London Health and Care Devolution

LONDON ESTATES BOARD:

OPERATING FRAMEWORK

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1. Context

London partners[1] recognise significant opportunities to enable greater value to be driven for Londoners from the health and care estate. These opportunities form the basis of London's devolution proposals. The London Estates Board (LEB) aims to directly solve some of the challenges involved in securing NHS estates approvals and disposals, through more transparent and collaborative working, for the benefit of London's health and care system. The LEB will provide a single forum for estate discussions in London and ensure early involvement of London government partners[2]. As it matures, subject to agreed hurdle criteria, the LEB will also provide a forum within which NHS capital investment decision-making could be exercised, including delegated business case approvals and capital allocation considerations, within national approval thresholds[3].

This document describes the vision for how the LEB will operate. As a live document, this framework is subject to further iteration as the LEB moves through the phases and takes on additional functions. Any functions of the LEB must also be complementary to local and sub-regional arrangements, the details of which are still subject to change. Ongoing engagement is taking place with London partners to ensure this alignment.

In the longer-term, the LEB's functions are contingent on the wider devolution asks, particularly around the devolution of powers around business case approvals, capital receipts and the framework set by national partners in respect of capital control totals. The LEB's ability to fulfil the desired objectives will be contingent on these devolved or delegated powers and resources being granted.

2. Terminology

'London partners' and 'national partners' are defined in full within the membership section (section 6). It should be noted that these terms have slightly different definitions from those used in the London Health and Care Devolution Memorandum of Understanding (MoU), given that some parties to the MoU do not have an interest in the estates workstream.

The following abbreviations are used within this document:

LEB	London Estates Board
GLA	Greater London Authority
OPE	One Public Estate[4]
STP	Sustainability and Transformation Plan *The term is also used to refer to the local area that collectively forms the plan, along with "STP area"*
CDEL	Capital Departmental Expenditure Limit
ETTF	Estates and Technology Transformation Fund
LEDU	London Estates Delivery Unit
DH	Department of Health
NHSPS[5]	NHS Property Services
CHP	Community Health Partnerships
HMT	Her Majesty's Treasury

[1] See section 6 (pg. 14) for a list of 'London partners' and 'national partners'.

[2] In this context, the term 'London government partners' refers to London local authorities and the GLA.

[3] This to exclude business case approvals requiring ministerial approval where the LEB would make a non-binding recommendation.

[4] One Public Estate is not a separate legal entity, but a programme of work funded by the Cabinet Office Properly Unit and the Local Government Association.

HLP	Healthy London Partnership
CCG	Clinical Commissioning Group
DPB	London Health and Care Devolution Programme Board
LHB	London Health Board
FT	Foundation Trust
PFI	Private finance initiative
MoU	Memorandum of Understanding
SPB	London Health and Care Strategic Partnership Board

3. Vision and objectives

The size and value of the NHS estate in London is considerable and there is an opportunity to make vast improvements in the way NHS buildings and land are used and – where these are surplus to requirements – to release capital to reinvest in London's health and care system. The vision for the LEB is to release surplus NHS estate in London and to allow the London system to have more control over this estate, so that health, care and wider public sector opportunities are realised.

In order to achieve this vision, the LEB will create a single collective forum where London partners can come together to discuss London-wide estate challenges and opportunities. In turn, this will facilitate and enable collaborative decision-making to inform the best possible use of the London NHS and wider public estate. This approach builds on the work of the London Health and Care Devolution Programme Board and the associated estates subgroup.

Partnership working with the GLA and London boroughs enables a wider public sector view, political accountability, recognition of marriage value with wider public sector land, and access to planning, development and delivery expertise. The LEB will work closely with the OPE programme, and recognises a wider ambition to work towards One Public Estate in London.

The LEB aims to facilitate more joined-up strategic decision-making for London and to enhance effectiveness, efficiency, quality and transparency of process and decisions. The nature of the LEB's functions and its decision-making ability will be phased over time, with the LEB commencing with a strategic and advisory role and, subject to the achievement of clear gateway criteria, progressing to take on a level of delegated decision-making functions.

a. Core **strategic and advisory** functions:

- Bringing together London[6] and national partners (including, health and government) to provide a single forum for discussions regarding NHS estates, and a forum within which discussions can take place around the wider public estate with health and care implications, including estate owned by local government and land under shared ownership.
- Gaining clarity on London's total capital need, availability and expectations for release.
- Supporting local and sub-regional areas to develop clear estates strategies aligned to clear commissioning strategies (including primary, community, mental health, secondary and tertiary), in particular across the STP footprints.
- Enabling whole system strategic estates planning, including the need to drive utilisation, building a London view from local and sub-regional estates strategies and taking a wider one public sector approach.
- Enabling high quality business case development by ensuring early input and leveraging expertise from constituent organisations.

[6] London partners include CCGs, boroughs, providers and the GLA.

- Developing a clear and prioritised list of capital cases under development with status tracked.
- Developing a robust and professional business case support function within the London Delivery Unit (LEDU) to support local and sub-regional areas with preparation of "right first time" capital investment/disposal business cases, which satisfy national standards of business case preparation, and to provide confidence as to the experience and competence available to support shadow and formal business case approval decision-making at the LEB. Through the LEDU, the LEB will also support the sharing and co-development of good practice.
- Working with DH and sub-regional areas to ensure that when surplus NHS sites are released, this is done with due consideration of wider local health economy and public sector opportunities.
- Working in partnership with DH, NHSPS and CHP to develop an approach for NHSPS and CHP investments and sales which balances national and London needs and priorities.
- Negotiating with national partners the parameters for the LEB to secure wider devolved and delegated powers, including business case approvals, delegated or devolved capital budgets and the application of capital receipts generated within the London system.

b. Core **decision-making** functions:

- Working with pilot and STP areas to develop a clear pipeline of capital projects, including prioritisation of schemes.
- Decisions regarding prioritisation of support available to develop capital cases, including through the OPE initiative. Decisions which sit with OPE will be taken through delegations within OPE to a named LEB member.
- Making recommendations on and ultimately approving capital business cases, thus mitigating the need for sequential approval processes by different organisations. This would not involve changes to statutory accountabilities, but instead would operate through delegations within national partners to named LEB members. London partners have sought the inclusion of OPE projects within the business of the LEB, in order to ensure that a wider public sector approach is maintained. The LEB aims to meet the need for further collaborative working and collective consideration of the public estate as a whole. To this end, estate for health, care and wider public sector purposes, including both health and local government assets, will be considered holistically by all partners at local, sub-regional and London level, consistent with the One Public Estate vision. At London level, this collaboration, including collective consideration and decision-making around business cases and disposals with a health and/or care element, will take place within the forum of the LEB. This is to exclude business case approvals requiring ministerial approval where the LEB would make a non-binding recommendation.
- Decisions on capital expenditure within London's allocated funds, including NHS England CDEL budgets (particularly ETTF), and other national capital allocations (administered by both NHS England and wider partners) will be delegated internally to an LEB representative, to enable city-wide considerations.
- Supporting sub-regional and pilot estates boards to take on robust governance and accountability functions to a sufficient standard to enable delegation and/or devolution of powers from national partners to be made to sub-regional level. Draft governance and accountability requirements for local health economies to administer devolved powers are set out at Appendix E.
- Supporting the reinvestment of capital receipts generated through rationalisation of the NHS estate in London, for the benefit of users of NHS services, in order to enable the release of:
    - Prioritised health and care investment in London (primarily invested through sub-regional areas).
    - Capital contributions to national capital requirements.
- Supporting the release of:
    - Land for health and care, including primary and community facilities and housing for health and care workers.

    - Land for wider public sector use, including housing.
- Making recommendations pertaining to the application of capital receipts until robust sub-regional governance and accountability mechanisms are in place and subsequently enabling these areas to make such recommendations. While the deployment of capital in the NHS from all sources combined must be equitable in relation to need across different parts of the country, in London, it is recognised that there is significantly greater opportunity to raise capital through disposal of surplus assets, but the costs of capital investment are also significantly higher than elsewhere in the country. The principle of equity must therefore recognise the higher cost of developing buildings and services in London. It is also recognised that incentives are needed for the health and care systems to release surplus land. National partners will work with the London system through the LEB to explore how the health and care system incentives can be optimised. The LEB provides an opportunity to explore these through example cases in the first year of operation.

