

Joint Commissioning Committee

Sheffield City Council • Sheffield Clinical Commissioning Group

Monday 24 June 2019 at 12.30 pm

A Committee Room at Sheffield Town Hall

The Press and Public are Welcome to Attend

Membership

Councillor Olivia Blake – SCC Cabinet

Councillor Lewis Dagnall – SCC Cabinet

Councillor Jackie Drayton – SCC Cabinet

Mark Gamsu – NHS Sheffield CCG

Councillor George Lindars-Hammond

Dr Tim Moorhead – NHS Sheffield CCG

Maddy Ruff – NHS Sheffield CCG

Leigh Sorsbie – NHS Sheffield CCG

JOINT COMMISSIONING COMMITTEE

Sheffield City Council • Sheffield Clinical Commissioning Group

The Joint Commissioning Committee is a meeting of representatives of Sheffield City Council's Cabinet and NHS Sheffield Clinical Commissioning Group's Governing Body, with the purpose of agreeing joint health and social care commissioning plans for the City.

The Committee will bring a single commissioning voice to ensure new models of care deliver the outcomes required for the City.

The Committee will support Sheffield City Council and NHS Sheffield Clinical Commissioning Group to deliver national requirements, including but not limited to, NHS Long Term Plan, Social Care Green Paper and Spending Review.

The Committee will ensure in the first instance delivery of outcomes in the three priority areas of focus; Frailty, SEND and Mental Health.

PUBLIC ACCESS TO THE MEETING

A copy of the agenda and reports is available on the Council's website at www.sheffield.gov.uk. You can also see the reports to be discussed at the meeting if you call at the First Point Reception, Town Hall, Pinstone Street entrance. The Reception is open between 9.00 am and 5.00 pm, Monday to Thursday and between 9.00 am and 4.45 pm. on Friday. You may not be allowed to see some reports because they contain confidential information. These items are usually marked * on the agenda.

Meetings are normally open to the public but sometimes the Committee may have to discuss an item in private. If this happens, you will be asked to leave. Any private items are normally left until last. If you would like to attend the meeting please report to the First Point Reception desk where you will be directed to the meeting room.

If you require any further information please contact Abby Brownsword on 0114 273 5033 or email abby.brownsword@sheffield.gov.uk

FACILITIES

There are public toilets available, with wheelchair access, on the ground floor of the Town Hall. Induction loop facilities are available in meeting rooms.

JOINT COMMISSIONING COMMITTEE AGENDA
Sheffield City Council • Sheffield Clinical Commissioning Group

24 JUNE 2019

Order of Business

1. Election of Co-Chairs and Welcome

To formally elect the Co-Chairs of the Joint Commissioning Committee.

2. Apologies for Absence

3. Declarations of Interest

(Pages 1 - 4)

Members of the Committee to declare any interests they have in the business to be declared at the meeting.

4. Public Questions

To receive any questions from members of the public.

5. Minutes of Previous Meeting

(Pages 5 - 8)

Minutes of the meeting of the Committee held on 29th April 2019.

6. Joint Commissioning for Health and Care - Terms of Reference

(Pages 9 - 20)

Joint Report of the Director of Public Health (SCC) and Executive Director of Delivery, Care Outside of Hospital (CCG).

7. Joint Commissioning for Health and Care - Care Outside of Hospital

(Pages 21 - 30)

Report of the Director of Commissioning Inclusion and Learning (SCC) and the Executive Director of Delivery, Care Outside of Hospital (CCG)

8. Health Inequalities Presentation

Presentation of the Director of Public Health (SCC).

9. Date of Next Meeting

The next meeting of the Committee will be held on Monday 19th August 2019 at 12.30pm in the Town Hall.

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ADVICE TO MEMBERS ON DECLARING INTERESTS AT MEETINGS

If you are present at a meeting of the Council, of its executive or any committee of the executive, or of any committee, sub-committee, joint committee, or joint sub-committee of the authority, and you have a **Disclosable Pecuniary Interest (DPI)** relating to any business that will be considered at the meeting, you must not:

- participate in any discussion of the business at the meeting, or if you become aware of your Disclosable Pecuniary Interest during the meeting, participate further in any discussion of the business, or
- participate in any vote or further vote taken on the matter at the meeting.

These prohibitions apply to any form of participation, including speaking as a member of the public.

You **must**:

- leave the room (in accordance with the Members' Code of Conduct)
- make a verbal declaration of the existence and nature of any DPI at any meeting at which you are present at which an item of business which affects or relates to the subject matter of that interest is under consideration, at or before the consideration of the item of business or as soon as the interest becomes apparent.
- declare it to the meeting and notify the Council's Monitoring Officer within 28 days, if the DPI is not already registered.

If you have any of the following pecuniary interests, they are your **disclosable pecuniary interests** under the new national rules. You have a pecuniary interest if you, or your spouse or civil partner, have a pecuniary interest.

- Any employment, office, trade, profession or vocation carried on for profit or gain, which you, or your spouse or civil partner undertakes.
- Any payment or provision of any other financial benefit (other than from your council or authority) made or provided within the relevant period* in respect of any expenses incurred by you in carrying out duties as a member, or towards your election expenses. This includes any payment or financial benefit from a trade union within the meaning of the Trade Union and Labour Relations (Consolidation) Act 1992.

*The relevant period is the 12 months ending on the day when you tell the Monitoring Officer about your disclosable pecuniary interests.

- Any contract which is made between you, or your spouse or your civil partner (or a body in which you, or your spouse or your civil partner, has a beneficial interest) and your council or authority –
 - under which goods or services are to be provided or works are to be executed; and
 - which has not been fully discharged.

- Any beneficial interest in land which you, or your spouse or your civil partner, have and which is within the area of your council or authority.
- Any licence (alone or jointly with others) which you, or your spouse or your civil partner, holds to occupy land in the area of your council or authority for a month or longer.
- Any tenancy where (to your knowledge) –
 - the landlord is your council or authority; and
 - the tenant is a body in which you, or your spouse or your civil partner, has a beneficial interest.
- Any beneficial interest which you, or your spouse or your civil partner has in securities of a body where -
 - (a) that body (to your knowledge) has a place of business or land in the area of your council or authority; and
 - (b) either -
 - the total nominal value of the securities exceeds £25,000 or one hundredth of the total issued share capital of that body; or
 - if the share capital of that body is of more than one class, the total nominal value of the shares of any one class in which you, or your spouse or your civil partner, has a beneficial interest exceeds one hundredth of the total issued share capital of that class.

If you attend a meeting at which any item of business is to be considered and you are aware that you have a **personal interest** in the matter which does not amount to a DPI, you must make verbal declaration of the existence and nature of that interest at or before the consideration of the item of business or as soon as the interest becomes apparent. You should leave the room if your continued presence is incompatible with the 7 Principles of Public Life (selflessness; integrity; objectivity; accountability; openness; honesty; and leadership).

