London Health and Care Devolution

Integration

Technical pack

December 2017

Contents

The need to ensure better integration of service delivery across health and care has been recognised nationally and within London

National

Integrated Care Pioneers (2013) – local areas developing joined up approaches to health and care.

BCF (2013) – required all HWBBs to have a pooled budget and joint working between health and local government.

The **Five Year Forward View (FYFV)** (October 2014): "increasingly we need to manage systems – networks of care – not just organisations…services need to be integrated around the patient."

In 2015, 50 vanguards were established to test and develop the **New Care Models** set out in the FYFV.

Sustainability and transformation partnerships (STPs) were announced in NHS planning guidance. These required CCGs, local authorities and providers to jointly create a plan for their local health economy.

London

In March 2015, the London partners signed **Better Health for London: Next Steps**, which set out a series of shared aspirations across health and care and actions to deliver them.

In December 2015, the London Partners signed the **London Health and Care Collaboration Agreement**. Central government and national bodies backed this vision through the **London Health Devolution Agreement**, which referenced London's integration ambition:

"the city…will lead the way to become one of England's first large urban areas to deliver integration of services and transformation at scale and pace."

Within the devolution pilot areas, local partners (including local authorities, CCGs, and providers of health and care services) have worked collaboratively to accelerate the progress of transformation within existing powers.

All London **STP plans** acknowledged the need for further integration of services and a focus on person-centred care.

HWBB: Health and wellbeing boards; BCF: Better Care Fund

More integrated and person-centred models of care are being developed across London at all spatial levels

Localities

Many local, multi-borough and sub-regional plans are built on 'localities'. The 'locality' may simply describe a population defined by geography. In some cases, local areas prefer this population to be supported by a tailored delivery system.

For example, Barking & Dagenham, Havering and Redbridge describe populations of 50,000-70,000 with a capitated budget within each borough.

Boroughs

Local authorities, CCGs, and providers of health and care services have increasingly engaged in joined up working to accelerate integration within existing powers. Some areas, such as Hackney, Lewisham, Croydon and Kingston are developing joint governance arrangements or pooled budgets.

Multi-borough

Some areas are developing models of care delivery that respond to local needs, under the umbrella of consistent standards, and an integrated system managing system-wide risk. This can be seen in BHR, where care models would be reinforced by a strong digital platform, responsive system-wide intelligence and innovation units, shared corporate functions and co-located estates.

Sub-regional

All London draft STP plans acknowledged the need for further integration of services and a focus on person-centred care.

Some STP areas, for example North West London, describe care pathways that are tailored to groups of citizens with similar needs e.g. mostly healthy adults; older people; those at the end of life.

Regional

In London, the Health and Care Integration Collaborative was conceived to share and spread learning. This will now be taken forward by the London Health and Care Strategic Partnership Board.

Integration has been an explicit area of focus for devolution, with commitments expected to support governance, commissioning, funding flows, regulation and workforce.

Devolution aims to accelerate the delivery of ambitious health and care integration

- Within the London Health Devolution Agreement and London Health and Care Collaboration Agreement, a number of themes emerged as **enablers to support health and care integration**. The devolution pilots subsequently worked through the barriers to achieving local and sub-regional ambitions, as part of their early analysis and the integration section of the London MoU was co-developed through an iterative process between pilots, London and national partners.
- This work identified the **four themes below as key devolution opportunities to support commissioners and providers to move at pace to design and implement new models of care and to enable local health and care integration**.
- Many of the devolution ambitions around integration are aligned with the work of the New Care Models Programme and pilots have benefited from key learning from the vanguards. Pilot work on integration has surfaced similar challenges to these experienced by CCGs working across borough boundaries or as health and care systems come together in Vanguards and STPs. Devolution work therefore inscribes itself in the overall direction of travel to support health and care integration.

Regulation

Regulation is one of the key ways in which the quality and safety of the services being provided can be assured. However, the current system is based on each provider of health services being regulated (and each commissioner being 'assured') on an individual basis, against national standards. This traditional model of provider-based regulation does not directly support the more advanced integration models being developed.

Commissioning Levers and Financial Flows

The current structure of commissioning and the associated financial flows do not incentivise or enable more ambitious integration of health and social care. Funding flows are largely determined on an individual service basis. This means that it is difficult to shift funding between services to address locally specific needs or to prioritise prevention initiatives, rather than acute service provision. London partners see opportunities to commission services with a whole system outlook, with the overall aim of improving outcomes. Although there is much that can be done to develop integrated systems by flexing the current system, faster and more ambitious transformation would be enabled by the devolution of key funding streams and changes to the commissioning and financial frameworks.

Workforce

In order to enable London's integration aims to move forward, the shape and skills of the workforce needs to evolve to support a more person-centred model. This will involve solving the current challenges pertaining to staff retention and turnover. Devolution gives the opportunity for action to be taken at London and local level to facilitate health and care workforce collaboration and integration and secure much needed talent to deliver health and care services to Londoners.

Governance

A more integrated system will require governance mechanisms to enable collaborative working and joined-up decision-making at every spatial level.

Regulation

Whilst regulation cannot be formally ‘devolved’, there is an opportunity to support integration through the regulatory model

- Provider regulation, and commissioner accountability remained unchanged by the legislative changes introduced via the Cites and Local Government Devolution Act 2016. There is very limited scope for the devolution of national regulatory functions, as those held by national bodies (such as NHS England, the CQC, and NHS Improvement) are not available for transfer to a combined or local authority.

- London’s devolution pilots have been exploring how the regulatory landscape can be enhanced, so as to ensure that the integration aspirations within London can be realised. This work has focused on two key areas of opportunity:

1. **An aligned approach to regulation, assurance and oversight at national and regional level.**

2. **Supporting integrated working through a system-based and supportive model of regulation and oversight.**

1

The current landscape is complex given that most health and care organisations are held accountable by multiple bodies

Regulation, oversight and assurance are processes by which those responsible for commissioning and providing health and care services are held accountable for performing their functions to the benefit of the service users. Regulation puts in place a set of standards against which a group of organisations will be assessed. Publicity of these standards enables the public to understand what they should be able to expect from those services. Transparency around assessments then also enables the public to take informed decisions as to their care and treatment.

Regulatory body or party	Regulatory and oversight activity category				
	Performance objectives and standards	Financial	Place-based management / enabling	Assurance	Failure mitigation
NHS England	✓	✓	✓	✓	✓
NHS Improvement	✓	✓	✓	✓	✓
Care Quality Commission	✓	X	X	✓	✓

Regulatory body or party	Regulated body				
	NHS Trust	NHS Foundation Trust	Other providers (e.g. GPs, private providers)	Local authorities	CCGs
NHS England	✓ (for providers of specialised services and other directly commissioned NHS England services)	✓ (for providers of specialised services and other directly commissioned NHS England services)	✓ (for providers of specialised services and other directly commissioned NHS England services)	X	✓
NHS Improvement	✓	✓	✓ (for providers of NHS funded care)	✓ (for providers of NHS funded care)	X
Care Quality Commission	✓	✓	✓	✓	X

1

A more joined up model could enable integration to move further and faster

It is recognised that CQC, NHS England and NHS Improvement each has its own remit and statutory duties which must necessarily be fulfilled. However, health and care organisations have reported frustrations with multiple mechanisms of regulation and oversight. Given the differences between the frameworks of CQC, NHS Improvement and NHS England, London's devolution pilots have recognised the following opportunities:

- Differing frameworks can impose reporting requirements which are duplicative. **There is an opportunity to reduce the administrative burden on providers by way of greater alignment of reporting requirements and sharing of data**.

- Different frameworks can cause conflicting advice. **There is scope for further formal coordination to address the risks of inconsistent requirements/advice**.

  "The regulatory system is complex and imposes a burden on all of our organisations. The frameworks developed by various bodies impose additional and sometimes contradictory reporting requirements; it is a struggle to drive whole system improvement through often disjointed regulatory recommendations." [1]

- Different organisations are subject to different frameworks, and different elements of the patient pathway are often inspected separately and at different times, which does not directly encourage a joined-up approach to solving system-wide issues. **There are further opportunities to coordinate the different processes to enable clearer identification and targeting of system-wide issues**.

  "A regulatory approach that crosses organisational boundaries and ensures linkage between what the respective regulators are assessing would support the objectives of integration. This would allow regulators to join up and present an aligned approach to address issues which span a number of organisations." [2]

[1] Source: BHR Devolution Pilot Business Case, pg. 35
[2] Source: Hackney Devolution Pilot Business Case, pg. 45

1

The need for greater alignment between regulators has been recognised at a national level

- The need for cooperation is recognised in legislation: The Health and Social Care Act 2012 (section 288) provided Monitor with a duty to co-operate with CQC.

- Collaboration between CQC and NHS England: CQC and NHS England signed a partnership agreement in 2013 with a key focus being to set the tone for joint working at both national and local level.[1]

- Greater alignment between NHS Improvement and CQC: The NHS Improvement Single Oversight Framework (SOF)[2] replaces both Monitor's risk assessment framework and the TDA's accountability framework with a SOF, which applies to both NHS Trusts and NHS Foundation Trusts. Going forward, NHS Improvement will focus their support on five oversight themes which are linked to CQC's key questions/domains. By focussing on these five themes, NHS Improvement aims to simultaneously support providers to attain/maintain a CQC 'good' or 'outstanding' rating. There is joint NHSI and CQC commitment to co-developing an approach to assessing financial and resource management and developing a shared system-view of what constitutes good governance and leadership and to build on the current NHSI and CQC Well-Led Framework.

- A 'one stop shop' for Accountable Care Systems: 'Next Steps on the Five Year Forward View' explained the intention for Accountable Care Systems to benefit from "*a single 'one stop shop' regulatory relationship with NHS England and NHS Improvement in the form of streamlined oversight arrangements.[3]"*

[1]Sour:ce Agreement between CQC and NHSE, 2013
[2] Source: NHS Improvement Single Oversight Framework, September 2016
[3] Source: NHS England, Next Steps on the Five Year Forward View

1

There are further opportunities to join up processes at regional level to enable London to achieve its transformation goals

- London is on a journey to greater transformation, and the vision of enabling much stronger collaborative working between London and national partners is reflected in the wider objectives of devolution.

- Steps towards alignment have begun to materialise at a regional level. In August 2016 **NHS England and NHS Improvement appointed a joint regional chief nurse for London**. The new appointee will discharge the regulatory and statutory functions for which both organisations are accountable. The appointee reports to the London NHS England and NHS Improvement regional directors who has described the development as "*a significant development in the collaborative working arrangements now in place between NHS England and NHS Improvement, and a chance to strengthen the joint working and quality agendas across the NHS*."[1]

- However, more focused alignment of regulators at a London level is still desired to:

    - Reduce siloed working, and ensure consistency of advice and guidance across the system;
    - Reduce the administrative burden on local organisations by aligning regulatory actions and timelines for reporting wherever possible; and
    - Enable regulators to take a joined up and targeted approach to addressing key issues within the system.

[1] Source: NHS England press release, August 2016

2

The traditional model of regulating/assuring individual units could also be built on to further support person-centred models of care

The current framework can sometimes disincentivise a place-based approach as different stakeholders are focused around different priorities:

- **Individual organisations** are required to demonstrate their compliance with relevant standards, rather than how they are enabling a more holistic approach to health and care. Furthermore, the current approach to regulation encourages activity through the acute sector rather than providing care in the most appropriate setting or more proactively. The practical impact of these issues is demonstrated in the lack of truly integrated care for older adults and the impact this has on the acute sector (in terms of 'bed blocking' and inappropriate use of acute resources) and, more widely, on the care sector. It has been reported that bed-blocking has risen more than 40 per cent within the last year, and "*days lost to delayed transfers of care*" totalled 193,680 in November 2016[1]. A refreshed regulatory model could incentivise providers to focus more widely on the impact they have on the patient's entire pathway of care as part of a wider 'system' of care delivery.

- The **focus of regulators** is similarly on issues within the control of single organisations. Issues involving multiple organisations (e.g. blockages to discharge from acute services due to issues in community services/primary care) can be attributed to capacity constraints outside of the control of the organisation, without this being fully tested and explored. Furthermore, under-performance by an organisation is primarily seen as an issue for that individual organisation to address. Measures to improve performance are similarly narrowly-focused, with a view to addressing the organisation-specific issues. This discourages a more holistic approach and reduces the ability of organisations to engage with more transformative proposals, particularly where participation would involve a degree of risk (whether financial, regulatory or other). Where something has gone wrong, regulation needs to acknowledge the potential for wider system contribution, and the ability of other organisations in the system to help diagnose and address the issues.

  "We are also keen to move to a regulation model which measures these system impacts rather than individual provider performance…Current regulatory frameworks can mean that there is a lack of formal coordination across health and social care with different elements of patient pathways being inspected separately and at different times…This can mean that issues involving multiple organisations (e.g. delayed discharge or pan organisation pathways) are not fully tested /or explored."[2]

- Assessment of **patient perspectives** focuses on their satisfaction with the services provided by a single organisation, rather than considering whether the care they received was appropriate in a wider system context (e.g. even if the care they received at A&E was otherwise excellent, from a system perspective they may not have needed to be seen at A&E). There is a need to improve information about the quality of care that specific populations experience as they move between services and organisations.