Through this, the LEB can deliver:

- A holistic estates strategy that supports clinical strategy within London.
- Faster and greater disposals of surplus NHS land, and release of capital for health and care.
- Access to development and delivery opportunities including innovative financing mechanisms.
- Marriage value by realising the opportunities of NHS and adjacent surplus site(s) at the same time.
- Decisions involving London's NHS estates being taken within London.

Through the above, the LEB will deliver greater value including economic and wider social value for Londoners, the health and care system and central government.

The role and function of the LEB has significant interdependencies with wider devolution proposals. The LEB's ability to fully meet the desired objectives would therefore be contingent on these devolved or delegated powers and resources being granted. For devolved powers to be fully transferred, partners acknowledge that there will be a need to meet nationally applicable devolution criteria.

4. Overarching principles

The LEB will aim to operate according to the following key principles:

- Subsidiarity, with decisions taken at the lowest appropriate level, subject to robust governance mechanisms, and only taken at the LEB when needed.
- Transparency, with all relevant discussions taking place at the LEB.
- All partners bringing the collective expertise of their constituent organisations via the LEDU, to achieve the greatest value for Londoners. This could be through partnership working as well as consideration of joint appointments as appropriate.
- Decision-making will seek to achieve consensus so far as is possible, while respecting the views and statutory accountabilities of constituent organisations.

5. Phasing of functions

The LEB has significant interdependencies with the London Health and Care Devolution MoU, STP estates and service strategies, sub-regional and local governance and capital availability/expectations. It is also an innovative partnership forum with success being contingent on trust, collaboration and the ability of constituent members to work to deliver collective value rather than acting in organisational self-interest. It is therefore appropriate to have phased progression from an advisory to a decision-making function, with

gateways to ensure that governance and accountability mechanisms are sufficiently robust to proceed to the next phase. Decisions to move between the initial phases will be made by the LEB constituent organisations, acting by consensus. Should a gateway require delegation or devolution, this will need formal approval from the organisation with the statutory accountabilities, will be assessed against the relevant sender's devolution criteria and will be limited by the statutory framework. The gateways from phases 1-4 only require internal or 'synthetic' delegations.

The London Health and Care Strategic Partnership Board (SPB) will provide oversight and ensure alignment between London's estates strategies and delivery of health and care more broadly. The SPB will review progress updates, and can make recommendations to constituent organisations[7] as to whether the LEB has made sufficient progress to secure Partners' support to proceed into the next phase or endorse a particular course of action.

Through phases 1-4, delegated decision-making will work within the existing legal framework. The proposals for these initial stages do not look to change organisational accountabilities. Within the current legal framework, the LEB cannot operate as a decision-making entity, although the phased approach sees decisions being taken within the forum of the LEB by member representatives (the idea of 'synthetic devolution', as adopted in Greater Manchester).

The anticipated phasing is described below, along with the gateway process. The LEB will transition through phases subject to meeting gateway criteria. The timeline indicates draft review dates, for the LEB and national partners to evaluate whether these criteria have been met or what further work is needed. The dates below are indicative as being points of review. Rather than progression being based on specified dates it is more important to demonstrate clear progression through specified gateways and seek approval through the SPB.

The LEB began phase 1 in December 2016. To move into the first phase the LEB was asked to demonstrate agreement from all partners to establish the LEB, a clear statement of membership and established hosting arrangements. The LEB members also agreed, in principle, draft ways of working and Terms of Reference to govern phase 1.

Phase 1 (Advisory)

The functions of the LEB in phase 1 are to:

- Provide a single forum for discussions regarding NHS estates, and a forum for wider discussions around the public estate.
- Gain clarity from national partners on London's total capital availability and expectations for release.
- Engage with local and sub-regional groups within London to ensure the LEB adds value and is complementary to local priorities and emerging governance arrangements.
- Engage with London and national partners to ensure that the LEB adds value and is complementary to the wider London system and national priorities.
- Engage with DH, NHS Improvement[8] and NHS England on wider devolved and delegated powers, including business case approvals, capital allocations and the application of capital receipts generated within the London system.
- Provide strategic oversight of London activity to enhance utilisation, taking on HLP estates accountabilities.

[7] National Partners will review recommendations via the Devolution Programme Board which meets quarterly and includes HM Treasury, DH, NHS Improvement, NHS England and wider national partners.

[8] NHS Improvement is not in itself a statutory entity, but carries out the statutory functions of the NHS Trust Development Authority (TDA) and Monitor. References to 'NHS Improvement' in this document should be interpreted as encompassing NHS Improvement's role in relation to both TDA and Monitor functions, or to one set of these functions (as appropriate).

- Review the Operating Framework in light of national policy implications (for example, the Naylor review).

The extent to which the LEB takes on functions in the four key areas of decision-making is set out below:

(i) Capital availability and expectations
- The LEB will gain clarity on national capital availability from different sources and expectations of London.
- There will be high-level challenge of STP assumptions regarding capital availability and investment requirements.
- The LEB will negotiate parameters for London generated NHS capital receipts to be re-deployed in London health and care infrastructure.

(ii) Business case development
- The LEB will be supportive, through development of the LEDU.

(iii) Business case approvals
- No functions.

(iv) Capital allocation decisions
- No functions.

Gateway to phase 2

The LEB will review its operation in November 2017, to determine if it is ready to move into phase 2. The gateway criteria for phase 2 are as follows:

- Full assumption of strategic functions from other London-wide bodies, including the HLP estates programme.
- Clarity on national capital availability and the expectations of London.
- A signed devolution MoU which sets out the agreement of national partners to the estates devolution proposals.
- LEDU established and ready to take on operational functions of other London-wide estates bodies. As a minimum, the LEDU must have a Director, hosting arrangements and formalised governance arrangements in place.
- Agreed and published LEB Operating Framework.

Phase 2 (Strategic)

The functions of the LEB in phase 2 are to:

- Provide a single forum for discussions regarding NHS estates, and a forum for wider discussions around the public estate.
- Support local and sub-regional areas to develop clear estates strategies aligned to clear commissioning strategies (including primary, community, mental health, secondary and tertiary), particularly across the STP footprints. In particular, the LEB will work with the five sub-regional estates boards to support the development of a clear, affordable capital and estates plan for each sub-region that is aligned to clear commissioning strategies.
- Develop a clear capital plan for London, drawing from local and sub-regional estates strategies and ETTF bids.
- Enable whole system strategic estates planning, building a London view from local and sub-regional estates strategies and taking a wider one public sector approach.
- Develop a prioritisation framework for decisions.

- Develop a robust and professional business case support function within the LEDU to support local and sub-regional areas with the preparation of "right first time" capital investment/disposal business cases, which satisfy national standards of business case preparation, and to provide confidence as to the experience and competence available to support shadow and formal business case approval decision-making at the LEB.
- Enable high quality business case development by ensuring early input and leveraging expertise from constituent organisations.
- Develop a clear list and status of capital cases under development.
- Work with STP areas and devolution pilots to develop a clear pipeline of capital projects, including prioritisation of schemes.
- Agree governance and accountability requirements for sub-regional areas to draw down national powers. Draft governance and accountability requirements for local health economies to administer devolved powers are set out at Appendix E.
- Support sub-regional and pilot estates boards to take on robust governance and accountability functions to a sufficient standard to enable delegations and devolutions from national partners to be made to sub-regional level.
- Consider the recommendations of a London report on NHS estate utilisation.
- Work with DH, NHSPS and CHP to develop an approach for NHSPS and CHP investments and sales, which balances national and London needs and priorities.
- Work with DH and sub-regional areas to ensure that when surplus NHS sites are released, this is done with due consideration of wider local health economy and public sector opportunities.
- Work with national partners to explore how incentives for the health and care system to release surplus land can be optimised.

