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Report of:	*Executive Director of People Services Portfolio*
Report to:	*The Leader and Cabinet*
Date of Decision:	*20 March 2019*
Subject:	*Joint Commissioning for Health and Social Care*

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

Purpose of Report:

This Report updates the Leader on progress to date on delivering the Sheffield City Council and Sheffield Clinical Commissioning Group's (SCCG) integrated commissioning agenda and sets out a proposal for enhancing the governance arrangements. These enhanced arrangements are designed to ensure that commissioners have a truly joint approach to commissioning in a way that secures the transformational change that is required to realise our ambitions.

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

The recent Care Quality Commission (CQC) Local System Review, and the CQC / OFSTED SEND inspection recognised that some good, preventative interventions are happening, but at neither scale nor pace and thus there is more to do to scale up our response in the community and primary care to keep people as well as possible and reduce the need for more acute services. This in turn will drive a different system and balance of investment across the system.

We have not yet achieved our stated goal of greater emphasis on prevention at all levels of complexity. The main purpose of the joint commissioning committee is to ensure we maintain a focus on a preventative model that aims to keep people living independent, healthy, active lives is what is required to sustainably reduce demand for hospital care and ensure that Sheffield remains a healthy and successful city.

Recommendations:

The Leader and Cabinet are recommended to:

- Note the progress made to date on joint commissioning and the proposals for future joint commissioning
- Endorse the objectives, principles and priorities for joint commissioning set out in this Report

The Leader is recommended to:

- Agree to 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.

Background Papers:

none

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<tr><th colspan="3">Lead Officer to complete:-</th></tr>
<tr><td rowspan="3">1</td><td rowspan="3">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.</td><td>Finance: Liz Gough</td></tr>
<tr><td>Legal: Gill Duckworth</td></tr>
<tr><td>Equalities: Bashir Khan</td></tr>
<tr><td></td><td colspan="2">Legal, financial/commercial and equalities implications must be included within the report and the name of the officer consulted must be included above.</td></tr>
<tr><td>2</td><td>EMT member who approved submission:</td><td>Jayne Ludlam</td></tr>
<tr><td>3</td><td>Cabinet Member consulted:</td><td>Cllr Chris Peace, Cllr Jackie Drayton, Cllr Olivia Blake, Cllr Lewis Dagnall</td></tr>
<tr><td rowspan="3">4</td><td colspan="2">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 Decision Maker by the EMT member indicated at 2. In addition, any additional forms have been completed and signed off as required at 1.</td></tr>
<tr><td>Lead Officer Name:
Greg Fell</td><td>Job Title:
Director of Public Health</td></tr>
<tr><td colspan="2">Date: (Insert date)</td></tr>
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1. PROPOSAL

1.1 What are the problems?

1.1.1 People in Sheffield are more likely to be admitted to hospital than in other cities. And are more likely to stay for longer than they need to. Even people whose main need is for social support to help with physical activities of daily living, assistance in relation to their wider lives (including housing, benefit advice, recreational activities etc.) or mild to moderate illness, often end up admitted to hospital when the community proves ill-equipped to meet their needs, particularly in emergencies. Once in hospital, our data tells us that people stay too long and we know Sheffield needs to improve around delayed transfers of care by better supporting the earliest possible discharge. Long stays leads to higher risk of functional decline for individuals, leave services overwhelmed and is financially unsustainable. In short, our current system shape means too many people need to go into hospital, and stays are too long. We need to do more to develop a joined up approach to prevention across the city.

1.1.2 This is also an inequalities issue. This problem is seen more frequently in deprived communities, where inequitable access to preventative, primary and community care services results in a higher rate of emergency hospital admissions.

1.1.3 Children and Young People with Special Educational needs are not achieving the outcomes that we would expect. We jointly face significant challenges outlined in the Ofsted/CQC local area inspection report published in January 2019. The report highlights commissioning as one of seven significant weaknesses; specifically the need to “remove variability and improve consistency in meeting the education, health and care needs of children with SEND”. The report also identifies strategic oversight of SEND at the CCG and multi-agency transition arrangements as significant weaknesses.

1.2 What is already in place?

1.2.1 How we work together to commission health and care services

1.2.1.1 Good work is already happening in Sheffield. We already work closely with colleagues in the Clinical Commissioning Group (CCG) to jointly plan and deliver a range of programmes to help people stay out of hospital and to support them to recover quickly if they do need to be admitted. These include People Keeping Well, Active Support and Recovery, Ongoing Care and Mental Health Programmes. In 2014 our joint Better Care Fund (BCF) Plan set out the following ambitions:

- Ensure service users have a seamless, integrated experience of care, recognising that separate commissioning can be a block to providers establishing integrated services.
- Achieve greater efficiency in the delivery of care by removing duplication in current services.