[1] Source: NHS England figures, January 2017
[2] Source: Hackney Devolution Pilot Business Case, pg. 45

2

The national policy direction has began to support a more system-based approach to regulation

	CQC	NHS Improvement	NHS England
2016	Through the "**Quality of Care in a Place**" pilot schemes (Tameside September 2015, Lincolnshire February 2016, Salford May 2016), CQC has explored how it could look at the provision of care across a locality.[1]	CQC, NHS Improvement and NHS England have been working together to support the New Care Models programme. Regulators announced that they were keen "*to ensure regulation is not an unnecessary barrier to innovation … CQC, along with our system partners, will support services to innovate, collaborate and improve. In particular, we will* ***work closely with vanguard providers, STP footprint leads and our system partners across health and social care and are committed, where possible, to addressing any regulatory obstacles that may stifle progress***." [2] The NHS Improvement Single Oversight Framework applies to both NHS trusts and NHS foundation trusts, thereby **aligning the processes for regulating different providers** [3]**.**	
2017	In May 2016, CQC published their 'Shaping the Future' strategy outlining their ambitious vision to adopt a more targeted, responsive and collaborative approach to regulation. [4] To inform the development of this collaborative model of regulation, the CQC launched an initial consultation in December 2016 – *'Our next phase of regulation'* [5] that outlined principles to support the regulation of new care models (NCMs) and complex providers, and changes to the assessment frameworks for health and social care and to how services for people with a learning disability are registered. In June 2017, the CQC published *'Our next phase of regulation'* [5] a second consultation that outlined their proposals in relation to: Structure of registration; new and complex providers; provider-level assessment and rating; **Quality of care in a place;** Regulation of primary medical services; regulation of adult social care services; and fit and proper persons requirement.	In February 2017, NHS Improvement published an updated FAQs [6] document that **outlined their approach to the oversight of new care models** including issues relating to competition, governance, payments and organisational form	In response to the NHS England Review Of Uniting Care Contract Collapse, NHSE and NHSI initially launched the Integrated Support and Assurance Process (ISAP) in November 2016 to **support the procurement of New Care Models**. The ISAP is an **integrated assurance model** based on existing processes such as NHSI Transaction review and does not replace existing statutory regulatory functions. In August 2017, the New Care Models programme – in collaboration with NHS England and NHS Improvement – published the **ACO contract package**. As part of that package, an **updated three-part ISAP guidance document**[7] **was also published** providing **additional detail about the process and how it would be applied**. The document describes the factors that determine when the ISAP is likely to apply including **contract value and duration**.

[1] Source: CQC 'Quality of Care in a Place', Sept 2015 – May 2016
[2] Source: CQC Statement of Intent, July 2016
[3] Source: NHS Improvement Single Oversight Framework, September 2016
[4] Source: CQC 'Shaping the Future' strategy
[5] Source: CQC 'Our next phase of regulation' consultation, September 2017
[6] Source: NHS Improvement FAQs
[7] Source: Integrated Support and Assurance Process, November 2016

2

This approach could enable local health and care partners to take shared accountability for system wide transformation

"Regulation is currently based on a model whereby each organisation providing health and wellbeing services is subject to an individual regulatory assessment and regime…Within our own organisations, leadership is accountable for different parts of the system rather than the overall system challenge. Devolution provides the opportunity to govern and regulate on a whole system basis…" [2]

While it is recognised that regulation cannot be devolved[1], the development of more integrated health and care models impacts the current system of regulation, oversight and assurance in a number of ways, for example:

- The national model for integrated care systems (ICSs) involves more local monitoring of quality and performance and a role for the ICS in holding sub-systems or 'places' to account and take action to improve performance.
- Whilst regulators will continue to have a duty to regulate each service provider, integrated care models require a more-system based approach to regulation with the integrated organisation or partnership working with regulators in order to fulfil their management roles.

[1] See page 7 for detail
[2] Source: BHR Devolution Pilot Business Case, pg. 35

2

Freedoms and flexibilities will also be required in the initial stages of transformation

- There will be a transition period required when integrated approaches are being tested and implemented. It is recognised that implementation may have a perceived destabilising impact in the short-term.
- The details of the freedoms and flexibilities required will be understood with greater specificity as the integrated care models develop. The detail will need to be co-developed with NHS Improvement, CQC and NHS England, to ensure a robust framework is developed that ensures financial, organisational and clinical risk is kept within acceptable tolerances.
- A supportive and permissive approach from national regulatory bodies will also ensure that new models have the headspace required to development and implement proposals, and build local partnership arrangements.
- Phasing may also be used to support gradual implementation, in line with agreed assurance check-points.
- Any freedoms and flexibilities would need to ensure delivery of agreed core responsibilities (including the NHS Constitution and Mandate) and that risk is kept within acceptable tolerance.

The **devolution pilot business cases** note the need for further collaboration between local and national partners to flesh out the detail of an approach which sufficiently enables the necessary flexibilities:

- *"We will work together with national partners to develop a system model that meets choice and competition requirements; and explore whether additional regulatory flexibilities are required to help overcome disincentives for prevention and place-based care."* [1]
- The Hackney pilot requests *"commitment by NHS England, NHS Improvement and CQC to explore new ways of inspecting and regulating health and social care. This would focus on developing a model that means regulation is flexible and responsive enough to adapt with the sectors as they change."* [2]

[1] Source: BHR Devolution Pilot Business Case, pg. 36
[2] Source: Hackney Devolution Pilot Business Case, pg. 45

Through the MoU, London and national partners have committed to ensure that regulation supports transformation

	1	2
Identified need	Take an aligned approach to regulation, assurance and oversight at national and regional level.	Support integrated working through a system-based and supportive model of regulation and oversight.
MoU commitment	Regulators have committed to taking a more aligned approach, with joined up processes at regional level, including alignment of regulatory actions and timelines for reporting wherever possible.	NHS England, NHS Improvement and CQC have committed to work with London to develop, support and resource a regulation and oversight model that meets the needs of the London system (to include appropriate freedoms and flexibilities during the development stage).
	This aims to enable: • Consistency of advice and guidance across the system • A joined up and targeted approach to issues • A reduction in the administrative burden on local organisations.	A new regulation and oversight model would include: • The ability for an integrated/single delivery system to be regulated as a whole, alongside the underlying distinct organisational operating units; • Supporting the development of lead accountable providers who can be accountable for quality and productivity across individual units; and • Bringing together (as far as possible) the oversight of CCGs and the oversight of providers into a single shared framework. A system-based approach to regulation and assurance will support integrated care models and enable shared leadership and accountability for care pathways and system challenges.

Commissioning levers and financial flows

London has worked with national partners to explore barriers to more integrated commissioning arrangements

Pilot exploration of challenges

- The **Hackney pilot** explains in their business case their interest in more joined up working:

  "Ultimately we want to join up local public services with closer planning, working and decision making across the Local Authority and the CCG and ensure integration across our providers. Only with this delivery architecture in place can we tackle the problems we face and make the biggest impact for our residents. We need devolution to help us go further and faster."

  "Integrated commissioning will also help facilitate the development of new delivery arrangements and models across the local provider landscape, the rapid integration of services, generate savings through increased efficiencies and a reduction in transaction costs and support the emergence of an accountable care system which may, subject to compliance with legislation, ultimately take greater responsibility for the health of the population."

- The business case also explains the issues arising from the current framework:

  "Whilst we can use current legislation to support joint commissioning there are limitations in what we can do and how flexible our governance structure can be to allow full partnership working and the level of joint commitment we aspire to.[1]*"*

Legislative framework governing joint or lead commissioning arrangements

- The National Health Service Act 2006 (as amended by the Cities and Local Government Devolution Act 2016) enables CCGs to exercise their commissioning functions jointly with combined authorities, by way of a 'joint committee'. However, the relevant statutory definitions exclude London local authorities. Outside London, it is notable that the provision still does not contain the necessary flexibilities to enable joint working at all spatial levels. The provision also only applies to CCG functions (not the functions of local authorities).
- CCGs and local authorities currently have some ability to work together under the National Health Service Act 2006 and the Local Authority Partnership Arrangements Regulations 2000 ("the s.75 Regulations"). However, these permissions are limited because:
  - Certain services are excluded from the scope of the s.75 Regulations (for instance surgery, radiotherapy and other invasive procedures); and
  - The ability for CCGs and local authorities to form joint committees in relation to functions that are commissioned under the s.75 Regulations is restricted to the formation of a "management" joint committee. This would not normally be interpreted to enable decision-making joint committees and so requires the use of work-around solutions to enable decision-making.

[1] Source: Hackney Devolution Pilot Business Case, pg. 31

NHS England permits local areas to commission primary care

Primary care commissioning

In 2014/15, NHS England invited CCGs to take on greater responsibility for general practice commissioning through one of three models:

- **Greater involvement** – an invitation to CCGs to work more closely with their local NHS England teams in decisions about primary care services.
- **Joint commissioning** – enables one or more CCGs to jointly commission general practice services with NHS England through a joint committee.
- **Delegated commissioning** –an opportunity for CCGs to take on full responsibility for the commissioning of general practice services. Delegated primary care commissioning would be exercised by:
    - A single CCG,
    - A joint committee of CCGs (see above), or
    - Committees in common (where CCGs have fully delegated responsibilities).

Co-commissioning enables primary care to be commissioned in a way that is more integrated and locally focused. However, 'double delegation' means that CCGs can only commission primary care jointly if NHS England remains at the table.

The Primary Care Strategic Commissioning Framework sets out a vision for general practice in London and an overview of the considerations required to achieve it. The document explains that:

"NHS England (London), CCGs and local authorities recognise that the vision in this Framework will require significant collaboration across all parts of the commissioning system and that co-commissioning will be a key enabler. The NHS Five Year Forward View set out the aim to allow CCGs more control over NHS budgets, with the objective of supporting more investment in primary care. All CCGs in London will become more involved in the commissioning of primary care services in 2015/16."[1]

Terminology

'Double-delegation'

Double-delegation' is a principle of law which means that an entity exercising a delegated power cannot further delegate that power (i.e. functions cannot be delegated externally* more than once). Under delegated arrangements the delegator will always retain ultimate accountability for the function**, and enabling further delegation would result in the accountable party losing the necessary oversight.

**This principle would not apply to internal 'synthetic' delegations as the organisation will remain the accountable person for legal purposes.*

*** This can be distinguished from devolution, where the function transfers in its entirety.*

'Joint committee'

The term 'joint committee' is used to refer to decision-making committees provided for by legislation. Section 13z of the NHS Act 2006 enables CCGs and NHS England to form a joint committee to exercise primary care functions.

'Committees in common'

Under a 'committees in common approach', each organisation would create a committee, who meet 'in common' for the purposes of discussion, but then take decisions only on behalf of their employing organisation.

All London CCGs are now operating fully delegated primary care commissioning.

[1] Source: Transforming Primary Care in London: A Strategic Commissioning Framework

Commissioning specialised services at a more local level could enable more integrated and locally tailored care

- Specialised services are those which are provided in relatively few hospitals and accessed by comparatively small numbers of patients. NHS England is responsible for commissioning £15.6 billion of specialised services, including renal dialysis and secure inpatient mental health services, treatments for rare cancers and life threatening genetic disorders.
- Certain specialised services could benefit from more local commissioning, to enable better linkages with local health and social care/community services. However, specialised services, by their nature, will not be exercised in all local areas and there spatial level must be carefully considered. Any delegations would likely exclude highly specialised services.
- NHS England has stated that:

  "The transition to place and population based commissioning is challenging. Services are contracted directly by NHS England on a provider basis rather than population footprint, and the portfolio of 149 services is highly diverse in terms of both patient numbers and provider landscapes.

  Many services in the portfolio will need to be commissioned at a national or regional level. However, many would benefit from being planned on an STP or multi-STP footprint. For those services identified as potentially benefiting from being commissioned on an STP or multiple-STP footprint we are inviting STP leaders to explore how NHS England and STP partners can more formally collaborate on the commissioning of those services."[1]

Work ongoing in London

London established a Specialised Commissioning Planning Board in 2016 as a forum to discuss strategic and sustainability issues related to specialised services in London. The group enables pan-London discussions and wider conversations with neighbouring regions. The meetings bring together representatives of the five London STPs with NHS England (including senior representatives of the South and the Midlands and East of England Specialised Commissioning teams). Key providers (single specialty, and representatives of the 'Tier 1' providers) are also invited.

Learning from Greater Manchester (GM) [2]

As part of the devolution arrangements which went live on 1 April 2016, the GM Health and Social Care Partnership took delegated responsibility for a suite of commissioned services previously directly commissioned by NHS England. These services have a total annual spend in excess of ~£850m and include ~£500m of "Tier 1" specialised services including services such as renal dialysis, cardiac surgery, chemotherapy and cancer surgery.

