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COMMISSIONING PARTNERSHIP BOARD

Date	Thursday 30 August 2018
Time	12.30 pm
Venue	Crompton Suite, Civic Centre, Oldham, West Street, Oldham, OL1 1NL
Notes	1. DECLARATIONS OF INTEREST- If a Member requires any advice on any item involving a possible declaration of interest which could affect his/her ability to speak and/or vote he/she is advised to contact Paul Entwistle or Elizabeth Drogan in advance of the meeting.

2. CONTACT OFFICER for this Agenda is Liz Drogan Tel. 0161 770 5151 or email Elizabeth.drogan@oldham.gov.uk

3. PUBLIC QUESTIONS – Any member of the public wishing to ask a question at the above meeting can do so only if a written copy of the question is submitted to the Contact officer by 12 Noon on Friday 24th August 2018.

4. FILMING - The Council, members of the public and the press may record / film / photograph or broadcast this meeting when the public and the press are not lawfully excluded. Any member of the public who attends a meeting and objects to being filmed should advise the Constitutional Services Officer who will instruct that they are not included in the filming.

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Recording and reporting the Council's meetings is subject to the law including the law of defamation, the Human Rights Act, the Data Protection Act and the law on public order offences.

MEMBERSHIP OF THE COMMISSIONING PARTNERSHIP BOARD IS AS FOLLOWS:
Councillors Chadderton, Chauhan, Fielding and Shah
Majid Hussain Lay Governing Body Chair CCG (Chair)
Ben Galbraith Chief Finance Officer CCG
John Patterson Chief Clinical Officer CCG
Ian Milnes Deputy Chief Clinical Officer CCG

NHS
Oldham
Clinical Commissioning Group

Oldham
Council

Item No

1 Election of Chair

The Panel is asked to elect a Chair for the duration of the meeting.

2 Apologies For Absence

3 Urgent Business

Urgent business, if any, introduced by the Chair

4 Declarations of Interest

To Receive Declarations of Interest in any Contract or matter to be discussed at the meeting.

5 Public Question Time

To receive Questions from the Public, in accordance with the Council's Constitution.

6 Minutes of the Commissioning Partnership Board held on 26th July 2018 (Pages 1 - 4)

7 S.75 Agreement (Pages 5 - 10)

S.75 agreement to follow.

8 Domiciliary Care Commissioning (Pages 11 - 28)

9 Revised Commissioning Partnership Board Terms of Reference (Pages 29 - 44)

NHS
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Clinical Commissioning Group

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Council

COMMISSIONING PARTNERSHIP BOARD
26/07/2018 at 12.30 pm

Present: Councillor Chauhan (Chair)
Councillor Chadderton, Dr Andrew Vance GP Governing Body Member North Cluster, Graham Foulkes Deputy Chair of CCG Commissioning Committee and Lay Member, Ben Galbraith Chief Finance Officer CCG

Also in Attendance:

Dr. Mudiyur Gopi	Hospital Consultant Representative
Nadia Baig	Director of Performance and Delivery
Rebekah Sutcliffe	Strategic Director of Reform
Carolyn Wilkins OBE	Chief Executive / Accountable Officer
Liz Drogan	Head of Constitutional Services
Nicola Boaler	Senior Executive Secretary

1 **ELECTION OF CHAIR**

The meeting was opened and adjourned for fifteen minutes as there was no quorum present.

The meeting was reconvened at 12.45pm, notwithstanding the absence of quorum, those members present could proceed to discuss the business on the agenda.

RESOLVED – That Councillor Chauhan be elected Chair of the Commissioning Partnership Board for the duration of the meeting.

2 **APOLOGIES FOR ABSENCE**

Apologies for absence were received from Councillors Fielding and Shah, Majid Hussain, Dr Ian Patterson, Dr Ian Milnes.

3 **URGENT BUSINESS**

There were no items of urgent business received.

4 **DECLARATIONS OF INTEREST**

There were no declarations of interest received.

5 **PUBLIC QUESTION TIME**

There were no public questions received.

6 **MINUTES OF THE COMMISSIONING PARTNERSHIP BOARD HELD ON 28TH JUNE 2018**

RESOLVED – That the minutes of the Commissioning Partnership Board held on 28th June 2018 be approved.

7 **INTEGRATED CRISIS SAFE HAVEN AND HOME TREATMENT TEAM**

The Board gave consideration to a report of Dr Keith Jeffrey, Clinical Director for Mental Health and Gary Flanagan, Senior Commissioning Business Partner (CCG) which sought support of the recommendations to approve the business case proposal as set out in the report, for the Oldham allocation of Greater Manchester funding to support enhanced adult crisis and urgent care options.

It was reported that the proposal was for a Crisis Safe Haven service, based at Forrest House, located at the Royal Oldham site, with integrated Home Treatment Team support.
The service would be developed based on the existing home treatment resource, with practitioners being available from 4pm to review any referral information and take a handover from core mental health services.
Initially the service would be provided overnight from 6pm to 9am, 5 nights a week.

The service would support people who may experience a mental health crisis overnight, either known to secondary care services already or referred by RAID following presentation at A&E.
The days of operation were to include the weekend however the heat map as detailed within the report showed a higher number of admissions mid-week and therefore the proposed days for the Crisis Safe Haven may need to be reviewed.
The Home Treatment team did operate over a 7 day period until 9pm in the evening however the 5 Year Forward View for Mental Health asserted that a 24/7 service was required to save lives by reducing suicide.

It was acknowledged that the Safe Haven could not be directly accessed by someone not previously known to mental health services or someone without a current risk assessment or care plan. The initial mental health assessment and risk evaluation would need to be completed by the RAID practitioner in A&E.
It was further noted that and that known secondary care users could self-refer and access the safe haven directly out of hours without attending via A&E.

The report had been considered by the Finance and Contracts Committee on the 19th July 2018 and the business case was recommended to the Commissioning Committee subject to the following:

- The uncommitted funding from within Oldham's Mental Health Transformation Fund allocation for crisis care could be utilised at the discretion of the Senior Commissioning Business Partner and Clinical Director for Mental Health to understand:
  - How the model could include additional non-medical support through integration with voluntary and third sector partners;
  - Whether there was flexibility to scale the service up to 7 days;
- Agreement between the CCG and the Trust on how and when funding would be transferred i.e. Funding for actual costs incurred up to the agreed financial envelope
- Adjustment to the costings to recognise overheads should not be included in transformation funded schemes.
- Agreement of a schedule of KPIs and outcomes to ensure the service was delivering on the objectives set put in the business case around admission avoidance and deflections.

Members welcomed the report and made a number of observations/comments including:

- Providing an equivalent service for young people and children
- The definition of 'known user' needed to be clear
- The use of social prescribing within the model
- Request for further information on out of Borough placements
- Request for further information on number of patients under 18 with Mental Health issues, presenting at A&E
- Request for further information in relation to the overall offer
- Primary Care links when user is classed at DNA and file closed
- Request for information on projected numbers using the safe haven
- Request for early sight of proposed business cases for all Members of the Board, to enable comment and contribution before final decision is made.
- List of Committees any business case presented to the Board has been considered by.
- Request that an 'idiots guide' was produced which provided details of the offer.

Options/Alternatives considered

Do nothing – This was not an option as it was likely to increase costs to the CCG through increasing A&E attendances and inpatient admissions and the GM funding had been allocated to develop crisis care options for out of hospital. If the business case was not accepted an alternative proposal would be required.

RESOLVED – That the Commissioning Partnership Board supported the approval of the Business case for the Oldham allocation of GM Crisis Care Funding: Integrated Crisis Safe Haven and Home Treatment Team.

The meeting started at 12.30pm and ended at 1.21pm

Commissioning Partnership Board Report

Decision Maker:	Executive Member Councillor Z Chauhan, Cabinet Member for Health and Social Care
Date of Decision:	30 August 2018
Subject:	Approval of S75 Partnership Agreement
Report Author:	Gioia Morrison – Finance Manager Ext 4491
Officer Contact:	Anne Ryans, Director of Finance

Reason for the decision:

To approve the signing a S.75 notice between the Council and the CCG that will enable and encourage closer working and a more integrated approach.

Summary:

The partners have carried out consultations on the proposals for Pooled Funds and commissioning arrangements under the Section 75 Agreement with those persons likely to be affected by the arrangements.

What are the alternative option(s) to be considered? Please give the reason(s) for recommendation(s):

Approve the signing of the S.75 Partnership Agreement to enable closer working between Oldham MBC and Oldham CCG.

Continue with the current agreement and update the schedules in line with inflation and budget adjustments. This would enable us continue to pool the BCF, iBCF and Community Equipment Fund but would not reflect our ambition as a health economy.

Do nothing. This would mean that we would be operating with an out of date S.75 in respect of the BCF, iBCF and Community Equipment Fund.

Recommendation(s):	To approve the signing of an updated S.75 Partnership Agreement.

