Terms of Reference for the Southampton Health & Care Partnership Board

1. Introduction

1.1. Southampton City Council (the Council) and NHS Hampshire & Isle of Wight Integrated Care Board have developed a shared ambition for change:

'Integrated Health and Wellbeing Commissioning allows the city to push further and faster towards our aim of completely transforming the delivery of health and care in Southampton, so that it is better integrated, delivered as locally as possible, person centred and with an emphasis on prevention and intervening early to prevent escalation'.

For the purpose of these Terms of Reference, Health and Wellbeing is defined as Health and Care services outlined in the scope Annex A.

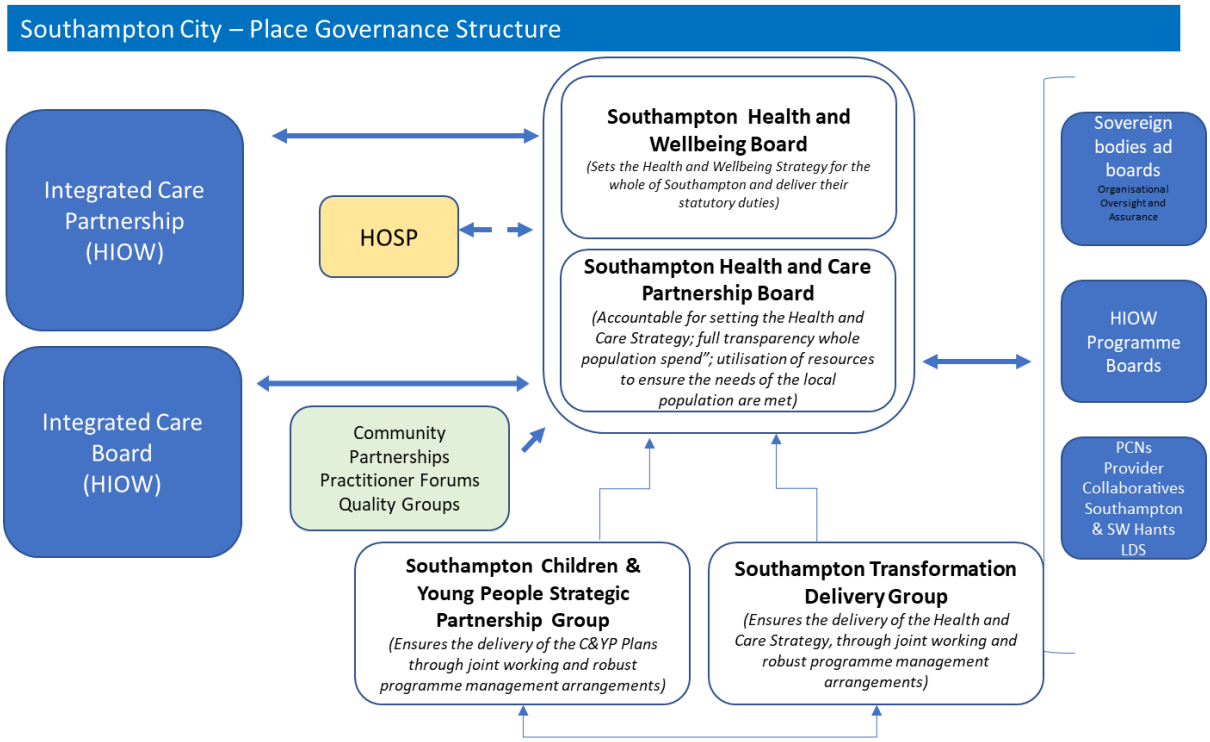
If we are to realise this vision and meet the challenges we face then we will need to:

- Act as one for the city by
  - developing and delivering a single view of the city's needs and how we can ensure they are best met
  - aligning and allocating our collective resources to achieve prioritised outcomes
  - working for the whole population
- Support people to become more independent and do things for themselves by changing the relationship between citizens and services
- Be innovative and have an appetite for risk to make the change
- Ensure that the health and care system is financially sustainable and flexible enough to meet current and future challenges.

