Working with you to make Sheffield HEALTHIER

NHS Sheffield Clinical Commissioning Group

Better Care Fund Section 75 Agreement

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Governing Body meeting

5 March 2015

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Sponsor	Tim Furness, Director of Planning and Partnerships

Is your report for Approval / Consideration / Noting

The attached report is seeking approval for the establishment of pooled budget arrangements with Sheffield City Council (SCC) and delegation of authority for signing the Section 75 Agreement to the Chair and Accountable Officer.

Are there any Resource Implications (including Financial, Staffing etc)?

The proposed pooled budget arrangements will include £165m of CCG funding in 2015/16. Inclusion of this funding will enable the development of integrated health and social care services that will provide better service experience for users and enable the CCG and SCC to make best use of the available resources.

Audit Requirement

CCG Objectives

The proposal contributes to all the CCG objectives:

- To improve patient experience and access to care
- To improve the quality and equality of healthcare in Sheffield
- To work with Sheffield City Council to continue to reduce health inequalities in Sheffield
- To ensure there is a sustainable, affordable healthcare system in Sheffield

Equality impact assessment

Have you carried out an Equality Impact Assessment and is it attached? Yes

PPE Activity

How does your paper support involving patients, carers and the public?
The report includes a summary of engagement activity and responses.

Recommendations
That the Governing Body: • Approves the establishment of pooled budget arrangements to enable integrated commissioning, in line with previous discussions • Notes the requirement to have a robust legal agreement in place that underpins our partnership, prevents ambiguity and provides a reference point for problem solving • Notes the progress in developing the detailed agreement • Approves the proposed content of the S75 Agreement • Delegates authority for signing the Agreement to the Chair and Accountable Officer

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1. Introduction

This paper proposes that the CCG enters into formal pooled budget arrangements with Sheffield City Council (SCC) to enable the development of integrated health and social care services and to create flexibility between health and social care budgets, to enable best use of the available resource in the city for this purpose. The paper describes the rationale for establishing pooled budget arrangements, the scale and scope of the proposed pooled budget(s), and the governance arrangements that will be set out in a formal legal agreement between the two organisations. It proposes that authority for signing the legal agreement is delegated to the Chair and Accountable Officer, with advice from Directors and with independent legal advice.

2. Background

Sheffield's Health and Wellbeing Board developed its first strategy in autumn 2012 and started discussing the potential benefits of integrated services as part of that process. It recognised the work of the Right First Time programme and agreed that integrated commissioning and pooled budgets were necessary to enable development of fully integrated services.

In June 2013 the CCG Governing Body considered the potential benefits and risks of integrated commissioning and supported the development of proposals to integrate commissioning with SCC.

In December 2013 the Health and Wellbeing Board supported plans for integrated commissioning. The CCG and SCC established a Joint Commissioning Executive Team and then an Integrated Commissioning Programme to develop firm plans for integrated commissioning arrangements and pooled budgets.

During 2014 the CCG Governing Body has supported development of those plans, including the ambitions and the scope of the pooled budget(s), as set out below.

Our plans are in line with the Department of Health (DH) requirements for a Better Care Fund, but are significantly greater in scale and ambition (the DH stated minimum Better Care Fund for Sheffield is £37.7m excluding capital grant income). Sheffield's Better Care Fund plans were formally approved by DH in January 2015.

3. Our Ambition

Our two organisations have agreed, through discussion at the Health and Wellbeing Board, that establishment of integrated commissioning arrangements, with a single budget for health and social care, should enable us to build on the achievements of current partnership working to establish truly integrated health and social care services for the

people of Sheffield. A single approach to commissioning with, for example, single service specifications, is essential to enable providers to deliver integrated services.

Equally importantly, we believe that having a single budget for health and social care will enable us to together make the best use of the resources available to us, which are of course reducing as a result of cuts to funding for Councils whilst demand for health and social care services is growing. Together we can ensure we commission the most efficient and effective services for our population and avoid actions that simply transfer costs between us and do nothing to help us manage within our budgets.

