Report To:	**EXECUTIVE BOARD**
Date:	15 March 2017
Executive Member/ Reporting Officer:	Councillor Jim Fitzpatrick – First Deputy (Performance and Finance) Kathy Roe – Chief Finance Officer - Tameside & Glossop Clinical Commissioning Group Ian Duncan - Assistant Executive Director – Finance
Subject:	**TAMESIDE COUNCIL AND TAMESIDE & GLOSSOP CLINICAL COMMISSIONING GROUP – INTEGRATED COMMISSIONING FUND – SINGLE FINANCE AGREEMENT FROM 1 APRIL 2017**
Report Summary:	This report has been prepared jointly by officers of the Council and Tameside and Glossop Clinical Commissioning Group (T&G CCG) as part of the Care Together Programme in Tameside. It sets out the key principles required to establish a joint (single) fund between the Council and the CCG managed by the Single Commissioning Board. The report provides an update on progress made and seeks approval from the Tameside Council Executive Cabinet and the Tameside and Glossop Clinical Commissioning Group Governing Body to consolidate the value of pooled resources via an Integrated Commissioning Fund agreement from 1 April 2017. The same report will be presented to the Governing body of the CCG on 29 March 2017. The Tameside & Glossop Care Together Single Commissioning Board will be required to manage all resources within the Integrated Commissioning Fund and comply with both organisations statutory functions from the single fund.
Recommendations:	The Executive Cabinet is recommended to : 1. Note that an identical report will be presented to the Tameside and Glossop CCG Governing Body for approval on 29 March 2017. 2. Approve the inclusion of 2017/2018 Tameside Council service budgets as stated in **Appendix 1** within the existing section 75 joint finance pooled agreement (currently in existence for the Better Care Fund). To also approve the inclusion of 2017/2018 Tameside Council service budgets as stated in **Appendix 1** within an aligned partnership agreement. The section 75 agreement and aligned partnership agreement will formulate an overall Integrated Commissioning Fund (ICF) for the Tameside and Glossop economy. It should be noted that the CCG have also included budget allocations within the section 75 agreement, aligned partnership agreement and in addition services in collaboration agreement. Services in collaboration refer to services which cannot be included within a section 75 agreement and which the CCG co-commission with NHS England for the Tameside and Glossop economy. The details are stated in **Appendix 1**. The governance arrangements for managing, and the accountability for

delivering, statutory duties from the single fund will be undertaken by the Tameside & Glossop Care Together Single Commissioning Board.

3. Approve the management of the associated share of financial risk during 2017/2018 as stated within section 13 of the report. Executive Cabinet Members should also note that the Council agrees to increase the value of Council resources within the ICF by a maximum sum of £ 5.0 million in both 2017/2018 and 2018/2019 on the condition that the T&G CCG agrees a reciprocal arrangement in 2019/20 and 2020/21 should this be necessary. These sums are additional to the risk share values stated within section 13.
4. Approve that Tameside Council should continue to be the host organisation for the existing Section 75 pooled fund agreement.
5. Delegate authorisation to the Executive Director for Governance, Resources & Pensions to finalise the terms of the financial framework **(Appendix 3)** which will support the Integrated Commissioning Fund to be approved by both the Council and CCG by 31 March 2017.

Links to Community Strategy:

The Sustainable Community Strategy and Local Area Agreement are key documents outlining the aims of the Council and its partners to improve the borough of Tameside (agreed in consultation with local residents). Within health the CCG's Commissioning Strategy and Primary Care Strategy are similarly aligned to these principles and objectives.

Policy Implications:

The pooled fund extends the reach of the Better Care Fund to include other service areas within the local health economy. This fund is part of a wider project to integrate health and care services at a large scale across the Tameside and Glossop economy.

Financial Implications:

(Authorised by the Section 151 Officer)

This report explains the proposals for the Integrated Commissioning Fund (ICF) arrangements from 1 April 2017.

It should be noted that the ICF will be bound by the terms within the existing Section 75 agreement and associated Financial Framework agreement which will be duly approved by both the Council and CCG by 31 March 2017.

It should also be noted that the Council agrees to increase the value of Council resources within the ICF by a maximum sum of £5.0 million in both 2017/2018 and 2018/2019, should this be necessary, on the condition that T&G CCG agrees a reciprocal arrangement in 2019/20 and 2020/21.

A key section of the Financial Framework agreement is the revised risk sharing arrangements. The associated variance to the total net budget allocation at the end of each financial year will be financed in proportion to the percentage of the net budget contribution of each organisation to the ICF. However, the variance will be initially adjusted to exclude any CCG net expenditure associated with residents of Glossop as the Council has no legal powers to contribute to such expenditure. Details of the risk sharing arrangements are provided within section 13 of the report and the values are additional to the £5.0 million

contributions explained in the previous paragraph.

Executive Cabinet Members should also note that the Council Service budgets within the ICF exclude related overheads and the additional funding for Adult Social Care announced by the Government on 8 March 2017.

The update of the five year economy financial strategy is currently in progress in response to the recent financial settlements for both the Council and the CCG. Associated details will be provided within subsequent reports to both the Executive Cabinet and the Tameside & Glossop Care Together Single Commissioning Board during 2017/2018.

Legal Implications: (Authorised by the Borough Solicitor)

Section 75 partnership agreements provided by the National Health Service Act 2006 allow budgets to be pooled between local health and social care organisations and authorities. Resources and management structures can be integrated and functions can be reallocated between partners. The legal mechanisms allowing budgets to be pooled under the section 75 partnership agreement enable greater integration between health and social care and more locally tailored services. This facilitates a strategic and more efficient approach to commissioning local services across organisations and a basis to form new organisational structures that integrate health and social care.

The associated Financial Framework Agreement makes provision for governance and accountability of the ICF, the authorities and responsibilities delegated from the partners, financial planning and management responsibilities, budgeting and budgetary control, including forecasting and identifies the responsibilities of each partner organisation.

Risk Management:

The report identifies a number of specific risks arising from the proposed pooled funds and presents ways in which these will be addressed by robust governance, advice, and accountability arrangements. There is specific reference to the financial risk sharing arrangements within section 13 of the report.

Access to Information:

Background papers relating to this report can be inspected by contacting :

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1. INTRODUCTION

1.1. This report has been prepared jointly by officers of the Council and Tameside and Glossop CCG as part of the Care Together Programme in the Tameside area. The same report will be presented to the Governing Body of the CCG on 29 March 2017.

1.2. This report seeks to continue the existing Integrated Commissioning Fund in place which was previously approved by the Executive Cabinet (24 March 2016) and the CCG Governing Body (23 March 2016).

1.3. Members should note that the associated Integrated Commissioning Fund reporting arrangements have evolved during the current financial year with a single Health and Social Care economy wide monthly monitoring report presented to the Single Commissioning Board. The monthly report includes the financial details of respective Council services (detailed in **Appendix 1**), the Tameside and Glossop CCG together with the Tameside and Glossop Integrated Care NHS Foundation Trust.

1.4. Non-recurrent funds were identified by both organisations in 2015/2016 financial plans to serve as an investment/contingency fund to facilitate the delivery of Care Together. Details of the non recurrent fund is provided within section 12 of this report.

1.5. The financial framework (**Appendix 3**) governing the Integrated Commissioning Fund will be approved by both organisations by 31 March 2017. The fund will be managed and accountable to the respective governing bodies via the Tameside & Glossop Care Together Single Commissioning Board.

2. BACKGROUND

2.1 Members are reminded that the Care Together Programme over recent years has focused on designing and testing models for improving health and social care services across Tameside and Glossop. This work culminated in the hospital regulator, Monitor, approving a plan for an Integrated Care Organisation (ICO) in September 2015 to bring together health and social care services to improve how these work collectively for the benefit of our population.

2.2 At a joint Board meeting between Tameside Hospital Foundation Trust, NHS Tameside and Glossop Clinical Commissioning Group (CCG) and Tameside Metropolitan Borough Council on 23 September 2015, all parties unanimously agreed to work together within the Care Together programme structure to implement the plan and agreed the principles set out below:

i. *We agree that an integrated system of health and social care is the best way to ensure optimum health and care outcomes for our population and to ensure collective financial sustainability.*

ii. *We welcome the Contingency Planning Team's ('CPT') final report of 28 July 2015 and the assurances it provides as to the new model of care that the Tameside and Glossop Clinical Commissioning Group ('the CCG'), Tameside Metropolitan Borough Council ('TMBC') and Tameside Hospital Foundation Trust ('THFT') have jointly agreed to develop and operate to create a new integrated system of health and social care in Tameside and Glossop.*

iii. *We acknowledge that creating an ICO will not resolve the significant budget challenges facing all organisations but it goes someway to reducing it and it will be necessary to continue to work closely together with all stakeholders to manage the deficit set out in the CPT report.*

iv. *We agree that a Tameside & Glossop Locality Plan setting out our vision to work together to reform health and social care services to improve the health outcomes of our residents and reduce health inequalities as quickly as possible, be considered and approved in due course at the statutory Health and Wellbeing Board, and that the model of care, which is as outlined in the CPT creating a new integrated system of health and social care in Tameside and Glossop report is a key component of that Plan.*

v. *We agree that THFT represents the best legal delivery vehicle for the integrated care system subject to an amended foundation trust licence and constitution to enable a new legal entity of an Integrated Care Foundation Trust to be constituted by the 1 April 2017. Such an organisation will need to be appropriately representative of all three bodies and other stakeholders including primary care and the voluntary sector, which will be reflected in its constitution. We agree to work together to support the THFT in this transformation with a view to be in the ICFT shadow form from the 1 April 2016.*

vi. *We agree that in working together to reform health and social care services to improve health outcomes for residents as quickly as possible and enable system wide change to take place transparently and clearly, robust and inclusive governance structures need to be developed and agreed. The key principles of any governance arrangements include:*

vii. *The objective of providing governance arrangements which aim to provide streamlined decision making; excellent co-ordination of services for the residents of Tameside & Glossop; mutual co-operation; partnering arrangements, and added value in the provision of shared services.*

- *an acknowledgement that the arrangement does not affect the sovereignty of any party and the exercise and accountability for their statutory functions.*
- *A commitment to open and transparent working and proper scrutiny and challenge of the work of the Programme Board and any party to the joint working arrangements.*
- *A commitment to ensure that any decisions, proposals, actions whether agreed or considered at the Programme Board carry with them an obligation for the representative at the Programme Board to report these to their own constituent bodies.*

viii. *We agree to delegating our decision making power, regarding the implementation of the recommendations of the CPT report, to the Programme Board.*

ix. *We agree to develop a Memorandum of Understanding, the Programme Board Terms of Reference, and a detailed Scheme of Delegation for consideration and ratification at a future meeting.*

x. *To provide mutual assurance to the constituent bodies, we agree that there will be regular reports from the Programme Board to the Boards of the constituent bodies.*

xi. *We agree to the formation of a Programme Management Office to manage the implementation of the new Model of Care and will jointly look to resource this as appropriate.*

xii. *The Commissioners agree to deliver a joint commissioning function, to be in place by 1 January 2016.*

xiii. *We agree that the governance arrangements will be kept under regular review and be revised from time to time to reflect the changing status of the integrated care delivery vehicle.*

2.3 An important initial step in the development of an Integrated Care Organisation was the transfer of the Tameside and Glossop community staff previously employed by Stockport Foundation Trust into Tameside and Glossop Integrated Care NHS Foundation Trust. This process was completed on 1 April 2016.

2.4 During 2016 Greater Manchester (GM) Devolution submitted a five year comprehensive Strategic Sustainability Plan for health and social care in partnership with NHS England and other national partners. Each of the GM areas was required to submit a Locality Plan to provide a "bottom up" approach to the development of the GM Plan. The GM Strategic Sustainability Plan included objectives to:

a. improve health and wellbeing of all residents of Greater Manchester, with a focus on prevention and public health, and providing care closer to home;
b. make fast progress on addressing health inequalities;
c. promote integration of health and social care as a key component of public sector reform;
d. contribute to growth, in particular through support employment and early years services;
e. build partnerships between health, social care, universities, science and knowledge sectors for the benefit of the population.

2.5 As such, the Tameside and Glossop Locality Plan addressed how the locality will meet these objectives and on the 12 November 2015, the Health and Wellbeing Board endorsed the Tameside and Glossop Locality Plan.

