Agenda Item 9

SHEFFIELD CITY COUNCIL

Cabinet

Report of:	Laraine Manley, Executive Director, Communities
Report to:	Cabinet
Date:	27 May 2015
Subject:	Integrated Commissioning of Health and Care
Author of Report:	Joe Fowler, Director of Commissioning

Summary:

- Describes how pooled budgets and integrated commissioning could enable improved outcomes for the people of Sheffield
- Provides background and context on the Section 75 Agreement between Sheffield City Council and Sheffield Clinical Commissioning Group, which establishes pooled budgets and integrated commissioning arrangements for Health and Care Services in Sheffield
- Proposes that the Council works with the Clinical Commissioning Group to develop ambitious plans to use our pooled budgets to develop better, more joined-up health and care services that help more people stay independent, safe and well.

Recommendation:

Cabinet supports the increased joining up the work of the Clinical Commissioning Group and Sheffield City Council so that our pooled health and care budgets can be used to commission better, more joined-up health and care services that help more people stay independent, safe and well.

Statutory and Council Policy Checklist

Financial Implications
Cleared by: Hugh Sherry
Legal Implications
Cleared by: David Hollis
Equality of Opportunity Implications
Cleared by: Phil Reid
Tackling Health Inequalities Implications
YES
Human rights Implications
NO:
Environmental and Sustainability implications
NO
Economic impact
YES
Community safety implications
NO
Human resources implications
NO
Property implications
NO
Area(s) affected
Relevant Cabinet Portfolio Leader
Mary Lea
Relevant Scrutiny Committee if decision called in
Healthier Communities & Adult Social Care
Is the item a matter which is reserved for approval by the City Council?
NO
Press release
YES

Report to Cabinet

1. Management Summary

1.1 This report outlines how integrated commissioning of health and care services with a pooled health and care budget could enable improvements to the management and delivery of health and care services in Sheffield, which should in turn help to improve outcomes for the people of Sheffield.

1.2 The report recommends that Cabinet agrees that the Council should work with partners on further joint ventures to develop and deliver more joined-up, innovative and efficient health and care services for the people of Sheffield – recognising that the delivery of these plans will involve further risk-sharing across health and social care budgets.

1.3 The report explains how the recently agreed Section 75 Agreement between Sheffield City Council and Sheffield Clinical Commissioning Group has brought together £271m of health and care budgets into a single pooled investment budget that the Council and the Clinical Commissioning Group will manage and prioritise together.

1.4 The report also sets out how the Section 75 Agreement will provides the legal and governance framework for quickly creating further joint ventures – meaning that we can move further budgets into the pool and / or increase the level of risk sharing between the Council and the CCG on budgets included within the pool.

2. What does this mean for the people of Sheffield?

2.1 Sheffield people have told us that it often feels like they are passed ‘from pillar to post’ between different parts of the health and care system. People also say that it is frustrating when aspects of their care and support are delayed (or uncertain) because health services and social care are debating which part of the system should pay for what element of their care and support.

2.2 Health and care practitioners on the ground speak about having to spend time dealing with multiple organisational processes and tensions between budget holders. They want to spend their time making sure people get the care and support they need to live as independently, safely and well as possible.

2.3 Managers in health and social care also want to be able to identify and pursue obviously projects that benefit Sheffield people – regardless of whether the resulting financial benefits accrue to a separate organisation.

2.4 The city’s Health and Wellbeing Board recognises the issues discussed above and has agreed that *part* of the solution is integrated

commissioning arrangements for health and care – with a single pooled health and care budget. The intention is simple: we want to focus on getting the best outcomes and services for Sheffield people whilst getting the best value for the '*Sheffield pound*'.

2.5 The potential efficiencies from working better together should also give us a much better chance of maintaining a sustainable health and care system in the face of significant local government funding cuts and increasing demand pressures.

3. Our Ambitions

3.1 Our plans to integrate our commissioning and health and care budgets are in line with the Department of Health (DH) requirements for a Better Care Fund. However, our plans 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' has created a pool of £271m.

3.2 The size of our pooled budget means that we are establishing one of the most ambitious integration programmes in England.

Strategic Aims

3.3 Our aims for our pooled budget, drawn from the city's Joint Health and Wellbeing Strategy and the Council's new Corporate Plan 2015–2018, are simple and bold:

- We want to promote good health
- We want to prevent and tackle ill health
- We want to reduce health inequalities
- We want to help more people stay independent, safe and well.

