively focus on addressing health inequalities, improve accessibility to high quality care, maintain low waiting times and move from financial crisis to recovery. The review warned that, without closer integration, the Croydon system would be unlikely to achieve significant service improvements and/or financial balance in the near future.

Furthermore, the NHS Long Term plan, published in January 2019, supports our aspirations of place-based care by committing to the creation of regional Integrated Care Systems (ICSs) by 2021. We view the collaboration underway in Croydon as a first step on this trajectory, and one that will importantly lead to considerable benefits both in terms of the quality of care and the overall financial stability of the Croydon system in its own right.

We do not believe a “Do Nothing” or a “Status Quo” scenario is an option for Croydon. The ways in which we can work within the current environment to influence positive change and deliver the desired benefits to patients, individual organisations, and the wider system, will not be able to meet the desired pace of change. Furthermore, the challenges facing Croydon around urgent care, workforce, and right-place/right time care require system-wide transformation to solve. By pushing forward now with our plans for integration and alignment now, we position Croydon in a stronger position to retain control of key areas of spending as and when further developments happen in the future.

2.3 Background to collaboration

2.3.1 Croydon-wide collaboration

Croydon has a growing track record of collaborative working, with various partnerships already in place between the CCG, NHS providers (acute, community and mental health), GPs, the local authority and voluntary sector. In 2017, the Trust and CCG signed a landmark agreement with South London and the Maudsley NHS Foundation Trust (SLAM), Croydon Council, the Croydon GP Collaborative and Age UK Croydon to create the 'One Croydon' Alliance. The vision for One Croydon is:

> *'to support people in Croydon to be independent and live longer, healthier and fulfilling lives and be able to access high quality care, in the right place and at the right time, thereby reducing health inequality in Croydon. The aim is to achieve this vision while realising financial sustainability in the system and maintaining improved outcomes'*

The One Croydon Alliance has focussed on working together to improve the quality of care provided to the over-65s, shifting from reactive care to proactive care, via the use of multi-disciplinary teams and coordination across care-settings. To date it has implemented several key initiatives, including:

- the establishment of six multi-agency, integrated care networks and huddles across Croydon;
- the implementation of a Living Independently for Everyone (LIFE) scheme;
- the establishment Croydon-wide transformation board to support the change delivered through the Alliance.

As a result of these initiatives, the Alliance has and is making major improvements in care for older people, reducing the number of unplanned admissions in hospitals and supporting the reablement of individuals to independent living after discharge. In its first year, the implementation of integrated care networks and GP hubs as part of the Alliance resulted in a 15% decrease in the number of unplanned admissions amongst the over 65s, compared to an increase in unplanned admissions in the under 65 age-group. At the same time 60% of people going through the Alliance's Living Independently for Longer programme (LIFE) did not require long-term care packages after discharge from hospital, this compared to 100% of people not going through the programme requiring long-term care.

However, it is now critical that we consider how we can learn from the One Croydon Alliance and achieve improved outcomes across our broader population. This includes working with our partners to consider how we best respond to the requirements of local people with both physical and mental health needs and looking to further develop the care delivered through Croydon's integrated care networks. In March 2018, the partners signed an agreement to extend the One Croydon Alliance for another nine years and to significantly increase its scope to cover a number of additional care pathways.

The 2018 Public Health Report for Croydon highlighted the first 1,000 days of a child's life as a key focus area for Croydon, in order to minimise the health inequalities that exist later in life. Of the thirty-four recommendations, which are laid out in the report, many require joined-up and collaborative working to be able to address them, including revising maternal mental health pathways, new smoking cessation pathways and Croydon-wide staff training.

While One Croydon has allowed us to make significant progress in key areas, especially around developing relationships between teams and organisations across Croydon, it does not address some of the structural and organisational barriers to collaboration, which will need to be overcome in order to create a fully system-wide and place-based approach to care.

2.3.2 CHS and CCG collaboration

Recognising that greater collaboration would be needed to move to a population-based system and to address some of the healthcare challenges laid out above, CHS and Croydon CCG have been jointly exploring options for greater alignment, achieved through increased collaboration and the removal of organisational barriers. The table below summarises the work undertaken to date.

Table 1: CHS and CCG Collaboration to date

1: June 2018 – Assessment of Alignment Options
The CCG and CHS jointly produced an Options Paper that analysed the benefits and risks associated with a variety of alignment options. The paper made the case that full system alignment, which brings together health and social care provision and commissioning, was the desired end-state for the Croydon system. However, it also recognised the complexity in reaching the end-state, and as such, proposed a multi-step process: 1. The first of these stages being 'progressive alignment', where the Trust and the CCG identified initiatives and areas of collaboration that can be pursued jointly, including looking to identify functions and teams that could be shared across the two organisations. This has been implemented and an assessment of the progress made is included in section 5. 2.The second stage is 'systemic alignment', which continues with many of the elements of 'progressive alignment' but also included shared decision-making forums and a number of joint executive level roles between the Trust and the CCG, including the potential for a shared place-based leader across both organisations. This is the next step in our journey and the purpose of this paper. 3. The third stage, and our end state ambition, is to move to a fully integrated approach through further alignment with other system partners in Croydon and South-West London.
2: August 2018 – Alignment Delivery Plan
Following the development of the Options Paper, the CCG and CHS jointly developed a Delivery Plan, outlining the proposed initiatives and actions required to pursue the chosen journey. Our assessment of progress of progress to date is outlined in section 5.

3 Direction of travel

3.1 National direction of travel

3.1.1 Integrated Care Systems

Despite the legislative framework moving increasingly towards a quasi-competitive market, the policy objective in recent years has been to increase integration, with Simon Stevens (NHS England's chief executive officer) stating that Integrated Care Systems (ICSs) will effectively end the purchaser provider split, bringing about integrated funding and delivery for a given geographical population.

The recently published NHS Long Term Plan reaffirms the direction of travel and commits to every region being an ICS by April 2021. It also indicates that current Sustainability and Transformation Partnerships (STPs) will be used as the geographical basis for future ICSs.

The most recent definition describes their function as *"… bringing together local organisations to redesign care and improve population health, creating shared leadership and action."* In an ICS, NHS organisations, in partnership with local councils and others, take collective responsibility for managing resources, delivering standards, and improving the health and wellbeing of the population they serve. For example, ICSs are expected to improve health and care by:

- Supporting the coordination of services, with a focus on those at risk of developing acute illness and being hospitalised;
- Providing more care in a community and home-based setting, including in partnership with council social care, and the voluntary and community sector;
- Ensuring a greater focus on population health and preventing ill health;
- Allowing systems to take collective responsibility for how they best use resources to improve health results and quality of care, including through agreed cross-system spending totals.

The NHS Long Term Plan states that every ICS will have:

- a partnership board, drawn from and representing commissioners, trusts, primary care networks, and – with the clear expectation that they will wish to participate – local authorities, the voluntary and community sector and other partners;
- a non-executive chair (locally appointed, but subject to approval by NHS England and NHS Improvement) and arrangements for involving non-executive members of boards/ governing bodies;
- sufficient clinical and management capacity drawn from across their constituent organisations to enable them to implement agreed system-wide changes;
- full engagement with primary care, including through a named accountable Clinical Director of each primary care network;
- a greater emphasis by the Care Quality Commission (CQC) on partnership working and system-wide quality in its regulatory activity, so that providers are held to account for what they are doing to improve quality across their local area;
- all providers within an ICS will be required to contribute to ICS goals and performance, backed up by a) potential new licence conditions (subject to consultation) supporting NHS providers to take responsibility, with system partners, for wider objectives in relation to use of NHS resources and population health; and b) longer-term NHS contracts with all providers, that include clear requirements to collaborate in support of system objectives; and
- clinical leadership aligned around ICSs to create clear accountability to the ICS. Cancer Alliances will be made coterminous with one or more ICS, as will Clinical Senates and other clinical advisory bodies. ICSs and Health and Wellbeing Boards will also work closely together.

In a mature SWL ICS, Croydon would be a place-based system of care. In this model, we anticipate and strongly advocate for a devolved model, where 80-90% of funding is delegated to a Place level. This is aligned with the expectations of the current STP and our system partners.

Although not the focus of this report, CHS and Croydon CCG are fully committed to the development of a South-West London ICS and to wider integration within Croydon (e.g. with Mental Health). We anticipate that these developments will progress in parallel with the proposals in this report.

3.1.2 Commissioning

As outlined above, the national direction of travel is away from competition and toward collaboration and integration, with commissioners and providers working together and making shared decisions. This will necessitate a different type of commissioning organisation.

In relation to commissioning, the NHS Long Term Plan outlines 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.*

- *We will continue to support local approaches to blending health and social care budgets where councils and CCGs agree this makes sense.*

The impact of the above will lead to a single ICS for South-West London with a single CCG, also for South-West London. Croydon will exist as a Place within this system.

Over time we anticipate that this will create a fundamental shift in the role of commissioners, and, with potential changes to legislation in the long-term, CCGs may no longer exist in the form that we know them.

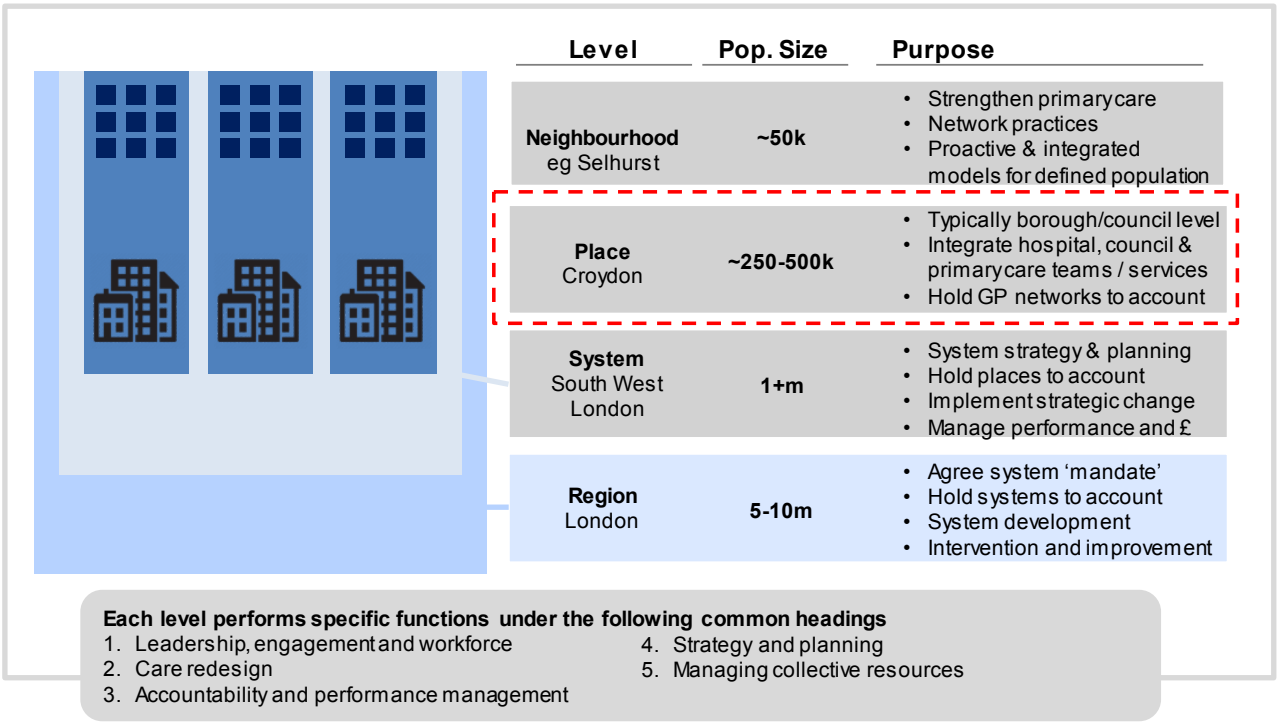
3.2 South-West London and Croydon direction of travel

3.2.1 Integrated Care in South West London

Aligned to the national direction of travel, our vision for Croydon is to be part of a mature Integrated Care System (ICS), working with partners across South West London (SWL). Within the SWL ICS, we envisage a number of ‘layers’; with each layer responsible for taking-on certain functions on behalf of its population.

Figure 6 outlines some example functions that we anticipate within each layer. However, we note that our current collaboration between CHS and Croydon CCG, as well as the wider One Croydon Alliance, will result in substantial benefit in its own right.

Figure 6: Layers of an Integrated Care System



The specific functions at each level need to be designed with engagement from all partners, and we anticipate that the distribution of functions will change overtime as the system, and the partners within it, mature.

– Place-based integration in Croydon

In the context of the national policy outlined above, the direction of travel within Croydon is to develop a **place-based model of integration** that delivers the 'triple integration' of primary and specialist care, physical and mental health services, and health with social care.

We anticipate that the following functions will be part of a Croydon system:

Delivering this functionality will require the Croydon system to have:

Figure 7: Features of the Croydon system

	Beginning	Maturing
Leadership, engagement & workforce	• Engage staff and local community • Implement actions to address workforce shortages, including within primary care	• Develop multidisciplinary workforce models to address skill shortages • Develop meaningful and continuous ways to involve staff and residents in decisions
Strategy and Planning	• All organisations engaged in system wide strategy and planning	• A single integrated plan for Croydon health and care
Care Redesign	• Designing more integrated care ('triple integration' – primary and specialist, physical and mental, health and social care) • Working together to address performance priorities (e.g. UEC, LoS, bed occupancy, DTOCs) • Implementing NHS Long Term Plan • Primary Care Network development	• Investment in targeted prevention programmes Identify population segments with high utilisation or unmet need (population health analyses) • Develop integrated services and teams (NHS and social care) to keep people out of hospital • Network hospitals and mental health services to improve resilience and standardise care
Primary Care Development	• Establishing primary care networks at a neighbourhood levels • Building relationships between GPs and secondary care	• Maturing the neighbourhood based approach, integrating care between primary and community care • Building primary care at scale
Accountability & performance management	• Improve delivery of constitutional standards	• Clinically-led quality improvement • Hold networks/neighbourhoods to account • Lead improvement of standards, without outside intervention
Managing collective resources	• Manage within aggregated provider and commissioner control totals • Deliver health investment standards (e.g. mental health)	• Capable of taking on a delegated budget • Collaborate across system and with other providers to improve efficiency • Understanding of patient-level costing

- Mature and stable system partners;
- Strong relationships between all partners;
- System-wide rather than organisation-centric decision making;
- System-wide leadership;
- Aligned (and where possible integrated) governance; and
- A shared understanding of our challenges and opportunities and a single plan for addressing them.