2.6 The Tameside and Glossop Locality Plan is based on the following objectives to:

- ✓ improve health and wellbeing of residents with a focus on prevention and public health, and providing care closer to home;
- ✓ make fast progress on addressing health inequalities;
- ✓ promote integration of health and social care as a key component of public sector reform;
- ✓ contribute to growth, in particular through support employment and early years services;
- ✓ build partnerships between health, social care, and knowledge sectors for the benefit of the population.

2.7 On 18 December 2015, updated governance proposals were considered and approved by the Joint Meeting of The Greater Manchester Combined Authority and AGMA Executive Board.

2.8 At the local level, full Council approved arrangements on the 21 January 2016 for local governance arrangements to ensure that we have the right leadership for the pace of change required to deliver health and social care integration including the joint committee known as the Tameside & Glossop Care Together Single Commissioning Board.

2.9 The purpose of the governance was to:

- ✓ Ensure a strong clinical voice is secured in the governance arrangements
- ✓ Ensure commissioner/provider engagement
- ✓ Alignment to the pooled budget arrangements
- ✓ Securing appropriate primary care engagement within the governance structure, acknowledging the breadth and range of primary care including pharmacies, general practice, dental and optometry practices. Locally good engagement is

developing across the wider primary care partners who are keen to play a full role in this transforming agenda.

3 FINANCIAL CONTEXT FOR THE COUNCIL

Background

3.1. The overall Council budget is set in the context of reductions in Government funding to all councils. This will be the eighth year of reductions in funding with at least another two years to follow.

3.2 The Council budget brings together the Council's many service plans and delivery strategies and sets out an overall plan in financial terms. The budget also ensures that the Council uses resources to deliver services to local people in line with the agreed priorities of the Council and its partners. Some of the key messages are:

- By the end of 2016/17 the Council will have had to make efficiency savings of £144.5 million, due to a combination of reductions in funding and an increase in the cost of providing services.

- The Council has managed this difficult challenge by taking tough decisions, early, and will continue to do this.

- The Council is committed to growing Tameside as outlined in the Corporate Plan – to building houses, attracting businesses, creating jobs and promoting better health, skills and education for our communities. By doing so the Council will seek to tackle the causes of service demand, and so continue to reduce the overall cost of Council services.

- The Council budget for 2017/18 has been prepared following an intense review of the resources required to support and deliver the services of the Council. It takes account of the pressures that services are facing as well as increasing demographic demands to enable the Council to achieve its desired outcomes.

- The Council continues to find new ways to deliver services that are sustainable and even more efficient.

- There will be step up in the partnership working with the NHS which will require a change in risk sharing in order to see transformational changes in service delivery in Health and Social Care. Funding of £23.2 million has been approved from the GM Health and Social Care Partnership to assist with implementing some of these changes. The associated investment agreement was signed on 16 December 2016.

3.3 It is essential to note that the Integrated Commissioning Fund **(Appendix 1)** does not include all Council service budget allocations. The services included are Adult Social Care, Childrens Services and Public Health. These service budget allocations currently exclude related overhead budgets and the additional funding for Adult Social Care announced by the Government on 8 March 2017.

Forward planning and key challenges facing the Council

3.4 There are a number of key challenges facing the Council in 2017/18 and future years, these include:

a) Continuing to review the delivery of sustainable services to local people from a much reduced level of resources; delivering the necessary further reduction in the overall

size of the Council in the subsequent years and securing ongoing cost reductions in a timely manner.

b) The increasing number of people that need to access adult social care services. The Council welcomes the fact that people are living longer, and indeed, it is the Council's ambition for this improvement in health to continue. However, an increasing number of people living longer will mean the Council is exposed to additional financial demands on its constrained resources. Furthermore, the cost of care is increasing, in part as a result of the introduction of the New Living Wage, which adds to the pressure on the budget.

c) There is increasing recognition nationally that the solution to many of the difficulties confronted by the NHS is to invest more in social care. So far this has not resulted in any significant additional resources from the Government, although it is permitting some costs to be passed on to local council tax payers. The response in Tameside has been to create a partnership approach operating under the banner of Care Together.

d) Under Care Together, the three organisations will, for the first time, be taking shared financial risks which are seen as essential for the initiative to succeed. This will mean the Single Commission being exposed to a greater degree of risk than it is currently.

e) Demands on services are not restricted to Adults' Services. The Council is experiencing a surge in the number of children being referred to Children's services. The Council is responding to this demand by increasing significantly the budget for Children's care services so that vulnerable children are not put at risk.

f) Business Rates are set nationally by the Government but collected locally by the Council. It is only since April 2013 that councils have been able to share in any growth in business rates and whilst the Council supports this move, it has meant at the same time that councils have had to share responsibility for losses in business rates. Tameside Council, like many others, has experienced losses arising from successful appeals against rateable values placed on properties. From April 2017 a completely new valuation list comes into force and the reaction of businesses is likely to be the start of a fresh round of appeals. This brings uncertainty into the Council's financial planning and is likely to exist for a number of years.

g) The Council has a significant capital investment programme over the medium term which can have a direct impact on residents, businesses and visitors to the borough. In recent years spending performance has been disappointing and therefore improvements are needed in effective delivery of capital and infrastructure investment e.g. Vision Tameside.

The Grant Settlement

3.5 Whilst the current Government has eased back on the pace by which public expenditure has to come into balance with available resources it is still adopting a policy of spending constraints, no more so than in the support given to local government.

3.6 Last year the Government gave an offer of a fixed four year settlement on condition each Council published an efficiency plan for the period 2016-20. The Council's efficiency plan was published in October 2016. The Council is now guaranteed the main financial settlement through to, and including, 2019-20. Altogether 97% of local councils took up the offer of a fixed settlement and whilst it gives some certainty to assist financial planning, it is still nevertheless a reduction in central government support.

3.7 Greater Manchester is to participate in a pilot scheme to retain 100% of business rates, ahead of a national rollout of the scheme in 2020. Under the arrangement the 10 district councils in GM will no longer receive any revenue support grant or public health grant. This will be adjusted through the amount received in respect of business rates grants and therefore the financial settlement for the Council has been restated in **table 1** as follows:

Table 1

Restated Settlement	2016/17 £000	2017/18 £000	2018/19 £000	2019/20 £000
Revenue Support Grant	34,493	0	0	0
Business Rates Baseline	27,481	47,701	49,285	51,094
Business Rates Top-up Grant	24,043	43,635	37,267	30,865
Total Settlement Funding Assessment	**86,016**	**91,336**	**86,552**	**81,959**
Section 31 Grant	1,960	3,960	3,960	3,960
Public Health Grant	15,699	0	0	0
Total SFA and Public Health	**103,675**	**95,296**	**90,512**	**85,919**
Reduction in Year		**(8,379) 8.1%**	**(4,784) 5.0%**	**(4,593) 5.1%**
Cumulative Reduction				**(17,756) 17.1%**

3.8 Another aspect of the grant settlement was the introduction of a new grant for adult social care worth £241 million across England. The grant will last for one year only and the Council share of this grant is £1.159 million. However, to pay for this the Government has reduced the amount paid to local authorities in New Homes Bonus (NHB). Tameside will lose £1.165 million in NHB and as a result is marginally worse off and therefore does not receive any benefit from this change.

3.9 There were other changes relating to New Homes Bonus. The grant was introduced in 20211 and a bonus (grant) is paid for six years for every newly built home, conversion and long term empty property brought back into use. Following a consultation, this mechanism will be amended as follows:

- A move to 5 year payments for both existing and future Bonus allocations in 2017/18 and then to 4 years from 2018/19; and
- The introduction of a national baseline of 0.4% for 2017/18, below which allocations will not be made.

3.10 The Government will continue to pay the funding as an un-ringfenced grant and also retains the option of making adjustments to the baseline in future years to reflect significant and unexpected housing growth. It will also revisit the case for withholding New Homes Bonus from 2018-19 from local authorities that are not planning effectively, making positive decisions on planning applications and delivering housing growth. To encourage more effective local planning the Government will also consider withholding payments for homes that are built following an appeal.

Council Tax

3.11 As part of the finance settlement an announcement was also made about council tax, including options concerning the adult social care precept.

3.12 When the grant settlement was announced in December 2016 the Secretary of State set out his guidelines on Council Tax. He announced it would be permissible for the

adult social care precept to be increased above the 2016/17 level of 2% (of the Council's tax level) as follows :

2017/18: maximum increase of 3%;
2018/19: maximum increase of 3%;
2019/20: maximum increase of 2%;

Over the three year period the maximum combined increase is 6%.

For general increases in Council Tax, the trigger point for a referendum to be called is 2% or more.

3.13 On 28 February 2017 the Council agreed to increase council tax by 4.99%. **Table 2** below illustrates the effect of increases in Council Tax on the affordability of the Council's medium term plan. The budget for 2017/18 has been balanced but there remains a shortfall in future years even after a tax increase.

Table 2

	2017/18 £000	**2018/19 £000**	**2019/20 £000**
Resources			
Revenue Support Grant	0	0	0
Business Rates Baseline	(47,701)	(49,285)	(51,094)
Business Rates Top-up Grant	(43,635)	(37,267)	(30,865)
Collection Fund Surplus	(1,000)	(1,000)	(1,000)
Amount to be funded from Council Tax	(74,333)	(74,333)	(74,333)
Use of Reserves and Balances	(2,600)	(1,600)	(300)
Total Resources	**(169,269)**	**(163,485)**	**(157,592)**
Spending Plans			
Director of People	83,117	80,998	79,343
Public Health	16,707	16,740	16,548
Director of Places	58,595	59,783	60,079
Director of Governance and Resources	9,652	9,725	9,824
Corporate Costs	9,325	15,472	19,249
Total Spending	**177,396**	**182,718**	**185,043**
Council Tax Increases			
Council Tax Increase - 4.99% (1.99% in 2019/20)	**(3,824)**	**(7,871)**	**(9,597)**
Revised Tax Base & Collection Rate	**(2,303)**	**(2,612)**	**(2,922)**
Additional Collection Fund Surplus	**(2,000)**	**(500)**	**(500)**
Remaining Gap to be addressed	**0**	**8,250**	**14,432**

Key assumptions

3.14 In line with these key principles, the following specific assumptions have been made in the development of the 2017/18 MTFS:

- Government support in accordance with the four year fixed funding agreement
- Pay awards - 1%;
- Employer's pension contribution rate increase of 1.3% in 2017/18 and maintained thereafter;
- Inflation on running expenses - 2% per annum. Increased allowance for adult services contract costs due to New Living Wage;
- Fees and charges - average increase of 2.5% unless costs are not being recovered or market conditions require a higher or lower level;
- Allowance for demographic change in children and adults' service;
- Average investment return on cash deposits of 0.5%;
- The Council will remain in an under-borrowed position. A limited amount of new borrowing to take place at an average interest rate of 2.70%;
- Increase in levies per guidance issue by GM Combined Authority and GM Waste Disposal Authority;
- Provision of loss on business rates of £0.5 million per annum.

Increased Demand for Council Services

3.15 Each year the Council anticipates increased demand for services, particularly for Children and Adults' care services. In 2016/17 the Council has seen an unprecedented increase in the number of children coming into care services. This is clearly illustrated in **Table 4**

Table 4

Caseloads	Apr 2014	Apr 2015	Apr 2016	Jul 2016	Sep 2016	Dec 2016
Children In Need	888	840	732	681	971	1,224
Children Looked After	423	417	435	437	446	479
Child Protection Plans	167	212	223	261	259	344
Total	**1,478**	**1,469**	**1,390**	**1,379**	**1,676**	**2,047**

3.16 Such demand results in costs in two main ways. One is for the additional staffing costs, mainly social workers, to deal with increased caseload whilst also keeping children safe. The second is the cost in providing care that each child has been assessed as needing. This can vary widely depending whether at one end of the range the child can be cared for safely in a home environment which may involve only modest or no cost or needs, to the extreme of a child needing a secure permanently staffed external placement external placement.

3.17 The Council is already addressing the situation and is facing increased costs in 2016/17 which will be managed within the overall budget envelope. For 2017/18 a recurrent budget provision of £6 million is being made to cope with this demand. In

addition a non-recurrent sum is included in the children's services budget as outlined in paragraph 4.8. Spending at this level is not sustainable in the context of declining resources and therefore managers will need to identify over the medium term how expenditure can be brought within available resources. The impact of this increased demand in terms of outcomes for children and also financial sustainability will be monitored by an independently chaired Improvement Board and also by a panel of elected Members.

