



right care  
right place  
right time  
right outcome

## MERTON CLINICAL COMMISSIONING GROUP GOVERNING BODY

**Date of Meeting:** 23<sup>rd</sup> February 2017

**Agenda No:** 3.2

**Attachment:** 03

<b>Title of Document:</b> London Health and Social Care Devolution Memorandum of Understanding	<b>Purpose of Report:</b> Approval
<b>Author:</b> Peter Kohn - Director - Office of CCGs	<b>Responsible Director:</b> Dr Andrew Murray – Clinical Chair
<p><b>Executive Summary:</b> In December 2015, all 32 Clinical Commissioning Groups (CCGs), London Councils on behalf of the 32 London boroughs and the City of London, the Mayor of London, NHS England and Public Health England came together as ‘London Partners’, and signed the London Health and Care Collaboration Agreement. Through this, the Partners committed to work more closely together to support those who live and work in London to lead healthier independent lives, prevent ill-health, and to make the best use of health and care assets.</p> <p>Central government and national bodies backed this vision through the London Health Devolution Agreement, and invited London to explore devolution – the transfer of powers, decision-making and resources closer to local populations – as an important tool to accelerate transformation plans and respond to the needs of Londoners more quickly.</p> <p>A draft of the London health and care devolution Memorandum of Understanding (MoU) was circulated in December 2016 for comment. A number of CCGs requested clarification on the implications of commitments within the MoU for non-pilot relative to pilot areas. A further document was produced to provide this clarification was produced and considered at the January 2017 Governing Body meeting.</p>	
<b>Key sections for particular note areas of concern etc:</b> Whole document	
<b>Recommendation(s):</b> To approve the London Health and Social Care Devolution Memorandum of Understanding	
<b>Committees which have previously discussed/agreed the report:</b> <b>Governing Body Meetings</b> 24.11.16; 15.12.16; 26.01.17	
<b>Financial Implications:</b> None at present	
<b>Implications for CCG Governing Body:</b> None at present	
<b>How has the Patient voice been considered in development of this paper:</b> Not at this stage.	

**Other Implications:** None apparent at this stage.

**Equality Assessment:** Not at his stage

**Information Privacy Issues:** None

**Communication Plan:**

As part of the Part 1 Governing Body papers, this document is available at the CCG's website.

## **London Health and Social Care Devolution Memorandum of Understanding**

### **1. Introduction**

This Memorandum of Understanding (MoU) aims to enable the widest and fastest improvement in the health and wellbeing of 8.6 million Londoners by transforming the way that health and social care services are delivered, how they are used and how far the need for them can be prevented. London and national partners<sup>1</sup> have been working together to achieve this shared objective.

In December 2015<sup>2</sup>, London and national partners came together to describe their aim to test opportunities to transform health and wellbeing outcomes, inequalities and services in London through new ways of working together and with the public. Through a programme of collaboration and co-development with the five London devolution pilots, it has become clear to London partners that decision-making and powers should be administered at different spatial levels within London and that the pace, degree and nature of transformation will differ for different parts of the city and for different functions. These efforts over the past year have confirmed that devolution is a small but essential component unlocking far broader changes and accelerating integration and more effective collaboration in London. To that end, this MoU sets out a framework for achieving greater collaborative working and devolving greater control of, and influence over, health and care to London.

Through this MoU, London partners aim to lead the way to becoming England's largest urban area to deliver transformation at scale and pace. All partners agree to act in good faith to support the objectives and principles of this MoU for the benefit of the health and wellbeing of all London citizens and patients, which includes a commitment to disseminate learning within and beyond the London system. Many of the issues under consideration are complex and require further collaboration to design and understand the implications of new approaches. New approaches will also require continuing evaluation, to ensure maximum value and best outcomes are being achieved for Londoners. In addition to the commitments contained in this document, national partners extend an offer of a continuing dialogue with London partners regarding further delegation or devolution and, more broadly, to support shared objectives for prevention, health and social care integration and best value for London.

### **2. Parties**

The Parties to the agreement are:

- All 32 London Clinical Commissioning Groups (CCGs), London Councils representing the 32 London boroughs and the City of London, and the Greater London Authority (GLA).
- The 'national partners', comprising HM Treasury (HMT), the Department of Health (DH) (including Community Health Partnerships (CHP) and NHS Property Services (NHSPS)<sup>3</sup>), the Department for Communities and Local Government (DCLG), the Department for Work and

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<sup>1</sup> See section 2 for a description of 'London and national partners'.

<sup>2</sup> London Health Devolution Agreement, December 2015. Available at: <https://www.gov.uk/government/publications/london-health-devolution-agreement/london-health-devolution-agreement>  
London Health and Care Collaboration Agreement, December 2015. Available at: [https://www.london.gov.uk/sites/default/files/london\\_health\\_and\\_care\\_collaboration\\_agreement\\_dec\\_2015\\_signed.pdf](https://www.london.gov.uk/sites/default/files/london_health_and_care_collaboration_agreement_dec_2015_signed.pdf)

<sup>3</sup> The MoU refers to NHSPS and CHP but it is recognised that the Government intends to establish a new NHS property organisation that will, in due course, take on the strategic estates planning and other functions of the two existing property companies.

Pensions (DWP), the Department for Culture, Media and Sport (DCMS), the Department for Education (DfE), the NHS Commissioning Board (referred to in this document as NHS England or NHSE), Health Education England (HEE), the NHS Trust Development Authority and Monitor (referred to collectively as NHS Improvement or NHSI)<sup>4</sup>, Cabinet Office, the Care Quality Commission (CQC) and Public Health England (PHE).

As NHSE, PHE and NHSI all have a London presence, the terms ‘London’ or ‘London partners’ are used in this document to refer collectively to all 32 CCGs, all 33 members of London Councils, the GLA, NHSE London Region, NHSI London Region and PHE London Region<sup>5</sup>.

### 3. Context and relationship to previous agreements

London partners have a clear vision of better health and care for the benefit of Londoners. In October 2014, the London Health Commission published a vision for health and care<sup>6</sup>, building on the Five Year Forward View<sup>7</sup> and the views of Londoners to describe a delivery plan for London. In March 2015, London partners collectively signed up to ten joint aspirations and agreed to collective and individual actions to help London become the healthiest major global city<sup>8</sup>.

The London Health and Care Collaboration Agreement (“the 2015 Collaboration Agreement”) described London’s three key areas of focus: prevention, health and care integration and estates. Given the complexities and size of the London system, London partners planned to work at three levels: local, sub-regional<sup>9</sup> and London-wide. Through five local and sub-regional devolution pilots<sup>10</sup>, the London partners pledged to explore how greater collaboration, integration and devolution could work in practice, including impacts within and beyond the London system. Complementing the 2015 Collaboration Agreement, the London Health Devolution Agreement described commitments by national and London partners to support the delivery of this vision. This MoU builds upon the 2015 commitments<sup>11</sup>.

Recognising that devolution is one of a range of enablers to support health and care transformation, the London Health and Care Devolution Programme has been closely aligned to other transformation activities in health and care. These include NHS England’s New Models of Care

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<sup>4</sup> It is noted that NHS Improvement is not a statutory entity. The parties to this agreement will be the NHS Trust Development Authority and Monitor, but with a single representative signing this agreement in reflection of the shared arrangements.

<sup>5</sup> So far as ‘London partners’ refers to a regional office of a national organisation, these partners will not sign up to the agreement separately, but relevant ‘London’ or ‘London partner’ commitments will refer to these regional offices/departments.

<sup>6</sup> Better Health for London: the report of the London Health Commission was published in October 2014 following a period of engagement, which captured the views of over 14,000 Londoners. Available at: [http://www.londonhealthcommission.org.uk/wp-content/uploads/London-Health-Commission\\_Better-Health-for-London.pdf](http://www.londonhealthcommission.org.uk/wp-content/uploads/London-Health-Commission_Better-Health-for-London.pdf).