Implications:

*What are the **financial** implications?*	The financial implications of the preferred option are significant for both organisations because each partner would be committing significant funds to the various pools. The precise figures for each partner's contribution are included in the Schedule to the Section 75 Agreement to be presented at the CPB meeting. However, the majority of the fund will be held within the pooled aligned budget. Each partner will maintain control of its contribution to the pooled aligned budget but this has to be done in liaison with the other partner. The amounts to be pooled by each partner will amount to a total of circa £148m.
What are the ***procurement*** implications?	None.
*What are the **legal** implications?*	Oldham Council and Oldham CCG have both sought separate external legal advice in relation to the preparation of the section 75 Agreement to be presented to the board for approval. Senior representatives from both partner organisations have participated in the negotiations to ensure that each party has agreed the content of the pooled budgets and the pooled aligned budgets, the decision making processes for each organisation and the risk sharing profile for each area of spend. (Elizabeth Cunningham Doyle.)
*What are the **Human Resources** implications?*	None
***Equality and Diversity Impact Assessment** attached or not required because (please give reason)*	The commissioning decisions to be taken under the auspices of the Section 75 Agreement will be subject to Equality Impact Assessments to address the impact upon individuals with protected characteristics.
*What are the **property** implications*	None

Risks:

The Section 75 Agreement sets out the framework and the arrangements for risk sharing, liabilities and insurance and indemnities and the governance arrangements. Subject to Legal colleagues being satisfied that the appropriate process has been undertaken, it is understood that failure to approve the agreement, may hinder the delivery of benefits arising from closer working between Oldham MBC and Oldham CCG.

(Jane Whyatt)

Has the relevant Legal Officer confirmed that the recommendations within this report are lawful and comply with the Council's Constitution/CCG's Standing Orders?	Yes
Has the relevant Finance Officer confirmed that any expenditure referred to within this report is consistent with the S.75 budget?	Yes
Are any of the recommendations within this report contrary to the Policy Framework of the Council/CCG?	No

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Reason why this Is a Key Decision

(1) to result in the local authority incurring expenditure or the making of savings which are, significant (over £250k) having regard to the local authority's budget for the service or function to which the decision relates; or

The Key Decision made as a result of this report will be published within **48 hours** and cannot be actioned until **five working days** have elapsed from the publication date of the decision.

This item has been included on the Forward Plan under reference CPB-01-1819.

List of Background Papers under Section 100D of the Local Government Act 1972:

Title	Available from
Section 75 Partnership Agreement and Schedules	

Report Author Sign-off:	
Date:	

Please list any appendices:-

Appendix number or letter	Description
	2018/19 S75 Agreement

1. **Background**

1.1 Oldham Council and Oldham CCG have been working towards an integrated health and social care system for a number of years. This has been limited in scope financially to pooling budgets around the Better Care Fund (BCF)/improved Better Care Fund (iBCF). In the autumn of 2017 at a meeting of the Integrated Commissioning Partnership Board, Oldham Council and Oldham CCG both agreed to pool the commissioning elements of budgets to increase the scope of the integrated delivery of services, to reduce duplication and get the best value for money from the Oldham pound. The elements of the budgets which were agreed to be included in the pooled budgets were the commissioning of individual placements for service users, domiciliary care, mental health, learning disability and older people services.

1.2 In addition as a borough, Oldham has successfully bid for £21.3m Transformation Funding from Greater Manchester Health and Social Care Partnership. Although this funding has to be paid directly to the CCG the money relates to spend for both OMBC and the CCG. As a consequence the Transformation Fund is being incorporated into the S75 Partnership Agreement.

1.3 A S.75 Partnership Agreement is made under the provisions of Section 75 of the National Health Service Act 2006 and enables funds to be pooled between the CCG and the Local Authority. However, there are two distinct types of pools within this agreement.

1.4 Pooled Budget – This is a fund where both partners pay in to the pooled fund and the money is hosted by one of the partners and the decision on how to spend is delegated to that partner. The Community Equipment budget and the Transformation Fund are both Pooled Budgets hosted by the Council and the CCG respectively.

1.5 Pooled Aligned Budget – This is a fund where each respective partner keeps control of its own contributions and spend. Instead decisions are taken in collaboration with the partner to maximize impact and reduce duplication. Currently the BCF, iBCF budgets are all pooled aligned budgets. The intention is for the commissioning budgets referred to in paragraph 1.1 above to be pooled aligned budgets.

2 Current Position

2.1 As stated a S.75 Agreement is currently in place that incorporates the Better Care Fund (BCF) and the Community Equipment Store. This was updated to reflect the introduction of the improved Better Care Fund (iBCF) in 2017 but does not reflect the figures for the current financial year or the increased ambition to jointly commission individual placements, mental health services, packages of domiciliary care and learning disability services. However, it does not align to the new governance structures of Oldham Cares. Therefore a new s.75 Partnership Agreement has been drawn up to address these issues.

3 Proposals:

3.1 Approve the signing of the S.75 Partnership Agreement to enable closer working between Oldham MBC and Oldham CCG.

3.2 Continue with the current agreement and update the schedules in line with inflation and budget adjustments. This would enable us continue to pool the BCF, iBCF and Community Equipment Fund but would not reflect our ambition as a health economy.

3.3 Do nothing. This would mean that we would be operating with an out of date S.75 in respect of the BCF, iBCF and Community Equipment Fund.

4 Conclusions:

4.1 Option 3.1 is the preferred option as this allows us to align our work more closely and reflects both organisations' current risk appetite. It would also make it relatively simple to increase the areas the two parties want to pool in the future.

4.2 The signing of the Section 75 Partnership Agreement by Oldham Council and Oldham CCG demonstrates the commitment of the partners to the co-operative agenda within the borough.

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Commissioning Partnership Board/Commissioning Committee Report

Decision Maker	**Cabinet Member for Health and Social Care: Cllr Z Chauhan and Dr John Patterson**
Date of Decision:	**30th August 2018**
Subject:	**Domiciliary Care Commissioning**
Report Author:	**Vicky Walker/Victoria Wood**

Reason for the decision:

To agree the Joint Commissioning Framework for Domiciliary Care from April 2019

Summary:

The purpose of the report is to agree the options for the procurement of domiciliary care services in Oldham across health and social care

What are the alternative option(s) to be considered? Please give the reason(s) for recommendation(s):

The options are:

1. Procurement framework
    a) To procure all domiciliary care services under one overarching dynamic purchasing system (including health and children's). These will be separated into 4 lots: standard care based in each of the 5 clusters, extra care housing, health and complex care; children's social care
    b) To procure each service separately under separate tender arrangements

Option a) is recommended for reasons of efficiency and consistency. As a dynamic procurement system we can add new providers onto the framework and the light touch arrangement allow us to call off the framework when required.

2. The procurement strategy -

a) We procure two main providers for standard adult care within each cluster, one borough wide provider for extra care, and specialist providers for complex care and children's
b) We procure all provision on a cluster based approach on a standard framework

Option a) is recommended as it allows for the work to be divided across 10 providers for adult social care which allows providers to deliver locally at volume. The more specialist provision will be delivered by specialist providers providing consistency in more complex cases and environments.

3. Contract length:

a) 5 years or
b) 5 years, plus an option to extend for a further 2 years

Option b) is recommended to ensure stability in the market, and allow us to work with providers to bed in changes related to cluster based working and integration. The Council will retain the ability to vary or serve notice within the contract term.

4. Payments:

a) We continue to pay providers the annually agreed fee rates for core wellbeing and individual hours. Individual hours will be reconciled on a regular basis against actual delivered hours.

Recommendation(s): *See above recommended options/decision*

Implications:

*What are the **financial** implications?*

As highlighted earlier in the report the spend for domiciliary care services fluctuates daily dependent on need. We can provide an estimated pocket of spend benchmarked against previous years spends.

For care at home services delivering approximately 606,000 hours of care per year to over 1,000 individuals at an estimated cost of £9 million per annum.

For Oldham CCG Continuing Health Care for the provision of social, personal and nursing care for adults, children and young people 4,000 hours of care per annum to approximately 50 individuals at a cost of approximately £70,000.

For Extra Care Housing Services there is approximately 105,000 commissioned hours of care per annum at an approximate annual cost of £1.5 million.

Children's Domiciliary care services commission approximately £600,000 of care.

What are the ***procurement*** implications?

Strategic Sourcing supports the options in this report regarding appointing 2 lead providers per cluster for Care at Home and 1 lead provider for Extra Care. Given the nature of the services that are being procured in this commission, and the challenges within the market, Strategic Sourcing is currently undertaking an analysis with regards to the suitability of implementing a Dynamic Purchasing System utilising the flexibilities afforded by the Light Touch Regime. Strategic Sourcing will work with the services to develop a system for allocating care packages from the back up list that is in accordance with procurement obligations such as value for money and equal treatment.
Neil Clough, Sourcing & Contracts Consultant. 12th July 2018.