3.18 For Adults' services, the number of people coming into the service should be easier to predict and consequently have less volatility in this budget. Having said that the Council is having to care for an increased number of people with a learning disability and there can be a wide range of costs depending on what their assessed needs are; for elderly people there are more with dementia who need more support. Caseload details are provided in tables 5 and 6:

Table 5

					Projected		
Caseloads	**Apr 16**	**Jul 16**	**Sep 16**	**Dec 16**	**2017-18**	**2018-19**	**2019-20**
People in Care Home placements	793	789	800	800	807	820	832
Homecare hours provided p/w	9,543	9,283	8,982	9,467	9,459	9,600	9,744
Homecare - number of clients	948	945	916	960	956	971	985
Extract of Number of people helped to live at home;							
Day Care	439	446	462	462	459	466	473
Supported Accommodation (incl Extra Care Housing)	400	399	411	411	411	417	424
Shared Lives	150	141	140	141	145	147	150

N.B.

Please note that the above growth projections are based on POPPI & PANSI demographic growth assumptions the numbers do not include the impacts of activity deflections from Acute services into community based settings arising from implementation of new models of care through Care Together. The prevalence rates for Dementia are also increasing, the extract below demonstrates the projected local trend

Table 6

Dementia - all people	2016	2017	2018	2019	2020
People aged 65-69 predicted to have dementia	161	153	147	141	136
People aged 70-74 predicted to have dementia	266	293	310	328	347
People aged 75-79 predicted to have dementia	428	433	445	457	470
People aged 80-84 predicted to have dementia	597	610	657	708	762
People aged 85-89 predicted to have dementia	583	622	622	622	622
People aged 90 and over predicted to have dementia	508	508	536	566	597

Total Tameside population aged 65 and over predicted to have dementia	2,543	2,619	2,717	2,822	2,934

3.19 Alongside the increased service demand within Childrens Services, there will also be additional investment required within the service for 2017/18 of £2.6 million funded from reserves. This is for the current demand faced by children's services which is anticipated to decline over the medium term plus a non-recurrent sum to facilitate service improvement initiatives following the recent Ofsted inspection. These improvements include a review of service provision pathways and the associated business processes and system infrastructure together with additional capacity to improve the development of the service workforce.

Savings and Efficiencies

3.20 Over the past seven years of austerity the Council has removed substantial sums from both back office and service costs. Costs are kept under review and new initiatives for savings are constantly sought. For 2017/18 services have again identified measures to make further savings :

People Directorate (£ 0.336 million)

3.21 There have been a number of services reviews within Adult Social Care which will achieve a £0.336m recurrent saving from 2017-18 onwards. Areas reviewed include Sensory Services, Learning Disabilities Day Services and Respite Provision. Further work is ongoing to ascertain the suitability of the Reablement service and invest to save proposals are currently being evaluated to expand the community based model for people with sub-threshold needs to enable them to live independently.

Public Health (£ 0.436 million)

3.22 The Directorate has reviewed and recommissioned a number of contracts to deliver recurrent savings of £0.436 million from 1 April 2017. Contracts where savings will be delivered include the provision of support for residents with issues associated with drugs and alcohol and sexual health needs. Savings will also be realised within the contract for the provision of 0-19 public health services.

3.23 It should be noted that there are also further savings initiatives within the Governance and Resources and Place directorates of the Council which total £ 1.581 million.

4 COUNCIL RISKS

4.1 A critical element of the Medium Term Financial Strategy and budget is to ensure that the financial consequences of risk are adequately reflected in the Council's finances.

4.2 A risk-based assessment of issues which could have a major impact on the Council's finances provides a flexible and responsive approach that reflects the continuously changing environment within which local government has to work. A risk assessment of the overall 2017/18 budget has been undertaken covering the following areas:

- Performance against the current year's budget.
- Realistic income targets.
- 'At risk' external funding.
- Reasonable estimates of cost pressures.
- One-off cost pressures identified.
- Robust arrangements for monitoring and reporting performance.
- Reasonable provision to cover the financial risks faced by the Council.

The risk-based approach takes into account relevant external factors such as changes in Government policy, the state of the local economy and the impact of this

on the demand for Council services, and any potential changes to the underlying financial assumptions within the period.

5 CCG FINANCIAL PLANS

5.1 The NHS Operational and Contracting Planning Guidance 2017-2019 was published on the 27 September 2016 by NHS England (NHSE) and NHS Improvement (NHSI) for use by NHS commissioners and NHS providers. The guidance explains how the NHS operational planning and contracting processes will now change to support Sustainability and Transformation Plans (STPs) and the 'financial reset'. It reaffirms national priorities and sets out the financial and business rules for both 2017/18 and 2018/19.

5.2 The key objectives underpinning all 2017-2019 healthcare planning are to implement the Five Year Forward View to drive improvements in health and care, restore and maintain financial balance and deliver core access and quality standards.

5.3 The 2017-2019 operational planning and contracting round is built out from STPs. Two-year contracts will reflect two-year activity, workforce and performance assumptions that are agreed and affordable within each local STP. NHSE and NHSI issued a two-year tariff for consultation and two-year CQUIN and CCG quality premium schemes. A joint NHSE and NHSI oversight process will provide a unified interface with local organisations to ensure alignment of CCG and provider plans. The timetable was brought forward by three months for agreeing contracts and all 2017-19 contracts were required to be signed by 23 December 2016. NHS Tameside and Glossop CCG achieved this timeline. Furthermore, the Single Commission agreed a block contract with Tameside and Glossop Integrated Care NHS Foundation Trust as a means of mitigating risk across the economy.

6 CCG ALLOCATION

6.1 In October 2016, the CCG received confirmation of its allocation adjustments for 2017-2019 and these show a net reduction to T&G's allocation of £1.340 million and £1.361million respectively for 2017/2018 and 2018/2019. This net reduction is a result of adjustments for information rules on specialist commissioning and tariff. These values had been derived from national modelling undertaken by NHSE and NHSI.

6.2 The reduced allocation was challenged as this implied the CCG would incur reduced costs for secondary care and specialist commissioned services and local modelling demonstrated a £ 2.1 million pressure to the CCG. As a result of the challenge, the CCG was granted an additional allocation of £1.192 million which has been shared between the CCG and ICFT to off-set some of the risk associated with the tariff changes in secondary care.

Financial Plans submitted to GM Health and Social Care Partnership and NHS England

6.3 A high level summary of the CCG financial plans submitted to NHSE on 24 February 2017 is shown in Table 7 below. This demonstrates how the CCG total allocation of £381.491 million for 2017/2018 and £389.212 million for 2018/2019 is planned to be spent over the next two years. The 2016/2017 values are shown for comparative and illustrative purposes:

Table 7

Revenue Resource Limit	2016/17 £'000	2017/18 £'000	2018/19 £'000
Recurrent	373,734	381,628	389,414
Non-Recurrent	11,615	(137)	(202)
Total In-Year allocation	**385,349**	**381,491**	**389,212**
Income and Expenditure			
Acute	197,418	196,448	196,448
Mental Health	28,991	29,645	30,234
Community	27,544	27,724	27,724
Continuing Care	12,647	13,247	13,611
Primary Care	50,572	49,409	50,796
Other Programme	32,705	27,104	31,488
Primary Care Co-Commissioning	30,926	31,988	32,954
Total Programme Costs	**380,803**	**375,565**	**383,255**
Running Costs	4,545	4,018	4,010
Contingency	0	1,908	1,947
Total Costs	**385,348**	**381,491**	**389,212**

6.4 **Assumptions underpinning the Financial Plan**

The CCG has statutory responsibilities referred to as the business rules with which it must comply. These comprise:

- Maintain expenditure within the revenue resource limit and make an underlying recurrent surplus of 1%
- Maintain expenditure within the allocated cash limit;
- Maintain capital expenditure within delegated limits;
- Ensure that 1% of recurrent funds are spent non-recurrently in line with the 2016-17 uncommitted 1% fund. However, for 2017-18 0.5% is available to spend immediately on transformational schemes and 0.5% to be held uncommitted in a risk reserve;
- Ensure a minimum 0.5% contingency is held;
- Ensure running costs do not exceed the allocation of £5.155 million;
- Ensure compliance with the Better Payment Practice Code whereby the CCG ensures it pays all NHS creditors within 30 days of receipt of a valid invoice.

These are incorporated in the plans above together with the following assumptions outlined in table 8 below taken from the planning guidance:

Table 8

2017/18	Gross Provider Efficiency %	Inflation %	Net tariff inflation %	Activity Growth (Demog) %	Activity Growth (Non-Demog) %	Total %
MENTAL HEALTH	-2.00	2.10	0.10	1.00	0.90	2.00
ACUTE	-2.00	2.10	0.10	1.00	0.70	1.80
PRIMARY CARE - CCG	-2.00	2.10	0.10	1.00	1.65	2.75
PRIMARY CARE - DELEGATED	0.00	0.00	0.00	0.00	3.73	3.73
CONTINUING CARE	-2.00	2.10	0.10	1.00	1.65	2.75
COMMUNITY HEALTH SERVICES	-2.00	2.10	0.10	1.00	0.70	1.80
OTHER	-2.00	2.10	0.10	1.00	0.90	2.00
CORPORATE	0.00	0.00	0.00	0.00	-0.14	-0.14
2018/19	**Gross Provider Efficiency %**	**Inflation %**	**Net tariff inflation %**	**Activity Growth (Demog) %**	**Activity Growth (Non-Demog) %**	**Total %**
MENTAL HEALTH	-2.00	2.10	0.10	1.00	0.89	1.99
ACUTE	-2.00	2.10	0.10	1.00	0.70	1.80
PRIMARY CARE - CCG	-2.00	2.10	0.10	1.00	1.65	2.75
PRIMARY CARE - DELEGATED	0.00	0.00	0.00	0.00	3.01	3.01
CONTINUING CARE	-2.00	2.10	0.10	1.00	1.65	2.75
COMMUNITY HEALTH SERVICES	-2.00	2.10	0.10	1.00	0.70	1.80
OTHER	-2.00	2.10	0.10	1.00	0.89	1.99
CORPORATE	0.00	0.00	0.00	0.00	-0.16	-0.16

6.5 Incorporated within the above plans is the intention that the CCG will meet the Mental Health Investment Standard, formerly known as the Parity of Esteem. This comprises investment growth of 2.5% in 2017-18 giving a total investment in mental health of £37.611 million and 2.0% growth in 2018-19 giving a total mental health investment of £38.359 million. This includes all mental health services including those aligned to learning disabilities and dementia.

7 CCG RECOVERY PLAN

7.1 The CCG has made good progress on realising savings as part of its Financial Recovery Plan in 2016/2017. The CCG has met the 2016/2017 Quality Innovation Productivity and Prevention (QIPP) target of £13.5 million in full and although a

significant proportion was a result of non-recurrent means, many of the schemes started in 2016-17 will continue to be developed delivering increasingly more savings recurrently in 2017-18 and beyond. The CCG has a QIPP target of £23.9m in 2017/2018 but planned recurrent savings from work started in 2016/2017 and negotiated within 2017/2018 contracts are shown in Table 9.

Table 9

CCG Recovery Plan Schemes:	2017-18 £		2018-19 £
Tameside ICFT	4,438,659	Consistent with agreed contract.	4,438,659
Other Associate Providers	2,752,729	Savings built into signed associate contracts. Increased risk of overperformance, but if we are able to prevent referrals and admissions, it is not unreasonable to realise the savings.	2,755,456
Other Acute	2,321,286	Within the gift of the CCG to reduce Independent Sector referrals which would deliver this saving.	1,323,164
GP Prescribing	2,516,350	Targeted schemes directed at reducing demand and stopping growth. T&G are an outlier at 4.28% prescribing volume growth against a national average of 2.08%.	2,514,846
CCG Commissioned Primary Care	2,787,825	Plans at an advanced stage of implementation on these areas including over 75s and Primary Care Quality Schemes.	797,599
Delegated Primary Care	587,500	Part year effect of Equitable Access Services.	587,500
Community Health Services	1,583,217	Re-procurement of certain community services including the Wheelchair contract.	756,681
Continuing Care	934,552	High risk area but work on-going to better understand care home spend across the economy.	331,843
Mental Health	1,285,062	Some savings incorporated into the Pennine Care contract but we must ensure the Mental Health Investment Target is met.	1,283,191
Corporate	1,137,000	Includes various efficiencies as a result of forming a Single Commissioning function.	1,137,000
Other	2,405,711	This primarily includes the Estates and IM&T strategies and considered high risks at this stage.	2,517,863
Reserves	4,970,860	Technical accounting savings in accordance with statutory guidance.	4,970,000
Grand Total	**27,720,751**		**23,413,802**

7.2 Planned QIPP savings have been categorised across 2 broad categories: Phase 1 and Phase 2 QIPP. Phase 1 QIPP comprise schemes where decisions have been made, but where there may be some implementation risk. Phase 2 QIPP is where potentially decisions are still required, for example, to de-commission/stop services but where savings can be realised in 2017/2018 once a decision is made. Phase 2 QIPP can be highly emotive and contentious requiring some very difficult and unpalatable decisions.

