MAYOR AND CABINET			
Report Title	Update on Integration with NHS and the creation of a Borough Based Board		
Key Decision	Yes		Item No.
Ward	All		
Contributors	Executive Director, Community Services		
Directorate	Community Services		
Class	Part I	Date: 11 December 2019	

Reason for Urgency

The report has not been available for 5 clear working days before the meeting and the Chair is asked to accept it as an urgent item. The report was not available for dispatch on Tuesday 3 December 2019 due to a delay in clarifying the final legal details pertaining to the development of the Borough Based Board. The report cannot wait until the next meeting due to the need to progress staffing arrangements as set out in the report.

1. Purpose of the report

1.1 The purpose of this report is to inform Mayor and Cabinet of the establishment of a regional Clinical Commissioning Group for South East London with effect from April 2020 and to seek agreement in principle for the Council to participate in a local integrated care partnership for the borough, to be known as a Borough Based Board. The report sets out detail of preparatory work that has been undertaken to date by the Council and its partners to respond to the reorganisation of Clinical Commissioning Groups in south east London and, subject to agreement in principle to participate in a Lewisham Borough Based Board, asks officers to bring back a more detailed report setting out fully the proposed governance arrangements and the work necessary to implement the new arrangements.

1. Recommendation

Mayor and Cabinet are asked:

1 To note that a new regional clinical commissioning group, the South East London Clinical Commissioning Group (SELCCG) is to be established with an implementation date of 1 April 2020;

2 Subject to the matters set out below, to agree in principle to participate in the Lewisham Borough Based Board;

3 To ask officers to bring back to the Mayor and Cabinet a further report at the earliest opportunity for approval of the governance structure and decision making processes for the Council's participation in a Lewisham Borough Based Board to include the measures which would be necessary to implement if approved;

4 To note that the Council has seconded the Managing Director of Lewisham Clinical Commissioning Group to the Council, part-time, to assist it in preparatory work required to inform the further report to be brought back to Mayor and Cabinet for formal approval to participate in the Lewisham Place Based Board; and

5 To note that, subject to the agreement in principle to participate in the Lewisham Borough Based Board, officers will continue work on staffing arrangements to support the Council's participation in the Board, such arrangements to proceed in accordance with the Council's usual legal and employment requirements.

Policy Context and Background

3.1 The develops in this paper, and the Council's response to them, directly contributes to the following implementation of the Council's priorities from the Corporate Strategy 2018-2022 particlarly in relation to delivering & defending health, social care and support and ensuring everyone receives the health, mental health, social care and support services they need.

3.2 Lewisham, like many local authorities faces significant health and social care challenges. Here as elsewhere, there have been moves to greater integration between NHS, Council and other providers. This paper sets out the context for those moves and the current proposals for integration. The purpose of this report is:-

- To set the Lewisham context in relation to demand for health and social care services
- To set the national context in relation to the drivers and challenges of integrated care and commissioning across the health and social care system
- To set the London and sub-regional context in relation to integrated care and commissioning across the health and social care system and economy
- To describe the proposed integrated commissioning model in Lewisham via a Borough Based Board
- To propose the next steps to provide assurance to the Council in relation to the proposed model and approach in Lewisham

4. Lewisham Health and Social Care context

4.1 In Lewisham, life expectancy remains lower than the England average and there are significant differences in life expectancy rates in different wards within the borough. Cancer is now the main cause of death in Lewisham, followed by circulatory disease and respiratory disease. Many of these deaths could have been prevented by healthier lifestyles.

4.2 There are also significant health inequalities in Lewisham. People living in the most deprived wards have poorer health outcomes and a lower life expectancy compared to England's average. The borough is also one of the most ethnically diverse areas of the country. The Department of Health and Social Care has highlighted ethnicity as the major inequality in severe mental illness. In Lewisham Black, Asian and Minority Ethnic (BAME) service users are overrepresented in crisis and acute wards and teams that support people in the community with a mental health condition, such as promoting recovery teams and home treatment teams. In July 2019 Lewisham's Health and Wellbeing Board made addressing BAME health inequalities one of its main priorities for the next 3 years focusing specifically on mental health, cancer and obesity.