<sup>7</sup> NHS Five Year Forward View, October 2014. Available at: <https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf>

<sup>8</sup> Better Health for London: Next Steps, March 2015. Available at: [https://www.london.gov.uk/sites/default/files/gla\\_migrate\\_files\\_destination/Better%20Health%20for%20London%20Next%20Steps\\_2.pdf](https://www.london.gov.uk/sites/default/files/gla_migrate_files_destination/Better%20Health%20for%20London%20Next%20Steps_2.pdf)

<sup>9</sup> The term ‘sub-regional’ refers to a collection of London boroughs and CCGs. The terms ‘local’ refers to an area geographically defined by one borough and/or one CCG and ‘London’ refers to the area defined by all boroughs (including the City of London) and all 32 London CCGs.

<sup>10</sup> There are three local pilots: Lewisham, Hackney and Haringey. There are also two multi-borough pilots: North Central London (Barnet, Camden, Enfield, Haringey and Islington) and BHR (Barking & Dagenham, Havering and Redbridge).

<sup>11</sup> While a MoU, by nature, is not legally binding, partners have closely co-developed this document to ensure that the stated commitments have the requisite support and detail for successful implementation.

programme and the Better Care Fund. London's plans therefore align with the government's priorities on the integration of health and social care, on creating a seven-day NHS and on transforming the health and care system to secure its sustainable financial future. London's transformation efforts have accelerated over the last year through local initiatives, the development of the five sub-regional sustainability and transformation plans (STPs) and, at London level, the establishment of Healthy London Partnership (HLP) to support collective transformation. Both devolution and sub-regional planning encompass the need for long-term sustainability and for decisions to be made locally to meet the needs of local populations. The devolution pilots have involved joint working between London's local authorities, CCGs, providers of health and care services and other local partners to accelerate progress within existing powers, including developing joint governance arrangements. In many cases, these arrangements build on established Health and Wellbeing Boards.

London partners have built on the underpinning principles of engagement modelled through the London Health Commission. From the outset, devolution proposals have been co-developed locally by pilots and their populations<sup>12</sup>, and shaped through collaboration with national and London partners. Frontline health and care staff have been engaged in – and have often led – the development of the workstreams within each pilot. The pilots have wide partnerships including local providers, clinical leaders, the voluntary sector and wider public sector partners. They continue to collaborate and engage with their local stakeholders and communities, and this is considered to be an integral component of the devolution offer. Discussions around the implications of health and care devolution have also taken place on a broader scale within the London system. Going forward, programmes of engagement will continue at local, sub-regional and London level, as appropriate.

The London Health and Care Devolution Programme Board has provided a forum to develop and test emerging proposals. This Board has brought together representatives of London and national partners and reports to the London Health Board (LHB). These efforts have culminated in the formal agreement to collaborate on steps towards devolution, delegation or sharing of functions, powers and resources currently exercised by national partners where there is a clear case that this will assist, enable or accelerate improvements.

#### **4. Overarching principles**

All partners are committed to upholding the principles set out in the 2015 Agreement (described in Annex 1). In particular:

1. Subsidiarity – decisions should be taken or influenced locally wherever possible.
2. London should be involved in all decisions that materially impact on London's health and care.
3. London and national partners will work towards improving outcomes through greater integration and by phased delegation or devolution of decision-making for health and care in London to the lowest, most appropriate level, subject to robust governance and accountability mechanisms and reflecting the statutory accountabilities of individual organisations, nationally agreed principles and criteria for assessment of devolution proposals<sup>13</sup>.

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<sup>12</sup> Pilots have each utilised tailored mechanisms of engagement and co-development with local populations and partners. These are further detailed in the relevant business cases.

<sup>13</sup> <https://www.england.nhs.uk/commissioning/devolution/>

4. Healthcare services in London will remain part of the NHS. The commitments described in this MoU aim to strengthen health and care in the London area and continue to uphold the NHS values and standards, including the NHS Constitution, ongoing involvement of the public and co-development of plans with local populations.
5. National partners are committed to continue a co-production approach with London partners to facilitate ultimate decisions on devolution – both by national partners to devolve and by London to exercise and ‘receive’ devolved functions. Partners share an expectation that these co-produced solutions will, in time, transform the entire London health and care economy.
6. Further devolution or delegation decisions will continue to be subject to careful consideration by national partners, taking into account the needs of people in London and elsewhere and reflecting the principles and criteria agreed by NHS England.

London partners commit to working with national partners to ensure alignment between national policy objectives, and the strategic direction taken by London. London partners will work together to support nationally agreed priorities, including those set out in the Five Year Forward View. All organisations retain their current statutory accountabilities for health and social care and any commitments made are subject to organisations’ continuing ability to meet these accountabilities.

## **5. Scope**

This MoU constitutes a roadmap, with initial commitments that can be agreed by each constituent party now, and further anticipated steps that will require consideration in the light of experience and developments in the future.

The scope of London’s transformational plans covers all aspects of health and care, specifically:

- Primary care
- Acute care (including specialised services)
- Community services
- Mental health services
- Social care (adult and child)
- Public health, including maximising opportunities to influence wider determinants of health

Key enablers will include:

- Delegation or devolution of funding and commissioning functions as agreed with the relevant national partners.
- Fiscal and regulatory levers to promote health through planning, licensing and employment support.
- Strengthened system leadership, supported by effective governance, clear accountability and transparency.
- A shared strategic approach to estates planning, including NHS capital investment decision-making.
- Joint workforce strategic planning.
- Full involvement in development of new payment mechanisms to support new models of care.

## **6. Future roadmap**

This MoU describes the aspiration for London (including the wider London system and local and sub-regional areas) to achieve transformation of health and social care at pace and scale. London and national partners will continue to work together during 2017/18 to agree the preferred mechanisms and timescales for any devolution or delegation of powers and resources to achieve the aims and objectives described in this MoU.

Through this MoU, devolution may ultimately be secured by the London system, with local and sub-regional areas having the ability to draw down delegated or devolved functions subject to developing suitable plans, delivery and governance arrangements. Progression towards delegation and devolution of responsibilities and resources from national partners to the London system will take place in agreed phases of change, with progression subject to achievement of nationally applicable devolution criteria, demonstrated capability, robust governance arrangements, a clear delivery plan and gateway milestones. New approaches undertaken within London will be tested and evaluated, to assess impacts and ensure maximum value for Londoners.

This MoU sets out how national partners will support implementation of the pilots as well as new ways of working at pan-London level, subject to local readiness and in accordance with national statutory responsibilities and the principles set out in Section 4. Each pilot has developed a business case setting out more detailed arrangements for implementation, to be supported by robust, transparent governance. These business cases are published alongside this MoU and pilots will commence implementation in accordance with the timelines described in these documents, recognising the need for a phased approach.

Within other local and sub-regional areas, any devolution of health functions will be subject to the appetite of local areas and careful consideration of business cases<sup>14</sup> and governance and accountability arrangements, taking into account the needs of people in London and elsewhere<sup>15</sup>.

By working together, London and national partners will be able to fully understand and manage risk together. The London system will take more control of its own future and responsibilities, in a phased way that is safe and beneficial for patients and communities and ensures the duties and accountabilities in the NHS Constitution and legislative framework continue to be upheld.

## **7. Shared commitments between government, national partners and the London partners**

### *a) Capital and estates*

The NHS estate in London is considerable, but significant capital investment is required to ensure high quality health and care infrastructure and greater investment in primary and community care facilities. Partners recognise the opportunity to improve system-wide planning, reduce under-utilisation, release surplus land and capital and realise wider one public sector estate opportunities.

London and national partners commit to establishing a London Estates Board (LEB) to directly solve some of the challenges involved in securing NHS estates approvals and disposals, working in more transparent and collaborative ways 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. As it matures, subject to agreed hurdle criteria, the LEB would also provide a

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<sup>14</sup> Business cases would be considered by the national organisations statutorily accountable for the relevant functions or duties.

<sup>15</sup> It is recognised that London provides expertise and services for people who live outside the capital and that benefit the country more widely. London will work collaboratively with other regions and national bodies to consider and mitigate the impact of London decisions on surrounding populations reliant on London-based services.

forum within which NHS capital investment decision-making could be exercised, including delegated business case approvals and capital allocation considerations.

