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**MEMORANDUM OF UNDERSTANDING**

**FOR**

**THE CLINICAL COMMISSIONING GROUPS (CCG):**

**NHS NORTH LINCOLNSHIRE CCG**

**NHS NORTH EAST LINCOLNSHIRE CCG**

**AND**

**NORTHERN LINCOLNSHIRE GOOLE NHS FOUNDATION TRUST**

**NAViGO**

**CARE PLUS GROUP**

**EFFECTIVE DATE:**

**1 APRIL 2015**

**Add NAViGO CARE Plus logos**

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**Contents:**

1. Introduction 2
2. Parties to the MOU
3. Purpose 4
4. Principles and Values
5. Roles and Responsibilities 6
   1. NHS England North and Sub Regional Team
   2. Appointment of Senior Responsible Officer (SRO)
   3. Community Finance Plan 7
   4. Parties Open Book 2015-16 Contract/Transition Plans
      1. NEL CCG Plan 8
      2. NL CCG Plan 9
      3. NLaG Plan
      4. NAViGO Plan
      5. Care Plus Group Plan 10
6. Financial framework and incentives 11

6.1 Principles

6.2 Conditions

1. Shared financial risk strategy
2. Governance framework

8.1 All parties

8.2/8.3 Provider Governance framework

1. Status and Next Steps
2. Dispute Resolution

Appendix 1

Appendix 2

Appendix 3

Appendix 4

Appendix 5

**MEMORANDUM OF UNDERSTANDING FOR COLLABORATIVE WORKING (MOU)**

**1 Introduction**

CCGs are established under the Health and Social Care Act 2012 (“the 2012 Act”). The duties of CCGs to commission certain health services are set out in section 3 of the 2006 Act, as amended by section 13 of the 2012 Act, and the regulations made under that provision.

There is a long history of collaborative commissioning across the geography of Northern Lincolnshire and this is principally driven by the shared reliance of provision of acute care from Northern Lincolnshire and Goole NHS Foundation Trust which serves the two localities in broadly equally terms.

Most recently this has been through the development of the Better Care Fund (BCF), and the Healthy Lives Healthy Future (HLHF) programme focused on ensuring a quality and financially sustainable local NHS supply chain and system as a whole for the future in particular with three local Providers being NLAG FT, NAVIGO and Care Plus Group.

**2 Parties to the MOU**

This agreement is between the two Clinical Commissioning Groups in Northern Lincolnshire and the three local providers, namely:

* NHS North Lincolnshire Clinical Commissioning Group (NLCCG)
* NHS North East Lincolnshire Clinical Commissioning Group (NELCCG)
* NHS Northern Lincolnshire and Goole NHS Foundation Trust (NLaG)
* NAViGO
* Care Plus Group

Here in referred to as the ‘Parties’ to the MOU.

Whilst these parties have agreed to work together for joint planning purposes, there are other parts of the Health and Social care system engaged in HLHF e.g. RDASH, Councils, Primary Care, Specialised Commissioning. The aim will be to incorporate other commissioner and provider organisations as the plans develop.

In addition, it is also the parties’ intention to continue to discuss our HLHF strategy potentially with neighbouring patches to the North and South where this is of mutual benefit.

**3 Purpose**

The parties recognise the need to work together and work smarter, drawn together by their common purpose to deliver quality outcomes and desire to get maximum value from their resources. In order to ensure a resilient and sustainable health system this requires co-operation.

Benefits are recognised by doing things together including optimising capacity to meet demand and reducing costs, duplication and importantly maximising influence with regulators by having a single voice which benefits patients, carers, local employers and partners.

The MOU is focused on enabling the parties to:

-Direct and co-ordinate strategy and approaches amongst themselves in line with the HLHF strategy.

-Adopt a joint approach to planning and contract management with the parties and work collaboratively to interact with other CCGs/other providers as part of HLHF.

Share experiences and adopt common solutions, where appropriate, in respect of;

* HLHF and Quality Innovation Productivity Performance value for money improvement (QIPP)
* Oversee HLHF transformation plan arrangements
* Development of joint financial (revenue, capital, investments and cash), risk management and delivery Plans and monitoring thereof.

**4 Principles and Values**

In working together the parties commit to working in a **positive** and **open minded** manner with **transparency across all organisations**.

They will **trust and support** each other as part of the MOU and ensure they are **open and honest** and keep the patient and their populations at the centre of their activities.

The parties agree to **communicate openly** about concerns issues and opportunities in relation to the MOU.

**Key principles** that will underpin the MOU include:

-Collaborative working will be undertaken where it has been demonstrated there is **benefit** to all parties in one or more of the following drivers:

* **value for money**
* **specialist** resource
* **negotiating** power/influence with local partners and regulators
* **risk to be mitigated where possible and share**

-In all discussions and decisions the impact on **quality and outcomes** will be explicitly considered and recognised as will the need to **reduce inequalities and increase access** across the parties’ interests.

-Taking a **singular approach** with, and speak in an **unified voice**, with shared interests – particular in areas of poor or limiting performance where contract arrangements are in place.

-Collaborative working will be guiding principle and all organisations are commited to this principle thoguth this MOU

-Collaborative working will allow **local variation** in recognition of variable levels of patient and population needs and resources e.g. commissioning for place.