7.3 The QIPP plans detailed in table 9 comprise both Phase 1 and Phase 2 QIPP schemes. The CCG has applied a RAG rated weighting to each of the schemes to reflect optimism bias and provide a clearer understanding of the level of risk of delivery. The outcome of this further analysis for 2017/2018 QIPP reduces the planned savings outlined in table 9 by £10.421 million to £17.300 million. The composition of this analysis is shown in table 10 below:

Table 10

Total QIPP savings	Phase 1 £'000	Phase 2 £'000	Total £'000	Expected Saving £'000
RED	1,123	6,016	7,139	714
AMBER	7,991	0	7,991	3,995
GREEN	11,867	724	12,591	12,591
Total	**20,981**	**6,740**	**27,721**	**17,300**

7.4 As table 10 clearly demonstrates, it is crucial that momentum continues and the pace and scale of CCG schemes and economy wide transformation is accelerated to ensure the planned savings are delivered and reduce financial risk across the wider health and social care economy.

8. GREATER MANCHESTER HEALTH AND SOCIAL CARE PARTNERSHIP

8.1 Members are reminded there was a direct allocation of £ 450 million revenue resources to Greater Manchester from NHS England representing its 'fair share' of available transformation budgets over a five year period. The GM Strategic Partnership Board will oversee the deployment of funding to deliver the major change programme set out in the GM Strategic Plan.

8.2 The transformation funds will enable the delivery of the Tameside and Glossop Locality Plan. This will ensure more effective and efficient service provision and in the longer term, will significantly improve the health and wellbeing of the Tameside and Glossop community.

8.3 On 30 September 2016, the Partnership Strategic Partnership Board ratified the full transformational funding award of £23.226 million to Tameside and Glossop economy over a four financial year period.

8.4 Work commenced with the Greater Manchester Health and Social Care Partnership (GMHCP) thereafter to develop our investment agreement. Inclusion in this was implementation and delivery milestones to measure progress against the national "must do's" and our transformation priorities as outlined in the Cost Benefit Analysis submission.

8.5 The full suite of documentation for the Investment Agreement was submitted, reviewed and refined over three weeks, with final submission taking place on 2 December 2016.

8.6 The Investment Agreement was formally signed on 16 December 2016 by:

- Councillor Kieran Quinn - Executive Leader – TMBC
- Karen James - Chief Executive – Tameside and Glossop Integrated Care Foundation
- Trust)
- Lord Peter Smith - Chair – Greater Manchester Health and Social Care Strategic
- Partnership Board)
- Dr Alan Dow - Chair – Tameside and Glossop Single Commissioning Board
- Steven Pleasant - Chief Executive – Tameside MBC and Accountable Officer of
- Tameside and Glossop CCG.

8.7 Monitoring of the Investment Agreement within the locality will take place on a monthly basis, with progress updates provided to Greater Manchester on a quarterly basis.

8.8 The transformational funding award unfortunately does not include any capital for IM&T and Estates. Liaison continues with Greater Manchester Health and Social Care Partnership and NHS Improvement to understand the potential for funding bids and progress will be continually provided to the Members.

9 CARE TOGETHER OPERATIONAL PROGRESS

Programme Management

9.1 The new Care Together (CT) programme structure was implemented from January 2017 and will see the CT Programme Board move to quarterly meetings instead of monthly.

9.2 Priority programmes of work, such as the potential transfer of Adult Social Care services into the Integrated Care Organisation Foundation Trust (ICFT) require dedicated resources, and as such, resources from the Care Together Programme have been deployed to work on this.

9.3 In addition, as the programme moves towards implementation phase, the Care Together Programme Support Office will need to be enhanced to provide the necessary system assurance. External management consultancy support has been procured to set up the necessary systems to inspire confidence and provide the appropriate reassurance across the system.

Adult Social Care Transaction

9.4 The Adult Social Care Transaction Board continues to meet monthly, a full business case and due diligence process is being developed to ensure organisational and regulatory approval for the transfer of the service to the Integrated Care NHS Foundation Trust.

.

9.5 Associated workstreams have been agreed and established during January 2017.

Healthy Neighbourhoods

9.6 Three Neighbourhood managers have now been appointed. This is a significant milestone towards achieving our vision for the neighbourhoods, overseeing multidisciplinary teams working jointly across health and social care to ensure the best possible outcomes for our local people.

Savings Assurance

9.7 In November 2016, the Locality Executive Group (LEG) discussed the importance of aligning the financial work across the locality to provide a holistic view of progress against the projected financial gap.

9.8 To facilitate the in-depth support and challenge required, it was agreed to set up half day sessions in January to test the robustness of action plans in each scheme. These sessions will :

- Confirm the Senior Responsible Officer and accountability for each scheme, key team leads and savings target for 2017/2018 to 2020/2021;
- Review the action plans of each scheme;
- Agree on the level of savings achievable in 2017/2018;
- Confirm if any additional support is required to ensure delivery of targets.

10 CARE TOGETHER ORGANISATIONAL UPDATE

Single Commissioning Function

10.1 As part of the drive to improve efficiency and reduce the costs of commissioning, New Century House was vacated during the spring of 2016/2017. Officers were relocated to existing Council locations.

Integrated Care Organisation

10.2 The governance of the models of care is currently being reviewed and revised within the Integrated Care NHS Foundation Trust to take into account a move towards implementation phase.

10.3 As such, a new Joint Management Team has been established in Tameside and Glossop Integrated Care NHS Foundation Trust to lead the implementation work, standing down the Models of Care Steering Group. It met for the first time on 21 December 2016. Chaired by the Trust's Chief Executive, Karen James, it will bring together the Trust's executive team and clinical directors with the clinical GP leads for the five neighbourhoods and the lead directors for public health and social services.

Next Stages

10.4 The notable next stages are as follows :

- Monitoring and reporting of the GM Transformation Fund Investment Agreement;
- Agree financial sustainability plan for the economy;
- Procurement of additional Programme Support
- Development and sign off of the business case for the transaction of adult social care into the Integrated Care Organisation;
- Continued discussions to determine options for aligning primary care outcomes alongside those of the Integrated Care Organisation and therefore for the whole population;
- Continue the review of the Mental Health Contract for the locality, to be completed by the end of 2016/2017;
- Developing and implementing a measurement framework which accurately ensures our planned transformational schemes are improving the healthy life expectancy of the Tameside and Glossop population.

11 CAPITAL INVESTMENT

11.1 In addition to the revenue funding detailed in **Appendix 1**, the Council is proposing capital investment within the Tameside Care Together economy. The associated details are included in table 11 below.

Table 11

COUNCIL CAPITAL PROGRAMME	16/17	17/18	18/19	TOTAL
	£'m	£'m	£'m	£'m
Children's Services - In Borough Residential Properties	0.812	0.100	0.000	0.912
Active Tameside - Leisure Estate Reconfiguration	3.814	9.930	6.524	20.268
Adult Services - Disabled Facilities Grant - Adaptations	1.300	0.678	0.000	1.978
Total	**5.926**	**10.708**	**6.524**	**23.158**

11.2 It is important to note that the estimated additional annual revenue expenditure associated with the repayment and interest for the prudential borrowing (unsupported) required to finance the Childrens Services and Active Tameside estate investment in table 11 will be an associated cost against the Integrated Commissioning Fund in the respective financial year.

12 NON RECURRENT INVESTMENT FUND

12.1 Members are reminded that the Council and the CCG approved a non-recurrent investment budget totalling £ 6.38 million. This sum is additional to the revenue budgets stated in **Appendix 1** and the capital investment in section 11.

The contributions from each organisation are stated in table 12 below:

Table 12

Organisation	£ m
CCG	3.00
Tameside MBC	3.38
Total	**6.38**

12.2 The 'investment fund' finances specific non-recurrent or capital investments required to support service reconfiguration and in particular for the pump priming of schemes and double running costs. This fund may also be called upon to support investment in infrastructure to secure greater overall efficiency (e.g. IT investment). All such bids supported with a robust business case are subject to approval by the Care Together Programme Board.

12.3 It should be noted that there will be an estimated residual balance of £ 2.58 million on 1 April 2017.

13 ICF RISK SHARE

13.1 The arrangement agreed for 2016/2017 was that, whilst working as a single commissioning function, the Council and CCG would retain full responsibility for their own financial risks. After a year of formally working together the current financial arrangements feel out of step with the concept of a single commissioner.

13.2 The proposal is that from 1 April 2017 each organisation will begin to share financial risk in proportion to the respective contributions they make into the Integrated Commissioning Fund. This would result in a sharing arrangement of 80 % for T&G CCG and 20 % for the Council as calculated in table 13.

Table 13 – Net Budgets Per Appendix 1

Commissioner	Total Net Budget	ICF % Contributions
	£'000	%
T&G CCG	381,491	80
TAMESIDE MBC	96,438	20
TOTAL	**477,929**	**100**

13.3 This would be a significant step for both organisations given the current financial climate and the scale of the savings that must be delivered in the short term and the risks that the local health and social care economy face currently.

The variance to the total net budget allocation at the end of each financial year will be financed in proportion to the percentage of the net budget contribution of each organisation to the ICF (per table 13). However, the variance will be initially adjusted to exclude any CCG net expenditure associated with residents of Glossop (13% of the total CCG variance) as the Council has no legal powers to contribute to such expenditure. The associated adjusted total variance of both the CCG and the Council would then be financed in proportion to the % contributions as stated in table 13.

13.4 In addition it is also proposed that a stepped approach is taken to risk sharing and that a cap is placed on the shared financial exposure that each organisation would be expected to meet. For 2017/2018 it is proposed that :

- a cap of £2.0 million is placed on CCG related risks that the Council will contribute to;
- a cap of £0.5 million is placed on Council related risks that the CCG will contribute to.

13.5 The differential cap is recognises that it would be difficult for the CCG to assume responsibility for 80% of the Council's risks at a time when it is facing the highest QIPP target across Greater Manchester.

13.6 For clarity, the risk sharing arrangement applies to the Section 75 pooled fund, the aligned fund and the 'in collaboration' budget as set out in Appendix 1. It should be noted that the Council's cap of £2.0 million (per section 13.3) is over and above the non-recurrent contribution to the ICF of up to £5.0 million in both 2017/18 and 2018/19 (on the condition that the T&G CCG agrees a reciprocal arrangement in 2019/20 and 2020/21 should this be necessary – per section 3.5).

14 RECOMMENDATIONS

14.1 As detailed on the report cover.

APPENDIX 1

See separate attachment

APPENDIX 2

Annex 1

FUNCTIONS OF NHS BODIES

NHS functions that can be the subject of S75 partnership arrangements

Legislation	Function
Sections 3 & 3A of the NHS Act 2006 (NHS Act) **Note these functions need to be read together with the exclusions in Annex 2*	Duty of a CCG to arrange for the provision of the following to the extent it considers necessary to meet the reasonable requirements of the persons for whom it has responsibility: • hospital accommodation; • other accommodation for the purposes of any service under the NHSA; • medical, dental, opthalmic, nursing and ambulance services; • such other services or facilities for the care of pregnant women, women who are breastfeeding and young children as the CCG considers are appropriate as part of the health service; • such other services or facilities for the prevention of illness, the care of persons suffering from illness and the after-care of persons who have suffered from illness as the CCG considers are appropriate as part of the health service; • such other services or facilities as are required for the diagnosis and treatment of illness. Power of a CCG to arrange for the provision of such services or facilities as it considers appropriate for the purposes of the health service that relate to securing improvement: • in the physical and mental health of the persons for whom it has responsibility; or • in the prevention, diagnosis and treatment of illness in those persons. NB: This includes rehabilitation services and services intended to avoid admission to hospital.