The extent to which the LEB takes on functions in the four key areas of decision-making is set out below:

(i) <u>Capital availability and expectations</u>

- The LEB will test STP assumptions regarding capital availability and investment requirements.

(ii) <u>Business case development</u>

- The LEB will develop the prioritisation framework based on likely capital investment requirements and capital availability.
- The LEB will develop an agreed pipeline of high priority schemes for LEB and LEDU focus, based on STP priorities, the Naylor review and applying the emerging prioritisation framework.
- The LEB will develop a robust and professional business case support function within the LEDU to support local and sub-regional areas with the preparation of "right first time" capital investment/disposal business cases, which satisfy national standards of business case preparation, and to provide confidence as to the experience and competence available to support shadow and formal business case approval decision-making at LEB.
- The LEB will implement business case development support via the LEDU, drawing on expertise from partners.

(iii) <u>Business case approvals</u>

- All London-related business case submissions by national partners will be shared with the LEB.
- The LEB will issue non-binding recommendations and guidance to organisations, and the London system.

(iv) <u>Capital allocation decisions</u>

- The LEB will support sub-regional estates boards to develop robust accountability and governance mechanisms to make recommendations on the application of capital receipts.

The Devolution Asks which would enable the LEB to work effectively in the phase are:

- Agreement by NHS Improvement, NHS England, DH, CHP, NHSPS, OPE and HMT that all health and care capital cases which are best considered jointly within the London system, covering both NHS England and local government investments, will ultimately be considered by the LEB or (for lower limits) local or sub-regional estates boards.
- Agreement by NHS England, NHS Improvement, DH, OPE and HMT, in principle, and subject to agreed phasing and the achievement of agreed gateway criteria, to internal delegations of a level of business case approval authority to named individuals, operating as members of the LEB. This to exclude business case approvals requiring ministerial approval where the LEB would make a non-binding recommendation.
- Commitment from all partners for the LEB to establish an LEDU.
- Commitment by NHS Improvement, NHS England, DH, CHP, NHSPS, OPE and London partners to commit their existing London estates resources to work collaboratively as part of a virtual team in the LEDU to develop clear priorities, measurable objectives, roles and responsibilities and appropriate ways of working together. This will include consideration of joint appointments as appropriate.
- Commitment from NHS England, NHS Improvement and DH that sub-regional estates boards to take on a management role of capital control totals, within a London envelope, subject to robust governance structures.
    - Agreement of national partners to NHS Trusts and Foundation trusts in London retaining capital receipts, on the basis that the LEB will identify how to reinvest these receipts to support agreed system-wide health priorities. To inform this prioritisation the LEB will develop an agreed annual pan-London capital plan based on robust local and sub-regional estates capital strategies and with the full involvement of London partners, including NHS Trusts and Foundation Trusts.
- Commitment from DH, NHSPS and CHP to working in partnership with the LEB to develop an approach for NHSPS and CHP investments and sales related to London assets, which balances national and London needs and priorities.
- Agreement from all partners to work with DH and sub-regional areas to ensure that when surplus NHS sites are released, this is done with due consideration of wider local health economy and public sector opportunities.
- Commitment from national partners to working with the London system through the LEB to explore how incentives to dispose of surplus land within the health and care system can be optimised. The LEB provides an opportunity to explore these through example cases in the initial phases.
- Commitment by partners to support local and sub-regional estates boards to take on governance and accountability functions.
- Agreement that London, in discussion with national partners, will develop a London report on NHS estate utilisation in 2017 and considering the recommendations through the LEB thereafter.

Gateway to phase 3

The LEB will review its operation in April 2018, to determine if it is ready to move into phase 3.

The gateway criteria for phase 3 are as follows:

- A robust and professional business case support function within the LEDU to support local and sub-regional areas with the preparation of “right first time” capital investment/disposal business cases and to provide confidence as to the experience and competence available to support shadow and actual business case approval decision-making at the LEB.
- Clear local and sub-regional estates strategies aligned to clear commissioning strategies (including primary, community, mental health, secondary and tertiary), particularly across the STP footprints.
- Demonstrated competence of LEB as a strategic body as demonstrated by development of a clear capital plan for London drawing from local and sub-regional estates strategies.

- Clear pipeline of sites and agreed prioritisation framework in place to be tested in phase 3.
- Agreement from national partners for the LEB to commence shadow running, by way of recommendations to national partners through the nominated representative on the LEB, including agreement from national partners that sufficient mechanisms and satisfactory commitments are in place for collective consideration of both health and local government assets.
- Evidence that the cases considered at the LEB and the discussions enabled through this forum represent a collaborative approach between health and local government, with each local partner being equivalently committed to leveraging their assets and expertise for the benefit of the health and care system, and for Londoners.
- Key individuals appointed to enable shadow running at phase 3.
- Agreed governance and accountability requirements for sub-regional estates boards to draw down national powers.
- MoU(s) signed by all partners which set out the specifics of the internal delegations and agreed prioritisation framework.
- LEB membership reviewed.

Phase 3 (Shadow decision-making)

The functions in phase 3 are as in phase 2 plus:

- Making recommendations to national partners regarding prioritisation of support available to develop capital cases, including through the One Public Estate initiative.
- Demonstrating competence in undertaking capital business case assurance in accordance with the nationally applicable guidance, standards and protocols as in force at the time, and making robust and sustainable approval recommendations to relevant national partners through their representatives on the LEB.
- Recommendations related to capital expenditure within London's allocated funds, including NHS England CDEL budgets (particularly ETTF) and other national capital allocations. LEB recommendation to national decision makers (i.e. shadow decision-making).
- Making recommendations on the application of capital receipts until sub-regional governance and accountability mechanisms are in place. If robust sub-regional governance mechanisms are in place then these estates boards can make the recommendations. Recommendations are to be made in line with an annual capital plan that is based on robust local and sub-regional estates capital strategies and takes account of existing statutory accountabilities of individual organisations.
- Securing agreement to delegations by national partners to their respective representatives on LEB.

The extent to which the LEB takes on functions in the four key areas of decision-making is set out below:

(i) <u>Capital availability and expectations</u>
- The LEB will assess the current status of capital availability and investment requirements.

(ii) <u>Business case development</u>
- The LEB will refresh the pipeline and implement business case development support via the LEDU, drawing on expertise from partners.

(iii) <u>Business case approvals</u>
- Shadow running through demonstrably robust recommendations to constituent organisations.

(iv) <u>Capital allocation decisions</u>
- Recommendations to national partners related to capital expenditure within London's allocated funds, including CDEL (particularly ETTF).
- Recommendations to decision-makers on application of capital receipts.

- Recommendations made by sub-regional estates boards where these are mature.

The Devolution Asks which would enable the LEB to work effectively in the phase are as in phase 2 plus:

- Agreement by NHS England, NHS Improvement and DH to allow the LEB (through that national partner's representative on LEB) to make recommendations (shadow running) on the approval of NHS business cases within the following limits:
  - NHS England – initially up to £5 million, to be increased to values up to £20 million on NHS business cases requiring NHS England approval[9], on a phased basis and subject to satisfactory administration of lower limits, as approved by the NHS England Chief Financial Officer[10]. London Partners have an ambition to ultimately progress to achieving full delegation of NHS England business case approvals but recognise that any further extension of levels of delegation would be subject to further discussion with, and agreement by, NHS England.
  - NHS Improvement - up to £15 million for NHS Trust business cases. Where an NHS Foundation Trust is required to submit a business case for detailed review, this function will be administered jointly by NHS Improvement (carrying out Monitor's functions) and the LEB during the shadow running period. Recommendations to FTs will continue to be made by through the current NHS Improvement national process during this period.
  - DH – the function of making recommendations to ministers will be exercised by the LEB and DH jointly. Where ministerial approval is not required, the LEB will make recommendations to the DH decision-makers.
- Agreement by One Public Estate that shadow decisions on One Public Estate London bids with a health element will be made at the LEB.
- Agreement of national partners to NHS Trusts and Foundation trusts in London retaining capital receipts, on the basis that the LEB will identify how to reinvest these receipts to support agreed system-wide health priorities. To inform this prioritisation the LEB will develop an agreed annual pan-London capital plan based on robust local and sub-regional estates capital strategies and with the full involvement of London partners, including NHS Trusts and Foundation Trusts.
- Agreement that decisions on capital expenditure within London's allocated funds, including NHS England CDEL budgets (particularly ETTF), and other national capital allocation decisions will be delegated internally to an LEB representative, on a phased basis and subject to the gateway criteria in the LEB Operating Framework.
- Agreement from national partners that the LEB and sub-regional estates boards will make recommendations on the application of capital receipts.

