



Title:	Integrated health and care in London
Authors:	<ul style="list-style-type: none"> • Clive Grimshaw, Strategic Lead for Health & Adult Social Care Head of Children’s Services (London Councils) • Khadir Meer, Chief Operating Officer (NHS England London region) • Nabihah Sachedina, Director of Strategy (Healthy London Partnership)

Strategic Partnership Board

22 March 2018

1. Partners want to make best collective use of the opportunities within the Memorandum of Understanding (MoU)

- 1.1. There is a widely acknowledged need for more joined-up, personalised care which puts the citizen, rather than the service, at the centre of the system. In London, much of this work has been developed organically within boroughs or across a small number of boroughs. All areas of London have developed their thinking on integration to varying degrees and this paper describes some illustrative examples of the emerging approaches.
- 1.2. National policy also looks to encourage better integrated working, with the most recent initiative being the development of Integrated Care Systems (ICSs). National policy direction has now converged with many long-standing local ambitions. There is broad agreement regarding the need to create more collaborative commissioning arrangements, deliver health and care services in ways that are more seamless and provide care closer to home in out of hospital settings.
- 1.3. Empowering local systems to tailor approaches to their communities and supporting local areas to proactively assert locally-developed solutions were vital elements underpinning the case for devolution. Furthermore, the devolution agenda has been led by five local and multi-borough ‘pilot’ areas. Opportunities gained through devolution provide a platform to accelerate the development of locally designed models of integrated care and improve health and care outcomes for Londoners. To do this effectively, London partners need to:
 - Harness collective ambition to deliver on the MoU and improve health and care for Londoners;

- Ensure that reform enabled by the MoU emerges through bottom-up, locally designed solutions but that there is shared focus on identifying and removing those barriers that are collective;
- Work collaboratively with local areas where the right conditions exist and ensure that they are supported to deliver those reforms within the MoU commitments where there is a local appetite to deliver.

1.4. The degree to which the powers and freedoms in the MoU can be unlocked will be contingent on our ability to work together effectively, in a way that is consistent with the principle of subsidiarity. This principle respects and accommodates differing local circumstances and the importance of local systems pursuing those freedoms in ways that are supported by local consensus. This paper will consider how partners can best utilise the MoU commitments and new partnership approaches to support integration of health and care.

2. There are opportunities for local systems to lead and influence delivery

2.1. The MoU contains opportunities that could enable local integration efforts to go further and faster. Implicit within each of these opportunities is the need for supportive, local leadership and a shared focus on how local health and care outcomes will be improved.

2.2. Explicitly, and based on the interest and appetite of local and sub-regional areas, there are opportunities to pilot delivery in the following areas:

2.2.1. Payment models

The MoU offers London the opportunity for local (borough) and multi-borough¹ areas to develop innovative models of payment. Under the MoU, NHS England and NHS Improvement commit to supporting local and sub-regional areas in London to co-develop and adopt innovative models of payment. London partners, in return, commit to piloting new models, assessing them and ensuring they are useable across London. Subject to local appetite, this could enable a shift from episodic payments for the majority of services, with services instead commissioned via pooled/capitated budgets.

2.2.2. Integrated commissioning

London partners have the opportunity to:

- Jointly explore, with national partners, barriers to joint or lead commissioning approaches and how to fix them, including barriers to reform of governance. Partners can build on the work of the devolution pilots who identified legislative barriers to integrated commissioning.

¹ Refers to the spatial level at which services are currently commissioned.

- Explore delegation of some specialised commissioning to STPs. Greater Manchester reported that delegation of specialised commissioning enabled integration of care for the whole patient pathway and creative service design solutions.
- Explore whether changes to immunisation and screening delivery and/or commissioning arrangements could address fragmentation and enable better outcomes.

2.2.3. Regulation

The MoU contains commitments by NHS England and NHS Improvement to streamline regulation and oversight. NHS England, NHS Improvement and CQC have also committed to closer working at London level (including alignment of regulatory actions and timetables). This is likely to be particularly pertinent at the borough and multi-borough levels where multiple oversight mechanisms are in play², and aims to ensure consistency of advice and guidance across the system, a joined up and targeted approach to issues and a reduction in the administrative burden on local organisations. Discussions are underway between STP leads, NHS England and NHS Improvement regarding ways to effectively transition to a ‘single voice’ regulatory approach³.