Section 3B of the NHS Act **Note these functions need to be read together with the exclusions in Annex 2*	Regulations may require NHS England (NHSE) to arrange the provision, to such extent as it considers necessary to meet all reasonable requirements, for the provision as part of the health service of: • dental services of a prescribed description; • services or facilities for members of the armed forces or their families; • services or facilities for persons who are detained in prison or in other accommodation of a prescribed description; • such other services or facilities as may be prescribed
Section 83 of the NHS Act	From 1 April 2016 the function of arranging the provision of primary medical services where these are commissioned under an APMS contract.
Paragraphs 9-11 of Schedule 1 to the NHS Act	Power for a CCG to make arrangements for the provision of vehicles (including wheelchairs) for persons for whom the CCG has responsibility and who appear to it to have a physical impairment which has a substantial and long-term adverse effect on their ability to carry out normal day-to-day activities. Power for a CCG to make arrangements for: • the adaption of the vehicle; • the maintenance and repair of the vehicle; • the taking out of insurance policies relating to the vehicle and payment of any duty; • the provision of a structure in which the vehicle may be kept and the provision of all material and execution of all works necessary to erect the structure. Power of a CCG to make grants in connection with such a vehicle.

Section 117 of the Mental Health Act 1983 (MHA)	Duty of the CCG to arrange for the provision of, in co-operation with relevant voluntary agencies, after-care services for persons who are: • detained under section 3 of the MHA; or • admitted to a hospital in pursuance of a hospital order made under section 37 of the MHA; or • transferred to a hospital in pursuance of a hospital direction made under section 45A of the MHA; or; • a transfer direction made under section 47 or 48 of the MHA; and then cease to be detained and (whether or not immediately afterwards) leave hospital, until such time as the CCG and the local social services authority are satisfied that the person concerned is no longer in need of such services (but they shall not be so satisfied in the case of a community patient while he remains such a patient).
	Function of providing the after-care services referred to above.
Section 12A(1) of the NHSA and the *National Health Service (Direct Payments) Regulations 2013*	The function of making direct payments
Regulation 8A of the Healthy Start Scheme and Welfare Foods (Amendment) Regulations 2005	The function of arranging the provision of Healthy Start vitamins.
Schedule 1A of the Mental Capacity Act 2005	Functions relating to the Deprivation of Liberty

Annex 2
FUNCTIONS OF NHS BODIES

NHS Functions that cannot be the subject of Section 75 partnership arrangements include the following functions:

Legislation	Function
Sections 3, 3A & 3B of the NHS Act 2006 (NHSA)	The function of arranging the provision of: • surgery; • radiotherapy; • termination of pregnancy; • endoscopy; • the use of Class 4 laser treatments and other invasive treatments; • emergency ambulance services.

Sections 83, 92 & 99 of the NHSA*	The function of arranging the provision of: • primary medical services • primary dental services (*From 1 April 2016 the function of arranging the provision of primary medical services where these are commissioned under an APMS contract will be able to be the subject of a S75 partnership arrangement.)

Annex 3

FUNCTIONS OF LOCAL AUTHORTIES

Health-Related Functions that can be the subject of S75 partnership arrangements

Legislation	Nature of Function
Schedule 1 of the Local Authority Social Services Act 1970 **Note these functions need to be read together with the exclusions in Annex 4*	This Schedule covers a wide range of social services functions. If you require any further details, please let us know.
Regulation 8A of the Healthy Start Scheme and Welfare Foods (Amendment) Regulations 2005	The function of providing Healthy Start vitamins.
Sections 7 or 8 of the Disabled Persons (Services, Consultation and Representation) Act 1986	• Duty to arrange an assessment for persons on discharge from hospital, having received medical treatment for mental disorder as an in-patient for a continuous period of not less than 6 months, of their needs for healthcare services. (This duty is not yet in force). • Duty of local authority to take into account abilities of a carer
Section 19 of the Local Government (Miscellaneous Provisions) Act 1976	The functions of providing or securing the provision of recreational facilities.
	The functions of local authorities under the Education Acts as defined in section 578 of the Education Act 1996;
Part I of the Housing Grants, Construction and Regeneration Act 1996 and	Functions of local housing authorities.
under Parts VI and VII of the Housing Act 1996	

Section 126 of the Housing Grants, Construction and Regeneration Act 1996	Functions relating to regeneration and development.
Environmental Protection Act 1990	Functions of waste collection or disposal.
Sections 180 & 181 of the Local Government Act 1972	Functions of providing environmental health services.
Highways Act 1980 and Section 39 of the Road Traffic Act 1988	Functions of local highway authorities.
Sections 63 & 93 of the Transport Act 1985	Functions relating to passenger transport and travel concession schemes.
*Sections 22, 23(2) & 26 of the National Assistance Act 1948 (NAA)**	Where the partners enter into a Section 75 partnership arrangement in respect of the provision of accommodation under Sections 21 or 26 of the NAA, the function of charging for that accommodation.
Section 17 of the Health and Social Services and Social Security Adjudications Act 1983 (1983 Act)	Where the partners enter into a Section 75 partnership arrangement in respect of the provision of welfare services under any enactment mentioned in Section 17(2)(a) to (c) of the 1983 Act, the function of charging for those services.
Functions under or by virtue of Sections 2B or 6C(1) of, or Schedule 1 to, the NHSA	• Functions relating to the improvement of public health; • Public-health functions of the Secretary of State (where local authorities are required by Regulations to exercise these); • Local authority functions under Schedule 1 of the NHSA, including: - medical inspection and treatment of pupils; and - weighing and measuring of children.

Annex 4

FUNCTIONS OF LOCAL AUTHORTIES

Local Authority Functions that cannot be the subject of S75 partnership arrangements include the following functions:

Legislation	Nature of Function
*Sections 22, 23(3), 26(2) (but note exception in Annex 3 – see *) 26(3),26(4), 43, 45 and 49 of the National Assistance Act 1948*	Functions relating to charging for accommodation, recovery of costs of providing certain services and defrayment of expenses for local authority officer applying for appointment as deputy for certain patients.
Section 6 of the Local Authority Social Services Act 1970	Function of appointing an officer, to be known as the director of adult social services.
Section 3 of the Adoption and Children Act 2002	Function of maintaining an adoption service and providing the requisite facilities for that purpose.
Sections 114 & 115 of the Mental Health Act 1983 (MHA)	Function of approving a person to act as an approved mental health professional for the purposes of the MHA. Power of an approved mental health professional to enter and inspect premises.
Parts VII to IX and Section 86 of the Children Act 1989	Functions relating to: • the provision of accommodation for children by voluntary organisations; • private children's homes/ limits on number of foster children; • privately fostered children; • children accommodated in care homes or independent hospitals.

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APPENDIX 3

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FINANCIAL FRAMEWORK

Between

Tameside & Glossop Clinical Commissioning Group and

Tameside Metropolitan Borough Council

A. Document Information

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Date:	
Version:	V5.00
Project:	Care Together
Authors:	Stephen Wilde and Tracey Simpson
Owner (SRO):	

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DRAFT

C. Sign off

This is version 6 of the Financial Framework signed on 1 April 2017 by:

…………………………………………………………..

Authorised Signatory on behalf of Tameside & Glossop Clinical Commissioning Group

…………………………………………………………..

Authorised Signatory on behalf of Tameside Metropolitan Borough Council

DRAFT

C. Sign off
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Defined Terms

Save for the following, defined terms in this Financial Framework shall have the same meaning as those give in the s75 Agreement.

Aligned Fund means budgets for commissioning prescribed services that the Regulations specify shall not be pooled (including In Collaboration Services), but which will be managed alongside the Pooled Fund.

Care Together Programme – means the programme agreed between the Partners to improve the health and wellbeing of Service Users in their respective areas.

CCG – Tameside and Glossop Commissioning Group, one of two partners to the Integrated Commissioning Fund and the s75 agreement

Council – Tameside Metropolitan Borough Council, one of two partners to the Integrated Commissioning Fund and the s75 agreement

DH – Department of Health.

Financial Framework – (this document) describes the ground rules under which the financial decisions relating to the Integrated Commissioning Fund will be made.

Tameside Health and Wellbeing Board – established as a Council committee under s194 of the Health and Social Care Act 2012, the purpose of which is to promote more joined up delivery of services and involves oversight of achievement of the objectives of the integrated commissioning function; and oversight of proper governance of the integrated commissioning function

The Accountable Officer – this is the Chief Executive of the Council and the Accountable Officer of NHS Tameside and Glossop Clinical Commissioning Group collectively referred to as the Single Commission.

The Greater Manchester Health and Social Care Partnership - is the body made up of the 37 NHS organisations and councils in the city region, which is overseeing devolution and taking charge of the £6bn health and social care budget.

Integrated Commissioning Fund means the total of the Pooled Fund and Aligned Fund.

Single Commissioning Team – the team tasked with planning, managing and administering commissioning through the Integrated Commissioning Fund.

Partners – the CCG and the Council are partners to the section 75 agreement and the Integrated Commissioning Fund.

Pooled Fund means any pooled fund established and maintained by the Parties as a pooled fund in accordance with the Regulations.

Pooled Fund Host means the Partner that will host and provide the financial administrative systems for the Pooled Fund and undertake to perform the duties for which they will be responsible, as set out in paragraph 7(4) and 7n(5) of the Regulations

Pooled Fund Manager(s) means the Chief Financial Officer(s) of the Single Commission

Section 75 agreement (s75) – section 75 of the NHS Act 2006: the legislation that allows the establishment of pooled funds between NHS bodies and local authorities at a local level.

SoDA – Schedule of delegated authorities, or equivalent, of the CCG, the Council and the Integrated Commissioning T eam.

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Terms of the Financial Framework – Tameside and Glossop Economy

1. Consultation and approval

1.1. The process for consulting on management and oversight of the Integrated Commissioning Fund and the Section 75 agreement (s75) agreement will include, as a minimum:

- Approval of the CCG (Governing Body)
- Approval of the Council (Executive Cabinet)
- Single Commissioning Board

1.2. This Financial Framework is to be referred to, in the s75, as an adopted document, by both the CCG and Council, but will not necessarily be appended to the s75. This approach allows for regular update of the Financial Framework, as required, under agreed delegated arrangements.

1.3. The process of consultation for the Financial Framework will be aligned with the development of the s75 agreement and the arrangements for the development of the Integrated Commissioning Fund. It will be considered by both Partners, as part of the document pack supporting the Section 75 agreement

1.4. Approval of the Financial Framework will be by:

- the CCG (Governing Body)
- the Council (Executive Cabinet)
- Single Commissioning Board

2. Frequency of review and renewal

2.1. This Financial Framework will be reviewed and revised, as necessary on an annual basis. This review will involve the designated financial leads and governance leads of both Partners. The Single Commissioning Board will recommend approval of the reviewed Financial Framework to the:

- The CCG (Governing Body)
- The Council (Executive Cabinet)

2.2. The Partners may, at some point in the future, agree to extend the period between formal review and adoption of the Financial Framework and Section 75 Agreement. Any changes will be subject to approval as above.

2.3. Detailed guidance about specific aspects of this Financial Framework may be issued from time to time. This guidance will be approved by the Single Commissioning Board, or by specific groups or individuals as delegated.

3. Scope of this Financial Framework

3.1. This Financial Framework lays out the general rules and sets the scope for the management and expenditure of public sector funds originating from NHS and Local Government sources.

3.2. It supports the relationship between the Partners via the Section 75 Agreement and the use of Aligned Funds. It:

- Provides detail of the framework of the formal relationship with regard to the management of the Integrated Commissioning Fund;
- Sets the expectation that the Partners will continue to work closely together; and with Providers, to ensure that the best quality care is provided and best value is achieved in the use of resources;
- Recognises the statute and regulations under which the Pooled Fund is established i.e. section 75 of the National Health Services Act 2006 and NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000.

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3.3. This Financial Framework sets out the requirements and makes provision for governance and accountability of:

- The Integrated Commissioning Fund;
- Authorities and responsibilities delegated from the Partners
- Financial planning and management responsibilities;
- Budgeting and budgetary control, including forecasting.

3.4. This Financial Framework identifies the responsibilities of each Partner to:

- Support and facilitate the achievement of the objectives of the Integrated Commissioning Fund;
- Ensure that the objectives and functions of the Partners and of the Integrated Commissioning Fund are complementary and mutually supportive;
- Ensure due diligence and appropriate oversight of financial decisions;
- Ensure the achievement of the Partners' objectives.

4. Objectives of the Partners and of the Single Commissioning Board

4.1. The strategy for the Integrated Commissioning Fund has been developed by the Care Together Programme. This reflects the shared priorities and obligations of the Partners.