3.4 If we can achieve these aims we will improve outcomes for individuals *and* reduce the demand pressures on the health and care system – making the system more sustainable.

Plans and partnerships

3.5 Achieving our aims in the context of reducing Council budgets and significant demand pressures on health and care services will require more than the pooling of budgets. We will need ambitious, collaborative and trusting partnerships between the Council, the Clinical Commissioning Group, and public, private and voluntary sector health and care providers. We will need to work with partners on joint ventures that deliver more efficient, joined-up health and care services that genuinely focus on helping people maintain and recover their independence and wellbeing.

3.6 The shift in investment we should see over the coming years from treatment to prevention creates a real opportunity for Sheffield's many

voluntary, charitable, community and independent sector organisations. These organisations will be encouraged to use their capability and creativity to make an increasing impact – delivering services that can successfully reduce the risk of people losing their independence and wellbeing.

Risk sharing

3.7 The Section 75 Agreement between the Clinical Commissioning Group and Sheffield City Council creates a framework for pooling budgets and sharing risk. The Agreement pools £271m of health and care budgets – with any *underspend* on these budgets being retained within the pool to offset any pressures elsewhere in the pool.

3.8 The Council and the Clinical Commissioning Group do however remain responsible for the vast majority of the budgets that each has put into the pool. This means that if the overall pooled budget *overspends*, then each organisation has to find the money to balance 'their' budgets within the pool.

3.9 Currently, the only exception to this arrangement is the Independent Living Solutions (community equipment) budget. The 'joint venture' arrangement for this budget means that any overspend on this budget that isn't offset by an underspend elsewhere in the pool would be met by the Clinical Commissioning Group and the Council in proportion to the financial contribution that each organisation made to the joint venture.

3.10 The Section 75 Agreement has been designed to accommodate an increasing number of these 'joint ventures' – allowing for full risk-sharing across an increasing proportion of the overall pooled budget. We believe that this will help us better deal with the pressures on the health and care system, whilst achieving our strategic aims and really focusing on getting the most for the 'Sheffield pound'.

3.11 However, it is important that we recognise that the more 'joint ventures' we commit to as a Council, the less independent and direct control we will have over the budgets included in the pool. Decisions on varying the budgets for 'joint ventures' will need to be made *with* Sheffield Clinical Commissioning Group.

3.12 More information on the Section 75 Agreement is provided in section 4.

Links to wider devolution agenda

3.13 It is recognised that the support people need to improve or maintain their independence and wellbeing often extends beyond traditional 'health and social care' services – and to public services that are currently outside local control.

3.14 For example, there is good evidence that meaningful employment or training can make a tangible positive difference to someone's wellbeing – and reduce current and future need for formal health and care services. Currently those services do not always join up or work together as effectively as they might ideally do.

3.15 This type of thinking has led a number of organisations from across the city, supported by Government, to come together to think about how the £4.5bn that is currently spent on public services in the city each year could be invested differently to focus on:

- Achieving the best possible outcomes for people rather than fragmented agencies and budgets
- Prevention – making sure that people are given the support they need to stay healthy or the skills they need to find employment rather than relying on benefits, and reducing long term dependency on the state
- Making sure that public money is used as efficiently and effectively as possible.

3.16 To do this, some of the main public service organisations in the city have proposed that we explore the potential for all public investment in Sheffield to be combined together in a way that makes the biggest difference to the wellbeing of Sheffield people. And, this includes not only money held locally, but also budgets currently controlled by national bodies.

3.17 We therefore expect the next few years to see us increasingly move to more integrated investment, and greater control over budgets that are currently managed nationally to achieve better outcomes for local people through more joined up public services.

3.18 In health and social care, this could include:

- Increasingly pooled budgets and risk-sharing between health and care using the Section 75 Agreement as a framework
- Asking Government for more control and/or influence over national health budgets (e.g. primary care) – potentially requiring new legal frameworks and agreements with national Government and local partners (as per recent developments in Greater Manchester)
- Proposals to Government for increased devolution of budgets or rule changes to allow more intelligent investment of public money in Sheffield to achieve improved outcomes.

3.19 The current work on health and care integration should be seen as part of our journey towards genuine 'public investment reform' in Sheffield.

4. Background and Context

Section 75 Agreement

4.1 Our Section 75 Agreement ('the Agreement') with the Clinical Commissioning Group is a legally binding document that sets out the terms of our integrated commissioning. It came into force at the start of April 2015.