These services continue to be commissioned by NHS England, but decisions about service changes, finances, and quality and performance are delegated internally to the Chief Officer of GM Health and Social Care. Services must meet national specifications and policies, however standards may be augmented in response to the local needs of the population.

[1] Source: NHS England's Commissioning Intentions for Prescribed Specialised Services 2017-19
[2] Source: GM Devo: Internal Delegation by NHS England to GM Chief Officer, 3 March 2016 and Strategic Partnership Board papers, 24 February 2017

Partners are also exploring how health and care can best commission and deliver immunisation and screening services

A number of organisations within the health and care system have responsibilities for public health commissioning and key functions continue to sit nationally.

Department of Health/Public Health England (PHE)

- The Secretary of State has overall responsibility for improving public health.
- PHE provides specialist public health advice to support the commissioning of NHS services. This includes producing evidence reviews, undertaking data analysis and interpretation and producing needs assessments.

NHS England

- Section 7A of the NHS Act 2006 enables the Secretary of State to arrange for a number of bodies to exercise his public health functions, including NHS England, a CCG or a local authority.
- Each year DH and NHS England produce an agreement which sets out the arrangements under which the Secretary of State delegates responsibility to NHS England for certain public health services (known as 'Section 7A services').[1]
- Section 7A also enables NHS England to then arrange for certain local organisations to exercise the functions in question. Within the London region, NHS England can only delegate s.7A public health functions to a CCG. The Cities and Local Government Devolution Act 2016 also enables delegation to a 'combined authority', however the legislation does not permit the establishment of combined authorities in London.
- Within Greater Manchester, section 7A public health functions are exercised at Greater Manchester level, by way of internal delegations within NHS England.

Local authorities

Statutory duties for public health were conferred on local authorities by the Health and Social Care Act 2012. Since 1 April 2013, local authorities have been responsible for improving the health of their local population and for public health services (including most sexual health services and services aimed at reducing drug and alcohol misuse).

[1] The agreement for the 2016/17 financial year can be found here: https://www.gov.uk/government/publications/public-health-commissioning-in-the-nhs-2016-to-2017

Delegating transformation funding to London level could enable partners to apply funding to best meet shared priorities

As part of the 2015 Spending Review settlement, NHS England were allocated **£2.1bn** to invest in a "Sustainability and Transformation Fund", to be spent over a five year period.

The 'transformation' element of the fund is intended to support the ongoing development of new models of care along with the investment identified to begin implementation of policy commitments in areas such as 7 day services, GP access, cancer, mental health and prevention.

Transformation funding has enabled a number of areas to begin to deliver on key ambitions, for example:

- A direct allocation of £450m has been made to Greater Manchester, representing their fair share of available transformation budgets over the five year period. Initial allocations were made to Stockport and Salford in July 2016, to provide patients with better access to GPs, pharmacies and community care, improve mental health services and reduce the length of time patients are needlessly spending in hospitals through the setting up of local Integrated Care Organisations.

- £101 million of funding was pledged to support and spread the work of the New Care Model vanguards. London vanguards include Royal Free (Acute Care Collaboration) and Tower Hamlets Together (Multispecialty Community Provider).

Sources:
- NHS England Board papers, 17 December 2015
- NHS England paper: Indicative 2020/21 STP funding including transformation
- Greater Manchester press release: 'GM makes £36 million funding commitment to improve health and social care', 19 July 2016

Separately, there is also an opportunity to develop and implement payment models that support integrated working

Payment models in the current system:

- Activity-based or 'block' payment models often do not facilitate integrated working; disincentivise system-wide collaboration; and have limited emphasis on prevention
- Providers are largely remunerated for delivering a service within their part of a care pathway ('outputs') rather than on the basis of outcomes for their population
- The existing models inhibit the effective management of risk within the system. An activity-based model has the potential to expose the commissioner to uncapped utilisation risk. A block model exposes a provider to utilisation risk where revenue is decoupled from fluctuations in activity
- The implementation of new payment models can be challenging where data quality, particularly in relation to cost, can be variable or insufficient

Potential future models:

- Integrated whole population budgets or capitated payments aim to better incentivise a 'whole population health management' approach with improved integration, collaboration and encouraging 'upstream' prevention. These payment models would require the ability to improve data quality and sharing between parties within the system and, in some cases, the pooling of budgets between different commissioners.
- Future payment models would aim to commission against outcomes, with payment contingent upon delivering outcomes that matter to people and improve their health and wellbeing
- These models would also aim to align incentives for all providers delivering the care model and ensure risks and rewards are managed more effectively and transparently.

Learning from devolution pilots and New Care Models:

- *"Contracts for services are based on activity rather than outcomes, creating artificial and perverse incentives which pay for services based on the number of people that they treat, as opposed to the experience and outcomes of those that receive them. By changing the way in which we commission and contract for services, and pooling the resources and expertise of commissioners and local authorities, we would be able to utilise greater budgetary flexibility to enable financial incentivisation and prioritisation that more accurately responds to local needs."* [1]

- *"Moving to outcomes-based commissioning and capitated payment models will help address some of the current issues and help shift focus to 'upstream' activities that promote health, wellbeing and staying well. As integration proposals develop, new payment models may also emerge to address specific local needs/arrangements and the focus on control totals and expenditure limits. What we would like to see around the development of new payment models are linked to those relating to governance (including greater ability for CCGs and local authorities to develop joint working) and the pooling of budgets, both of which are important in enabling truly capitated payment systems and joined up planning."* [2]

- National work is underway as part of New Care Models to develop greater flexibilities in relation to payment models[3].

[1] Source: BHR Devolution Pilot Business Case, pg. 35
[2] Source: Hackney Devolution Pilot Business Case, pg. 44
[3] Source: 'Whole population models of provision: Establishing integrated budgets', August 2017

The MoU aims to enable London to move faster and further with its integration efforts

Devolution or delegation of NHS England functions to within the London system, including:

- Delegation of primary care commissioning and consideration of what steps could be taken to devolve this function;
- Delegation of London's fair share of transformation funding;
- Collaboration to explore internal delegation of some specialised commissioning functions;
- Collaboration to explore how immunisation and screening services could best be organised going forward.

Supporting personalised, joined up care at all spatial levels and developing a shared understanding of any current barriers to joint or lead commissioning arrangements.

Support to co-develop and adopt **innovative payment models** at pace and scale.

- More joined-up pathways and services that focus on the individual rather than the service provider.
- A clear shift from siloed organisations and fragmented services to health and care systems that respond to local population needs.
- The rapid piloting and scaling of place- and outcomes-based commissioning and capitated payment models to enable pathways of care and incentivise early intervention and rapid discharge.
- A shift in investment towards community services.
- Commissioning with a whole-system outlook on the basis of shared priorities, agreed to address local needs and challenges, and improve outcomes for Londoners.
- More effective, joined up and accountable health economies, working at different spatial levels.
- More flexibility for local areas to commission by the route which best serves their population.
- Simplification of decision-making and commissioning processes, leading to greater transparency and lessening the need for more bureaucratic, siloed processes.

Workforce

The people that work in health and care are critical to achieving transformation goals

Borough

The **Lewisham pilot** has examined workforce as an enabler for integration:

> *"Lewisham Health and Care Partners are committed to working in new and different ways to deliver real benefits for our population. Devolution offers a significant opportunity to accelerate specific elements of our overall transformation plan and contribute to the delivery of our vision. In particular we welcome the commitments set out in the London Devolution MoU around estates and workforce, enabling us as devolution pilot to…**Develop a more flexible workforce to work and support residents in their own homes**. These roles need to be generic, bridge organisational differences and focused on outcomes."*[1]

London

On a wider scale, each STP contains a workforce plan and all **London STPs** have identified workforce transformation as a critical enabler of sustainability and transformation. For example, the North East London draft STP plan (which covers four of the London devolution pilot boroughs) explains that:

> *"Developing the existing workforce is **critical for the scale, pace and sustainability of the required transformation**. We envision our 'workforce of the future' will have the capability to fully support the new service models. For example, the **workforce should be able to work across integrated health and social care systems**."*[2]

National

New Care Models also recognise workforce as the bedrock of new delivery models. For example, the Multispecialty Community Provider (MCP) model explains:

> *"The **workforce component is critical to the delivery of the MCP model in each local system**. It takes time and effort to develop a new workforce culture, build skills and develop roles to **support multi-professional working between health and social care teams**.."*[3]

[1] Source: Lewisham Devolution Pilot Business Case, pg. 5
[2] Source: NEL STP Plan, pg. 28
[3] Source: NHS England MCP Framework

London has explored how it can best secure and maintain the workforce it needs

Aims

There is a recognised need for **joint health and care training and workforce development** to support integrated working.

London also needs to **address its challenges in respect of staff retention and turnover**.

Themes

To meet these aims, London has focused on three key themes:

1. **Funding and governance to support workforce transformation**
2. **Levers to enable new and extended roles in health and care.**
3. **Incentivising London's workforce to improve recruitment and retention.**

There are a number of organisations with an interest in workforce development in London

Health Education England (HEE) is responsible for the education and training of the healthcare workforce (including doctors, nurses, midwives, paramedics, physiotherapists). HEE's work covers a range of professions, programmes and activity, from planning and commissioning, to recruiting and developing healthcare staff in a range of healthcare and community settings.

Skills for Care provide practical tools and support to help adult social care organisations and individual employers in England recruit, develop and lead their workforce.

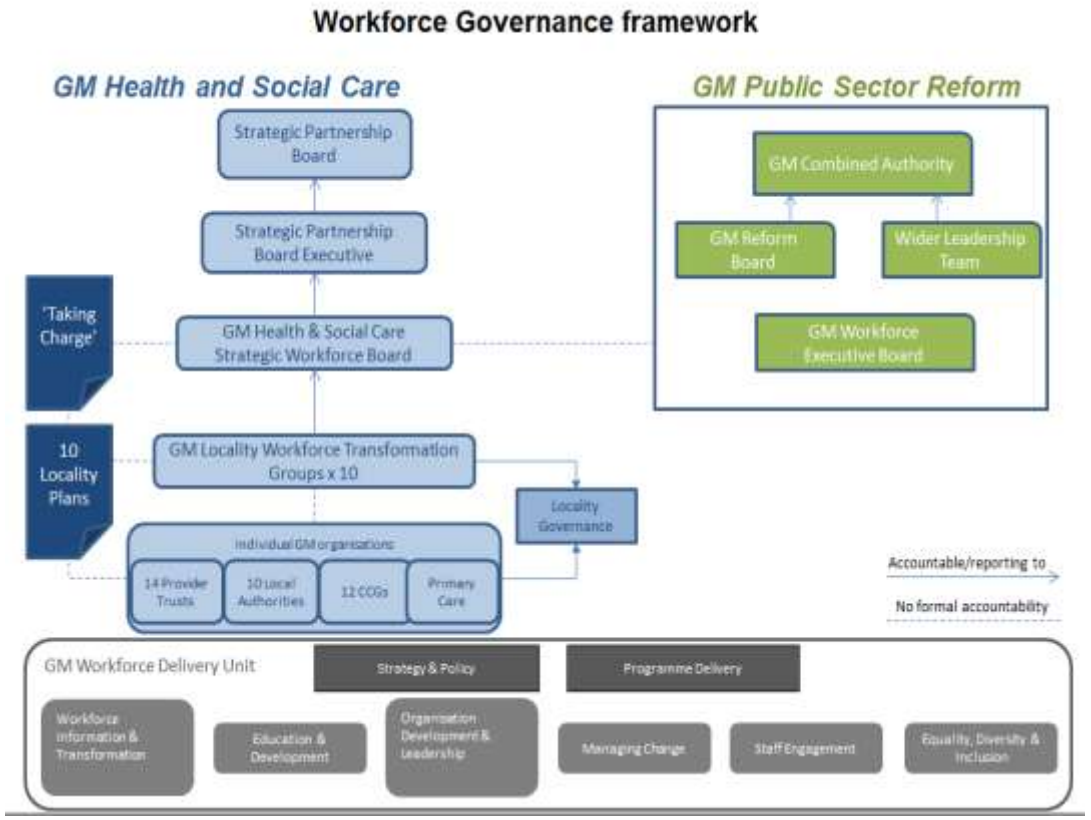
Skills for Health help to inform policy and standards focusing on health, education and improving wider wellbeing through public health. Skills for Health provide workforce and organisational development, designed to increase quality of healthcare, patient safety and productivity.

Other organisations with an interest in health and care workforce development in London include:

- Service providers and employers
- Health and care trade unions
- Academic institutions, including universities, AHSCs and AHSNs
- Association of Directors of Adult Social Services
- Association of Directors of Children's Services
- Department of Health
- Local Government Association
- London Councils
- Greater London Authority
- NHS England
- NHS Improvement
- CCGs

Greater Manchester has developed workforce governance to deliver its transformation agenda

- The Strategic Workforce Board in Greater Manchester (GM) is now established and reports to the GM Health and Care Strategic Partnership Board [1].
- It provides the governance structure to deliver the strategic workforce agenda through the creation of a GM workforce strategy.
- This Board will be responsible for operational oversight of specific workforce challenges within the system and will work with partners to facilitate appropriate solutions.
- The Board will be responsible for the delivery and oversight of the GM Memorandum of Understanding with Health Education England.
- The role of the Board includes activity that would normally be covered by an Local Workforce Action Board
- The Workforce Delivery Unit will develop the workforce elements of the GM strategic/implementation plans.