*What are the **legal** implications?*

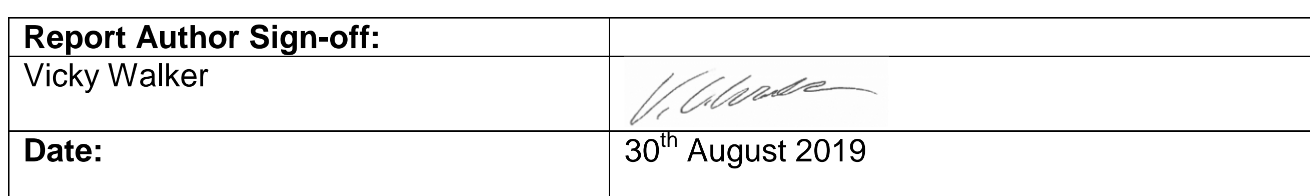
The Council has decided to use the flexibility afforded to it by the Public Contracts Regulations 2015 under the Light Touch Regime using a Dynamic Purchasing System DPS) to procure providers for the various lots outlined in the body of the report. A DPS has the advantage of allowing providers to join the system throughout the life of the contract. This has the advantage of enabling the Council to meet its duties under the Care Act 2014 to develop the market and actively manage

	market failure. **(Elizabeth Cunningham-Doyle)**
*What are the **Human Resources** implications?*	Although there are no staffing implications for the Council, there will be staffing implications for the providers. MioCare currently undertake both extra care housing and care at home services, dependent on the outcome of the tendering process, it is highly likely that there will be TUPE transfers both in and out of the company. People Services will support this ensuring that the process is legally compliant and in accordance with the company's policies and procedures. **(Emma Gilmartin, HR Business Partner)**
***Equality and Diversity Impact Assessment** attached or not required because (please give reason)*	*Equality and Diversity Impact Assessment (EIA): Initial Screening – see Appendix A. No negative implications have been identified and therefore a full EIA was not been completed.*
*What are the **property** implications*	*None*
Risks:	*The risks identified are:* • *Current providers are not successful, and new entrants to the market impact on the ability of the sector to deliver. This should be mitigated through the diversity of the framework, including 10+ main providers, evaluation of provider capacity within the tender process, assessment of implementation plans, and the application of TUPE.* • *Some disruption for service users, providers and staff as contracts align to the new model of provision. TUPE will apply for staff which should minimise the impact on service users. There will be a three month implementation period following award of contracts to ensure the process of transfer is as smooth and effective as possible.* • *The cluster arrangements and one main provider for extra care reduces client choice. This is mitigated by ensuring there are specialist provider on the framework who can deliver to client needs, and all clients have the choice of taking a direct payment*

Has the relevant Legal Officer confirmed that the recommendations within this report are lawful and comply with the Council's Constitution/CCG's Standing Orders?	Yes
Has the relevant Finance Officer confirmed that any expenditure referred to within this report is consistent with the S.75 budget?	Yes
Are any of the recommendations within this report contrary to the Policy Framework of the Council/CCG?	No

List of Background Papers under Section 100D of the Local Government Act 1972:
(These must be Council documents and remain available for inspection for 4 years after the report is produced, there must be a link to these documents on the Forward Plan).

Title	Available from
Cabinet report re extension of Care at Home and Extra Care contracts	https://committees.oldham.gov.uk/documents/s94882/ECH%20and%20CAH%20Exemptio



Report Author Sign-off:	
Vicky Walker	
Date:	30th August 2019

Please list any appendices:-

Appendix number or letter	Description
Appendix A	Initial Screening: Equality Impact Assessment (EIA)

Background:

1.1 The process of integration between health and social care has identified a number of areas which should be jointly commissioned between Oldham CCG and Oldham Council. This report sets out the options appraisal for jointly

commissioning domiciliary care provision for the borough under Section 75 arrangements.

1.2 Cabinet approved the extension of this contract to 31st March 2019 to allow time to develop a single specification and contractual framework for the joint commissioning. A project group comprising of both CCG and Oldham Council colleagues have undertaken the scoping and development work to combine both organisations delivery objectives for domiciliary care.

1.3 The outcome from this scoping work has identified that the joint commissioning for domiciliary care in Oldham should comprise of one overarching framework for all domiciliary care, incorporating separate lots including:

- Care at Home;
- Extra Care Housing;
- Complex Needs (including Learning Disability and complex health needs), and
- Children's Domiciliary/Continuing Care provision.

1.4 This paper sets out the various models for operational delivery and seeks approval for the preferred options, where there is significant change.

2 Current Provision and Commissioning Approach to Care at Home within Oldham

2.1 Care at Home is commissioned in different ways at present, by three sets of commissioners: Adult Services, the CCG and Children's Services, and multiple contracts.

2.2 There is a framework and approved provider list for Oldham Council Care at Home. Oldham Council's current Care at Home contract was commissioned February 2014. The providers on the framework are delivering approximately 606,000 hours of care per year to over 1,000 individuals at an estimated cost of £9 million. Oldham Council's current Extra Care Housing (ECH) Contract was commissioned in 2015 as a mini competition from the care at home approved list for care at home. There are six Extra Care Housing schemes based in three of the GP clusters with two separate care providers, delivering approximately 105,000 commissioned hours of care per annum at a total cost of approx. £1.5 million.

2.3 The contract and service specifications for Care at Home and Extra Care Housing diverge and it can be difficult to manage a consistent approach when one element of service delivery changes.

2.4 Oldham CCG also have a separate specification and contract for the delivery of their Continuing Health Care contract with regards to social, personal and nursing care for adults, young people and children. The contract was commissioned in April 2017 by the CCG and is due to expire 31st March 2020. This contract delivers approximately 4,000 hours of care per annum to approximately 50 individuals at a cost of approximately £70,000.

2.5 Children's services have a separately commissioned range services known as 'Short Breaks' of which one element provides for domiciliary care and respite service. It is this element that will be included in the Joint Commissioning arrangements. The individual commissioned provision for domiciliary care

provision for children's were commissioned by Children's Services Commissioners in October 2017, with a contract end date of 31st March 2019. The value is approximately £600,000 per annum.

2.6 The current payment approach for care at home of paying by minute on actual delivered hours was developed to minimize the cost of care at home services and ensure that payment was only made for delivered care hours only. This was facilitated through an electronic call monitoring (ECM) system. The current ECM system is no longer fit for purpose and will cease to be supported from December 2018. Separate approval has been sought to de-commission the current system with a view to scoping alternative options. It is also worth noting that the CCG do not use an ECM system and pay on a manual invoice basis.

2.7 The current payment approach for extra care is based on a sixty hour weekly core amount per scheme to pay for the presence of a senior care worker. Care staff are paid per care run in a similar way to care at home. The model has been reviewed for the new tender process and we have consulted with our current providers. It has been found that as carers are not paid per shift, but by number of calls, there are times where they are on site but are not being paid, leading to little flexibility, and staff waiting on scheme between peak periods but reluctant to do any additional ad hoc work, helping with activities etc. as they are not being paid.

2.8 The night service is paid separately using funding from the Better Care Fund based on 2 carers and a mobile night van.

Proposals:

3. Procurement Approach

3.1 To maximise efficiencies and resources it is proposed that we combine the NHS and Oldham Council contracts through Section 75 arrangements. The packages of care delivered through Care At Home, Continuing Health Care, Continuing Care Extra Care Housing, and Children's Care are very similar in nature, albeit delivered to different client groups in different contexts. Combining the contracts provides the opportunity to streamline provision and the contract monitoring approach. This would allow services to be commissioned together under one purchasing system.

3.2 It is proposed that the NHS standard short form contract is used and any additional requirements are added to this via schedules. The rationale for this is due to legal considerations where some of the work commissioned under this arrangement would be clinical in nature and NHS terms and conditions taking precedence.

3.3 A single specification and tendering process for the delivery of care would ensure consistent requirements for the delivery of care in the community. This would assist with improving quality through a shared understanding of expectations and quality standards. This process would also reduce duplication and time constraints through the tendering process for the local authority, Oldham CCG and providers alike.

3.4 Through a framework commissioning approach, a joint set criteria for delivering domiciliary care will be identified through a single overarching specification in Oldham. A lotting strategy will identify the specific service delivery requirements with additional service requirements outlined in the procurement of each Lot.

3.5 The price per hour for the delivery of care will be consistent across health and social care and set at a fixed price relating to each service lot so the evaluation of the bids will be based on quality, outcomes and social value.

4 Procurement and Lotting Strategy

4.1 It is proposed that under this particular framework the lotting strategy would be as follows:

- Lot 1 – Adults Domiciliary care at home (inclusive of continuing health care, and with the a night sitting service option to increase capacity/complement the Marie Curie service)
- Lot 2 – Extra Care housing
- Lot 3 - Complex care: including Learning Disability, complex health needs, and for individuals with domiciliary night care needs (rather than overnight sitting)
- Lot 4 – Children's domiciliary care

4.2 Provider and stakeholder consultation and a benchmarking exercise with neighbouring authorities, have informed our proposals for the different lots:

Lot 1: Adult Domiciliary Care (standard) delivered at scale

4.3 As we continue on the integration journey between health and social care, the delivery of services is now focused around the five GP clusters. For future delivery of care at home services it is envisaged that the cluster based approach would allow better neighbourhood working and integration with our health colleagues. It is proposed that we have a lead provider(s) for each cluster who can drive innovation and quality. The provider would work effectively with the community based health and social care teams providing a joined up approach, and maximising the use of all community assets.

