right care
right place
right time
right outcome

NHS
Merton
Clinical Commissioning Group

MERTON CLINICAL COMMISSIONING GROUP
GOVERNING BODY

Date of Meeting: 26th January 2017

Agenda No: 6.1 **Attachment:** 6

Title of Document: The London draft MOU – implications for pilot and non-pilot areas	**Purpose of Report:** Discussion
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Executive Summary:

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.

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.

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. This document aims to summarise these implications.

Key sections for particular note areas of concern etc: Whole document
Recommendation(s): For Note & Discussion
Committees which have previously discussed/agreed the report: None
Financial Implications: None at present
Implications for CCG Governing Body: None at present
How has the Patient voice been considered in development of this paper: 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.

The London draft 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, 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 legislative change 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) could 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	- Represented on London Estates Board **through pilot representatives, directly engaged in testing new ways of working**. - More streamlined/accelerated NHS estates approvals and disposals, and consideration of wider public sector opportunities. - **Support to develop sub-regional and/or local estates boards to take on governance and accountability functions.** 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. - Existing pan-London and regionally-deployed national estates resources brought together in a London Estates Delivery Unit (LEDU). - **Contribute to shaping the LEDU to meet local and sub-regional needs and challenges.** - **Retention of capital receipts for reinvestment in health and care.**	- Represented on London Estates Board **through STP representative. Organisations involved with schemes for discussion will be invited to attend relevant LEB meetings.** - More streamlined/accelerated NHS estates approvals and disposals, and consideration of wider public sector opportunities. - Support for STP estates board to take a strategic view and take on governance and accountability functions if desired by local health economy**. Opportunity to receive further support from the LEDU to develop local or STP estates governance.** - Existing pan-London and regionally-deployed national estates resources brought together in a LEDU. Ability to **draw on LEDU capability and capacity to accelerate delivery of estates plans.** - **Retention of capital receipts where this supports a clear estates strategy.**
Commissioning models and payment mechanisms	• Operate delegated primary medical care commissioning **in pilot area from April 2017**, subject to CCG agreement and necessary capabilities in place. **Exploring progression to devolution from April 2018**. • 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. • **Proposed joint governance structures to administer agreed health and care commissioning functions with associated pooling of budgets, as desired.** • **Further collaboration with DH and NHSE to explore more formalised joint commissioning and decision-making** opportunities (through London level commissioning board). • **Piloting of new payment models** at different spatial levels with the aim of developing scalable solutions that can be implemented more widely within London and beyond. • **Commitment to more formal integrated**	• Operate delegated primary medical care commissioning at local level, subject to CCG agreement and necessary capabilities in place. • 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. • Existing or new joint LA/CCG structures could administer agreed health and care commissioning functions with associated pooling of budgets**, if relevant local health and care commissioning organisations want to take up new arrangements.** • Opportunity to **engage in work to explore more formalised joint commissioning and decision-making opportunities** (through London level commissioning board). • **Opportunity to adopt new payment models**, based on testing, evaluation and scalability work of devolution pilots, if desired by local areas.

	joint working and opportunities to pool budgets to incentivise early intervention and rapid discharge. • Commitment to continuing to develop detailed STPs through to implementation. • Commitment to **sharing learning and experiences** of pilot programme.	• Opportunity to build on the work of devolution pilots in **pooling budgets and moving to more formal integrated joint working, if desired by local areas**. • Commitment to continuing to develop detailed STPs through to implementation.
Regulatory approaches	• CCG and provider assurance will continue to be exercised by the London system, as at present • Joined up processes for regulation at regional level between NHSI, NHSE and CQC. This will include alignment of regulatory actions, reporting timelines and joint appointments for some key roles. • **Testing a place-based framework for system regulation** so that integrated delivery systems (e.g. primary care, acute trusts) can be regulated as a whole, rather than just the constituent organisations.	• CCG and provider assurance will continue to be exercised by the London system, as at present • Joined up processes for regulation at regional level between NHSI, NHSE and CQC. This will include alignment of regulatory actions, reporting timelines and joint appointments for some key roles. • If local areas choose to adopt more integrated ways of working, **the potential to use the new systems being trialled by the pilots**.
Workforce and skills	• Health and care workforce being considered more holistically (see details in next column). • 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 should be increased. • Integration pilots **exploring the benefits of a single employer framework to enable greater integration of the health and care workforce where this supports integrated care**. 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.	• Health and care workforce being considered more holistically with: o Expanded membership of the London & 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' o The London Workforce Board deploying HEE's transformation funding and using the apprenticeship levy more collectively and flexibly across health and care. o A collaborative London training and development system bringing together HEE, Skills for Health and Skills for Care. These have previously worked more separately nationally or regionally. • 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 should be increased. • **If local areas choose to adopt more integrated ways of working, the potential to use the trialled single employer framework.**

Prevention	**Testing improvements to the Fit for Work service. Commitment to trial or build the evidence-base for healthier environments** e.g. • Local freedom to extend smoke-free areas. • Including health and wellbeing as a licensing objective. • Establishing a London-wide illegal tobacco and counterfeit alcohol enforcement team. • Amending the 'use classes' of food outlets to limit new fast food takeaways. • Restricting advertising/marketing of unhealthy food/drink in specific locations based on health harm. • Restricting betting terminals, location and opening hours of betting shops	Opportunities to draw on the evidence generated by the devolution pilots and **contribute to trialling activities, where locally desired and appropriate**. Where an evidence base for change is successful, **opportunity to draw new prevention powers into local plans**.
Governance arrangements and accountability – local/sub-regional	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 **proceed with the governance arrangements as set out in their business cases and develop them further to ensure robust governance and accountability**. The details of these arrangements differ depending on the particular focus of the pilot.	**If a non-pilot area wishes to take on delegated or devolved functions, appropriate governance and accountability arrangements will need to be in place**. These arrangements must be tailored to local needs and focus. If a non-pilot area does not wish to undertake these specific opportunities, there is only a need to **collectively ensure that the STP is represented on pan-London governance structures** (see below).
Governance arrangements and accountability – London	Proposals for London-level governance include representation from pilots and non-pilots: • Each London STP will be represented on the Strategic Partnership Board and the London Estates Board. ***Representatives will not be taking formal decisions as these continue to sit with the accountable organisations.*** They will aim to ensure that the views of those within the STP are represented at London level. • 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. 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. • Pilots are represented on the London Estates Board and will be represented on new pan-London governance structures through their STP representative. • 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. 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.	