4.2 The Agreement details robust, fair, effective and legal mechanisms to enable us to make decisions about money and responsibilities in the pooled budget, including how much each organisation contributes and how we share any efficiency savings or financial pressures.

4.3 The Agreement 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 organisational process to a joint process.

4.4 The Agreement includes:

- 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.

4.5 Arguably the most important elements of the Agreement are those that set out how we make decisions about use of the pooled funding; how we manage and share risk – financial, reputational, and legal; and, how we place and manage contracts.

4.6 The proposed arrangements for each of these are set out below. These arrangements reflect the fact that in 2015/16, most budgets will still be managed separately whilst plans to implement single commissioning arrangements are developed further. However the arrangements also need to create the right environment for joint ventures, more collaborative working, and combined decision-making.

Proposed Funding to be covered by the Section 75 Agreement

4.7 Significant work has been undertaken by Directors and senior managers from SCC and CCG to establish the budgets to be included in our local Better Care Fund arrangements for 2015/16.

4.8 This work has been reported to the relevant Cabinet Member, through the budget process, and to members of the internal Strategic Health and Wellbeing Outcome Board, and the city's Health and Wellbeing Board.

4.9 Members will be aware of the issues, challenges and pressures faced by both organisations to established balanced budgets for 2015/16. The Agreement sets out the indicative budgets for 2015/16 as agreed within each organisation - including assumptions being made on price, demand and other pressures, and any savings agreed by SCC and CCG.

4.10 Over the last few weeks both organisations have been undertaking further work to finalise budgets for next year, and the table below gives the position at 20 April 2015.

4.11 It is intended that these are the figures included within the Agreement, but as discussed below, these figures can be changed in year with the agreement of both parties and are still subject to some marginal fine-tuning. The figures are consistent with those included in the CCG financial plan submitted to NHS England on 27 February 2015 and those agreed in the budget agreed at Full Council on 6 March 2015.

Individual Schemes	2015/16 Initial 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 (eg Care Planning)	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
Scheme 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
Scheme 2 Total - Active Support & Recovery		**49,960**

3	**Independent Living Solutions**	
	NHS Sheffield CCG	
	Community Equipment (to be included in new ICES contract)	1,925
	sub total	1,925
	Sheffield City Council	
	Equipment (to be included in new ICES contract)	887
	Equipment & Adaptation Teams	678
	Minor adaptations and Sensory Impairment Assessment (to remain outside of scope of ICES contract in 2015/16)	101
	sub total	1,666
Scheme 3 Total - Independent Living Solutions		**3,591**
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)	51,592
	Grants to SCC re Learning Disabilities services	2,650
	sub total	66,640
	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

Scheme 4 Total - Long Term High Support	**154,268**
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
Scheme 5 Total - Inpatient Medical Emergency Admissions	**52,932**
TOTAL REVENUE SHEFFIELD BETTER CARE FUND BUDGET	**270,568**
Expenditure against capital grants awarded to SCC for social care and Disability Facilities – All Sheffield City Council	**3,456**
Scheme 6 Total – Capital grants	**3,456**

4.12 The themes are described briefly below. The intention is that during 2015/16 these schemes will be developed into one or more ‘joint ventures’.

4.13 **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. This theme includes a range of Council funding including some of the grant aid budget and public health investment in services and organisations that focus on health and wellbeing.

4.14 **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).

4.15 **Independent Living Solutions**: Community equipment services have been re-commissioned as a genuinely integrated and user focussed service, which will start in July 2015. This new service is a joint venture with a fully risk-shared budget.

4.16 **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 – i.e. heath care is free at the point of delivery whilst people generally make a contribution to the cost social care.

4.17 **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.

4.18 Importantly, the Council's contribution to the pooled budget over the next few years is aligned to our **medium-term financial strategy** – meaning that our contribution will change each year in line with any reductions to our overall budget. This, along with increasing pressure on the health care system, means that balancing the pooled budget in the medium-term will be a significant challenge – a challenge that we can only meet by working closely with Sheffield Clinical Commissioning Group.

Decision Making and Governance

4.19 Neither the CCG nor SCC Constitutions allow delegation of decisions to a joint committee. It is therefore proposed that Cabinet and CCG Governing Body **retain ownership over decisions** – particularly in the first year as new ways of working are established.

