Internal WCCG structure

1. Background

This paper provides commentary on the attached 'high-level structure 2012.13' which aims to establish functions, and form (i.e. people) by April 2012 (subject to NHS SWL HR process). The attached sets out the high-level WCCG internal structure by function, including senior level posts.

MT and CCGC colleagues have previously endorsed the approach for WCCG to deliver a broad range of internal functions, with the Commissioning Support Organisation delivering those functions that require collegiate action, or are specialised.

A Task & Finish group have discussed at length how the internal functions could be structured, and how the form should be established to support this.

At the outset, it is critical to note that any structure will only be operationally effective if people understand the importance of working in a 'matrix' approach and to contribute to the CCG as a collective.

2. Context

The proposal will need to be approved by the CCG Committee on 11th January to fit with national timescales. The structure on the 'form' has initially been drafted and will be shared with staff as part of a consultation process (circa early Feb) in line with NHS SWL procedure.

As a reminder, the overall commissioning functions of WCCG have to be delivered within £25 per head, circa £7.5million. This includes those functions executed on behalf of WCCG by the Commissioning Support Organisation.

Indicatively the CSO will deliver functions currently provided by NHS SWL, within circa £10 per head. The internal WCCG form is currently drafted at £15 per head (circa £4.7mn).

Exclusions – this paper does not include the structure of the Joint Commissioning Unit with the Local Authority or Continuing Care. However, explicit governance arrangements will be established with the LA in respect of the JCU. At all times, as the accountable body, the CCG will maintain the lead on strategic commissioning and will work in partnership via the Health & Well-being Partnership to facilitate health and social improvements.

3. Mandatory posts

There are three nationally mandated posts, those of:

- Chair of the Governing Body (locally described as Executive Clinical Chair)
- Accountable Officer (locally described as Chief Operating Officer)
- Chief Financial Officer (ring-fenced for PCT Directors of Finance).

CCG's will have to nominate candidates for the NHS Commissioning Board to formally ratify and appoint. There will be an assessment centre approach for these posts in the new year. It is expected that the Clinical Chair will be nominated/elected via GP's in the first instance.

The Executive Clinical Chair, as Chair of the Board will have responsibility for the mandatory posts of two lay members and a doctor and nurse member. As a GP, they will also line manage the three Locality Clinical Leads, with a responsibility of service re-design (via Clinical Reference Groups) and locality performance.

4. CCG structure

In transforming the health and well-being of Wandsworth residents, the CCG will:

- require assurance that its commissioned services are delivering agreed activity, performance, and within budget, i.e. assurance
- work with partners on a range of service improvement initiatives, i.e. delivery.

For ease of reference, these are deemed as 'internal assurance' and 'external delivery'.

Given the nature of responsibility for each of these domains, two posts, Director of Integrated Governance and Director of Planning & Delivery will be created. These posts will report into the Chief Operating Officer who will maintain an overview of all internal and external functions.

5. Internal assurance

As agreed at MT on 21st December, an 'Integrated Governance' function will be created that will:

- develop a sub-committee of the Board to receive information on:
    - **Clinical Governance**. Quality and patient safety (from Clinical Quality Review Groups) and to create a learning / outcomes improvement approach.
    - **Business Management**. Integrated Reporting – combining the reporting of finance and performance to reflect a holistic approach to commissioned services. This will include working with the NHS Commissioning Board on information required as the body the CCG is accountable to.

The purpose of this is to capture information (inputs of the CCG) at the right time, at the right place, and to ensure the CCG Board has the relevant information needed. To facilitate this, a Board Secretary post will be created to work closely with the Executive Clinical Chair.

5.1 Performance, QIPP and Quality Outcomes

Each of these functions primary purpose is to use information to bring about performance improvements. QIPP is a function that could sit anywhere within the CCG however it is felt that by sitting separate to the delivery function, they could present a degree of challenge and objectivity to enhance performance.

Quality Outcomes would be delivered through a more robust emphasis on the Quality letter of QIPP. This advocates that the CCG will not only 'make sense' out of all its information, but will actively seek to improve the quality of services it commissions.

5.2 Medicines Management

As per MT discussion on 14th December, MM will be delivered as an internal CCG function. For reporting purposes, it will be via the Director of Integrated Governance given its compliance and performance nature.

5.3 Safeguarding

As a statutory function of the CCG, this function sits with internal assurance (i.e. Integrated Governance). Professional accountability will sit with the Executive Clinical Chair, although operational management via the Director of IG.

6. External delivery

The Director of Planning & Delivery will, in addition to managing the functions outlined below, ensure the CSO are delivering against agreed contractual arrangements.

6.1 Policy, Planning & Projects

Central to improving the health of the population is in having a dedicated service re-design team. This was approved at MT on 21st December. This will strengthen re-design with Clinical Reference Groups, led by an appointed clinician to work with commissioning leads on actions against an agreed Project Plan.

This function will assume the responsibility of planning, given this teams understanding of progress against the Operating Plan.

6.2 Localities & Primary Care

Via a clear Standard Operating Protocol, delegated responsibility to the Localities of key commissioning functions will be established. For example, the devolvement for reviewing, contracting and monitoring of the LES budgets.

As a membership organisation the CCG will need to ensure the engagement of every practice in contributing to, and actively improving the performance of commissioned services. Localities have a pivotal role in this and this will be strengthened.

6.3 Patient Experience

Alongside a dedicated team, the key to improving patient experience is in embedding the approach to PPI at all levels within the Localities, and Policy, Planning & Projects teams.

7. Recommendations for MT

MT are asked to approve the attached high-level structure, noting the justification and commentary provided in this paper. Subject to CCG Committee approval in January, NHS SWL will continue to work on an appropriate HR process to enable the structure and people to be in position by April 2012. This will allow for a six-month 'full shadow' period so that WCCG can make its application for authorisation from October 2012 in time to become a statutory body by April 2013.

MT should be confident that the functions can be delivered within the proposed structure, and in turn, within the £15 per head (with the CSO functions subsuming the remaining £10).