The MoU also contains an opportunity for London partners to work with regulators to develop new models of oversight which support integrated working and pilot a place-based framework for system regulation. This could better support integration at all spatial levels and London will need to co-develop and test new approaches with local systems to ensure fit for purpose solutions. At STP level there is also potential for oversight and assurance of quality, operational and financial performance.

2.3. Commissioning, payment models and regulation provide a gateway to integrated care solutions and the MoU commitments provide a platform for new approaches to be designed to fit the specific needs of London. As the SPB considers the strategy for implementation of the MoU, it will be important to ensure the wider system has the opportunity to bring forward their own local propositions. The SPB will need to consider how to strike the right balance between focused use of limited resources for supporting reform and ensuring all of London has access to the opportunities in the MoU. Subject to any relevant due diligence, through the SPB London will be keen to support localities which are keen to utilise the reforms available through the MoU.

2.4. It is proposed that local leadership representing the local borough(s) and the relevant STP leadership will be invited to submit expressions of interest to test or

² Alongside CQC regulation, oversight by NHS Improvement becomes a consideration for providers and CCGs are assured by NHS England.

³ The ‘single voice’ refers to NHS England and NHS Improvement

deliver solutions against the commitments set out in the integration section of the MoU or wider opportunities. Those proposals may cover a range of spatial levels (local, multi-borough, sub-regional), but should have support from across health and care in an area. This section sets out the devolution commitments, but wider opportunities for consideration are also contained at Appendix 1.

FOR DECISION:

- **Do SPB Members support a strategy of delivering the MoU through locally developed propositions?**
- **Does SPB support the proposal that STP and borough leaders are invited to come forward with expressions of interest to test and deliver against the MoU commitments?**

3. Locally developed models are key to delivery of person centered care

3.1. Locally-led models of health and care necessarily vary across the Capital, to meet the needs of local citizens and communities in a tailored way. However, developing approaches suggest that there are some common features that partners all want to realise for Londoners:

Access	<ul style="list-style-type: none"> • Citizens have a clear, single point of access for health and care services. • Citizens can see a GP when they need to and at a time that suits them, supported by primary care working at scale.
Empowering and involving Londoners	<ul style="list-style-type: none"> • Local approaches are designed in partnership with and in response to the needs of local communities, with democratic accountability through local politicians. • Education and support empowers citizens to take better care of their own health and wellbeing. • Londoners are supported to manage long term conditions independently and remain in their homes where possible. • Londoners can influence and direct the support they receive.
Personalised and holistic care	<ul style="list-style-type: none"> • Multidisciplinary teams support all elements of health and wellbeing. • Approaches address the wider determinants of health (e.g. housing and education). • Mental health and wellbeing are more prominent parts of the care model.
Care in the community	Appropriate care delivered as close to home as possible.