4.3 The demand for care is also increasing, both in numbers and complexity, particularly the demand for urgent and emergency care. Lewisham's older population of over 60 is projected to increase by around 33,000 by 2040 which will increase the demand for the health and care services. As seen nationally, people who access services in Lewisham say that care is not always provided in the most consistent, co-ordinated, efficient or cost effective way, is often duplicated and confusing, particularly if support is sought out of hours. This confusion is often particularly acute at the interface between health and social care services with the challenges to addressing some of these issues explored in more detail in section 3 below.

4.4 The cost of delivering care is rising and early intervention is not consistently effective which would reduce the need for longer term support and associated costs. This is an issue across children's and adult services. Transition from children's services to adult services is often problematic, planning is inconsistent and early intervention to prepare young people for adulthood is underdeveloped. As the provision of Adult Social Care moves towards an increasingly preventative approach it is vital that all elements of the system are redesigned to support this and make best use of the local resources available. Improving the service user/patient experience and the efficiency of the overall system through the integration of services is key to meeting some of these challenges.

5. Health and Social Care Integration – historic overview

5.1 Health and Social Care Services in England have traditionally been funded, administered and accessed separately. Health has been provided free at the point of use through the National Health Service, whilst Local Authorities have provided means tested social care to their local populations. It is argued that people with both health and social care needs are not well served by the traditional model, and that by integrating the NHS and Local Authorities' health and social care function, the person can be put at the centre of how care is commissioned, organised and delivered. The Council has a duty under the Care Act 2014 to promote the integration of care and support services with health services and health related services where this will benefit people and the quality of care.

5.2 Both the NHS and local authorities have focused on policy to support integration. This has involved delivering care outside of hospital by delivering care as close as possible to the person, either at home or in the community. It has also sought to reduce problems caused by the ineffective interaction of health and social care, such as unnecessary hospital admissions and delayed discharge. Demographic trends, such as an ageing population and increasing life expectancy for those with multiple, long term conditions, mean that there is an increasing number of people with both complex health and social care needs. This is coupled with increasing expectations in relation to the quality of experience and further exacerbated by reducing resources and a shrinking financial envelope across both the NHS and local authorities.

5.3 There are a number of challenges in attempting to better integrate health and social care, these include:-

- Different funding incentives for the NHS and Local Authorities
- Different funding models; free at the point of access versus means tested
- Challenges integrating different workforce cultures
- Difficulties implementing effective information sharing
- Different Inspection Frameworks
- The cost to NHS bodies and local authorities of integrating services
- Different governance and joint departmental oversight arrangements.

However, it is argued that, as well as improving the service experience, integration can save money by cutting down on emergency hospital admissions and delayed discharges. This is particularly significant in light of current funding pressures for the NHS and Local Authorities, although the scope of potential savings has been disputed.

5.4 There has been a raft of policy initiatives in England over recent years that have attempted to tackle this national issue by promoting the closer integration of health and care services. In 2012, the Health and Social Care Act, introduced

a number of changes including some designed to promote the closer integration of services (including Monitor, which was told that its role in supporting integration should 'trump' its role in applying competition rules), and arrangements around markets in health care provision. Health and Wellbeing Boards were created and tasked with assessing their local population needs, developing a joint Health and Wellbeing Strategy and promoting greater integration of health and care services.

5.5 In the 2013 Spending Review, the government announced a new pooled fund of £3.8 billion to try to encourage health and social care organisations to better co-ordinate their services. This came to be called the Better Care Fund (BCF) and built on the Government's investment in 2010 to pool some local funds for the development of integrated services. However, although this was a new initiative, it contained no new money, only a reallocation of existing funds and transfers from the NHS budget. The original intention was for a proportion of the payments from the BCF to be made in local areas in stages to reflect performance in improving services through local integration. However following a redesign of the fund in 2014 the priority shifted to reducing emergency hospital admissions, with money staying in the NHS if the targets were not met.

5.6 The 2015 Spending Review pushed the target for full integration of local services through the BCF back to 2020 with all areas to have a plan for integration in place by 2017. In addition, it also announced new funding for the BCF from 2017/18, sometimes referred to as the improved BCF. An additional £2 billion funding for local authority social care was announced in the 2017 Spring Budget, although it was later clarified that this would be directed through the BCF as additional improved Better Care Fund (iBCF) funding.