3.2.2 Development of primary care networks and integrated care networks

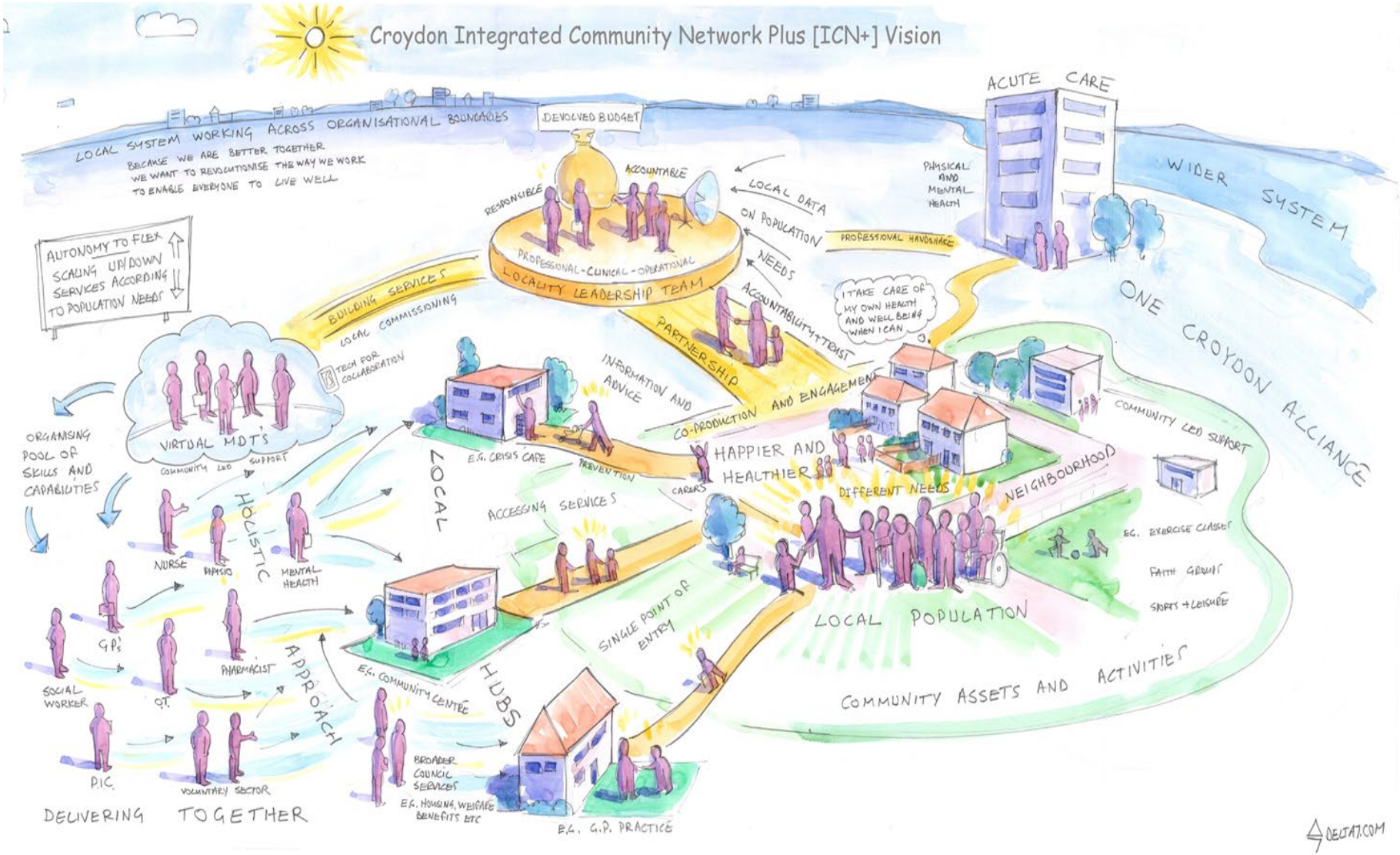
In our vision of the Croydon system, primary care will be key to developing a sustainable, place-based, healthcare system. Croydon has made considerable progress in developing primary care through the creation of Primary Care Networks (PCNs), which work across populations of between 30-50k to assess local population risk and ensure that local provision supports the needs of the local population. Croydon currently operates five primary care networks and although these networks are still maturing they have been integral to the progress made as part of the One Croydon Alliance.

The NHS Long Terms Plan commits to the development of PCNs. As part of a set of multi-year contract changes individual practices in a local area will enter into a network contract, as an extension of their current

contract, and have a designated single fund through which all network resources will flow. The direction of travel suggests that there may be 8-13 PCNs across Croydon in the future.

The below diagram demonstrates how the approach will be developed and as this approach develops, Croydon will look to increase integration across primary and community care into full integrated care networks, so both are delivered at a level to ensure services adequately reflect the needs of the local population.

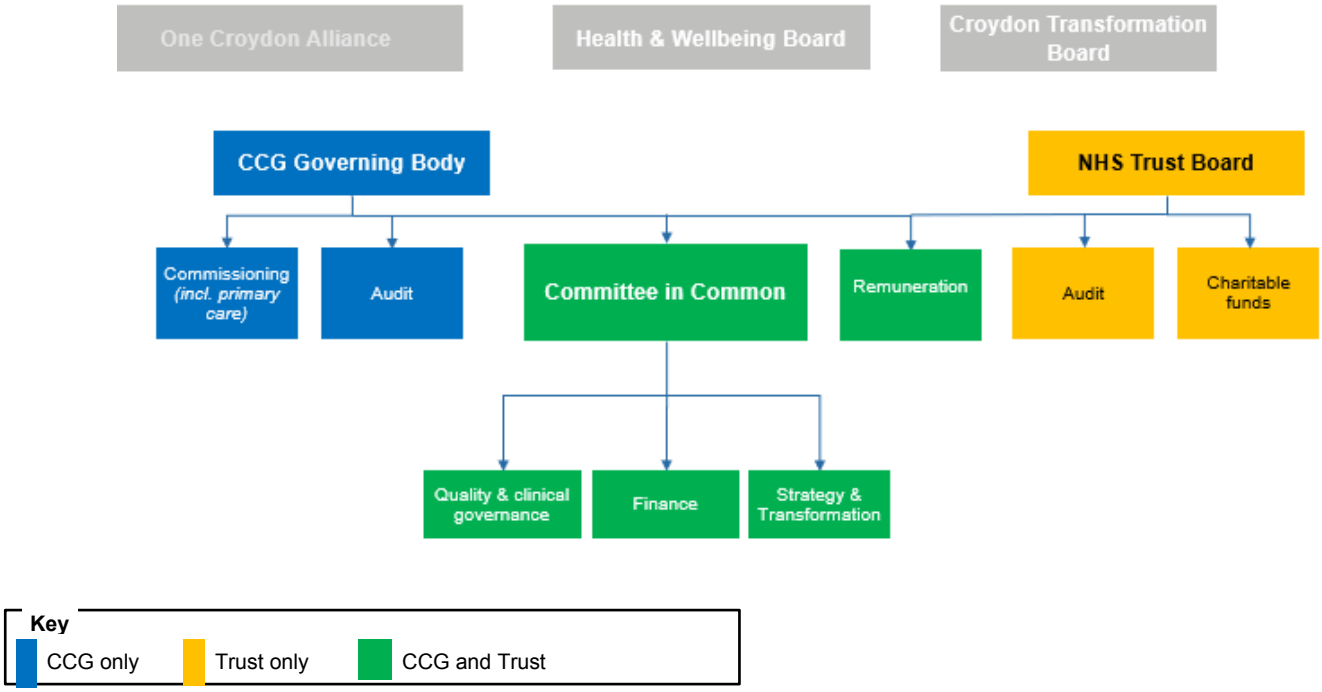
Figure 8a: Croydon Integrated Community Network Plus (ICN+) Vision



3.2.3 SWL support of the Croydon plan

South West London (SWL) are supportive of Croydon's plan to move to a place-based model of care in light of wider ambitions to create a SWL Integrated Care system. SWL view Croydon as a potential model for how place-based care will delivered as part of the ICS and will be looking to develop the ICS in conjunction with the work happening in Croydon.
The below diagram demonstrates how the varying regions and partners within SWL are expected to work together going forwards

Figure 9: SWL proposed ICS governance model



3.3 How we get there

Developing the model outlined above will be a continuous journey, with many achievements and small milestones along the way. We foresee four major stages as outlined in the figure below.

These major stages are:

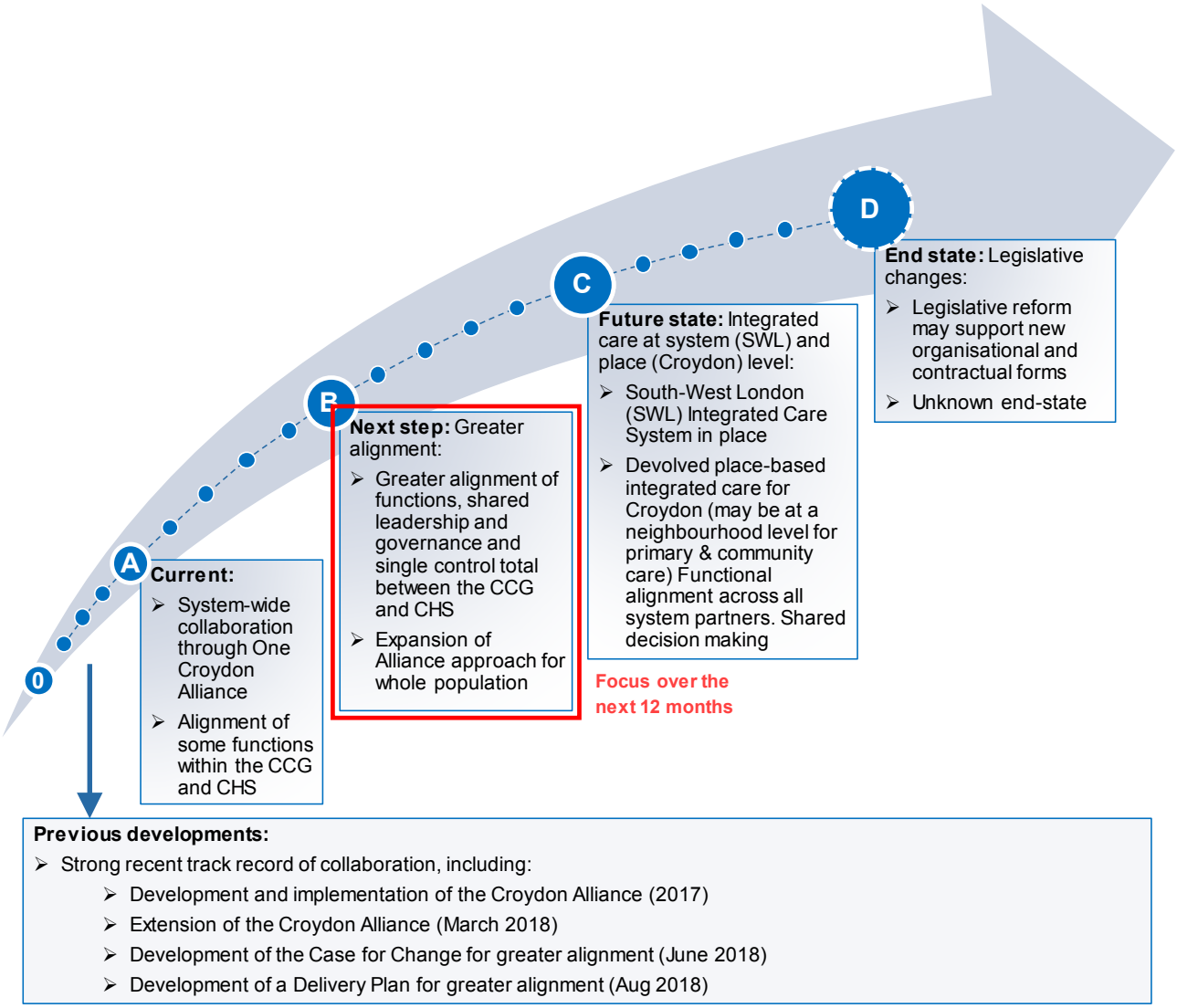
A. **Current:** This first describes where we are today, and the progress already made within the Croydon system – this is described in detail in section 5.

B. **Next step: Greater alignment:** The second describes our proposed next step and includes greater alignment between the CCG and CHS (through the bringing together of functions, leadership and governance) – described in detail in section 6 – and extensions to the One Croydon Alliance.

C. **Integrated care at system (SWL) and place (Croydon) level:** The third describes a foreseeable end-state – comprised of a SWL ICS and a place-based model of integration for Croydon that includes all system partners.

D. **Legislative changes:** The fourth corresponds an unknown end-state. We include this to acknowledge that further changes are likely – for example, in the form of legislative changes that may reduce some of the current barriers to integrated care through new organisational forms and/or contractual models.

Figure 10: Major stages in moving to place-based integration within Croydon



The focus of the remainder of this document is on our plans for moving from Stage A to B. We believe this step is critical for the Croydon system to solve some of the key challenges it is facing and will deliver considerable benefits in its own right, as well as sitting on the critical path for a wider integrated care system.

Considering the pace of policy change within and outside the NHS, we recognise that the next stage (Stage B) will evolve over the coming months and years to reflect these changes. These changes include both how the partners of One Croydon Alliance join this journey, and what impact the expected creation of one South West London CCG will have. Whilst these are critical developments, we believe beginning the journey now between Croydon CCG and CHS provides the best platform for further transformative change.

4 Case for change

4.1 The expected benefits of greater alignment

Greater alignment of the health and care organisations in Croydon will allow us to create a health and social care system that works better for patients and their families and which makes best use of scarce resources.

Solving the key issues facing Croydon and addressing core focus areas, including: improving health inequalities, supporting urgent an emergency care and ensuring the Croydon population has the best start in life (the key focus highlighted in the 2018 Public Health Report) requires a joined-up approach to health management.

Through minimising the structural barriers that exist between organisations we remove the competing priorities of individual organisations and move to a model where our aligned objective is improving the quality of health services across the whole of the Croydon system.

The ultimate goal of greater alignment is to improve the health of the Croydon population, provide better quality care for patients, improve ways of working and return the system to financial balance, by a more effective and efficient use of assets and resources. We will achieve this through transforming clinical services across both primary and secondary care, but also improving organisational alignment and system performance across other areas, including shared functions and shared governance.

By improving organisational alignment, the Trust and CCG will be better able to deliver large-scale service and clinical transformation projects across acute, community and primary care, which benefits the whole system rather than individual care settings

Alongside this, it will also:

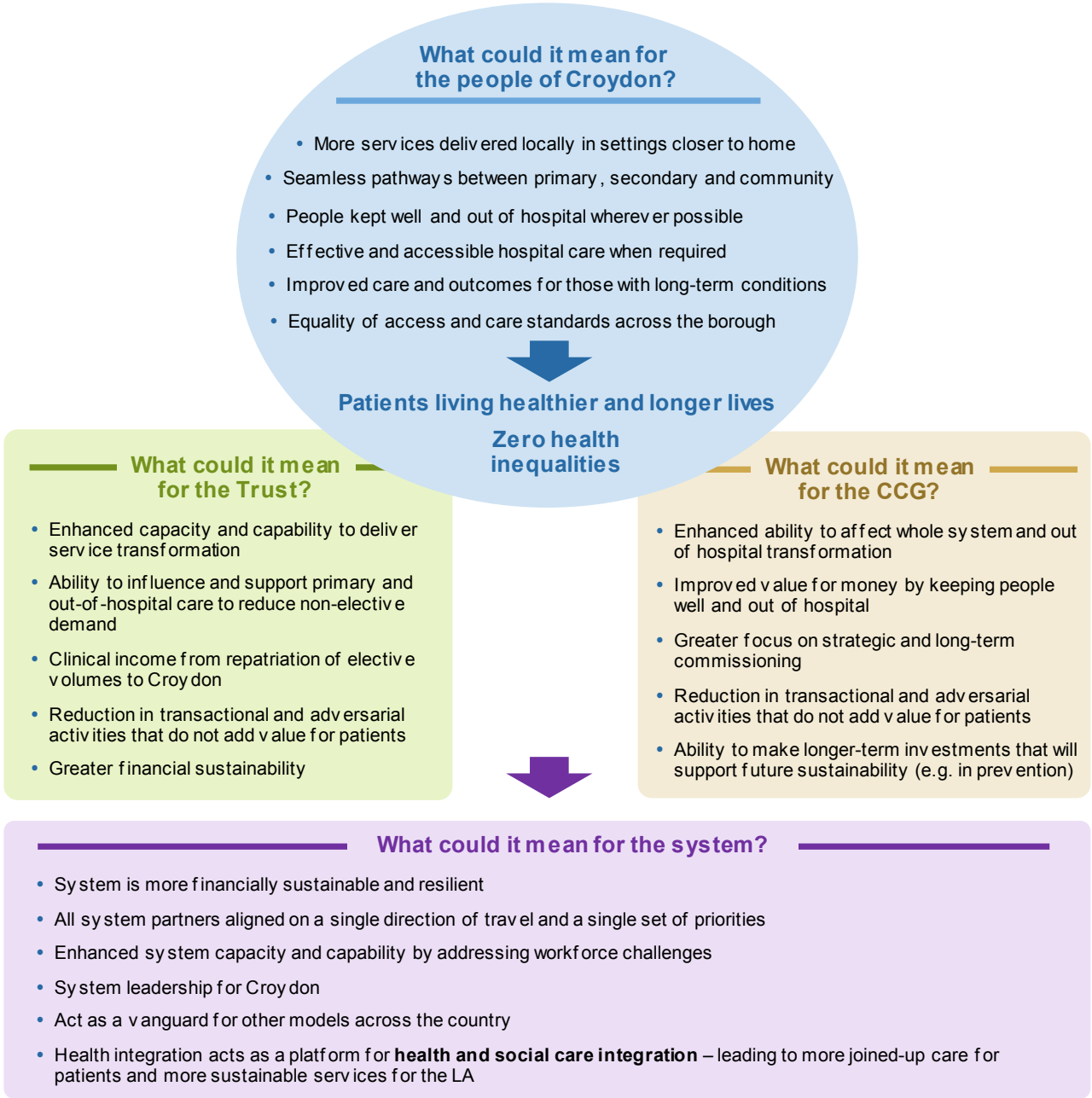
- Remove duplication of function to enable resources and assets to be used more effectively;
- Reduce misalignment, divergent priorities, and conflicts, which waste unnecessary time and resources;
- Allow the Trust and CCG to share approaches, capability and best practice with one another.

