Cheshire and Merseyside
Health and Care Partnership

Joint Committee of the Cheshire & Merseyside Clinical Commissioning Groups

Terms of Reference

May 2021

NHS Cheshire Clinical Commissioning Group
NHS Halton Clinical Commissioning Group
NHS Knowsley Clinical Commissioning Group
NHS Liverpool Clinical Commissioning Group
NHS Southport and Formby Clinical Commissioning Group
NHS South Sefton Clinical Commissioning Group
NHS St Helens Clinical Commissioning Group
NHS Warrington Clinical Commissioning Group
NHS Wirral Clinical Commissioning Group

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Author(s)	Dianne Johnson, Accountable Officer, NHS Knowsley CCG
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Terms of Reference for the Joint Committee of Cheshire and Merseyside Clinical Commissioning Groups

1. Introduction

1.1 The Cheshire and Merseyside Health and Care Partnership (C&M HCP) is on a journey to be designated as an Integrated Care System (ICS) by April 2021. Key to this is developing the system architecture to support consistent operating arrangements for the future ICS. In response to this, Cheshire and Merseyside Clinical Commissioning Groups (CCGs) are seeking to establish a Joint Committee of the nine CCGs to make some commissioning decisions 'at scale' across Cheshire and Merseyside. The default principle, however, is that wherever possible, commissioning decisions should be made at 'Place' with only those commissioning decisions which make sense to do at scale being undertaken at a Joint Committee of CCGs across the Cheshire and Merseyside footprint.

1.2 The NHS Act 2006 (as amended) ('the NHS Act'), was amended through the introduction of a Legislative Reform Order ("LRO") to allow CCGs to form joint committees. This means that two or more CCGs exercising commissioning functions jointly may form a joint committee as a result of the LRO amendment to s.14Z3 (CCGs working together) of the NHS Act. Joint committees are statutory mechanisms which enable CCGs to undertake collective strategic decision making.

1.2 Health and Care Partnerships have been established nationally in accordance with the NHS Shared Planning Guidance requirements 2015/16, which required every health and care system to come together to develop plans to accelerate implementation of the NHS Five Year Forward View and the NHS Long Term Plan. CCGs are encouraged to form Joint Committees to facilitate effective, collaborative decision-making, where appropriate.

2. Establishment

2.1 The CCGs have agreed to establish and constitute a Joint Committee with these terms of reference to be known as the Joint Committee of the Cheshire and Merseyside Clinical Commissioning Groups (CCGs).

3. Role of the Joint Committee

3.1 The overarching role of the Joint Committee is to enable the Cheshire and Merseyside CCGs to work effectively together and make binding decisions on agreed service areas, for the benefit of the both the resident population and population registered with a GP practice in Cheshire and Merseyside.

3.2 Decisions will be taken by members of the Joint Committee in accordance with the delegated authority granted to them from each of their respective CCGs. As Joint Committee Members, individuals will represent the whole Cheshire and Merseyside population and make decisions in the interests of all patients.

3.3 Decisions will support the strategic aims and objectives of the C&M HCP and will contribute to the sustainability and transformation of local health and social care systems at 'Place'. The strategic aims of C&M HCP are aligned to the NHS Long Term Plan (2019) and focus on improving and modernising our health and care services by:

3.1.1 Delivering safe and sustainable high-quality services;

3.1.2 Improving the health and wellbeing of local communities and tackling health inequalities; and

3.1.3 Delivering better joined up care closer to home.

3.4 The Joint Committee will at all times, act in accordance with all relevant laws and guidance applicable to the CCGs.

4. Remit of the Joint Committee of Cheshire and Merseyside CCGs

4.1 The Joint Committee will be responsible for making binding decisions on the agreed service areas (outlined in Appendix 1), for both the resident and registered with a GP Practice in Cheshire and Merseyside patient population. For these agreed service areas, to be jointly commissioned 'at scale' by the nine Cheshire and Merseyside CCGs, the responsibilities of the Joint Committee will include:

4.1.1 Population analysis of needs which should be addressed at a Cheshire and Merseyside level;

4.1.2 Setting common standards across the agreed commissioned service areas, to be adhered to across Cheshire and Merseyside and aligned to where services are commissioned outside of Cheshire and Merseyside;

4.1.3 Monitoring of these standards and providing assurance they are adhered to;

4.1.4 Oversight and co-ordination of any public consultation or engagement required in relation to these agreed service areas (individual CCGs would undertake the public consultation and engagement and take collective accountability); and

4.1.5 Allocation of spend related to the decisions made on the agreed service areas.

4.2 The services within scope will be defined in a workplan approved by each CCG, to be appended to the Terms of Reference. Given the changing NHS landscape there is a need to be flexible and be able to respond to change in year. It should be noted that any addition to the agreed annual workplan must be approved by each constituent CCG.