[1] Source: Greater Manchester Health And Social Care Strategic Partnership Board Paper, *"Enabling Better Care Transformation Programme: Workforce Workstream"*, 30 September 2016 and GM Presentation

1 In London, a new Workforce Board aims to build on existing collaborative working for issues that span health and care

London and the South East Local Education and Training Board (LETB)

- LETBs are statutory committees of the Health Education England Board. There are four in the country, one of which covers London and the South East.
- A LETB exercises HEE's statutory functions in relation to its geographical area.
- Amongst their functions, LETBs work to agree local priorities for education and training, inform national strategy and priorities, and advocate for local needs.
- LETBs play a crucial role in bringing together providers covering the whole local health economy to review and agree local workforce priorities and the quality of education and training, applying scrutiny to and approving local plans.
- Health service commissioners must ensure that providers cooperate with LETBs in planning and providing education and training for health care workers

In addition to the work of the LETB, some partners collaborate across organisations. Skills for Care and Skills for Health already have a history of collaboration and shared objectives. They have similar organisational and funding structures and each organisation has a regional director for London and the South East.

A number of issues are being considered by a multiple partners, and would benefit from further joined up thinking. For example, the role of 'Care Navigator' is being explored in the NHS, by Skills for Care, and in the voluntary sector. There are clear opportunities here to join up thinking to promote consistency, avoid duplication and share learning.

The London Workforce Board was formed in March 2017, and brings together health and care partners to consider workforce issues collectively.

1 Funding opportunities could be maximised to support London's ambitious workforce plans

The Apprenticeship Levy:

The apprenticeship levy was introduced on 6 April 2017 and requires the following employers operating in the UK to invest in apprenticeships:

- Those with a pay bill over £3 million each year;
- Those connected to other companies or charities for Employment Allowance, which in total have an annual pay bill of more than £3 million.

The levy is charged at 0.5% of the annual pay bill.

Employers who are not connected to another company or charity will have an allowance of £15,000 each year. Connected companies or charities will only have one £15,000 allowance to share between them. Public bodies each get a full allowance as they aren't considered to be connected companies.

Any unused allowance cannot be carried over into the next tax year.

Particularly given the time limit for usage, it is recognised that some employers will want to use funds in their account to pay for apprenticeship training undertaken by other employers (most likely, in the same chain of service provision). The Department for Education has stated that it is *"committed to allowing levy-paying employers to transfer up to 10% of the annual value of funds entering their accounts to other employers or apprenticeship training agencies in 2018. We have set up an employer working group to review."*[1]

HEE Transformation and Development Funding:

In 2016/17 the HEE Board set aside £35m in a "transformation fund". This fund was expended in support of a number of projects which focussed on strengthening the workforce in certain sections of the health and care system, including:

- End of life care,
- Dementia training,
- Adult mental health care,
- Learning disability training, and
- Paramedic training.[2]

London is allocated a share of this transformation and development funding.

- There are opportunities to use these funding sources in a more joined up way.
- This recognises that if the health and care workforce is increasingly working in a more an integrated way, this needs to be reflected in integrated training and development.

[1] Source: Department of Education guidance: 'Apprenticeship funding: how it will work,' 13 February 2017
[2] Source: HEE Finance Report, 19 July 2016

2

New care models will demand a more versatile and flexible workforce

Case Study: Lewisham has plans for hybrid roles for care at home

- Lewisham aims to "*develop a more flexible workforce to work and support residents in their own homes. These roles need to be generic, bridge organisational differences and focused on outcomes*".
- In Lewisham, four virtual multi-disciplinary teams of social care staff, district nurses and physio/occupational therapists ("Integrated Neighbourhood Community Teams") were recently introduced, to work across health and social care and improve multi-disciplinary working for those people with complex health and social care needs. There are approximately 200 staff working within these Neighbourhood Care Teams.
- The teams are organised on the neighbourhood footprint and funded by pooled budget arrangements. Alignment with the four GP federations enables greater information sharing and collaboration across the system.
- Taking inspiration from the Dutch Buurtzorg model, which has no distinction between nursing and domiciliary care roles, Lewisham aspires to develop the model for the neighbourhood community teams to encompass domiciliary care and community mental health, and to co-locate them in each neighbourhood, creating fully integrated teams.

Buurtzorg model: key facts

- Buurtzorg is a unique district nursing system which was founded in the Netherlands to address a fragmented system of nursing and home care services - financial pressures had led to home care providers cutting costs by employing a low-paid and poorly skilled workforce which was unable to properly care for patients with co-morbidities.
- The model gives district nurses far greater control over patient care with nurses leading on assessment, planning and coordination.
- The model consists of small self-managing teams, each with a maximum of 12 nurses, who take equal responsibility for their patients. Teams provide co-ordinated care for a specific catchment area, typically consisting of between 40 to 60 patients. The composition of these teams in terms of specialty and level of practice varies according to the needs of each catchment area.
- Buurtzorg cares for patients who are terminally ill, suffer from long-term conditions, dementia or require home care following major surgery. Each new patient relationship begins with high levels of support which is gradually withdrawn as self-management aids and support from social care, voluntary and third sector organisations are identified, assessed and put in place.
- Buurtzorg has achieved higher levels of patient satisfaction, significant reductions in the cost of care provision and the development of a self-directed structure for nurses.
- The model involved a substantial investment in smart technology and training.

Source: Lewisham pilot business case

2

However, the current health and care employer landscape is complex, with different pay and conditions of employment in different sectors

For example:

Non-medical staff within primary care are employed by private contractors who set their own terms and conditions.

Local government employers work to Green Book principles, but with scope for local negotiation. Typically, social care pay rates are significantly lower than for comparable NHS roles.

NHS staff (including non-medical) will generally be employed on Agenda for Change pay rates, and terms and conditions which are nationally negotiated.

Employers in the private or voluntary sector will determine their own terms and conditions. This includes **locum agencies**, who provide medical and non-medical staff to the NHS.

There are some mechanisms by which terms of employment have been rationalised elsewhere in the country:

- **Equal pay requirements apply to staff employed by the same organisation.** As a result, where staff have been transferred to a single organisations, this has the effect of equalising pay;
- There are no contractual or statutory bars to organisations that set their own terms and conditions voluntarily adopting pay/term equivalent to Agenda for Change. However, there are clearly cost implications for employers, should they currently pay staff at a lower rate.

2 Despite some existing flexibilities, there are further opportunities to collectively overcome barriers to workforce transformation

Training and team development

- It can difficult for organisations to modify training curricula to meet the needs of integrated working, as these are typically set at national level by professional accreditation bodies.[1]
- Training often varies by employer, making it challenging for teams from different employers to come together.
- There is a need for further training in integrated working across health and care.

Pay parity and contractual obligations/ performance requirements

- The Lewisham pilot describes how limited flexibility around job evaluations across organisations slows down and in some cases halts the creation of new roles that cross current professional boundaries. In addition, where these new roles are being considered, clinical governance implications can sometimes hinder developing and embedding these new roles.
- Lewisham also notes the potential challenges of pay differences between health and social care, while also recognising the cost pressures of harmonising with NHS salaries and terms and conditions [2].

Organisational and cultural barriers

- Health and social care continue to be separated by cultural and professional boundaries as well as by different systems of accountability.[3]
- There is a need to ensure accountability and oversight where roles cross boundaries.[4]

[1] Source: Policy Innovation Research Unit, 'Early Evaluation of the Integrated Care and Support Pioneers Programme,' September 2015
[2] Source: Lewisham Devolution Pilot Business Case, pg. 11 and 22
[3] Source: National Audit Report, 'Health and Social Care Integration', February 2017
[4] Source: Kings Fund 'Supporting Integration through new roles and working across boundaries', June 2016.

2 Significant knowledge and expertise could be pooled across organisations to support workforce integration

NHS England has produced guidance for providers looking to develop their multi-disciplinary teams[1].

The NHS is also shortly due to launch a consultation on a system-wide workforce strategy across health and care.

The **Local Government Association** has published a briefing on integrated workforce planning[3], which explains that:

- An integrated workforce does not necessarily mean new job descriptions, more it means developing new ways of working that support people holistically, building resilience and independence
- It means developing the existing workforce to adapt, rather than focusing only on recruiting and training new workers
- Some of the most common new roles in an integration context are 'Care Coordinators', 'Community facilitators' and 'Health Coaches'.

Skills for Care has published an evidence review which explores how the workforce would need to adapt to meet the challenges that transformation would present [2]. Key findings include:

- Good leadership is key to successful integration, and should be distinguished from clinical or professional leadership.
- The creation of new roles working across professional boundaries supports integrated delivery.
- A focus on the service user/patient helps in overcoming professional boundaries.
- Different terms and conditions can be challenging, but are a barrier which can be overcome.
- Training is a key success factor for integrated working, particularly to reflect changing roles and responsibilities.

Skills for Health has produced a 'Six Steps Methodology to Integrated Workforce Planning[4]:

At more local levels, individual boroughs, providers, CCGs and others in London and beyond are developing approaches to support health and care workforce integration. There is much that can be gained from spreading and sharing this learning.

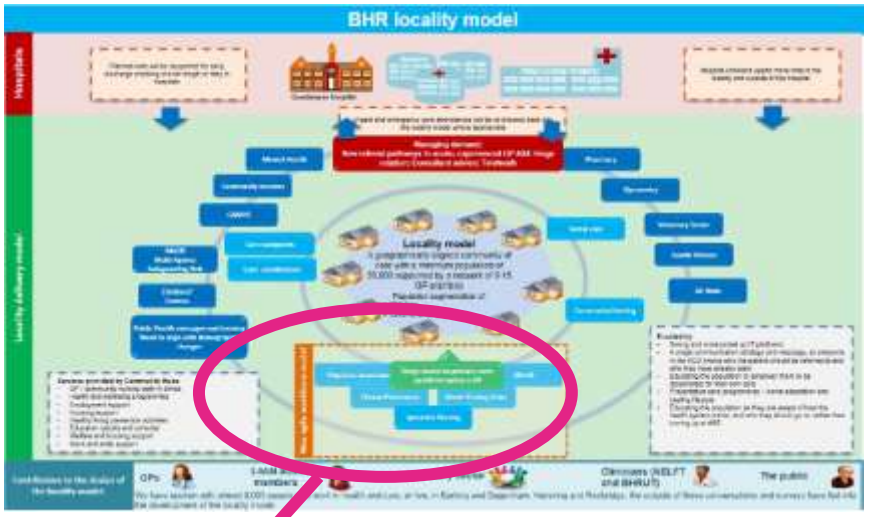
[1] Source: NHS England, 'MDT Development', January 2015
[2] Source: Skills for Care, 'Evidence review – Integrated Health and Social Care', October 2013
[3] Source: LGA briefing, 'Workforce Redesign', 10 February 2017
[4] Source: Skills for Health, Six Steps Methodology, undated

2

More flexible approaches aim to support health and care staff to work across organisational boundaries and care settings

The **BHR model** is underpinned by *"Multidisciplinary teams, involving clinicians and professionals from every part of the system co-located and working together to provide holistic treatment of peoples conditions…*

We want to change culture and working practices so that our health and care workforce is united together as one team, satisfied with their ways of working and able to pursue new opportunities. This will be primarily achieved through the creation of co-located multi-disciplinary teams."