5.7 The National Audit Office in 2017 reported on health and social care integration and looked at the performance of the BCF in its first year and found a mixed picture in terms of performance in relation to the reduction in the number of emergency hospital admissions and delayed discharges which have continued to rise in recent years. There was no compelling evidence that integration leads either to sustainable financial savings or reduced hospital activity. However, the report also found a significant majority of local areas had seen a positive impact in relation to the integration of health and social care and a more joined up service between health and social care provision, with the use of a common language and improved relationships.

5.8 NHS England and other national bodies published the NHS Five Year Forward View in October 2014, which set out a shared vision for how services needed to change in the future. At the heart of the vision were a number of new models of care in which services are much more integrated. As part of the delivery of the Five Year Forward View in 2015, NHS England and the LGA launched the Integrated Personal Commissioning Programme across nine 'demonstrator

sites' which gave high needs individuals personal budgets to commission integrated health and social care services themselves, as well as offering planning support; a further ten additional areas had joined the programme at the end of March 2017. NHS England plans for Integrated Personal Commissioning to become a model of care for around 5% of the population once it is fully rolled out.

5.9 Local Authorities and NHS partners had been encouraged to set up joint 'Sustainability and Transformation Partnerships' (STPs) to take forward the integration agenda. The local STP is the South East London STP; partners include Lewisham Clinical Commissioning Group (Lewisham CCG), the Council and others. In December 2015, NHS England published planning guidance which asked NHS organisations and their partners to create area-based plans for the five year period from October 2016 to March 2021. The plans are intended to show how local services will improve quality of care, promote population health and become more financially sustainable. NHS England's 'Next Steps on the NHS Five Year Forward View' sets out plans for the most integrated of the STPs to develop into 'Integrated Care Systems' (ICS), the aim of which is that NHS bodies and Local Authorities will take collective responsibility for commissioning resources and for the health and social care of their STP area. The Local Government Association has stated its support for the STP process, hailing the plans as 'significant milestones' in the integration of health and social care.

5.10 In spite of the raft of policy initiatives and incentives most are relatively new and so detailed triangulated evidence of performance and outcomes is sometimes limited and can vary depending on the local conditions for change in relation to the integration of health and social care. The most recent developments and the implications of these for Lewisham are set out in the next section.

6. Current policy context and implications for Lewisham

6.1 Government issued the NHS Long Term Plan in 2019. As part of the delivery of that Plan, local NHS bodies are expected to work within the local STP – and therefore with local authority partners - to develop and implement strategies for the next five years, to take local action to improve services and the health and wellbeing of local communities. The name given to the South East London STP was Our Healthier South East London (OHSEL). This is a collaborative working arrangement between the partners; there is no contract or formal arrangement between the parties and it is not a separate legal entity.

6.2 In part in response the NHS Long Term Plan, Our Healthier South East London (OHSEL) was designated as an aspirant Integrated Care System (ICS) on 19 June 2019, in which the participants in OHSEL work in collaboration. The partners in OHSEL are local health and care organisations and local councils with the joint aim being to re-design care and improve population health,

through shared leadership and collective action. The aims of the ICS are to build on existing collaboration, to integrate local services, and to help people stay well for longer by supporting them to lead healthier lives, manage their own health conditions and provide good access to care when they need it, often closer to where they live.

6.3 Lewisham Council and Lewisham CCG have, over the years, sought to strengthen integration, including through their existing local commissioning arrangements. It is intended that these will be further strengthened as part of the development of the place based system which is referred to below. The partnership for Lewisham is currently called Lewisham Health and Care Partners (LHCP)[1]. This is not a formal contractual arrangement; it is a working arrangement between the partners. LHCP's vision is to achieve a sustainable and accessible health and care system to support people to maintain and improve their physical and mental wellbeing, to live independently and have access to high quality care when they need it, through local and collective south east London action. A key focus of the partnership's work is on the integrated delivery of proactive, co-ordinated and accessible community based care, and establishing effective working across that and secondary provision. Four priorities have been identified as areas where improvements in delivery and outcomes are required: Frailty, Mental Health, Respiratory and Diabetes. Various particular steps have been taken or are intended, as set out below.

6.4 On 1st July 2019 OHSEL agreed the development of 6 Primary Care Networks (PCNs) in Lewisham, involving 35 GP practices. These are groups of GP practices coming together locally in partnership with community services, social care and other providers of health and care services around the needs of local patients. Again, OHSEL's involvement is not a formal contractual arrangement involving the Council.