We aim to commission genuinely integrated services in community settings that support people to stay well at home and provide a rapid response to health and social crises that enable them to stay home whenever possible. This will lead to a significant reduction in non-elective hospital admissions (the CCG is aiming for a 20% reduction in five years) and in admissions to long term care, enabling us to invest in the services described above, within the combined resource available to us.

We expect that delivery of these plans will lead to significant change in the way we commission, with increasing integration of commissioning functions and the likely establishment of a single budget for the whole of health and social care.

Achievement of these aims requires integrated commissioning and pooled resources in the following areas of care:

1. **Keeping People Well in their Community** – primary care, social care and non-clinical interventions to support people identified as at risk of needing hospital care to stay well
2. **Active Support and Recovery** – clinical and social care services that provide short term interventions as an alternative to hospital care and help people get home and regain independence following a spell in hospital (including intermediate care and community nursing)
3. **Independent Living Solutions** – recommissioning of community equipment services as a genuinely integrated and user focussed service
4. **Long Term High Support** – integration of assessment and contracting for long term care, including NHS Continuing Healthcare and Funded Nursing Care and SCC funding of residential and home based social care. Within this theme we recognise that it will be important to maintain the different legal funding requirements which apply to health as opposed to social care – ie heath care free at the point of delivery and funding assessments for social care.
5. **Non-elective (non-surgical) hospital admissions** – because our plans seek to reduce expenditure in this area, so this funding is included to release money, and to share risk. It should be noted that the Regulations which govern pooling of funding only formally allow for the inclusion of CCG spend on medical emergency admissions as opposed to those classed as surgical admissions. However, this does not change our collective objective to reduce all unnecessary admissions to hospital and this will be built into our risk management arrangements.

4. Engagement in Development of Our Plans

Through a wide range of engagement activity in the vision over a number of years, we are confident that the vision that we articulate in our plan for an integrated health and care system in Sheffield is widely shared. For example, over 1,500 members of the public, as

well as commissioners and providers, helped us to identify our priorities for our Joint Health and Wellbeing Strategy.

Sheffield's Health and Wellbeing Board has engaged with Sheffield people and with providers of health, social care and wellbeing services on the topic of integration since its establishment as a shadow and then as a formal Board in April 2013.

We published a six-page public information document setting out our plans for integrated commissioning in early March 2014, providing the opportunity for those interested to register their interest in being involved in the developmental work in 2014-15. To date, over 200 people and organisations have registered an interest.

We have organised a range of engagement opportunities for members of the public and providers to influence our vision and strategy. This has included:-

- A number of engagement events that have brought together a range of individuals and organisations, including our key providers.
- Specific work with a wide-ranging group of citizens, providers and other organisations.
- Work by Healthwatch Sheffield with members of the public and Health and Wellbeing Board members.
- Consistent communication with members of the public and providers through publishing presentations and papers online, and sending out our monthly e-bulletin, as well as using other communications tools such as our popular Twitter feed.
- Engagement work done as part of our RFT Programme, including:
    - Active citizens reference group formed with 50+ members to help with culture change and shaping of Right First Time and oversee involvement work
    - 50 people engaged in a consultation looking at the relationship between physical health and activities for people with serious mental illness
    - Deaf community consultation on the overall principles for Right First Time- report fed to RFT senior teams
    - Six focus groups held with reference group members to guide individual involvement projects, design surveys and plan meetings.

There has been clear support for integration of services to improve service user experience by reducing handovers improving planning of the entire pathway.

The CCG engaged with the public in development of its commissioning intentions for 2014/19, which set out ambitions including the development of primary and community care services as an alternative to hospital admission, a key part of the integrated commissioning programme. The responses to these plans were generally supportive.

5. The Formal Section 75 Agreement

The section 75 agreement is a legally binding document that sets out the terms of our integrated commissioning, with robust, fair, effective and legal mechanisms to make decisions about the money and responsibilities in the pooled budget, including how much we each contribute and how we share benefits and consequences of any failures. It recognises the ongoing statutory responsibilities of each organisation and respects the mandate each has. It is explicit about where authority for decision making has moved from a single organisation to a joint process, with delegated authority.