Source: Barking & Dagenham, Havering and Redbridge Devolution Pilot Business Case

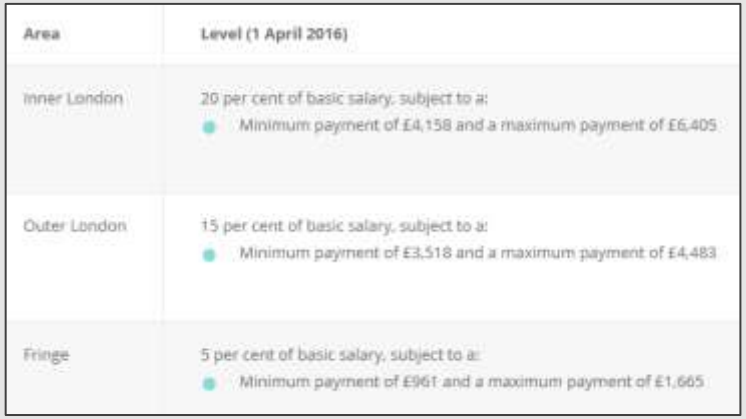
3 Within health and care, the London Living Wage has been applied to differing extents

Comparison of health and care roles against London Living Wage

	Hourly rate	Equivalent annual salary (based on a 37.5 hour week)
National Living Wage (2016/17)	£7.20	£14,040
Average wage for a care worker in London[1]	£8.81	£17,175 (senior care worker average was £20,600)
London Living Wage (2016/17)	£9.75	£19,012.50
Agenda for Change (2016/17) minimum point (Band 1) with HCAS for inner/outer London (likely roles at Band 1 include domestic support worker, housekeeping assistant, nursery assistant.)	£9.95 (inner London)/£9.63 (outer London)	£19,409 (inner London)/£18,769 (outer London)
Starting salary for a qualified nurse in London on Agenda for Change pay scale (Band 5).	£13.48 (inner London)/ £12.92 (outer London)	£26,290 (inner London)/ £25,195 (outer London)

Terminology:

- The **National Living Wage** was introduced on 1 April 2016 for all working people aged 25 and over.
- The **London Living Wage** is voluntary and employers choose whether or not they pay it. It is independently set by the Trust for London.
- **High cost area supplements** (HCAS) are paid to all NHS staff groups who are covered by the Agenda for Change agreement on working in inner and outer London and the fringe zones:



Area	Level (1 April 2016)
Inner London	20 per cent of basic salary, subject to a: Minimum payment of £4,158 and a maximum payment of £6,405
Outer London	15 per cent of basic salary, subject to a: Minimum payment of £3,518 and a maximum payment of £4,483
Fringe	5 per cent of basic salary, subject to a: Minimum payment of £961 and a maximum payment of £1,665

[1] Source: NMDS-SC dashboard figures on 9 March 2017

3 The high costs of living and working in London have significant impacts on staff recruitment and retention across health and care

- There are recruitment challenges across the system with shortages in a range of staff areas including qualified and experienced social workers, occupational therapist and nurses. In the borough of Lewisham alone, 24% of Healthcare Assistant positions in primary care are vacant, the highest of any general practice staff group. [1]
- BHR's business case cites a common challenge in the London system: *"Our current system cannot cope with current demand and we have significant challenges in the recruitment and retention of suitably qualified staff."*
- More than a third of the workforce who train in London subsequently choose to move away [2].
- London's health and social care workforce is ageing, with 15% of London GPs aged 60 and over compared to 8% in the rest of England [2].
- Staff turnover is recognised as being higher in London than in other regions (e.g. for NHS 111, attrition rates for health advisors are between 6 and 41%, and clinical advisors are between 3 and 36%) [2].

- Low pay, anti-social working hours, limited personal development and work-life balance all contribute to significant workforce attrition, and existing high vacancy rates across a number of professions. [2]
- The high cost of living in London means that recruiting and retaining staff remains a significant challenge, particularly around geographical boundaries.[2].

Staff shortages can:

- Restrict patient face to face time with health and care professionals;
- Put additional pressure on staff workloads, creating dissatisfaction and further exits from the profession; and
- Create patient safety concerns and delays.

Improved recruitment and retention would also contribute to reducing agency spend.

[1] Source: Lewisham Devolution Pilot Business Case, pg. 11
[2] Source: Healthy London Partnership, London Workforce Strategic Framework , March 2016

The MoU describes a joined-up approach to addressing London's health and care workforce challenges

1

Funding and governance to support workforce transformation

- Establishment and resourcing of a **London Workforce Board** to examine issues across health and care. This will including consideration of HEE transformation funding and maximising the opportunities offered by the apprenticeship levy.
- Establishment of a **London-wide workforce delivery system** with partners working together on key training and development priorities.

2

Levers to enable new and extended roles in health and care

Exploring risks and issues of **pay arrangements that cover all staff** in line with Government pay policy. This could include:

- More unified performance management arrangements where roles cross health and care.
- Overcoming challenges in pay arrangements for joint roles across health and care.
- Supporting co-location of health and care staff.

3

Incentivising London's workforce to improve recruitment and retention

Working with the Department of Health to **explore London weighting** in the context of challenges around recruitment and retention.

This aims to :

- Support a collaborative, integrated health and care workforce where this has been identified as a key enabler of new models of care and integration of services. This consequently aims reduce non-elective admissions, improve delayed transfers of care and reduce the cost of community based care.
- Enable London to build on its position as the home of popular and world-class health education, by developing new roles and secure the workforce it needs
- Ensure that London is in a position to support current and future staff to forge successful and satisfying careers in health and care.

Governance

Since the 2015 agreements, health and government partners have worked together within and beyond the London system

National

NHS England

Public Health England

Care Quality Commission

chp

Department for Communities and Local Government

Department for Culture Media & Sport

NHS Improvement

HM Treasury

Cabinet Office

Department for Work & Pensions

Department for Education

Department of Health

NHS Health Education England

NHS Property Services

NICE National Institute for Health and Care Excellence

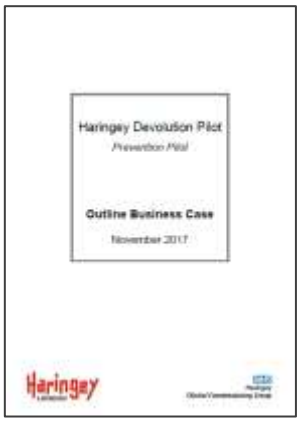
London

GREATER LONDON AUTHORITY

LONDON COUNCILS

NHS Office of London Clinical Commissioning Groups

Pilots



Haringey

Barking & Dagenham, Havering and Redbridge (BHR)

Hackney

Lewisham

North Central London (NCL)

Significant progress is underway to put in place enabling governance to deliver transformation

	December 2015	Autumn 2017
Local and sub-regional	Newly formed devolution pilots, with some mechanisms for partnership working in place.	Devolution pilots have prioritised areas of local focus, designed new and tailored ways of working in partnership, and are moving forward with more integrated governance structures, including: • Partnership boards at local/sub-regional level, supported by operational boards/committees, enabling a whole system outlook and targeted work streams to jointly address specific local challenges. • Mechanisms for more joined-up commissioning between CCGs and local authorities. • Local/sub-regional estates workstreams/boards to consider the NHS and wider public sector estate in a more holistic way.
	STP and vanguard programmes recently introduced, and some areas exercising more joined up ways of working.	• More areas have mechanisms for integrated working (e.g. partnership boards, joint appointments, s.75 agreements). Direction of travel supported by national policy e.g. Five Year Forward View: Next Steps. • Local and sub-regional areas are represented on all new London-wide governance structures. All STPs and devolution pilots are members of the London Estates Board, and three representatives from each STP sit on the London Health and Care Strategic Partnership Board. The Devolution Pilots are formal members of the Devolution Programme Board.
London	London Health and Care Devolution Programme Board, with political oversight through the London Health Board (LHB). A number of strategic groups in place across London to enable better integrated working.	• A new **London Health and Care Strategic Partnership Board** first met formally in May 2017. This provides strategic oversight and absorbs functions of a number of existing strategic groups. • Plans to expand membership of the **LHB** as required. Provider representation now added. • **London Estates Board** began operation in December 2016, and London Estates Delivery Unit (LEDU) is under development, with an LEDU Steering Group in place to progress plans. • **London Workforce Board** met for the first time in March 2017. • Exploration of more aligned regulatory functions. • Collaborative **strategic delivery function** to be established, to support the London system across its transformation efforts. Healthy London Partnership agreed as London's collective vehicle for delivery of transformation.

Local and sub-regional governance

Local and sub-regional areas are developing different governance mechanisms sharing a set of core principles

The **London Health and Care Collaboration Agreement 2015** set out the following principles:

"At the local level, governance will:

- *Seek to maximise pooling of finances compatible with the local context*
- *Appropriately engage the public, providers and other interested parties*

At sub-regional level, governance will:

- *Free members to act in line with the interests of the area covered by the partnership*
- *Ensure decision making on an equal footing between places and types of institution"*

Local and sub-regional areas have built on these aims to develop the following core set of principles, reflected in the **2017 London Health and Care Devolution Memorandum of Understanding**.

Local and sub-regional governance mechanisms will:

- Be co-developed, owned and agreed by local partners. They will be developed by local and sub-regional areas and may take different forms in different areas. The different governance and accountability models developed by London's five devolution pilots are illustrative of this approach.
- Enable organisations to identify areas of complementarity between parts of the health and care system, to work together to avoid duplication and ensure that solutions are workable and beneficial for the local population. This builds on work underway through local and sub-regional planning processes, including composition and utilisation of Joint Strategic Needs Assessments.
- Enable partnership working and shared ownership by local health and government partners in order to achieve plans and strategies that reflect the needs of the local health economy, with the ability for both health and care to influence decisions regarding the administration of delegated or devolved powers.
- Ensure that mechanisms are in place for appropriately engaging the public and stakeholders, in order to ensure that plans reflect population wants and needs. Those proposing transformation will aim to get the widest possible local support and will take full account of the consultation and engagement responsibilities of constituent organisations.
- Ensure that partners collectively enable improvement in health and care which addresses the health and wellbeing needs of local populations. Different places and types of institution will be on an equal footing. All organisations, including providers, will be key partners in plans, engagement and implementation and will work to collectively shape the future of health and care in the local area.
- Ensure that responsibilities and accountabilities remain clearly within the statutory framework, with robust monitoring of the potential for conflicts of interest.

Achievement of these principles requires certain delivery functions

To deliver against these principles:

- Arrangements will be locally determined, whilst ensuring that they satisfy accountability and statutory requirements, and are complementary with the wider London system.
- Local and sub-regional areas will need to establish the extent to which organisations want to work collectively and the levels at which joint or partnership working should take place. The majority of functions that currently sit locally are likely to continue to be exercised at this level, but the Sustainability and Transformation Partnerships and devolution pilots have identified that some functions may be more appropriately exercised collectively at a multi-borough level.
- Arrangements will provide health and care commissioners with the opportunity to jointly develop, engage on and deliver strategic plans, allowing joint decision-making and pooled resources where possible. Providers will be key partners in plans, engagement and implementation, while respecting the need for clear separation of provider and commissioner functions.
- Partnership arrangements must enable providers and health and care commissioners to be able to make strategic and advisory recommendations within the bounds of a robust conflicts of interest framework and – if delegated or devolved powers are sought – to take decisions in partnership, in accordance with local strategies. If formal joint governance is to be commenced with a more limited partnership, it will be necessary to make an assessment of how wider involvement and engagement will be sought.
- Local and sub-regional governance is likely to evolve, and it is appropriate that this would happen at different pace depending on local appetite or requirements. These arrangements could be phased, commencing with a strategic and advisory function and evolving to take on more formal decision-making functions, commencing with some joint functions or budgets and evolving to take on formal strategic and commissioning functions if desired by the local partnership. Devolved or delegated decision-making from relevant bodies would be agreed – and related resources released – based on the decision-making criteria published by those bodies, working in partnership to meet these criteria.
- Governance arrangements at local and sub-regional arrangements will describe the intended political oversight arrangements.
- Robust mechanisms will preserve financial and clinical accountability of relevant bodies, with strong clinical input at every spatial level. Governance arrangements that involve pooled budgets will need to be supported by a jointly developed financial strategy and agreed financial management processes.

Within the same 'type' of organisation, joint working can take on different forms

The boxes below set out some non-exhaustive options for joint working:

Between CCGs

- Under s. 14Z3 of the NHS Act 2006, joint decision making committees can be formed between CCGs or between CCGs and NHS England. CCGs can delegate functions into the joint committee by way of change to the constitution/Scheme of Delegation.
- Merger by way of application to NHS England.
- Joint leadership/appointments and consolidation of back office functions.
- Committees in common approach.

Between Local Authorities/boroughs

- Section 102 of the Local Government Act 1972 enables local authorities to set up joint committees. These arrangements must comply with the Local Authorities (Arrangements for the Discharge of Functions)(England) Regulations 2000. Limited as to what functions can be exercised through these committees.
- Joint leadership/appointments.
- Leadership forum (for example, as utilised by London Councils).

No ability to form combined authorities in London.