-The parties will at all times observe “such generally accepted principles of good governance” in the way it conducts its business, in accordance with section 14L (2) (b) of the 2006 Act (inserted by section 25 of the 2012 Act). This includes:

-The highest standards of propriety involving impartiality, integrity and objectivity in relation to the stewardship of public funds, the management of the individual organisations working in collaboration and the conduct of business

The *Good Governance Standard for Public Services* (OPM, CIPFA 2004) the standards of behaviour published by the *Committee on Standards in Public Life* (1995) known as the ‘seven Nolan Principles’ being; selflessness, integrity, objectivity, accountability, openness, honesty and leadership:

The MOU doesn’t negate the requirement for all organisations to comply with national regulation and guidance including for example NHS Consitution and Equality act

**5 Roles and Responsibilities**

Four key functions of the MOU have been identified as being:

* Working collaboratively to manage the relationship with the NHS England Sub Regional Team as well as with the North of England Regional Team
* Working collaboratively to manage the relationship with Regulators including Monitor and NHS England Commercial Directorate, responsible for regulation and pricing add care plus and Navigo
* Working collaboratively on bringing together joint plans and commissioning work programmes

Working collaboratively to manage and mitigate the risks associated with transformation and its impacts

**5.1 NHS England North of England and the Sub Regional Team**

The parties will work with NHS England at national, regional and local level collaboratively in matters of common interest and with regards the local health system issues.

The parties will seek to work collaboratively with the NHS Sub Regional Team, in its respect of its direct commissioning responsibilities, and prescribed specialised services commissioning as part of horizon scanning, discussions, review and redesign of care pathways and services, and in its relationships with local providers across the system.

This is in recognition of the Sub Regional Teams responsibilities as a direct commissioner in areas such as primary care, children services, emergency planning (*co-commissioning*) and specialist services (*collaborative commissioning*).

The parties will establish where appropriate a shared way of working with the NHS Sub Regional Team in its CCG assurance role which will include principles of working such as assurance regarding system performance undertaken once and collaboratively.

**5.2 Working with Regulators**

The parties will work with Monitor, Community Interest Company Regulator, Financial Conduct Authority , Companies House and where appropriate Care Quality Commission at national, regional and local level collaboratively in matters of common interest and with regards the local health system issues.

Commissioners and Providers have agreed to support each other for mutual benefit for the residents of Northern Lincolnshire as part of a joint planning approach. These plans are outlined in the next section.

**5.3 Appointed Leads for Program delivery**

|  |  |  |
| --- | --- | --- |
| Marcus Hassall | DoF, NLAG | PDC bid and cash plan |
| Laura Whitton? | DCFO, NELCCG | Financial Risk Strategy |
| Pam Clipson? Plus CB/HK | DOP&S, NLAG | Joint Delivery Plan |
| Therese Paskell | CFO, NLCCG | MOU and governance |

**5.3 Community Finance Plan**



Joint Cash Plan

This shows the level of PDC requirement for 15/16 to support Northern Lincolnshire health economy as a whole.

A cash profile for NLAG for both NLCCG and NELCCG is attached at Appendix x. This reflects the need for a higher than average drawdown for the first few months until a PDC bid is successfully made.

5.4.1 NELCCG Plan

A summary is attached as Appendix …..

5.4.2 NLCCG Plan

A summary is attached at Appendix ….

5.4.3 NLAG Plan

5.4.4 NAViGO Plan

5.4.5 Care Plus Grou

A summary

1. Financial Framework and incentives

6.1 Agreed principles for a new framework include:

* Support service modernisation and the elimination of avoidable activities;
* Favour standardised streamlined pathways designed by MDTs;
* Support and incentivise clinicians to work together;
* Retain clear service standards (access, waiting times, patient experience)
* Retain clear quality measures (safety and clinical accountability)
* Support personalised care and choice - where appropriate
* Recognise the real costs of current delivery;
* Support effective management of system financial risk – which means more certainty, less volatility;
* Support moving resources around the whole system to deliver optimal results;
* Support control of activity growth;
* Support streamlined pathways which eliminate avoidable activities;
* Prioritise community interests over organisational interests.

6.2 Conditions

In order to incentivise the above for delivery of transformation, this MOU will form an addendum to the contract. Following a review of various incentive options, the financial mechanism of a Minimum Income Guarantee will apply with a further potential sum linked to the key performance deliverables (outcomes based where possible) and transformation joint delivery plan. This then provides a maximum figure potentially available to the Provider(s).

A worked plan example of this for NL and NELCCG for NLAG is shown in Appendix x (shown with and without BCF investments which are dependent on projects starting).

It has been agreed that the other parties to the MOU, namely, NAViGO and Care Plus Group, will use xxxxxx as their incentive mechanism as referred to in.xxxxxx.

1. Shared financial risk strategy

To support this high level finance plan and financial mechanism, the parties have agreed to develop a shared risk strategyencompassiong existing risk share agreements eg BCF

A first draft risk strategy which maps where the financial risks are held, mitigations and who is responsible for them is shown at Appendix X. The aim is to expand this for future years for the whole health and social care economy.

In the circumstance that contractual penalties are applied the financial resource will be ringfenced within the Health community for mutually agreed use.

1. Governance framework
   1. This MOU will be overseen by the HLHF Planning and Resources group chaired by the Director of Commissioning, NLCCG with decisions made by the parties within through locality structures.

* 1. Providers may agree to share financial resources to mitigate financial risks or enter their own risk share arrangements across pathways. Where these are agreed any governance arrangements will be entered in the next section.
  2. Provider Governance Framework

Insert here. The parties to this agreement are NLAG, NAViGO and Care Plus Group.

9. Status and next Steps

This MOU forms an addendum to each of the parties contracts

It is intended that this arrangement will be used over several years alongside HLHF to support delivery.

A work programme, with timescales and responsibilities are attached at Appendix x and will be monitored via HLHF governance and reporting structure.

10. Dispute Resolution

If there are any disputes in year to this MOU, the first steps should be through the local mechanism where appropriate Director representation is in place with escalation to the most appropriate forum for Chief Executive resolution.