5.1 What a section 75 Agreement Should Include

- Aims and Objectives
- Scope of the Pooled Budget (in terms of Commissioning Expenditure themes)
- Budgets – for 2015/16 initially
- How strategic direction has been set and will be set in future
- How operational decisions will be made
- Operational Budget Management
- Benefit and risk share arrangements
- Approach to procurement and contracting
- Performance & Quality performance monitoring
- Information Governance
- How we expect staff to work together

5.2 Key Issues for Both Organisations

Arguably the most important elements of our agreement will be those that set out how we make decisions about use of the pooled funding, how we manage and share risk – financial, reputational, legal, and we place and manage contracts. The proposed arrangements for each of these are set out below.

These arrangements need to reflect the decisions needed in 2015/16, with most budgets still managed separately next year, and plans to implement change being developed, but also need to create the right environment for taking decisions together and for our staff working together.

5.2.1 Decision Making

Recognising that neither the CCG nor SCC Constitutions allow delegation to a joint committee, and the need to maintain Governing Body and Cabinet ownership – perhaps particularly in the first year, the following is proposed. The partners may of course wish to vary either the provisions in the s75 agreement, or the delegations to members, committees or officers, for future years if that will improve delivery of our objectives:

Strategic Oversight and Direction

- The Health and Wellbeing Board (HWB) to continue to act in this role
- HWB role is to hold each other to account, to agree aspirations, and be the public meeting that monitors progress. If it feels insufficient progress is being made it can ask the organisations to explain to the HWB and discuss remedial action
- Neither body delegates budgetary responsibility or operational commissioning decisions to HWB

Decisions Reserved for Governing Body (GB) and Council Leader/Cabinet

- No change to delegation of authority to members, committees or officers
- Council Leader/Cabinet & GB to approve
  - schemes within the pooled budget arrangements
  - financial contributions and budgets
  - changes to the written agreement
  - budgets for individual schemes
  - virement and transfers beyond delegated limits
  - contract awards beyond delegated limits
- Business will need to be planned ahead to schedule decision points at Cabinet and GB

Executive Management Group (EMG)

- Responsible for day to day management – meeting at least monthly
- Authority within delegated limits of individuals (which it is not proposed to change from current delegations)
- EMG meets together as an Executive Team to implement plans, manage contracts, manage budgets
- Programme team, with project leads, will report into the EMG, with the Programme Director a member of EMG
- If EMG cannot agree – i.e. is unable to reach the same decision when needed to – the matter will refer to next meeting, then use dispute resolution in s75 if agreement still not reached.

5.2.2 Risk Sharing

In developing the following proposals, we have sought to maintain the principle of a single budget – the Sheffield pound – that has underpinned the development of the Integrated Commissioning Programme, and to ensure budgetary responsibilities and risk promote the behaviours and changes we want. In reality, as we start 2015/16 most budgets will still be managed by one organisation, rather than as joint ventures (Independent Living Solutions (ILS) being the exception). Over the year, as we develop specific commissioning plans to achieve our ambition, more budgets will be supporting joint ventures and the below will need to be varied (through a formal variation to the s75 agreement) to adjust risk sharing arrangements to reflect that.

Risk Sharing Proposal

- Concept of a single overall budget but with separate budgets within that for each scheme and within each scheme for each key area of expenditure
- Budgets set at the beginning of the year but capable of being changed in year by agreement
- Lead commissioner for each scheme and for the budget lines within schemes
- Contingency risk reserves sitting outside of the pooled budgets
- Initial s75 will limit risk sharing, to be replaced or varied with more sharing of risk when specific plans for 2015/16 in place and risks fully understood.