6.5 Lewisham Council and Lewisham Clinical Commissioning Group have worked together to prepare a joint health and wellbeing strategy. This strategy explains what priorities the local Health and Wellbeing Board has set in order to tackle the needs identified in the joint strategic needs assessment (JSNA). The 2019 JSNA programme was agreed by the Health and Wellbeing Board in March 2019.

6.6 The NHS Long Term Plan envisages the creation of a number of area-based Clinical Commissioning Groups which will absorb the current more localised Clinical Commissioning Groups. In south east London there are currently six CCGs (Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark). The

[1] Lewisham Health and Care Partners (LHCP) consists of:
London Borough of Lewisham (LBL), Lewisham Clinical Commissioning Group (LCCG),Lewisham and Greenwich NHS Trust (L&G), Lewisham Local Medical Committee (LLMC), One Health Lewisham Ltd (OHL), Primary Care Networks (PCN) and South London and Maudsley NHS Foundation Trust (SLAM)

six borough approach has been in existence since 2017 when commissioning for acute hospital services (e.g. for Lewisham and Greenwich NHS Trust) began being undertaken at a sub-regional level. The NHS intends to establish a single CCG to operate across the six boroughs from 1 April 2020. This will be the 'NHS South East London Clinical Commissioning Group. In considering the establishment of that new CCG, the NHS has engaged with a wide range of stakeholders, including the Local Authority and residents. The proposal seeks the restructure of NHS commissioning organisations and will not make any changes to services that residents receive.

6.7 An application to create NHS South East London Clinical Commissioning Group was made to the CCG regulator, NHS England and Improvement, at the end of September 2019 following endorsement by NHS Lewisham CCG's Governing Body at their Public Meeting on 12 September 2019 and subsequently agreement by the CCG Membership on 17 September 2019.

6.8 The creation of the South East London CCG means that local arrangements need to established for the on-going strategic management and commissioning of those functions and services best determined at a local level. It is intended to achieve this through the establishment of a formal 'Borough Based Board' for Lewisham (see section 5).

7. Integrated Commissioning Model in Lewisham

7.1 Lewisham Council has been committed to achieving a sustainable and accessible integrated health and care system to better support people to maintain and improve their physical and mental wellbeing, to live independently and to have access to high quality care when needed. It is not proposed that there should be any change to that general approach, which assists with the Council's delivery of its duty under the Care Act 2014.

7.2 Joint commissioning arrangements between health and social care have been in place since 2004; staff have been formally seconded to work in joint teams from 2011; there are various agreements in place for joint working in individual service areas; the joint commissioning relationships are strong at local level across children's and adults; and there are existing Section 75[2] agreements and an Integrated Joint Commissioning Group. The proposed new arrangements will build on and extend the current arrangements.

7.3 The Lewisham Health and Care Partnership is committed to develop and deliver community based care which is:

[2] Section 75 partnership agreements, legally provided by the NHS Act 2006, allow budgets to be pooled between local health and social care organisations and authorities, and allow cross-delivery of functions. Agreements are already in place for a range of services in Lewisham including Mental Health services commissioning jointly by the CCG and the Council and delivered by SLAM.

- Population based
- Expands and strengthens primary and community care
- Promotes health and wellbeing
- Provides a co-ordinated response to the specific needs of the individual
- Works in partnership with patients, service users and wider communities
- Takes a whole system approach
- Evidence based and outcome focused

7.4 The proposed merger of the 6 SE London CCGs and the establishment of NHS South East London CCG (set out in paragraphs 6.6 - 6.8 above) would not change those aims. The new CCG (which would be a statutory and sovereign body) would continue to be a partner of the Council

7.5 However, as highlighted above it is necessary to ensure the new CCG remains locally responsive and connected to borough populations. In order to secure this connection the NHS proposals are that a 'Borough Based Board' is created in each of the boroughs. In Lewisham it is proposed that the local authority will take the lead in hosting the Board which will ensure that the Council can ensure system leadership across health and social care (but this will not involve taking responsibility for our partners' statutory duties). By taking the lead in these arrangements the Council can ensure that it has greater oversight of local community health services and the process of integration with social care.