4.3 In addition, the Joint Committee will also provide a forum for the nine CCGs to consider national initiatives and/or new policy implementation which would/will impact on the delivery of CCG functions. Working collaboratively, the CCGs would review, determine at which level commissioning should take place i.e. C&M scale or at 'Place' and, where appropriate, agree common standards. The Joint Committee would form and submit any subsequent recommendations to each Constituent CCGs Governing Body for consideration.

5. Functions of the Joint Committee

5.1 The Committee is a Joint Committee of: NHS Cheshire CCG; NHS Halton CCG; NHS Knowsley CCG; NHS Liverpool CCG; NHS South Sefton CCG; NHS Southport and Formby CCG; NHS St Helens CCG; NHS Warrington CCG; and NHS Wirral CCG established through the powers conferred by section 14Z3 of the NHS Act 2006 (as amended). Its primary function is to make collective binding decisions on agreed service areas, for the Cheshire and Merseyside population within its delegated remit.

5.2 In order to deliver its delegated functions the Joint Committee will:

- 5.2.1 Make decisions to enable delivery of activities defined in a work plan, approved in line with the Joint Committee principles and responsibilities
- 5.2.2 Agree and oversee an effective risk management strategy to support decision-making in all areas of business related to the Joint Committee's remit. These risks will be managed by the Joint Committee.
- 5.2.3 Act as a decision-making body; authorising sub-groups to oversee and lead implementation of service changes
- 5.2.4 Within the defined work plan, approve service models, specifications, and business cases up to the value as determined for the Governing Body by each constituent CCG's Scheme of Reservation & Delegation.
- 5.2.5 Ensure appropriate patient and public consultation and engagement, which meets best practice standards and is compliant with CCGs' statutory responsibilities with regard to involvement, as set out in the NHS Health and Social Care Act 2012.
- 5.2.6 Ensure compliance with public sector equality duties, as set out in the Equality Act 2010 for the purposes of implementation.
- 5.2.7 Ensure appropriate consultation with the Overview and Scrutiny Committees and Health and Wellbeing Boards (or equivalent) established by the relevant Local Authorities

5.3 Whilst it is acknowledged that individual CCGs remain accountable for meeting their statutory duties, the Joint Committee will undertake its delegated functions in a manner which complies with the statutory duties of the CCGs as set out in the NHS Act 2006 and including:

- 5.3.1 Management of conflicts of interest (section 14O)
- 5.3.2 Duty to promote the NHS Constitution (section 14P)
- 5.3.3 Duty to exercise its functions effectively, efficiently and economically (section 14Q)
- 5.3.4 Duty as to the improvement in quality of services (section14R)
- 5.3.5 Duties as to reducing inequalities (section 14T)
- 5.3.6 Duty to promote the involvement of patients (section 14U)
- 5.3.7 Duty as to patient choice (section 14V)
- 5.3.8 Duty as to promoting integration (section 14Z1)
- 5.3.9 Public involvement and consultation (section 14Z2)

5.4 In discharging its responsibilities the Joint Committee will provide assurance to each Governing Body through the submission of minutes, presented to Governing Body meetings, setting out key actions and decisions from each meeting and an annual report to inform constituent CCGs' annual governance statements.

5.5 The Joint Committee will conduct an annual effectiveness review which will be reported to each CCG's Audit Committee.

6. Membership

6.1 The Cheshire and Merseyside Joint Committee member organisations are:

- NHS Cheshire CCG
- NHS Halton CCG
- NHS Knowsley CCG
- NHS Liverpool CCG
- NHS South Sefton CCG
- NHS Southport and Formby CCG
- NHS St Helens CCG
- NHS Warrington CCG
- NHS Wirral CCG

6.2 A CCG member with statutory duties (Accountable Officer or Chief Finance Officer) of each full member organisation will sit on the Joint Committee. The CCG member with statutory duties will be a voting member of the Joint Committee.

6.3 Figure 1 depicts the Joint Committee membership

Figure 1: Membership

VOTING MEMBERS
Per CCG, one member with statutory duties • CCG Accountable Officer (x7) • CCG Chief Finance Officer (x2)* **** When an AO is the AO of 2 CCGs***
• x1 Chair** • x1 Vice Chair** ***** To be appointed from incumbent Chairs/Vice Chairs*** Each CCG to provide one of the following Governing Body roles • x4 Clinical Leads • x1 Secondary Care Doctor • x1 Registered Nurse • x1 Lay Member – audit & governance • x1 Lay member - PPI • x 1 Quality Lead

IN ATTENDANCE – NON VOTING
Healthwatch representative
Cheshire & Merseyside ICS representative
Public Health representative

6.4 Decisions made by the Joint Committee, within its remit, will be binding on its member Clinical Commissioning Groups.