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 is expected to 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, in accordance with the legislative framework and statutory accountabilities of LEB member organisations. This is described in full in the LEB Operating Framework<sup>16</sup>. The LEB will work with the GLA to ensure optimum land assembly through links with the Homes for Londoners Board and London Land Commission, for wider public sector utilisation (e.g. housing), where land is surplus to health and care requirements.

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. These plans will build up from the local estates strategies developed by CCGs and local authorities to set out the planned sources and intended applications of capital funding, running up to 2021. Sub-regional and local boards will be supported to develop accountability and governance arrangements to a sufficient standard to enable delegated decisions to be taken at more local levels<sup>17</sup>. The LEB, sub-regional and local estates boards will be supported by a London Estates Delivery Unit (LEDU), a virtual team bringing together regional and regionally-based national expertise to support the collaborative development of robust estates strategies and capital business cases. A new national approach to NHS estate has been described through the Naylor Review process, including the establishment of a new national NHS property organisation. This will initially create a single strategic estates planning function and, in due course, is expected to bring in other functions currently undertaken by NHS Property Services and Community Health Partnerships. It is intended that the LEB will be the London regional expression of estates governance and that relevant strategic delivery expertise will be accessed through the LEDU.

To achieve this:

- NHSE, NHSI, DH, One Public Estate (OPE) and HMT agree in principle, and subject to agreed phasing and the achievement of agreed gateway criteria, to support the internal delegations of a level of business case approval authority to named individuals, operating as members of the LEB<sup>18</sup>.
- Decisions on capital expenditure within London's allocated funds, including NHS England CDEL<sup>19</sup> budgets (particularly ETTF<sup>20</sup>), and other NHSE and non-NHSE 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. Decisions falling to national partners pertaining to the application of capital receipts generated within the London system will ultimately be taken at LEB or sub-regional level, subject to robust governance arrangements being agreed.

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<sup>16</sup> LEB operating framework [DN: to be published on same day – link to document]

<sup>17</sup> Such decisions would be taken by way of representatives from national organisations exercising delegated authority as part of a more local forum (for example, a sub-regional estates board).

<sup>18</sup> To exclude decisions requiring ministerial approval where the LEB would make a non-binding recommendation.

<sup>19</sup> NHS Capital Departmental Expenditure Limit fund

<sup>20</sup> Estates and Technology Transformation Fund

- All health and care capital cases which are best considered jointly within the London system, covering both NHSE and local government investments, will ultimately be considered by the LEB or (for lower limits) local or sub-regional estates boards.
- All partners commit to supporting sub-regional estates boards to develop governance and accountability mechanisms, to enable the capability to administer delegated or devolved functions.
- NHSI, NHSE, DH, CHP, NHSPS, OPE and London partners 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.
- The CHP and NHSPS estate planning teams will be brought together as one team as part of the new national property organisation, together with existing partnerships such as LIFT Companies (LIFTCo)<sup>21</sup>. This team will form part of the LEDU.
- London partners will operate in line with the commissioner capital control total framework set by national partners and, subject to robust governance structures, sub-regional estate boards could take on a management role of capital control totals, within a London envelope.

These arrangements will facilitate a whole-system, collaborative approach. Any LEB decisions must be consistent with, and aligned to, estate strategies set out at local and sub-regional level. The work of the LEB must also be consistent with jointly owned national policy objectives and the legislative framework.

London and national partners are continuing to explore systemic issues that may be a barrier to best use of estates or assets; or may be hindering the disposal of surplus land. Partners also recognise both the significant capital investment requirements within health and care in London and the significant opportunities for generating receipts and additional housing from the disposal of surplus land. To address this:

- National partners agree in principle to London retaining the capital receipts generated by trusts and Foundation Trusts in London to enable investment in health and care. This will be subject to robust sub-regional and London estates strategies and existing statutory accountabilities.
- While individual trusts and Foundation Trusts own most of the health estate, the DH-owned property companies (NHSPS and CHP) hold some land utilised by the health and care system in London. This includes estate used for primary and community services. It is therefore important that decisions around this estate are informed by discussions with the LEB, to ensure that all opportunities (including for marriage value) are considered. This is consistent with the 'one public estate' approach. To this end, DH, NHSPS and CHP commit to working in partnership with the LEB to develop an approach for NHSPS and CHP investments and sales, which aligns national and London needs and priorities.
- 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

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<sup>21</sup> Local Improvement Finance Trust (LIFT) companies are locally-based joint ventures between the public and private sectors.

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 commit to working 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.

- Recognising the difference in statutory obligations, oversight and freedoms of different estate holders, the LEB will 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.

London and national partners agree that both sub-regional and London-wide plans should aim to align with and deliver against any national health estate or public sector targets and estates/asset sale plans. National partners commit to clarifying and agreeing these requirements in partnership with the London system in the early phases of the LEB's operation.

London and national partners also commit to working towards the aim of optimising the use of existing NHS estate, by:

- Developing a London report on NHS estate utilisation by April 2017 and implementing the recommendations through the LEB thereafter.
- DH and NHS England introducing a vacant space policy by April 2017.

London partners agree to share and deploy their knowledge, expertise, resource and contact networks in support of this agenda including, where appropriate, from boroughs, CCGs, and the GLA.

*b) Commissioning models and payment mechanisms*

London partners recognise opportunities to commission services with a whole-system outlook, with the overall aim of improving outcomes for service users by enabling more integrated, joined-up pathways and services that focus on the individual rather than the service provider.

London partners, Government and NHS England commit to supporting place-based commissioning of health and care services at the most appropriate level to best meet the needs of patients and communities across London. Partners recognise that payment mechanisms, financial allocations and budget pooling are key enablers to greater integration and support further development within statutory permissions.

Central to the Government's objectives over this Parliament is the restoration of financial balance in the health system, both in terms of providers' and commissioners' finances, as well as a determined focus on operational performance and quality of care. London partners commit to build on STP development by continuing to develop detailed and credible place-based plans to enable London's health economy to achieve sustainability whilst maintaining and improving quality and outcomes. A London-level strategic plan, drawn from sub-regional health economy plans, will enable oversight of the impact on health outcomes and financial sustainability of the system across the Capital.

NHS England and NHS Improvement commit to supporting local and sub-regional areas in London to co-develop and adopt innovative models of payment, building on the work done for New Care Models. In return, London commits to:

- Rapid piloting of new payment models at different spatial levels and across a wide range of sectors and organisations.

- Co-development of scalable solutions that can be implemented more widely within London and beyond.
- Robust assessment of efficacy and disseminating learning at pace.

Transformation will require commissioners and providers to work in partnership including ensuring, where possible, greater alignment of decision making to inform joint commissioner and provider plans and greater involvement of commissioners to support providers in delivery.

NHS England commits to enable delegation or devolution of its functions and budgets to within the London system, subject to its established process for readiness assessments, and to enabling targeted allocations and more integrated approaches to commissioning across health and care. Specifically, NHS England commits to:

- Delegate all primary medical services commissioning to the local level by April 2017, subject to CCG agreement, and to consider in the financial year 2017/18 how steps towards further devolution could be taken, subject to the relevant decision-making criteria being met.
- Delegate London's fair share of the population-based allocation of transformation funding to London from April 2018<sup>22</sup>.
- Explore delegation of some specialised commissioning functions, excluding highly specialised commissioning, to the sub-regional level from April 2018, contingent on the development of robust plans and governance arrangements, subject to its standard readiness assessment.

Public Health England, NHS England and the Department of Health commit to collaborating with London partners to explore how immunisation and screening commissioning arrangements and service provision relate to local plans and how partners could organise from April 2018 so that this resource and expertise can be shared to deliver mutual objectives and enable more effective local delivery. The Department of Health and NHS England will work with London partners to consider what further steps could be taken to support more personalised, joined up care at all spatial levels. This includes developing a shared understanding of any current barriers to joint or lead commissioning arrangements and whether there is a case for change for addressing such issues, taking into account wider policy considerations, views from other local areas and legislative implications.