4.4 The focus on two providers per cluster, provides a more vibrant market, with providers having a guaranteed level of hours, which will help stabilise the market. It will support providers to recruit and retain staff who can work locally, have consistent hours and the introduction of new tasks/responsibilities will provide opportunities to learn new skills. Learning taken from other GM authorities taking the two provider per cluster approach has shown that this creates capacity within the system. The providers would work on a rota basis: one week on, one week off. This would mean the care arrangers would place packages of care with the provider when it was their week on rota.

4.5 Alternative options are to:

- Have one provider per cluster which would reduce administration, but reduce the capacity in the market, and cause more risks around seeking alternatives for individuals care packages in the event of dealing with provider failure.
- Continue to commission services as currently, but capacity is an issue with many providers, and provision can be scattered across the borough with no clear link to cluster arrangements and local assets.

Lot 2: Extra Care

4.6 It is proposed that under the new service delivery model for Extra Care Housing one lead provider operates borough wide.

4.7 The borough wide approach would allow us to commission an experienced extra care provider, ensure consistency, and retain our focus on the development of the extra care service. Extra Care is a different service to Care at Home as it is a 24/7 service, requires site management skills and partnership working with the housing provider and contractors. One point of contact for care delivered within an Extra Care setting, will reduce the time health and social care staff need to spend communicating and developing relationships and services.

4.8 We have recently developed extra care night provision, which operates across different schemes/providers. By including this provision formally within one contract, we can reduced the number of providers delivering different elements of the service, which promotes better communication and management.

4.9 Having one lead provider for the delivery of Extra Care Housing does cause some risks which are associated with provider failure. However the Extra Care Housing provision is usually more stable than the home care market. The payment model for Extra Care Housing will support stability in the market place.

4.10 The alternative options are to continue to have multiple providers delivering extra care, based on a split of schemes, or delivered by a cluster lead. Extra Care provision is currently only based in three of the five clusters (three schemes based in the Central Cluster, two schemes based in North Cluster and one scheme based in East Cluster) which would skew the number of hours delivered by the cluster lead providers, and a decision would have to be made regarding which lead cluster provider is allocated extra care. If decisions regarding who was commissioned to provide extra care is based on experience, a care at home cluster based approach for extra care would also limit the number of providers who could bid, as there are fewer specialist providers within this market.

Lot 3: Complex Care including Health and Learning Disability

4.11 Complex care including health and learning disabilities are specialist areas and have lower demand in terms of volume. As a result we are proposing a separate lot to include specialist providers providing domiciliary type care, who can work across the borough. Care at night, outside of extra care, will also be included within this lot as this is more effective as a borough wide service, as the volume is

small and therefore it would not be an efficient use of resources to have six separate services running per cluster.

4.12 The alternative option is to separate out the commissioning for specialist provision, so we have separate tenders for health provision, learning disability, night services etc. This would potentially dilute our ability to co-ordinate contractual changes and develop services consistently across domiciliary care type provision.

Lot 4: Children's Domicillary Care – short breaks

4.13 Again the volume of children receiving domiciliary care services is smaller, with around 70 receiving directly commissioned care, and these children will be scattered across the borough. In order to ensure those providers working with children have the specialist skills and adhere to the appropriate regulations we have separated this into a different lot and are looking for providers who can operate across the borough. It is envisaged that the service may by delivered by one of the providers delivering in a cluster, or by another specialist provider in Lot 3, as long as they can also deliver this service borough wide.

4.14 The alternative option is to separate out the commissioning for children's social care into a separate tender. However this would miss the opportunity to commission social care consistently and link with health Continuing Care provision, and for providers to gain some economies of scale.

4.15 NB: The understanding is that the Oldham Care's provider The Mio Care Group would be the 'provider of last resort' should there be any provider / market failure, in circumstances where:

- There is a failure of another provider that is of such short notice that alternative longer term arrangements cannot be made, or
- The Council is unable to secure, within the required timescales, any other provider to deliver a service, or
- There is an identified need to offer short term support to another provider to enable them to continue to provide a service where the assessed needs of service users cannot be met in a safe way.

This will mitigate any associated risks with provider / market failure.

5. Contract term

5.1 In order to create sustainability for the market, and effectively embed the new cluster based approach and the joint service delivery specification between health and social care, it is proposed that a longer length contract be created to help facilitate this. It is proposed that the new joint contract should be for the maximum that a framework agreement allows which is seven years, based on a five years plus the option to extend for a further two years. This will give us the time to stablise the market, develop best practice and evolve future ways of working. The advantage of having an option to extend are; if things are going well, there is no need to scope, commission and procure a new service at the end of the five year period.

5.2 It should be noted that at any time during the contract period, should any issues arise, the contract obligations can be brought to an end by virtue of material breaches etc. However, if contract clauses are invoked this does bring an element of risk via way of legal challenge.

5.3 The alternative option would be reduce the contract period but it could be argued that the shorter time frame of a contract does not provide stability within the market place as once the contract is up and running, it would soon be time to review and scope service delivery again and commence once again with the commissioning cycle. Not only does this create excessive resources within commissioning and procurement, it also causes lack of uncertainty for providers, and employees staff thus de-stabilising an already fragile market. It also reduces the ability to provide continuity of care for service users, as staff can choose whether to TUPE or stay with the outgoing care provider.

6 Future changes to the payment models:

6.1 As the contracts for care at home come together through the joint commissioning arrangements it is important that finance arrangements between both organisations are understood. A separate working group for financial arrangements has been devised and both parties are satisfied with the manual invoicing approach on actual delivered care hours as an interim basis.

6.2 It is proposed that moving forward, care at home providers within the clusters would be paid based on a minimum commissioned hours approach. We anticipate that this will help stabilise the market by providing more security to providers. It will also assist with any future recruitment issues that might be faced when moving over to a lead provider cluster based model. Finance will be consulted to ensure the right balance of payment is implemented, and this will be finalized prior to commencement of the procurement process.

6.3 As Extra Care schemes have now matured in terms of a balance of need, we are proposing the following payment model to support the ability of providers to:

- To pay a 360 hours per week core block payment (average 60 hours per scheme) to provide wrap around care, supervision and additional building and care management tasks.

- To pay a block for the night service, which is based on a 11pm-7am mobile availability across schemes, addressing short term and emergency care needs.

- To pay a monthly amount based on a balance of need in schemes. This will be calculated based on current commissioned hours, and the ideal balance in schemes based on high, medium, low/no need. However, payments will be reconciled against individually delivered hours, and any overpayment or underpayment will be addressed on a quarterly basis.

6.4 The block amount will address the fixed elements of the service which provide the wrap around care 24 hours per day. The provider can choose to use the block core payment flexibly to meet the needs of each scheme, as it may vary according to the arrangement of building, the number of people on temporary step up, and

the vulnerability of tenants. The expected senior staffing of the building (7am to 11pm) will continue to be part of the care specification. The block for the night service could be included within the payment, reducing administration.

6.5 The stable monthly payment for individual care hours will ensure that there can be core shift paid staff, and there is capacity to pick up new packages of care and any restarts of packages of care following a stay in hospital. This approach would allow for dedicated extra care staff paid per shift rather than care hours delivered which reduces issues with recruitment and retention and creates stability for the provision. There would also be greater scope to promote good working relationships across housing and care through joint activities, enabling them to focus on the wider extra care roles of social inclusion and re-enablement and to work with providers to develop enhanced services.

6.6 By separating the two elements of the payment will allow for the option that tenants a degree of choice. Tenants in receipt of care will continue to be responsible for paying the weekly wellbeing charge for the wrap around care service delivered by the on-site contracted provider, as this is part of the 'extra care' provision they have chosen to move into. However, they can choose to opt for an off-site provider for their individual care hours.

6.7 The CCG already use Council standard fee rates for providers, with additional slightly higher rates for more complex health care. Children's services pay different rates. By procuring services together we can look at standardising all the fee rates, based on complexity of care rather than client group.

Conclusions:

7.1 We are recommending that all the domiciliary care services are commissioned together under one joint Council and CCG overarching specification and purchasing system. The different specialisms and differences in arrangements will be addressed within the four separate lots. Services will be jointly monitored, reducing duplication and ensuring consistency across services, pricing and outcomes.