1.2. There are a number of benefits from integrated commissioning that have been grouped under three broad headings

1. **Using integrated commissioning to drive provider integration and service innovation**. It is through these innovations that integrated commissioning has the greatest potential to benefit citizens and patients.
2. **Improving the efficiency of commissioned services**. This includes both streamlining process and reducing duplication and variation. This is particularly relevant for services/providers working across both commissioning organisations.
3. **Increasing the effectiveness of commissioning – across the whole of the commissioning cycle.** Combining the knowledge, expertise and importantly authority and leaderships of both organisation (clinical and democratic) has the potential to significantly increase the effectiveness of commissioning across the City.

1.3. The Council and ICB established the Partnership Board to commission health and social care in the City of Southampton. It will encourage collaborative planning, ensure achievement of strategic objectives and provide assurance to the governing bodies of the partners on the progress and outcomes of the work of integrated commissioning. The Southampton Health & Care Partnership Board hereafter will be referred to as the Board.



1.4. The Board will act as the single health and wellbeing commissioning body for the City of Southampton and a single point for decision makers. The Board will convene and exercise their functions following consensus / consultation with each other on those functions in scope. This includes those areas of health and social care commissioning covered by the Better Care Fund Section 75. (BCF)

1.5. The Board has been established to ensure effective collaboration, assurance, oversight and good governance across the integrated commissioning arrangements between Southampton City Council and HIOW ICB.

1.6. As such, the Board will develop and oversee the programme of work to be delivered by the Integrated Commissioning Unit and review and define the integrated commissioning governance arrangements between the two bodies.

1.7. The Board will monitor the performance of the Integrated Commissioning unit and ensure that it delivers the statutory and regulatory obligation of the partners of the Better Care Fund and relevant Section 75 agreements.

1.8. The Board will ensure the development and implementation of the Southampton Five Year Health and Care Strategy

1.9. Evidence based commissioning will be key to achieving our vision and the Board will be informed and driven by needs assessment, market analysis, user experiences, consultation and engagement.

1.10. The Board will maintain a focus on the commissioning of services to meet the outcomes of the citizens of Southampton, and those registered with GP's in Southampton whilst working in the Southampton and SW Hampshire and wider Hampshire and Isle of Wight context.

2. Scope

2.1 The Board will have oversight of all schemes established under the Better Care Section 75 and other remaining Partnership Agreements which in some cases may have their own specific Partnership Board, under the NHS Health Act 2006 flexibilities, and Local Government Act 1972 (s.113). This will include shadow monitoring of schemes under development and scrutinising their suitability for future inclusion in the BCF Partnership Agreement or other Partnership Agreements. An example of schemes to be included is to be found in Annex A.

2.2 There may also be services in scope for which the commissioning responsibility/ decision making remains solely with the HIOW ICB or City Council but the funding is aligned to deliver a jointly agreed strategy. Examples can be found in Annex A

2.3 Beyond this, there could be areas of shared commissioning where the Council and ICB will want to discuss and share information about relevant commissioning intentions, budget and spend. The Board could also consider bids that are of joint interest. These 3 categories are described below:

- Jointly commissioned/funded services
- Single agency commissioning aligned under a jointly agreed strategy
- Other areas relevant for the achievement of the outcomes

2.4 The scope of the Board will cover joint NHS and City Council services commissioned.

2.5 The Board may, where appropriate, support a wider range of services subject to final approval of the ICB and Council.

2.6 Subject to the agreement of the ICB and the Council, the Board membership may be amended to include any other partner who jointly commissions with the City Council or ICB and other agency representatives may be co-opted as necessary.

3 Role and Objectives

3.1 To agree shared commissioning priorities for the Council and ICB based on where a partnership approach will improve outcomes and promote greater efficiencies.

3.2 To approve and monitor the development and implementation of the Integrated Commissioning Plan to ensure it meets agreed priorities, objectives, savings and performance targets and aligns commissioning arrangements with partners' financial and business planning cycles.