London will be able to access any relevant new or additional health and/or social care funding streams that become available during the Spending Review period.

London partners commit to:

- Utilising these arrangements to enable financial incentivisation and prioritisation that more accurately responds to local needs.
- Moving to more formal integrated joint working, building on a proven track record in London.
- Developing detailed and credible local and sub-regional health and care plans to enable London's health economy to achieve sustainability while maintaining and improving quality and outcomes.
- Using opportunities within legislative and policy frameworks to pool budgets in order to more appropriately allocate funding to primary and community care and incentivise early

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<sup>22</sup> This function will be exercised through the London Health and Care Strategic Partnership Board by way of internal delegations within NHSE to representatives who will make decisions within the forum of that Board.

intervention and rapid discharge. Utilising funding and conducting functions within these frameworks.

- Putting the required capabilities and standard delegation agreements in place to operate delegated primary medical care commissioning by CCGs in local areas by April 2017.
- Sharing and spreading learning from pilot programmes - both within London and nationally.

c) Regulation and oversight

London partners are committed to transforming the health and care landscape including supporting commissioners and providers to move at pace to design and implement new models of care. To enable this, national partners support giving greater accountability to local health and care systems. By closer alignment with London's ambitions for transformation, regulation can support and reinforce local health and care collaboration and integration.

Although legislation does not permit devolution of national regulatory functions for health services, regulators commit to taking a more aligned approach in London. NHS England and NHS Improvement commit to streamlining regulation and oversight with joined up processes at regional level, including joint appointments for some key roles. CQC, NHS Improvement and NHS England commit to closer working at London level, including alignment of regulatory actions and timelines for reporting wherever possible. London commits to working with national partners to ensure that any joint arrangements developed minimise the administrative burden and ensure robust governance and conflict of interest management.

London will work with national partners and pilots to explore the potential for new models of oversight to enable and promote the implementation of ambitious new ways of integrated working. In support of local integrated delivery models, London will pilot a place-based framework for system regulation, ensuring clear commitment to complying with agreed core standards and existing legal responsibilities. National regulatory partners (NHSE, NHSI and CQC) will work with London to develop, support and resource<sup>23</sup> a regulation and oversight model that meets the needs of the London system. Consistent with wider national policy, and working within the legislative framework, this will include:

- The ability for an integrated/single delivery system to be regulated as a whole, alongside the underlying distinct organisational operating units<sup>24</sup>.
- Supporting the development of lead accountable providers, who take responsibility for providing integrated health and care services across a locality and can therefore be accountable for quality and productivity across individual units, with clear protocols to protect patient choice and ensure transparent referral patterns. With the increasing development of accountable care models, bringing together as far as possible the oversight of CCGs and the oversight of providers into a single shared framework within London.

Recognising the challenges faced by local areas in moving to an integrated commissioning and, potentially, delivery system, NHS England, NHS Improvement and CQC commit to co-developing a robust assurance approach to enable freedoms and flexibilities during the development and initial implementation stages of implementation. This must ensure delivery of agreed core requirements (including the NHS Constitution and Mandate) and that risk is kept within acceptable tolerance.

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<sup>23</sup> It is intended that this work be funded from within existing resources.

<sup>24</sup> It is recognised that, under the current statutory and policy framework, regulators must continue to be able to conduct an assessment of each organisational unit.

d) Workforce and skills

The people that work in health and care are critical to achieving London's transformation goals. London will build on its position as the home of popular and world-class health education to develop new roles, secure the workforce it needs and support current and future staff to forge successful and satisfying careers in health and care.

London partners have recognised the need for joint health and care training and workforce development, to support integrated working as a key enabler to new models of care. To achieve this, HEE, Skills for Health, Skills for Care, the Department for Education, the Department of Health and London partners commit to:

- Establish a London Workforce Board through expanded membership of the London and the South East Local Education and Training Board (LETB) for issues related to London, to ensure a collaborative strategic and implementation approach. Recognising the critical importance of clinical representation, the London Workforce Board will include appropriate clinical membership.
- Empower the London Workforce Board to seek agreement amongst member organisations to pool resources where appropriate, including HEE's delegated transformation and development funding, for spending on joint projects whilst respecting the governance, accountability and priorities of member organisations.
- Working with national partners and through the London Workforce Board to ensure the employers within an integrated health and care workforce can take advantage of the opportunities offered by the apprenticeship levy. Consistent with national policy to enable transfers between employers by 2018, this will include the ability to transfer funds between individual employers within an integrated health and care system. Together with the delegated HEE transformation and development funding, this could enable integrated training and workforce development.
- Establish a collaborative, London-wide workforce delivery system with HEE, Skills for Health and Skills for Care working together on key training and development priorities.

London partners, with the relevant central Government departments, will work to harmonise this activity with efforts championed by the GLA and London Councils to maximise opportunities for links with further education colleges and local training efforts to support unemployed Londoners. To support integrated working, London and national partners commit to take a common approach to explore a single employer framework, which, in line with Government pay policy, seeks to re-distribute and better target the existing pay envelope, and to working in partnership with trade unions and employers. This would include:

- Exploring opportunities for more unified job evaluation and performance management arrangements where roles cross health and care.
- Developing a business case to examine the implications for pay scales of joint roles to provide parity between health and care. This would be subject to partnership working with trade unions and employers and include an assessment of affordability.
- London partners exercising existing employment freedoms to set terms and conditions and professional requirements for new combined roles.
- Ability to co-locate health and social care staff across a local or sub-regional footprint, to enable collaborative working.

London trains a significant proportion of the national health and care workforce but continues to experience challenges in staff retention and turnover. London partners will work with the Department of Health to explore London weighting in this context.

e) Prevention

Improvements in the health and wellbeing of Londoners have to be led within communities. Through a place-based approach that puts health and wellbeing at the heart of devolution plans, London partners have real opportunities to tackle the wider determinants of health - including employment, planning and housing - and address health inequalities. Devolution could provide further opportunity to create better environments in which people can flourish, complementing the efforts of individual Londoners to stay healthy.

Some of the prevention proposals put forward by the pilots to date would have implications for national policy and legislation. It is therefore appropriate that a strong evidence base is first established to inform this. London and national partners commit to collaborating on and contributing expertise to establish the opportunities and explore the evidence base for:

- Granting local authorities the freedom to extend smoke-free areas to include alfresco dining areas of restaurants and pub gardens.
- Including health and wellbeing as a licensing objective, through a Haringey and London School of Hygiene and Tropical Medicine research programme, which will conclude in September 2017<sup>25</sup>.
- Establishing a borough-led London-wide illegal tobacco and counterfeit alcohol enforcement team. This team would work to reduce the availability of cheap illicit tobacco and alcohol and minimise health harms, especially to children and young people, along with strengthening citywide action on illegal tobacco and alcohol and generating more duties paid to the exchequer.

Fiscal levers provide opportunities to invest in prevention. The recently announced sugar levy provides opportunities to invest in measures to combat childhood obesity, which is a particular challenge in London. London is already undertaking significant efforts to support physical activity in schools and to ensure healthier school environments. As recognition of this, HM Treasury commits to ensuring that London's "fair share" proportion of revenue from sumptuary taxes, such as the soft drinks industry levy, is invested with consideration of synergies with current and planned programmes to address London's public health priorities.

Locally determined reliefs and discounts could enable more strategic planning around high streets to meet wider public health objectives, for example by rebalancing the food offer on the high street away from the proliferation of unhealthy takeaways. London government has put forward an ambitious set of proposals in response to the Government's business rates reforms that will see 100% of business rates retained by the sector by 2020. London will support city-level action to address the wider determinants of health where this is the most effective scale; including transport, planning, and regulatory interventions to support the public health agenda. The Mayor of London's actions on air quality illustrate London government's commitment to issues of health harm. London partners commit to strengthen health related planning considerations as part of the refreshed London Plan. Subject to consultation and wider due process, this could include:

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<sup>25</sup> The research programme considers how health and wellbeing could work as a licensing objective.