7.2 The key recommendations are then:

- Procurement through a dynamic purchasing system/light touch to allow for call off arrangements for specialist services

- To separate services into four lots to account for different deliver arrangements and regulation frameworks. These will be:
  - Standard care delivered by two providers within the five cluster areas
  - One borough wide provider for Extra Care
  - Specialist providers to deliver complex care including health, night care and learning disability
  - Specialist providers to deliver social care services to children

- To set up the contract for a term of five years, with the option to extend for a further two years. This will ensure stability and allow for development of key partnerships and delivery arrangements.

- Payments will be based on delivered hours at agreed annual fee rates, and at a level of commissioned service. This will be reconciled against delivered hours on a regular basis.

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Click on the symbols to view the guidance for each stage

Stage 1: Initial screening

The Stage One screening is a quick and easy process. It should:

- *identify those projects, policies, and proposals which require a full EIA by looking at the potential impact on any of the equality groups*
- *prioritise if and when a full EIA should be completed*
- *justify reasons for why a full EIA is not going to be completed*

Not all policies will require an EIA: Click on the information symbol to view a set of key questions which will help you to decide whether you need to complete the form. If you do not need to go any further because a full EIA is not required, please ensure that you complete all the questions in Stage 1 and get the EIA signed off by the appropriate person (see Section 5). ***Please note, if you are assessing a budget proposal please complete all the questions. The information in 1e, should be transferred to the Equality Impact Screening section on the budget proposal form.***

Lead Officer:	Vicky Walker Planning and Commissioning Manager/ Helen Ramsden Interim Assistant Director of Joint Commissioning
People involved in completing EIA:	Vicky Walker

General Information

1a	Which service does this project, policy, or proposal relate to?	Oldham Cares/Adult Social Care/Continuing (Health Care)
1b	What is the project, policy or proposal?	The purpose of the report is to agree, under the section 75 agreement, the options for the joint procurement of domiciliary care services in Oldham across health and social care, from April 2019
1c	What are the main aims of the project, policy or proposal?	The process of integration between health and social care has identified a number of areas which should be jointly commissioned between Oldham CCG and Oldham Council. This report sets out the options appraisal for jointly commissioning domiciliary care provision for the borough under Section 75 arrangements.

		The proposals relate to the procurement framework, the lotting strategy/arrangements, contract term and payments to providers
1d	Who, potentially, could this project, policy or proposal have a detrimental effect on, or benefit, and how?	This proposal will ensure that we are promoting a stable care market which focuses on meeting the needs of individuals requiring care in the borough. It takes into account different client groups and different levels of service and specialist need.

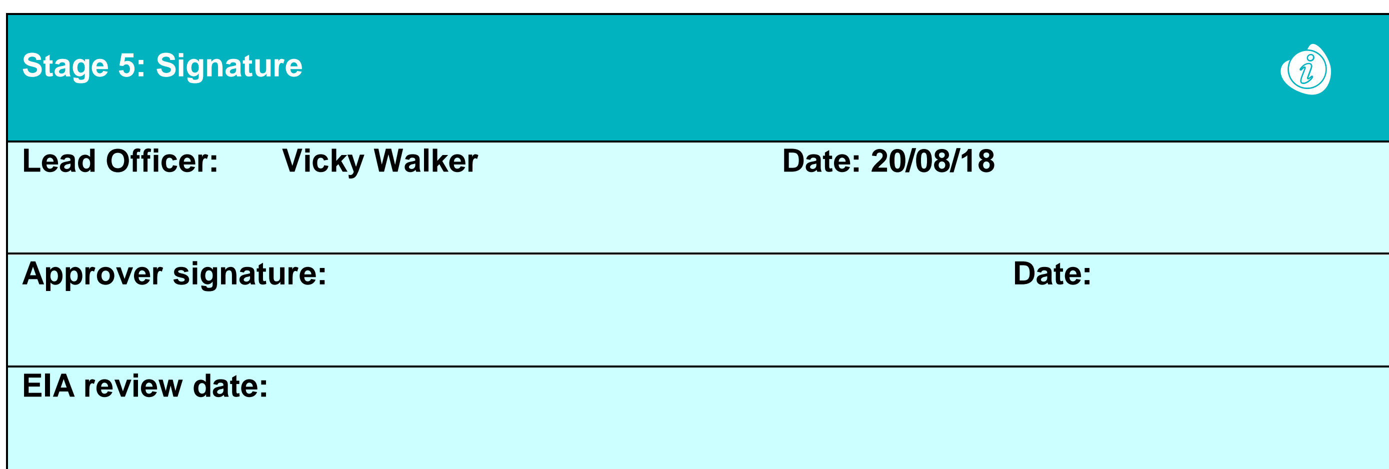
1e. Does the project, policy or proposal have the potential to <u>disproportionately</u> impact on any of the following groups? If so, is the impact positive or negative?				
	None	**Positive**	**Negative**	**Not sure**
Disabled people	☐	✓	☐	☐
Particular ethnic groups	✓	☐	☐	☐
Men or women (include impacts due to pregnancy / maternity)	✓	☐	☐	☐
People of particular sexual orientation/s	✓	☐	☐	☐
People who are proposing to undergo, are undergoing or have undergone a process or part of a process of gender reassignment	✓	☐	☐	☐
People on low incomes	✓	☐	☐	☐
People in particular age groups	✓	☐	☐	☐
Groups with particular faiths and beliefs	✓	☐	☐	☐
Are there any other groups that you think may be affected negatively or positively by this project, policy or proposal?				
		☐	☐	

If the answer is "negative" or "unclear" consider doing a full EIA

1f. What do you think that the overall NEGATIVE impact on groups and communities will be? <u>Please note that an example of none / minimal impact would be where there is no negative impact identified, or there will be no change to the service for any groups.</u> Wherever a negative impact has been identified you should consider completing the rest of the form.	**None / Minimal**	**Significant**
	☐	☐
	NONE	

1g	Using the screening and	*No*

	information in questions 1e and 1f, should a full assessment be carried out on the project, policy or proposal?	
1h	How have you come to this decision?	This is on the basis that the proposals do not negatively affect any groups or communities. The proposals have been based on research and benchmarking to ensure that they are well thought through, and continue to meet the care needs of everyone in Oldham using commissioned services.
1i	Review date	



Stage 5: Signature	
Lead Officer: Vicky Walker	**Date: 20/08/18**
Approver signature:	**Date:**
EIA review date:	

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NHS
Oldham
Clinical Commissioning Group

Oldham
Council

Commissioning Partnership Board Report

Decision Maker:	Executive Member Councillor Z Chauhan, Cabinet Member for Health and Social Care
Date of Decision:	30 August 2018
Subject:	Amendment to Commissioning Partnership Board Terms of Reference
Report Author:	Julie Daines, Strategic Director of Corporate Affairs and Resources, Oldham CCG
Officer Contact:	Julie Daines, Strategic Director of Corporate Affairs and Resources, Oldham CCG

Reason for the decision:

To consider amendments to the Commissioning Partnership Board Terms of Reference, following discussions at the Commissioning Partnership Board held on 28 June 2018.

Summary:

(i) Changes to section 5 removing the 'casting vote' mechanism.
(ii) Addition to section 2, and minor changes to section 7 and 8, describing the relationship of Commissioning Partnership Board in the context of the Health and Wellbeing Board and its duties.
(iii) Addition to section 9, describing the values and behaviours of Oldham Cares.

What are the alternative option(s) to be considered? Please give the reason(s) for recommendation(s):

(i) Continue with the existing Terms of Reference,
OR
(ii) Amend the Terms of Reference to:
- remove the 'casting vote' and require further dialogue to reach decision through simple majority;
- Reflect the context of the Health and Wellbeing Board and its duties
- Reflect the Values and Behaviours

required of the Commissioning Partnership Board as part of Oldham Cares Alliance.

Recommendation(s):	Option (ii) to amend the Terms of Reference. The common agreement of the Commissioning Partnership Board Terms of Reference by Oldham Council and Oldham CCG members demonstrates the commitment of the partners to the co-operative agenda within the borough.
Implications:	
*What are the **financial** implications?*	None.
What are the ***procurement*** implications?	None.
*What are the **legal** implications?*	Oldham Council and Oldham CCG have both sought separate external legal advice in relation to the preparation of the Commissioning Partnership Board Terms of Reference. Senior representatives from both partner organisations have participated in the negotiations to ensure common agreement to the Terms of Reference. None of these proposed changes undermine those agreements. (Julie Daines)
*What are the **Human Resources** implications?*	None
***Equality and Diversity Impact Assessment** attached or not required because (please give reason)*	The commissioning decisions to be taken by the Commissioning Partnership Board will be subject to Equality Impact Assessments to address the impact upon individuals with protected characteristics.
*What are the **property** implications*	None
Risks:	The Commissioning Partnership Board is a joint committee of the Council and the CCG established under Regulation 10(2) of the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000 (the Partnership Regulations). The Commissioning Partnership Board is established in accordance with the CCG's constitution, standing orders and scheme of delegation and in accordance with the Council's constitution. The Commissioning Partnership Board is accountable to the CCG and the Council in accordance with the

arrangements set out in CCG Standing Orders and the Council's Constitution.