Initial Risk Sharing Arrangements

- Where a scheme is truly joint (e.g. ILS), one budget manager and we share risk share pro-rata to contribution
- Where budgets within a scheme are attributable to one party, the risk and responsibility primarily sits with that party (as the levers for control and change sit there)
- If overspend
  - First, can cover with underspends from other PB areas (subject to the law or other directives that might govern use of specific funds)
  - Secondly, use contingency reserves
  - Thirdly, ask other partner to contribute underspends from pool
  - Underspends have to stay within pooled budget, so available to support partner's overspend
- Further joint schemes within budget lines will be proposed in year and risk/gain share agreements put in place
- We will make our commitment to joint working explicit to avoid actions that shift cost between partners, unless agreed as above (MoU?)
- This proposed arrangement for is for 2015/16 only, with wider shared risk in future years

5.2.3 Contracting and Procurement

Our arrangements must, of course, be compliant with the law and other binding directives, must support achievement of our aims, and should minimise bureaucracy. It is proposed that:

- Each procurement will be led by one partner, in accordance with that partner's rules – with the proposed exercise (whether open tendering to the market, a more limited market approach, or a partnership approach) agreed with the other partner
- The procurement lead will then be contract lead – but contracts to be agreed by both partners
- NHS contracts will be used unless services are clearly not clinical
- The contract lead will also be the performance management lead
- The Executive Management Group will be responsible for overseeing procurement, contract and performance management

5.2.4 Hosting

Section 75 arrangements require one organisation to be designated as host of each pooled budget and with that come certain formal requirements in terms of preparation of financial records and audit of the pooled budget. We are still in discussion as to which organisation is best placed to be host, so that we can achieve the maximum benefit from the pooled budget arrangements.

We are clear that we wish to operate with the overarching financial risk arrangements set out in 5.2.2 above, but at the same time in 2015/16 we will have both organisations leading commissioning and contracting on various budgets which they will need to do under their own financial governance and operational arrangements. We want to minimise the need for unnecessary cash flow and other administrative processes between our two organisations. Thus we may decide that it makes best operational sense to have a series of pooled funds and/or aligned funds in 20151/6. Legal and audit advice is currently being sought on this matter.

5.3 Development of the Written Agreement

CCG officers, led by the Director of Business Planning and Partnerships and the Director of Finance, have been working with SCC colleagues to agree the content of the agreement and inform the drafting of it. The above proposals are agreed between officers of both organisations. Initial drafting of the document has been undertaken by SCC's legal team, with support from Bevan Britten. At the time of writing, a full draft document is expected by Monday 2 March. Officers will need to scrutinise that draft, and the CCG will seek independent legal advice, before recommending signature.

It is proposed that, if Governing Body approves the proposed content of the document as set out above, signature is delegated to the Chair and Accountable Officer, noting that an agreement must be signed by 31 March 2015 to enable pooled budget arrangements to be established for 2015/16 (it would be unwise to enter into pooled budget arrangements without being clear about decision making, risk sharing, contracting approaches etc.)

6. Proposed Funding to be covered by the Better Care Fund Section 75 Arrangements

Governing Body has previously been appraised of the significant work which has been undertaken by Directors and senior managers from both organisations to establish the budgets to be included in our local Better Care Fund arrangements for 2015/16. This has partly been through the monthly shadow financial monitoring reports which Governing Body has received in private session during 2014/15. Members also received a joint

presentation from the Directors of Finance of both organisations in January 2015. This outlined the issues, challenges and pressures faced by both organisations to established balanced budgets for 2015/16. It set out the indicative budgets for 2015/16 including the key assumptions being made on price, demand and other pressures, savings schemes and on income and non recurrent funding for each of our organisations.

Over the last few weeks both organisations have been undertaking further work to finalise budgets for next year, and the table below and as summarised in more detail at Appendix A, gives the position at 24 February 2015. It is intended that these are the figures included within the Section 75 agreement, but as discussed in section 5 above, can be changed in year with the agreement of both parties. For the CCG the figures are consistent with those included in our financial plan submission to NHS England on 27 February 2015. However, as has been highlighted to Governing Body in the planning update papers to this meeting, some budgets remain subject to further change due to the continued uncertainty as to the final tariff price arrangements for 2015/16.