3.3 To ensure that all commissioning decisions are made in line with the principles set out in the Integrated Commissioning plan, including providing challenge regarding the scale and pace of integrated commissioning approaches.

3.4 To monitor the financial plans and financial performance of the integrated Commissioning Unit including forecasts for the year.

3.5 To ensure compliance with any specific reporting requirements associated with the formal pooled fund described in the Section 75 agreement.

3.6 To ensure compliance with rules and restrictions associated with any other blocks of funding, including specific grant funding.

3.7 To ensure the appropriate management of risks regarding the integrated commissioning function.

3.8 To agree, subject to the financial decision-making limits of the council and the ICB, all financial planning commitments across areas of integrated commissioning responsibility for pooled or non-pooled budgetary provision.

3.9 To receive and consider reports on service development, budget monitoring, audit and inspection reports in relation to those services, which are the subject of formal partnership arrangements.

3.10 To seek assurance on the quality and safety of commissioned services in relation to key performance indicators and standards.

3.11 To provide system leadership and direction to the staff of the integrated Commissioning Unit.

3.12 To promote quality and identify how the health and wellbeing strategic intentions and priorities of partners will be supported and enabled through integrated commissioning.

3.13 To maintain oversight of the Section 113 arrangements between the two organisations for the Integrated Commissioning Unit.

4. Better Care Section 75 Partnership Agreement

The Board:

4.1 Shall oversee and review the schemes established under the Better Care S75 Partnership Agreement, ensuring adherence to the relevant legislation and protocols in the development of Partnership Agreements have been followed.

4.2 Shall receive, review and approve Business Cases for new pooled fund schemes to be established under the Better Care Section 75 Partnership Agreement (with reference to the respective Schemes of Delegation).

4.3 Shall receive and review quarterly reports on each Better Care pooled fund scheme on the exercise of the partnership arrangements. These reports shall include details of:

- Annual forward financial plans setting out the projected annual spend
- Review of the operation of each scheme covering:
    - evaluation of performance against agreed performance measures targets and priorities and future targets and priorities;
    - quality of service delivery and how the arrangements benefit and meet the needs of client
    - groups;
    - any service changes proposed;
    - any shared learning and opportunities for joint training;
    - assurance that monitoring and evaluation processes take account of statutory guidance
    - and policy directives pertaining to quality standards, best value and audit arrangements of the Council and the HIOW ICB.

4.4 Shall ensure the Services provided under each scheme are meeting the needs of the service users and their carers.

4.5 Shall ensure that commissioning decisions are the result of the wide ranging consultation and discussion with the key people involved in all aspects of the function of delivering joined up health and social care.

4.6 Shall encourage and ensure that service providers work collaboratively with service users, other providers and commissioners and that it is promoted through positive design of payment packages and risk and benefit share arrangements into commissioning contracts.

4.7 Shall ensure that commissioners listen to service users and providers and respond supportively to ideas to make services more effective for the user and more responsive to needs.

4.8 Shall assess and manage any liabilities or risks reported in relation to each of the Better Care pooled fund schemes and act upon these at the earliest opportunity and monitor their impact throughout the delivery of the services. This shall include consideration of proposed changes to the services and funding and how these may impact on each organisation.

4.9 Shall monitor financial contributions of the Council and the ICB and make recommendations regarding future financial contributions.

4.10 Shall provide the Council and ICB with an annual review report and forward plan of the S75 Better Care Partnership Agreement arrangements, incorporating financial and activity performance, risks, benefits and evidence of improvements for service users.

5 Risk Sharing principles

5.1 The pooled budget arrangements will be managed in such a way as to avoid destabilising either organisation, the detailed arrangements for managing the pooled funds are detailed in the Section 75 Pooled Fund Agreement and its scheme specifications.

5.2 Each organisation will retain responsibility for dealing with any deficit it has at the start of the pooled budget arrangement. For the avoidance of doubt this includes a situation where commitments against the pooled fund are greater than or are likely to be greater than the budget set.