Failure to resolve the concerns raised by Commissioning Partnership Board members may hinder decision-making and therefore the delivery of benefits arising from closer working between Oldham MBC and Oldham CCG. (Julie Daines)

Has the relevant Legal Officer confirmed that the recommendations within this report are lawful and comply with the Council's Constitution/CCG's Standing Orders? Yes

Has the relevant Finance Officer confirmed that any expenditure referred to within this report is consistent with the S.75 budget? Yes

Are any of the recommendations within this report contrary to the Policy Framework of the Council/CCG? No

Reason(s) for exemption from publication: N/a

Reason for urgent report N/a

Reason for exemption from call in N/a

List of Background Papers under Section 100D of the Local Government Act 1972:

Title	Available from
Commissioning Partnership Board Terms of Reference	Attached.

Report Author Sign-off:	
Julie Daines	
Date: 21st August 2018	

Please list any appendices:-

Appendix number or letter	Description
Appendix 1	Amended CPB Terms of Reference with track changes

1. Background

1.1 The Commissioning Partnership Board is the integrated strategic commissioning body for health and social care services established under section 75 of the NHS Act 2006 between NHS Oldham Clinical Commissioning Group (the CCG) and Oldham Metropolitan Borough Council (the Council or OMBC).

1.2 The Commissioning Partnership Board is a joint committee of the Council and the CCG established under Regulation 10(2) of the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000 (the Partnership Regulations).

1.3 The Commissioning Partnership Board is established in accordance with the CCG's constitution, standing orders and scheme of delegation and in accordance with the Council's constitution. The Commissioning Partnership Board shall be accountable to the CCG and the Council in accordance with the arrangements set out in CCG Standing Orders and the Council's Constitution.

1.4 The Commissioning Partnership Board shall exercise on behalf of the CCG and the Council such integrated commissioning functions as may be delegated to it pursuant to such agreement or agreements that they may enter into from time to time pursuant to the Partnership Regulations (section 75 agreement).

1.5 The Commissioning Partnership Board may appoint sub-committees as it considers appropriate to exercise any functions that are exercisable by it insofar as any such functions may be sub-delegable. The Commissioning Partnership Board may delegate tasks to such sub-committees and to officers in accordance with the delegation arrangements set out in the section 75 agreement between the CCG and Council.

1.6 The terms of reference outline how the Commissioning Partnership Board will direct and drive the commissioning function of 'Oldham Cares', they also describe the membership, remit, responsibilities and reporting arrangements of the Commissioning Partnership Board and shall have effect as if incorporated into the CCG's constitution and standing orders.

1.7 At the Commissioning Partnership Board held on 28 June 2018, the committee received the Commissioning Partnership Board Terms of Reference for ratification at its inaugural meeting.

1.8 The Board gave consideration to the Terms of Reference of the joint committee of Oldham Council and Oldham Clinical Commissioning Group under Regulation 10 (2) of the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000 which had been agreed by the respective organisations via CCG Governing body and the Council's Cabinet.

1.9 The Board would exercise on behalf of the CCG and Council the integrated commissioning functions established under Section.75 of the NHS Act 2006.

1.10 The Chair expressed some concern at having the casting vote should there be an equality of voting and advised the Board that the preference would be to ensure that there was full agreement on matters before the Board.

1.11 It was suggested that should a simple majority not be reached, the matter would be taken outside of the meeting to obtain further detail/information and the issue would be reconsidered at the next available Board meeting.

1.12 The Chair also requested two further additions to the Terms and Reference in relation to the context of the Health and Wellbeing Board and its duties, and the values and behaviours of the Commissioning Partnership Board.

2. Proposals

2.11 Oldham Council and Oldham CCG had both sought separate external legal advice in relation to the preparation of the current Commissioning Partnership Board Terms of Reference. Senior representatives from both partner organisations had participated in the negotiations to ensure common agreement.

2.12 Casting Vote

Section 5 of the Commissioning Partnership Board Terms of Reference, could be amended.

To remove:
In the event of a tied vote, the Chair of the day has a casting vote;

And to replace with:

Should a decision not be reached, then the process will be to take the issue outside of the meeting to obtain further detail/information relevant to the decision in hand. The issue will then be brought back to the next meeting of the committee with a clear recommendation for approval.

This alternative mechanism was a considered option when originally discussed with legal advisors. It was not the preferred solution due to the potential for decision-making to become protracted through deferral to a future meeting.

2.13 Context of Health and Wellbeing Board and its duties

Health and Wellbeing Boards bring into one forum representatives from health, social services and the local community to decide what the main public health needs of the local population are, and to determine how best to meet them in an integrated and holistic manner.

Health and Wellbeing Boards have a statutory duty to encourage the integrated delivery of health and social care to advance the health and wellbeing of people in their area.
It is within this context that the Commissioning Partnership Board functions in supporting the Health and Wellbeing Board and its Partners in the delivery of those duties.

The following recommendations are made to reflect that context in the Commissioning Board Terms of Reference:

Insert in section 2:
The Commissioning Partnership Board is accountable to the Health and Wellbeing Board for the commissioning of services that meet the main public health needs of the local population and support the integrated delivery of health and social care to advance the health and wellbeing of the people of Oldham.

Change under section 7:

From:
To set the high-level commissioning strategy and health & wellbeing outcomes for the Borough in order to meet assessed population, community and individual need within the financial resources of the pooled funds over which the Commissioning Partnership Board has control.

To:

Support the Health and Wellbeing Board to set the high-level commissioning strategy and health & wellbeing outcomes for the Borough in order to meet assessed population, community and individual need within the financial resources of the pooled funds over which the Commissioning Partnership Board has control.

AND

From:
To provide assurance to NHS Oldham CCG and Oldham MBC for the achievement of the agreed outcomes, commissioning strategies and plans within the available financial envelope.

To:
To provide assurance to the Oldham Health and Wellbeing Board, NHS Oldham CCG and Oldham MBC for the achievement of the agreed outcomes, commissioning strategies and plans within the available financial envelope.

2.14 **Values and Behaviours of the Commissioning Partnership Board**

Significant deliberation has taken place in establishing the arrangements for Oldham Cares Alliance, Values, Behaviours and Principles have been considered and enshrined in key documents associated with the alliance arrangement.

The following is recommended to be inserted in section 9 to reflect the values and behaviours of the Commissioning Partnership Board as part of that Oldham Cares Alliance governance.

Insert in section 9:

To demonstrate the values and behaviours enshrined in the emerging Oldham Cares Alliance: Collaborate, Cooperate, Open, Transparent, Act in good faith, and learn from each other in working together as a single, integrated high performance team (Single Budget. Single System)

3. Options

(i) Continue with the existing Terms of Reference,
OR
(ii) Amend the Terms of Reference to:
- remove the ‘casting vote’ and amend as proposed to require further dialogue to reach decision through simple majority;
- Reflect the context of the Health and Wellbeing Board and its duties, and
- Reflect the Values and Behaviours required of the Commissioning Partnership Board as part of Oldham Cares Alliance.

4. Conclusions:

Option (ii) to amend the Terms of Reference is the recommended option.

The common agreement of the Commissioning Partnership Board Terms of Reference by Oldham Council and Oldham CCG members demonstrates the commitment of the partners to the co-operative agenda within the borough.

NHS Oldham Clinical Commissioning Group

Oldham cares — Health and social care for Oldham

Oldham Council

COMMISSIONING PARTNERSHIP BOARD

(S75 JOINT COMMITTEE)

TERMS OF REFERENCE

1. Purpose

The Commissioning Partnership Board is the integrated strategic commissioning body for health and social care services established under section 75 of the NHS Act 2006 between NHS Oldham Clinical Commissioning Group (the CCG) and Oldham Metropolitan Borough Council (the Council or OMBC).

The Commissioning Partnership Board is a joint committee of the Council and the CCG established under Regulation 10(2) of the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000 (the Partnership Regulations). The Commissioning Partnership Board is established in accordance with the CCG's constitution, standing orders and scheme of delegation and in accordance with the Council's constitution. The Commissioning Partnership Board shall be accountable to the CCG and the Council in accordance with the arrangements set out in CCG Standing Orders and the Council's Constitution.

The Commissioning Partnership Board shall exercise on behalf of the CCG and the Council such integrated commissioning functions as may be delegated to it pursuant to such agreement or agreements that they may enter into from time to time pursuant to the Partnership Regulations (section 75 agreement).

The Commissioning Partnership Board may appoint sub-committees as it considers appropriate to exercise any functions that are exercisable by it insofar as any such functions may be sub-delegable. The Commissioning Partnership Board may delegate tasks to such sub-committees and to officers in accordance with the delegation arrangements set out in the section 75 agreement between the CCG and Council.

These terms of reference outline how the Commissioning Partnership Board will direct and drive the commissioning function of 'Oldham Cares', they also describe the membership, remit, responsibilities and reporting arrangements of the Commissioning Partnership Board and shall have effect as if incorporated into the CCG's constitution and standing orders.