Gateway to phase 4

The LEB will review its operation in September 2018, to determine if it is ready to move into phase 4. The gateway criteria for phase 4 are as follows:

- Shadow operation demonstrated the ability to make effective decisions as a collective as illustrated by the LEB recommendations being high quality and approved by national partners, and agreement from national partners that mechanisms and satisfactory commitments for collective consideration of both health and local government assets have worked effectively in shadow form, or any necessary changes made.
- Shadow operation demonstrated the ability to make effective decisions in respect of business cases, which satisfy NHS rigour, across a caseload which is of sufficient volume and case-mix
- A fully operational LEDU which is able to demonstrate the ability to deliver high quality business cases

[9] It is noted that a sub-set of business cases must be transferred to DH/HMT for approval, and therefore NHS England/NHS Improvement will not have final sign-off ability.

[10] Movement between delegated limits will also be subject to NHS England having amended its Standing Financial Instructions to enable higher delegations, up to £20 million.

- Funding packages agreed
- MoU(s) reviewed and any required changes made.
- Delegated decision-making abilities granted to all necessary member representatives and internal governance arrangements amended as necessary.
- Continued evidence that the cases considered at the LEB and the discussions enabled through this forum represent a collaborative approach between health and local government, with each local partner being equivalently committed to leveraging their assets and expertise for the benefit of the health and care system, and for Londoners.

Phase 4 (Formal decision-making)

The functions in phase 4 are as in phase 2 plus:

- Decisions regarding prioritisation of support, including through the One Public Estate initiative, through internal delegations to named individuals operating at members of the LEB members.
- Capital business case review, recommendation and approval functions exercised within the LEB forum through internal delegations to named individuals operating as members of the LEB. See Appendix C for further detail of business cases requiring review and/or approval from national partners.
- Capital allocation decisions related to NHS CDEL (including ETTF) and other national capital allocations within an agreed capital envelope. Decisions taken through internal delegations to named individuals operating as members of the LEB.
- Recommendations pertaining to the application of capital receipts until robust sub-regional governance and accountability mechanisms are in place then enabling these areas to make the recommendations.

Initially the LEB will run with formal delegated decision-making powers at lower limits. As the LEB demonstrates competence these limits would be increased to eventually achieve delegated authority for all NHS business case approvals[11].

The extent to which the LEB takes on functions in the four key areas of decision-making is set out below:

(i) <u>Capital availability and expectations</u>
- As in phase 3

(ii) <u>Business case development</u>
- As in phase 3

(iii) <u>Business case approvals</u>
- Internal delegations to named individuals operating as members of the LEB and decisions to be made at LEB level.
- Where STP estates governance/accountability is robust, ability to recommend business case approvals to £15m with LEB ratification.

(iv) <u>Capital allocation decisions</u>
- As phase 3 plus delegated decision-making ability for an LEB member to take decisions pertaining to allocations of CDEL (including ETTF) within the forum of the LEB.

The Devolution Asks which would enable the LEB to work effectively in the phase are as in phase 2 and 3 plus:

[11] So far as possible within statutory permissions and subject to the caveats within the devolution asks below.

- Formal delegation of business case approval authority to named individuals appointed by the relevant national partner, operating as members of the LEB, within the following limits:
  - NHS England - initially up to £5 million, to be increased to values up to £20 million on NHS business cases requiring NHS England approval[12], on a phased basis and subject to satisfactory administration of lower limits, as approved by the NHS England Chief Financial Officer[13]. London Partners have an ambition to ultimately progress to achieving full delegation of NHS England business case approvals but recognise that any further extension of levels of delegation would be subject to further discussion with, and agreement by, NHS England.
  - NHS Improvement – initially up to £15 million for NHS Trusts, to be increased to all NHS business cases which pass through NHS Improvement for approval on a phased basis. Detailed reviews of NHS Foundation Trust business cases will be administered by the LEB level, and recommendations issued to FTs by the NHS Improvement representative.
  - DH – DH representative to take decisions on business cases which do not require ministerial approval. Recommendations to ministers on all NHS business cases will be made by the LEB as a collective.
- One Public Estates representative with authority to take decisions around London bids with a health element at the LEB.
- Agreement from NHS England, NHS Improvement and DH that capital allocation decisions relating to NHS CDEL (including ETTF) and other NHS England and non-NHS England national capital allocations will be delegated internally to an LEB representative.

The LEB will work within current legal constraints. The initial structure based on the individual organisation-based delegations to representatives on the LEB will help build confidence and strengthen existing partnership arrangements, allowing partners to co-develop the later stages of the LEB. The LEB aspires to progress into a more fully devolved model in phase 5, and it is recognised that this would likely require some form of legislative change. The LEB will explore the options for collective, binding decision-making through the initial stages and would only seek support to progress into phase 5 after building a strong evidence base of efficient, effective and robust operation. Full transfer of powers would require the satisfaction of nationally applicable devolution criteria.

6. Membership and hosting arrangements

Membership

(i) <u>London partners</u>

- 5 STP leads, nominated by each STP area. Potential for the STP estates lead to also be the lead of the STP Estates Board, where these arrangements are in place.
- Devolution pilot representation, where pilots not coterminous with STP area (Hackney, Lewisham and BHR (Barking & Dagenham, Havering and Redbridge)).
- Representative for GLA
- Representative for London CCGs
- Representative for London Councils
- Representative for NHS England

[12] It is noted that a sub-set of business cases must be transferred to DH/HMT for approval, and therefore NHSE/NHSI will not have final sign-off ability.

[13] Movement between delegated limits will also be subject to NHSE having amended its Standing Financial Instructions to enable higher delegations, up to £20 million.

- Representative for the NHS Trust Development Authority and Monitor, collectively known as NHS Improvement (noting that one representative can take delegated authority for both Monitor and TDA decisions)[14]

(ii) National partners[15]

- Representative for NHS Property Services
- Representative for Community Health Partnerships
- Representative for Her Majesty's Treasury
- Representative for the Department of Health
- Representative for One Public Estate

Within phases 1 and 2, members will take decisions on a consensus basis. Subject to the progression of the LEB, shadow voting rights will be introduced in phase 3. See Appendix F for further details.

It is expected that the LEB would invite additional individuals or organisations to attend meetings on an ad hoc basis where relevant to inform discussions. In particular, it will be expected that provider representation will be sought for relevant discussions, in addition to provider representation through STP areas. STP representation is designed to ensure engagement with all constituent organisations, and it is expected that STP representatives (to be nominated by STP areas) will undertake consultation with all constituent organisations, including providers, prior to LEB discussions.

The LEB will be led by a Chair from a national partner and an independent Co-Chair. One of the Co-Chairs must be independent, which is taken to mean that he or she should not be a director, employee or otherwise affiliated to any of the member organisations listed above. The other Chair will be an NHS representative for financial accountability purposes.

Representatives will be appointed by their constituent organisation.

Membership will be reviewed as part of the gateway to phase 3. At this stage, decisions will be taken as to who should exercise delegated decision-making powers in phase 4, in order that this individual can be appointed and active during the shadow running phase.

Hosting arrangements

The LEB will operate as a forum for a number of partner organisations, whose collaboration will be required for the LEB to function efficiently and effectively.

The LEB will be hosted by the GLA ("the Host") as a city-wide resource and to leverage the planning and development expertise of the GLA.

The Host will provide facilities and premises for the meetings and any staff who work for the LEB and the LEDU. The Host is responsible for recruitment of staff and for hosting any seconded staff. Termination costs of seconded staff will be borne by employing authorities. The Host will also be responsible for procurement, which will be undertaken in accordance with the GLA's Standing Orders and Standing Financial Instructions. Any public-facing documents that are published through the host will then be dealt with under the host's information governance procedures[16].