Figure 1111 outlines how greater alignment between Croydon CCG and CHS will contribute to improved patient outcomes and a more sustainable system, making care better for patients, staff, organisations, and for the system.

Figure 11: Benefits of greater Alignment in Croydon

			Impact	
Source of benefit	**From…**	**To…**	**Patient outcomes**	**Sustainability**
A single approach to transforming services in Croydon	• Transformation priorities or approaches that are not always aligned • Limited out-of-hospital transformation • Insufficient capacity and capability	• Greater focus on out-of hospital care • Pathways designed 'end-to-end' across care settings • Shared and enhanced capability and capacity • Resources focused on a single set of priorities	✓✓ • *Improves waiting times* • *Reduces av. number of appointments before diagnosis* • *Reduces length of stay*	✓✓ • *Cost benefits through reducing appts. per patient & decreasing length of stay*
Improved relationships between primary, community and secondary care	• Lack of agreement between GPs, community and secondary care clinicians on key pathways • Reputational and operational issues between CHS and GPs	• Single approach to pathway development across primary, community and secondary care • Better relationships and communication • Targeted repatriation of elective activity to Croydon	✓✓ • *Improves right time right place care* • *Improves information sharing, which results in better diagnosis & treatment*	✓✓ • *Sustainability benefits from more care delivered closer to home, in Croydon* • *Better communication leads to efficiency benefits*
A more joined-up approach to population health management	• Trust required to focus on immediate pressures of acute hospital, with limited capacity or capability to focus on population health management	• Opportunity for enhanced population health management approach for high risk people (e.g. elderly and multiple long-term conditions)	✓✓ • *Improves health through earlier preventative intervention, keeping the population healthier for longer*	✓✓ • *Lowers cost of care through preventing illness*
Aligned financial plans and incentives	• Misaligned financial incentives • Separate financial plans • Combative relationship	• Aligned financial incentives • Resources can be moved within system more easily • Single and jointly-owned financial plans including CIPs • Ability to make positive long-term investments	✓ • *Enables long term investment in health care* • *Investment decisions made to improve the health across the whole system and not siloed in care settings*	✓✓ • *Removes incentives to retain activity in costlier settings*
Reducing non-valuing adding transactional activities	• Significant amount of time and energy spent on transactional or adversarial activities that do not add value for patients	• Reducing non value-add activities will free-up capacity that can be refocused on service transformation	✓ • *Time and money saved can be redirected towards delivering care*	✓✓ • *Financial saving through removing resource associated with transactional activities*
Sharing resources and removing duplication	• Functions duplicated across Trust and CCG, for example in relation to oversight and assurance	• Functions shared across the system; reducing duplication and ensuring a single approach	✓ • *Time and money saved can be redirected towards delivering care*	✓✓ • *Financial saving through removing duplication*
Single system view	• Siloed datasets within each organisation • No single view of challenges and weaknesses	• Joined-up information systems • Single version of the truth	✓ • *Shared data makes it easier to understand the root cause of quality issues and rectify quicker*	✓ • *Shared data results in financial savings from the removal of duplication and transactional activities*

Figure 12: Anticipated outcomes for patients, organisations and the system



4.2 Importance of shared leadership

There is no technical reason as to why the benefits outlined in section 4.1 cannot be achieved by two aligned but separate organisations, with two separate leadership teams.

However, the practicalities of this arrangement, and learnings from other systems, suggests that this would be extremely difficult to achieve. The Trust and CCG believe that, without a shared leadership team, it will be challenging to achieve the transformative change required to improve the quality of care provided, whilst ensuring financial stability to the Croydon system.

This is supported by a wealth of learnings from other systems, where organisations (both commissioners and providers) have attempted to collaborate but where separate leadership has created material, and in some cases insurmountable, barriers to alignment. Table 2 outlines a series of observed barriers from across the system and how shared leadership could address some of these.

Table 2: Barriers in other health systems without single leadership

Barrier observed in other systems	How aligned leadership addresses the barrier
Misaligned incentives: Individual leaders feel compelled to focus on the benefit and cost to their own organisation, rather than to patients and the system	**Aligned incentives:** Shared leadership would ensure fully aligned incentives in key areas – e.g. in setting priorities for service transformation
Slow decision making: Decision making across organisational boundaries is slow and bureaucratic, with some initiatives that would improve patient outcomes never implemented	**Effective decision-making**: Shared leadership would simplify decision making. Resulting in faster more effective decisions on initiatives that will deliver benefits to patients and return the system to financial balance
Relationship dependent: Relies on strong personal relationships, which cannot be guaranteed and are susceptible to changes in people. Where organisations have strong relationships, there remains a lack of full trust and transparency	**Future proofed**: Does not rely on personal relationships as is future proofed against leadership changes
Focus and impetus: Leaders begin with strong intentions to collaborate, but the demands and pressures of the system, mean that this often falls quickly down the agenda	**Commitment**: Shared leadership would ensure that cross-organisation collaboration is at the very top of the agendas of both organisations
Multiple points of contact: Contradictory messages and interactions inhibit progress and support from stakeholders	**Single point of contact**: Single point of contact with regulators and stakeholders ensures unification of messaging and reduces unnecessary duplication
Duplication: Resources and activities are duplicated, with little or no extra value	**Effective use of resources**: Resources deployed to deliver the best value

NHS organisations up and down the country are recognising aligned leadership as an enabler for collaboration, and the number of shared Executive-level leadership posts (including joint CEOs and AOs) has grown exponentially over the last three years.

Many of these shared posts are provider-provider or commissioner-commissioner posts. However, the principles (although admittedly, not the complexity of execution) remain the same.

Although relatively less common, there are several examples of shared commissioner-provider leadership posts. One example is the Director of Finance and IM&T at Frimley Health NSH FT who is also the CFO at

the local CCG. This example, outlined in more detail below, provides a good case for how conflicts can be managed across the commissioner-provider boundary.

We believe that the NHS will see more of these shared roles emerging and a number of other organisations for which shared leadership would be a significant enabler for closer working.

Case study: shared CFO in Frimley

The Frimley Health and Care System is developing towards an 'Integrated Care System' (ICS) with:

- System-wide financial control total;
- Single, shared Operating and Financial plan;
- Collective approach to agreeing strategy, plans and priorities; and
- ICS ethos to "get best value and outcomes for the Frimley pound".

However, in the absence of a system entity, the Trust and CCGs (Bracknell & Ascot, Slough and Windsor Ascot & Maidenhead) felt that shared appointments of key roles would be an obvious and highly valuable opportunity. Recognising the significant benefits of operating in this way, the organisations appointed a single Chief Finance Officer.

The benefits of the shared CFO have been:

- Transparency of system-wide financial position;
- Driving common underpinning assumptions and a single system plan approach;
- System-approach to CIP/QIPP
- Avoiding cost-shunting; focusing on cost/demand and drivers of cost/demand
- Driving a collaborative approach to the delivery of improvement plans
- Encouraging cultural change to collegiate working more widely; and
- Modest cost saving through a single post.

The Trust and CCG manage potential conflicts of interest through several different mechanisms, including:

- Commissioning functions relating to the provider Trust are excluded from the CFO's role
- The CCGs have a Deputy Director of Finance who reports to the CFO, except in a conflict of interest situation, when they report directly to the AO
- It is intended that ICS arrangements will include provision for other partners to object to CFO decision and guidelines for which decisions require sign off by ICS Board

4.3 How we will measure success

In line with the Croydon vision: **Working together for a Healthier Croydon,** greater alignment is expected to improve the health of the Croydon population, provide better quality care for patients, improve ways of working and return the system to financial balance, by a more effective and efficient use of assets and resources.

As such, programme success will be measured according to these aims and expected benefits. In Table 3, we outline how success will be measured.

Table 3: Measures of programme success

Aim:	Measure of success
Improving care provided to patients	• CHS continue to meet and show improvement against quality targets, surpassing or meeting NHS standards across all areas
Improving the overall health of the Croydon population	• Reduce variation in life expectancy and incidence of disease • Reduce the number of unplanned secondary care admissions • The population living healthier and more independently for longer
Improving ways of working	• Improvements in staff satisfaction • Reduce staff vacancy rate • Increase staff tenure
Improving financial stability	• Both organisations to achieve and maintain financial balance • Croydon CCG to achieve its 20% saving target
Readiness for integrated care	• Create joint roles and functions between the CHS and Croydon CCG • Set-up shared decision-making forums

5 Achievements to date

5.1 Overview

The overall alignment vision is **Working together for a Healthier Croydon**. Through a collaborative approach and greater alignment, CHS and Croydon CCG believe they can improve the health and wellbeing of the Croydon population and return the system to financial balance. This is, and will continue to be, the key measure of success across the programme.

Since the creation of the Delivery Plan in August 2018, Croydon CCG and CHS have been progressing their plans for greater alignment. Below we outline a number of high-level achievements; however, in appendix 6.1 we outline these in more detail:

Figure 13: CHS and Croydon CCG achievements to date

Joint working on the "here and now" challenges facing the Trust and CCG

- *Activity to date includes: Mapping elective flows and jointly communicating with GPs to strengthen pathways and working to improve emergency and urgent care, both as part of the One Croydon Alliance (attendance/ admittance avoidance) and more recently supporting CHS's newly opened emergency department (improving patient flows through ED)*

The creation of shared functions and roles between the Trust and the CCG

- *Two joint roles have been appointed across the Trust and CCG. A joint Chief Pharmacist post and an Associate Director of Safeguarding now work across both organisations. Work is currently progressing to create a joint safeguarding function and medicines management team to support the newly created joint roles*

A shared quality committee

- *A joint quality committee between CHS and Croydon CCG has been stood-up to improve challenge and transparency around quality*

A plan in place to move to a joint financial control total by 2019/20

- *The finance committees of the CHS and Croydon CCG have an agreement in principle for a 2019/20 Joint Control Total*
- *The shared control total has now been agreed for 19/20*

Agreement of year-end financial deal for 18/19

- *The year-end finance deal has been agreed (early). This is in direct comparison to previous years, where STP mediation has been required*

The creation of shared forums to encourage joint working

- *Joint working groups have been set up across both clinical and back-office areas. The purpose of these groups is to build relationships between organisations and identify and track initiatives*

Establishment of a robust Programme Governance structure

- *A Programme Delivery Board has been set-up to monitor and maintain the pace of delivery. The group meets every two weeks and contains executives and NEDs from both organisations as well as NHSI and NHSE representation. Alongside this a joint programme director has*

been employed by the Trust and CCG

Establishment of organisation development (OD) and stakeholder engagement workstreams to support and manage the organisational change associated with the alignment

- *As part of programme governance, an OD and stakeholder engagement workstream have been set-up. The Kingsfund has been engaged to support OD, while a stakeholder engagement programme is in place with all employees of both organisations informed of plans*

The design of a proposed leadership and governance structure to support the next stage of the alignment

- *A proposed leadership and governance structure have been designed, this has been circulated to the Board and the Governing Body of both organisations for approval with workshops held to test the strength of the governance structure (see section 6)*

5.2 Assessment of progress

In this section we look to assess progress to date against our stated vision for the alignment.

Working together for a healthier Croydon

To achieve this vision, the Trust and CCG must be comfortable that the alignment is able to improve the **quality** of care it provides, whilst delivering value for money and ensuring **financial stability**.

Figure 14: CHS and Croydon CCG quality benefits

We believe alignment to-date has had a positive impact on the QUALITY of care provided, through:

- **Greater transparency and single view of quality**
  - The establishment of a shared quality committee and a single control total for quality has resulted in a more united and transparent approach to quality, with the Trust and CCG working together to identify root causes and address quality issues
    - For example, the CCG is currently actively supporting CHS, to resolve recent challenges surrounding the opening of the new emergency department. This is different from a monitoring and 'narrating' relationship that existed historically between the CCG and the Trust
    - Furthermore, since Croydon CCG and CHS started the process towards greater alignment in July 2018 it has seen its 62-day cancer targets increase from 78% to 80% (Nov 2018), and its RTT targets have continually remained above the 92% national targets
- **Sharing resources across care settings**
  - A single safeguarding lead has ensured that the CCG's and the Trust's approach to safeguarding is consistent and continuous across primary and secondary care settings, resulting in better care for some of Croydon's most vulnerable residents
  - A joint pharmacy lead has provided the Croydon population with more seamless access to medicines and improved medicines management across Croydon

A joined-up approach to population health management

  - The One Croydon Alliance, which brings together eight different organisations across the Croydon system, has been improving the health and wellbeing of Croydon's over 65s
    - Successes include the creation of an integrated LIFE (Living Independently for Everyone) team, which has led to a reduction in the number of residents requiring long term care after discharge from hospital and a reduction in unplanned hospital admissions amongst the over 65s. 60% of people going through the life programme have been able to return to independent living, compared to no-one in the group the that did not go through the programme
    - The Alliance also saw a 15% decrease in the number of unplanned admissions amongst the Over 65s, compared to an overall increase in unplanned admissions amongst the whole population
- **Improved relationships between primary and secondary care**
  - The Trust and the CCG have been working together to ensure that patients are receiving care in the most appropriate setting, closer to home and to reduce waiting times
    - This has been achieved through jointly assessing patient flows between primary and secondary care, identifying challenge areas and then jointly communicating with GPs to ensure that they have access to the most accurate and up-to-date information to allow them to make the most appropriate referrals

Figure 15: CHS and Croydon CCG financial benefits

We believe the alignment has had, and will continue to have, a positive impact on the FINANCIAL stability of CHS and CCCG, through:

- **Reduction in duplication**
  - The appointment of joint roles across pharmacy and safeguarding has realised cashable savings
- **More efficient use of resources across the Croydon system**
  - A single Chief Pharmacist across primary and secondary care has released savings through improved medicines management
  - CHS's and Croydon CCG's joint focus on strengthening local patient pathways within Croydon, not only improves the quality of care provided, but also ensures that more Croydon spend remains in Croydon, with more patients treated closer to home
  - The cost of delivering has been lowered across the system through One Croydon work in reducing unplanned admissions and supporting reablement into independent living after discharge
- **Improved relationships**
  - Greater joint working between the financial function of the Trust and the CCG has resulted in the early agreement of 18/19 year end
    - This is a significant improvement from the previous year, where local mediation from the STP was required to agree a deal
- **Aligned financial plan and incentives**
  - Critical to ensuring future savings has been the work undertaken to move to a 2019/20 joint control total. Aligning the financial objectives of both organisations removes incentives to act in the interest of individual organisations and encourages activity which benefits the entire system
- **The CCG is forecasting a balanced position for the first time in its history**

More detail on the benefits achieved is outlined in Appendix 7.1.

5.3 Barriers

Significant progress has been made towards greater alignment, yet there are areas that have progressed more slowly than anticipated. In this section we assess the barriers faced and outline proposed mitigations going forward.

Table 4: Barriers to progress

Barrier to progress	Description	Mitigation going forward	Overall risk of programme
Capacity	• Both organisations have historically struggled to release sufficient capacity	• Capacity may continue to be a challenge but will lessen as the organisations look to share functions • A joint programme director has been appointed to	**Med:** *Joint programme director in place to manage this risk*

		support the alignment • Forums such as the regular board to board and OD workstreams are helping to identify where there is lack of capacity and provide additional support	
Short-term focus	• Current financial and operational pressures within the system have led to greater focus (by both organisations) on initiatives that will deliver short-term improvements • This has reduced our ability to focus on those actions that will deliver in the longer-term	• As Croydon CCG's and CHS's short-term pressures are stabilised (partly driven through joint working), both organisations will have greater capacity to focus on longer-term initiatives • Regular board to board meeting between the Trust and CCG provide early visibility on short term challenges, with both organisations working together to resolve them	**Med:** *Going forwards both organisations are expected to have greater capacity to focus on longer term initiatives. However, short-term stability will continue to be a priority*
Joined-up decision making	• There have been missed opportunities to progress with initiatives as decision making is still taking place in respective organisations	• Our proposals include plans to bring leadership and governance together (see section 6)	**Low:** *All key decisions expected to be made jointly going forwards*
Existing contractual arrangements	• Existing contracts (e.g. with the CSU) have made combining functions more difficult than originally anticipated	• Opportunistically assess alignment as and when contracts come up for renewal	**Low:** *Although this may slow progress in some places, none of these initiatives currently sit on the critical path for further alignment*
Separate delivery functions	• Lack of alignment at the functional level has made some of the proposed initiatives harder to deliver, especially where this has been coupled with a lack of capacity at either the Trust or the CCG	• Plan to align delivery functions through joint transformation teams and PMO functions	**Low:** *Joint programme director in place to manage this risk; however, challenges are expected to decrease as alignment increases*

We do not anticipate any of these barriers being a significant risk, nor do we believe it represents a significant reason to delay the programme. Furthermore, a number of these barriers are expected to lessen as overall alignment increases and as plans are put in place to manage them going forwards.