6.5 Other organisations may be invited to send representatives to the meetings. In attendance members may represent other functions / parties/ organisations or stakeholders who are involved in the work plan of the Joint Committee and may provide support and advice to members.

7. Deputies

7.1 Each full member organisation will identify a named deputy member to represent members in the event of absence.

7.2 A named deputy will have delegated decision making authority to fully participate in the business of the Joint Committee.

8. Quoracy

8.1 The meeting will be quorate with at least one representative of each CCG (including the Joint Committee Chair/Deputy).

8.2 In the event of the Joint Committee making a formal decision which requires a vote, one voting member from each full member organisation/ CCG will be required for the meeting to considered quorate.

8.3 A duly convened meeting of the Committee at which quorum is present shall be competent to exercise all or any of the authorities, powers and directions vested in or exercisable by it.

9. Voting

9.1 The Joint Committee will aim to make decisions through consensus.

9.2 In the event of a requirement to make a decision by taking a vote, where a minimum of 75% of the voting committee membership, in attendance at the meeting, are in agreement; a recommendation or decision will be carried i.e. of the 9 voting members, where 7 voting members are in agreement.

9.3 Joint Committee members will make decisions in the best interests of the whole Cheshire and Merseyside population, rather than just the population of their constituent CCG.

10. Conflicts of Interest

10.1 A register of interests will be compiled and maintained for the Joint Committee which will require members (full and associate) to declare any interest in respect of their role across Cheshire & Merseyside in addition to their own CCG. This register shall record all relevant and material, personal or business interests, and management action as agreed by the individual's CCG. The Joint Committee register of interests will be published on each individual CCG's website and available for inspection at the offices of each CCG.

10.2 Each member and attendee of the Committee shall be under a duty to declare any such interests. Any change to these interests should be notified to the Chair as soon as they are known and no longer than 28 days from any change.

10.3 Where any Joint Committee member has an actual or potential conflict of interest in relation to any matter under consideration at any meeting, the Chair (in their discretion) taking into account any management action in place at the individual's CCG and having regard to the nature of the potential or actual conflict of interest, shall decide whether or not that Joint Committee member may participate in the meeting (or part of meeting) in which the relevant matter is discussed. Where the Chair decides to exclude a Joint Committee member, the relevant CCG may send a deputy to take the place of that conflicted Joint Committee member in relation to that matter, as per section 7 'Deputies' above.

10.4 Should the Committee Chair have a conflict of interest, the committee members will agree a deputy for that item in line with NHSE guidance.

10.5 Any interest relating to an agenda item should be brought to the attention of the Chair in advance of the meeting, or notified as soon as the interest arises and recorded in the minutes.

10.6 Failure to disclose an interest, whether intentional or otherwise, will be treated in line with the respective CCG's Conflicts of Interest Policy, the Standards of Business Conduct for NHS Staff (where applicable) and the NHS Code of Conduct.

11. Meetings

11.1 The Joint Committee shall meet bi-monthly and then as required in order to make decisions regarding the work plan. The Chair will have authority to call an extraordinary meeting with at least 5 days' notice.

11.2 Meetings will be scheduled to ensure they do not conflict with respective CCG Governing Body meetings.

11.3 Meeting dates will be published on the nine CCG websites at least 5 working days before the meeting. Agendas and papers will be published on each of the nine CCG websites.

11.4 The Joint Committee may appoint task and finish groups or sub-committees for any agreed purpose which, in the opinion of the Joint Committee, would be more effectively undertaken by a task and finish group or sub-committee. Any such task and finish group or sub-committee may be comprised of members of the CCGs or other relevant external partners, who are not required to be members of the Joint Committee. Minutes/reports of task and finish group or sub-committees will be promptly submitted to the Joint Committee.

11.5 Joint Committee meetings will be held in public but are not public meetings. Members of the public may observe deliberations of the Joint Committee, with feedback encouraged through the public engagement or consultation process. Items the Joint Committee considers commercial in confidence or not to be in the public interest will be held in a private session (Part 2) of the meeting, which will not be held in public as per Schedule 1A, paragraph 8 of the NHS Act 2006.

11.6 Members of the Joint Committee may participate in meetings in person or virtually via video, telephone, web link or other live and uninterrupted conferencing facilities.

12. Infrastructure/Organisational Support

12.1 To enact the business of the Joint Committee and progress the work plan for agreed service areas, dedicated administrative resource for the Joint Committee will be agreed by the nine CCGs.

12.2 Papers for each meeting will issued to Joint Committee members no later than five working days prior to each meeting. By exception, and only with the agreement of the Chair, amendments to papers may be tabled before the meeting. Every effort will be made to circulate papers to members earlier if possible.