[14] NHS Improvement is not in itself a statutory entity, but carries out the statutory functions of the NHS Trust Development Authority (TDA) and Monitor. References to 'NHS Improvement' in this document should be interpreted as encompassing NHS Improvement's role in relation to both TDA and Monitor functions, or to one set of these functions (as appropriate).

[15] NHS England and NHS Improvement are also included within the definition of 'national partners', but the intention is that only the London regional representative will attend LEB meetings as a 'member' on a long-term basis.

[16] Further information to be contained in separate information governance documents.

Financial reporting will run through the Host. The LEDU will prepare a budget for all phases, which will be submitted by the Host, and London partners will agree how that budget is funded. The Host will also provide financial information on the cost of the LEB and financial reports for the LEB and the LEDU. Any expenditure chargeable to a particular organisation (for example, NHS England) must be supported with an annual audit statement from the Host. The cost of the auditors will be allowed for in the budget of the LEB.

The secretariat function would be initially provided by the London Devolution Programme Team and, subsequently, the LEDU. The secretariat will arrange for papers to be prepared and circulated prior to meetings, and will also be responsible for scheduling meetings.

7. Statutory/policy Framework

The framework for business case approvals is required for context, and set out at Appendix C.

Decisions around business case approvals would come into effect in phase 3 (in shadow form) and phase 4 (full running). The scope of decisions to be taken would be formalised through an MoU prior to entering phase 3.

8. Operating principles

The Operating Framework is underpinned by the following operating principles:

Collaboration:

- All members will engage in collaborative, constructive conversations about the optimum use of health and care assets across the London system to maximise value and utilisation.
- The LEB members will work collaboratively with local non-LEB member bodies[17] and take into account the impact of decisions upon both member and non-member bodies and their communities.
- All members will collaborate when considering investment priorities and allocation of capital.
- Asset holders will take an open and transparent approach in relation to land and property assets, including early notification of possible land and buildings for disposal.

Decisions made within the LEB forum

- Partners will seek to achieve consensus so far as is possible, whilst respecting the views and accountabilities of each member.
- All member organisations will work collectively and collaboratively to ensure that decisions taken locally and within the forum of the LEB align with the priorities for London.
- All member organisations will ensure that decisions prioritise optimisation of the use of health and care estate over organisational self-interest.
- National members will align decision-making processes, so far as is possible, within the forum of the LEB in order to streamline the relevant approval and assurance processes.
- The organisations recognise the key principle of subsidiarity, and will aim to ensure that decisions are taken or influenced locally wherever possible, subject to robust governance mechanisms.
- No change of ownership is proposed; however this would be reviewed in line with national policy direction of travel and jointly reviewed by London and national partners at a later stage.

[17] Chiefly local commissioners and providers including CCGs and NHS Trusts/Foundation Trusts

- A staged decision process may, in some complex cases, be agreed in advance. A number of factors could impact on the staging of decisions, including requirements for public engagement and consultation.
- The Operating Framework will not require changes to statutory organisational responsibilities. Each organisation will remain accountable for performing its statutory functions.

9. Scope

The discussion and decision-making carried out within the LEB forum will be focused on the London NHS estate, as owned/held by NHSPS, CHP, NHS Trusts and NHS Foundation Trusts. The area covered is geographically defined by the five London STP areas. However, it is recognised in some cases that developments will cross those boundaries. In those circumstances, there is a need to consult with relevant local authorities, CCGs and providers to determine next steps.

When exercising delegated authority, the LEB member representatives will not make decisions around any land and buildings owned or exclusively used by independent sector providers. This includes land privately owned by GPs. It is recognised that there are organisations outside of those within the membership that may have health and social care estate in London, in particular with regards to the primary care estate. The LEB recognise the opportunities from these areas, and despite having no formal powers over privately owned land, look to work collaboratively with such parties, even though they are not currently members of the LEB.

Whilst the formal decision-making of those with delegated authority is focussed on the NHS estate, the work of the LEB goes wider in that the approach is designed to promote a One Public Estate approach by close collaboration with the OPE team, and by bringing together decision-makers from other public sector organisations to promote marriage value of publicly-held land. The GLA and London Councils will play an important role in this respect. The GLA will act as an information conduit between the LEB and the Homes for Londoners board to share information pertaining to any sites where more efficient land assembly of public sector assets is deemed favourable to the development of NHS estates.

The LEB's work relates to strategic decisions on London's NHS estate, not facilities management. Utilisation of buildings and land owned by NHS trusts and NHS Foundation trusts, are, however, in scope.

10. Terms of decision-making

The members of the LEB will make 'soft'[18] and formal decisions within the bounds of the remit as set out below, and in accordance with the principles set out in this document.

The aim of the LEB will be to align approaches and achieve consensus decision-making, whilst respecting that member representatives cannot fetter their discretion, and would still be required to make decisions on the basis of objective relevant criteria and in line with the terms of their delegated authority.

All members will agree and follow a prioritisation framework by the end of phase 2. A draft is set out at Appendix D below.

[18] 'Soft' decision-making is the process by which the LEB will collectively agree and make recommendations, and issue guidance to partner organisations. It is recognised that the LEB, as a strategic body, can only issue recommendations and guidance, and cannot formally take collective decisions on statutory functions. Decisions will be taken on statutory functions within the LEB, but **only** by those representatives with the requisite delegated authority.

Within the process of formal decision-making each member organisation representative with an interest[19] will take a decision for, and on behalf of, their constituent organisation, so far as they are enabled to do so under the limits of their delegated authority. Member representatives must legally retain the ability to disagree, or revoke decisions, so far as would be possible within the current framework. No organisation with an interest can be bound unless the decision has been expressly signed off by their appointed representative.

Strategic 'soft' decision making

The role of the LEB as a strategic body is to facilitate estates discussion and alignment between member organisations. Under this framework the LEB members can make non-binding recommendations to the decision-making bodies that each member represents and issue guidance. The principles of collaboration, partnership and early engagement aim to ensure that member organisations take an aligned view and LEB recommendations are implemented effectively by London and national partners.

As a strategic body the LEB has no formal decision-making powers and so any issues requiring an actual decision on the exercise of a statutory function would need to be taken separately by member organisations.

As a strategic body, the LEB would be able to undertake the functions in phase 1 (see above), albeit that formal governance documents will require sign-off by boards (or similar).

In accordance with the proposed Terms of Reference, the papers for the LEB meetings would be circulated in advance of the meetings to allow representatives the opportunity to establish an organisational view on the content. At LEB meetings the representative would then present that view and agree/disagree to the strategic direction of travel and recommendations. Following the meeting, internal reporting mechanisms would ensure that member organisations were kept informed of the strategic direction of travel.

It is also expected that sub-regional areas will engage with providers and commissioners at an early stage, and present an aligned view from the perspective of that sub-regional area. Relevant sub-regional governance systems should allow for reporting mechanisms to collate views and keep constituent organisations updated as to the direction of travel.

Within phases 1 and 2, the LEB members will only act by consensus. Within phase 3 and 4, LEB members will aim to act by consensus, but will also be able to vote on the content of non-binding recommendations made collectively to constituent organisations in the unlikely event that consensus cannot be reached.

The process for delegated responsibility decision making on formal decisions

Delegated responsibility decision-making will begin in shadow form in phase 3, and will take full effect from phase 4.

Each member organisation will appoint a representative for the LEB, and ensure that the representative has appropriate authority to express a view on behalf of the organisation/grouping and commit the organisation to the extent necessary (dependant on the role), so far as this falls within the scope of the LEB's remit. The levels of authority required will differ, depending on the organisation in question. For organisations with a formal decision-making role, this would need to be within clear delegated limits.