2. Accountability

The Commissioning Partnership Board is accountable to the Health and Wellbeing Board for the commissioning of services that meet the main public health needs of the local population and support the integrated delivery of health and social care to advance the health and wellbeing of the people of Oldham.

The Commissioning Partnership Board is the commissioning body for the services in scope of integrated commissioning. The Commissioning Partnership Board has delegated executive responsibility and may exercise executive decision making for these services.

The Commissioning Partnership Board can, on behalf of the CCG and the Council:

- commit resources within agreed limits
- decide policy within the scope of services
- commission research or reviews to inform decision making
- oversee integrated commissioning action plans.

Ultimate legal accountability for the provision of statutory services will however be unaffected and will remain with NHS Oldham CCG and Oldham Council through the Governing Body and Cabinet respectively. Due to the nature of the decisions, the Commissioning Partnership Board may therefore be required to seek additional approvals from the CCG Governing Body and Cabinet in accordance with the terms of a section 75 agreement or otherwise as directed.

The Commissioning Partnership Board will also provide a quarterly update to the Health and Wellbeing Board, providing information on key issues it has considered over the last quarter, and issues on the horizon.

3. Membership

The composition of the Commissioning Partnership Board is the core and advisory members of the Commissioning Committee made up of officers and members from the CCG and the Council, as well as the Single Accountable Officer, in post from time to time, save that when the Commissioning Partnership Board exercises commissioning functions related to extended primary care, its core members shall exclude GP member representatives.

The role of Chair of the Commissioning Partnership Board will be shared by the Governing Body Lay Chair and a Council Cabinet Elected Member. This will be by way of alternative meetings unless otherwise mutually agreed between the Chairs. Should neither Chair be available for the meeting then a deputy Chair will be nominated from the joint deputies.

Core Members (voting)

CCG

- Governing Body Lay Chair (Joint Chair)
- Chief Clinical Officer (CCO) / Deputy CCG Accountable Officer
- Deputy Chief Clinical Officer (DCCO)
- Chief Finance Officer

Council

- Leader of the Council and Cabinet Member for Economy and Enterprise
- Deputy Leader of the Council and Cabinet Member for Neighbourhoods
- Cabinet Member for Children's Services
- Cabinet Member for Health and Social Care

Advisory Members (non-*voting*)

Joint roles

- Joint Accountable / Chief Executive Officer
- Strategic Director of Joint Commissioning / Chief Operating Officer

CCG

- Executive Nurse
- Hospital Consultant Representative
- GP Governing Body Member – North Cluster
- GP Governing Body Member – East Cluster
- Lay Member for Patient and Public Involvement (Deputy Joint Chair)
- Director of Performance and Delivery
- Director of Primary Care and Community Enablement

Council

- Strategic Director of Reform
- Deputy Chief Executive – People and Place
- Deputy Chief Executive – Commercial and Corporate
- Director of Adult Social Services (DASS)
- Director of Children's Services (DCS)

Other officers may be invited to support any agenda items as agreed by the chair of the meeting. When considering a confidential matter, the chair of the meeting may ask non-voting members to leave the meeting. The voting members may decide that a matter is confidential if in their view publicity about it would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons that they specify arising from the nature of that business or of the proceedings.

4. Nominated deputies

The CCG and Council may nominate deputies for Core Members and Advisory Members provided they notify the Joint Chairs in writing of the identity of the deputies.

5. Quorum and voting

The quorum will be six core members (or their nominated deputies), 3 from each of the CCG and Council. The three CCG Core Members or their deputies must include one CCG Lay Member, either Chief Clinical Officer or Deputy Chief Clinical Officer and one CCG Executive Officer. The Council Core Members or their nominated deputies must be Council Cabinet Elected Members.

Should the GPs (CCO/DCCO) be conflicted then quoracy and voting will be assigned to the Executive Nurse and Hospital Consultant Representative.

Should either of the GPs (CCO/DCCO) be absent from the meeting, their vote will be given to another GP in attendance at the discretion of the Chair.

The Lay Member for Patient & Public Participation will deputise as Joint Chair in the absence of the CCG Chair. Should the Council Joint Chair be absent then a deputy will be nominated from the Council Cabinet Elected Members.

Decisions made by the Commissioning Partnership Board shall be made on a simple majority basis. Should a decision not be reached, then the process will be to take the issue outside of the meeting to obtain further detail/information relevant to the decision in hand.

The issue will then be brought back to the next meeting of the committee with a clear recommendation for approval.

6. Decision-making

The Council and the CCG are delegating their functions to the Commissioning Partnership Board and not to their individual representatives on the Commissioning Partnership Board.

Through its decision making processes the Commissioning Partnership Board will adhere to the decision making processes of both Council and the CCG.

Where a decision of the Council is required at a Commissioning Partnership Board meeting then the requirements of the Local Government Act 2000 and the Local Authorities (Executive Arrangements) (Meetings and Access to Information) (England) Regulations 2012 must be adhered to (publication of notice of key decisions 28 days in advance, publication of reports 5 clear working days in advance, formal decision notice signed by decision maker and Proper Officer (Constitutional Services must attend for this purpose for these items).

Decisions that are ‘key decisions’ are subject to the Council’s ‘call-in’ procedures and cannot be implemented until the time for call-in has expired or the matter has been dealt with in accordance with Overview & Scrutiny Procedure Rules. The activities of the Commissioning Partnership Board may be subject to enquiry by the Council's overview and scrutiny committees including the Pennine Acute Hospitals NHS Trust Joint Health and Overview Scrutiny Committee and the Pennine Care NHS Trust Joint Mental Health Overview and Scrutiny Committee.

A decision will be a “key decision if it falls within the definition set out in:

1) Regulation 8 of the Local Authorities (Executive Arrangements) (Meetings and Access to Information) (England) Regulations 2012; and

2) the Council’s Constitution,

as both may be amended from time to time, The definition of a key decision, as at the date of these terms of reference, is set out in the Appendix to these terms of reference.

The Commissioning Partnership Board will be accountable to the Council’s Cabinet and / or Council as appropriate and the CCG’s Governing Body. It will work in partnership with the Health and Wellbeing Board and the CCG Commissioning Committee.

7. Remit and Responsibilities

The Commissioning Partnership Board shall:

a. Take responsibility for the management of partnership arrangements in accordance with such section 75 agreement or agreements that the CCG and the Council may from time to time agree, including monitoring the arrangements and receiving reports and information on the operation of the arrangements;
b. Together with the Commissioning Committee provide assurance to the Governing Body, CCG members and other relevant parties on delivery of statutory functions and responsibilities exercisable by the CCG.

The Commissioning Partnership Board will:

a. To support the Health and Wellbeing Board to set the high-level commissioning strategy and health & wellbeing outcomes for the Borough in order to meet assessed population, community and individual need within the financial resources of the pooled funds over which the Commissioning Partnership Board has control.
b. Make commissioning recommendations for the financial resources not controlled by the Commissioning Partnership Board
c. Support the dissolving of traditional boundaries between commissioning and provision of services in Oldham to improve outcomes for Oldham population against the agreed Oldham Cares Outcomes Framework.
d. Have responsibility for all matters relating to the pooled funds as may be set out in a Section 75 agreement.
e. Develop, implement and monitor those elements of the Alliance contract for the Oldham Integrated Care Organisation that relate to the provision of services that are subject to the integrated commissioning arrangements.
f. Make recommendations regarding the other elements of the Alliance contract for the Oldham Integrated Care Organisation.
g. Recommend the high level parameters for the Strategic Commissioning Function
h. Recommend the high level parameters for the Primary Care and Community and Social Care Clusters within the ICO
i. Recommend that appropriate contracting mechanisms are in place within the ICO Alliance and outside of ICO arrangements e.g. specialist hospital services
j. Maintain a strategic overview and assurance role on behalf of the Health and Wellbeing Board to ensure implementation and delivery of the agreed high level strategies and outcomes set jointly between Oldham CCG and Oldham Council.
k. Monitor and review high level outcomes and performance data to ensure that the ICO is achieving the goals established by commissioners for the transformation of health and social care services against the Oldham Cares Outcomes Framework.