- Strengthened wording regarding the duty to consult with local health and care services and statutory directors of public health, and strengthened requirements for health impact assessments in major developments.
- Strengthened guidance on tackling childhood obesity, including through challenging the spread of hot food takeaways in areas close to schools.
- Under the London Plan, new premises categorised as ‘A5 hot food takeaway uses’<sup>26</sup> not being permitted where these are within 400 metres of an existing or proposed primary or secondary school. Boroughs that wish to set a locally determined boundary from schools would be expected to give clear justification for why this planning policy is not appropriate for their borough.

In support of this approach, DCLG and London partners will examine the interaction between planning policy and guidance and London’s health and wellbeing objectives. If this process identifies approaches where the planning practice guidance could support better outcomes for public health and other Government objectives, national partners commit to further discussions with London partners to explore these options.

To go further in tackling harms caused by unhealthy food and drink, gambling and smoking, national partners make the following commitments:

- London partners to explore options to further restrict the advertising and marketing of unhealthy food and drink in specific locations based on health harm. London partners commit to test and evaluate the impact of such policies and to further explore the evidence base for a London-specific approach in order to tackle the city’s obesity epidemic. London partners will work closely with the Committee of Advertising Practice as they bring into effect on 1 July 2017 new rules banning the advertising of high fat, salt or sugar (HFSS) food or drink products in children’s media
- London partners to work closely with DCMS as they undertake their review of gaming machines and social responsibility measures<sup>27</sup>. DCMS aims to publish its findings and any resulting proposals during the Spring of 2017 and commits to liaising closely with all stakeholders, including London’s devolution pilots, as the review progresses.
- Involving London partners in HM Revenue and Custom’s (HMRC) review of sanctions to tackle illicit tobacco. This includes exploring how to make the best use of existing sanctions and consideration of proposals for new sanctions, on which HMRC will be consulting later this year.
- Drawing on evidence from Haringey and other London boroughs in DH’s complementary review of the sanctions for individuals and businesses that break tobacco laws, including looking at further use of civil penalties where appropriate.
- Involving London partners in further consideration of the potential licensing of the tobacco supply chain, where HMRC has undertaken a formal public consultation that gave a commitment to consider the outcomes with DH and the devolved administrations.

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<sup>26</sup> The term ‘uses’ refers to ‘use classes’ under the Town and Country Planning (Use Classes) Order 1987 (as amended) which categorises different uses of land and buildings.

<sup>27</sup> The review will consider robust evidence on the appropriate maximum stakes and prizes for gaming machines across all premises licensed under the Gambling Act 2005; the number and location of gaming machines across all licensed premises; and social responsibility measures to protect players from gambling-related harm. It will also close look at the issue of B2 gaming machines (more commonly known as Fixed Odds Betting Terminals or FOBTs) and specific concerns about the harm they cause, be that to the player or the communities in which they are located. The review aims to ensure that legislation strikes the right balance between allowing the industry to grow and contribute to the economy whilst ensuring consumers and communities are protected.

*f) Employment and health*

London and national partners have a shared aim to improve both the employment outcomes for people with health conditions and disabilities and the health outcomes of working age people through active labour market participation. Given the strength of London's jobs market, there are significant opportunities for improving outcomes for people with health conditions and disabilities in London and London partners are ambitious about the Capital's ability to deliver the best service for its residents.

The 2015 Spending Review confirmed that the London boroughs and Mayor of London will jointly commission employment support to assist the very long-term unemployed and those with health conditions and disabilities to (re-)enter work. London partners, DH and DWP commit to ensuring that local areas in London are able to jointly shape every element of the commissioning process: from strategy to service design, managing provider relationships and reviewing service provision.

London partners are keen to pilot further joining up of local public services in order to improve outcomes for this group, exploring new models for integrating health and employment support and the role prevention and early intervention can play. To achieve this:

- DWP commits to the transfer of the Work & Health Programme funding to London for London to procure and deliver an equivalent programme tailored to the needs of Londoners.
- Through the joint Work and Health Unit, DH and DWP commit to working with Haringey and London partners to test improvements to support people at risk of becoming long term unemployed; to understand what volumes of additional referrals to Fit for Work the enhanced service will achieve; and to explore signposting from Fit for Work to local services through the Return to Work plan.

Through the Haringey pilot, London and national partners (NHS, DWP and Fit for Work) commit to exploring options related to data sharing between relevant partners to facilitate a robust evaluation of the impact of enhanced local support for people experiencing mental health problems and who are at risk of falling out of work.

*g) Governance arrangements and accountability*

Governance arrangements will reflect the importance and complementarity of local, sub-regional, and London-level working, with decisions taken at the most local level so far as is possible within the legislative framework, consistent with the principles underpinning devolution. London partners have agreed the following arrangements as the best means of leading and assuring the necessary improvements in health and wellbeing for the population of London.

***Local and sub-regional arrangements***

Governance arrangements for local and sub-regional working aim to:

- Be co-developed, owned and agreed by local partners. They will be developed by local and sub-regional areas and may take different forms in different areas. The different governance and accountability models developed by London's five devolution pilots are illustrative of this approach.
- Enable organisations to identify areas of complementarity between parts of the health and care system, to work together to avoid duplication and ensure that solutions are workable

and beneficial for the local population. This builds on work underway through local and STP planning processes, including composition and utilisation of Joint Strategic Needs Assessments.

- Enable partnership working and shared ownership by local health and government partners in order to achieve plans and strategies that reflect the needs of the local health economy, with the ability for both health and care to influence decisions regarding the administration of delegated or devolved powers.
- Ensure that mechanisms are in place for appropriately engaging the public and stakeholders, in order to ensure that plans reflect population wants and needs. Those proposing transformation will aim to get the widest possible local support and will take full account of the consultation and engagement responsibilities of constituent organisations.
- Ensure that partners collectively enable improvement in health and care which addresses the health and wellbeing needs of local populations. Different places and types of institution will be on an equal footing. All organisations, including providers, will be key partners in plans, engagement and implementation and will work to collectively shape the future of health and care in the local area.
- Ensure that responsibilities and accountabilities remain clearly within the statutory framework, with robust monitoring of the potential for conflicts of interest.

To deliver this,

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

- Robust mechanisms will preserve financial and clinical accountability of relevant bodies, with strong clinical input at every spatial level. Governance arrangements that involve pooled budgets will need to be supported by a jointly developed financial strategy and agreed financial management processes.

### ***London arrangements***

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

Underlying design principles:

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

### **London Health Board**

Political leadership is vital at all spatial levels and a re-cast London Health Board will enable political accountability of health and care in London, and provide political oversight of wider London transformation efforts. The London Health Board will continue to be chaired by the Mayor of London. Membership will be strengthened as required to reflect political leadership from sub-regional groups. The London Health Board will have strategic political oversight for health and care in London.

### **London Health and Care Strategic Partnership Board**

From early 2017, a London Health and Care Strategic Partnership Board (SPB) will provide strategic and operational leadership and oversight for London-level activities, building on national direction (such as the Five Year Forward View) and London plans (including Better Health for London), but crucially emphasising the partnership approach and an agreed strategy for sustainability and transformation built up from local and sub-regional plans. This will replace existing collaborative London-wide fora. The Devolution Programme Board will continue operation but meet quarterly during 2017 to enable national and London partners to keep abreast of the devolution programme and developments within the London system, and allow exploration of any further devolution opportunities.

Under the current framework, the SPB will not have statutory or legal responsibilities and will not affect or replace the statutory responsibilities and accountabilities of each partner, or change the operational arrangements for application of budgets. The SPB will also be accountable to the individual partners through their respective membership.