5.3 Each organisation will strive to achieve a balanced budget within the pooled budget.

5.4 The statutory requirements of each organisation must be maintained.

5.5 The pooled budget (in line with the Section 75 agreement) will contain a mechanism for dealing with significant changes to the funding or statutory responsibilities of either organisation that effect the areas in scope of the pooled budget arrangement.

5.6 Both organisations will provide robust management information in line with their responsibilities in the Section 75.

5.7 Both organisations will ensure the early identification of potential in year under or over spends and for remedial actions to be put into place.

6 Governance and Reporting

The Board will be accountable to the Council's Cabinet and / or Council as appropriate and the ICB.

6.1 The Board will need to demonstrate contribution to the Health and Wellbeing Strategy outcomes

6.2 The Board will need to be informed by the Joint Strategic Needs Assessment, needs assessments, market analysis and feedback from consultation and engagement with residents and patients.

6.3 The Board will meet 6 times per year as a combination of briefing meetings and public meetings (with at least two of those meetings taking place in public). Additional meetings may be held on an exceptional basis at the request of the Chair.

6.4 At least one meeting each quarter will receive and review the performance of the Better Care S75 Partnership Agreement, undertaking those responsibilities as set out in Section 4.

6.5 The Board shall be entitled to call a meeting, at any time, outside of the agreed meetings schedule, for any purpose, subject to compliance with any statutory requirements in relation to decision making under the Local Government Acts and ICB Constitution.

6.6 All minutes from the Board will be available to the ICB and Council's Cabinet.

6.7 Agendas will be jointly agreed in line with the Forward Plan and will need to be circulated at least 5 working days in advance of the meeting. All new agenda items are subject to agreement of the Chair or Vice Chair. Where a decision of the Council (Member or Officer) is required at a Board meeting then the requirements of the Local Government Act 2000 and Access to Information regulations 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 (Democratic Services must attend for this purpose for these items). Decisions that are 'key decisions' within the meaning of the Local Government Act 2000 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.

6.8 The agendas, minutes, decision notices and briefing papers of the meetings of this Board are subject to the provisions of the Freedom of Information Act 2000, the Environmental Information Regulations and the Data Protection Act 2018. If the Chair concludes that specific issues are exempt from publication and should not be made available under the terms of the Freedom of Information Act, a Part 2 meeting of the Board shall be convened to consider them.

6.9 Part 2 meetings have to be notified 28 days in advance of the meeting and reasons for excluding the public included on the report / agenda item or the decision cannot be taken. There are limited urgency provisions but these require prior consent from the chair of the Health Overview and Scrutiny Panel.

6.10 Meetings of the Board shall be advertised in advance on the calendar of meetings of the ICB and Council and shall, unless notice of consideration of an excluded item has been given, shall be open to the public to attend.

6.11 The Chair will invite questions or statements by members of the public on matters pertaining to that agenda at the beginning of the meeting.

6.12 Administrative support for the Board will be a shared responsibility although agenda publication will be undertaken by both the Council and the ICB to meet both organisational requirements.

6.13 The Health and Wellbeing Board have delegated responsibility for Better Care and the Southampton City Five Year Health and Care Strategy implementation to the Board and the Board will be accountable to the Health and Wellbeing Board for this element.

6.14 The Board will receive the minutes from the Better Care Southampton Steering Board

7 Membership

7.1 The representation on the Board will be as follows:

Organisation	Position
Southampton City Council	Leader of the Council and Chair (delegated to Cllr Lorna Fielker)
	Deputy Leader and Cabinet Member for Adults, Housing & Health (yearly alternating Chair with Dr Sarah Young)
	Cabinet Member for Children & Learning
	Executive Director Wellbeing and Housing (DASS)
	Executive Director Wellbeing (Children and Learning) (DCS)
	Director of Public Health
Integrated Care Board	Southampton Place Director
	Place Clinical Director (alternating Chair with Lead Member)
Southampton Voluntary Services/ Healthwatch	Chief Executive Officer, Southampton Voluntary Services
Providers	Solent NHS Trust Chief Operating Officer, Alasdair Snell, (has delegated attendance to Jo Pinhorn, Deputy Chief Operating Officer).
	Southern Health Trust Chief Operating Officer Eugene Jones (has delegated attendance to Sarah Olley, Divisional Director of Operations)
	University Hospitals Southampton, Partnership and Strategy Director
	Clinical Director, Primary Care Network
	Clinical Director, Primary Care Network
Other attendees (non-voting)	Director of Commissioning and Integrated Care
	Finance Lead, HIOW
	Executive Director, Corporate services and statutory section 151 officer (finance lead)