4.20 The partners may of course wish to vary either the provisions in the Section 75 agreement, or the delegations to members, committees or officers, for future years if they believe that this will improve delivery of our objectives (or the national policy or legislative landscape changes).

4.21 It is proposed that **strategic oversight and direction** for decision-making remains with the city's Health and Wellbeing Board (HWB). The HWB role is to enable organisations to hold each other to account, to agree aspirations, and be the public meeting that monitors progress.

4.22 If the HWB feels insufficient progress is being made it can ask the organisations to explain to the HWB and discuss remedial action.

4.23 It is not proposed that the Council or the CCG delegates any budgetary responsibility or operational commissioning decisions to HWB. These remain within each organisation.

4.24 **No change to delegation of authority to members, committees or officers is proposed** at this stage. This means that Council Leader / Cabinet (and CCG Government body) would 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.

4.25 In many cases, aligned decision-making between the Council and CCG will be required (e.g. to approve respective contributions to a pooled budget). This means that business will need to be planned ahead carefully to enable aligned decision points at Cabinet and with the CCG's Governing Body.

4.26 The Section 75 Agreement proposes the establishment of an **Executive Management Group** (EMG), which would be responsible for day to day management of the pooled budget and Section 75 Agreement.

4.27 The EMG would meet at least monthly to monitor combined budgets, agree contract specifications, and consider business cases for future 'joint ventures'. Individuals on the Group would have Authority within their delegated limits (e.g. to make changes to budgets). Membership of the group would be equal split across the Council and the CCG, with full membership to be agreed.

4.28 The Section 75 agreement and pooled budget will develop rapidly over the year – with increased risk sharing arrangements as new joint ventures and commissioning / contractual arrangements are agreed.

4.29 A Programme Team will provide support to EMG, with project leads for each of the workstreams reporting to the Group. The Programme Director for Integrated Commissioning will be 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 the next meeting. Dispute resolution processes are set out in the Section 75 Agreement.

Risk Sharing Proposal

4.30 The basic arrangements for risk sharing are:

- There will be a single overall budget but with separate budgets within that for each 'scheme' (e.g. Active Recovery) and key areas of expenditure within that scheme (e.g. intermediate care beds)
- Budgets will be set at the beginning of the year but will be capable of being changed in year by agreement
- There will be a lead commissioner for each scheme and for the budget lines within schemes
- The overall budget and that for each scheme will be monitored by the EMG
- Any underspends on individual budgets within the pooled budget will remain within the overall pooled budget and be used to offset overspends on other budgets
- Contingency 'risk reserves' will sit outside of the pooled budgets to ensure that each organisation can cope with any financial pressures arising from the pooled arrangements.

Initial Risk Sharing Arrangements

4.31 Where a scheme is a true *joint venture* (e.g. Independent Living Solutions), there will be one budget manager and the Council and CCG will share the risk of overspend pro-rata to the initial contribution.

4.32 Where budgets for 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). This will generally apply to schemes and activities that have not yet been worked up as joint ventures.

4.33 If there is any overspend on any aspect of the pooled budget, the first call would be any underspends within the pooled budget (subject to the law or other directives that might govern use of specific funds). The second call is the use of the contingency reserves.

4.34 Further joint ventures with fully risk-shared budgets will be proposed in year and risk / gain share agreements put in place. The position agreed for the Independent Living Solutions budget (a pro-rata risk share) will be the default option.

4.35 We will make our commitment to joint working explicit to avoid actions that shift cost between partners, unless agreed as above.

Contracting and Procurement

4.36 Our contracting and procurement arrangements must, of course, be compliant with the law and other binding directives. They must support achievement of our aims, and should minimise bureaucracy. Therefore:

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

Hosting

4.37 The Council will be the host organisation for the pooled budget. During 2015/16 both organisations will lead commissioning and contracting on various budgets under their own financial governance and operational arrangements. We will make sure that we minimise

the need for unnecessary cash flow and other administrative processes between our two organisations.

Development of the Section 75 Agreement

4.38 SCC officers, led by the Director of Finance, have worked with CCG colleagues to agree the content of the Section 75 Agreement.

4.39 Initial drafting of the document was undertaken by SCC's legal team, with support thereafter from external lawyers.

5. Financial Implications

5.1 Given the nature of the Agreement, the financial implications are fairly limited and do not pose additional risk to the council beyond the 'business as usual' risk already inherent in balancing the budget during 2015-16.