7.6 The NHS anticipates that the new NHS South East London CCG will formally delegate certain NHS decisions to the Borough Based Board under their 'prime committee' arrangements. The matters they will delegate will include the South East London CCG's powers, budget and decision-making on borough based matters for primary care, community-based care services including mental and physical health services, prescribing and all client group commissioning. The detail of those arrangements has yet to be resolved.

7.7 The NHS proposals are that the Borough Based Board would have responsibility for strategy and delivery of primary care services alongside community and out of hospital services. In respect of GP services a South East London Primary Care Commissioning Committee would retain responsibility for NHS decisions in relation to signing off and agreeing contractual changes.

7.8 The NHS would intend that the new Board, as a prime committee of the CCG, will be required to meet in public for some of its meetings but will still need to discuss commercially sensitive and confidential information so there will be a necessity for some items to be held in private as per Mayor and Cabinet Part 2 items.

7.9 The new Board will include representatives from the Council, CCG (executive, clinical and lay), local NHS providers and Healthwatch, although some discussions will be limited to commissioners only.

7.10 It is not intended that the establishment of the Borough Based Board would alter the decision making process for Lewisham Council with the Council remaining the sovereign body for decisions as currently under the Council's Constitution and Scheme of Delegation. Rather, the Borough Based arrangements will ensure that health and social care commissioners work collaboratively alongside provider partners, enhancing the existing roles and responsibilities of the joint commissioners. This will strengthen whole system leadership, the more effective sharing of data and performance information and will maximise opportunities for joint planning and the alignment of outcomes – as well as offering more explicit opportunities for the Council to influence local NHS commissioning.

7.11 This arrangement builds upon the current Joint Commissioning arrangements whereby officers from both the Council and the CCG meet to discuss proposals and agree strategic approaches with a view to presenting final recommendations to Mayor and Cabinet and the relevant CCG Committee or Governing Body for sign off as required for resource allocation. Under this proposed new arrangement there will be greater Council involvement in the shaping and delivery of strategies across health and social care.

7.12 An example of how this currently works is the joint planning of support and care for individuals in need of accommodation based services to support with their Mental Health. Currently, the Integrated Joint Commissioning Group discusses the overall strategic approach, pathways and the specifications and contractual arrangements for specific services with recommendations for the allocation of resources for clinical community Mental Health services ultimately taken to the CCG Finance and Investment Committee, and those for Mental Health supported housing taken to Mayor and Cabinet, for agreement or otherwise.

7.13 It is intended that the creation of the Borough Based Board will remove the need for referral of NHS decisions back to the CCG (as it will have formal delegation of powers, budget and decision-making). It is not intended that the creation of the Board will change Council decision making arrangements; accordingly it will be important to sequence meetings correctly to ensure that the decision making at the Board and via Mayor and Cabinet happen in a coordinated way.

7.14 The local arrangements for the Lewisham Health and Wellbeing Board (HWBB) and scrutiny via the Healthier Communities Select Committee and through Healthwatch will remain unchanged by these developments. The Borough Based Board could be described as the "engine room" to deliver the strategies agreed by the HWBB. Progress made will be reported back to the HWBB.

7.15 The Council and NHS partners have various existing arrangements in place, including joint commissioning arrangements, staff secondments, section 75 arrangements for integrated services etc. Various of those arrangements involve Lewisham CCG. The abolition of that organisation and the creation of South East London CC means that the affected arrangements will have to be amended in order that they continue in force. Work will be done in order to ensure that there is a smooth transition to the new arrangements.

7.16 If the agreement in principle is given as set out in the recommendations to this report a further reports will be brought to Mayor and Cabinet at the earliest opportunity. This will include consideration of and recommendations about the Council's approach to and any involvement in the governance structure and decision making processes for a Lewisham Borough Based Board; information about the measures which would be necessary to implement the Board; and the transition of the Council's current arrangements from Lewisham CCG to South East London CCG and/or the Borough Based Board.

8. Staffing implications

8.1 The abolition of Lewisham CCG and the creation of the Borough Based Board outlined above creates the need for a local leadership and management structure to be created, which is aligned with the current local arrangements.

8.2 A number of the required posts already exist within an integrated structure e.g. the Director of Adult Integrated Commissioning (NHS post) and the Director of CYP Integrated Commissioning and Early Help (Council post) but these arrangements may need to be extended due to the scope of the services and budgets to be managed via the Borough Based Board.