5.4 Next steps

The Trust and CCG are pleased with the progress to date and plan to continue to identity and undertake joint initiatives and align functions. Where the opportunity presents itself the Trust and CCG will also look to pursue wider alignment with other system partners across Croydon and across South-West London (SWL).

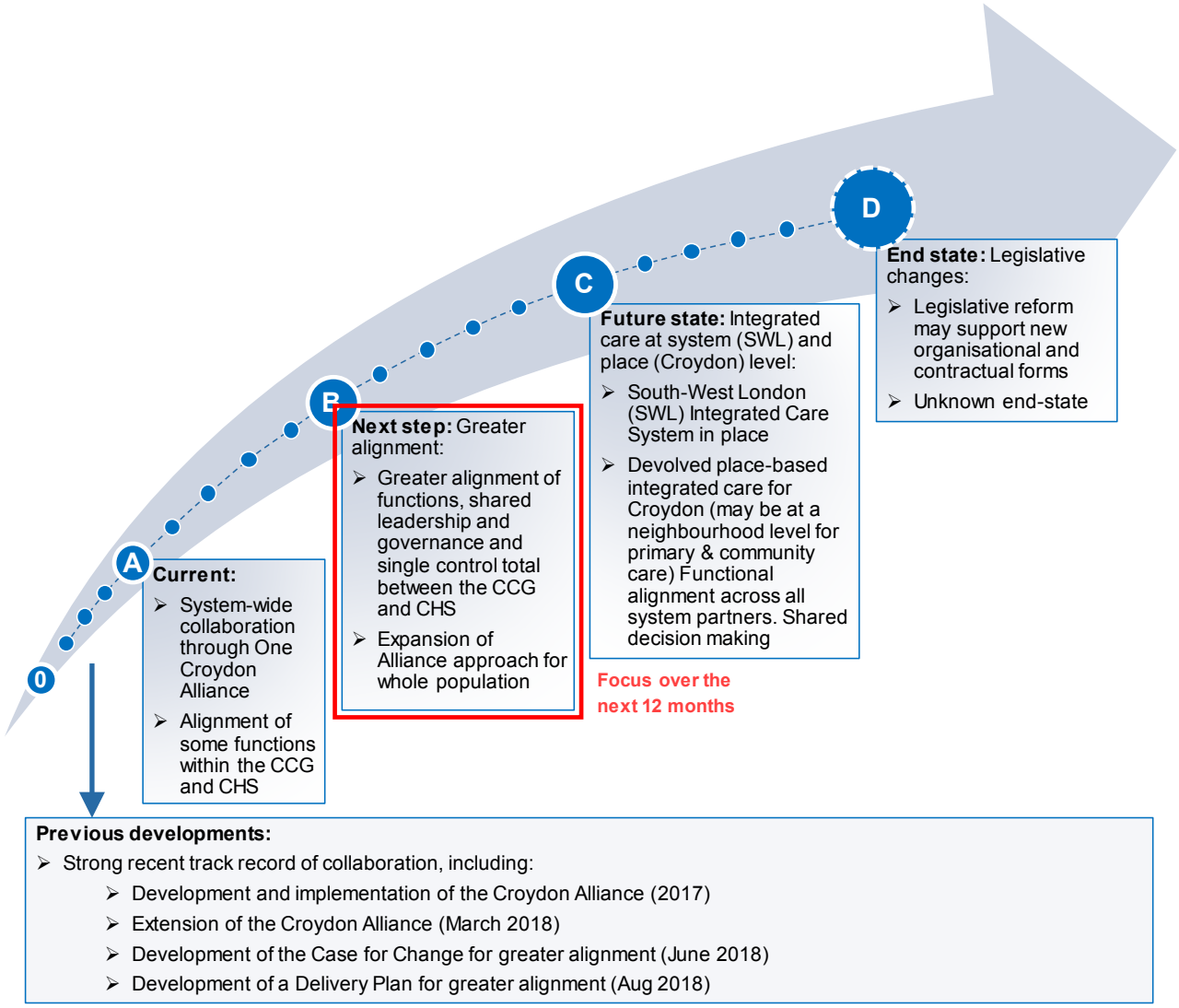
However, we believe that in order to fully achieve our stated aim of providing safe, effective, high quality and value for money care to the Croydon population, even greater alignment is needed, not only through working together more, but through removing some of the organisational barriers that exist. This is to be achieved through pursuing the next step in our alignment journey, focussed on shared leadership and governance, as described in section 6.

6 Detailed design

6.1 Overview of proposed model

Section 3 outlines our direction of travel and the major stages along that journey. Our proposed next step is to move from Stage A to B as shown in the figure below.

Figure 16: Major stages in moving to place-based integration



We believe that greater alignment will allow Croydon CCG and CHS to work together to improve the health and wellbeing of the Croydon population, while making substantial steps toward a more integrated system in totality, that encompasses mental health and social care. We hope that Croydon will act as a system leader, highlighting one possible route towards a more integrated system, incorporating place-based and neighbourhood level care as part of a wider integrated system.

The key characteristics of Stage B are:

Figure 17: Characteristics of proposed Stage B model

- **A number of shared forums across assurance and decision making, e.g. exec, finance and quality**
- **A set of functions and/or roles that are employed jointly and shared between CHS and the CCG**
- **Shared strategic priorities and single delivery plan across CHS and the CCG**
- **A single control total and financial plan**
- **A number of joint executive posts between the two organisations**
- **A joint place based leader**
- **A common "voice" and representation externally**

Some of these aspects are already in place or in progress – for example, within the category of shared functions we have a joint Chief Pharmacist employed across both organisations – these are outlined in section 5 and in detail in the Appendix.

As more details of the Long Term Plan emerge, and its potential impact on Croydon are understood, it is now expected that South West London will move towards a single CCG. Although some of the precise details of the above characteristics may change as a result (e.g. an SWL CCG will naturally need multiple delivery plans across its multiple Integrated Care Networks within the SWL region), we expect the principles will remain the same, as these are what deliver the benefits for the population of Croydon and to other local populations within SWL.

We recognise that closer alignment, comes with risks. Both in terms of organisational risk associated with the alignment and integration of CHS and Croydon CCG but also the commitment to financial risk we are taking through moving towards a joint control total. To manage these risks a clear leadership and governance model needs to be laid out, with proposed milestones and a clear timescale towards implementation, alongside a robust programme governance structure (see appendix 7.2).

The rest of this section outlines our plans for how greater alignment will work in practice and the proposed timescales for implementation, although we recognise that an evolving policy landscape requires us to be flexible in the future. We approach this by answering the following questions:

- **Leadership model:** What functions are required in the joint executive team to deliver the proposed benefits and ensure that both organisations have the required capacity and capability to deliver their responsibilities?
- **Governance model:** What near-term governance arrangements are required to deliver the proposed benefits and to support greater organisational alignment?

Section 6.2

- **Statutory duties and conflicts of interest:** How we will manage potential conflicts of interest and ensure the CCG and CHS continue to fulfil their statutory duties?

6.2 Leadership and governance

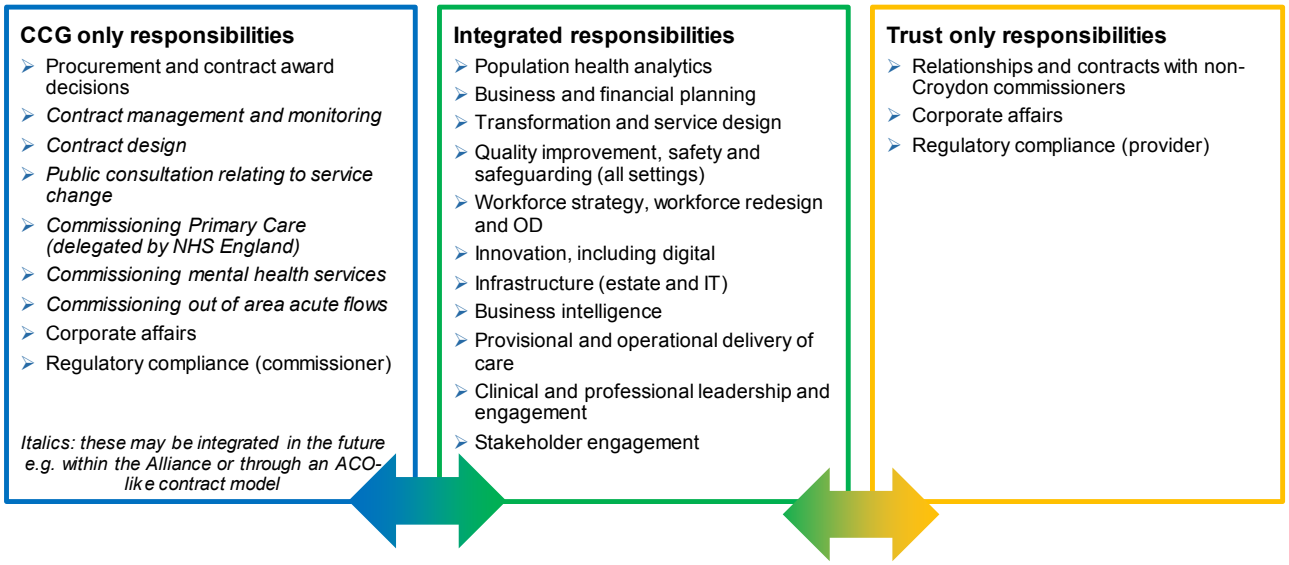
6.2.1 Leadership model

Achieving the benefits outlined above will require a significant and joined-up effort across the CCG and CHS. Having a single leadership team is an enabler in allowing us to achieve this quickly and effectively for the benefit of those living in Croydon, and create a platform for further alignment with other Croydon partners.

Before we outline the form of the leadership team we must first describe its function. For some functions the benefit of a single or aligned approach is significant and will deliver material improvements to patient care, while others act as enablers, deliver secondary benefits or reduce duplicated effort between the two organisations.

To ensure the appropriate management of conflicts of interest, some functions must remain distinct – these are discussed in more detail in section 6.4 on statutory duties and conflicts of interest.

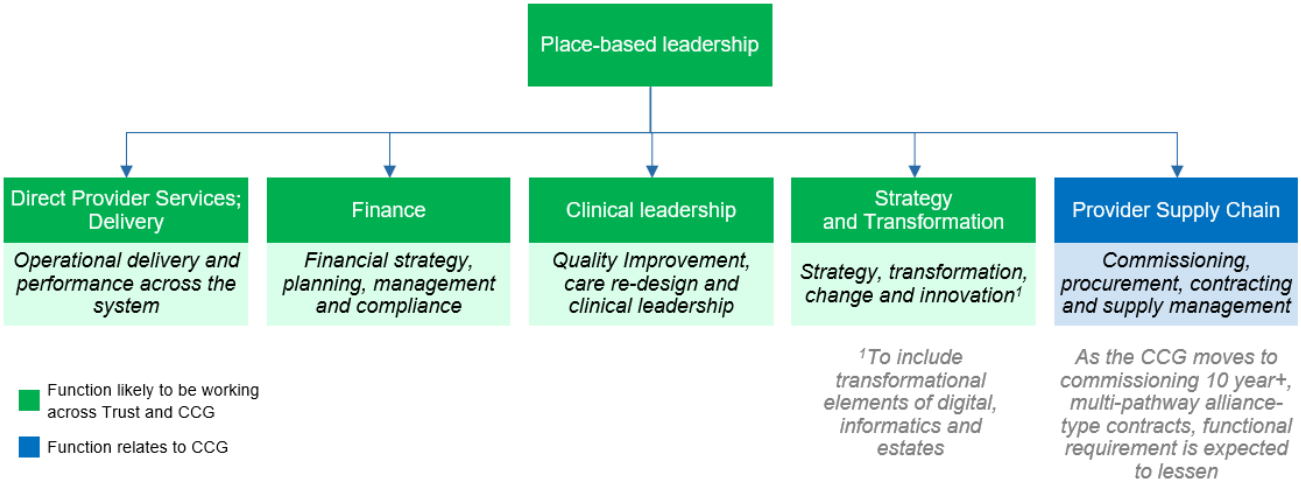
Figure 18: Proposed functions for integration across CCG and CHS



Some of the functions listed in Figure 18 are expected to be consolidated on a broader footprint than CHS and the CCG. For example, defining the population health need should be done across all partners within Croydon, and business intelligence may be better provided at scale across the whole of South-West London, especially if the CCGs were to be merged. We will therefore consider opportunities, as and when they arise, to further consolidate functions, although we expect that 80-90% of activities, resources and funding will remain undertaken at a Croydon level. This is aligned to the expectations of SWL STP.

Given the above, we anticipate transitioning to a single executive team. Figure 19 outlines our current view of what functions may be included in the single team. The next level of detail (including roles and responsibilities), and the transition plan, is still under development and is likely to evolve over time, potentially to include other One Croydon Alliance partners

Figure 19: Functions within a future integrated leadership team



The table below outlines the core functions in more detail.

Table 5: Functions within the near-term future leadership team

Role	Description	Rationale
Place-based leadership	• *A single place-based leader across CHS and Croydon CCG*	• *Fully-aligned priorities* • *Aligned and agile decision making* • *Removes organisation-centric behaviours*
Direct Provider Services; Delivery	• *Integrated service delivery across all care settings*	• *Supports delivery of transformation priorities* • *Promotes joined-up care and care delivered in the 'right' setting*
Finance	• *Management to a single financial plan across both organisations*	• *Enabler to delivering a single financial plan and a single control total* • *Ensures aligned incentives and removes organisation-centric behaviours*
Clinical leadership	• *Single approach to clinical engagement and clinical leadership* • *Single approach to quality improvement; safety, effectiveness and patient experience*	• *Supports quality improvement and care redesign across care settings* • *Supports a different (system-wide) approach to clinical engagement and leadership* • *Removes duplication in quality assurance*
Strategy and Transformation	• *Delivery of a single transformation plan* • *Covers strategy, care redesign, workforce redesign, organisation and behavioural change, and innovation and digital*	• *Ensures a single set of priorities* • *Supports transformation across different care settings* • *Removes duplication* • *Supports delivery of NHS Long Term Plan*
Provider Supply Chain	• *Function to remain CCG focussed* • *Responsibility for commissioning activities outside of CHS (e.g. primary care and mental health)* • *Oversees procurement decisions*	• *To remain a CCG focussed activity to manage potential conflicts of interest* • *Over time this requirement is expected to lessen as the CCG moves to commissioning 10 year+, multi-pathway alliance-type contracts*

Beneath the functions outlined above, we anticipate several other areas and roles that might be shared across the CCG and CHS. These include existing posts such as pharmacy and safeguarding and corporate functions such as HR, analytics and estates.

6.2.2 Governance

As this is not a formal merger, the CCG Governing Body and the Trust Board will continue to exist and be held accountable for their statutory duties.

However, the case above highlights the need for aligned and agile decision making. The best way to achieve this within the current statutory framework is to create a single forum for collective decision making between CCCG and CHS, while maintaining the principles of good governance and appropriate levels of oversight.

Under current rules, the CCG and CHS may not appoint a statutory joint committee, however, they may instead appoint 'committees in common'. This involves the CCG and CHS each creating a committee with delegated authority from the CCG Governing Body and Trust Board respectively. The two committees would operate as a virtual joint committee, meeting at the same time and venue and sharing agendas and papers.