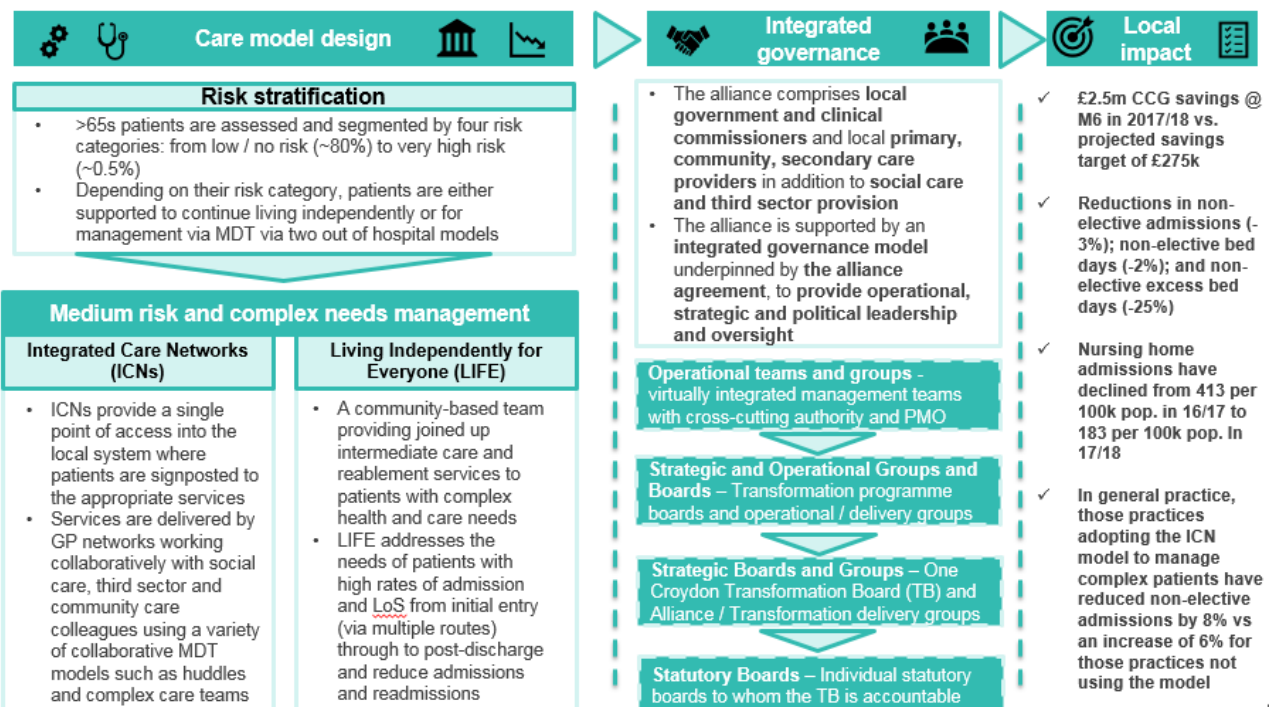
3.2. As an example, models of care start in a place with a defined population and build out from a primary and community care-based approach.

Borough case study: One Croydon Alliance

The 'One Croydon Alliance' is an integrated single-borough model already delivering impact. The model aspires to:

- improve personal outcomes;
- improve financial sustainability; and
- shift activity to the right place at the right time.

The aspirations are underpinned by an emphasis on proactive and preventative care that will fundamentally change the way that services are delivered to the local population of ~380k. The care model has initially been focused on the >65 year old population, with ambitions to expand to include the whole population.

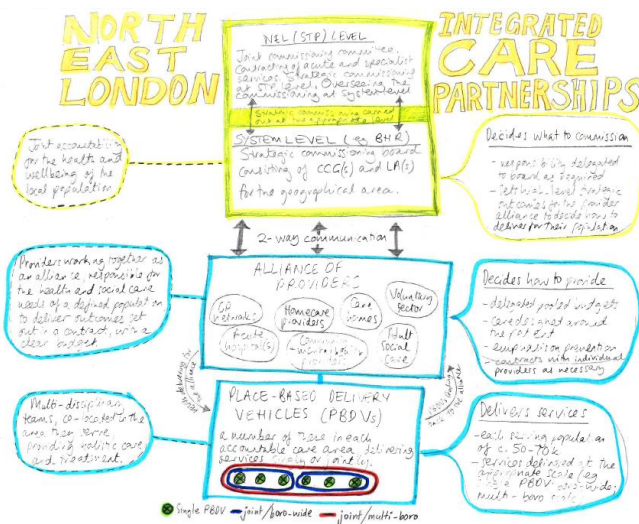


FOR DECISION: Do Board members support these principles?

3.3. It is not possible to meet all the needs of Londoners within their local community or home borough. Sometimes Londoners will need to go into the next borough, or further across the city, to receive the very best care for their condition. There is a recognised need to work across larger geographical footprints for some pathways of care (e.g. cancer) and projects (e.g. estates) to improve outcomes and work more efficiently. Within London, most citizens receive most of their care within a few boroughs of their home. Within each STP over 80% of elective, day case and

non-elective flows remain within the footprint⁴. Building on both locally driven work and the work of the STPs, cross-borough partnerships are developing across the Capital. These aim to preserve the principle of subsidiarity, with aggregation only where required.

Multi-borough case study: Barking and Dagenham, Havering and Redbridge



Strategic commissioning and service provision are distinct, but have a strong two-way connection.

Localities are geographic footprints of integrated provision but could also have a role in the tactical commissioning function.