7.2 In exceptional circumstances for Southampton City Council, a decision maker can be changed from a cabinet member to the Leader of the Council as long as the forward plan has been amended in line with appropriate timescales and papers have not been published

7.3 Other attendees

- Key senior managers from the Council and the HIOW ICB as required.
- The relevant commissioning lead for each of the pooled budgets under the S75 Better Care

- Partnership Agreement will attend as appropriate the quarterly meetings to present the
- Performance report for the S75 Partnership Agreement.

7.4 The Chair will be a politician from the council or the Clinical Director of Southampton Place – HIOW ICB. The Vice Chair of the Board will be from the alternate partner organisation.

8 Quorum, Decision Making and Voting

8.1 The ICB and SCC Cabinet may grant delegated authority (with any appropriate caveats) to those of its members or officers participating in the Board to make decisions on their behalf, whilst retaining overall responsibility for the decision made by those members or officers. It is therefore the individual member or officer who has the delegated authority to make a decision rather than the Board itself.

8.2 The Board will require consensus prior to any delegated decisions being taken; consensus will be demonstrated by a show of hands. It is important that given the nature of the decisions, securing the support of partners will be critical to the success of this Board. The Board will be quorate if there are at least 4 members in attendance with a minimum of 2 from the City Council and HIOW ICB.

8.3 In those circumstances where consensus cannot be reached, the matter will be deferred for further consideration by the parties and will be reconsidered after discussions between the Chair and respective partner lead.

8.4 Schemes of Delegation to City Council Members and Council Officers shall be amended to reflect that decisions should not be taken under delegation and should stand either deferred to a future meeting or referred back to the parent body where a consensus of those present do not support the decision proposed. The Chair of the Board shall consult those present before deferring the decision or directing that it be referred back to each partner organisation.

8.5 Legally, it is not possible to have a mechanism that requires individual decision makers to exercise their decision making function in accordance with the will of a majority or quorum of a Board. Any individual decision maker must consider any decision on its merits as a whole in accordance with established decision making principles. The process for seeking the support of the Board prior to exercising any delegation meets a requirement in the Scheme of Delegation to limit the power to exercise that delegation to situations only where the support of the Board is demonstrated. For the ICB the delegated authorisation limit is up to £500,000 for the City Council the delegated authorisation limit is up to £2 million with any decisions over £500k being classed as a key decision.

8.6 Functions outside the decision making scope of the Board, but related to health and social care will be discussed for information only at the Board, with the considerations and any recommendations of the Board formally minuted. Items will then be referred to the relevant decision maker (e.g. ICB, Council).

9 Dispute Resolution

9.1 If disputes relating to the Better Care Section 75 Partnership Agreement arise then the Dispute Resolution process within that will be followed. Otherwise, any matter of dispute will be referred for further discussion by the Leader of the Council and Chair

of the ICB before referring back to the Board for further consideration. It is recognised that as the desire is to reach agreement on any matter by consensus that if this is not reached that matter may not move forward. There will be no formal and binding external arbitration procedure.

10 Scrutiny

10.1 Decisions of members of the Board will be subject to formal scrutiny normally undertaken by the Health Overview and Scrutiny Panel, on behalf of the Council and Call in. Health scrutiny is a fundamental way by which democratically elected councillors are able to voice the views of their constituents, and hold NHS bodies and health service providers to account. In Southampton the Health Overview and Scrutiny Panel undertakes the scrutiny of health and adult social care. The Panel meets every 2 months. However, there may be some major decisions may be considered by the council's Overview and Scrutiny Management Committee.