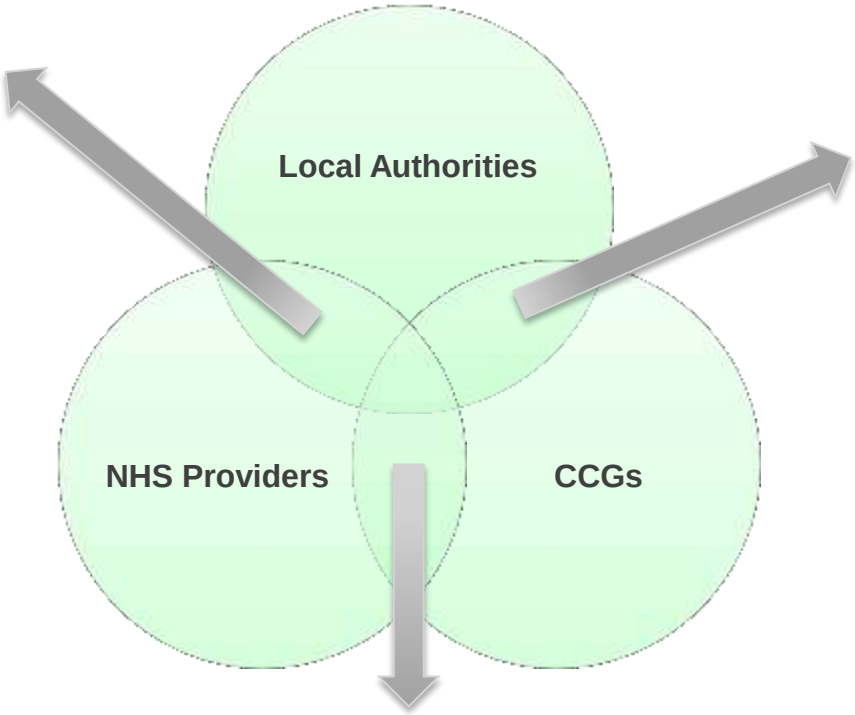
Between NHS Trusts/NHS Foundation Trusts (FTs) [1]

- Buddying/information partnerships
- Joint leadership/appointments
- Neither FTs nor NHS Trusts have the ability to set up legally binding joint committees. However, they could operate a committees in common approach (both will usually have the power to delegate to committees).
- Corporate joint venture creates a separate legal entity, but FTs remain liable for decisions (*FTs only*).
- Contractual joint venture can create legally binding rights and responsibilities.
- Merger/acquisition.
- Leaders forum, could also bring in voices from GP federations/independent providers.

[1] Examples taken from NHS Improvement guidance, Options for Structuring Foundation Trusts

There are a number of options for joint working between <u>different</u> 'types' of organisations

- Under the current legislative framework, providers and commissioners cannot take collective, binding decisions.
- Local authorities and providers can meet in partnership and take separate decisions, but only so far as these decisions fall within the scope of their functions, and there is a need to be vigilant as to the potential for conflicts of interest.



- Under the current legislative framework providers and commissioners cannot take collective, binding decisions.
- CCGs and providers can meet in partnership and take separate decisions, but only so far as these decisions fall within the scope of their functions, and there is a need to be vigilant as to the potential for conflicts of interest.
- The commissioner/provider split is an important tenet of NHS legislation.

Options possible under the current legislative framework:

- Strategic partnership boards.
- Committees in common approach.
- Partnership arrangements and oversight committees (non-decision making) under s.75 NHS Act and corresponding regulations, including pooled budgets.
- Joint appointments/leadership (e.g. Tameside and Glossup).
- LA could provide a 'commissioning support' style function without formal transfer of functions.

Legislative change could enable:

- Joint decision-making committees with pooled budgets.
- A wider range of functions exercisable under s.75 (again, including pooled budgets).
- Double-delegation issues still arise around functions delegated from NHS England to a CCG, unless legislation is change to allow for direct delegation to a joint committee.

Pilots are exploring different models of governance at local level

Haringey (local)

The Health and Wellbeing Board provides overall strategic direction for Haringey's devolution pilot supported by senior officers of the council and CCG in the Joint Executive Team. The Health and Wellbeing Board is chaired by the Leader of the Council and its membership is made up of:

- Council cabinet members
- Senior council officers
- CCG governing body members
- Healthwatch
- The Bridge Renewal Trust, the council's strategic partner for the voluntary and community sector.

1) Sustainable Employment

Since January 2016 Haringey Council has led a partnership 'Sustainable Employment Working Group': including senior representatives from Public Health, Economic Development, CCG and GP representatives, Barnet, Enfield and Haringey Mental Health Trust, voluntary and community sector, Job Centre Plus and DWP.

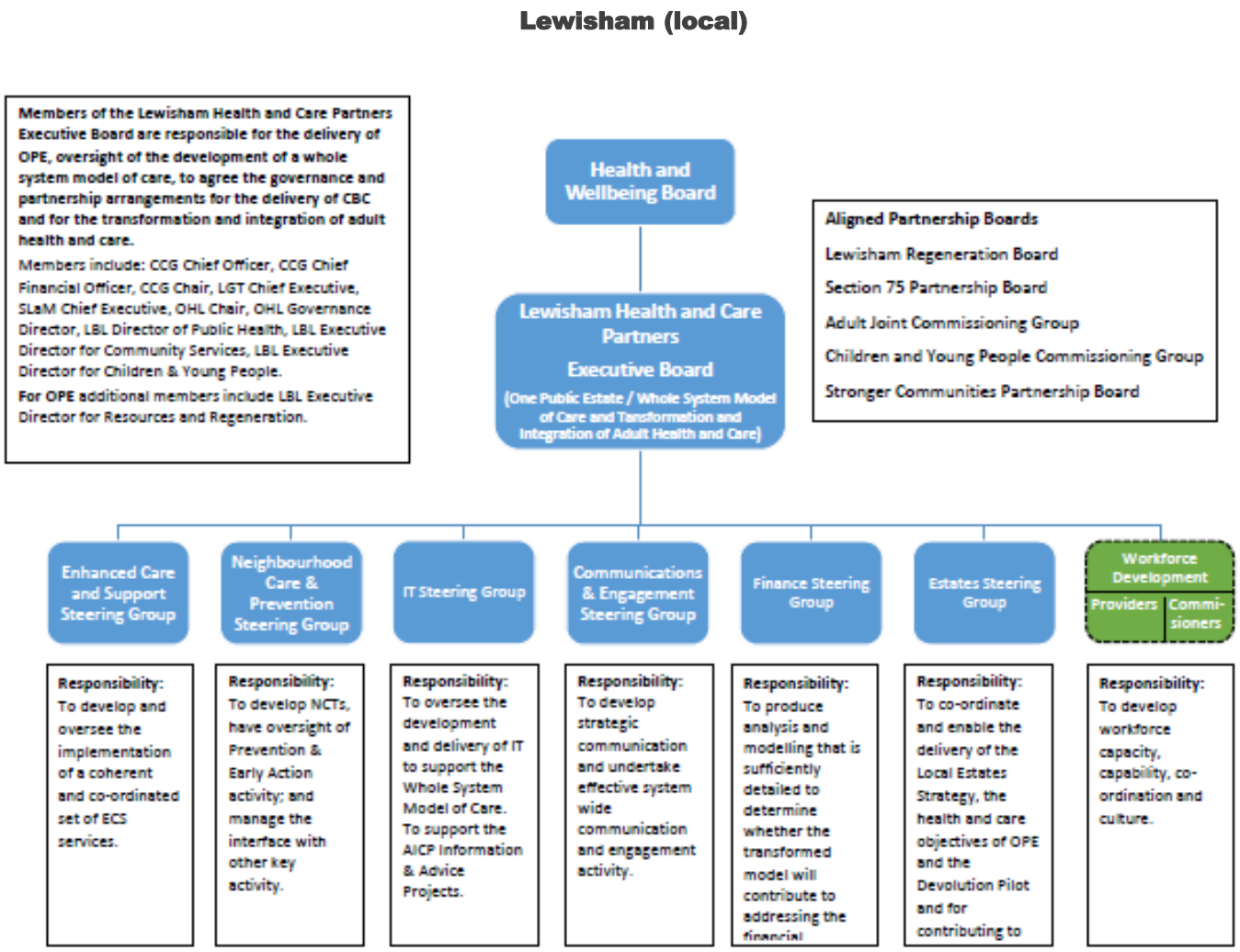
This partnership will oversee implementation of the devolution pilot project on sustainable employment, reporting to the Joint Executive Team.

2) Healthy Environments

Since January 2016 Haringey Council has led a partnership working group with senior representatives from Public Health and Regulatory Services who have liaised extensively with the London Healthy High Streets Group (linked to London Association of Directors of Public Health), Public Health England regional and national teams as relevant, and other experts in these areas.

Source: Haringey Devolution Pilot Business Case

Pilots are exploring different models of governance at local level



Source: [Lewisham Devolution Pilot Business Case]

Pilots are exploring different models of governance at multi-borough level

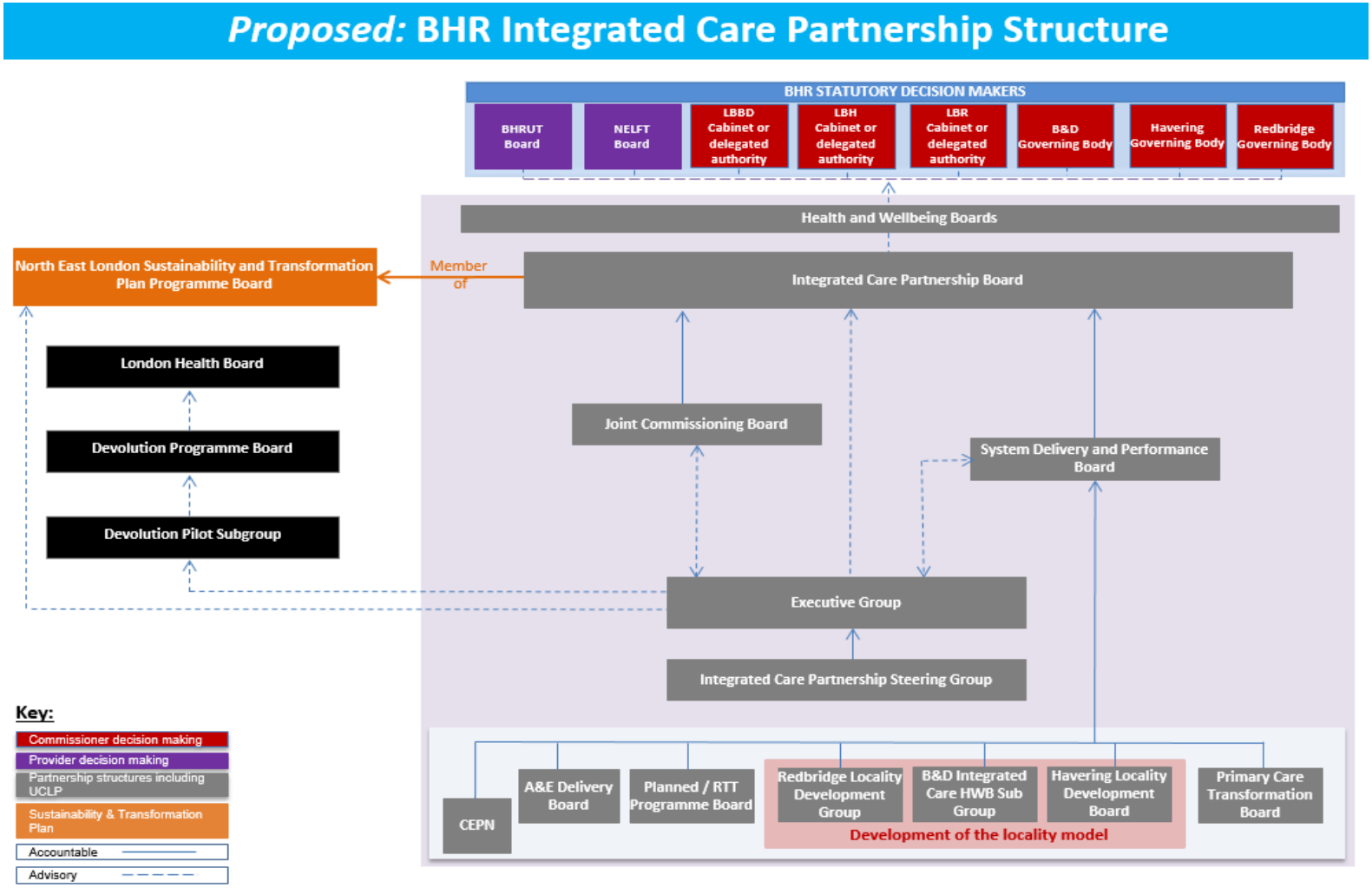
Hackney and the City (two boroughs/single CCG) commissioning governance

- In April 2017, two Integrated Commissioning Boards were established, one for Hackney and the other for the City of London.
- The Boards use the current s75 legislation to control a single pooled budget between the Hackney & the City CCG and each local authority.
- The Board members have delegated decision making from the statutory organisations to make decisions together in the forum of the Boards.
- The arrangements are underpinned by a financial framework outlining how the statutory bodies set and manage the pooled budget each year.
- The two statutory Health and Wellbeing Boards continue to oversee local workplans that improve local services and outcomes.