4.2 The Care Together Model of Care includes 3 key workstreams – Healthy Neighbourhoods (incorporating the Healthy Lives and Integrated Neighbourhoods initiatives), Planned Care and Urgent Care, each of which are responsible for leading the design and implementation of the structure of our integrated model of care. Implementation plans are being developed to move at pace to transform to our new model of care and start to deliver the transformation and significant financial savings required.

4.2. Detailed strategic objectives for acute care are contained within the CCG Contracts; and elements of these overlap into the three workstreams above.

5. Objectives of the Single Commissioning Board

5.1. Section 24 of the National Health Services Act 2006 sets out the requirement of the CCG to prepare a plan to improve:

- The health of people for whom it is responsible;
- The provision of health-care to those people,

5.2. The Section 75 Agreement states that:

*(A) The **aims and objectives** of the Parties in entering in to this Agreement are to:*

(a) meet the National Conditions and local objectives;

(b) integrate the commissioning activities of the Parties in respect of the relevant populations (resident and GP registered) of Tameside and in relation to the NHS Related Functions also Glossop in line with the Tameside Health and Wellbeing Board's vision of integrated health and wellbeing and through the pooling or aligning of financial resources and integrated governance in order to create a sustainable health and wellbeing system with improved system performance;

(c) agree strategies and ensure commissioning activity in order to make more effective use of resources to achieve improved health and wellbeing for the populations of Tameside and in relation to the NHS Related Functions also Glossop and prioritise prevention by ensuring people receive 'the right care in the right place at the right time';

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ensure the delivery of quality services which maximise patient health and care outcomes

(d) *help people take control of their lives and communities and ensure children, young people and adults are safe and confident in their lives and communities and that people are treated with dignity and respect.*

5.3. The key objectives of the arrangements is to deliver Integrated Commissioning that will focus on developing joined up, population based, public health, and preventative and early intervention strategies and adopt an asset based approach to providing an single system of health and wellbeing, focusing on increasing the capacity and assets of people and place.

5.4. Objectives for the three workstreams support the delivery of the Tameside & Glossop Locality Plan

5.5. The overall project is linked to and delivering the objectives of the Better Care Fund but also addresses a significantly larger remit of Integrated Commissioning and the wider single commissioning of health and social care services.

5.6. These objectives are reflected in the terms of reference of the Single Commissioning Board.

6. Objectives and targets of Integrated Commissioning

6.1. Both Partners shall recognise the Integrated Commissioning objectives, targets and decisions that are shared

6.2. The mandated objectives include:

- NHS Constitution requirements (statute);
- Targets and performance measures identified by NHS England (regulation) / GM H&SCP;
- Standards set by external agencies, e.g. CQC, Ofsted and NICE (regulation).
- Adherence to the associated terms of the GM Health & Social Care Partnership Investment Agreement

6.3. Advised objectives include:

- Best practice identified by external agencies, e.g. NICE and GM Medicines Management Group

6.4. Locally defined objectives include:

- Living wage for care workers (policy);
- Removal of ‘zero hours’ contracts for staff of service providers (policy).
- Welfare Reform
- 7 Day Working
- Adherence to the Mental Health Investment Target
- Outcomes based Commissioning
- Delivery of efficiencies to address the projected Economy Financial Gap

6.5. The CCG and the Council have agreed that there will be no change to the executive powers of the CCG Governing Body, or the Council Executive Cabinet.

Responsibilities

7. Partner responsibilities

7.1. The Partners have stated their commitment to developing Integrated Commissioning whilst ensuring the financial health of both Partners; and of other organisations in the local health and wellbeing economy.

7.2. The Partners recognise their obligation to comply with statute and regulations.

7.3. The Partners recognise that each Partner’s ultimate responsibility for service provision and delivery is not changed. However, they will delegate decision making and administration, where this improves

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the way that services are commissioned and where it is feasible. The Partners will identify limitations and restrictions clearly.

7.4. The Partners recognise specific responsibilities regarding services included within Integrated Commissioning:

- Obligations and commitments to the residents of; and patients registered within the Tameside and Glossop;
- Obligations and commitments to the wider population of patients within Tameside and Glossop, who are aligned to the Tameside and Glossop care economy;
- Obligations to the Provider community; delivering pace of change whilst creating a sustainable provider market.

8. Responsibilities of the Partner organisations' leadership

8.1. The Partners will agree and approve the strategic objectives for Integrated Commissioning. They will:

- Set the strategic objectives for the Partner organisation;
- Seek assurance that these are incorporated within the strategic priorities for Integrated Commissioning.

8.2. The Partners will approve the policy and performance framework (business plan) for Integrated Commissioning and will:

- Ensure the adequacy of the Integrated Commissioning function's business plan and alignment with the partners' plans
- Approve the adequacy of organisation, staffing and management of Integrated Commissioning

8.3. The Single Commissioning Board will approve the authority and governance framework for Integrated Commissioning, including:

- Approving the key governance documents (where these are different from the Partner organisations' documents);
- Approve the use of the relevant Partners Standing Orders, Standing Financial Instructions, Schedule of Decisions Reserved, Scheme of Delegated Authorities etc. The Partners will endeavour to unify these where appropriate;
- Ensuring the performance of the Pooled Fund is scrutinised regularly and appropriately;
- Delivering scrutiny and pre-approval of significant new programmes and projects.

9. Responsibilities of the Partner organisations' Accountable Officer and Chief Financial Officer(s)

9.1 The Accountable Officer

9.1.1. The Chief Executive and Accountable Officer of the single commission is responsible for :

- Settling disputes under the Section 75 Agreement;
- Signing approval of changes to the Section 75 Agreement;
- Ensuring the record of minutes of meeting of the Single Commissioning Board is maintained.

9.1.2. The scope of this role will be subject to the delegations approved by the Single Commission.
9.1.3. The Accountable Officer is a member of the Single Commissioning Board.

9.2 Chief Financial Officer(s)

9.2.1 The overriding responsibility of the Chief Financial Officer(s) will be to gain assurance as to the satisfactory standard of financial management, accounting and reporting of the Integrated Commissioning Fund. The Chief Financial Officer(s) will:

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- Ensure that the Integrated Commissioning arrangements are appropriate and sufficiently secure to safeguard public funds;
- Ensure that financial governance and internal controls conform to the requirements of regularity, propriety and good financial management; sufficient to deliver successful operations;
- Ensure that reporting of Integrated Commissioning on strategic, operational and financial performance, budgetary control and risk management is adequate and reliable.

9.2.2 The Accountable Officer will ensure that the specific obligations of the s151 officer are delivered in respect of transactions involving the funds of the Council.

9.2.3 The Chief Financial Officer(s) will ensure the adequacy of arrangements to deliver new services, programmes and projects.

9.2.4 The Chief Financial Officer(s) will report assurance to their respective Audit Committees.

10. Responsibilities of the Host Partner

10.1 For the Pooled Fund the Council has been appointed as the Host Partner. This appointment will be reviewed periodically.

10.2 The scope of role of the Host Partner is determined, in the first instance, by the decision to seek to minimise organisational change resulting from the development of the Integrated Commissioning arrangement. As a minimum, the Host Partner will deliver the regulatory requirements:

- Appoint the Chief Financial Officer(s) as Pooled Fund Manager(s);
- Deliver the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000 7(4) and 7(5) requirements:
  - Accounts and audit
  - Managing the fund
  - Reporting to the partners and reporting frequency
  - Exercise NHS and health-related functions

11. Responsibilities and role of the Chief Financial Officer(s) as the designated Pooled Fund Manager(s)

11.1 The Chief Financial Officer(s) designated as the Pooled Fund Manager(s) by the Host Partner in accordance with requirements of the Section 75 Agreement and associated regulations. The appointee attends the Single Commissioning Board and reports to the Accountable Officer. The responsibilities of the Pooled Fund Manager(s) as set out in the legislation and Regulations (7(4)) are limited and specific: -

- Managing the Pooled Fund
- Submitting monthly reports, and an annual return, about the income of, and expenditure from, the Pooled Fund and other information by which the Partners can monitor the effectiveness of the Pooled Fund.

11.2 The Chief Financial Officer(s) alongside other Executive Directors will report to and is/are accountable to the Single Commissioning Board (SCB) and will be responsible for the implementation of the Integrated Commissioning Strategy; direct procurement of services; and managing contract performance.

11.3 Other responsibilities, which will be delegated as necessary and as agreed by the Single Commissioning Board, will include:

- Compiling the annual Integrated Commissioning Strategy;
- Reporting monthly finance and activity performance to the Single Commissioning senior management team;
- Manage delivery of contracts, including outcomes and quality standards checks;
- Delivering value for money and effective performance of the Integrated Commissioning Fund.

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11.4 The Chief Financial Officer(s) will oversee the day to day operation and management of the Pooled Fund and will oversee the day to day operation and management of the Aligned Fund.

11.5 Financial governance arrangements will ensuring expenditure complies with the contractual specifications. Specific responsibilities include to be assured of the arrangements for:

- VAT;
- accounts timetable;
- charging arrangements;
- ledger arrangements.

11.6 The Chief Financial Officer(s) will be responsible for maintaining the joint financial position of the Pooled Fund:

- Ensuring the adequacy and completeness of financial records;
- Ensuring action is taken over projected over and underspends;
- Reporting performance to the Partners and the Health and Wellbeing Board.

12. Dissolution of the Section 75 Agreement

12.1 The legal position is set out within the Section 75 Agreement, as are the mechanisms for dissolution of the Section 75 Agreement. This Financial Framework identifies the scale of risks that both Partners will accept, before considering the need to reduce the scale of the Integrated Commissioning Fund, dissolve the Section 75 Agreement and/or this Financial Framework.

12.2 The Section 75 Agreement identifies a period of notice of three months, subject to the Partners' ability to implement secure alternative arrangements for commissioning of each of the Services included within the Integrated Commissioning Fund.

12.3 The Partners will agree the scale of financial pressures that either Partner will be willing to accept, before considering the need to dissolve the Section 75 Agreement or this Financial Framework.

12.4 The Partners will agree mechanisms for entering emergency arrangements to reverse adverse trends, including:

- protocol for suspending the Host Partner's management arrangements for the Pooled Fund;
- structure of governance and management of the Section 75 Agreement or this Financial Framework in emergency measures.

13. Cessation of the Pooled Fund

13.1 Where the Pooled Fund is to be ceased, due to the dissolution of the Section 75 Agreement from the Partner(s) decision to end the arrangement, the ownership of assets, liabilities and commitments will revert to the relevant Partner. If the relevant Partner is not clearly identified, ownership will fall to the Partner acting as the Lead Commissioner. This applies to:

- Ownership of invested assets;
- Ownership of consequential service obligations.

13.2 Where the Section 75 Agreement is to be dissolved due to financial insolvency, the Partners will agree the stages for realising the losses accumulated by the Pooled Fund. The stages are:

- apportionment of financial risk;
- allocation and apportionment of financial risk as agreed between Partners;
- agreement of continuation of Services to Service Users.

Scope and description of the Fund

14. Scope of Integrated Commissioning

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14.1 The Partners have agreed that the scope of the Integrated Commissioning Fund shall be the maximum commissioning resource that it makes sense to pool, or align to deliver joined-up commissioning:

- a formal Pooled Fund has been established where possible;
- Aligned Funds will be used where there are specific barriers to pooling (including legislative and regulatory barriers).

14.2 Commissioning funding will be pooled or aligned, at service and/or contract level. In the first instance, the service area, or contracts will be mapped entirely to either the Pooled Fund or the Aligned Fund. Contracts will only be split where there is value in disaggregating the commissioning arrangement and where this can be managed effectively. The Partners' financial ledger record will be designed to allow for the pooled, aligned and in collaboration elements of the fund to be identified and disaggregated clearly.

14.3 Either Partner will be allocated the Lead Commissioner role for each service area, or contract, based on the most logical and effective design for the commissioning function.

14.4 The Partners agree in principle that further Services may be added to the Integrated Commissioning Fund; or specific Services may be removed from the Integrated Commissioning arrangements, in future. The decision and approval approach to this process will follow best practice in business case development, analysis and challenge.

14.5 The Partners recognise that the Glossop community is included in the approach to planning for commissioning of care in Tameside and Glossop. The Partners will maintain a close relationship with Derbyshire CC & High Peak MBC for the health related service needs of the Glossop residents and registered patients.

14.6 The scope of the Integrated Commissioning Fund is illustrated in Appendix 2 and includes both the CCG's operating and commissioning resources.