You have a personal interest where –

- a decision in relation to that business might reasonably be regarded as affecting the well-being or financial standing (including interests in land and easements over land) of you or a member of your family or a person or an organisation with whom you have a close association to a greater extent than it would affect the majority of the Council Tax payers, ratepayers or inhabitants of the ward or electoral area for which you have been elected or otherwise of the Authority's administrative area, or
- it relates to or is likely to affect any of the interests that are defined as DPIs but are in respect of a member of your family (other than a partner) or a person with whom you have a close association.

Guidance on declarations of interest, incorporating regulations published by the Government in relation to Disclosable Pecuniary Interests, has been circulated to you previously.

You should identify any potential interest you may have relating to business to be considered at the meeting. This will help you and anyone that you ask for advice to fully consider all the circumstances before deciding what action you should take.

In certain circumstances the Council may grant a **dispensation** to permit a Member to take part in the business of the Authority even if the member has a Disclosable Pecuniary Interest relating to that business.

To obtain a dispensation, you must write to the Monitoring Officer at least 48 hours before the meeting in question, explaining why a dispensation is sought and desirable, and specifying the period of time for which it is sought. The Monitoring Officer may consult with the Independent Person or the Council's Standards Committee in relation to a request for dispensation.

Further advice can be obtained from Gillian Duckworth, Director of Legal and Governance on 0114 2734018 or email gillian.duckworth@sheffield.gov.uk.

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SHEFFIELD CITY COUNCIL

Joint Commissioning Committee

Meeting held 29 April 2019

PRESENT:

Sheffield City Council

Councillors Olivia Blake, Lewis Dagnall, Jackie Drayton and Chris Peace

Sheffield Clinical Commissioning Group

Dr. Tim Moorhead, Mark Gamsu, Brian Hughes (Substitute Member) and Dr. Leigh Sorsbie.

Also in Attendance

John Mothersole, Chief Executive, Sheffield City Council

Greg Fell, Director of Public Health, Sheffield City Council

Eugene Walker, Executive Director, Resources, Sheffield City Council

Jayne Ludlam, Executive Director, People Services, Sheffield City Council

Phil Holmes, Director of Adult Services, Sheffield City Council

Dawn Walton, Children and Schools Commissioner, Sheffield City Council

Nicki Doherty, Executive Director, Care out of Hospital. Sheffield Clinical Commissioning Group

Julia Newton, Director of Finance, Sheffield Clinical Commissioning Group

Jennie Milner, Integration and Better Care Fund Lead

1. ELECTION OF CO-CHAIRS AND WELCOME

- 1.1 **RESOLVED:** That Councillor Chris Peace, Cabinet Member for Health and Social Care, Sheffield City Council and Dr Tim Moorhead, NHS Sheffield Clinical Commissioning Group, Governing Body Chair, be appointed Co-Chairs of the Committee.

2. APOLOGIES FOR ABSENCE

- 2.1 An apology for absence was received from Maddy Ruff and Brian Hughes attended the meeting as the duly appointed substitute.

3. DECLARATIONS OF INTEREST

- 3.1 Members of the Committee were requested to declare if they had any interests which may impact on their participation in decisions at future meetings of the Committee. The following interests were declared:-

Dr Tim Moorhead – GP and shareholder in Primary Care Sheffield, a not for profit enterprise.

Councillor Jackie Drayton – Husband was an employee in the Voluntary Sector.

Mark Gamsu – Trustee of 3 voluntary organisations in the City, full details available on the CCG website.

Councillor Olivia Blake – Non-Executive Director of the Sheffield Health and Social Care Trust and partner of a Trustee of the Heeley City Forum.

Councillor Lewis Dagnall – Partner of a Non-Executive Director of the Sheffield Health and Social Care Trust and Trustee of the Heeley City Forum.

- 3.2 Members of the Committee commented that there was a need for clarification as to how interests would be managed by the Committee. It was agreed that the Director of Public Health, Sheffield City Council, Greg Fell and the Executive Director of Delivery, Care Outside of Hospital, Sheffield CCG, Nicki Doherty, would clarify this and report back to the next meeting of the Committee.

4. PUBLIC QUESTIONS

- 4.1 There were no public questions submitted. It was agreed that, should any written questions be required to future public questions, the responses be agreed with the Co-Chairs.

5. JOINT COMMISSIONING FOR HEALTH AND CARE - TERMS OF REFERENCE

- 5.1 The Director of Public Health, Sheffield City Council, introduced a report outlining the proposed Terms of Reference for the Committee. He commented that the establishment of the Committee had been jointly agreed by the City Council and the Clinical Commissioning Group and officers from both sides had been involved in its formation.
- 5.2 The work of the Committee focused on three broad areas as outlined in the report but it was not limited to that. The Committee was accountable to both bodies. It was scheduled to meet bi monthly but could meet more often if the committee agree.
- 5.3 Mark Gamsu commented that the challenge for the Committee was demonstrating the added value that the Committee would bring. It presented an opportunity to establish a shared conversation and a shared approach to complex issues.
- 5.4 Dr Tim Moorhead commented that the focus of the committee is using a single commissioner voice to improve patient experience, tackle health inequalities and achieve quality services, whilst ensuring financial sustainability for the city.
- 5.5 Mark Gamsu raised that the Committee needed recognise the links to the integrated care system, captured in the TOR .
- 5.6 **RESOLVED:** That:-

- (a) the Committee agreed amendments to the Terms of Reference, and revised copy to be brought back to the next meeting;
- (b) details of attendees to be removed from the diagram on page 9;
- (c) add the term 'and outcomes' to the end of the sentence in paragraph 3.2.5 of the report to read 'Improved people experience and outcomes'; and
- (d) add details of how conflicts of interest will be managed.

6. JOINT COMMISSIONING FOR HEALTH AND CARE - PRINCIPLES

- 6.1 The Director of Public Health, Sheffield City Council, and the SCCG Lead Officer submitted a report updating the Committee on progress on delivering the Sheffield City Council and Clinical Commissioning Groups (SCCG) integrated commissioning agenda. It set out the principles that had been agreed that would underpin the re-commissioning of services and gave an example of how this might work based on the Mental Health Transformation Plan risk share.
- 6.2 Greg Fell, Director of Public Health, Sheffield City Council, introduced the report and commented that the principles outlined were mostly based on the learning already shared by the City Council and the CCG Discussion was needed on how to embed the principles and how they would link in to finances.
- 6.3 Mark Gamsu commented that, traditionally, Sheffield had a good tradition of working with local communities. The Committee needed to build on that on a broader strategic level. The Committee should also not lose sight of previous experience and outcomes.
- 6.4 Dr Leigh Sorsbie stated that Quality and Equality Impact Assessments (QEIA's) often became mixed in with inequalities and they often didn't address the issue of inequalities. Consideration should be given to ensuring papers brought the committee are clear on how inequalities will be addressed. The Committee acknowledged that QEIA's should not just be a tick box exercise and should demonstrate a real impact.
- 6.5 Dr Tim Moorhead discussed how the committee could ensure it adds benefit to the health and social care system. Ensuring the commissioning cycle is appropriately followed to deliver transformational change that the committee can support. The committee requested baseline data to provide a platform to measure change from.
- 6.6 **RESOLVED:** That the Committee approves the Joint Commissioning Principles and requests a baseline data set.