Membership of the SPB will mature as London continues on its journey to greater autonomy, and will be reviewed formally in September 2017. It will be important to ensure that local and sub-regional partners continue to be able to shape the model of London governance going forward. Membership will include representatives from the following organisations or groups:

- Three sub-regional leads nominated by each London STP (comprising of a CCG, local authority and provider representative for each of the five London STPs).
- London Councils: One representative
- London CCGs: One representative
- GLA: Two representatives
- PHE: Regional Director
- NHS England: Two representatives including one Regional Director
- NHS Improvement: Executive Regional Managing Director
- Care Quality Commission, Health Education England, third sector and patient groups.

In addition to the above invited members, representatives from other London and national partners will attend as appropriate. The SPB will be co- chaired by the London Regional Director of NHS England and the Chief Executives' London Committee (CELC) Health Lead. Governance arrangements will ensure clear lines of accountability for any relevant funding as agreed and outcomes as appropriate. Membership and governance arrangements will be reviewed and further defined as and when delegated or devolved responsibilities are taken on to ensure probity and address any arising conflicts of interest.

Detailed governance arrangements for the SPB are under development, and will include clear protocols for decision-making and to ensure robust clinical input. It is anticipated that arrangements will be refined as the SPB matures, and governance documents will be updated accordingly.

#### Partnership Commissioning Board

From April 2017, London-wide health and care operational functions will be administered in shadow form through a London level Partnership Commissioning Board. These functions are likely to include assurance and the administration of any London-level delegated or devolved commissioning functions and budgets, and would initially be exercised through a period of shadow running.

The London-level commissioning board will not affect statutory local commissioning or decision-making functions, but look at how some national commissioning functions could be exercised at the regional level or how existing regional functions can be administered through greater engagement with local government and other partners.

During the initial phases of London governance, partners will finalise detailed strategies for administration of functions delegated to London. Decisions will be taken at London level by way of internal delegations within constituent organisations, and there are currently no proposals that change legal responsibilities or financial accountabilities.

Where possible there will be complementarity between representatives on the Partnership Commissioning Board, the SPB, local and sub-regional governance mechanisms.

### Strategic delivery group

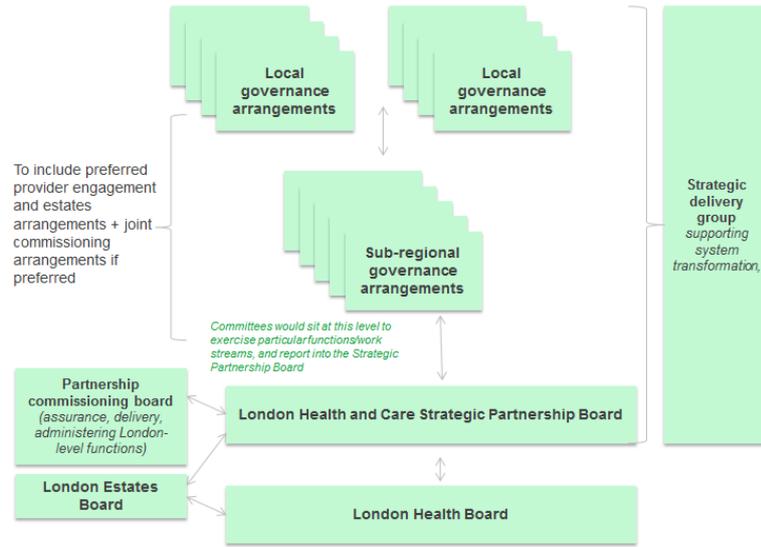
A London strategic delivery group will support delivery, system transformation, and collaborative working at all spatial levels, and will build on the transformation currently undertaken by London structures such as the Healthy London Partnership. London partners agree to share and deploy their knowledge, expertise, resource and contact networks in support of the commitments made in this MoU. A full financial plan for delivery will be developed during the advisory phase of the SPB, with arrangements in place by 1 April 2017.

### Phasing

A phased approach to London governance for health and care transformation will describe clear gateways for progression agreed between the London system and national partners.

1. **Advisory:** Representatives from existing governance structures will initially meet as the SPB to co-develop the framework under which London governance will operate. The SPB will provide a pan-London forum for discussion, and sit in an advisory capacity to support partners to commence implementation of agreed devolution. During this phase, the SPB will support partners to establish new operating models, including joint approaches to regulation. It is envisaged that this phase will begin in February 2017, and be reviewed against agreed gateway criteria for the strategic phase in April 2017 to determine whether the SPB can move into the next phase.
2. **Strategic leadership:** The SPB will provide a central point for co-location of current strategic oversight mechanisms. During this phase, the SPB will begin the process of building the London level strategic plan required for effective oversight, support sub-regional areas to develop and implement robust strategies and act as broker for proposals between national partners and local areas. This phase will be reviewed against agreed gateway criteria for shadow decision-making in September 2017 to determine whether the SPB can move into the next phase.
3. **Shadow decision-making at London level:** The SPB will continue to operate as a pan-London strategic function and London will also begin the process of shadow running by way of recommendations made to national organisations. Decision-making around a London share of certain budgets would begin, in shadow form, within the forum of the SPB as agreed with relevant national organisations, although there would be no change to statutory accountabilities. It is envisaged that this phase would be reviewed against agreed gateway criteria for the decision-making phase in April 2018 to determine whether the SPB can move into the next phase.
4. **Decision-making at London level:** The SPB will continue to operate as a pan-London strategic function. Following agreement by national partners, certain budgets and commissioning functions may be appropriate for formal delegations to a London level. Partners could begin the process of formal decision-making in phase 4, by way of internal delegations to organisational representatives on London governance structures.

The London system aspires to progress into a more fully devolved model via a phase 5, and it is recognised that this would require a strong evidence base of efficient, effective and robust operation, as well as further consideration of the available legislative options to support such an approach. Any future decisions would be subject to a full readiness assessment and to relevant national organisations being able to meet their ongoing statutory accountabilities with regards to both London and the rest of the country.



## **Annex 1: Aspirations, objectives and principles**

### **Aspirations and objectives**

The parties have a shared commitment to deliver on the 10 aspirations to promote health and wellbeing set out in Better Health for London: Next Steps and, in doing so, deliver on the NHS Five Year Forward View and secure the sustainability of health services and social care.

To meet these aspirations, the parties share the following objectives:

- To achieve improvement in the health and wellbeing of all Londoners through a stronger, collaborative focus on health promotion, the prevention of ill health and supporting self-care.
- To make rapid progress on closing the health inequalities gaps in London.
- To engage and involve Londoners in their health and care and in the health of their borough, sub-region and city including providing information so that people can understand how to help themselves and take responsibility for their own health.
- To improve collaboration between health and other services to promote economic growth in the capital by addressing factors that affect both people's wellbeing and their wider economic and life opportunities, through stronger partnerships around housing, early years, employment and education.
- To deliver integrated health and care that focuses on maximising people's health, wellbeing and independence and when they come to the end of their lives supports them with dignity and respect.
- To deliver high quality, accessible, efficient and sustainable health and care services to meet current and future population needs, throughout London and on every day. To reduce hospitalisation through proactive, coordinated and personalised care that is effectively linked up with wider services to help people maintain their independence, dignity and wellbeing.
- To invest in fit for purpose facilities for the provision of health and care services and to unlock the potential in the health and care estate to support the overall sustainability and transformation of health and care in the capital.
- To secure and support a world-class workforce across health and care.
- To ensure that London's world-leading healthcare delivery, academic and entrepreneurial assets provide maximum benefit for London and the wider country; and that health and care innovation is facilitated and adopted in London.

### **Principles**

All parties have agreed key principles for reform and devolution:

- Improving the health and wellbeing of Londoners will be the overriding driver for reform and devolution.
- We will work to secure a significant shift from reactive care to prevention, early intervention, self-care and care close to home that supports and enables people to maximise their independence and wellbeing.
- London will remain part of the NHS, public health and social care system, upholding national standards and continuing to meet and be accountable for statutory requirements and duties, including the NHS Constitution.
- Joint working will improve local accountability for services and public expenditure. Where there is local agreement to change accountability arrangements, accountability to NHS England will be maintained – in relation to issues including delivery of financial requirements, national standards

and the NHS Constitution. Any changes to current accountabilities and responsibilities will be agreed with national partners as necessary and may be phased to balance the pace of progress with ensuring a safe transition and strong governance. We commit to fulfil the legal requirements for making significant changes to commissioning arrangements, including statutory duties to involve the local population and submit proposals for local authority scrutiny.