- Be able to redesign the health and social care system, reducing reliance on hospital and long term care so that we can continue to provide the support people need within a reduced total budget for health and social care.

1.2.1.2 Our current pooled budget was set so that it includes all our current expenditure on four areas of citizen's need, focussing on those at risk of admission and those for whom there is the greatest opportunity for health outcomes improvement:

- People keeping well in their communities - incorporating GP care planning, focussed on preventing avoidable crises.
- Independent living solutions - recognising the current joint commissioning arrangements for community equipment and the opportunities presented by the expiry of the current contract
- Active Support and Recovery services (intermediate care) - to improve the range and efficiency of out of hospital step up and step down services, to reduce admissions to hospital and support reablement, reducing admissions to long term care.
- Long term high support care - integrating our assessment, placement, quality management and contracting processes to ensure a shared focus on achieving the most effective care for people, and avoiding the unproductive cost shift between health and social care that has often characterised approaches to achieving savings as single organisations.

1.2.1.3 In addition, we included the NHS expenditure on non-surgical emergency admissions so that the savings released from that budget can enable us to invest in the above commissioning projects.

1.2.1.4 However, our joint commissioning of the BCF has not yet achieved its full ambition, with joint opportunities not being fully taken advantage of.

1.2.1.5 NHS partners and the Council have stated their shared intentions to develop services that support the move towards a more integrated health and social care system to improve outcomes for Sheffield people. This is reflected in Sheffield's Place Based Plan, known as Sharing Sheffield (previously Shaping Sheffield). This plan describes the need to work collaboratively across agencies to achieve the best possible outcomes for individuals, supporting people to keep well and helping people with increased support needs to live as independently as possible, as well as ensuring the long-term financial sustainability of the health and care system in Sheffield.

1.2.1.6 In 2017 the Sheffield Accountable Care Partnership (ACP) was established, to take forward the ambitions of the Sharing Sheffield plan. The ACP is a collaboration between Sheffield City Council, NHS Sheffield Clinical Commissioning Group, Sheffield Children's NHS Foundation Trust, Sheffield Teaching Hospitals NHS Foundation Trust, Sheffield Health and Social Care NHS Foundation Trust, Primary Care Sheffield Ltd and the voluntary and community sector).

1.2.1.7 The ACP vision is as follows:

> *"Improving the health and wellbeing of Sheffield's residents through the promotion of a health and wellbeing culture in all we do and the development and delivery of a world class health and care system"*

1.2.1.8 Sharing Sheffield will be refreshed for April 2019 following considerable consultation. Specifically the partners have outlined their intent to:

- Deliver tangible improvements in local health and wellbeing
- Tackle persistent health inequalities
- Ensure the sustainability of the Sheffield care economy
- Support a happy, motivated and high-performing workforce
- Improve public engagement and empowerment

1.2.2 Health and Care services – areas of priority focus for commissioning

1.2.2.1 There are three areas of proposed initial focus; frailty, those with special educational needs and mental health. Proposals for investment or service improvement are being developed in each of these three areas. These are directly linked to the CQC System Review (older people), the CQC / OFSTED inspection (SEND) and our existing joint commissioning for mental health. These proposals are not covered in this Report, but there will be wide consultation prior to any change being made. All proposals will be based on the broad principles set out below (1.3).

1.3 What are our plans?

1.3.1 Shared Vision for Joint Commissioning

1.3.1.1 Our shared aspiration is to improve health outcomes and inequalities for Sheffield people. To do this, we will strengthen the way that we jointly commission health and care between SCCG and the Council. Joint Commissioning will focus on:

- Whole system change
- Giving a single commissioner voice
- Single commissioner plan
- Ensuring new models of care deliver the outcomes required by the city
- Building on the existing Better Care Fund Section 75 NHS Act 2006 to drive forward change

1.3.1.2 This would be based on the following principles:

- A preventive model built into delivery at all levels of complexity
- Care closer to home or a home via neighbourhood, localities hubs
- Reduced health inequalities in Sheffield
- Person centred commissioning joined up with placement and brokerage
- Effective and efficient use of resources whilst assuring safe and

effective standards of service
- Collective management of risks and benefits
- A democratic voice at the forefront of commissioning.