7. JOINT COMMISSIONING FOR HEALTH AND CARE - PRIORITIES

- 7.1 The Director of Public Health, Sheffield City Council and the SCCG Lead Officer submitted a joint report providing the objectives and priorities for Joint Commissioning of Health and Care and a summary of initial considerations for change to be included in the joint commissioning plan.

- 7.2 Nikki Doherty, Executive Director of Delivery, Care outside of Hospital, introduced the report and commented that it was recognised that targeted investment was needed. The report identified feedback and joint working that had taken place.
- 7.3 Councillor Chris Peace, Cabinet Member for Health and Social Care, commented that it was important to highlight the issues of housing, Special Educational Needs Development (SEND) and mental health and these were important priorities which the Committee should start their focus on.
- 7.4 Following a question from Councillor Jackie Drayton, Cabinet Member for Children and Families, Nikki Doherty commented that frailty did not necessarily mean older people who were frail it would include preventing frailty with an all age approach. It was important to ensure people were living well as close to their home as possible.
- 7.5 Mark Gamsu commented that the priorities in the report outlined where the City Council and the CCG had responsibility. They did not focus on a particular conditions, which was a positive approach to transformation. However it was less clear how these had being decided as the priority and requested the background to deciding these were the priorities.
- 7.6 Dr Tim Moorhead commented that there was well recognised methodology for undertaking the work that the Committee was prioritising. The Committee needed to ensure reports received reflected the commissioning cycle had being duly followed and wasn't responsive to current crisis. It was also important for the Committee to understand the work of providers and consult with service users to gauge their views.
- 7.7 Councillor Olivia Blake commented that the Committee needed to hear citizens stories to establish gaps in systems and why they existed. Frailty was not inevitable in all cases. Councillor Chris Peace added that the Committee needed a breakdown of what services were offered, where the gaps were and how the Committee could add value.
- 7.8 **RESOLVED:** That the Committee approve the priorities outlined in the report and background content to the priorities to be brought to the next meeting.

8. DATE AND TIME OF FUTURE MEETINGS

- 8.1 **RESOLVED:** That:-
- (a) the next meeting of the Committee be held on Monday, 24 June 2019, at 12:30pm at the Town Hall; and
 - (b) a Work Programme outlining future agenda items for the Committee be included as a standard agenda item for future meetings of the Committee.



Report of: SCC Lead Officer: Greg Fell, Director of Public Health
 SCCG Lead Officer: Nicki Doherty, Executive Director of Delivery, Care Outside of Hospital

Report to: Joint Commissioning Committee

Date of Decision: 24th June 2019

Subject: Joint Commissioning for Health and Care – Terms of Reference

Is this a Key Decision? If Yes, reason Key Decision:-	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
- Expenditure and/or savings over £500,000	<input type="checkbox"/>	
- Affects 2 or more Wards	<input type="checkbox"/>	
Has an Equality Impact Assessment (EIA) been undertaken?	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>
If YES, what EIA reference number has it been given? 533		
Does the report contain confidential or exempt information?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Which Scrutiny and Policy Development Committee does this relate to? Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee		

Purpose of Report:

This report updates on amendments made to the TOR as agreed on the 29th April 2019 at the Joint Commissioning Committee. It sets out the enhanced governance arrangements that will drive forward a truly joint approach to commissioning in a way that secures the transformational change that is required to realise our ambitions.

Questions for the Joint Commissioning Committee:

Recommendations for the Joint Commissioning Committee:

The Committee is asked approve the Terms of Reference.

Background Papers:

Lead Officer(s) to complete:-							
1	I have consulted the relevant departments in respect of any relevant implications indicated on the Statutory and Council Policy Checklist, and comments have been incorporated / additional forms completed / EIA completed, where required.						
	Finance: <i>(Insert names of SCC and CCG officers consulted)</i>						
	Legal: <i>Sarah Bennett, Service Manager (Commercial)</i>						
	Equalities: <i>(Insert name of officer consulted)</i>						
	<p>Other Consultees:</p> <p>Sheffield Clinical Commissioning Group</p> <ul style="list-style-type: none"> • Brian Hughes - Executive Director of Commissioning, • Nicki Doherty - Executive Director of Delivery, Care Outside of Hospital • Jackie Mills – Director of Finance • Jennie Milner – HoS Health SCC & Deputy Director Better Care Fund SCCG <p>SCC</p> <ul style="list-style-type: none"> • Cllr George Lindars Hammond • Greg Fell – Director of Public Health • John Doyle – Director of Business Strategy, People Portfolio 						
<i>Legal, financial/commercial and equalities implications must be included within the report and the name of the officer consulted must be included above.</i>							
2	EMT member who approved submission: <i>(Insert name of relevant Executive Director)</i>						
3	CCG lead officer who approved submission: <i>(Insert name of relevant officer)</i>						
4	I confirm that all necessary approval has been obtained in respect of the implications indicated on the Statutory and Council Policy Checklist and that the report has been approved for submission to the Joint Committee by the officers indicated at 2 & 3 above. In addition, any additional forms have been completed and signed off as required at 1.						
	<table border="1"> <thead> <tr> <th>Lead Officer Names:</th> <th>Job Titles:</th> </tr> </thead> <tbody> <tr> <td>Greg Fell</td> <td>Director of Public Health</td> </tr> <tr> <td>Nicki Doherty</td> <td>Executive Director of Delivery, Care Outside of Hospital</td> </tr> </tbody> </table>	Lead Officer Names:	Job Titles:	Greg Fell	Director of Public Health	Nicki Doherty	Executive Director of Delivery, Care Outside of Hospital
	Lead Officer Names:	Job Titles:					
Greg Fell	Director of Public Health						
Nicki Doherty	Executive Director of Delivery, Care Outside of Hospital						
Date: <i>(Insert date)</i>							

Joint Commissioning for Health and Care – Terms of Reference

1. Introduction/Context

- 1.1 Joint Commissioning Committee considered the Terms of Reference on the 29th April 2019, that detailed how the Joint Commissioning Committee would build on the shared commissioning arrangements and positive joint working have been in place for some time via the Better Care Fund (BCF) programme and the Mental Health risk share arrangement. The established joint commissioning commitments focus on integrating services to improve the experience of people, to remove duplication in services and to redesign our health and social care system to reduce reliance on hospital and long term care through commissioned models of care that promote prevention and early intervention; models that seek to reduce health inequalities through care that recognises the need of local populations.
- 1.2 The following amendments have being made to the TOR:
- 1.2.1 Details of attendees to be removed from the diagram on page 9
 - 1.2.2 Added the term 'and outcomes' to the end of the sentence in paragraph 3.2.5 of the report to read 'Improved people experience and outcomes'.
 - 1.2.3 Added details of how conflicts of interest will be managed
 - 1.2.4 Added a requirement for the CCG to request names of members of the public attending to be held on register for future foi requests.
- 1.5 The Cabinet approved:
- The amendment of the existing Better Care Fund partnership arrangements under s75 NHS Act 2006 to establish a joint committee to:
 - take responsibility for the management of the partnership arrangements;
 - lead on shaping the development of joint health and care commissioning
 - provide advice and guidance on ways in which the partnership arrangements could be strengthened and developed and on appropriate engagement of all relevant stakeholders, this should include guidance on specific areas of service improvement.
- 1.6 The CCG governing body approved:
- The establishment of the proposed Joint Committee be in place from April to lead development of health and care commissioning
 - The development of a process to confirm the CCG Governing Body representatives to be on the Joint Committee
 - To delegate the development of more detailed implementation and spending plans to Executive Management Group in consultation with Joint Committee