Where necessary, organisations may be required to internally delegate the relevant functions. Organisations may need to review and update their schemes of delegation and standing financial

[19] Representatives will have an interest when the decision falls within the scope of their constituent organisation's functions. In some cases, only one organisation will be empowered to take a specific decision. However, some decisions may have multiple interested parties.

instructions (or similar), to ensure that their representative has the necessary authority. Formal confirmation of delegation will be required from each organisation. Formal decisions would then be taken by those individuals with the delegated authority. Allowing this decision making to take place in the LEB forum, in accordance with agreed prioritisation framework, streamlines the process, promotes alignment of approaches, and allows the decision-makers access to all relevant parties and information.

Where a number of organisations have the power to take a decision (i.e. where a number of organisations are required to review or approve a business case), the approach of the LEB aims to ensure that the decisions are aligned. However, each empowered representative must still take the decision, and this must be taken in accordance with the powers delegated to them by their constituent organisation. Neither the LEB, nor sub-groups of the LEB (formed of representatives with decision-making powers) have the power to bind any member organisation in the context of these decisions, without sign-off from the authorised representative.

Decision-makers should consult with and take into account the collective view of the LEB, before making formal decisions. The LEB will come to a collective view through the 'soft' decision-making process explained above; through which members can be non-binding recommendations.

The LEB will explore the options for collective, binding decision-making through the initial stages and aims to progress to a more fully devolved model in phase 5 which enables collective, binding decision-making.

11. Dispute resolution

The LEB aims to achieve consensus in respect of decisions made within its forum. The aims and objectives encourage accelerated decision-making for collective organisations with due consideration given to public sector considerations. All members recognise that, through their role on the LEB, they are committing to the principles of collaborative, partnership working and relationship building. It is therefore expected that any disputes arising would be managed in accordance with these underlying principles. It is recognised that the LEB is a new forum and, given the innovative approach, it may not always be possible to achieve consensus. Members will make every effort to come to an agreed conclusion, whilst respecting their own statutory responsibilities.

However, there may be circumstances under which consensus cannot be reached:

- In the event that agreement cannot be reached by the LEB when issuing **non-binding recommendations or guidance**, it is proposed that LEB members would follow the process at Appendix F, which currently serves as an illustrative approach.

- Where it is not possible for member representatives to take **formal decisions** that align, such members would need to take decisions without securing alignment. Member organisations should ensure that these arrangements are set out in the delegation, as organisations may wish to specify the process that would be followed in these circumstances.

These provisions will be considered to be a last resort, but provide mitigation in the event that members cannot agree.

The decision-making process will be monitored throughout the life of the LEB and there will be regular analysis of the effectiveness and efficiency of the process. After a trial period of 6 months from commencement of phase 3 the process will be subject to formal review and members will take a view on whether the decision-making process requires any modification.

12. Governance and accountability

The LEB reports to the Strategic Partnership Board.

The London Health Board (LHB) will provide political oversight from phase 1 and assess the extent to which the LEB is meeting its stated objectives. The LEB will provide assurance to the LHB that the key objectives are being met and that the LEB is performing within the boundaries and principles set out in this Operating Framework. Political oversight will also be provided by Homes for Londoners.

Separately, the LEB representatives will be accountable to their consistent organisations in respect of decisions taken within the LEB forum (both strategic and formal). Whilst the LHB oversight will be focused on the extent to which the LEB is meeting its objectives, the scrutiny function provided by the constituent organisations will be focused on ensuring that the LEB is complying with the relevant frameworks for decision-making in terms of business case approval etc. Each partner organisation will be able to agree its own internal mechanisms of accountability. It is envisaged that the representative for each organisation will report to its Board (or equivalent, in the case of Government Departments) on a regular basis.

13. Operational costs of the LEB

Operational costs of the LEB will initially be met by the Healthy London Partnership estates programme and through the London Health and Care Devolution programme. Subsequently, the operational costs of the LEB will flow from any agreed partner resource. It is intended that the costs will be met through existing London resources.

The resourcing arrangements for the LEDU will be considered during the first phases of the LEB's operation.

14. Changes in membership and exit strategy

If the constitution of member organisations changes (e.g. through merger or organisational change), the new body would be recommended as an LEB member, subject to approval by the other members. The Terms of Reference would be updated accordingly, as necessary.

Within phases 1 and 2, risks are very limited, in that the LEB operation brings members together to exercise partnership working and does not look to change decision-making processes. The gateway process works to ensure that the building blocks on partnership and alignment are put in place, prior to the exercise of decision-making powers by individuals. This mitigates the risk of failure in the later stages.

In phase 3 and 4, the member representatives will exercise decision-making powers, initially on a shadow basis. The purpose of the LEB is to enable collective partnership working and cessation of the LEB would be a last resort, following appropriate escalations to member organisation chief officers (or the equivalent). In the event of exit, the statutory accountability would remain with member representatives of constituent organisations. Member organisations should include provision in their delegation arrangements which set out what process the individual should follow, in the event that decisions cannot be taken at LEB level.

Following a motion to disband the LEB, members will jointly consider next steps and make recommendations to member organisations as to next steps.

Appendix A – Standards of business conduct and managing conflicts of interest

- Representatives sitting on the LEB will at all times comply with this Operating Framework and will be aware of their responsibilities as outlined in it, in addition to their primary accountabilities to their constituent organisations. They should act in good faith and in the interests of the public.

- Each representative will be bound by their own organisation's conflicts of interest framework. Member representatives agree that where a representative has an interest, or becomes aware of an interest which could lead to a conflict of interests in the event of the LEB considering an action or decision in relation to that interest, that must be considered as a potential conflict. If in doubt, the individual concerned should assume that a potential conflict of interest exists.

- Members will declare any interest that they have, in relation to a decision to be made within the LEB forum as soon as they are aware of it and in any event no later than twenty eight (28) days after becoming aware. The LEB will maintain a register of interests. The registers shall contain names of individuals and details of the interest.

- If an individual fails to declare an interest and the Chair determines that the interest is relevant and material, the Chair shall refer the matter to that individual's constituent organisation who will decide how to manage the conflict for their own purposes.

Appendix B – LEB Terms of Reference

1. Introduction

1.1. These Terms of Reference have been drawn up to regulate the proceedings of the LEB so that it can fulfil its stated objectives, whilst each member organisation fulfils its statutory obligations.

1.2. The Terms of Reference provide a procedural framework within which the LEB discharges its business. They set out:

(a) the arrangements for conducting the business of the LEB;

(b) the appointment of members; and

(c) the procedure to be followed at meetings of the LEB.

2. Membership and appointment process

1.3. Section 6 of the Operating Framework provides details of the membership of the LEB.

1.4. Organisation representatives will be appointed by their constituent organisation, and granted with appropriate delegated authority. They will remain in post until they resign or are removed by their constituent organisation.

1.5. The LEB Co-Chairs as described in section 6 are subject to the following appointment process:

1.5.1. Eligibility – One of the Co-Chairs must be independent, which is taken to mean that he or she should not be a director, employee or otherwise affiliated to any of the member organisations listed in Section 6. The other Chair will be an NHS, London partner, representative for financial accountability purposes.

1.5.2. Appointment process – The Chairs are to be appointed by the membership organisations, acting by consensus. Prior to appointment, member organisations will be asked to confirm that they are not aware of any reasons as to why the Chairs are not eligible to take up post.

1.5.3. Term of office – The Chairs shall remain in post until they resign or are removed from office.

1.5.4. Grounds for removal from office – The Chair may be removed from office by the member organisations, acting by consensus.

1.6. The Secretary shall be appointed by the LEB, acting by consensus, for such term, and upon such conditions as its members may think fit. Any Secretary so appointed may be removed by the LEB members acting by consensus.

1.7. Members of the LEB have a collective responsibility for the operation of the LEB and are expected to attend all meetings. They will participate in discussion, review evidence and provide objective expert input to the best of their knowledge and ability, and endeavour to reach a collective view.

2. Meetings

2.1. Frequency and notice

2.1.1. The LEB is currently meeting once every two months. It is acknowledged that the frequency of such meetings will be dependent upon the volume of business, including the volume of business cases to be processed. This frequency of meetings is proposed as a starting point and this paragraph of the Standing Orders may be subject to change. The frequency of meetings will be reviewed in November 2017.