1.3.1.3 Our objectives are to create:
- A single health and social care commissioning plan to create a shift of investment from acute services to preventative services
- An approach to a financial framework based on a capped risk-share budget
- A joint committee that has oversight of commissioning arrangements made up of Cabinet and CCG governing body members.

1.3.1.4 Within this, our priorities for 2019/2020 will be:
- To develop a service improvement framework for frailty and invest in preventative interventions within a risk sharing arrangement
- To develop a partnership approach to SEND, in the context of the Ofsted / CQC inspection and local required outcomes and resources; and
- To consolidate and build on our integrated mental health work.

1.3.1.5 The areas of scope listed above are based on immediate and pressing priorities, and are also well aligned with long term strategic goals. The scope is aligned around interventions and service flow, rather than organisational form and contractual models between organisations.

1.3.2 The new Joint Commissioning Committee and governance arrangements

1.3.2.1 It is recommended that a new joint committee will be created which will steer the development of a single approach to commissioning. It is proposed that the committee will be made up of 4 Cabinet Members and 4 members of the CCG Governing Body. It is hoped that the committee could be established by April.

1.3.2.2 It is envisaged that the committee will develop proposals for appropriate engagement of people/public, service providers and all relevant stakeholders and oversee a single health and social care commissioning strategy focused on the principles set out above. It is also envisaged that the committee will steer the development of new commissioning plans in the priority areas outlined above. It is anticipated that the work of the committee will be in sync with work being developed within the Accontable Care Partnershp.

1.3.2.3 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.

1.3.2.4 This proposal will enable us to respond more effectively to the challenges given to us by both the CQC system review and the CQC / OFSTED inspection. There is also a direct link to the Sheffield Health and Well Being Strategy and the aspirations set out in Sharing Sheffield.

1.3.2.5 The proposal will continue to build on our existing stated priorities and our joint commitments within the BCF. 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.

1.3.2.6 The new committee with work with and complement existing arrangements such as the Health and Wellbeing Board and Accountable Care Partnership.

1.3.2.7 Further development of more integrated commissioning, potentially with provider organisations in a similar arrangement to mental health, can be considered as a future development, if this will lead to greater potential of more integrated commissioning to improve outcomes for people. An arrangement like this would ensure collective ownership of risks and opportunities with provider organisations. Any proposals of this kind will be subject to separate decision making.

1.3.3 Commissioning arrangements for Health and Social Care

1.3.3.1 It is likely NHS England, through the Long Term Plan will seek to significantly 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 significant place based orientation of commissioning of NHS and social care.

1.3.3.2 An updated shared commissioning plan will be developed, initially focussing on frailty but eventually moving to all age services including SEND, mental health and learning disability services. It is intended that the Better Care Fund s75 agreement will be updated to reflect this updated commissioning plan and that it will then come within the oversight of the new joint committee.

2. HOW DOES THIS DECISION CONTRIBUTE ?

2.1 The proposals directly align with each of the current Health and Well Being 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.

2.2 In addition the proposals align to the direction of travel in the following areas of the '**NHS Plan January 2019**

1. 'We will **boost 'out-of-hospital' care**, and finally dissolve the historic divide between primary and community health services.
2. The NHS with partners will **redesign and reduce pressure on emergency hospital services.**
3. Improving **upstream prevention** of avoidable illness and its exacerbations. E.g. smoking cessation,
4. Local NHS organisations will increasingly **focus on population health** and local partnerships with local authority-funded services, through new Integrated Care Systems (ICSs) everywhere.'

3. HAS THERE BEEN ANY CONSULTATION?

3.1 There is no duty to consult arising from the proposal to establish a joint committee. Consultation on future proposals for new or revised services will be carried out on a case by case basis as appropriate and informal consultations have already been taking place with provider organisations, Healthwatch and others. HealthWatch are involved in both the ACP and the Health and Wellbeing Board and so will be consulted via those routes.

4. RISK ANALYSIS AND IMPLICATIONS OF THE DECISION

4.1 <u>Equality of Opportunity Implications</u>

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 commission arising from the joint commissioning plan.

4.2 <u>Financial and Commercial Implications</u>

4.2.1 The Council and NHS partners work together as a whole system to ensure that funding can serve Sheffield's population effectively This incorporates achieving the strategic shift to prevention that all partners see as the key change required to improve health and wellbeing as well as making the best use of available resources.