8.3 Pending formal agreements being established the Managing Director of the Lewisham CCG has been seconded to work with the Council part time and lead on the design of the integrated commissioning arrangements in order that a Borough Based Board can "go live" in April 2020.

8.4 Discussions have been taking place between the Council and the CCG on the design of integrated management structures to take effect from April 2020.

8.5 Subject to the agreement in principle to participate in the Lewisham Borough Based Board, officers will work up staffing arrangements which would support the Council's participation in it, in accordance with the usual Council legal and employment requirements if final approval is given to proceed. Current proposals are that this will result in proposals to create two senior level posts, being a net increase of one senior post.

9. Social Value Implications

9.1 There are no direct social value implications as a result of this report.

10. Financial Implications

10.1 This report describes the proposed integrated commissioning model in Lewisham via a Borough Based Board. The Council contribution towards the new structure will be from base budget and from Better Care Fund.

10.2 The new arrangements are expected to secure improvements to commissioning for both health and social care although it is too early to quantify these.

11. Legal Implications

11.1 This report sets out the position regarding current and future arrangements in relation to integrated health and social care, and asks Mayor and Cabinet to note the position.

11.2 This report and the forthcoming decisions have to be made within the current legal framework which underpins the integration of health and social care services, and thus between local authorities and the NHS. One of the barriers which has impeded progress to date on the integration of social care and health is legislative. The NHS Long Term Plan recognises this factor, but perhaps unsurprisingly, contains a particular emphasis on the law relating to health commissioning. In this respect the requirements in the Health and Social Care Act 2012 on CCGs to tender services with potential intervention by the Competition and Markets Authority remain on the statute book, and the duty on health commissioners and providers to collaborate awaits full expression in legislation. The national strategy proposals for Borough based partnerships and ICS appear to be in part a “workaround” in an attempt to ameliorate the negative impact of hard commissioner/contractor splits without any statutory assistance to do so. While there are proposals for legislative change, these are not in place and would not necessarily address all the issues from the perspective of local authorities. No doubt we will be able to obtain assurance in due course from our health partners on the NHS’s relevant legal and governance arrangements, including the arrangements for decision making by the Borough Based Board.

11.3 Arrangements in relation to integrated health and social care will entail decisions about joint working arrangements with the NHS, including decisions regarding section 75 arrangements, placing of contracts regarding provision of services, and staffing arrangements. The detailed arrangements for the operation of the Borough Based Board are not yet known; however, any involvement by the Council in that Board will need to be compliant with the matters set out in these Legal Implications. In considering this report the key features set out below will apply.

Council decisions

11.4 The basic rule, as is well established law, is that only the Council (whether at full Council, through a Council committee or the Mayor, or as appropriate as delegated) may make decisions which are for it to make. The Council cannot delegate its decision making to an outside body. Neither may it subjugate its decision making to the decisions of another body. It cannot fetter its discretion in this way.

11.5 This paper sets out that it is anticipated that two senior level posts will be established. The Council's legal and constitutional requirements will need to be followed in any such decisions, which may require that approval is sought from full Council for the creation of any such posts.

Mayoral decisions

11.6 By law, the full Council sets the Council's budget, proposals for which are made by the Mayor. Once the budget is fixed, unless a decision is specifically prohibited to him by law, all decisions are for the Mayor to make so long as they are consistent with the Council's budget and policy framework. There are regulations which set out what is and what is not a Mayoral decision, but decisions about social care and public health are for the Mayor (except to the extent that they fall to the Health and Wellbeing Board by regulation).

Mayoral delegation

11.7 The Mayor may delegate decision making but he may only do so in accordance with the law. He may delegate to the Executive (in Lewisham called the Mayor and Cabinet), a sub group of his Cabinet, an individual cabinet member, an area committee (which we do not have in Lewisham), a joint committee, or to an officer. He could not delegate anything to the Borough Based Board.

The scope of Executive Directors' delegation

11.8 In Lewisham, powers are delegated to the Executive Directors in accordance with the Mayoral Scheme of Delegation. There are a number of reserved decisions which are for members to make, for example as below. It is always possible for the Mayor to amend this scheme of delegation:

(1) decisions relating to the provision, commissioning or purchasing of services which in the opinion of the Executive Director would lead to major change in service delivery;
(2) decisions relating to the joint commissioning of services with health bodies or other external bodies which would have financial implications for the Council in excess of £500,000;
(3) Award of contracts above the European threshold including under the Light Touch Regime.