8. Objectives

The objectives of the Commissioning Partnership Board are;

a. To govern the arrangements for integrated commissioning in the Oldham borough providing assurance to NHS Oldham CCG and Oldham MBC that

their statutory and mandatory responsibilities and strategic objectives are being met and that their combined resources are being utilised to best effect.

b. To provide assurance to Oldham Health and Wellbeing Board, NHS Oldham CCG and Oldham MBC for the achievement of the agreed outcomes, commissioning strategies and plans within the available financial envelope
c. To prepare an annual integrated commissioning strategy, setting out specific goals and outcomes for commissioning in the Borough and the intentions of the whole system to transform health and social care delivery in order to reflect best practice and value for money.
d. Within the integrated commissioning strategy, describe how the outcomes and objectives set out in the Section 75 Agreement and the high level strategic goals and outcomes of NHS Oldham CCG and Oldham MBC will be achieved.
e. To commit resource at high level within the pooled fund(s) to achieve the objectives of the integrated commissioning strategy through the Oldham Cares system structure.
f. To develop a joint financial plan to underpin the overall commissioning strategy and providing direction in relation to investments and savings to be made jointly by the Council and CCG.
g. To oversee the implementation of the integrated commissioning strategy.
h. To set the high level quality standards for, and monitor and review the outcomes and performance for commissioned services within the s.75 agreement, identifying areas of good practice and taking action where outcomes and performance fall short of requirements.
i. To ensure that the prescribed functions of Oldham Council and Oldham NHS CCG are properly and effectively discharged through the pooled funds and the strategic commissioning arrangements as appropriate.
j. To ensure the engagement of stakeholder groups - including users, patients, carers, providers and community organisations - in the commissioning cycle and the co-design of commissioned services and the formulation of strategy as appropriate.
k. To provide assurance to the Health and Wellbeing Board, CCG Governing Body, Oldham Council Cabinet and the Council's Overview & Scrutiny Committees of the quality and safety of commissioned services within the Section 75 agreement, of the proper and effective use of resources in the pooled fund and of the achievement of agreed strategy and outcomes.
l. To conduct all business in accordance with the provisions of the Section 75 Agreement including the standards on partnership behaviours and the code of conduct on conflicts of interest
m. To be fully aware of the Greater Manchester integrated commissioning arrangements as they develop in the context of the Greater Manchester Devolution Agreement and ensure full alignment between the arrangements in the Oldham borough, the North East sector, and the city region.
n. To identify, record, mitigate and manage all risks associated with strategic integrated commissioning, including the maintenance of a risk register which will be included on the risk registers of both NHS Oldham CCG and Oldham MBC.
o. To review regular high-level performance and financial monitoring reports relating to strategic integrated commissioning and the pooled fund and ensure, if required, appropriate action is taken to ensure annual delivery of expected performance targets and approved schemes within permitted budget for the financial year.
p. To promote improvement and innovation and demonstrate leadership in pursuing the objectives and upholding the principles underpinning the ways of working in the newly established partnership.

9. Principles

The core principles of the Commissioning Partnership Board are:

a. To demonstrate the values and behaviours enshrined in the emerging Oldham Cares Alliance: Collaborate, Cooperate, Open, Transparent, Act in good faith, and learn from each other in working together as a single, integrated high performance team (**Single Budget. Single System**);
b. to place quality, innovation, productivity and prevention at the heart of its business by considering the impact of decisions on the quality of care and the patient experience;
c. to ensure that equality is the fundamental principle on which the Commissioning Partnership Board operates in the commissioning of services which address the diversity of needs within the borough
d. to support the ICO, through the Alliance Board, in its role as a key system leader for health and social care in the borough
e. to take a holistic, personalised, individualised and integrated approach to people (customers and patients);
f. to take a holistic and integrated approach to the health and social care system, including for investments and savings. This is to focus on the areas in scope but be mindful of the wider health and social care system;
g. to ensure transparent information sharing in relation to business planning, and therefore minimising risk from unforeseen unplanned activity;
h. to ensure transparent information sharing in relation to performance and financial information;
i. to share strategic and operational good practice;
j. to provide the leadership of development and reporting of integrated commissioning across health and social care; and
k. to provide assurance to member organisations to comply with all statutory and mandatory duties, including but not limited to, the duties to involve and/or consult (as appropriate) the public; the duty to consult the Overview and Scrutiny Committee; and relevant procurement guidance;
l. to undertake such involvement and/or consultation (as appropriate) with patients, users and the public on issues within the Commissioning Partnership Board's scope;
m. to take a proactive approach to sharing information in order to help partners work more effectively with service users and communities, where this is appropriate and safe to do so.

10. Financial Arrangements for Joint commissioning

One of the core functions of the Commissioning Partnership Board is to oversee the alignment and integration of budgets for the services in scope.

Integrated commissioning will be achieved through pooled budgets; aligning of budgets whereby each partner will control their own budgets and spending will be reduced to a minimum.

The operation of the Commissioning Partnership Board will be underpinned by the section 75 agreement and it will oversee one or more pooled funds.

11. Administration

The CCG and OMBC Corporate Office Teams will provide administrative support to the Commissioning Partnership Board, supporting the chair, as appropriate. They will be supported by the Chief Operating Officer and Strategic Director of Corporate Affairs and Resources to set the agenda.

12. Frequency and notice of Meetings

The Commissioning Partnership Board will normally meet monthly and at least quarterly in public.

Unless otherwise agreed, at least 14 days notice of a date and place of a meeting will be given. In the case of urgent business the chair will call a meeting with notice as they see fit.

Agenda planning meetings will take place in advance of the next meeting and include the Joint Chairs as a minimum. The agenda and supporting papers will be sent to member representatives no less than 5 clear (full) working days before the meeting.

13. Conduct of meetings

Except as outlined in these Terms of Reference, meetings of the Commissioning Partnership Board shall be conducted in accordance with the provisions of the CCG's Standing Orders, Scheme of Reservation and Delegation and Prime Financial Policies (as approved by the CCG) and the Council's Scheme of Delegation for Officers and Procedure Rules (as set out in the Council's Constitution and approved by the Council) and reviewed from time to time. Where different rules apply, the higher standard shall be adopted.

The Commissioning Partnership Board shall ordinarily meet jointly with the Commissioning Committee and have shared notices of meetings, agendas, papers and minutes.

The secretary shall minute the proceedings of all meetings of the Commissioning Partnership Board, including recording the names of those present and in attendance and any conflicts of interest declared.

Minutes and action log of each meeting will be circulated within 5 working days of the meeting taking place. Their approval shall be considered as an agenda item at the next meeting.

The representatives of the Commissioning Partnership Board will act as the overall communication links to their organisation and relevant departments. Members shall disseminate the approved minutes for the Commissioning Partnership Board to relevant stakeholders.

14. Reporting Mechanism

The Commissioning Partnership Board shall make any such recommendations to the Governing Body and Commissioning Committee, or OMBC governance it deems appropriate on any area within its remit, where action or improvement is needed.

15. Review and Termination

In the event of a dispute, the disputes procedure within the section 75 agreement shall be followed.

The basis and procedure for termination of the Commissioning Partnership Board is included within the section 75 agreement.

16. Other Matters

The Commissioning Partnership Board is authorised by the Governing Body and Council Cabinet to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Commissioning Partnership Board.

The Commissioning Partnership Board is authorised by the Governing Body and Council Cabinet to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary, within its Terms of Reference within a limit determined by the Chief Financial Officer.

The Commissioning Partnership Board shall:

- Have access to sufficient resources to carry out its duties
- Be provided with appropriate and timely training, both in the form of an induction programme for new members and on an on-going basis for all members
- Give due consideration to laws and regulations impacting on the work of the Commissioning Partnership Board
- At least once a year, review its own performance and Terms of Reference to ensure it is operating at maximum effectiveness and recommend any changes it considers necessary to the Governing Body and Council Cabinet.

Appendix

Article 14.2.2 of the Council's Constitution

14.2.2 Key Decisions

a. a key decision is any decision which is likely to result in a local Council incurring expenditure which is, or the making of savings which are, significant having regard to the local Council's budget for the service or function to which any decision relates; or

b. to be significant in terms of its effects on communities living or working in the area comprising two or more wards in the area of the local Council

Key Decision - Definitions

a. "Significant expenditure or savings" is defined as:

   i. Revenue expenditure or saving that is neither provided for within the Budget, nor virement permitted by the Constitution.

   ii. Capital expenditure that is not provided for within:

   iii. The capital estimate for a specific scheme; or

   iv. A lump sum capital estimate.

   v. Of the declaration of land or property, the estimated value of which exceeds £250,000, as surplus to the Council's requirements.

   vi. Securing approval in principle to the acquisition or disposal of land or property the value of which is estimated to exceed £250,000.

   vii. Securing approval in principle to the taking of, or the granting, renewal, assignment, transfer, surrender, taking of surrenders, review, variation or termination of any leases, licences, easements or wayleaves, at considerations in excess of £250,000 over the term of the agreement or a premium of £250,000.

   viii. Any decision which involves expenditure or savings over £250,000.

b. Key Decisions are also those decisions which:

   i. Require an application to be made for planning permission, listed building, ancient monument or conservation area consent.

   ii. Comprise or include the making, approval or publication of a draft or final scheme which may require, either directly or in the event of objection, the approval of the Secretary of State or of a Minister of the Crown.

   iii. Require the passage of local legislation or the adoption by the Council of national legislation.

   iv. Propose a response on behalf of the Council to consultation by the Secretary of State or a Minister of the Crown, where the consultation response could have a potential impact upon the Council to the extent defined in Article 15.3.2-15.3.4

   v. Propose an alteration in the standard charges which the Council makes for any of its services.