Source: Hackney Devolution Pilot Business Case

Pilots are exploring different models of governance at multi-borough level

Barking & Dagenham, Havering and Redbridge (BHR) (tri-borough)



Source: [BHR Devolution Pilot Business Case]

NHS 'New Care Models' have also considered joint governance arrangements

Care Model	Overview	Governance considerations
Multi-specialty community providers (MCP) [1]	• An MCP combines the delivery of primary care and community-based health and care services in a 'place-based' model of care. • The range of services included is dependent on the particular locality. This is likely to include some services currently based in hospitals (e.g. some outpatient clinics or care for frail elderly people). It will often include mental as well as physical health services, and potentially social care provision. • This requires a new type of integrated provider, who act as the focal point to deliver care required by their registered patients. • The MCP will cover the sum of the registered lists of the participating GP practices, and the unregistered population.	*"In developing a bid to deliver an MCP, prospective providers will need to agree an organisational form and decide how it will relate to GP practices and other staff groups. In all cases, an MCP will need to be a formal legal entity, or group of entities acting together to form the MCP, that is capable of bearing financial risk, and which has clear governance and accountability arrangements in place for both clinical quality and finance."* Options include: • A limited company or limited liability partnership, potentially a GP federation or newly formed joint venture vehicle. • A community interest company (a particular type of company, bringing parties together as a social enterprise). • An NHS trust or foundation trust, building on its existing assets and workforce.
The Integrated Primary and Acute Care Systems (PACS)	*"A PACS is a whole population health and care system.… At its most developed it will include primary, community, mental health, social care and most acute services for the population it serves. In terms of acute services, a PACS will include all secondary care and some tertiary care services. Some specialised services commissioned by NHS England could be in scope for a PACS."*	*"Commissioning a PACS will require NHS and local authority commissioners to work closely together and agree robust and sustainable collaborative commissioning arrangements. We expect PACSs to explore expanded collaborative commissioning models that bring together funding for NHS and social care services that have historically been funded separately….Accountable care models like MCPs and PACSs redefine the roles of commissioner and provider. …Commissioners will retain a strategic role, which would likely include setting contract outcomes, managing the procurement process, overseeing the PACS delivery against the contract, and ensuring service user voice and choice are maintained. The PACS provider, meanwhile, would have the freedom to define the detailed service model, determining how providers (including sub-contractors) would work together to deliver this and defining the operating and governance model across the PACS."*

[1] Source: NHS England MCP Framework

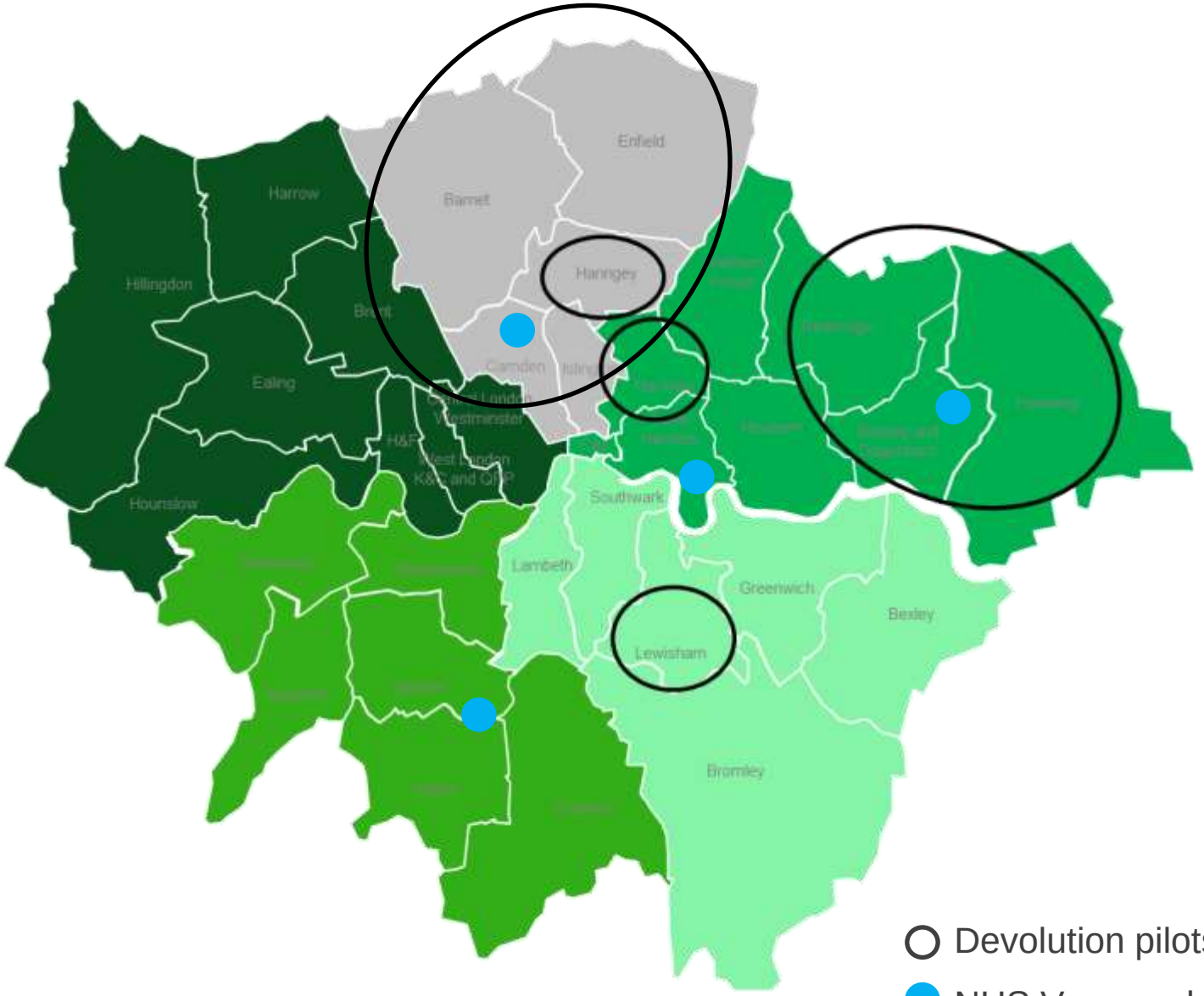
[2] Source: NHS England PACS Framework

NHS 'New Care Models' have also considered joint governance arrangements

Care Model	Overview	Governance considerations
Acute Care Collaboration (ACC)	An ACC model involves local hospitals working together to enhance clinical and financial viability, aiming to reduce variation in care and efficiency. This model may offer options for a viable future for smaller district general or community hospitals, and aims to integrate community and acute services.	Initial steps often include sharing of guidance and back office / clinical support functions. Going forward, ACCs could include buddying, partnerships and federations, or more formal moves such as mergers and acquisitions.
Urgent and Emergency Care	This aims to develop new approaches to improve the coordination of services, thereby reducing the number of individuals inappropriately attending A&E. This reduces strain on the emergency services, costs incurred by unnecessary admissions and allows patients in need of emergency care better access to necessary care and treatment.	Governance mechanisms often include providers of urgent and community/primary care services, commissioners and also voluntary sector partners. For example, the West Yorkshire Urgent Emergency Care Network vanguard is a partnership consisting of Bradford District Care Foundation Trust, Bradford Metropolitan District Council and The Cellar Trust charity.
Enhanced Health in Care Homes (EHCH) [1]	*"The EHCH model has three principal aims:* • *To ensure the provision of high-quality care within care homes;* • *To ensure that, wherever possible, individuals who require support to live independently have access to the right care and the right health services in the place of their choosing; and* • *To ensure that we make the best use of resources by reducing unnecessary conveyances to hospitals, hospital admissions, and bed days whilst ensuring the best care for residents."*	The model requires care homes (residential and nursing, often independent providers) to work closely with NHS providers (including community reablement/rehabilitation services and urgent care providers), local authorities, CCGs, the voluntary sector, carers and families.

[1] Source: NHS England EHCH Framework

Devolution pilots are a part of London's transformation landscape, under the 'umbrella' of STPs



Some functions may lend themselves to consideration at a multi-borough level

In January 2016, 44 'footprints' came together as STPs as a result of NHS England planning guidance which provided for local health economies to produce a joint plan by place. STPs are relatively new, and footprints are working to establish locally-suitable governance arrangements. Some areas already have informal or formal mechanisms in place which enable partnership working. Others are less keen to take forward formal arrangements at this time.

Work is ongoing within STPs to explore the spatial levels which best align with different functions. The range of functions that local organisations would want to exercise at an STP level will differ, dependant on the locality and particular needs.

The categories of functions below could be exercised at different spatial levels, however these are themes that have emerged from many STPs:

Supporting local implementation of **demand management programmes**

(e.g. the GP forward view)

Ensure **clinical sustainability of specialties** across the STP geography

(e.g. maternity services and acute mental health)

Financial

(e.g. managing system control totals, capitated budgets)

Supporting local implementation of geography-wide **clinical outcome improvement programmes**

(e.g. Mental Health Five Year Forward View and Diabetes)

Service reconfigurations

(e.g. where reconfigurations include a number of CCGs, and will impact on local authority services)

Estates

(e.g. business case approvals, capital receipt reinvestment and alignment of estates strategies).

Commissioning

(ensuring commissioning strategies align, joint commissioning where appropriate at STP level, and consideration of pathways that cross borough boundaries)

Workforce

(e.g. consideration of a more integrated workforce)

London governance

There is a growing need for collaborative strategic leadership in London

Increasing collaboration and integration between health and care	• With increasing emphasis on Health and Wellbeing boards, the Better Care Fund, New Models of Care and STPs, the health and care system is working more closely together – at all spatial levels and in strategic and operational terms. London has a strong foundation of joint working. Improved collaboration and accountability will enable more ambitious joint working and help achieve shared aspirations and objectives.
Recognising the city locus as a complementary spatial level	• Some elements of health and care require aggregation to either achieve sufficient scale (e.g. specialised commissioning and workforce), or to be addressed 'once for London' (e.g. leveraging London-level assets and developing preventative interventions and permissive frameworks). These must be supportive and complementary to local and sub-regional action.
Advocating for London	• In discussions with national bodies, London partners need to demonstrate a compelling shared position with political support.
Strategic assessment of activities across the city	• Given city-wide health and care challenges and opportunities, there are instances when strategic assessment of activities may be beneficial across the health and care system (e.g. developing a health inequalities strategy and evaluation of progress against this strategy and the 10 ambitions for London set out in *Better Health for London: Next Steps*).
Reducing duplication	• A number of groups have emerged in London to encourage greater collaboration. These often have considerable overlap in scope and attendees, with the potential for fragmentation and duplication.

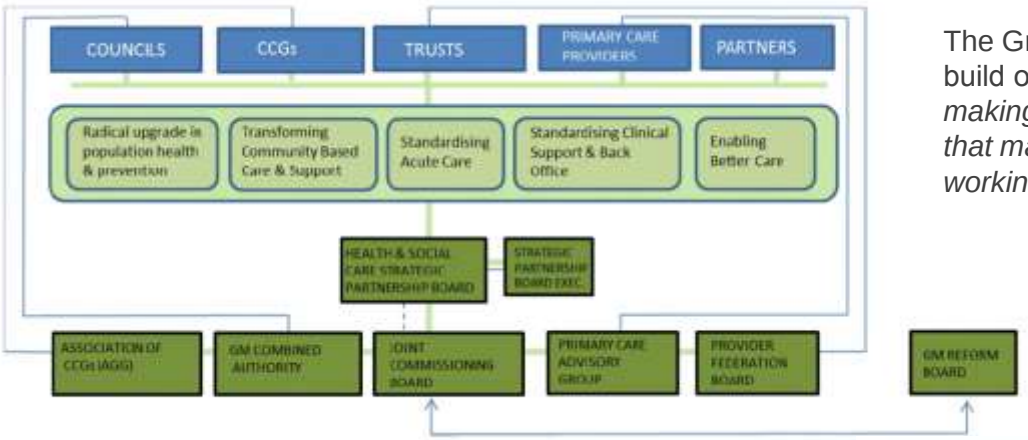
London governance has been developed on a number of underlying design principles

London has a strong foundation of joint working. Improved collaboration and local accountability will enable more ambitious partnership working and help achieve the aspirations and objectives agreed for London. London-level governance aims to provide complementary functions to add value to local and sub-regional arrangements. Governance mechanisms in London will be phased to evolve from existing arrangements.

Underlying design principles:

- Subsidiarity to the lowest appropriate spatial level is the keystone to a framework of principles. The default position should be to the borough level.
- Multi-borough governance must have the agreement of all relevant parties and may vary according to locally determined need.
- Functions will only be aggregated to the London level where there is a clear case and it is preferable to all partners to do “once for all” to avoid duplication, enable scale or acceleration.
- Any new regional and multi-borough governance will be implemented with a view to rationalising the wider governance infrastructure to ensure duplication is avoided.
- Any arrangements must consider the implications for both devolution and wider transformation and operational governance. Approaches will be ‘future-proofed’ to allow evolution to accommodate further devolution, delegation and joint decision-making, with functions phased over time.
- The NHS in London will remain within the wider NHS and subject to the NHS Constitution and Mandate.