2. Main body of report and matters for consideration

2.1 Purpose of the Joint Commissioning Committee

- 2.1.1 The Committee will bring a single commissioning voice to ensure new models of care deliver the outcomes required for the city and will support SCC and the CCG to deliver national requirements, including but not limited NHS Long Term Plan, Social Care Green Paper and Spending Review.
- 2.1.2 The Committee will also ensure in the first instance delivery of outcomes in the three priority areas of focus; Frailty, Send and Mental Health.
- 2.1.3 It is proposed that initially authority to make decisions regarding the partnership arrangements will continue to be reserved to the respective organisations. However, this could be reviewed in the future. Procurements will continue to be able to be undertaken jointly or led by one organisation or the other. The existing arrangements are based on good joint commissioning principles agreed on the 29th April by the Joint Commissioning Committee.

2.2 Membership

- 2.2.1 The Committee is made up of Cabinet Members and CCG Governing Body members. The terms of reference at Appendix 1 provide more information.

2.3 Overarching Governance

- 2.3.1 The committee operate in the context of a wider Governance framework which includes the Sheffield Health and Wellbeing Board, Executive Management Group (EMG) and the Accountable Care Partnership.
- 2.3.2 The Joint Committee will be accountable to the Clinical Commissioning Group (CCG) Governing Body and Sheffield CC Cabinet. The Health and Wellbeing Board will set the overall direction.
- 2.3.3 The proposed terms of reference at Appendix 1 set out more information in relation to Governance arrangements.

3.0 What does this mean for the people of Sheffield?

3.1 Better Health and Wellbeing Outcomes

- 3.1.1 The principles directly align with the current Health and Wellbeing outcomes for Sheffield set out below:
- Sheffield is a healthy and successful city
 - Health and wellbeing is improving
 - Health inequalities are reducing
 - People get the help and support they need and feel is right for them
 - The health and wellbeing system is innovative, affordable and provides good value for money.

3.2 Improved Collective Response to Future Changes

- 3.2.1 There is no intention to change existing stated priorities, nor to move away from any of our joint commitments within the Better Care Fund (for e.g. CHC or Children's services). The intention is to add pace into areas where we know we need to make improvements and build on successful joint arrangements. The possibility of developing a single commissioning function at officer level, to complement the Cabinet / Governing Body level arrangements, around frailty and SEND will be explored. The model established in mental health may be the template for this.
- 3.2.2 It is likely NHS England, through the Long Term Plan will seek to reshape NHS commissioning arrangements, this will change the way in which the CCG delivers its business. A Sheffield oriented joint committee will ensure there remains a place based orientation of commissioning of NHS and social care.

4.0 Implications

4.1 Equality of Opportunity Implications

- 4.1.1 The Equality impact assessment indicates that there will be a positive implication for Older People, People with Learning Disabilities and Long Term Conditions and Children and Young People with SEND
- 4.1.2 For staff working in services that will be part of the joint commissioning plan it is expected that implications will be neutral.
- 4.1.3 We anticipate a targeted positive impact on those who are experiencing greater inequality in deprived areas.
- 4.1.4 Individual EIAs will be drafted for each new service proposition that will be part of the joint commissioning plan.
- 4.1.5 A single workforce development plan, focussed on preventative outcomes and shared principles, will optimise our collective strengths, skills and resources, and develop our staff to give the best care and support. This will be co-developed by representatives from Sheffield City Council, the CCG and ACP members.

4.2 Financial and Commercial Implications

- 4.2.1 We will use our shared principles to look for ways to invest more in prevention, reducing demand on acute services. Short term additional funding will be required and it is anticipated that we will need to pool resources. Current local delivery plans show that social care will still require funding to balance and therefore the proposed financial risk share agreement that will underpin the proposed integrated commissioning plan is the only way that the outcomes can be met. We are intending to consider different funding sources such as:
- Using existing spending differently within the Sheffield health and care system;
 - Using one off money from within the Sheffield health and care system,
 - Seeking new, one-off money from beyond Sheffield or social investment arrangements

4.3 Legal Implications

4.3.1 S75 of the National Health Service Act 2006 and the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000 (as amended) set out the basis on which NHS bodies and local authorities can work together. Regulation 10(2) specifically provides that this may include establishment of a joint committee to take responsibility for the management of partnership arrangements including monitoring the arrangements and receiving reports and information on the operation of the arrangements.

4.3.2 The terms of reference are consistent with the requirements of the Regulations and the decisions previously taken by the Council's Leader and Cabinet and the CCG's Governing Body to establish the Joint Committee.

4.4 Other Implications

4.4.1 There are other implications arising directly out of this Report.

5.0 Reasons for Recommendations

5.1 The recommended terms of reference are consistent with the requirements of the Regulations and the decisions previously taken by the Council's Leader and Cabinet and the CCG's Governing Body to establish the Joint Committee and provide a clear purpose and direction for the Joint Committee.

Appendix 1 - Joint Commissioning Committee Terms of Reference



Terms of Reference

Name of Committee/Group	Joint Commissioning Committee
Type of Committee/Group	Committee of CCG's Governing Body and SCC's Cabinet