- Decision-making will be underpinned by transparency and the open sharing of information between partners and with the public.
- Transformation will be locally owned and led and will aim to get the widest possible local support. We will ensure that commissioners, providers, Academic Health Science Networks (AHSNs), patients, carers, the health and care workforce, the voluntary sector and wider partners are able to work together from development to implementation to shape the future of London's health and care.
- All decisions about London will be taken in or at least with London. Our goal is to work towards resources and control being devolved to and within London as far as possible, certainly in relation to outcomes and services for Londoners.
- Collaboration and new ways of working will be needed between commissioners, providers, patients, carers, staff and wider partners at multiple levels. Recognising that the London system is large and complex, commissioning and delivery will take place at three levels: local, sub-regional or pan-London. A principle of subsidiarity will underpin our approach, with decisions being made at the lowest appropriate level.
- Given London's complexity we recognise that progress will happen at different paces and in different orders across the different spatial levels. We will ensure that learning, best practice and new models for delivery and governance are shared to support and accelerate progress in all areas. Subsidiarity as a principle will extend to the adoption of ideas piloted in other areas to allow flexibility and adaptation to local conditions.
- The people that work in health, health care and social care are critical to achieving London's transformation goals. We will build on London's position as the home of popular and world-class health education, to develop new roles, secure the workforce we need and support current and future staff to forge successful and satisfying careers in a world-class London health and care system.
- We recognise that considerable progress can be made, building on existing foundations, with existing powers and funding – and we are committed to doing so. But devolution will be sought to support and accelerate improvements where the appropriate national criteria are met.
- While embedding subsidiarity, we will ensure the strategic coherence and maximise the financial sustainability of the future health and care system across London. Political support for jointly agreed change will be an important feature of the arrangements. New London-level arrangements, including governance and political oversight, will be established to secure this. We commit to minimising bureaucracy as much as possible to enable delivery of local innovation.
- In 2016/17 sustainability and transformation plans have been developed for health and care as part of NHS and local authorities' planning arrangements. A London-level strategic plan, drawn from sub-regional sustainability and transformation plans, will enable oversight of the impact on health outcomes and financial sustainability of the system across the capital.
- We recognise that London provides expertise and services for people who live outside the capital and that benefit the country more widely. London will work collaboratively with other regions and national partners to consider and mitigate the impact of London decisions on surrounding populations reliant on London-based services.

# The London draft Memorandum of Understanding (MoU) – implications for pilot and non-pilot areas

## Context:

A draft of the London health and care devolution MoU was circulated in December for comment. A number of CCGs have requested clarification on the implications of commitments within the MoU for non-pilot relative to pilot areas. This document aims to summarise these implications.

The MoU includes four types of commitments:

- 1. Powers, resourcing and decision-making moving from national or London to a local or sub-regional level.** This is typically, although not exclusively, paired with greater collaboration between partners within a local health economy. Local or sub-regional areas are not obligated to draw on these new opportunities. For these to be drawn down by a local or sub-regional area, certain 'gateway' criteria would need to be met, for example the strength of the local partnership, appropriate governance and accountability arrangements in place, and consideration of the impact on surrounding populations. These are consistent with the published NHS England devolution 'decision criteria'. Pilots have set out their proposals to meet these criteria and will agree to work to implement their business cases and the relevant parts of the MoU.
- 2. New ways of working at a local or sub-regional level.** These aim to enable collaborative working where this is desired by the local health economy. For example, at present it is not possible for a London local authority and CCG to form a 'joint committee'. The MoU expresses a desire to explore the case for change (including legislative implications), to enable this. This does not seek to change the statutory accountabilities of local organisations and any new way of working would need the approval of all relevant local partners. As such, local or sub-regional areas are not obligated to draw on these new ways of working.
- 3. Powers, resourcing and decision-making moving from the national level to the London system.** For example, capital business cases normally get approved at a national level by NHS England, NHS Improvement, Department of Health or Treasury. The MoU describes capital business case approvals being a core function of a new London Estates Board.
- 4. New ways of working at a London level** to administer any new devolved functions and to ensure representation of the views and issues of diverse partners and different health economies. For example, a London Health and Care Strategic Partnership Board (SPB) will provide strategic and operational leadership and oversight for London-level activities, building on national direction and London plans (e.g. Better Health for London), but crucially emphasising the partnership approach and an agreed strategy for sustainability and transformation built up from local and sub-regional plans. This would then replace existing collaborative London-wide fora to minimise duplication. The SPB would act as an advocate for London in discussions with central government and national bodies, and enable London to demonstrate a compelling shared position with political support. By approving the MoU, CCGs would commit to collaborate with the proposed governance arrangement and, collectively, work with their STP to ensure representation of local views and issues at a London level.

The following table describes the implications for relevant pilot and non-pilot areas for each of the different themes of devolution currently being negotiated. Where the implication is different these are highlighted. **The implications for pilots will differ depending on pilot type and stated ambition.**

Theme	Implications	
	Pilot areas	Non-pilot areas
Estates	<ul style="list-style-type: none"> <li>- Represented on London Estates Board <b>through pilot representatives, directly engaged in testing new ways of working.</b></li> <li>- More streamlined/accelerated NHS estates approvals and disposals, and consideration of wider local health economy and public sector opportunities enabled by collective consideration of business cases and disposals at London and sub-regional level.</li> <li>- <b>Support to develop sub-regional and/or local estates boards to take on governance and accountability functions, including delegated or devolved functions at sub-regional level.</b> Subject to robust governance structures, these could consider capital business cases and take on a management role of capital control totals, within a London envelope. Sub-regional boards could ultimately take on business case approval functions, through representatives from national organisations with delegated decision-making abilities.</li> <li>- Existing pan-London and regionally-deployed national estates resources brought together in a London Estates Delivery Unit (LEDU).</li> <li>- <b>Contribute to shaping the LEDU to meet local and sub-regional needs and challenges.</b></li> <li>- <b>London retention of capital receipts generated by trusts and Foundation Trusts for reinvestment in health and care.</b></li> </ul>	<ul style="list-style-type: none"> <li>- Represented on London Estates Board <b>through STP representative. Organisations involved with schemes for discussion will be invited to attend relevant LEB meetings.</b></li> <li>- More streamlined/accelerated NHS estates approvals and disposals, and consideration of wider local health economy and public sector opportunities enabled by collective consideration of business cases and disposals at London and sub-regional level.</li> <li>- Support for sub-regional estates board to take a strategic view and take on governance and accountability functions if desired by local health economy. <b>Opportunity to receive further support from the LEDU to develop local or STP estates governance.</b></li> <li>- Existing pan-London and regionally-deployed national estates resources brought together in a LEDU. Ability to <b>draw on LEDU capability and capacity to accelerate delivery of estates plans.</b></li> <li>- <b>London retention of capital receipts generated by trusts and Foundation Trusts where this supports a clear estates strategy.</b></li> </ul>
Commissioning models and payment mechanisms	<ul style="list-style-type: none"> <li>• Operate delegated primary medical care commissioning <b>in pilot area from April 2017</b>, subject to CCG agreement and necessary capabilities in place. Working with NHSE during the financial year 2017/18 to explore how steps towards further devolution could be taken.</li> <li>• Work with NHSE, through a London level commissioning board, to explore delegation of some specialised commissioning functions to the sub-regional level. Option to draw down the delegation of some specialised commissioning functions to the sub-regional level as they become available.</li> <li>• <b>Proposed joint governance structures to administer agreed local health and care commissioning functions with associated</b></li> </ul>	<ul style="list-style-type: none"> <li>• Operate delegated primary medical care commissioning at local level, subject to CCG agreement and necessary capabilities in place.</li> <li>• Work with NHSE, through a London level commissioning board to explore delegation of some specialised commissioning functions to the sub-regional level. Option to draw down the delegation of some specialised commissioning functions to the sub-regional level as they become available.</li> <li>• Existing or new joint LA/CCG structures could administer agreed local health and care commissioning functions with associated pooling of budgets, <b>if relevant local health and care commissioning</b></li> </ul>