13. Review of Terms of Reference

13.1 These terms of reference shall be reviewed by the Joint Committee annually, with input from CCG Governing Bodies, and any amendments approved by each CCG.

13.2 They may also be amended by mutual agreement between the CCGs at any time to reflect changes in circumstances as they may arise.

14. Withdrawal from Committee

14.1 Should the Joint Committee arrangement prove to be unsatisfactory, the Governing Body of any member CCG can decide to withdraw from the arrangement, but has to give a minimum of six (6) months' notice to partners, with consideration by the Committee of the impact of a leaving partner – a maximum of 12 months' notice could apply.

15. Dispute Resolution

15.1 Where any dispute arises between the member CCGs or where the Joint Committee cannot reach a decision in accordance with its terms of reference, the member CCGs must use their best endeavours to resolve that dispute on an informal basis at the next meeting of the Joint Committee.

15.2 Where any matter referred to dispute resolution is not resolved under 14.1, any Party in dispute may refer the dispute to the Accountable Officers of the relevant CCG, who will cooperate in good faith to recommend a resolution to the dispute within ten (10) Working Days of the referral.

15.3 If the dispute is not resolved under Clauses 14.1 and 15.2, any CCG in dispute may refer the dispute to NHS England and each CCG will co-operate in good faith with NHS England to agree a resolution to the dispute within ten (10) Working Days of the referral.

15.4 Any referral to NHS England under Clause 15.3 shall be to Director of Commissioning Operations, NHS England.

15.5 Where any dispute is not resolved under Clauses 15.1. to 15.4, any CCG in dispute may refer the matter for mediation arranged by an independent third party and any agreement reached through mediation must be set out in writing and signed by the member CCGs in dispute.

Appendix 1: Joint Committee work plan

A1.1 Discussions on the focus of the Joint Committee of Cheshire and Merseyside CCGs have been undertaken with system leaders, on a one-to-one basis (in October and November 2020), which included CCG Accountable Officers, CCG Chairs, Local Authority Chief Executives and Place leads, and Health and Care Partnership leads.

A1.2 There was consensus on the need for the majority of commissioning to remain local at Place. There was general agreement that Primary Care services, Community Care services and Voluntary Care services should continue to be commissioned at Place.

A1.3 There was also consensus that there was merit in exploring services that could be commissioned at scale and that CCGs should consider establishing a Joint Committee of Cheshire and Merseyside CCGs. Using the principles outlined in the figure below this list has been refined with the CCG Accountable Officers.

Figure 2: Principles

HCP strategic aims	Principles for identifying service areas which could be managed 'at scale'
a) Delivering safe and sustainable high-quality services	**The service requires a critical mass beyond a local Place level to deliver safe, high quality and sustainable services;** ▪ *A level of activity required to ensure optimal patient outcomes* ▪ *Clinical evidence base* ▪ *A scarcity in the workforce required to deliver a safe and sustainable service* ▪ *Working at scale will result in efficiencies and greater value for money than would be achieved otherwise* ▪ *Reduce inequalities and improve all aspects of quality* ▪ *To undertake activities in such a way as to support provider collaboratives to develop and mature*
b) Improving the health and wellbeing of local communities and tackling health inequalities	**Working together collaboratively to tackle collective health inequalities across Cheshire and Merseyside** • *Must require a C&M approach* • *Levelling up approach – prioritising one area must not lead to increased inequalities in another area*
c) Deliver better joined up care closer to home	**Working together will achieve greater effectiveness in improving health and care outcomes** • *Low volume/high cost* • *Activities must complement local arrangements and support integration at place* • *Brings together a team of talents to look at more complex issues*

A1.5 An outline initial workplan for the services is provided in Figure 3.

Figure 3: Initial outline workplan

Service area to be commissioned 'at scale'	Specific services to be included in the workplan of the Joint Committee of Cheshire and Merseyside CCGs
Mental Health Services	A. Children and Young People mental health services • Crisis services • Eating disorder services B. Agree common standards and develop a common workforce strategy to address widespread variation in access, provision, quality and outcomes C. Out of area placements
Acute services	A. Specialist Rehabilitation services (Neuro, Mental Health, Stroke, complex cases) B. To re-procure Bariatric services during 2021/22. C. Spinal services D. Standardise clinical commissioning policies e.g. IVF, interventions of low clinical importance E. Agree to adopt the National Specification for Stroke services across C&M.

A1.6 More service areas may be added to the work plan as the Joint Committee of Cheshire and Merseyside CCGs develops, any such development will be aligned to the principles outlined in Figure 2 and will require approval from each CCG for any changes to the Committee's approved annual workplan.

A1.7 It should be noted that commissioning at scale does not mean that the result will be a one size fits all solution when delivering at Place.