1. Purpose of Committee/Group	<p>The Committee will bring a single commissioning voice to ensure new models of care deliver the outcomes required for the City.</p> <p>The committee will support Sheffield City Council (SCC) and NHS Sheffield Clinical Commissioning Group (CCG) to deliver national requirements, including but not limited NHS Long Term Plan, Social Care Green Paper and Spending Review.</p> <p>The Committee will ensure in the first instance delivery of outcomes in the three priority areas of focus; Frailty, SEND and Mental Health.</p>
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2. Authority/Accountability	<p>The Joint Committee is a meeting of the Council Cabinet and CCG's Governing Body representatives with the purpose of agreeing joint health and social care commissioning plans for the City. In discharging this, the Committee will not have direct decision making powers delegated to it in the first instance: all decisions will still be ratified separately via in accordance with statutory requirements. However, by meeting jointly the joint decision making will be simplified. Any future delegations would have to be agreed by SCC and CCG</p> <p>The Committee is also authorised to create working groups as necessary to fulfil its responsibilities within these terms of reference. The Committee may not delegate executive powers (unless expressly authorised by the Governing Body) and remains accountable for the work of any such group. The existing Executive Management Group of CCG and SCC officers will report to and support the Joint Committee.</p>
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3 Objectives of Committee	<p>3.1 The Committee shall strengthen the way that we commission health and social care between the CCG and SCC.</p> <p>3.2 In particular, the Committee shall focus on:</p> <ul style="list-style-type: none"> i. Giving a single commissioning voice
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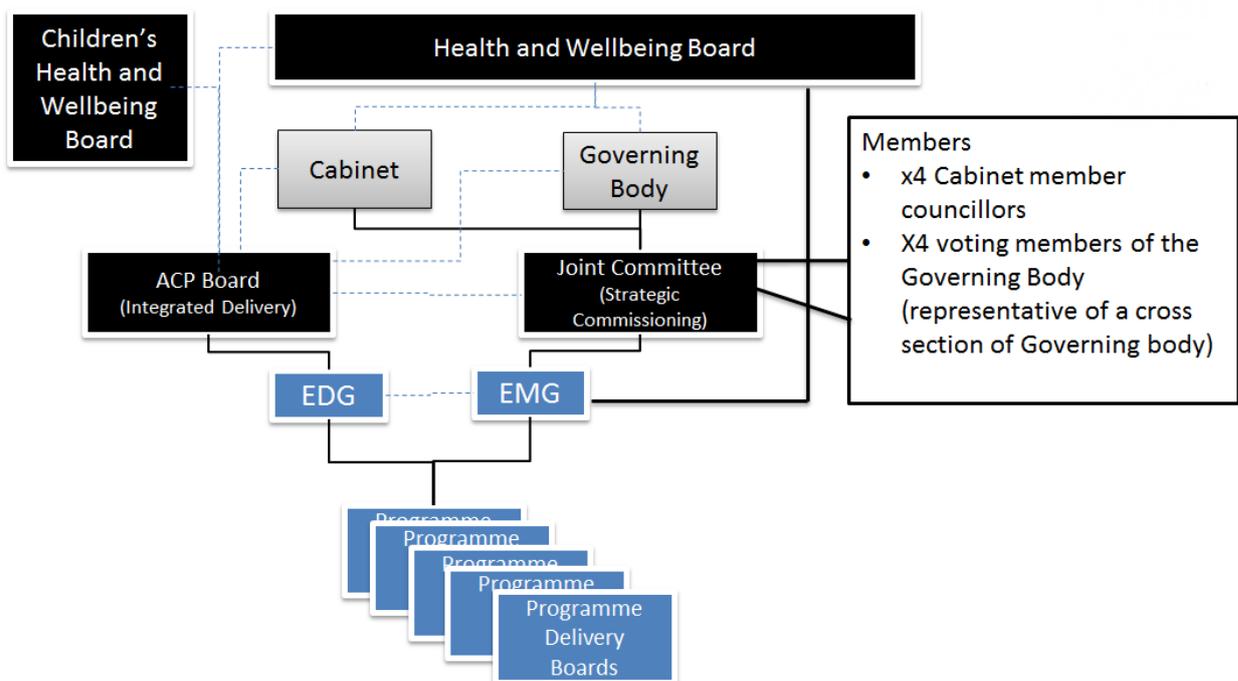
- ii. Single commissioner plan;
- iii. Ensure new models of care deliver the outcomes required by the city;
- iv. Building on Better Care Fund and Section 75, driving forward change;

This would be based on the following principles

- 3.2.1 A preventive model built into delivery at all levels of complexity
- 3.2.2 Care closer to home or a home via neighbourhood, localities
- 3.2.3 Reduction health inequalities in Sheffield
- 3.2.4 Person centred commissioning joined up with placement and brokerage
- 3.2.5 Improved people experience and outcomes
- 3.2.6 Effective and efficient use of resources whilst ensuring safe and effective standards of service
- 3.2.7 Collective management of risk and benefits

These Terms of Reference should be read in the context of the Health and Wellbeing Board, Executive Management Group (EMG) and the Sheffield Accountable Care Partnership (ACP) Board and the ACP's Executive Delivery Group (EDG)

Figure 1. The Joint Committee in the context of overall governance framework and arrangements



4 Membership
<p>The Committee shall consist of the following 8 members:</p> <ul style="list-style-type: none"> • From the CCG, to reflect the composition of the 19 voting Members of Governing Body: <ul style="list-style-type: none"> ○ one executive Member of the Governing Body; ○ two GPs who are Members of the Governing Body; ○ one Lay person who is a Member of the Governing Body, from Lay Members and out of area Secondary Care Doctor; <p>As part of this, the clinical Chair of the CCG shall be one of the GP Members and Accountable Officer shall be the executive Member. The Finance Director will deputise for the Accountable Officer.</p> <ul style="list-style-type: none"> • From SCC <ul style="list-style-type: none"> ○ four Cabinet Members <p>It will be important that nominated members commit to attend the Joint Committee but Members may appoint a deputy to act in their absence in advance of the meeting.</p> <p>The Joint Committee will be jointly chaired by SCC's Lead Cabinet Member for Health and Social Care and by the Chair of NHS Sheffield CCG, with chairing responsibility rotated between meetings. The Joint Chairs will agree the agenda.</p>

5. Managing Conflicts of Interest: General
<p>SCC and SCCG will share knowledge, respond to requests for information and carry out their duties in an atmosphere of courtesy and respect in accordance with their Codes of Conduct.</p> <p>Individual members of the Joint Committee, and any individual directly involved with the business or decision-making on behalf of SCC and SCCG, will comply with the arrangements determined by SCC and CCG for managing conflicts or potential conflicts of interest.</p> <p>The CCG manages conflicts of interest of members, employees and contractors in line with statutory guidance, as outlined in its Standards of Business Conduct and Conflicts of Interest Policy and Procedure available on its website. http://www.sheffieldccg.nhs.uk/our-information/documents-and-policies.htm</p> <p>SCC Members will declare personal and Disclosable Pecuniary interests in accordance with the Members Code of Conduct set out in Part 5a of the Council's Constitution.</p>

6. Attendees
Note: Attendees should be referred to by title or where appropriate by name. Minute taker should be stated either as member or in attendance.
In addition to the Committee members, the following executive directors shall be in attendance: <ul style="list-style-type: none"> • on behalf of the CCG: Director of Finance, Director of Delivery, Care Out of Hospital, Director of Commissioning & Performance and Chief Nurse • on behalf of SCC: Executive Director of People, Director of Public Health, Director of Commissioning, Director of Adults Services and Director of Business Strategy. • Director - Accountable Care Partnership • Integration and Better Care Fund Lead <p>Others may also be invited to attend the Joint Committee as necessary on an ad-hoc basis to inform discussions and in addition, may cover areas including administration and communications.</p>

7. Quorum
As the Joint Committee will be making recommendations that will provide direction for work being undertaken by officers it is important that meetings are quorate. The Joint Committee will be quorate providing 50% of the membership is in attendance, with at least two members in attendance from each of the CCG and SCC.
The Joint Committee will aim to achieve a consensus for all recommendations and so formal Voting would be a last resort. Given the nature of the programme, securing the support of both partners will be critical to the success of the Joint Commissioning for Health and Care.
Members will be aware of what may constitute a conflict of interest, will ensure that conflicts of interest are formally disclosed and will ensure they are subsequently managed in adherence with the organisations' respective policies. In addition, relevant Codes of Conduct will be followed at all times alongside adherence to the Nolan Principles and compliance with any statutory bar on participation and/or voting in particular circumstances.