The committees are expected to have overlapping membership (for example through the joint appointment of executives, as outlined above), reducing the likelihood of inconsistent decisions or deadlock. Shared roles would be limited to executive (salaried) posts and would include a shared place-based leader; non-executive (elected and lay members of the CCG Governing Body and Non-Executive Directors of the Trust) must remain distinct under the current 'disqualification for appointment' rules.

Supporting the Committees in Common, would be a range of other shared-forums, including:

- Sub-committees reporting to the Committees in Common, focusing on Strategy and Transformation, Finance and Quality and Governance;
- A separate 'committees in common' for remuneration; and
- A joint Executive Team Meeting.

Some committees would remain distinct for the purposes of managing conflict of interests – for example, a Health Commissioning Committee, Audit Committees and the Trust's Charitable Funds Committee.

This structure is summarised in Proposed governance structure

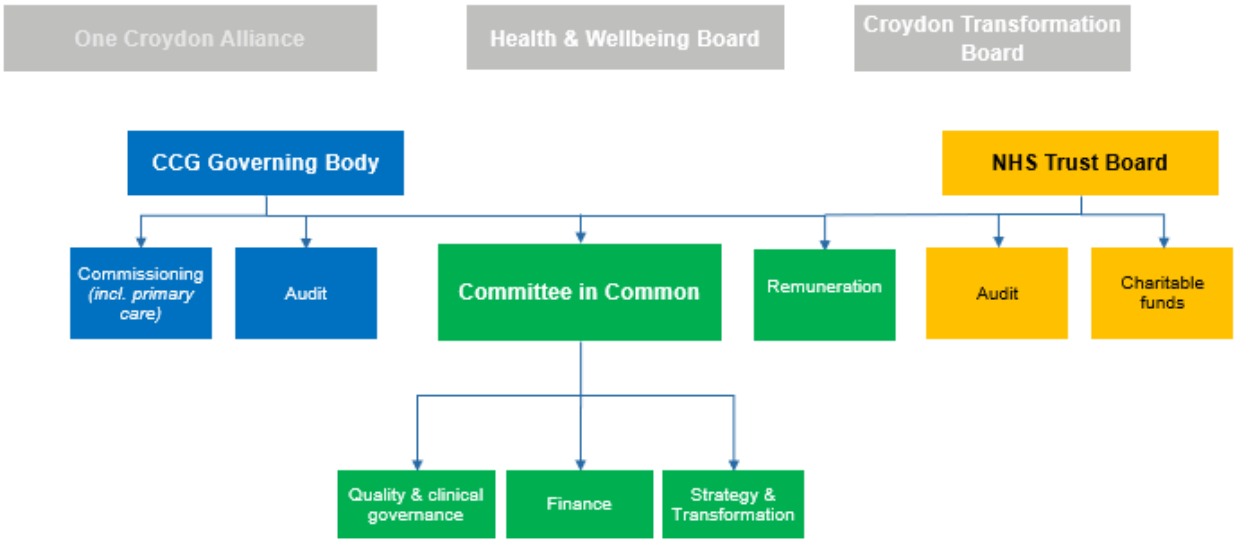


Figure 20. As outlined above, the CCG entity may change from a Croydon CCG to a South West London CCG in the medium-term. Again, we would expect that the above direction of travel can still be pursued, although the details (e.g. committee membership) may evolve from that as presented in Figure 18.

6.2.3 Committees in Common

Our proposal is to create committees in common that will operate as a virtual joint Board. The primary purpose of the Committees in Common will be to *"improve the health and wellbeing of Croydon by ensuring an aligned and integrated approach across Croydon CCG and Croydon Health Services NHS Trust."*

To deliver this objective, the Committees in Common will receive delegated responsibility for the following:

- On behalf of the Governing Body and the CHS Board, the Committees in Common will be responsible for:
  - Defining a shared strategy across CHS and the CCG
  - Development and approval of a shared transformation plan, with a single set of agreed priorities
  - Development and approval of a single financial plan
  - Development and approval of business cases, within agreed delegated financial limits
  - Receiving reports from the quality, strategy and transformation and finance committee and taking actions where required
  - Agreeing a strategy for staff, partner and stakeholder communications and engagement, particularly with regards to developing relationships between primary and secondary care
  - Development of the Croydon place-based integrated care model

- For the avoidance of doubt, the Committees in Common would not have delegated authority for:
  - Approval of the annual commissioning plan – the plan would be developed with system-wide engagement; final sign-off would remain the responsibility of the CCG Governing Body
  - Approval of CCG contracts; and
  - Procurement and contract award decisions.

The appendix includes a more detailed scheme of delegation, including those powers that are reserved for the CCG Governing Body and the CHS Board and the responsibilities of the sub-committees shown in Proposed governance structure

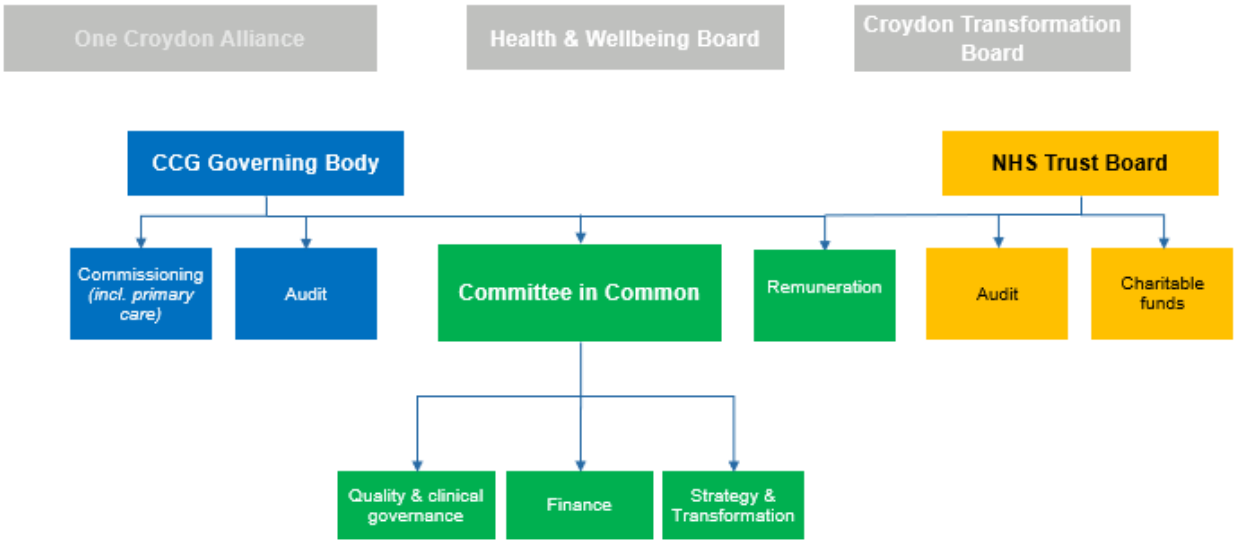


Figure 20.

Proposed governance structure

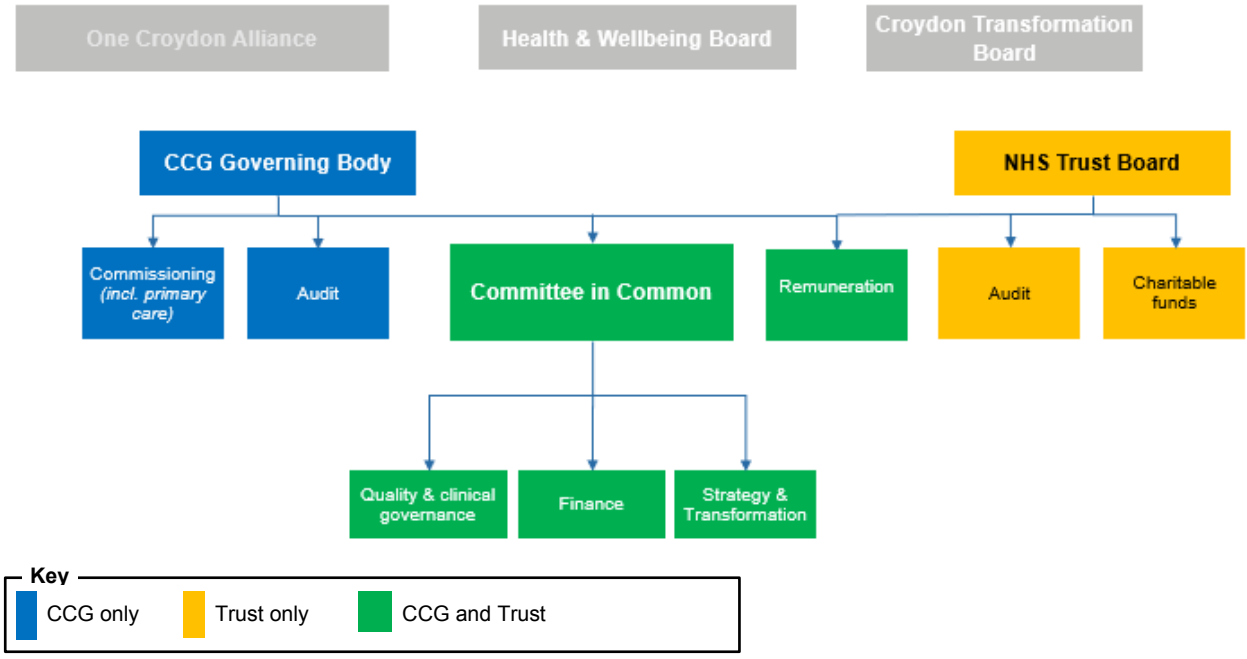


Figure 20: Future near-term Governance arrangements

As the primary decision-making group, we will ensure that the Committees in Common (CiC) meets the following principles of good governance:

- The committee will be comprised of both executive (salaried) and non-executive (independent or elected) members, with non-executive members representing a majority (by a minimum of 1); and
- The committee will be comprised of both clinical and non-clinical members, with clinical members representing a majority (by a minimum of 1).

Table 6: Committee roles

Committee	Key responsibilities	Rationale
Commissioning *(CCG only)*	• *Primary care commissioning* • *Approval of contracts* • *Procurement decisions* • *Contract award decisions*	• *Oversees decisions and functions in relation to commissioning that give rise to a conflict of interest*
Audit *(CCG only)*	• *Oversee the maintenance of an effective system of internal financial control and management reporting* • *Ensure all business is conducted in accordance to the law and to proper standards* • *Oversee all internal and external audit services*	• *Audit to be retained as an organisational specific responsibility to ensure the CCG continues to meet its statutory duties*
Remuneration *(committees in common)*	• *Consider and agree the remuneration and terms of service of Executive Directors, other Directors and senior employees* • *Monitor and evaluate performance of individual Executive Directors*	• *Committees in Common to ensure information is consistent when presented to the Trust Board and Governing Body relating to joint senior employees*

Quality and Clinical Governance *(sub-committee of the CiC)*	• *Provide assurances on all aspects relating to quality including, delivery, governance, clinical risk management, workforce, and the maintenance of regulatory standards of quality* • *Monitor, and where necessary act and/or escalate, to ensure quality targets and improvements are met*	• *The shared forum aims to improve transparency and increase challenge, supporting an overall improvement in quality governance and assurance* • *Should ensure a shared and evidence-based understanding of 'what good looks like' through aligned data-systems and robust benchmarking*
Finance *(sub-committee of the CiC)*	• *Provide assurances to the Committees in Common on all matters relating to finance* • *Carry out financial planning and monitor progress, and where necessary act to ensure the delivery of the financial plan*	• *Shared forum required to manage against single financial plan and control total*
Strategy and Transformation *(sub-committee of the CiC)*	• *Define the health and care needs of the local population* • *Develop and monitor the delivery of a single transformation plan* • *Develop business cases for specific initiatives*	• *Shared forum required to manage to single transformation plan* • *Allows for co-ordinated approach across care settings*
Audit *(Trust only)*	• *Oversee the maintenance of an effective system of internal financial control and management reporting* • *Ensure all business is conducted in accordance to the law and to proper standards* • *Oversee all internal and external audit services*	• *Audit to be retained as an organisational specific responsibility to ensure CHS continues to meet its statutory duties*
Charitable funds *(Trust only)*	• *Oversee the management, investment and disbursement of charitable funds*	• *To remain independent to comply with statutory regulations*

The Committees in Common will include elected, lay and salaried members of the CCG Governing Body as well as Executive and Non-Executive Directors of the Trust. A number of salaried / executive posts will be members of both committees as joint employees.

The Committees in Common will be co-chaired by the CCG Clinical Chair and the CHS Chair.

6.2.4 Evolution of leadership and governance

The NHS Long Term Plan confirmed that there is to be a nationwide shift towards integrated and place-based care, with ICSs to be established across England by April 2021 and expected to cover the footprint of existing STPs.

The opportunity exists for the NHS and partners to design and develop System (ICS), place (borough) and Neighbourhood leadership and organisational arrangements. We recognise that we are operating in an environment of "unknowns", with the exact route to establishing a South West London ICS currently being designed. We know the "what?" is a place-based model of integrated care for Croydon, nestled within a wider South-West London (SWL) integrated care system.

In developing our place-based solutions for Croydon we are assuming that decisions will continue to be delegated to a place-based level, and that Croydon decision makers will continue to direct 80-90% of commissioning resources related to Croydon under delegated arrangements; however, the exact form of the local place-based functions is still to be determined and may impact on the overall leadership and governance model. We will in Croydon remain flexible and plans to work closely with the rest of South

West London to answer the remaining unknowns and ensure the solution is one that meets the needs of the population of Croydon and is supportive of the long-term plan.

As such we believe Croydon should continue to progress with its plans for greater alignment and not delay or slow our progress. Croydon's aspirations for place-based care at the level of Croydon is in support of wider ambitions for a South-West London ICS. Progress made in Croydon is expected to support wider ICS implementation, with Croydon acting as a potential model as to how place-based care will delivered within the ICS, with South West London looking to develop the ICS in conjunction with the work happening in Croydon.

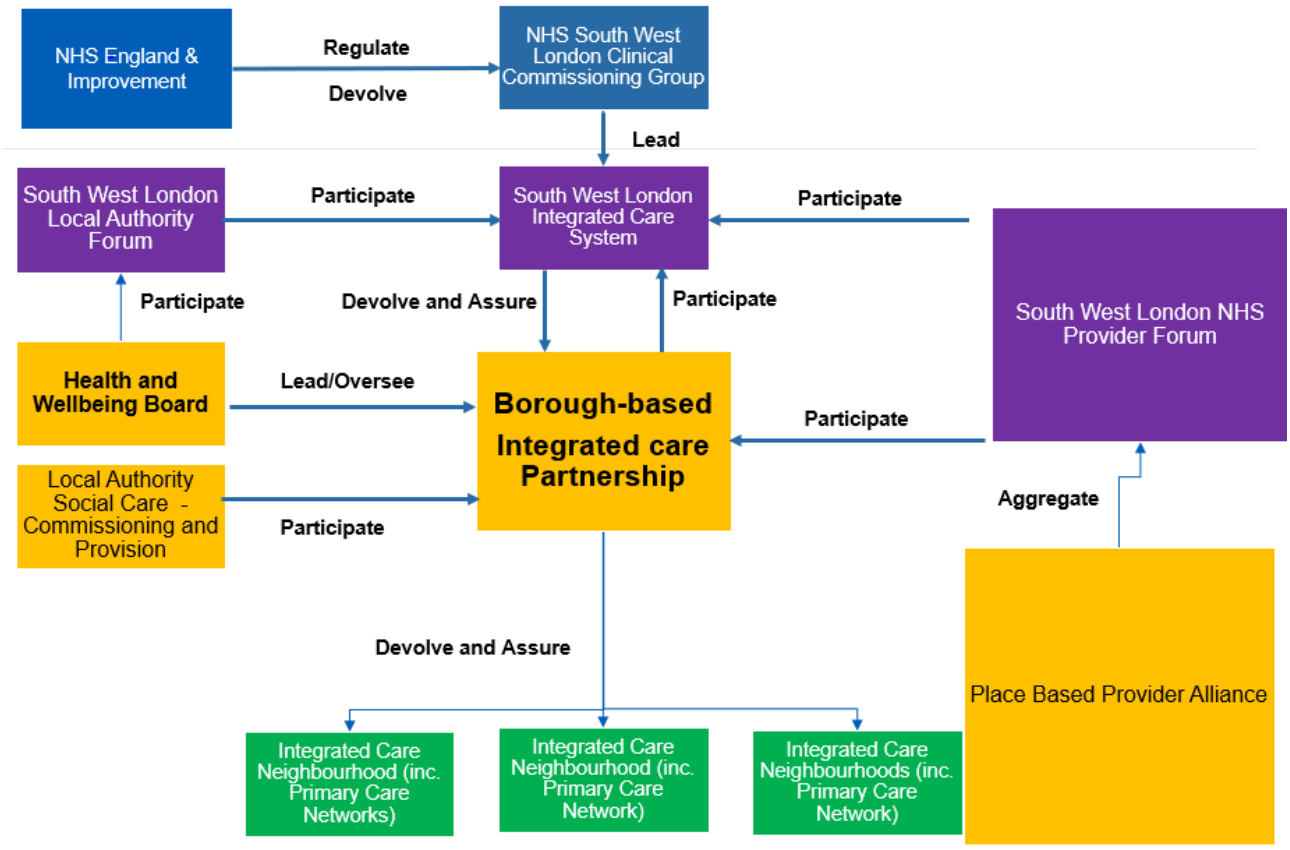
However, recognising these areas of ambiguity, we remain open and flexible with regards to the proposed model and recognise that there are two major axes of development that would take us beyond the bi-lateral model described in section 6.2:

Further integration within Croydon

- Our proposals for greater alignment between the CCG and CHS are s substantial step in further developing in building on the existing Ince Croydon Alliance that in addition to the CCG and CHS incorporates Croydon Council, primary care providers, SLAM and the voluntary sector
- We envisage that, over time, that these arrangements will converge to create shared leadership and governance across the whole Croydon system, potentially working through a series of alliance-type delivery partnerships, contracts and the further development integrated community networks to support primary and community care across our localities
- Specific consideration will be given to how we include the voluntary sector within any future arrangements, for example, through the development of a local voluntary partnership framework
- This evolution will also include considerations for how to incorporate and develop local governance arrangements, including that of the existing One Croydon Alliance and the strategic leadership role of the Croydon Health and Wellbeing Board
- The timing of this evolution will be at the discretion of the Alliance partners to integrate further to secure health improvement and the level of support and encouragement offered by the wider system

Further integration across South-West London

- The NHS Long Term Plan states that Integrated Care Systems (based on existing STP footprints) will have a single CCG that is leaner and more strategic in focus than today's CCGs. We therefore foresee that Croydon CCG may become part of a single CCG for South-West London
- We strongly believe that the right model for Croydon is a place-based health and care system with devolved autonomy for managing a population-based budget, and that this is not inconsistent with the direction of travel for a single CCG, so long as appropriate delegations are made
- In this scenario, we believe that the principles of the model outlined hold, true and it presents the opportunity to design and build new arrangements for local place-based partnership and leadership across the borough, and with an important and influential voice say within the SWL ICS



6.3 Future contracting and commissioning model

The national direction of travel is to commission large population-based contracts (multi-pathway contracts) for delivering care, similar to the One Croydon Alliance contract, which was commissioned to deliver care across Croydon for the over 65s.

As part of the proposed model, Croydon CCG expects to develop more population-based contracts with provider-commissioner alliance agreements, to cover services, such as, Planned Care, Children's services and Mental Health services.
This approach to commissioning:

- Supports our ambition to develop a place-based system of care;
- Drives the aim of 'triple integration';
- Ensures the alignment of incentives across providers and commissioners; and
- Reduces the inherent conflict of interest between commissioners and providers as described in section 6.4.

6.4 Managing conflicts and fulfilling statutory duties

Both CHS and the Croydon CCG will need to continue to fulfil their statutory duties as sovereign organisations (until any other major changes occur, such as the creation of a single SWL CCG, although such statutory duties would still exist, albeit over a large geographic footprint). In the most part, the duties of the two organisations are able to co-exist within the leadership and governance model outlined above without giving rise to conflict or contradiction.

However, there are five areas where potential or perceived contradictions or conflicts could arise; these are:

- How will the CCG ensure **contestability of commissioning decisions** considering real or perceived conflicts of interest?
- How will the CCG **maintain its role as an independent arbitrator** across providers in Croydon?
- How will the CCG ensure that it is **objective in assessing whether services are safe, effective and efficient**?
- How will the CCG ensure that it upholds its duty to **promote patient choice**?
- How will the CCG and CHS uphold the **purchaser-provider split**, inherent within the current legislation?

Each of these questions is explored in more detail below, where we have highlighted the relevant duties, perceived issues and our proposed solutions or safeguards.

Should the merging of SWL CCGs occur as currently expected, it should be noted that the potential for conflict of interest would naturally lessen.

We note that the assurance that is available for Croydon residents remains as-is today through the statutory functions of the two organisations.

Table 7: Key questions relating to statutory duties and conflicts of interest

Question	Relevant statutory duties	Perceived challenges	How this will be managed
How will the CCG ensure the contestability of commissioning decisions considering real or perceived conflicts of interest?	• The CCG has a duty to *"Declare any conflict or potential conflict of interest that the person has in relation to a decision to be made in the exercise of the commissioning functions of the group"* • And to *"… make arrangements for managing conflicts and potential conflicts of interest in such a way as to ensure that they do not, and do not appear to, affect the integrity of the group's decision-making processes."*	• Shared leadership posts could have a potential conflict of interest when making commissioning decisions that impact CHS • For example, if the CCG were to market test for out of hospital services, a conflict would arise if the same individuals were responsible for both the CCG's procurement and CHS's bid	• It is the CCG's intention to build on the success and learnings from the One Croydon Alliance by extending its scope, over time, to encompass a whole population approach with a number of discrete pathways. This approach – where an alliance is commissioned on a multi-year, multi-pathway, population basis – will significantly lessen the scope for conflicts of interest to arise • We will ensure that all processes relating to specification design, procurement and contract award are open and transparent, with strong system-wide consultation and engagement • We will develop a single commissioning plan, with system-wide engagement. We will seek to gain agreement and approval of this plan at both a South-West London level (through the future ICS) and at a place-level through the Alliance. Commissioning decision-making will then be aligned to the plan (with appropriate oversight and assurance), reducing the likelihood of conflict • We will work with SLAM to develop a mental health investment plan to ensure there is parity and transparency between acute and mental health • For commissioning decisions where a real or perceived conflict of interest arises, we will ensure appropriate delegation and/ or escalation protocols are in place. Such protocols may include: – Delegation to a place-based, system-wide forum such as the Croydon Alliance Board, with conflicted individuals abstaining from the decision – Escalation to the South-West London (SWL) ICS Partnership Board or the SWL CCG Governing Body (assuming these bodies exist in the future, in line with the national direction of travel) – The Health Commissioning Committee (see above) will be comprised of individuals who are not conflicted • For decisions that may normally fall to an individual (e.g. the CFO), where the individual in question is conflicted, these will be delegate to another individual (e.g. a deputy) who does not have a real or perceived conflict

			• Investment standards and ring-fencing budgets across mental health and primary care, e.g. the Mental Health Investment Standard, ensure that the CCG's allocation of resources between different parts of the health and care system is fair and equitable
How will the CCG maintain its role as an independent arbitrator across providers in Croydon?	• None	• Commissioners often play a critical role in supporting system-wide decision making by arbitrating or mediating potential conflict between providers within a region • The CCG's relationship with CHS could be perceived as the CCG losing its independence in such discussions	• The direction of travel is to have a mature placed-based system of care in Croydon, where decisions are made collectively and transparently through alliance-type arrangements • This model: – Aligns incentives and therefore significantly lessens the likelihood of conflict between providers within a region; and – Ensures transparency of process and decision making, such that the CCG could not be perceived to favour CHS.
How will the CCG ensure that it is objective in assessing whether services are safe, effective and efficient?	• The CCG does not have any explicit statutory duties relating to the monitoring of services • However, this could be considered implicit if the CCG is to meet its duty to *'commission services that meet the needs of the persons for whom they are responsible'* and to *'secure improvement in the quality of services and outcomes for patients, with particular regard to clinical effectiveness, safety and patient experience'*	• Under current arrangements, the CCG monitors and scrutinises the performance of CHS against its contracts • Under a more aligned structure, the CCG could be perceived to be less objective • For example, it may be perceived that the tension between customer and supplier is diminished, resulting in less robust challenge	• Greater integration and alignment between the CCG and CHS should improve transparency and therefore support an overall improvement in quality governance and assurance • It should also ensure a shared and evidence-based understanding of 'what good looks like' through aligned data-systems and robust benchmarking • Notwithstanding the above, there are substantial arrangements in place for oversight and scrutiny of provider performance through a range of routes, including: – Health Overview and Scrutiny Committee (HOSC) – Croydon Health and Wellbeing Board – Regulators: NHS Improvement, England and CQC – National programmes: Model Hospital, NHS Rightcare and GIRFT – Health Watch Croydon – Trust Non-Executive Directors and CCG lay persons • We will also invite additional independent scrutiny by inviting organisations such as NHS England, NHS Improvement and Health Watch to attend our Quarterly Quality Assurance Committee

			• Within the CCG we will maintain a Quality Assurance function that is independent of CHS, and therefore able to provide independent and robust challenge • Arrangements within the future South-West London (SWL) ICS will provide a route of escalation and intervention on quality issues, should they arise
How will the CCG ensure that it upholds its duty to promote patient choice?	• The CCG has a duty to *"… act with a view to enabling patients to make choices with respect to aspects of health services provided to them."*	• Under the model outlined above, individuals with shared roles may be perceived to have a conflict of interest with regards to whether patients are treated locally (at CHS) or are referred out of area • For example, the CCG may be perceived to have a vested interest in restricting elective flows outside of Croydon	• Our focus to date and in the future will be on creating local pathways that are high-quality and offer an excellent patient experience. We hope that this will positively influence choice, by making local pathways the "pathways of choice" for both referring clinicians and patients • We will not undertake any initiatives or actions that attempt to restrict or negatively influence choice
How will the CCG and CHS uphold the purchaser-provider split, inherent within the current legislation?	• Legislative reforms over the life of the NHS have created a purchaser-provider split that is hard-wired into the structure and duties of NHS organisations	• While there are no strict legal barriers to the joint appointment of executive leaders across a CCG and an NHS Trust, it could be legally challenged by way of judicial review as an attempt to 'dissolve the divide' • Similar issues at a national level gave rise to the claim against the new ACO contract	• The proposed model is consistent with the national policy direction of travel, relating to placed-based integrated care, and through collaboration and alignment, will deliver significant benefits for the population of Croydon • This model also 'paves the way' for a more mature model of integrated care across the Croydon system and across the broader South-West London system • Under the proposed model, there will continue to be two statutory organisations, both organisations will continue to meet their statutory duties, and we will ensure appropriate management of conflicts of interest. We therefore believe that the statutory distinction between the two organisations is maintained and consistent with current legislation

6.5 Timelines and milestones

In this section we outline the proposed timeline and key milestones for moving to greater alignment over the next 12 months and beyond.

CHS and the CCG plan to go-live with the proposed model and new governance structure in October 2019, building up to full implementation April 2020.

We recognise that this timeline is our current best view of expected progress; however, this will evolve as we progress towards greater alignment and the proposed model for place-based care in the wider South West London system is defined.

Table 8: Key Milestones

1

August 2018 – April 2019	*Focus: Undertaking joint initiatives and designing new leadership and governance structure*
Key Milestone	**Description**
Preparation for 19/20 joint control total	• *Work currently underway to agree a joint financial plan and control total for 19/20* • *Final definition and scope of the joint control to be agreed by February, with regulator approval of joint control total sought by March 2019* • *Shadow finance committee to be set-up ahead of April 2019*
Creation of single control total for quality and a shared quality committee	• *Control total for quality established and joint quality committee set-up through the merging of CQRG and Q+CG* • *Continue to embed and mature quality committee. Trust and CCG to reach final agreement on committee governance structure and define process for collective decision making within the committee* • *Look to embed culture of transparency and joint working below the executive level across quality functions*
Establishing joint posts and shared functions	• *Shared roles implemented across the Trust and CCG including, Associate Director of Safeguarding and Chief Pharmacist, further joint roles below are expected to be appointed by April '19, including joint IMT role* – *Alongside joint roles, functional alignment across safeguarding and medicines management is also underway* • *Appointment of first executive level joint role between the Trust and CCG. A Chief Nurse joint post is expected to be in place by April '19* • *The Trust and CCG to undertake further process to review all functions in order to identify next phase of role and functional alignment* • *Trust and CCG to design new roles and job descriptions across the Trust and CCG following the review process*

Joint focus on 'here and now' challenges	• *Joint focus on short term challenges facing the Croydon.* • *Jan-April priorities to include:* – *UEC improvement programme* – *Collaboration across community and out-of-hospital to support the discharging of 'stranded' patients* – *Review of elective flows and collaboration across GP communications, in order to provide better support to patients having to leave the borough to receive care. Weekly elective delivery group set-up between Croydon CCG and CHS to support this*
One Croydon Alliance and integrated models of care	• *A number of activities are planned to continue to progress the One Croydon Alliance and the design of integrated models of care* • *Jan-April priorities to include:* – *Out of hospital business case transitioning to BAU* – *Implement phase 2 of the Alliance, including care homes, frailty and end-of life* – *Pilot and contract phase 3 of redesigned services, including gynaecology, ENT, anti-coagulation and dermatology* – *Gynaecology integrated model of care has already been agreed and signed off. Next-step to finalise and sign-off ENT integrated model of care and agree light touch assurance process for Gynaecology and ENT by the end of March '19*
Design of a new leadership and governance model	• *Further testing of the proposed model with a wider group of stakeholders, including service leads* • *Internal agreement from the board and governing body of both organisations and support from regulators for a new model of leadership and governance* • *For each of the new leadership functions (as outlined in 6.2.1), CHS and Croydon CCG to carry out detailed design of joint structure, future roles and responsibilities, governance and decision-making processes. This is in preparation for standing up and testing shadow forms of committees and functions between April-October*
Engagement with South West London	• *Engagement with SWL to ensure Croydon progress is supportive of LTP aspirations and supports the creation of Integrated Care System in South West London*
2 **April 2019 – Oct 2019**	*Focus: Maturing joint finance function and implementing new leadership and governance structure*
Key Milestone	**Description**
Go live with joint control total from 1st April	• *Joint control total and shared committee in place across the Trust and CCG* • *Focus from April onwards will be on monitoring and maturing joint committee and beginning functional alignment of finance*

	• *Functional alignment to include the creation of a joint finance PMO and transformation team across the two organisations to monitor progress and jointly enact transformation initiatives*
Agreement from CCG members of any constitutional changes	• *Consultation and council of members vote to amend any changes to the CCG constitution* • *Following agreement from council of members, NHSE approval of the constitution change to be requested and agreed*
Appointment of joint roles across the Trust and CCG	• *Joint leadership roles to be appointed across the Trust and CCG, all joint executive level roles are expected to be in appointed by October 2019* • *Alongside the appointment of executive level roles, joint roles below executive are also expected to be appointed, as identified in the review of functions taking place between January and April 2019* • *Activities occurring between April-October '19 expected to include:* – *Designing of new roles and job descriptions* – *Staff consultation, where required (expected to take a minimum of three months)* – *Recruitment and appointment of roles*
Recruitment for a place-based leader	• *Design of a joint place-based role between the Trust and CCG* • Support *from NHSE/I on joint role* • *Begin the recruitment process of a joint place-based leader* • *Joint place-based leader to be in position by October 2019*
Standing up on shadow joint functions	• *Following the design and agreement on structure of joint functions (between January and April '19), shadow committees and functions to be formed to enable testing of joint leadership structure* • *Testing to focus on ensuring:* – *robust governance is in place to manage any potential conflicts* – *effective decision making is enabled through joint function* – *functions have the ability to respond to any challenges quickly, safely and effectively*
Standing up a shadow board between the trust and the CCG	• *Following design and approval of joint leadership function, a shadow board between the Trust and the CCG is to be set-up and final agreement achieved on governance structure and terms of reference for board in common* • *As with other the joint leadership functions focus shadow period will be to ensure robust governance is in place and effective decision making can be delivered via the joint committee*
Continued alignment across other initiatives	• *Alongside preparing for the go-live of the joint leadership and governance structure, the Trust and CCG to continue to*