2.1.2. The Chair can call an ordinary meeting of the LEB at any time by giving all the member organisations required to attend at least fourteen (14) days' notice. It is expected that member organisations will work collaboratively and approach the Chair to call a meeting where necessary. The exception to this is the first meeting, which will be called at Chairs' discretion.

2.1.3. When the Chair of the LEB deems it necessary in light of the urgent circumstances to call an exceptional meeting at short notice, the notice period shall be such as s/he shall specify.

2.1.4. Every notice calling a meeting must specify the place, day and time of the meeting and the general nature of the business to be transacted; and

2.1.5. A full agenda and supporting papers will be sent to each member representative no later than five (5) working days before the date of the meeting. The papers must set out in full any decisions to be made, and the decision-makers who will be required [for phases 3 and 4 of the Board's operation].

2.2. Attendance at meetings

2.2.1. For formal decision-making to take place within the LEB forum, it will be necessary to have the representative from each organisation required to take a formal decision, with the necessary delegated authority.

2.2.2. To issue non-binding recommendations and guidance, members agree that one representative from each partner organisations will be present in order to ensure that the recommendation issued best represents the aligned view of the LEB members.

2.3. Minutes

2.3.1. All meetings will be minuted to represent those present, apologies, matters discussed, decisions made, actions to be taken and by whom.

2.3.2. Where a decision is taken which requires a number of organisations to take the decision, in accordance with their statutory functions (e.g. business case approval), the minutes will set out the separate decisions made in respect of each membership organisation.

2.4. Publicity

2.4.1. Given the sensitive and/or confidential nature of the matters that will routinely be explored by the LEB, meetings of the LEB will be closed to the public and the press, unless a decision is taken otherwise by consensus of the members.

2.4.2. Following MoU signing, the Operating Framework and a public-facing summary of the LEB objectives (in a form that has been agreed by the London Partners) will be published by the LEB host. A short, public-facing summary of each meeting will be prepared, agreed with LEB members and published alongside these documents. Where appropriate, the LEB and LEDU may publish further documents (for example, guidance, reports and toolkits).

2.5. Apologies and substitutes

2.5.1. Representatives who cannot attend meetings should provide apologies as soon as possible and, in any event, seven (7) days prior to the meeting in question. Where a representative would be due to take a formal decision within the forum of that meeting, it is expected that the Secretary will establish their availability prior to booking the meeting as alignment will not take place without representatives with the requisite delegated authority.

In exceptional circumstances, a representative as listed at section 6 (or their organisation) may request a substitute from their constituent organisation to attend on their behalf. Unless this individual is also granted the requisite delegated authority, they will not be able to take formal decisions. Member organisations are asked to ensure that proxies can take 'soft' decisions (see section 9 of Operating Framework) i.e. agree to issue recommendations/guidance.

Appendix C – Context: Framework for business case approvals[20]

1. NHS Improvement

- NHS Improvement are required to approve business cases for NHS Trusts and review business cases for NHS Foundation Trusts, in line with the delegated approval limits set out in the table below.

- Provision for the approval of NHS Trust business cases is set out in the National Health Service Trust Development Authority Directions and Revocations and the Revocation of the Imperial College Healthcare National Health Service Trust Directions 2016 ("the TDA Directions"). Paragraph 6(k) provides for NHS Improvement (through the TDA) to have the following function:

  (k) Where an English NHS trust has proposals involving capital investment or significant commercial transactions under consideration—
  (i) Where such proposals do not exceed financial limits set by the Secretary of State from time to time and where such proposals are not, in the opinion of the Secretary of State, novel, contentious or repercussive to—
  (aa) determine which proposals do not require approval of the Authority; and
  (bb) assess and approve proposals not falling within sub-paragraph (k) (i) (aa); or
  (ii) Where such proposals exceed those financial limits or are, in the opinion of the Secretary of State, novel, contentious or repercussive, to assist the Secretary of State in assessing and approving such proposals;

- NHS Improvement have the ability to assess which proposals require its approval and, therefore, have the ability to alter the limits as currently set out in guidance. Trusts and FTs should refer to NHS Improvement's '***Capital regime, investment and property business case approval guidance for NHS trusts and foundation trusts***'[21].

- Foundation Trusts have more flexibility in terms of capital investment, however there are circumstances where business cases require review and the function sits with Monitor (now NHS Improvement). The circumstances where Foundation Trust business cases require approval are set out in the table below.

NHS Trusts	Business cases to be approved in accordance with the following delegated approval limits: • <£15m - Trust's own delegated limit and no NHS Improvement approval needed up to this level although notification requirements apply for schemes between £7.5m and £15m; • £15-30m: approved by the NHS Improvement Executive Director of Resources/Deputy Chief Executive or NHS Improvement Director of Finance and then DH; • £30-50m: NHS Improvement Resources Committee and then DH; • Over £50m: NHS Improvement Resources Committee, NHS Improvement Board, DH and HMT. There is an additional approvals process for Trusts in deficit. NHS Trusts in deficit may have their delegated limit lowered by NHS Improvement.

[20] It is noted that this Appendix reflects processes at the time of drafting, but may be subject to change in accordance with changes to national processes and approval limits to ensure that each organisation continues to comply with its general statutory duties.

[21] https://improvement.nhs.uk/resources/capital-regime-investment-and-property-business-case-approval-guidance-nhs-trusts-and-foundation-trusts/

	Regardless of the above limits, property transactions that are deemed novel and contentious, or are deemed to have novel and contentious financing arrangements, may also require NHS Improvement approval. Any schemes involving Private Finance Initiative (PFI) or Local Improvement Finance Trust (LIFT) schemes require discussion with the DH, and may require its approval.
NHS Foundation Trusts	Foundation Trust business cases for transactions and investments are subject to detailed review by NHS Improvement (previously Monitor) depending on: • the size of the investment relative to the Foundation Trust in terms of either income, gross assets or total capital, and • other risks perceived in the proposed investment, including but not limited to the Foundation Trust's leverage and other financial risks, and the potential impacts on its scope of activity and quality of care. **Trust constitutional requirements** An NHS Foundation Trust may designate certain transactions as 'significant transactions' in its constitution. If it has taken this step, the Foundation Trust may enter into a significant transaction only if more than half of the members of the council of governors of the trust voting approve entering into the transaction (s.51A, NHS Act 2006). **NHS Improvement powers in relation to Foundation Trust transactions** Reportable transactions Transactions must be reported to NHS Improvement if they are classified as 'material' or 'significant' (in accordance with the thresholds referred to in the above guidance). Transactions which are 'significant' will require detailed review by NHS Improvement. Where a capital or property investment is classified as "material", NHS Improvement, as part of its overall assessment of financial and governance risk, will request evidence to support the transaction and certification from the trust board. Statutory transactions In addition to reportable transactions, NHS Improvement also has a role in respect of 'statutory transactions'. These are mergers or acquisitions involving one or more Foundation Trusts, and separations and dissolutions of Foundation Trusts (s.56 to 57A, NHS Act 2006, as amended). If a transaction is statutory - regardless of whether it is small, material or significant – a formal application must be made to NHS Improvement to grant the relevant statutory application. NHS Improvement will grant approval if satisfied that the statutory requirements have been met. Statutory transactions also require that over half of the council of governors of a / both NHS Foundation Trust(s) vote in favour of the transaction. NHS Improvement Provider License Conditions

	Provider License Condition CoS2 requires FTs to maintain an asset register of all relevant assets. A "relevant asset" is defined as an asset without which the FT's ability to meet the obligations to provide Commissioner Requested Services would be materially prejudiced. If NHS Improvement has given a licensee notice in writing that it is concerned about the ability of the licensee to carry on as a going concern, then certain conditions apply to the disposal of any relevant asset. This includes a requirement for a licensee to obtain written NHS Improvement approval before disposing of, or relinquishing control over, any relevant asset. <u>Foundation Trusts "deemed to be in financial distress"</u> DH deems a foundation trust to be in financial distress if any of the following apply: • in financial special measure; • in breach of their licence (financial or non-financial breaches); and/or • in receipt of distress funding (received or planned). Foundation Trusts deemed to be in distress are subject to the same limits as NHS Trusts (see box above).