Please note the above arrangements are still under consideration

4. London is considering its approach to Integrated Care Systems

4.1. National policy is increasingly focussing on integration across multi-borough footprints. Most recently, the NHS 2018/19 Planning Guidance set out a plan for STPs to ‘evolve’ into Integrated Care Systems (ICSs)⁵. ICSs are defined as being systems where “commissioners and NHS providers, working closely with GP networks, local authorities and other partners, agree to take shared responsibility (in ways that are consistent with their individual legal obligations) for how they operate their collective resources for the benefit of local populations”. Within London, conversations around the approach to ICSs are currently taking place via the STP SROs, through a series of workshops, with wider engagement within the STP footprints.

⁴ The pattern for providers is more varied, with many Trusts receiving substantial activity from across the whole of London and beyond.

⁵ Previously termed ‘Accountable Care Systems’

The national ICS development programme

The guidance explains the desired outcomes of the ICS as:

- creating more **robust cross-organisational arrangements** to tackle the systemic challenges facing the NHS;
- supporting **population health management approaches that facilitate the integration of services** focused on populations that are at risk of developing acute illness and hospitalisation;
- delivering **more care through re-designed community-based and home-based services**, including in partnership with social care, the voluntary and community sector; and
- allowing systems to take **collective responsibility for financial and operational performance and health outcomes**.

Each building block operates at a different scale and fulfils different functions



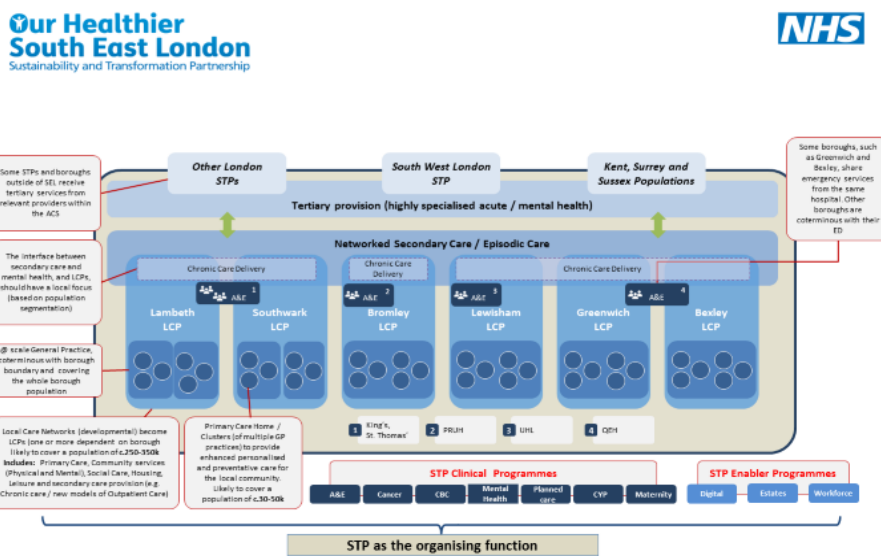
Integrated care system Care at the system level	Integrated providers Care in a place	Locality networks Enhanced primary care
<ul style="list-style-type: none">• +1million population• Providers and commissioners collaborating to:<ul style="list-style-type: none">○ Hold a system control total.○ Implement strategic change.○ Take on responsibility for operational and financial performance.○ Population health management.	<ul style="list-style-type: none">• ~100-500k population• Providers collaboratively:<ul style="list-style-type: none">○ Integrate primary care, mental health, social care and hospital services.○ Work preventatively to stop people becoming acutely unwell.• Care models to redesign care.	<ul style="list-style-type: none">• ~30-50k population• Link GP practices together to:<ul style="list-style-type: none">○ Enhance access.○ Give additional resilience.○ Share workforce.○ Provide proactive services.



Focus of national development programme

Case study 3: South East London

The South East London (SEL) partnership are considering a ‘system of systems’ approach, that builds on integration work already underway at a local level. The SEL region is complex with the needs of the diverse population served by multiple providers, often with footprints that extend beyond the STP or beyond London. For example, the specialised nature of many providers means that only a third of SEL provider income comes from SEL CCGs. SEL’s approach describes the way in which the constituent parts of the system may effectively and coherently interface with each other with responsibilities for different population sizes. For example, Primary Care at scale will provide enhanced personalised and preventative care to populations of ~30-50k. Primary Care at scale will interface with developing Local Care Networks – one or more depending on the borough – that become Local Care Partnerships to cover a population of ~250-350k and deliver a range of services including primary care, community services, mental health, social care and housing to its population.