	2015/16 Better Care Fund - Summary - Budgets by Theme	CCG	SCC	TOTAL
		£'000	£'000	£'000
1	Keeping People Well in their Local Community	1,968	7,849	9,817
2	Active Support & Recovery	42,055	7,905	49,960
3	Independent Living Solutions	1,675	1,666	3,341
4	Long Term High Support	66,890	87,628	154,518
5	Expenditure on Adult Inpatient Medical Emergency Admissions	52,932	0	52,932
		165,520	**105,048**	**270,568**

Governing Body is asked to approve inclusion of the CCG budgets as set out in the table above and **Appendix A.**

7. Recommendations

That the Governing Body:

- Approves the establishment of pooled budget arrangements to enable integrated commissioning, in line with previous discussions
- Notes the requirement to have a robust legal agreement in place that underpins our partnership, prevents ambiguity and provides a reference point for problem solving
- Notes the progress in developing the detailed agreement
- Approves the proposed content of the s75 agreement
- Delegates authority for signing the agreement to the Chair and Accountable Officer

Prepared by:
Tim Furness, Director of Business Planning and Partnerships
Julia Newton, Director of Finance

February 2015

NHS Sheffield Clinical Commissioning Group

NHS Sheffield CCG
Equality Impact Assessment

Title of policy or service:	Establishment of a Section 75 Pooled Budget (Better Care Fund)	
Name and role of officer/s completing the assessment:	Tim Furness, Director of Business Planning and Partnerships	
Date of assessment:	18/2/15	
Type of EIA completed:	**Initial EIA 'Screening'** ☒ ***or*** **'Full' EIA process** ☐	*(select one option - see page 4 for guidance)*

1. Outline	
Give a brief summary of your policy or service • Aims • Objectives • Links to other policies, including partners, national or regional	The paper proposes that the CCG enters into a formal pooled budget arrangement with Sheffield City Council (SCC) to enable the development of integrated health and social care services and to create flexibility between health and social care budgets to enable best use of the available resource in the city for this purpose. The paper describes the rationale for establishing a pooled budget, the scale and scope of the proposed pooled budget, and the governance arrangements that will be set out in a formal legal agreement between the two organisations. It proposes that authority for signing the legal agreement is delegated to the Chair and Accountable Officer, with advice from Directors and with independent legal advice.

Identifying impact:

- **Positive Impact:** will actively promote or improve equality of opportunity;
- **Neutral Impact:** where there are no notable consequences for any group;
- **Negative Impact:** negative or adverse impact causes disadvantage or exclusion. If such an impact is identified, the EIA should ensure, that as far as possible, it is either justified, eliminated, minimised or counter balanced by other measures. This may result in a 'full' EIA process.

2. Gathering of Information This is the core of the analysis; what information do you have that might *impact on protected groups, with consideration of the General Equality Duty*.					
(Please complete each area)	**What key impact have you identified?**			**For impact identified (either positive and or negative) give details below:**	
	Positive Impact	**Neutral impact**	**Negative impact**	**How does this impact and what action, if any, do you need to take to address these issues?**	**What difference will this make?**
Human rights	☐	☒	☐		
Age	☒	☐	☐	Older people are most at risk of hospital admission or of need for long term care – the main target group for much of the integrated commissioning programme.	The proposals should have a positive impact, providing better support to people to keep well and to regain independence after a period in hospital
Carers	☒	☐	☐	Many of the people likely to benefit from our plans will have formal or informal carers.	Helping people to stay well at home will include support to carers of vulnerable people
Disability	☒	☐	☐	People with physical disabilities, learning disabilities or mental illness are often more at risk of ill health than the general population.	That risk should be identified through the integrated commissioning workstreams.
Sex	☐	☒	☐		
Race	☐	☒	☐		
Religion or belief	☐	☒	☐		
Sexual orientation	☐	☒	☐		
Gender reassignment	☐	☒	☐		
Pregnancy and maternity	☐	☒	☐		

Marriage and civil partnership (only eliminating discrimination)	☐	☒	☐		
Other relevant groups	☐	☒	☐		
HR Policies only: Part or Fixed term staff	☐	☐	☐		

IMPORTANT NOTE: *If any of the above results in ' **negative'** impact, a 'full' EIA which covers a more in depth analysis on areas/groups impacted must be considered and may need to be carried out.*

Is a 'Full' Equality Impact Assessment required:	☐ **YES** ***or*** ☒ **NO**

Having detailed the actions you need to take please transfer them to onto the action plan below.