11 Conflict of Interests

11.1 The Board will be bound by the Standing Orders/Standing Financial instructions and Codes of Conduct of both parent bodies. Declaration of interests will need to be declared annually and at each meeting of the Board in line with the agenda. Depending on the topic under discussion and the nature of the conflict of interest appropriate action will be taken and recorded in the minutes

12 Variation

12.1 The parent bodies may agree from time to time to modify, extend or restrict the remit of the Board.

12.2. The Terms of Reference will be reviewed annually.

Annex A

Integrated Commissioning – Examples of potential scope

Jointly commissioned/funded services

1. These will be services currently in scope for the 2020/21 Better Care Fund S75 agreement. In addition, the scope will include other existing partnership agreements/shared funding arrangements:

    - Support Services for Carers
    - Integrated Locality Teams (previously known as cluster working): Community health services for adults (Community Nursing, Continence, Podiatry, Community Wellbeing Services, Community specialist services for people with long term conditions, case management, Palliative Care, community navigation, Community Adult Mental Health Services and IAPT (Improving access to psychological therapies) , Adult Long Term Social Care Teams)
    - Integrated rehabilitation, reablement and hospital discharge services (including the Hospital Discharge Team, Discharge to Assess, residential reablement and extra care, Falls Assessments)
    - Aids to Independence: including Joint Equipment Service, Wheelchair service and Disability Facilities Grant
    - Prevention and Early Intervention services –Older Person's Offer, Information, Advice and Guidance, Community Solutions and Housing Related Support
    - Integrated Learning Disabilities Commissioning (placements)
    - Promoting the uptake of Direct Payments
    - Transformation of Long Term Care provision (Adult Social Care additional/improved BCF funding to support transformation of Extra Care and conversion of a Residential Unit to Nursing Care as well as stabilising the Domiciliary Care and Care Home market)
    - Integrated services for children with complex health needs (specifically Building Resilience Service and SEND integrated health and social care team).

Single agency commissioning aligned under a jointly agreed strategy

2. This would mean that commissioning responsibility/ decision-making remains solely with the ICB or City Council but the funding is aligned to deliver a jointly agreed strategy. This could include:

    - Long Term Care provision (including domiciliary care, nursing and residential CHC and social care packages) – aligned to Better Care strategy
    - 0-19 prevention and Early Help, CAMHS, Community midwifery – aligned to 0-19 prevention and early help strategy/CAMHS Transformation
    - Sexual health (integrated level 3 service, voluntary and primary care prevention services, termination of pregnancies, vasectomies) – aligned to Sexual Health and Reproductive Strategy
    - Substance Misuse Services – aligned to Substance Misuse Strategy
    - Respite and Short Breaks – aligned to Replacement Care Strategy, services for children, e.g. Edge of care, Family Drugs and Alcohol Court, Looked After Children, Safeguarding – aligned to children's strategy
    - Benefits

3. The scope will increase the ability of both organisations to:
    - Realise a shared vision – e.g. a shared focus on prevention and early intervention and community solutions to promote independence & a shared commitment to realise it
    - Share risks and benefits associated with implementation of the shared vision, enabling us to do the “right thing” without unfairly disadvantaging or advantaging one organisation
    - Commission against a single agreed set of common outcomes and priorities – making best use of resources
    - Share needs data and good practice evidence – leading to more intelligent commissioning
    - Develop more innovative solutions to meet people’s needs in the round (as opposed to commissioning in silos for people’s “health” versus “social” needs – leading to improved outcomes for people
    - Bring together health, public health and social care resources and strip out duplication – leading to savings and efficiencies
    - Commission a more joined up health and care system, developing together whole pathways from prevention to care - fewer gaps
    - Enable providers to develop more innovative integrated pathways and organisational models – leading to less fragmentation
    - Shape and develop primary medical care as part of the integrated health and social care system
    - Better understand and manage demand through greater influence over assessment and review processes