8. Frequency and Notice of Meetings
Meetings in Public will be held at least quarterly. However, additional meetings may be required and the members of the Joint Committee can determine the exact frequency of meetings. In addition, the Chairs of the Joint Committee may call extraordinary meetings at their discretion. A minimum of five working days' notice will be required. The agenda and papers will be distributed by democratic services to members of the Committee at least 5 days working days in advance of the meeting, unless otherwise agreed by the Joint Chairs of the Committee. Papers for Meetings in Public will be available on both organisations' websites 5 working days in advance of the meeting.

9. Minutes and Reporting Arrangements
<p>The Joint Committee will formally record its deliberations within relevant minutes/action notes. This function will be undertaken by the designated officer support, alongside the management of paperwork and version control.</p> <p>For the CCG the minutes will be presented to the next available Governing Body meeting for information.</p>

10. Meeting Effectiveness Review
<p>Members of the Joint Committee have a collective responsibility for its operation. They will participate in discussion, review evidence and provide objective expert input to the best of their knowledge and ability, and endeavour to reach a collective view.</p> <p>Members of the Joint Committee will behave in a manner consistent with the Core Principles outlined in of these Terms of Reference and will adhere to the behaviours highlighted in the Nolan Principles, recognising that the success of the work programme will depend upon relationships and an environment of integrity, trust, collaboration and innovation.</p> <p>These Terms of Reference may be amended by mutual agreement between both parties at any time to reflect changes in circumstances which may arise.</p>

11. Admission of public and press
<p>Meetings of the Joint Commissioning Committee will be open and transparent in accordance with the Local Government Act 1972 and the Freedom of Information Act 2000. Meetings will be held in public and members of the public and representatives of the press may attend meetings of Joint Commissioning Committee. Only information that is expressly defined in regulations (in particular the Local Authorities (Executive Arrangements) (Meetings and Access to Information) (England) Regulations 2012 SI 2012/2089) to be confidential or exempt from publication will be considered in private.</p> <p>Members of the public or representatives of the press who attend public meetings of Joint Commissioning Committee will have the right to speak by invitation from the Chair.</p> <p>A record of members of the public attending will be held by the CCG and available on request.</p>

12.	Review to be conducted by Committee/Group Chair	
	Date Committee/Group established	29/4/2019
	Terms of Reference to be reviewed e.g. Annually	The terms of reference of the committee shall be reviewed when required, but at least annually.
	Date of last review	April 2019 update May 2019
	Date of next review	April 2020



Report of: SCC Lead Officer: Dawn Walton Director of Commissioning Inclusion and Learning

SCCG Lead Officer: Nicki Doherty, Executive Director of Delivery, Care Outside of Hospital

Report to: Joint Commissioning Committee

Date of Decision: 24 June 2019

Subject: Joint Commissioning for Health and Care – care outside of hospital

Is this a Key Decision? If Yes, reason Key Decision:-	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
- Expenditure and/or savings over £500,000	<input type="checkbox"/>	
- Affects 2 or more Wards	<input type="checkbox"/>	
Has an Equality Impact Assessment (EIA) been undertaken?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
If YES, what EIA reference number has it been given?	533	
Does the report contain confidential or exempt information?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Which Scrutiny and Policy Development Committee does this relate to? Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee		

<p>Purpose of Report:</p> <p>The purpose of this report is to outline the potential whole system changes required to support an improvement in the health and wellbeing of people in Sheffield and reduce health inequalities. The report outlines 2 key elements - the prevention of multi morbidity and the development of a robust out of hospital health and care system. Requirements to support these changes and next steps are outlined.</p>
<p>Questions for the Joint Commissioning Committee:</p> <p>The Joint Commissioning Committee is asked to provide a view on the proposals within this paper.</p>
<p>Recommendations for the Joint Commissioning Committee:</p>

The Committee is being asked to consider the report and provide views.

Background Papers:

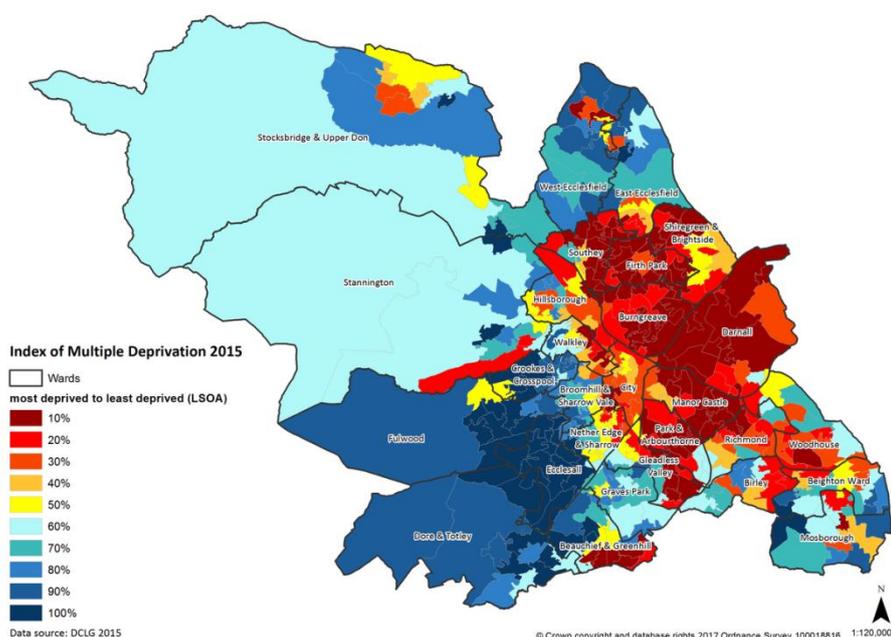
Lead Officer(s) to complete:-							
1	I have consulted the relevant departments in respect of any relevant implications indicated on the Statutory and Council Policy Checklist, and comments have been incorporated / additional forms completed / EIA completed, where required.						
	Finance: <i>(Insert names of SCC and CCG officers consulted)</i>						
	Legal: <i>(insert name)</i>						
	Equalities: <i>(Insert name of officer consulted)</i>						
	<p>Other Consultees:</p> <p>Sheffield Clinical Commissioning Group</p> <ul style="list-style-type: none"> • Brian Hughes - Executive Director of Commissioning, • Nicki Doherty - Executive Director of Delivery, Care Outside of Hospital • Sarah Burt – Director of Delivery, care outside of hospital <p>SCC</p> <ul style="list-style-type: none"> • Cllr George Lindars-hammond • Greg Fell – Director of Public Health • John Doyle – Director of Business Strategy, People Portfolio • Dawn Walton – Director Commissioning, Inclusion and Learning, People Portfolio • Eleanor Rutter – Public Health Consultant • Nicola Shearstone – Head of Commissioning, Inclusion and Schools Services, People Portfolio 						
<i>Legal, financial/commercial and equalities implications must be included within the report and the name of the officer consulted must be included above.</i>							
2	<p>EMT member who approved submission:</p> <p><i>(Insert name of relevant Executive Director)</i></p>						
3	<p>CCG lead officer who approved submission:</p> <p><i>(Insert name of relevant officer)</i></p>						
4	<p>I confirm that all necessary approval has been obtained in respect of the implications indicated on the Statutory and Council Policy Checklist and that the report has been approved for submission to the Joint Committee by the officers indicated at 2 & 3 above. In addition, any additional forms have been completed and signed off as required at 1.</p>						
	<table border="1"> <thead> <tr> <th>Lead Officer Names:</th> <th>Job Titles:</th> </tr> </thead> <tbody> <tr> <td>Dawn Walton</td> <td>Director of Commissioning Inclusion and Learning</td> </tr> <tr> <td>Nicki Doherty</td> <td>Executive Director of Delivery, Care Outside of Hospital</td> </tr> </tbody> </table>	Lead Officer Names:	Job Titles:	Dawn Walton	Director of Commissioning Inclusion and Learning	Nicki Doherty	Executive Director of Delivery, Care Outside of Hospital
Lead Officer Names:	Job Titles:						
Dawn Walton	Director of Commissioning Inclusion and Learning						
Nicki Doherty	Executive Director of Delivery, Care Outside of Hospital						