11.9 There are other exemptions. Decisions not reserved to members are for officers to make. Executive Directors establish their own Schemes of

Delegation; however, they could not delegate anything to the Borough Based Board.

The process for Mayoral decision making

11.10 This is largely prescribed in law. Many provisions apply irrespective of who makes the decision, so even if very much larger powers were granted to EDs sitting on the Borough Based Board, it would make no difference.

11.11 The law provides that some Mayoral decisions are to be "key decisions" (regardless of whether the decision is made by Mayor and Cabinet, or by an officer). The legal definition of a key decision is one which would be likely to have a significant effect in two or more wards, or is in excess of a financial threshold set by the Council. The Council has set a general threshold of £500,000. Where a decision relates to a contract award, this threshold is £200,000. There is also a number of specific instances where a decision would be key (for example granting interest in land over £500,000). Whoever makes a key decision, there is a legal requirement that it must be included in the Forward Plan (normally for 28 days) before the decision is made.

11.12 Also there is a legal requirement that once a decision has been made but before it has been implemented there must be an opportunity for "call in" by overview and scrutiny members. "Call in" is the right of overview and scrutiny members to ask the decision maker to reconsider. This function is exercised by the Overview and Scrutiny Business Panel. Where this happens, the decision is not effective until the decision maker has reconsidered.This process cannot be subverted except in cases of real urgency.

11.13 It would not be possible for a Borough Based Board established by South East London CCG to operate as some sort of committee that binds the Council. Council/Mayoral delegations to Council officers sitting on that Board would not allow decisions to be made by the Board. The Board could not have Council budgets delegated to it in the absence of permissive legislation. Such legislation exists for S 75 arrangements under which pooled budgets may be established, but not otherwise. Accordingly, the Board could do no more than make recommendations to the Council in relation to key decisions. Those decisions would then have to be taken in accordance with the legal process and the Council's own statutory duties.

Equalities issues

11.14 The Council has a public sector equality duty (the equality duty or the duty - The Equality Act 2010, or the Act). It covers the following protected characteristics: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

11.15 In summary, the Council must, in the exercise of its functions, have due regard to the need to:

- eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.
- advance equality of opportunity between people who share a protected characteristic and those who do not.
- foster good relations between people who share a protected characteristic and those who do not.

11.16 It is not an absolute requirement to eliminate unlawful discrimination, harassment, victimisation or other prohibited conduct, or to promote equality of opportunity or foster good relations between persons who share a protected characteristic and those who do not. It is a duty to have due regard to the need to achieve the goals listed above. The weight to be attached to the duty will be dependent on the nature of the decision and the circumstances in which it is made. This is a matter for the decision maker, bearing in mind the issues of relevance and proportionality. The decision maker must understand the impact or likely impact of the decision on those with protected characteristics who are potentially affected by the decision. The extent of the duty will necessarily vary from case to case and due regard is such regard as is appropriate in all the circumstances.

11.17 The Equality and Human Rights Commission (EHRC) has issued Technical Guidance on the Public Sector Equality Duty and statutory guidance. The Council must have regard to the statutory code in so far as it relates to the duty. The Technical Guidance also covers what public authorities should do to meet the duty. This includes steps that are legally required, as well as recommended actions. The guidance does not have statutory force but nonetheless regard should be had to it, as failure to do so without compelling reason would be of evidential value. The statutory code and the technical guidance can be found on the EHRC website.

11.18 The EHRC has issued five guides for public authorities in England giving advice on the equality duty. The 'Essential' guide provides an overview of the equality duty requirements including the general equality duty, the specific duties and who they apply to. It covers what public authorities should do to meet the duty including steps that are legally required, as well as recommended actions. The other four documents provide more detailed guidance on key areas and advice on good practice.

12. Environmental Implications

12.1 There are no direct environmental implications arising from this report.

13. Crime and Disorder Implications

13.1 There are no direct crime and disorder implications arising from this report.

14. Equalities Implications

14.1 There are no direct equalities implications arising from this report as no services will be changed as a result of the changes outlined. However, it is expectect that the creation of the Borough Based Board will bring decision

making between the Council and NHS closer together and therefore allow for more focused work taking inequalities, particularly health inequalities, in the borough.

If you have any queries relating to this report please contact James Lee on 0208 314 6548.