3. Action plan				
Issues/impact identified	**Actions required**	**How will you measure impact/progress**	**Timescale**	**Officer responsible**
Age	None beyond those already planned			
Carers	None beyond those already planned			
Disabilities	None beyond those already planned			

4. Monitoring, Review and Publication				
When will the proposal be reviewed and by whom?	**Lead / Reviewing Officer:**	**n/a**	**Date of next Review:**	

Appendix A

NHS Sheffield CCG and Sheffield City Council
Better Care Fund - Proposed 2015/16 budgets

Note: Budgets are shown NET of income

	Theme	2015/16 Proposed Budgets £'000s
1	**Keeping People Well in their Local Community**	
	NHS Sheffield CCG	
	Grants to SCC Health Trainers and CSWs	500
	Other Grants	60
	GP Locally Commissioned Services (Care Planning & Care Homes)	1,408
	sub total	1,968
	Sheffield City Council	
	Mental Heath - partnership working and grants	413
	Community Grants and support to VCF sector	1,695
	Public health	1,466
	Carers Support	789
	Housing Related Support for Older People	2,413
	Community Access Reablement Service (CARS)	647
	Supporting People with Learning Disabilities	426
	sub total	7,849
Theme 1 Total - Keeping People Well in their Local Community		**9,817**
2	**Active Support & Recovery**	
	NHS Sheffield CCG	
	Integrated Care Teams (including community nursing)	15,429
	Intermediate Care - Home & Bed based services	21,276
	Dementia Response	439
	Length of Stay and Discharge Teams	2,771
	Grants to SCC for STIT, AICS, CAICS and Social Workers	2,140
	sub total	42,055
	Sheffield City Council	
	Short term Intervention team (STIT)	5,513
	Intermediate Care Assessment Teams	1,258
	Community Support Workers	480
	Community reablement Service	654
	sub total	7,905
Theme 2 Total - Active Support & Recovery		**49,960**

3	**Independent Living Solutions**	
	NHS Sheffield CCG	
	Community Equipment	1,675
	sub total	1,675
	Sheffield City Council	
	Community Equipment	932
	Equipment & Adaptation Teams	678
	Sensory Impairment Equipment	56
	sub total	1,666
Theme 3 Total - Independent Living Solutions		**3,341**
4	**Long Term High Support**	
	NHS Sheffield CCG	
	Ex NHS England funding for social care support	12,399
	CHC, FNC and Palliative (including Housing Association grants)	51,842
	Grants to SCC re Learning Disabilities services	2,650
	sub total	66,890
	Sheffield City Council	
	Gross Social Care Costs	
	Adult Social Care Purchasing	66,266
	Learning Disabilities Purchasing	49,951
	Long Term purchasing and Others	8,211
	Carers Grants	424
	Long Term Placements	450
	Adult Placement Shared Lives	359
	Less: Client income	(34,376)
	Less: CCG income - ex NHS England funding	(12,399)
	Short Breaks - Respite	1,425
	In House LD, home Care and other LD Services	6,953
	CHC Team	364
	sub total	87,628
Theme 4 Total - Long Term High Support		**154,518**
5	**Expenditure on Adult Inpatient Medical Emergency Admissions**	
	NHS Sheffield CCG	
	In-Patients (PbR & non PbR)	52,932
	Sheffield City Council	
	No spend in BCF	0
Theme 5 Total - Inpatient Medical Emergency Admissions		**52,932**
TOTAL		**270,568**