15. Better Care Fund

15.1 The Better Care Fund (BCF) is mandated by government. It was launched through the Spending Round in June 2013, with the objective to deliver integration of services and improve outcomes for patients and service users and carers. The BCF is set up as a Pooled Fund, with the NHS commissioner and the local authorities contributing an agreed level of resource into a single pool that is then used to commission or deliver joined up health and social care services.

15.2 The proposals submitted for the BCF shows a pooled budget valued at £XXXX in 2017/18:

- £xxx Council Disabilities Facilities Grant
- £xxx CCG BCF funding contribution, meeting the minimum specified by DH.
- There is an additional £xxxm BCF funding contribution relating to the Glossop area.

15.3 The BCF plan is described in template submissions. It identifies:

- summary of total planned spend and planned spend on out-of-hospital services;
- more detailed plan of the service areas specified for spending of the BCF;
- analysis of expected benefits, including financial values.

15.4 The BCF for 2017/18 is subject to the following conditions set by NHS England (extracts from the BCF Policy Framework, December 2014):

- A requirement that the BCF is administered through pooled funds established under section 75 of the NHS Act 2006;
- A requirement that Health and Wellbeing Boards agree plans for how the money will be spent, these plans having been signed-off by the Council and CCG;
- A requirement that plans are approved by NHS England in consultation with Ministers;
- The fund is to be used in accordance with the agreed plan.

15.5 Local areas will also be asked to set targets against four national and two local key metrics:

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- delayed transfers of care
- Non elective activity;
- admissions to residential and care homes;
- Reablement;
- Newly Diagnosed Patient on Primary Care Register
- Overall Satisfaction of people who use services with their care and support.

15.6 The BCF is an element of the wider Pooled Fund for Tameside and Glossop. The Pooled Fund, in turn, is combined with the Aligned Funds to make up the total value of the Integrated Commissioning Fund.

16. Value of the Integrated Commissioning Fund

16.1 The Integrated Commissioning Fund comprises the Pooled Fund and Aligned Fund which it makes sense to plan and manage in a coordinated way where legislation allows for in collaboration funds as referenced in Appendix 1.

16.2 The CCG fund elements include (2017/18 opening budgets):

- Complete commissioning budget for patients registered with GPs in Tameside and Glossop, including the full acute services budget; and the administrative and support functions, as an aligned fund ;

16.3 The Council fund elements include:

- Adult Services and Childrens' Services within the "People" Directorate.
- The Public Health directorate budget.

16.4 Figures quoted in Appendix 1 are in line with the full budgets approved by the Council on 28 February 2017. The Council budgets exclude related overheads

16.5 The stated intention is to maximise the resources and the scale of commissioning to be included in the Integrated Commissioning Fund, as either an Pooled Fund or Aligned Fund. The prescribed services that cannot be pooled, as summarised in SI(2000)617: NHS Bodies and Local Authorities Partnership Arrangements Regulations includes:

NHS

- Acute surgical (unlikely to be able to disaggregate from hotel services);
- Emergency ambulance;
- Radiotherapy;
- Termination of pregnancies;
- Endoscopy;
- Laser treatments (class 4);
- Other invasive treatments.

Local Government

- Adoption services (Adoption & Childcare Act, 2003);
- Appointment of mental health professional (MHA, 1983);
- MHP powers of entry (MHA, 1983);
- Safeguarding children in care homes (Children Act, 1989);
- Appointment of director of social services (LASSA, 1970).

16.6 Where possible, these services will be included in the Integrated Commissioning Fund as an Aligned Fund.

17. Range of the Pooled Fund (cross boundary flows and issues)

17.1 The populations served by the Pooled Fund are not consistent between the Partners; and essential Integrated Commissioning extends beyond the boundaries of the Pooled Fund. The Partners agree to

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seek to avoid creating unnecessary barriers or inequalities of access for Service Users. They agree to seek to avoid creating perverse incentives in the design of commissioned and provided Services.

17.2 Funding inconsistencies are created by:

- Council residents registered with GPs outside of the Tameside and Glossop area;
- Non-Council residents registered with GPs within the Tameside borough;
- Individuals not resident; and not registered with GPs in the area requiring services within the scope of the Integrated Commissioning arrangement;
- Service Users who receive Services who are not physically present in the borough.

17.3 Unwanted barriers and incentives to commissioning are created by:

- The ‘footprint’ of the main providers of NHS services extending into neighbouring areas,

17.4 Potential service level boundaries and inconsistencies may also occur as a result of the range of local government commissioned services that remain with the Council.

Statutory reporting requirements

18. Annual financial accounts

18.1 The value of the budget for the Pooled Fund, as described in the Section 75 Agreement, will be material to both Partners; and as such will be subject to appropriate levels of external and internal audit scrutiny.

18.2 The annual financial accounts of both Partners will be required to include sufficiently detailed notes of the financial performance and records of the Integrated Commissioning arrangement:

- The structure of reporting to be followed for a “Joint Operation”, such as this Integrated Commissioning arrangement, is prescribed by the International Financial Reporting Standards (IFRS) in IFRS11(Joint arrangements) and IFRS 12 (Disclosure of interests in other entities);
- The Statement of Financial Performance of the formal Pooled Fund is to be reported in the Host Partner’s accounts and reflected in the other Partner’s accounts;
- The financial performance of the Aligned and In Collaboration Funds are to be reported within the body of the relevant Partner’s accounts;
- The financial performance of the entirety of the Integrated Commissioning Fund; and the associated risk share arrangement, is to be reported as an explanatory note in both Partners’ accounts.

18.3 Due to the annual accounts reporting timetables of both Partners, the risk share will be calculated on the basis of the month 11 forecast position for month 12. Any correction to the value of the risk share will be recognised at the start of the next financial year.

18.4 Planning for accounts preparation and required audit arrangements will take account of:

- Timetables for producing the annual accounts, their audit and reporting requirements; recognising the earlier reporting deadlines for NHS accounts. It is acknowledged that Council reporting deadlines are susceptible to change;
- The scope of required reporting, including the contribution to the CCG Quality Account; and to the Council Annual Report;
- The evidence required to support the annual statement on governance; and for reporting any financial concerns with the Integrated Commissioning Fund;
- The evidence required to support the Head of Internal Audit Opinion and the external audit Regularity Opinion.

18.5 The annual financial accounts will be delivered within the requirements of the financial regimes and rules of each Partner, specific to over and underspending:

- CCG – Resource Allocation Budgeting impact and treatment of over and underspends – impact carried forward into next year’s allocation;
- Council – not allowed to carry forward overspend for the year. Overspending to be met from reserves,

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19. Arrangements for audit and counter fraud

19.1 The Partners agree that they will seek a joint approach and joined up arrangements for the internal audit of the Integrated Commissioning function and associated budget resources:

- Access arrangements for both sets of (internal and external) auditors will be agreed as part of the annual audit planning and scoping exercise;
- Deliver combined assurance to the CCG and Council where possible;
- Deliver each Head of Internal Audit (HoIA) opinion and shared assurance for both Partner organisations.

19.2 In terms of the external audit legal and regulatory requirement:

- The Integrated Commissioning arrangements will represent a material and significant element of each Partner organisation's audit;
- The audit will account for the Pooled Fund fully within the Host Partner's accounts, with the required narrative note in the accounts of other Partner;
- The audit will address the aligned and in collaboration elements of the fund within the accounts of the Partner with the originating budget, or the Partner to which the funds were transferred through s76 or s256 of the National Health Services Act 2006, if such transfers occur;
- A note will be included in the accounts of both Partners setting out the results; and the risk share impacts, for the entirety of the Integrated Commissioning Fund.

19.3 The assurances required for the sign off of the audit of both sets of financial accounts will be agreed between the external and internal auditors.

20. Local Counter Fraud and Security Management Services (LCFSMS)

20.1 NHS Protect has confirmed that its focus will continue to be on NHS resources. The Partners agree that coverage of counter fraud culture and issues within the Integrated Commissioning arrangement will be joined up, as far as is practicable:

- The CCG and Council will agree arrangements for sharing the approach to promoting the counter fraud culture; and for investigating and addressing instances of suspicion of illegal activity;
- The Council counter fraud functions will continue to be delivered by its internal audit provider and specific fraud team.

Budget Setting

21. Budget setting ground rules

21.1 The Policy for commissioning through the Integrated Commissioning Fund is compatible with and delivers effectively the strategic priorities of both Partners.

21.2 Funds can only be used to commission prescribed services (as described in various legislation); and services that the Partners agree will contribute to the effective delivery of the commissioning priorities.

21.3 Delivery of a balanced outturn is a pre-requisite of commissioning decisions.

21.4 (Future Target) Budgets will be single fully, subject to specified limitations; and budget resource will be transferrable between the Partners, to enable optimum delivery of commissioned services and ensure best value in the use of resources. This will be recognised within each Partners medium term financial strategy.

21.5 The Partners agree that the Integrated Commissioning Fund will be reviewed during 2016/2017 and updated accordingly in recognition of national funding decisions of the Government and associated agencies together with funding decisions taken by the Council and CCG.

21.6 Commissioning decisions take account of the potential impact on services retained by the Partners.

21.7 Commissioning decisions are sensitive to the potential impact on the wider community of Providers.

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22. Budget setting methodology

22.1 Both Partners need to be satisfied that the other Partner's methodology for setting the annual budget is robust and reliable. If they are not, the issue shall be escalated through the appropriate governance arrangements. Each Partner will agree the other's methodology for setting the inaugural budget contribution; and future years' budgets. The factors that will be considered include:

- Clarity of the Services to be included in the Integrated Commissioning arrangement and risk share (Pooled Fund and Aligned Fund);
- Verification of budget determined for each Service;
- Assumed and modelled trends in demand;
- Deliverability of the savings targets applied;
- Sufficiency of the budget applied (e.g. compared with previous year outturn).

22.2 The Partners will agree:

- A transparent approach to setting budgets shared between the Partners;
- Validation of the key assumptions and approaches used by each Partner to determine the budget;
- Plans for migration to a more consistent approach to budget setting and demand forecasting that recognises the modelling challenges specific to each organisation.

22.3 Both Partners recognise the risk to resources from unmet need and rationed Services from previous years.

23. Accuracy of activity projections, trends and interventions

23.1 The CCG approach is based on totals agreed in contract negotiations with Providers.

23.2 The Council approach is based on cost and volume analysis of likely trends in demand for Services. As part of this, the Council will:

- Determine the access eligibility thresholds for health related services, as defined by the Care Act 2014 and any flexibilities allowed;
- Determine the charges to be levied against Service Users, where this is an option.

24. Accuracy of cost projections

24.1 The Council commissioning budgets will be recognised in gross value, as well as in net value:

- Other budgets, where costs are partially offset by income from fees and charges and grants, will be included at their net value in the risk share calculations.

24.2 The Councils scope to assess the eligibility thresholds for access to services; and to set fees for services, will be taken into account when negotiating relevant contracts.

25. Addressing conflicts in budget setting priorities

25.1 It is expected that the Integrated Commissioning budget planning process will not adversely impact on the other commissioning obligations of the Partner:

- The Partners' oversight and scrutiny functions (CCG Governing Body, Cabinet) will have the opportunity to challenge any changes proposed;
- The scheme of delegations will provide a level of control over the approval of changes;
- Arrangements will be adopted for administering proposals for significant re-engineering; and compliance with business planning and investment proposal discipline, including comprehensive consultation.

25.2 It is expected that changes in the strategic direction of the Partners will not impact adversely on each other, or on the commissioning obligations of the Integrated Commissioning function.

26. Use of Integrated Commissioning Funds

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- Integrated Commissioning Funds shall only be used for Permitted Expenditure.

27. Future budget settlements

Risk to be addressed: Financial settlements and budget uplifts for future years are insufficient to meet rising demands and rising costs

Possible scenarios:

- Local Government grant funding from government (Revenue Support Grant) is projected to reduce significantly;
- NHS allocation growth is significantly less than anticipated plans;
- Both Partners may be required to produce medium term efficiency plans in order to receive multi-year financial settlements.
- Greater Manchester Health and Social Care Partnership impose additional requirements.

27.1 Principles of response to these risks and future pressures:

- As far as is possible, the value of the single budgets will be kept at their equivalent current value
- Treatment of remaining resource gaps will be addressed within the single consolidated fund during the period to 2020/2021 with both Partners agreeing to vary contributions over 4 years to mitigate variable pressures in health and care services. It is agreed that the Council will increase the value of Council resources within the ICF by a maximum sum of £ 5.0 million in both 2017/2018 and 2018/2019 on the condition that the T&G CCG agrees a reciprocal arrangement in 2019/20 and 2020/21 should this be necessary.