1

FOR DISCUSSION: What approaches are other STPs and boroughs taking to enable integration at different spatial levels?

4.2. The Board has previously considered draft principles for ICSs in London. These principles are intended to be a regional expression of the national policy, ensuring that this is relevant and workable for the London context and that partners are agreed about the role and purpose of the ICS. Principles previously considered have been tailored to acknowledge the national design criteria and intended outcomes (confirmed in the 2018/19 Planning Guidance)⁶, whilst ensuring

⁶ Note that the Planning Guidance also contains a further criterion “A track record of delivery, with evidence of tangible progress towards delivering the priorities in Next Steps on the Forward View. These systems should be meeting NHS Constitution standards or provide confidence that by working as an integrated system they are more likely to be recovered”. It is recognised that systems wishing to be formally recognised in the national programme would need to meet this criterion.

London's shared vision is maintained⁷. This aims to ensure that London is able to respond to national requests with a clear vision of our ambitions that reflects London's context and priorities. Updated principles are as follows:

- 4.2.1. ICSs will support local approaches and **only aggregate functions where necessary**. The benefit of the scale of the ICS is that partners have the levers to take collective **responsibility for the total⁸ health and care needs of their population**, and for demonstrating shared outcomes which show tangible improvements for their local communities. This requires a **coherent and defined population** that reflects patient flows.
- 4.2.2. The focus will be on keeping Londoners healthy. **Prevention will be a fundamental part of the shared vision, recognising that approaches will differ across the ICS** and the borough/locality level is critical to address wider determinants of health. Population health management capabilities will be embedded across the ICS.
- 4.2.3. All parties with a role in improving the health and care of the population will be involved in the ICS, and will be **committed to partnership working across organisational boundaries at every level**. In particular:
- The ICS will integrate primary care, mental health, social care and hospital services using population health approaches to redesign care around people at risk of becoming acutely unwell. The ICS partnership will focus on 'horizontal integration' of providers across boroughs and 'vertical' integration which supports a variety of borough-based approaches.
 - Strong leadership across health and care will ensure involvement of clinicians and staff, third sector, service users and the public. Partnerships will be formalised through collective governance and decision-making as required⁹.
 - NHS commissioners will come together in formal arrangements. NHS and local government commissioning will integrate as agreed by local partners.
 - NHS providers will explore opportunities to collaborate more closely, e.g. shared back office functions as appropriate.
- 4.2.4. System planning and an agreed financial arrangement will enable **collective management of resources and sharing of risk**. CCGs and NHS providers will agree a system control total and operating plan.

FOR DECISION: Do Board members agree with these tailored national principles?

⁷ Appendix 2 shows changes to the ACS/ICS principles and rationale.

⁸ Close to total as possible, reflecting specialised services which may continue to be provided on a wider geographical scale.

⁹ This does not necessarily include any organisational change.

5. A pan-London support offer could augment local and STP efforts to help developing partnerships go further and faster

5.1. Given the differing integration ambitions at different spatial levels within and across London, it is important to enable and support this work while also ensuring strategic coherence within larger geographies (e.g. STP or London-wide). The SPB has previously agreed that the support offer would comprise common workstreams (e.g. leadership and governance), although the outputs and requirements would vary in their technical and structural nature. The proposed support offer described below aims to reinforce subsidiarity, with support only aggregated where appropriate.

5.2. The SPB will need to agree a process for decision-making regarding local proposals to use MoU freedoms. Such a process will inevitably involve a degree of due diligence to inform discussion. However, the presumption would always be that properly submitted proposals would be supported by the SPB and the London support offer would seek to provide resource to this end where possible.

FOR DECISION: Does the Board agree with this support offer?