Date: *(Insert date)*

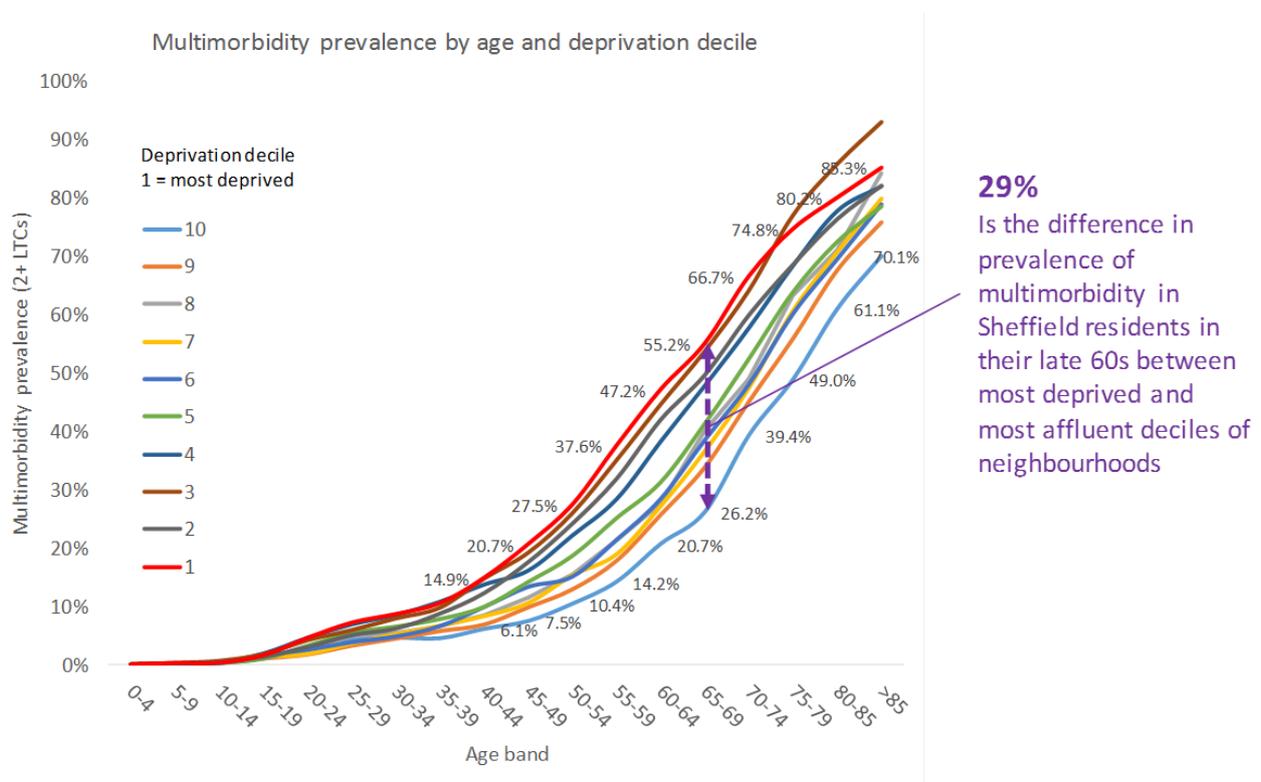
Joint Commissioning for Health and Care – Care Outside of hospital

1. Introduction/Context

- 1.1 Changing demographics, increasing demand and complexity all contribute to significant challenges within the health and care system.
- 1.2 Sheffield hospital admissions are high and the length of stay for people is above the target set for the city. A rebalancing of the system is needed to prioritise out of hospital care and drive better use of resources.
- 1.3 The CQC Local Area Review report 2018 was clear that too many people had a fragmented experience leading to feeling not well cared for and having to tell their story multiple times and on occasion with a lack of privacy and dignity.
- 1.4 The CQC review highlighted insufficient focus on prevention. The report stated that understanding that a focus on preventing hospital admission was as crucial to the effectiveness of the health and care system as enabling safe and timely discharge had not yet been fully translated into joint strategic delivery plans and as such the approach to prevention was underdeveloped.
- 1.5 There is increasing financial pressure across the system. People are living longer and public sector funding is reducing creating long term financial sustainability issues.
- 1.6 There are significant inequalities in health & causes of ill health within Sheffield experienced by both adults and children. The problem of multi-morbidity is seen more frequently in deprived communities, where how well people are able to engage in preventative behaviours or early support, results in a higher rate of emergency hospital admissions and shorter healthy life expectancy.
- 1.7 The healthy life expectancy of both males and females is strongly correlated with the indices of multiple deprivation for Sheffield.



1.8 There is a clear difference in prevalence of multi morbidity in Sheffield residents if age and deprivation are compared. This is evident in the graph below.



2.0 Main body of report and matters for consideration

2.1 Target population

2.1.1 There is no clear definition of frailty but the term relates to impairment of physical function and resilience most often the result of multiple long term conditions.

2.1.2 Used without qualification, the term frailty is often assumed to relate to the older population, leading decision makers to potentially exclude the needs and demands that are evident in the whole population. Multi-morbidity is a precursor to frailty and is now widely accepted to be a clear manifestation of inequalities affecting all ages.

2.1.3 Multi morbidity is therefore the preferred term as it encourages us to focus our attention equitably, on areas of greatest need, to focus on the key principle of prevention at all levels and by setting this work within a population context, to shift our focus upstream in terms of age and locus of intervention.

2.1.4 By focusing on multi morbidity and its impacts on both people and services, we are compelled to consider whole system changes which impact on the entire population rather than particularly high-risk cohorts.