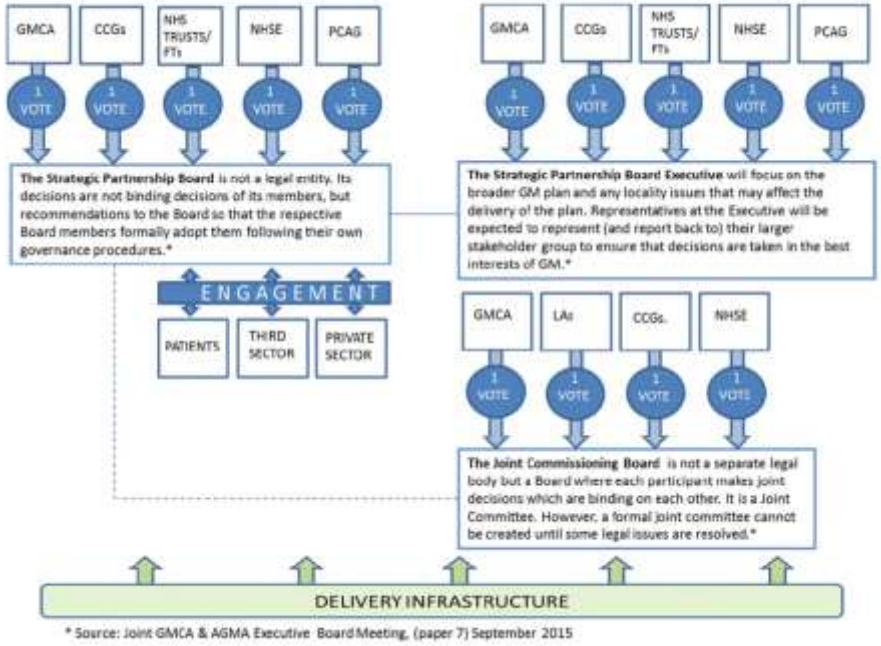
Greater Manchester (GM) has worked through some of these accountability & governance considerations, on a smaller footprint



The Greater Manchester 5 year strategic plan sets out initiatives to build on partnership working "*with well-established joint decisions making arrangements across health bodies and local government that make full use of existing powers of collaboration and joint working*".

The Manchester model is based on internal delegations within NHS England and collaborative decision-making

NHS England has internally delegated the exercise of specified functions to its employee, the GM Chief Officer (this is referred to as 'synthetic devolution', pending any more formal transfer / delegation arrangements). Under the delegation model, local CCGs and the Greater Manchester Combined Authority have a seat at the table for discussions with NHS England budget holders regarding service planning but accountability and responsibility for NHS services remains within NHS England. An 'Accountability Agreement' developed between GM and NHS England, sets out the principles under which these arrangements work.



Source: GM Strategic Partnership Board paper "*Summary overview of established governance structures and key relationships within the GM Health and Social Care Partnership*", 30 September 2016

Any London governance must recognise the legal and policy context for devolved arrangements

Legal and policy context

- NHS / local authority joint working possible via s75 arrangements
- CCGs can form joint committees and maintain pooled funds with NHS England / other CCGs. A CCG can also delegate its commissioning functions to another CCG.
- NHS England can delegate its functions to a CCG. It can also work jointly with a CCG(s)
- Specific requirements apply to delegation of NHS England's commissioning functions (e.g. specialised commissioning).
- Joint working under Devolution Act not currently an option in London due to definitions used in Act.

NHS England 'devolution spectrum' and devolution criteria

Model	Definition	Governance devolution criteria
Seat at the table' for commissioning decisions	• No legal change, or material organisational impact across the parties involved. • Decisions about a function are taken by the function holder but with input from another body. • Accountability and responsibility for function remains with original function. holder (including budgetary responsibility and funding for overspends).	• Clear and appropriate accountability and governance arrangements across all parties.
Co-commissioning or joint decision-making	• Two or more bodies with separate functions that come together to make decisions together on each other's functions. • Accountability and responsibility for function remains with original function holder (including budgetary responsibility and funding for overspends).	• Clear and appropriate accountability and governance arrangements across all parties.
Delegated commissioning arrangements	• Exercise of the function is delegated to another body (or bodies). • Decision-making and budget rest with the delegate(s). • Ultimate accountability and responsibility for function remains with original function holder (including budgetary responsibility and funding for overspends).	As above plus: • An employment MoU in place as necessary • Clarity on how governance and accountability arrangements will work if decision-making and accountability are to rest with different bodies
Fully devolved commissioning (i.e. transfer of functions)	• Function is taken away and given to another legal body on a permanent basis (meaning responsibility, liability, decision-making, budgets and everything else to do with that function) i.e. under a s.105A transfer order. • Accountability and responsibility for those functions transfers to the new 'owner' (including budgetary responsibility and funding for overspends) who will be accountable to the relevant national body for the function in question.	• Clear and appropriate accountability and governance arrangement across all parties • An employment MoU in place as necessary.

A London Health and Care Strategic Partnership Board now provides strategic and operational leadership

Purpose

The London Health and Care Strategic Partnership Board (SPB) **will provide strategic and operational leadership and oversight for London-level activities**, building on national direction such as the Five Year Forward View, and London plans including Better Health for London, but crucially emphasising the partnership approach and an agreed strategy for sustainability and transformation built up from local and sub-regional plans.

Membership

- Three leads from each STP (comprising of a CCG, borough and provider representative for each of the five London STPs)
- London Councils: One representative (in addition to the CELC Health Lead)
- London CCGs: One representative
- GLA: Two representatives
- PHE: Regional Director
- NHS England: Two representatives including one Regional Director
- NHS Improvement: Executive Regional Managing Director
- Care Quality Commission: Regional representative
- Health Education England: Regional representative
- Third sector and patient groups (details to be confirmed)

The SPB will be co-chaired by the London Regional Director of NHS England and the Chief Executives' London Committee (CELC) Health Lead.

Phasing

The development of the SPB will be subject to phased progression, with gateways to ensure that governance and accountability mechanisms are sufficiently robust to proceed to the next phase.

The SPB met for the first time in shadow form on 30th March and formally on 24th May 2017. It is currently engaged in set-up functions, including finalising membership. It is also establishing key areas of priority to support local and sub-regional areas with delivery.

SPB partners have agreed Terms of Reference which set out the broad functions for the initial phase of operation

The SPB will provide strategic leadership to the health and care system through the following functions:

- The SPB will streamline strategic and operational groups which currently exist to enable health and care collaboration, in order to provide a forum for all London partners to explore common challenges, discuss and co-develop the shape of health and care in London.
- The SPB will build on London's strong foundation of joint working to increase collaboration and integration between all stakeholders, and particularly focus opportunities to join up health and care partners. Improved collaboration and accountability will enable more ambitious joint working and help achieve shared aspirations and objectives.
- The SPB will provide strategic assessment of activities across the city, enabling whole system strategic planning and prioritisation, where appropriate. Given city-wide health and care challenges and opportunities, there are instances when strategic assessment of activities may be beneficial across the health and care system (e.g. developing a health inequalities strategy and evaluation of progress against the Health Inequalities Strategy (HIS) and the 10 ambitions for London).
- The SPB will ensure that policy which impacts on London health and care is jointly owned and built on the basis of local and sub-regional plans and priorities. The SPB will provide oversight of London-level governance structures and workstreams, including the Partnership Commissioning Board, Workforce Board, London Estates Board and STP/pilot governance arrangements.
- The SPB will act as the advocate for the London health and care system.
- The SPB will ensure sharing of learning across the London system. The SPB will support the recognition and sharing of learning, to avoid duplication of work and enable transformation to move faster.
- The SPB will provide ongoing assessment of the benefits and outcomes of devolution at different spatial levels within London, and share learning.

In later phases, it is proposed that formal decisions could be taken within the SPB forum. Member representatives could be enabled to take decisions through internal delegations within national organisations.* The scope of this decision-making will be detailed with further specificity as the SPB moves through its initial phases, however it is anticipated that the SPB members will be enabled to take decisions on London-wide strategic aims and priorities, and approvals of devolution business cases, to the extent that the functions fall within the statutory functions of their organisation. The focus will be on aligning the strategic approaches of partners.

** In accordance with the principle of subsidiarity, the intention is not that the SPB takes on decision-making that currently occurs locally.*

The London Health Board brings together health and care partners and political leaders in London

Purpose

- The LHB will drive improvements in London's health, care and health inequalities where political engagement at this level can uniquely make a difference.
- The LHB will seek ways of giving additional impetus to progress the ambition to make London the healthiest global city.
- The LHB will make the case for investment, power and freedoms to enable the improvement of health and care services and the wider determinants of health in London.
- The LHB will consider ways of supporting and accelerating the transformation of health and care services in the capital.
- The LHB will champion public participation in health and an increase in choice and accountability in health and care services.

Meetings and events

- The Board meets quarterly.
- It also hosts an annual engagement event to discuss progress to date and next steps in making London the world's healthiest city by 2020.

Membership

Chair: Sadiq Khan, Mayor of London

Borough Leaders:
- Cllr Kevin Davis, Leader, Royal Borough of Kingston upon Thames, and London Councils' Portfolio Lead for Health
- Cllr Denise Hyland, Leader, Royal Borough of Greenwich
- Cllr Richard Watts, Leader, London Borough of Islington

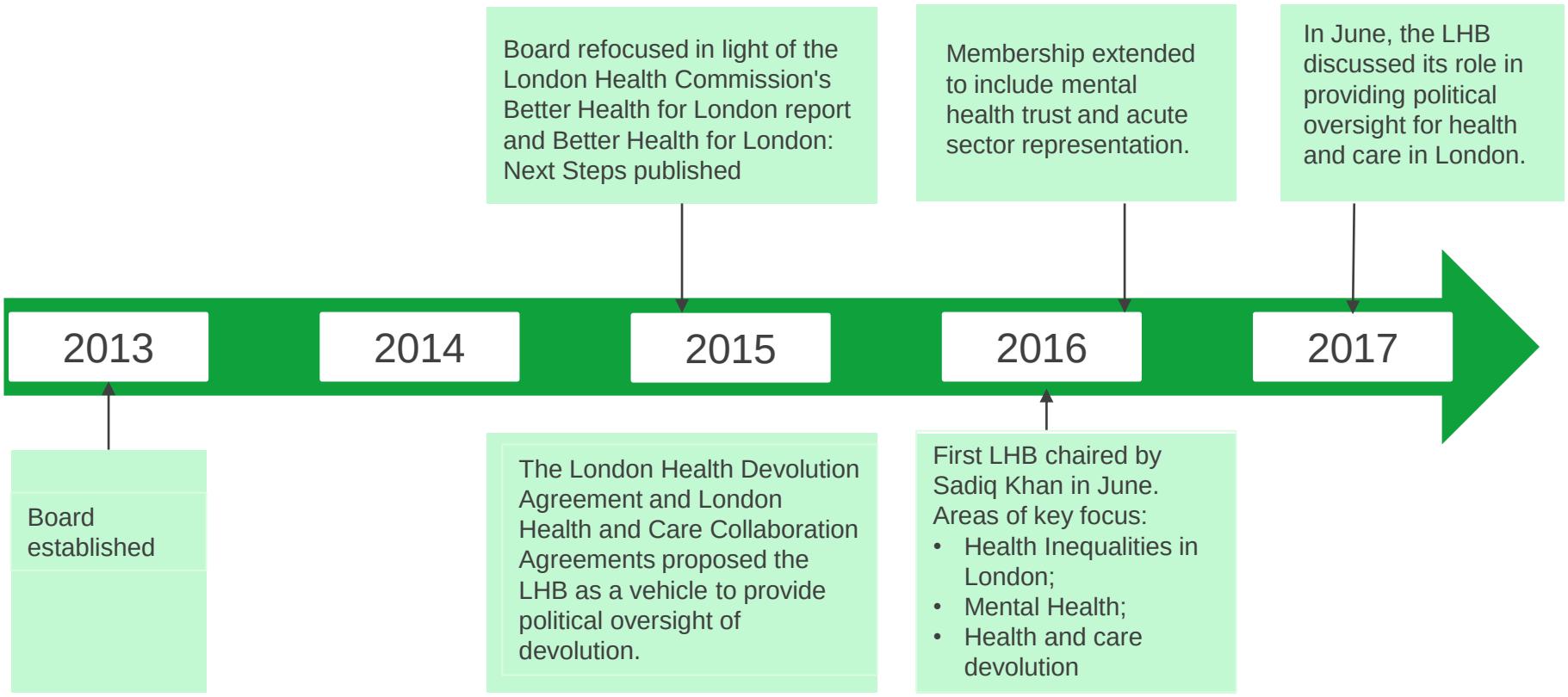
Provider representatives:
- Daniel Elkeles, Chief Executive, Epsom and St Helier University Hospitals NHS Trust
- Claire Murdoch, Chair, Cavendish Square Group

Commissioner representatives:
- Jane Cummings, Regional Director, NHS England London Region
- Marc Rowland, Chair, London-wide Clinical Commissioning Council

Wider health and care partners:
- Yvonne Doyle, Regional Director, Public Health England London Region and Mayor's Statutory Health Advisor

Going forward, the LHB aims to provide political oversight of health and care in London

- Political leadership is vital at all spatial levels and a re-cast LHB will enable political accountability of health and care in London, and provide political oversight of wider London transformation efforts.
- In its new role, the LHB will also oversee the operation of the SPB, with a focus on the extent to which the SPB is meeting its objectives and opportunities for political support.
- Over recent years, the LHB has widened its membership to ensure representation from across the London health and care system. Membership will continue to be strengthened as required.



Governance organogram from the MoU