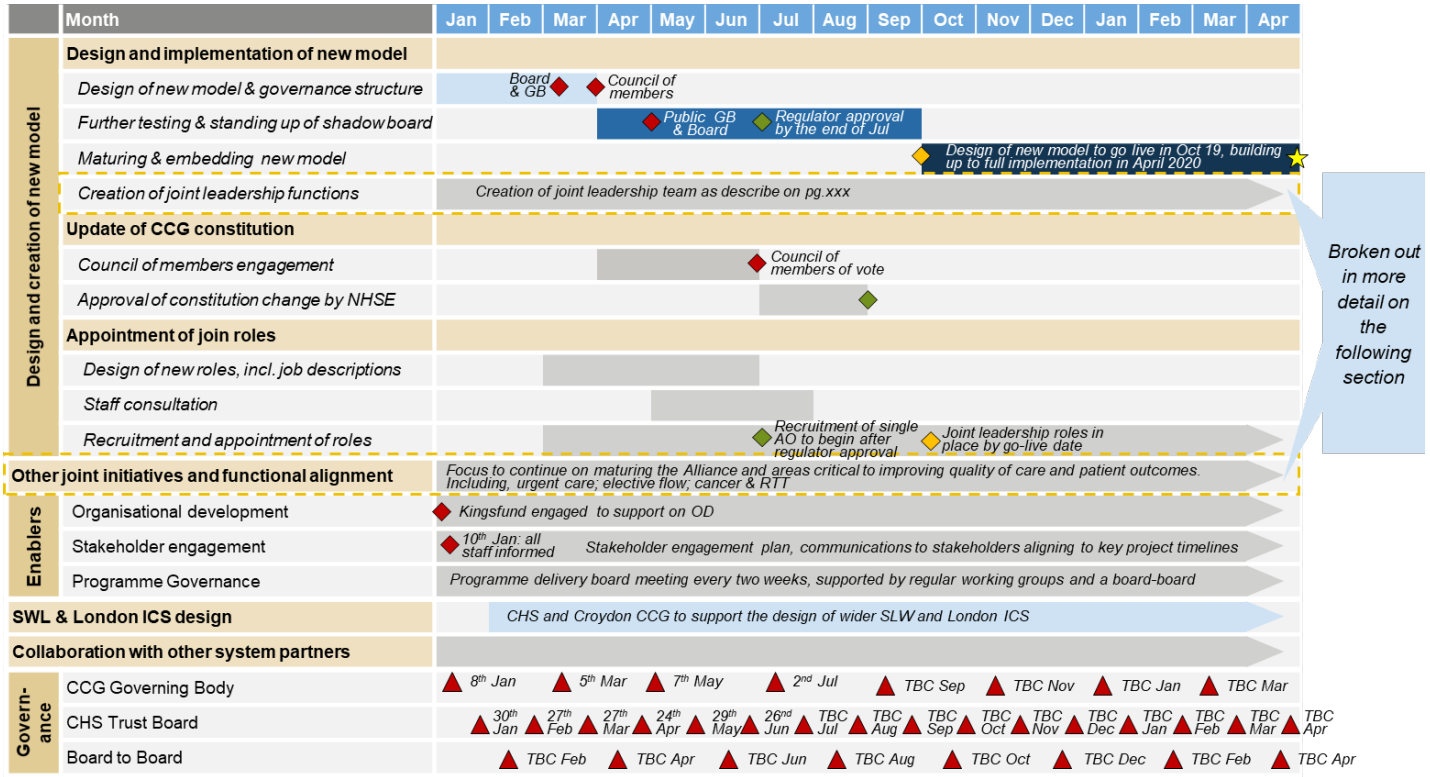
	identity and undertake joint initiatives and align functions • *As described in the previous section, this is expected to focus on the here and now challenges facing the trust and support the maturation of the One Croydon Alliance* • *Whilst functional alignment to focus on opportunity areas identified in the functional review carried out between Jan and April '19*
Engagement with South West London	• *Engagement with SWL to ensure Croydon progress is supportive of LTP aspirations and supports the creation of Integrated Care System*

October 2019	**Go live date for the new model planned for October 2019 building up to full implementation in April 2020**
3 October 2019 - Onwards	*Focus: Embedding of the new model and increasing functional alignment*
Key Milestone	**Description**
Embedding the proposed model	• *Focus on monitoring and maturing new model and governance structure, building up for full implementation in April 2020*
Continued appointment of joint roles	• *Joint roles to continue to be employed at both an executive and below executive level*
Functional alignment below leadership roles	• *Continue to create joint functions across the organisations*
Continued collaboration with other system partners	• *Wider alignment across the Croydon system*
4 Long term: A single integrated care partnership	**System wide shared governance and functional alignment**

6.5.1 Timeline: Present to April 2020

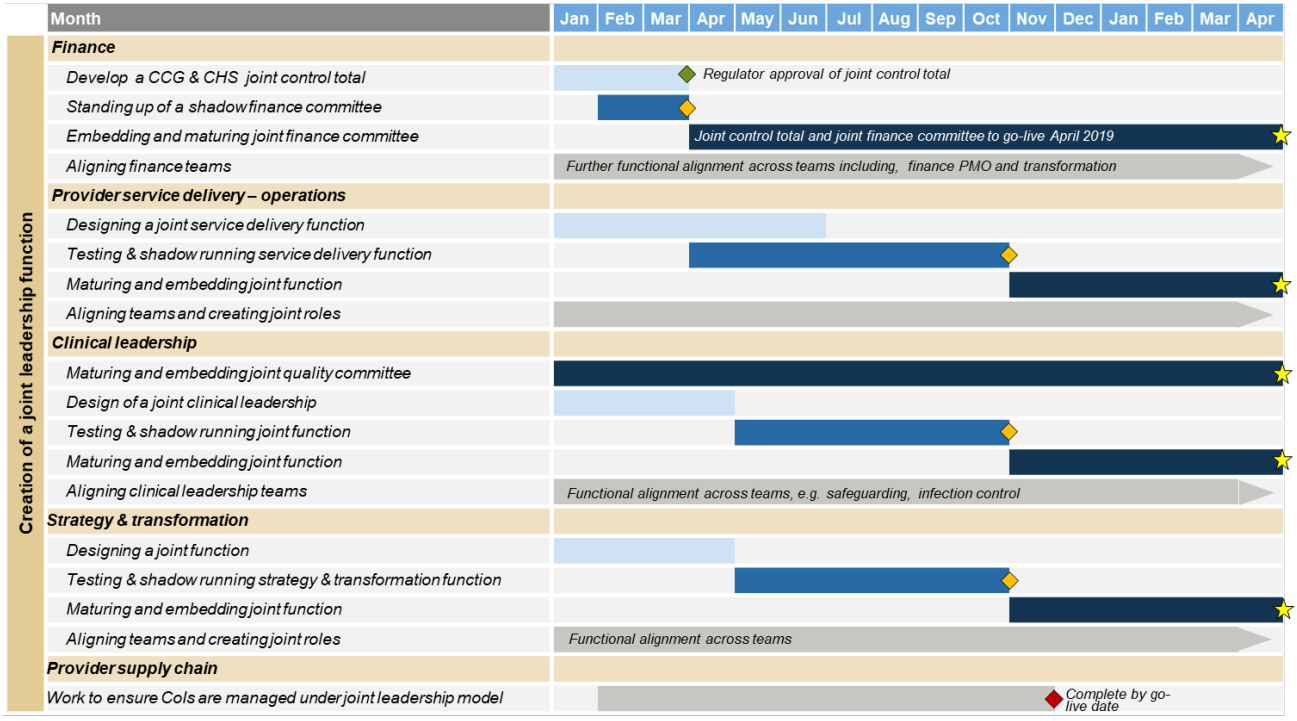
6.5.1.1 Summary

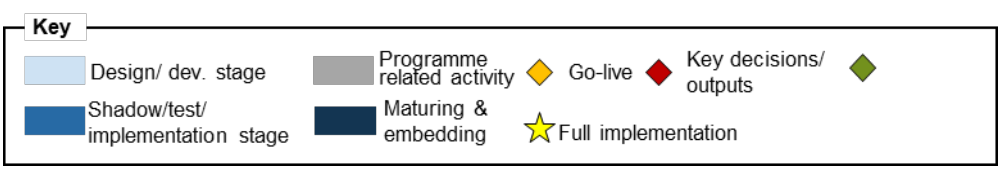
Figure 21: Summary Timeline



6.5.1.2 Joint Leadership function

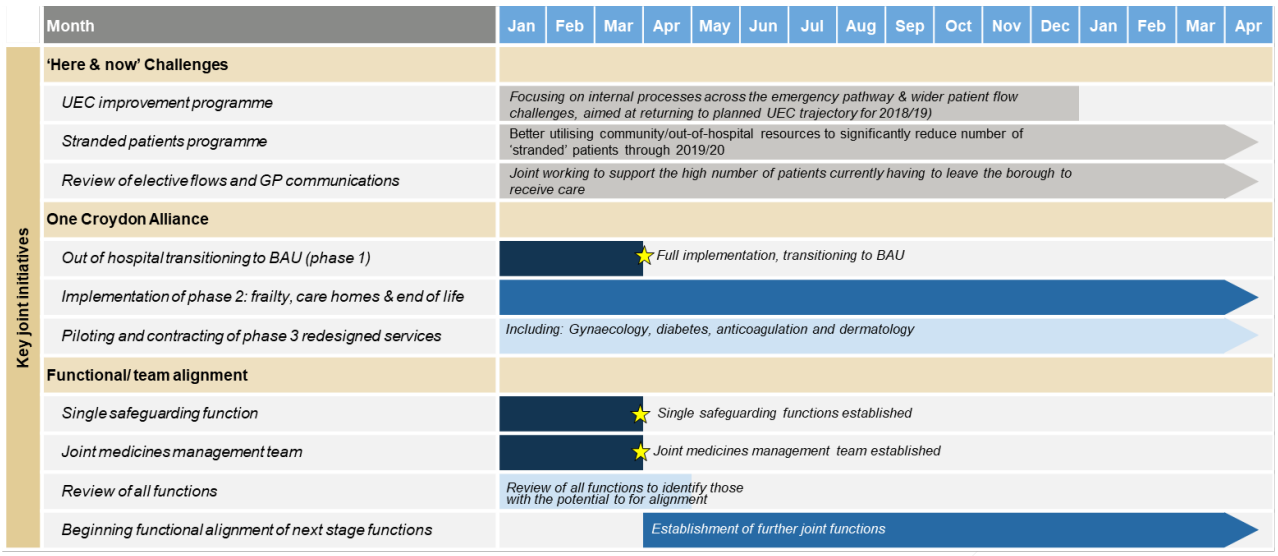
Figure 22: Timeline to create joint leadership function





6.5.1.3 Joint initiatives

Figure 23: Joint initiative timeline



7 Appendix

7.1 Detailed Progress to date

Table 9: Detailed progress to date

Milestones	Key activity to date:	Benefits:	Next steps
Joint working on the "here and now" challenges facing the Trust and the CCG	• CHS and CCCG have jointly focussed on supporting each other across the key challenges facing each organisation, including: – Joint working to assess and strengthen patient flows, in particular, those where a large number of patients are having to leave Croydon to receive care and jointly communicating with GPs to ensure they have access to up-to-date information – Croydon CCG have been providing 'on-the-ground' support to CHS to help resolve recent challenges surrounding the opening of the new emergency Department – As part of One Croydon Alliance CHS and Croydon CCG have been working together on pathway redesign, early success includes a reduction unplanned admission amongst over-65s and supporting reablement of patients after they are discharged	• Joint working has given rise to number of financial and quality benefits • **Quality benefits:** – Support in meeting and/or improving performance against quality targets across urgent and emergency care – Strengthening patient pathways and improving performance between primary and secondary care to ensure patients are receiving care in the most appropriate setting • **Financial benefits:** – By strengthening local patient pathways within Croydon, CHS and Croydon CCG are ensuring that more Croydon spend remains in Croydon increasing the stability of the Croydon system – Cost of delivery has been lowered through reducing unplanned admissions and supporting reablement back into independent living	• The Trust and the CCG to continue to focus on the 'here and now' challenges • As part of the work around patient flows and increasing communications between primary care and secondary care clinicians the following activities are planned: – Joint GP practice visits – Joint communications and GP engagement plan • The planned care transformation, which is being delivered as part of the One Croydon Alliance will focus on piloting pathways and contracting services that have redesigned including: – Gynecology; diabetes; anticoagulation and dermatology

Creation of shared roles – *The CCG and trust have jointly appointed a safeguarding lead and head of pharmacy*	**Pharmacy:** • Joint Chief Pharmacist Post appointed across the Trust and the CCG after the retirement of the CCG's Chief Pharmacist • The Trust's Chief Pharmacist now spends two days a week supporting the CCG **Safeguarding:** • Appointment of a joint safeguarding lead and establishment of a single safeguarding function for adults and children across the Trust and the CCG	**Pharmacy:** • Single leader across both teams enables movement towards aligned objectives • Greater links allows the sharing of best practice across medicine optimisation, medicine management and care settings **Safeguarding:** • Creates a simpler interface with other safeguarding teams within the LA and police • Provides safeguarding across health and stronger and more aligned voice (in line with the "2018 Ways of working review") • Removes duplication and reduces transactional nature • Financial benefits through a more streamlined team	• Continue to monitor and track progress as functions matures • Extend safeguarding partnership further to create a Croydon-wide safeguarding • Look to identify and appoint additional joint roles and establish more joint functions – Progress underway as part of joint working groups to identify next areas of functional alignment across a diverse range of activities, including: Complaints; infection control; PMO and transformation
Joint Quality committee – *CHS and Croydon CCG have combined quality committees to ensure all quality discussions occur in the same forum*	• Establishment of a joint quality control total for quality • Establishment of a shared quality committee between CHS and Croydon CCG through the merging of CQRG and Q+CG – Since the set-up of this committee executives from CHS and Croydon CCG, along with CHS NEDs meet in a single forum to discuss quality assurance	• Executive time saved through reducing duplication in the discussion and reporting requirements • Improves level of assurance, transparency and challenge around quality • Additional quality benefits via best practice sharing, benchmarking and a more thorough approach to identifying and embedding learnings (e.g. serious incidents)	• Continuing monitoring and maturing committee • Agreement on committee governance structure and process for collective decision making • Look to invite other system partners into the forum, such as CUCA (Croydon Urgent Care Alliance) who has its own CQRG • Below the executive level there is further work to be carried to embed a culture of transparency and joint working and investigate the establishment of joint post such as BI, to monitor quality and ensure a single source of truth across both organisations

Preparation for a joint control total at the start of 19/20	• CHS & CCG have an agreement in principle for a 2019/20 Joint Control Total and finance committee • Activities to get to this point have included: – Joint financial planning meetings set-up (every two weeks) – The planning gap (deficit) has been reduced. At the start of this process the planning gap stood at £12m this has been reduced to £7m, with plans in place to get to an aligned view with no gap by the end of Q4 – Both organisations have drafted joint financial aims in an aligned system. This is focussed on reducing the overall cost of the delivery of health care – Open book and transparency policies have been put in place with the active exchange of finance materials. The finance committees of each organisation have received copies of each organisation's business planning/budget setting approach for 2019/20 – Joint working across finance functions to support meeting in-year finance targets	• For effective joint decision making to occur at the management level the structure and management of financial controls totals needed to reflect this • Ensures aligned incentives and removes organisation-centric behaviours • Furthermore, A shared control total enables service transformation by allowing resources to effectively move between care settings. • A single financial position is also expected to increase the speed of decision making and in turn the rate in which transformational change can be enacted	• Agree on final definition and scope of the shared control total • Get agreement from regulators to approve a joint control total • Shadow run a CHS & CCG agreement in principle for a 2019/20 Joint Control Total • Create a joint finance PMO and transformation team across the two organisations to monitor progress and jointly enact transformation initiatives • Set-up specific finance governance process to manage the Joint control total