5.2 There is a risk that underspends on any SCC budgets may be called upon to offset overspend on CCG managed budgets within the pool (rather than offsetting other General Fund overspends within SCC). However, this is not deemed to have major financial implications as: (a) overall underspend is considered unlikely; and, (b) the reciprocal arrangement is in place if we were to overspend.

5.3 For financial planning beyond 2015-16, the better use of pooled resources should help to alleviate budget pressures within both organisations.

6. Health Inequalities Implications

6.1 The Joint Health and Wellbeing Strategy and the Council's new Corporate Plan 2015–2018 provide the strategic framework for the pooled budget, and reducing health inequalities is a key priority in both documents.

6.2 This means that the development of new schemes and joint ventures will focus on reducing health inequalities and the pooling of budgets should therefore help to support this aim.

7. Equalities Implications

7.1 Sheffield people have told us[1] that they do not like being passed 'from pillar to post' between different parts of the health and care system. People get especially frustrated when aspects of their care and support are delayed (or uncertain) because health services and social care are debating which part of the system should pay for what

[1] The Health and Wellbeing Board has held a number of events on this theme. See https://www.sheffield.gov.uk/caresupport/health/health-wellbeing-board/what-the-board-does/events/engagementevent.html.

element of their care and support. It is expected that this work will have a largely positive impact on people of all protected characteristics as this work progresses.

7.2 Sheffield people will continue to be consulted as part of the individual schemes, if this has not already happened, and more information about the impact of specific schemes will be submitted and published with any future Cabinet reports, and any action plans required will be included in these reports. Therefore, detailed Equalities Impact Assessments will be required as a central part of all workstreams.[2]

8. Legal Implications

8.1 The Care Act 2014 provides the legal framework against which care services must be provided. The main principles of the legislation are that whenever a local authority makes a decision about an adult, they must promote that adult's wellbeing and to ensure the provision of preventative services - that is services which help prevent, delay or reduce the development of care and support needs (including carers' support needs). In seeking further integrated working with the CCG the requirements of this legislation will need to be complied with.

8.2 Under that Act a local authority must exercise its functions with a view to ensuring the integration of care and support provision with health provision and health-related provision where it considers that this would:

- Promote the wellbeing of adults in its area with needs for care and support and the wellbeing of carers in its area
- Contribute to the prevention or delay of the development by adults in its area of needs for care and support or the development by carers in its area of needs for support; or
- Improve the quality of care and support for adults, and of support for carers, provided in its area (including the outcomes that are achieved from such provision).

8.3 The arrangements for integration are included in a legal agreement under s75 National Health Services Act 2006. As outlined this agreement sets the framework for integrated commissioning and was approved by the Leader of the Council on 26 March 2015.[3]

8.4 Unless there are specific delegations of functions in the future each of the Council and the CCG will retain liability for delivering its own legal functions under the arrangements.

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[2] An EIA has already been submitted for Independent Living Solutions See http://sheffielddemocracy.moderngov.co.uk/documents/s15634/Indpendent%20Living%20Solutions%20EIA.pdf. An EIA has also been completed for the Keeping People Well in their Community work.

[3] A record of this decision is available at: http://sheffielddemocracy.moderngov.co.uk/ieDecisionDetails.aspx?ID=1323.

9. Recommendation

9.1 Cabinet supports the increased joining up the work of the Clinical Commissioning Group and Sheffield City Council so that our pooled health and care budgets can be used to commission better, more joined-up health and care services that help more people stay independent, safe and well.

10. Reasons for Recommendation

10.1 Increased pooling of budgets and aligned incentives between health and care services should enable:

- The development of more joined-up health and care services - Sheffield people do not want to be passed from ‘pillar to post’.
- Frontline staff and managers in health and care services to spend less time on managing the system and more time on supporting Sheffield people to improve their health and wellbeing.
- Increased investment in preventative services – helping more people in Sheffield stay independent, safe and well.
- Improved medium-term planning for the health and care system as a whole – helping Sheffield cope with increased demand for health services and reduced levels of Local Government funding.

10.2 Achieving these benefits will require us to enter into a closer, strategic partnership with Sheffield Clinical Commissioning Group. The terms of this partnership are as set out in the Section 75 Agreement.

10.3 The Section 75 Agreement is designed to allow us increase the depth of our partnership and the level of risk-sharing with Sheffield Clinical Commissioning Group incrementally. Proposals for further joint ventures will however be taken forward within the Council’s decision-making processes.