	Spatial level	Primary source of support	Illustrative workstreams and content	Strategic coherence	Additional sources of support
A B C Support offer is focused on building local capability and the relational drivers of integration	A Locality	HLP provide direct support to localities that have expressed an interest with STP endorsement.	To be demand-led and informed by local requirements but likely to address key enablers:	Arrangements will be governed locally with the STP providing strategic coherence.	Systems could access other local support infrastructure e.g. AHSNs. Systems pursuing more formal integration ambitions, e.g. ACOs, are able to engage with the relevant NHSE national teams.
	B Borough	Flexible and permissive support to be provided in collaboration with colleagues from London Councils and accessed via the Health and Care Systems Working Group	<ul style="list-style-type: none"> Leadership & governance / collective decision making Care model design Commissioning Financial model Workforce Population health management Estates 		
	C Multi-borough				
D E Support offer is about facilitating the voluntary rollout of ICSs and the related technical challenges	D ICS / STP	NHSE (London) and NHSI (London), with support from HLP, could provide structured regional support to facilitate ICS development.	To be agreed with STP leads but likely to be similar to above and focussed on the workstreams that directly address the ICS criteria.	<ul style="list-style-type: none"> Each STP is governed by a partnership board. The Transformation Executive could provide forum to enable strategic coherence across STPs 	Systems potentially able to access additional national support to develop ICSs via STG.
	E Pan-London	HLP will be the delivery-vehicle for pan-London partnership work and will be supported by regional strategic partners.	To be agreed but likely to be focussed on developing products best done 'Once for London' e.g. regional BI platform.	<ul style="list-style-type: none"> The SPB will provide strategic leadership and oversight of pan-London work. The London Health Board will provide political leadership and oversight 	Additional access to support will be dependant upon the development of generative strategic partnerships.

To note: Following engagement with NHS England national and regional colleagues there now is an opportunity for several London systems at borough or multi-borough level to participate in a national programme that is trying to shine a light on positive examples of health and care integration. This programme will provide no-cost system learning and development opportunity and deliver a range of tools and resources for wider dissemination and utilisation. The national programme has approached four local health economies to date, with the aim of potentially accelerating local integration efforts and providing an opportunity to influence emerging national policy in a way that is consistent with the principles and terms of the MoU.

Appendix 1: Further emerging opportunities

Theme	Commonalities	Key opportunities
Delivery/ care model	<ul style="list-style-type: none"> • Within localities: The care model is based upon ‘hubs’ serving populations of 30k-80k, with horizontally-integrated multi-disciplinary teams supporting segmented populations and providing links to a wider range of services including social care and third sector. To support this model, primary care operates at scale with emphasis on coordination, enhanced access and proactive care. • At borough or multi-borough level: The focus is on vertical integration between locality models and acute services, with standardised clinical standards and service pathways. • At multi-borough (including STP) level: The focus is on horizontal collaboration between providers to deliver services sharing resources and expertise to reduce variation and improve quality. 	<ul style="list-style-type: none"> • All: Sharing expertise and knowledge about emerging care models and, by comprehensively mapping London’s emerging models, telling a compelling story to local, regional and national political leaders about London’s ambition. • Borough – STP: Exploring the relationship between large, complex providers and locality/borough based systems of health and care, particularly where provider footprints extend beyond an STP and/or beyond London.
Leadership and governance	<ul style="list-style-type: none"> • Within localities: Primary care leaders are collaborating in networks, often in partnership with social care and community services. The degree of collaborative decision-making and governance will vary in formality. • At the borough level: CCGs and boroughs are making decisions via joint arrangements that vary in formality, often led through Health & Wellbeing Boards. • At the multi-borough and STP level: There are examples of collaboration with shared governance and leadership roles. Each STP has shared governance (with varying formality) and shared clinical leadership structures. 	<ul style="list-style-type: none"> • Support the development of integrated leadership across health and local government at multi-borough and STP level. • Supporting greater collective clinical leadership within the STPs with a clear focus on clinical improvement.
Commissioning/ finances	<ul style="list-style-type: none"> • At the borough or multi-borough levels: In many cases, partnership arrangements are in place for integrated commissioning within a borough (e.g. via s.75 agreements). In some cases, CCGs and boroughs are operating integrated commissioning arrangements across borough boundaries. Whilst there is limited appetite within London for procuring an ACO, many commissioners are considering alliance arrangements with providers and boroughs which include a 	<p>Borough and multi-borough (including STP):</p> <ul style="list-style-type: none"> • Sharing learning on integrated commissioning models, including alliance arrangements and governance arrangements for integrated