2. NHS England

- NHS England does not have such a broad function to assess business cases but has an assurance role in respect of commissioning arrangements. As part of this role, NHS England's guidance[22] states that it approves business cases in the following sub-set of cases:

    - Under which there is a request for capital expenditure by NHS England;
    - Under which approval is sought to enter into any leasing arrangements by NHS England for land, buildings and/or equipment; and/or
    - Under which authority will be sought for NHS England to enter into commissioning commitments which underpin the revenue implications of a third party, such as NHSPS, CHP or NHS provider trusts investing capital, or entering into lease commitments.

- NHS England's Standing Financial Instructions [paragraph 14.3[23]] provide for approval of business cases requiring capital approval within the following limits:

    - Commitments up to £20m: can be approved by the NHS England Chief Executive or Chief Financial Officer.
    - Commitments from £20m-£35m: should be approved by the Investment Committee.
    - Commitments from £35m and above: should be approved by the Board (subject to consultation/approval with DH and HMT).

3. Department of Health

- The Department of Health will also review any business cases within the NHS which:

    - Propose investment of over £50m, or
    - Require any form of Government guarantee (e.g. a PFI type deal), or
    - Are 'novel, contentious or repercussive' as per Managing Public Money guidance.

[22] https://www.england.nhs.uk/resources/bus-case/

[23] The paragraph in the SFIs was updated by the Audit, Risk and Assurance Committee on 22 September 2016

- DH will undertake a review based on the full 'five case model' as outlined in the HM Treasury Green Book at Strategic Outline Case, Outline Business Case, and Final Business Case stages. DH officials will make recommendations to Ministers who, if content, will then allow passage of cases to HMT.

- HMT approval is coordinated by DH officials and will review the same business cases as are submitted to the DH. The HMT review tends to be a desk-based exercise focusing on affordability, value for money and strategic rationale. If HMT ministers approve the case, this is usually confirmed via a letter from the Chief Secretary to the HMT to the relevant DH minister, which includes any conditions of the approval.

- Under s.211 of the NHS Act 2006, the Secretary of State for Health has powers to acquire land 'required by him for the purposes of this Act' – conventionally this has been used for charitable transfers. Under s. 213 of the 2006 Act, the Secretary of State for Health may provide for the transfer of property between NHS bodies but this is only in limited circumstances (see s.213(1) of the 2006 Act) and examples of where these powers are exercised are on a reorganisation/dissolution of a trust. DH also has the power under s.40-42 of the NHS Act 2006 to give financial assistance to any NHS Foundation Trust and make determinations around Public Dividend Capital, however the Secretary of State must publish guidance on the powers conferred under these sections, requiring consultation with HMT, Monitor and such others persons as considered appropriate.

Appendix D – Draft Prioritisation Framework

Whilst recognising that each member representative will be constrained by their own statutory framework, policies, procedures, members agree to develop and agree a set of principles, which will assist in ensuring continuity and consistency of decision-making. This aims to ensure that the decisions taken best serve the holistic needs of Londoners. The content and relative prioritisation described below is draft and is subject to discussion and agreement by all partners. A final prioritisation framework will be agreed during Phase 2.

Draft prioritisation framework:

- The decision aligns with the HMT Green Book principles and applicable NHS guidance in relation to the valuation of land.
- The decision is strategically aligned with the priorities of the particular local area/sub-regional area and is supported by the local estates boards.
- The decision is deemed commercially viable, deliverable and has been soft tested with developers to ensure the site will be build out within a reasonable agreed timeline.
- The decision delivers best value for Londoners. The consideration of "value" should include explicit consideration of wider social value in addition to financial value.
- The decision suitably reconciles the London system considerations and those of any individual organisation or sub-set of organisations.
- The decision supports health and care transformation. Any reinvestment decision reaches the minimum ROI criteria as determined by NHS England finance and is fully ratified with the local/STP implementation plans
- The decision recognises a hierarchy of calls on released health and care land and capital. The LEB will give priority to health and care needs and subsequently the needs of the wider public estate, recognising the potential for marriage value. The LEB will also take due account of wider public interest needs, including the need for further housing, and the public interest in economic growth and development.
- The decision optimises the wider London public estate.
- A caveat will be included around estate that is used to provide national services, or otherwise go wider than the London regions. In these cases, there will be a clear need to consider national interests to ensure compliance with the principles of the NHS Constitution and Mandate and compliance with the statutory duties of the various bodies.

Appendix E - Draft governance and accountability requirements for local health economies to administer devolved powers

The London system is expected to have robust governance and accountability arrangements in place for devolved or delegated powers to be granted. Similar requirements will be placed on local or sub-regional areas by national partners if they intend to administer these powers. These requirements will be finalised during phase 2, in discussion with national and local partners. However, draft expectations are described below:

- Clear processes in place which allow the constituent organisations to make recommendations, and in due course, decisions around estates as a collective when the ability to do this has been demonstrated. Consideration will need to be given to the purpose and scope of these governance arrangements (i.e. do arrangements seek to achieve coordination, strategic decision-making or any movement of formal accountabilities). Consideration will also need to be given to the phasing of such arrangements and gateway processes which allow the governance arrangements to move between phases.

- Assurance that any model satisfies accountability and other statutory requirements.

- Clear description of risk management and mitigation measures.

- Complementarity with any other emerging transformation governance arrangements in the local area.

- Demonstration of a shared vision and objectives. This to include a joint estates strategy and agreed method of prioritisation which will guide collective decisions around estates. This must be finalised before proceeding to shadow decision-making – equivalent of phase 3 of the LEB.

- Commitment to governance arrangements from all constituent organisations.

- Clear hosting provisions, a named individual lead and a resource plan.

Appendix F - An illustrative approach to demonstrate how voting arrangements could be used in the event that consensus decision-making is not possible

NB: Voting is only applicable to the process of making non-binding recommednations and issuing guidance. Members cannot vote on formal decisions, which must be signed off by the apporpirate representatives with delegated authority.

- In the event that consensus cannot be reached, a sub-set of London LEB members at 6(i) (as decided in due course) will vote on a motion to decide the appropriate course of action. The motion will be passed if it receives the majority of votes. Where the votes are equally split, the Chair and Co-Chair will jointly take a decision on whether the motion should be passed. Where the Chair and Co-Chair cannot agree, the decision should be taken by the independent Co-Chair. This decision will represent the collective view of the LEB and should only be re-considered if further material considerations come to light. At this point, it would be open to member organisations to make a motion that the LEB consider the matter again. Nothing in this paragraph limits the decision-making abilities of member organisations and representatives, who cannot be bound to take or revoke a decision by the LEB.

- To illustrate this process, we take the example of a business case under which there is a request for NHS England capital expenditure. Within phase 3, the LEB members will make collective recommendations to the decision-makers around business cases. For the purposes of this example the decision-maker is only stated to be NHS England (in reality it is recognised that others (e.g. HMT) may have an interest). The sub-regional area presents a business case and the LEB members discuss the merits. Prior to a vote, it becomes clear that some members feel strongly that transformation in that area needs to include some provision for additional housing. Members abide by the prioritisation framework and assess the business case against this framework. The NHS England representative initially is not persuaded by the housing element (as proposed in the business case), but members are able to negotiate and propose amendments to the business case under which the NHS England representative can be assured that the expenditure benefits health and the wider public sector. The aim is that members would come to a consensus recommendation, which the NHS England representative could then adopt. However, it is also necessary to consider a scenario where this may not be possible to ensure that voting arrangements will achieve the necessary result:

    - In the first scenario, a representative with decision-making powers could vote against a motion which is agreed to by all other London partners. The recommendation would stand as the view of the LEB and the decision-maker should give due weight to this recommendation. However, the decision-maker is not obliged to accept the recommendation may ultimately take a decision that is contrary to that recommendation.

    - Alternatively, a majority of London partners may all vote to pass the motion, with two members dissenting who have no formal decision-making powers. The LEB recommendation would stand as the LEB view and those without formal decision-making powers would not be able to prevent the decision-maker acting on this recommendation.