	<p><b>pooling of budgets, as desired.</b></p> <ul style="list-style-type: none"> <li>• <b>Further collaboration with DH and NHSE to explore current barriers to joint or lead commissioning arrangements (including legislative barriers), and whether there is a case for change for addressing such issues</b> (through London level commissioning board).</li> <li>• <b>Piloting of new payment models</b> at different spatial levels with the aim of developing scalable solutions that can be implemented more widely within London and beyond.</li> <li>• <b>Commitment to more formal integrated joint working and opportunities to pool budgets</b> to incentivise early intervention and rapid discharge.</li> <li>• Commitment to continuing to develop detailed STPs through to implementation.</li> <li>• Commitment to <b>sharing learning and experiences</b> of pilot programme.</li> </ul>	<p><b>organisations want to take up new arrangements.</b></p> <ul style="list-style-type: none"> <li>• Opportunity to <b>engage in work to explore current barriers to joint or lead commissioning arrangements (including legislative barriers), and whether there is a case for change for addressing such issues</b> (through London level commissioning board).</li> <li>• <b>Opportunity to adopt new payment models</b>, based on testing, evaluation and scalability work of devolution pilots, if desired by local areas.</li> <li>• Opportunity to build on the work of devolution pilots in <b>pooling budgets and moving to more formal integrated joint working, if desired by local areas.</b></li> <li>• Commitment to continuing to develop detailed STPs through to implementation.</li> </ul>
Regulatory approaches	<ul style="list-style-type: none"> <li>• CCG and provider assurance will continue to be exercised by the London system, as at present.</li> <li>• National partners will aim to bring together, as far as possible, the oversight of CCGs and providers into a single shared framework.</li> <li>• Joined up processes for regulation at regional level between NHSI, NHSE and CQC. This will include alignment of regulatory actions, reporting timelines and consideration of joint appointments for some key roles.</li> <li>• <b>Testing a place-based framework for system regulation</b> so that integrated delivery systems (e.g. primary care, acute trusts) can be regulated as a whole, alongside the constituent organisations.</li> </ul>	<ul style="list-style-type: none"> <li>• CCG and provider assurance will continue to be exercised by the London system, as at present.</li> <li>• National partners will aim to bring together, as far as possible, the oversight of CCGs and providers into a single shared framework.</li> <li>• Joined up processes for regulation at regional level between NHSI, NHSE and CQC. This will include alignment of regulatory actions, reporting timelines and consideration of joint appointments for some key roles.</li> <li>• If local areas choose to adopt more integrated ways of working, <b>the potential to use the new systems being trialled by the pilots.</b></li> </ul>
Workforce and skills	<ul style="list-style-type: none"> <li>• Health and care workforce being considered more holistically (see details in next column).</li> <li>• Exploring opportunities to better target the existing pay envelope to improve staff recruitment and retention thereby reducing the agency pay-bill. As part of this, work is planned to explore whether London weighting can be used to improve staff retention and turnover.</li> <li>• Integration pilots <b>exploring the benefits of a single employer framework to enable greater integration of the health and care workforce where this supports integrated</b></li> </ul>	<ul style="list-style-type: none"> <li>• Health and care workforce being considered more holistically with: <ul style="list-style-type: none"> <li>○ Expanded membership of the London &amp; South East Local Education and Training Board so that London health and care workforce issues are considered together. This will become a 'London Workforce Board'</li> <li>○ The London Workforce Board seeking agreement to pool resources where appropriate, including HEE's transformation and development funding, where appropriate for</li> </ul> </li> </ul>

	<p><b>care.</b> This to include terms and conditions for new combined roles, exploring pay parity between health and care, co-location of staff and unified job evaluation and performance management.</p>	<p>spending on joint projects, and working to ensure that employers can take advantage of the opportunities offered by the apprenticeship levy (including abilities for transfer between employers).</p> <ul style="list-style-type: none"> <li>○ A collaborative London workforce delivery system bringing together HEE, Skills for Health and Skills for Care. These have previously worked more separately nationally or regionally.</li> <li>● Exploring opportunities to better target the existing pay envelope to improve staff recruitment and retention thereby reducing the agency pay-bill. As part of this, work is planned to explore whether London weighting can be used to improve staff retention and turnover.</li> <li>● <b>If local areas choose to adopt more integrated ways of working, the potential to use the trialled single employer framework.</b></li> </ul>
Prevention	<p>Testing improvements to the Fit for Work service. Commitment to trial or build the evidence-base for healthier environments e.g.</p> <ul style="list-style-type: none"> <li>● Local freedom to extend smoke-free areas.</li> <li>● Including health and wellbeing as a licensing objective.</li> <li>● Establishing a London-wide illegal tobacco and counterfeit alcohol enforcement team.</li> <li>● Restricting premises categorised as ‘A5 hot food takeaway uses to limit new fast food takeaways near schools.</li> <li>● Restricting advertising/marketing of unhealthy food/drink in specific locations based on health harm.</li> </ul> <p>Working with DCMS as they undertake their review of gaming machines and social responsibility measures, which includes consideration of the number, location and stakes of gaming machines.</p>	<p>Opportunities to draw on the evidence generated by the devolution pilots and <b>contribute to trialling activities, where locally desired and appropriate.</b></p> <p>Where an evidence base for change is successful, <b>opportunity to draw new prevention powers into local plans.</b></p>
Governance arrangements and accountability – local/sub-regional	<p>Within the pilots, work is underway to establish governance mechanisms to enable and facilitate integrated working and carry out delegated/devolved functions. Pilots agree to <b>proceed with the governance arrangements as set out in their business cases and develop them further to ensure robust governance and accountability.</b> The details of these arrangements differ depending on the particular focus of the pilot.</p>	<p><b>If a non-pilot area wishes to take on delegated or devolved functions, appropriate governance and accountability arrangements will need to be in place.</b> These arrangements must be tailored to local needs and focus.</p> <p>If a non-pilot area does not wish to undertake these specific opportunities, there is only a need to <b>collectively ensure that the STP is represented on pan-London governance structures</b> (see below).</p>

<p>Governance arrangements and accountability – London</p>	<p>Proposals for London-level governance include representation from pilots and non-pilots:</p> <ul style="list-style-type: none"> <li>• Each London STP will be represented on the Strategic Partnership Board and the London Estates Board. <b>Representatives will not be taking formal decisions as these continue to sit with the accountable organisations.</b> They will aim to ensure that the views of those within the STP are represented at London level.</li> <li>• Plans for a London-level commissioning board are under development and this will also include representation from CCGs and local authorities. This board is needed because the Strategic Partnership Board has providers on it, causing clear potential for conflicts. The London-level commissioning board will not affect statutory local commissioning or decision-making functions, but look at how some national functions (e.g. specialised commissioning) could be exercised at the regional level or how existing regional functions can be administered through greater engagement with local government and other partners.</li> <li>• Pilots are represented on the London Estates Board and will be represented on new pan-London governance structures through their STP representative.</li> <li>• By agreeing to the MoU, commissioners agree to collectively provide this representation in order to co-develop the future of health and care in London.</li> </ul> <p>There will also be some impact on interactions between local and national bodies. Local areas/organisations will begin to interact directly with the Strategic Partnership Board and the London Estates Board (rather than the separate member organisations e.g. NHS England, NHS Improvement) on a growing scope of business. Proposals for a more aligned regulatory or workforce approach are also likely to impact on how local and national organisations interact. In all cases, interactions with London governance mechanisms aims to replace and streamline the existing multitude of national interactions, rather than providing an additional layer of governance. For example, capital business cases would go to the London Estates Board for joint consideration by NHS England, NHS Improvement, the GLA, Department of Health and other national bodies.</p>
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