4.2.2 As outlined above the current health and social care system has a higher rate of admissions to hospital and individuals are having longer stays once there. This puts pressure on the system. Work in year has been to provide

better balance in the work on expediting discharge – acknowledging the admission prevention work has been not been adequately addressed across the system – and needs to do more to keep people as well as possible in their own communities and homes

4.2.3 This means that significantly greater cost is being incurred that previously envisaged by the Council on community arrangements to support discharge from hospital. Increasing demand is creating pressure on all organisations and it is acknowledged we need to address this. The budget book sets out the SCC financial pressures clearly. The broad approach to managing financial risk that will be established is of joint commissioning to minimise financial risk to all partners. In each of the three areas of focus the financial issues are different but the approach is to minimise risk, including across the provider sector as financial stability of providers is important to all parties. Individual schemes and broader programmes will be assessed for financial impact as is standard current practice.

4.2.4 Short term investment funding will be required to enable Council and NHS partners to redirect to focus on spending on prevention to ensure a sustainable health and social care system. Current local delivery plans show that social care will still require c.£10m funding from Council reserves to balance. The proposed financial risk share agreement that will underpin the integrated commissioning plan will enable the health and social care organisation to address the need for system wide change. .

4.2.5 As we consider the different interventions described at section(s) 1.3.3 there are several ways that these interventions could be paid for. These include:

- Using existing spending differently within the Sheffield health and care system;
- Using one off money from within the Sheffield health and care system,for example, improved BCF (iBCF) money,
- Seeking new, one-off money from beyond Sheffield (for example, from the Integrated Care System for South Yorkshire & Bassetlaw; from NHS England; or other funding bodies);
- Seeking social investment arrangements, whereby money is raised to provide finance for interventions in the Sheffield health and care system and the organisations within it – and repaid if pre-agreed outcomes are delivered.

4.2.6 Some of the above financing methods (one-off monies and social investment) have the advantage of providing '*double-running*' investment. This means, money that pays for new or different services in anticipation of subsequent reductions of demand which – in turn releasing spending to allow for sustainment of the new service model.

4.2.7 At this stage, and as more detailed and costed implementation and spending plans are being developed, we propose to keep all these options on the table.

4.2.8 We may seek to work with external organisations to help us develop these implementation plans, ideally at low or zero cost.

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.

4.4 Other Implications

4.4.1 There are no other implications arising directly out of the decisions recommended by this Report.

5. ALTERNATIVE OPTIONS CONSIDERED

5.1 **Do Nothing**

The Council is forecasting increasing funding pressures in the short-term and longer term forecasts predict a £61m funding gap by 2023 for SCC. Without social care, hospital discharge will suffer dramatically, beds will become unavailable for those who need them and NHS costs will rise. Business as usual is, therefore, not a realistic option, although it is important to recognise that it will be the default position unless we take action. The aim of developing joint risk sharing is to ensure there is a shared approach to risk and benefit sharing, recognising that doing nothing also carries financial risks, and these are set out below.

5.2 **SCC Delivers statutory responsibilities only**

A second option would be for SCC to focus solely on statutory responsibilities, removing discretionary support (such as STIT, People Keeping Well etc.) in order to address the immediate financial challenge. This would have dramatic effects on the people of Sheffield, leaving its most vulnerable residents unsupported. The impact on partner, NHS organisations would rapidly lead to financial failure and then inevitably, to very poor outcomes for individuals, which would include avoidable deaths. It would also lead to subsequent failure for SCC, as our budgets became more and more focused on dealing with more and more acute demand for services.

5.3 **Alternative Joint Commissioning Model**

The possibility of a model where one provider had responsibility for all provision was considered. However, it is not recommended that this option is actively considered at this time. The legal and structural changes that would be required to facilitate this model mean that progress would be much slower than with the proposed arrangements. In addition there is a risk that structural integration – where separate organisations merge to

form a new organisation – could become the main focus rather than better coordination and integration of services.

6. REASONS FOR RECOMMENDATIONS

6.1 Learning from other authorities suggests that significant progress can be made against downstream outcomes, at the same time as having a measurable impact on overall budget positions, by adopting different approaches to governance, management models, commissioning arrangements and delivery priorities, focussing on early intervention and prevention, by taking an asset-based approach

6.2 The health and social care system in Sheffield must create a shift towards delivering better outcomes for people, via a more preventative approach that supports individuals to remain as well as possible within communities, and reduces the population need for acute care, with a particular emphasis on reducing inequalities in acute need. The recommended approach will provide the basis for this shift.