2.1.5 Particularly the impact of multi-morbidity enables us to consider whole system changes which also impact on the whole population rather than specific cohorts.

2.2 Existing good practice

- 2.2.1 The CQC Local Area review report 2018 recognised that there were some good practice examples, but that these were not effectively evaluated and not given sufficient oversight to translate across the system. This led to projects being developed in silos rather than strategically cross the system.
- 2.2.2 There are number of examples of good practice developing across the city. These include primary care networks/neighbourhoods, person centred approaches, social prescribing, governance arrangements that support integrated working, agreed strategic priorities and existing tripartite risk shares.
- 2.2.3 It is recognised that there is scope for improvement. To do this we must develop more focus on prevention, further embed the person centred approach, develop the integration of primary and community care with a focus on the re-provision of treatment and care in a community setting. To do this we need to develop an outcomes focused approach, focusing on what we want to achieve and the difference we want to make to peoples life rather than how we will achieve this. This requires improved working with key stakeholders, developing ideas and initiatives through co production.

2.3 Vision and Aims

- 2.3.1 Our vision is to improve the health and wellbeing of people in Sheffield and reduce health inequalities. There are 2 key elements to this – the prevention of multi morbidity and the development of a robust out of hospital health and care system.
- 2.3.2 A number of aims have been identified:
- To develop a prevention focused health and care system
 - To identify people who are at risk of developing long term conditions and multi morbidity and maximise independence and resilience within their own home and community
 - To provide optimal support to people (and their families) who are multimorbid/complex or at the end of life
 - To build on an integrated approach across health and social care to ensure best use of shared resources
- 2.3.3 This vision and associated aims aligns with a number of key strategy commitments including the health and wellbeing strategy and the accountable care priorities for the city: care closer to home, living well / ageing well, personalisation, reducing health inequalities, a focus on prevention, neighbourhood development, and the best use of resources (sustainability).

2.4 What do we need to do?

- 2.4.1 To have a positive impact on people's health and wellbeing we need to shift to preventative and proactive evidence informed care which is delivered closer to home and away from hospital. This requires more than a change in service delivery models. We must change the culture in the way in which we manage people's health and social care needs. This includes improving people's confidence to

manage their needs in the community rather than relying on hospital treatment. This is reliant on increasing the capacity in communities to manage demand in order to prevent attendance in acute services.

- 2.4.2 There are a number of whole system changes that require exploration with key stakeholders to identify opportunities for development. These changes have a population approach which can support the long term sustainability of a more efficient and effective provision of care. These changes should develop a system that supports and enables future transformation.



- 2.4.3 Building resilient communities enables individuals and communities to harness local resources and expertise to help themselves. It enables them to take collective action to increase their own resilience as well as that of others. This gives a greater sense of community and reduces the impact of social, financial and health pressures.
- 2.4.4 Locally accessible integrated services in communities enables all sectors to work together to provide the support needed at the earliest opportunity. This multi-disciplinary approach should prevent the escalation of need and demand on more acute services.
- 2.4.5 There are currently a range of access points to services which can be confusing and lead to a delay in response to requests for support. Improving this should lead to a better customer experience through a quicker response, managing need in a timely and cost effective way.
- 2.4.6 Delivering health care out of acute hospital settings and closer to people's home aims to provide a better experience for people and reduce the number of unplanned bed days. Exploration of the opportunities for this need to assess the impact on quality and outcomes for patients and the financial impact.

2.4.7 There is a significant amount of data held within organisations but this is often not shared in an effective way. Improving this and utilising data and intelligence from across the system would enable the identification and targeting of early support which in turn should support a reduction in demand on services.

2.5 What would look different?

2.5.1 There are a number of significant differences that would be seen if we achieved the system changes required. These include:

- Care focused around communities and focused on wellbeing, self-care and prevention
- Improved use of all assets within a community – voluntary sector working alongside primary care and specialist teams
- Local people knowledgeable about how to access support within their own community
- Person centred approaches across all providers
- Hospital care used only when care cannot be provided in the community
- A system that is supported by shared intelligence and information which allows a proactive offer of support
- Improved access to specialist support from acute hospital to the community
- Investment in community based health and social care

2.5.2 It is important that we now work with providers and key stakeholders to explore these differences in more detail and identify actions required to achieve these outcomes.

2.6 How do we make this happen?

2.6.1 Delivering whole system change requires engagement from all stakeholders. A critical element of this will be the engagement of health and care providers at all levels, including senior leaders, to support the development of changes and delivery plans to enable the implementation of those changes. Communication with providers needs to identify key system leaders that can support the delivery of this work. Key to this will be a robust communication and engagement plan for all providers including the statutory, community, voluntary services and the public.

2.6.2 Initial steps require a detailed understanding of the existing services and what would look different if key outcomes were achieved. This includes intelligence which provides detailed knowledge of the population and interventions that currently take place. This can lead to the development of new initiatives, with identified ACP groups taking responsibility to develop detailed business cases for these areas of work which can start to create a shift in the system.

2.6.3 A crucial element of this will be workforce development and plans for this to align to the principles and vision for the city.

2.6.4 An outcomes framework is required to underpin the delivery plans. This would include agreed impact measures that support the measurement of progress and which are agreed by partners across this system.

2.7 What are the requirements to support system change?

- 2.7.1 The agreed changes that are developed to support this whole system transformation require a unified approach to commissioning. This will include the ability to matrix work across organisations and disciplines, identifying a shared commissioning resource with project management functions that enable the programme to be established and delivered. Information sharing will be a key element and will require exploration of existing information systems.
- 2.7.2 The whole system change proposed in this paper requires a change in organisations, networks and communities and this requires the active involvement and commitment from multiple stakeholders in order for this to be effective and sustainable. An ability to work at scale is crucial for this to be successful.
- 2.7.3 Clear leadership and decision making will be a driver for the delivery of this programme. It is proposed that this is managed through the Long Term Conditions Accountable Care partnership (ACP) Board, enabling the involvement of stakeholders from across the system. This will require the engagement with other ACP boards to recognise and manage the interdependencies.
- 2.7.4 The Joint Commissioning Committee will be required to agree joint health and social care commissioning plans that support this system change, managing risks collectively, and ensuring these changes meet the required outcomes for the city.

3.0 Next Steps

- 3.1 Discussions have not yet taken place with the ACP Long term Conditions Board to agree the role of that board and its interdependencies with the other ACP board priorities. This meeting is due to take place on the 24th June.
- 3.2 The CCG and SCC need to identify the multi-disciplinary joint commissioning function to support the development of this work by the end of June.
- 3.3 The next stage will be to develop a high level programme plan which should be in place by the end of July with a co-designed strategy and plan with stakeholders by the end of September. Engagement with other ACP boards in relation to the interdependencies would need to form part of this planning.

4.0 Recommendations

- 4.1 In summary this paper sets out the approach to whole system changes that would support the prevention of multi morbidity and the development of a robust outside of hospital health and care system.
- 4.2 Joint Commissioning Committee support the next steps set out in this paper, noting a follow up paper will be presented to the committee in September.

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