	<p>risk / reward share mechanism based upon agreed population outcomes and performance.</p> <ul style="list-style-type: none"> • At the STP level: Most STP geographies now have a shared CCG Accountable Officer and there is potential for commissioning services across the footprint, subject to local appetite. 	<p>commissioning committees.</p> <ul style="list-style-type: none"> • Systems could explore approaches to manage collective resources (e.g. via a system control total) with mechanisms to share risk and reward.
Population health management	<ul style="list-style-type: none"> • Locality level: Population health management can support clinicians and multi-disciplinary teams to respond to patient/population needs. • Borough – STP level: Population health management supports commissioning and care model design, including by way of risk-stratification and population segmentation. Emphasis on reducing avoidable variation and reducing inequalities achieved by embedding prevention, social prescribing and community participation in population health management approach. Population health management supports partners to take responsibility for total health and care needs of a defined population. It also enables development of systems outcomes framework for measuring effectiveness and impact in health and care informed by local engagement and consultation. • London level: Design and implementation of integrated, common business intelligence platform to identify and manage population health risks. Developing external strategic partnerships that build business intelligence and analytical capability. 	<ul style="list-style-type: none"> • STP/London: Developing external strategic partnerships that build business intelligence and analytical capability; developing an integrated, common business intelligence platform to identify and manage population health risks. • Borough – multi-borough: Supporting partnership approach to population health management and supporting local systems to become informed customers of any related solutions.

Appendix 2: Comparison of ICS principles to those previously discussed at SPB

Previously discussed principles	We have updated previously discussed principles to reflect the developing role of the ICS
Put Londoners first, with collaborative working enabling partners to better understand and meet the total health and care needs of their population.	ICSs will support local approaches and only aggregate functions where necessary. The benefit of the scale of the ICS is that partners have the levers to take collective responsibility for the total health and care needs of their population, and for demonstrating shared outcomes which show tangible improvements for their local communities This requires a coherent and defined population that reflects patient flows.
Partners will take collective responsibility for the total health and care needs of their population, and for demonstrating shared outcomes which show tangible improvements for their local communities.	<i>Edited to more clearly reflect the role of the ICS and the NHSE design criteria. Merged for brevity.</i>
Focus on keeping Londoners healthy, with prevention being a fundamental part of the shared vision and population health management capabilities embedded.	The focus will be on keeping Londoners healthy. Prevention will be a fundamental part of the shared vision, recognising that approaches will differ across the ICS and the borough/locality level is critical to address wider determinants of health. Population health management capabilities will be embedded across the ICS. <i>Edited to maintain the ambition around prevention but recognise the importance of the borough-level and local approaches.</i>
All parties with a role in improving the health and care of the population will be involved in the ACS, and will be committed to partnership working across organisational boundaries at every level. This will include 'horizontal integration' of providers and integration with primary and community care – either virtually or more formally.	All parties with a role in improving the health and care of the population will be involved in the ICS, and will be committed to partnership working across organisational boundaries at every level. In particular: <ul style="list-style-type: none"> • The ICS will integrate primary care, mental health, social care and hospital services using population health approaches to redesign care around people at risk of becoming acutely unwell. The ICS partnership will focus on 'horizontal integration' of providers across boroughs and 'vertical' integration which supports a variety of borough-based approaches. • Strong leadership across health and care will ensure involvement of clinicians and staff, third sector, service users and the public. Partnerships will be formalised through collective governance and decision-making as required. • NHS commissioners will come together in formal arrangements. NHS and local government commissioning will integrate as agreed by local partners. • NHS providers will explore opportunities to collaborate more closely, e.g. shared back office functions as appropriate.
Formalise local partnerships, through collective governance and decision-making*.	<i>Edited to reflect NHSE design criteria and focus on cross-borough integration where the ICS partnership particularly adds value. Merged.</i>
Ensure that partners are collectively meeting needs and adapting to changes through an agreed financial arrangement that enables collective management of resources (e.g. through a system control total) and risk to be shared.	System planning and an agreed financial arrangement will enable collective management of resources and sharing of risk. CCGs and NHS providers will agree a system control total and operating plan. <i>Edited to reflect NHSE design criteria.</i>
Arrangements maintain all the fundamental rights of Londoners, including patient choice.	<i>This is removed only because recognised that patient choice is a fundamental element of any new integrated model.</i>