The standing up of a number of shared forums to encourage joint working	• As part of the programme governance structure that has been set-up, several joint forums have been put in place, including: – Service Delivery – Clinical Governance & assurance – Strategy & transformation – Financial alignment & back office – Information, digital and technology – Other shared leadership & governance • These forums meet on a regular basis (between every two & four weeks) to track progress of joint initiative and identify further alignment opportunities	• Joint forums have a number of benefits: – Improve relationships between the two organisations – Maintain the pace of the alignment programme, through tracking process and establishing accountability – Provide forums to exchange best practice	• Joint working groups to continue in the near-medium term • Eventually joint working groups will be superseded by formal joint committees and aligned functions
Establishment of a robust Programme Governance structure	• A programme governance structure has been put in place to drive and oversee programme delivery • Underpinning this is the programme delivery board, which meets every two weeks with exec and board level representatives from CHS and Croydon, NHSI and NHSE also join on a monthly basis	• The programme delivery board has a number of key responsibilities: – Oversee and monitor the programme, ensuring appropriate focus and pace is maintained – Scrutiny of progress against the Delivery Plan – Oversight of the Workstream Action Groups (joint forums) – Holding individuals to account for the delivery of individual actions – Decision making/problem solving in relation to identified issues and risks – Systematic identification of new opportunities • As with the joint working group, the programme delivery board is responsible for maintaining the pace of the alignment	• Programme delivery board to continue in its current structure in the near-medium term
Establishment of OD and Engagement	• To support the organisational changes associated with the alignment an Organisational Development and	• The purpose of these workstreams is to ensure that CHS and Croydon CCG have both internal and external support of the	• Near-term focus of the OD workstream has been to on the board and executive levels;

workstreams to support	Engagement workstream has been set-up **Organisational development workstream:** • Focus of OD workstream has been developing common visions and purposes at a board and executive level • The kings-fund has been engaged to support CHS and Croydon CCG and been invited in to run two sessions to-date with the executive team of each organisation **Stakeholder engagement workstream:** • The focus of the stakeholder engagement workstreams has been to ensure all internal and external stakeholders are informed of the alignment and supportive of these plans • Formal communications have gone out to all employees of CHS and Croydon CCG to articulate the plan of the alliance – With opportunities for staff to have all their questions answered about the alignment • GP members have also been informed of alignment plans via GP membership open meetings • A comprehensive stakeholder engagement plan has been put in place to ensure all other partners are kept informed	alignment and robust governance structures are in place to reduce an organisational instability caused by the alignment	however, as greater functional alignment occurs the OD workstream will expand to cover front-line and delivery staff • Likewise, most stakeholder engagement to-date has been internal the next-steps for engagement workstream will be to focus on key external stakeholders as well as keeping internal stakeholders informed

7.2 Programme Governance

Figure 24: Programme Governance

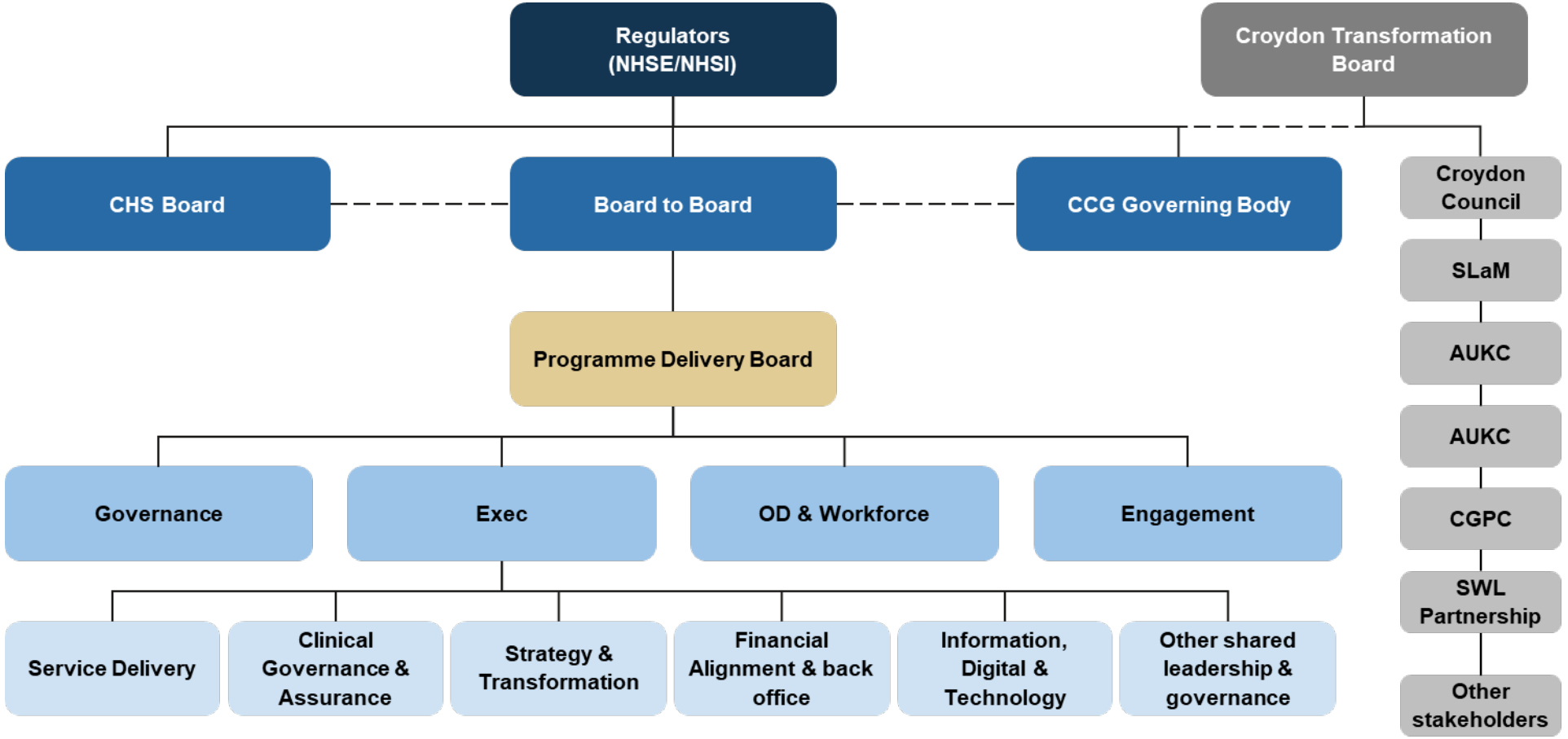


Table 10: Programme Governance

Forum	Summary of purpose	Membership	Direct reporting	Cadence

			line	
Board to Board	• Board to Board development and relationship building • Provide an open channel of communication for information sharing and for Board members to raise questions or concerns • To gain assurance that delivery of the Plan is on track	Board members of both the Trust and Governing Body members of the CCG	Regulators	Every two months
Programme Delivery Board (PDB)	• Scrutiny of progress against the Delivery Plan • Oversight of the Workstream Action Groups • Holding individuals to account for the delivery of individual actions • Decision making/problem solving in relation to identified issues and risks • Systematic identification of new opportunities	Representatives from both the Trust and the CCG, covering: • Trust and CCG Chairs • Trust and CCG Executives • Trust NED and CCG lay member • Croydon Programme Director • Director of Primary Care • Programme support Representative from regulators • NHS England • NHS Improvement	Board to Board	Every two weeks Regulators to join monthly
Exec to Exec	• Oversight of shared functions • Executive development and relationship building • Resolution of issues that arise as a result of delivering the Plan • Forum for information exchange • Identification of new opportunities • Responsible for monitoring progress of the workstream actions groups milestones and activities	• Executives of both the Trust and CCG • Croydon Programme Director • Programme support	PDB	Monthly
Governance	• Resolve the challenge of managing conflicts of interest that the CCG faces regarding	• CHS and CCG Head of Corporate	PDB	Monthly

	commissioning of services • Identify/pursue new opportunities to work together • Oversee the programmes that are already underway • Build closer relationships between the CCG and the Trust • To report to the PDB	affairs • CHS Head of Contracts • CHS Contracts Director • CCG Director of Commissioning • CCG Director of Quality and Governance • CCG Contract lead • Legal Advisor • Programme Director • Programme Support		
OD	• Building relationships between respective organisations • Imparting organisational knowledge and understanding • Creating a common purpose • Moving towards more joint ways of working	• CCG Director of Quality and Governance • CCG Director of Primary Care • CHS COO • CHS Director of HR & OD • OD Support • Engagement manager • Programme Director • Programme support	PDB	Monthly
Engagement	• Further development and implement of stakeholder engagement plan	• CCG Director of Primary Care • CHS COO • CHS Director of Communications • CCG Director of Communications • Engagement manager • Programme Director • Programme support	PDB	Monthly
Workstream Action Groups	• Working groups set-up chaired by the joint-	• Joint SROs (at least one representative	Exec	Monthly

	SROs for each of the following workstreams: – Service Delivery – Clinical Governance & Quality – Strategy & transformation – Financial alignment & back office – Information, Digital & Technology – Other Shared Leadership • Focused on the immediate delivery of initiatives in line with agreed milestones	from CCG and Trust for each Group) • Membership varies by workstream

7.3 Delegations

7.3.1 Decisions reserved for the CHS Board and CCG Governing Body

Please note, these schemes of delegations are not comprehensive, covering only key activities

Table 11: Decisions reserved to the CHS Board

Forum	Duty	Decisions reserved to the CHS Board
		General Enabling Provision
Board	CHS	• The Board may determine any matter, for which it has delegated or statutory authority, in full session
		Approval of regulations and controls, including:
Board	CHS	• Ratify any urgent decisions taken by the Chair and Chief Executive in public / private session
Board	CHS	• Approve a scheme of delegation of powers from the Board to committees
Board	CHS	• Manage conflicts of interests
Board	CHS	• Monitor the processes and procedures employed by Executive Directors
Board	CHS	• Receive committee reports and take action where required
Board	CHS	• Establish and remove committees and sub committees of the Board and approve terms of reference
		Appointments and dismissals, including:
Board	CHS	• Appoint, discipline and dismiss the Chief Executive and Executive Directors
		Monitoring and approvals
Board	CHS	• Approve annual quality accounts
Board	CHS	• Approve 3rd party Contracts
Board	CHS	• Approve NHS Contracts with Commissioners
Board	CHS	• Receive reports from the Committees in Common, audit committee and renumeration committee
		Audits and annual reports
Board	CHS	• Review external audit
Board	CHS	• Review and approve annual reports and accounts

Table 12: Decisions reserved to the Croydon CCG Members

Forum	Duty	Decisions reserved to the Croydon CCG Council of Members
Mem	CCCG	• Request permission of NHS England to amend the Constitution;
Mem	CCCG	• Request to the NHSE for a statutorily permissible change to the Geography of the CCG
Mem	CCCG	• Request to the NHSE for a statutorily permissible change to the name of the CCG
Mem	CCCG	• Propose de-selection of members of the Governing Body
Mem	CCCG	• Merger with another Clinical Commissioning Group where statutorily permissible

Table 13: Decisions delegated to the Croydon CCG Council of Members

Forum	Duty	Decisions reserved to the Croydon CCG Council of Members
		Approval of regulations and controls, including:
CM	CCCG	• Approve the appointment of Governing Body members, the process for recruiting and removing non-elected members to the Governing Body (subject to any regulatory requirements) and succession planning.
CM	CCCG	• Approve arrangements for identifying the CCG's proposed Accountable Officer
CM	CCCG	• Agree the vision, values and overall strategic direction of the CCG
CM	CCCG	• Approval of the CCG's annual report and annual accounts
CM	CCCG	• Consider a report describing all patient and public engagement activity, including consultations by the group and the findings and actions taken by the group as a result

Table 14: Decisions reserved to the Croydon CCG Governing Body

Forum	Duty	Decisions reserved to the Croydon CCG Governing Body
		Approval of regulations and controls, including:
GB	CCCG	• Approve a scheme of delegation of powers from the GB to committees
GB	CCCG	• Manage conflicts of interests
GB	CCCG	• Monitor the processes and procedures employed by Executive Directors
GB	CCCG	• Receive committee reports and take action where required
GB	CCCG	• Establish and remove committees and sub committees of the GC and approve terms of reference

		Strategy, Business Plans and Budgets
GB	CCCG	• Approve resource allocation and priority setting
GB	CCCG	• Approve annual commissioning plan
		Audits and annual reports
GB	CCCG	• Review external audit
GB	CCCG	• Review and approve annual reports and accounts
		Monitoring
GB		• Receive reports from Committees in Common, audit committee, renumeration committee and Health Commissioning committees

7.3.2 Decisions delegated to subcommittees of the board and governing body

Table 15: Decisions delegated to CHS Audit Committee

Forum	Decisions delegated to CHS Audit committee
CHS Audit	• Oversee the maintenance of an effective system of internal financial control and management reporting

Table 16: Decisions delegated to CHS Charitable Funds Committee

Forum	Decisions delegated to Charitable Funds Committee
CHS CFC	• Oversee the management, investment and disbursement of charitable funds

Table 17: Decisions delegated to CCCG Audit Committee

Forum	Decisions delegated to CCCG Audit committee
CCCG Audit	• Oversee the maintenance of an effective system of internal financial control and management reporting

Table 18: Decisions delegated to remuneration committees in common

Forum	Decisions delegated to remuneration Committees in Common
Remcom	• Consider and agree the remuneration and terms of service of Executive Directors, other Directors and senior employees
Remcom	• Monitor and evaluate performance of individual Executive Directors

Table 19: Decisions delegated to board and GB committee in common

Forum	Duty	Decisions delegated to Board and Governing Body Committees in Common (BiC)
		Strategy, Business Plans and Budgets
BiC	Joint	• Approval joint financial plan
BiC	Joint	• Define the joint strategic aims and objectives of the Trust and CCG
BiC	Joint	• Approve joint business plan
BiC	Joint	• Approve business cases, Strategic outline cases, OD, estate and workforce strategies
BiC	Joint	• Ensure financial stewardship
		Monitoring
BiC	Joint	• Receive reports from the quality, strategy and transformation and finance committees
BiC	Joint	• Monitor performance and ensure corrective action is undertaken
BiC	Joint	• Ensure high standards of corporate and clinical governance are maintained
		Communications
BiC	Joint	• Approve critical external communications
BiC	Joint	• Maintain dialogue with external bodies and local population

Table 20: Decisions delegated to health commissioning committee

Forum	Duty	Decisions delegated to Health Commissioning committee
Commissioning	CCCG	• Resource allocation and priority setting
Commissioning	CCCG	• Annual commissioning plan

Commissioning	CCCG	• Approval of contracts and commissioning agreements (including primary care)
Commissioning	CCCG	• Managing and developing the supply chain for services provided across Croydon

Table 21: Decisions delegated to the One Croydon Alliance Board

Forum	Duty	Decisions delegated to the One Croydon Alliance Board
Alliance	CCCG	• Defining population needs
Alliance	CCCG	• Strategic planning across the Croydon system
Alliance	CCCG	• Engagement and consultation on service change proposals
Alliance	CCCG	• Plans for addressing health inequality
Alliance	CCCG	• Integrating the provision of services across the system
Alliance	CCCG	• *Provide assurance on commissioning decisions and other areas where there are potential conflicts of interest – Performed by Alliance or other body, such as SW London STP*

7.3.3 Decisions delegated from the Committees in Common

Table 22: Decisions delegated to Quality and Governance Committee

Forum	Duty	Decisions delegated to Quality and Governance Committee
Q+G	Joint	• Provide assurance to the Committees in Common on all aspects of quality
Q+G	CCCG	• Development of outputs, outcome measures and monitoring quality
Q+G	Joint	• Develop clinical procedures, policies, guidelines and lines of accountability
Q+G	Joint	• Monitor and ensure the continuous improvement of quality
Q+G	CHS	• Produce annual quality accounts
Q+G	Joint	• Engage with the Croydon population and patients on issues relating to quality

Table 23: Decisions delegated to Finance Committee

Forum	Duty	Decisions delegated to Finance Committee
Finance	Joint	• Monitor and scrutinise finances
Finance	Joint	• Establish and maintain clear financial reporting
Finance	Joint	• Consider large business cases for revenue investment
Finance	Joint	• Ensure the sustainability of the CCG and Trust
Finance	Joint	• Carry out financial planning and produce financial plan
Finance	Joint	• Planning and implementation of cost improvement schemes

Table 24: Decisions delegated to Strategy and Transformation Committee

Forum	Duty	Decisions delegated to Strategy and Transformation Committee
S&T	CCCG	• Defining population needs
S&T	CHS	• Capacity management across Croydon
S&T	CCCG	• Demand management across Croydon
S&T	Joint	• Develop strategic and transformation plan
S&T	Joint	• Address health inequality and meet the needs of the population and patients in Croydon
S&T	Joint	• Care redesign
S&T	Joint	• Develop business cases, strategic outline cases, OD, estate and workforce strategies