28. Boundaries to the Fund

28.1 Budget setting will take account of boundaries on a number of planes:

- Pooled Fund versus retained funds;
- Pooled Fund versus aligned funds;
- Non-resident patients registered with GPs in Tameside and Glossop;
- Tameside residents registered with GPs outside of Tameside and Glossop;
- Budgets allocated to the Tameside and Glossop locality on a per-capita basis.

28.2 Budget setting will also to take account of patients registered with GP Practices in the Greater Manchester area, whilst recognising that they are outside of the Integrated Commissioning Fund arrangement.

29. Finalising the prior year position

29.1 Both Partners acknowledge that the financial performance of the relevant budgets in the current year should be regarded as a key indicator of future years' risks; and of the scale of the savings targets agreed between the Partners. The following constraints will need to be accommodated:

- Current year out-turn position will not be known until very late in the process.

29.2 The value of the Integrated Commissioning Fund will be based on the budget allocations

- Savings targets will be identified by the Partners.

30. Treatment of historical overspends

30.1 CCG would account for prior year deficit as a negative balance on the RAB (Resource Account Budgeting) settlement.

30.2 The Council cannot record a year-end deficit; and must fund remaining overspends from reserves.

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31. Prior year and in-year overspends

31.1. The Partners recognise that differences in funding regimes and freedoms result in a different response to recorded “overspends”:

- The CCG cannot carry “reserves” between years. Underspends and overspends are recognised within the annual resource allocation. Overspends in one year result in reduced allocation in the next. The CCG can set a budget that delivers a planned overspent position, but is expected to achieve balance over a 3 to 5 year period.
- The Council cannot record an overspend at the year-end; and has to account for overspent budgets through its reserves. But the reserves are limited and should be replaced through budget targets set in the subsequent year.

31.2. The Partners agree, in principle, that they will use these differing “flexibilities” in a combined approach to maximise protection to the Integrated Commissioning function.

32. Treatment of underlying and emerging deficit:

32.1 Underlying and emerging deficit will include:

- Unidentified deficit:
  - unmet need
  - unmet demand
- Identified deficit:
  - undelivered services
  - service delivery backlogs
  - waiting lists

32.2 The CCG and the Council agree to work together to identify responses to the threat of emerging unfunded demand pressures and growth in demand.

32.3 The first point of responsibility for addressing pressures through contracts will be the Lead Commissioner. A Lead Commissioner will be identified for each Service Contract.

32.4 Escalation arrangements will be agreed for Service Contracts and commissioning arrangements that appear to be overheating and indicate future losses. These arrangements will be agreed by the Single Commissioning Board and will be determined by the value and percentage growth indicated.

33. Setting subsequent years’ budgets

33.1 The Section 75 Agreement specifies that the Integrated Commissioning Fund will be subject to annual review. This will be alongside the medium term financial plans of each Partners.

33.2 The Partners agree to shared approach to:

- Identifying and agreeing future trends in demand and service design;
- Checking sufficiency of growth funding;
- Identifying and accounting for changes in cost pressures;
- Identifying and agreeing savings and efficiency approaches. Ensuring the robustness of planned savings programmes;
- Setting criteria for values for savings targets:
  - Minimum and maximum allowed;
  - Reality checked and deliverable.

33.3 The Partners agree to design a robust business case approach to service redesign; and to its financial impact. This will involve:

- Robust analysis of overall savings projections;
- Robust analysis of comparative impact on Partners; and recognition of the need to reflect (compensate) for these impacts in future budget setting;
- Agreement on the impact on the risk share.

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Risk Sharing Framework

34. Scenarios of operational pressures and risks in budget setting

34.1 The following sections set out a range of scenarios of risk:

35. Pressures on Partners' budgets

35.1. Risk: Pressures within either Partner which results in shortfall in growth funding and/or increased savings targets

35.1.1. Possible scenarios are:

- Shifting priorities in the Council from the People Directorate and other directorates and services;
- Internal pressure on overall CCG position resulting in pressure on budget allocation for Tameside and Glossop patients;
- Changes in targets set (externally) for performance in specific service area(s) within the Integrated Commissioning Fund.
- Increased savings targets set (externally).

35.1.2. Principles of response to these risks and future pressures:

- Impacts due to shifts in internal policy and priority have to be discussed by both Partners
  - Partners will agree to apply accumulated savings;

- Impacts due to external policy and target changes to be regarded as required changes; and partners to agree response
  - Accumulated savings can be applied to offset, but need to recognise limited resource

35.2. ***Risk: Available resources and budgets do not address current demand***

35.2.1. Possible scenarios are:

- Growth rates in demand for services exceed available funding increase;
- New commissioning arrangements and single approach to commissioning identifies previously un-met need;
- Providers are carrying backlogs in activity that need to be delivered and need to be funded.

35.2.2. Principles of response to these risks and future pressures:

- The Integrated Commissioning function must achieve a balanced financial out-turn;
- Providers of services will be encouraged, including through contracting, to manage service delivery costs within the allotted amount;
- Where possible, Services will be prioritised and needs assessed. Non-statutory services may be withdrawn, if impact is less significant than effect of rationing funds to areas of demand growth. Service rationing will not be organisation specific;
- Funds will be made available to promote more effective and streamlined provision of Services.

36. Savings targets, reserves and contingencies

36.1. ***Risk: Efficiency savings targets applied within budgets are undeliverable***

36.1.1. Possible scenarios are:

- A Partner is unable to show persuasive plans for achieving the savings expectations;
- Savings target exceeds sensible levels;

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- Savings proposals would have an adverse and costly effect on other elements of the overall service delivery.

36.1.2. Principles of response to these risks and future pressures:

- Agreed process for identifying efficiency savings targets:
  - From service delivery re-design;
  - From QIPP expectations;
  - From benefits expected of merged commissioning;
  - From share of organisation's overall target;
- Agreed approach to identifying benefit shares with Providers.
- Agreed process for verifying likelihood of delivery of the savings targets:
  - Arrangements for assessing schemes to deliver;
  - Risk assessment for schemes; and response to higher risk proposals.
- Agreed arrangements for sharing the risk of under-delivery of efficiency savings targets;
- Arrangements for allowing late amendments to budgets and savings target:
  - E.g. QIPP schemes determined late.

36.2. ***Risk: Insufficient resources to allow for a contingency or reserve to be set***

36.2.1. Principles of response to these risks and future pressures:

- Partners will agree rules specifying whether contingency (both recurrent and non-recurrent) is a required element of the annual budget; and what this level is:
  - Proportion of annual total allocation designated to contingency target to be agreed;
  - Arrangements for agreeing contingency that is lower than the agreed target;
- Partners agree proposed treatment of any reserves brought into the Integrated Commissioning Fund:
  - Budgeted from savings in previous year(s);
  - Agreement of priorities and triggers for calls upon reserves;
- Treatment of unspent contingency, or other underspend of the total budget to be determined by the Partners:
  - Proportion, or target value to retain within the Integrated Commissioning Fund;
  - Treatment of any underspend to be returned to the Partners;
- Agreement on accounting for reserves.

36.3 Risk Sharing Arrangements

36.3.1 The arrangement agreed for 2016/2017 was that, whilst working as a single commissioning function, the Council and CCG would retain full responsibility for their own financial risks. After a year of formally working together the current financial arrangements feel out of step with the concept of a single commissioner.

36.3.2 The proposal is that from 1 April 2017 each organisation will begin to share financial risk in proportion to the respective contributions they make into the Integrated Commissioning Fund. This would result in a sharing arrangement of 80 % for T&G CCG and 20 % for the Council as calculated in the table below :

Net Budgets Per Appendix 1

Commissioner	Total Net Budget	ICF % Contributions
	£'000	**%**
T&G CCG	381,491	80
TAMESIDE MBC	96,438	20
TOTAL	**477,929**	**100**

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36.3.3 This would be a significant step for both organisations given the current financial climate and the scale of the savings that must be delivered in the short term and the risks that the local health and social care economy face currently.

The variance to the total net budget allocation at the end of each financial year will be financed in proportion to the percentage of the net budget contribution of each organisation to the ICF (per table 13). However, the variance will be initially adjusted to exclude any CCG net expenditure associated with residents of Glossop (13% of the total CCG variance) as the Council has no legal powers to contribute to such expenditure. The associated adjusted total variance of both the CCG and the Council would then be financed in proportion to the % contributions as stated in table 13.

36.3.4 In addition a stepped approach will be taken to risk sharing and a cap will be placed on the shared financial exposure that each organisation would be expected to meet. For 2017/2018 :

- a cap of £ 2.0 million is placed on CCG related risks that the Council will contribute to;
- a cap of £ 0.5 million is placed on Council related risks that the CCG will contribute to.

36.3.5 The differential cap is recognises that it would be difficult for the CCG to assume responsibility for 20 % of the Council's risks at a time when it is facing the highest QIPP target across Greater Manchester.

36.3.6 For clarity, the risk sharing arrangement applies to the Section 75 pooled fund, the aligned fund and the 'in collaboration' budget as set out in **Appendix 1**. It addition, the Council's cap of £ 2.0 million is over and above the non-recurrent contribution to the ICF of up to £ 5.0 million in both 2017/2018 and 2018/2019 (on the condition that the T&G CCG agrees a reciprocal arrangement in 2019/20 and 2020/21 should this be necessary – per section 27.1)

37. Governance and delivery of outcomes

37.1 Tameside and Glossop ICFT is at the heart of health and care reform in Tameside and Glossop. The integration of providers requires a different approach to contracting, performance, insight and intelligence that takes account of the system's capacity to reach beyond traditional agency silos and tackle outcomes in a more efficient and joined up way from a patient's perspective. The work of Care Together will re-orientate the system and its relationship with the public, building on the public's role as partners not only in their own health, but also as key influencers over system design and development.

37.2 The new approach requires a stronger focus on outcomes based service delivery, highlighted by collaborative work between the Single Commissioning Function and ICFT on the development of an outcomes framework within clearly defined timescales.

37.3 New models of neighbourhood working will require the alignment of intelligence resource across health and social care. This will facilitate a whole system view of performance (alongside care models) to ensure strategic and operational management is underpinned by robust, forward looking insight and intelligence.

37.4 The ICFT are key in the delivery of Care Together which will lead to a clinically and financially sustainable health and care system, whilst simultaneously improving healthy life expectancy and outcomes for our residents. The key transformation programmes upon which Care Together is dependent are within the governance and leadership of the ICFT.

37.5 Tameside & Glossop's approach to commissioning for outcomes is in development. The SCF expect T&GICFT to engage in the further development of and pay 'due regard' to the system wide outcomes framework as it further develops. This will include the development of outcome measures which will determine the impact of the Healthy Neighbourhood model and point towards the shifts associated with self-care and person centred approaches.

37.6 Outcome measures under discussion include:
- Measure of population health literacy

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- PAM scores
- Proportion of people feeling supported to manage their long term condition
- The proportion of carers who report that they have been included or consulted in discussion about the person they care for

37.7 We will work as an economy to address the areas identified as areas for improvement from a financial efficiency and quality perspective in the NHS Right Care programme. We will also ensure our outcomes are agreed in line with the 2017-19 NHS Operational Planning Guidance 'Must Dos'.

37.8 The SCF and ICO will engage in a system approach to the delivery of these priorities, which cover the following areas:

- Sustainability Transformation Plans
- Finance
- Primary Care
- Urgent and emergency care
- Referral to treatment times and elective care
- Cancer
- Mental health
- People with learning disabilities
- Improving quality in organisations

38. Curtailing services

38.1. The existing contractual design allows the Council and the CCG options to curtail service commissioning mid-year. There is scope to review the notice period (the Council traditionally uses a 3 month notice period; CCG 1 year, but there is scope for earlier curtailment in event of failure to deliver the commissioned service).

38.2. The Service redesign procedure will include the requirement to identify and consider the likely knock-on and consequential effects of the proposed service.

39. Value of financial risk from the other Partner

39.1. The Partners recognise the high risk of overspending of the Integrated Commissioning Fund. This is based on the Partners' budgetary performance in recent years.

39.2. The Partners will be jointly responsible for the delivery of an annually balanced ICF during the period to the end of 2020/2021.

39.3. Contributions between Partners may vary in individual years to meet differing financial pressures in health and social care but the Partners will ensure the Integrated Commissioning Fund is in balance each year and individual Partner contributions will be fully restored and balanced by year ending 2020-21. (please refer to section 27.1)

Managing the transactions of the Pooled Fund

40. Transactions within the Pooled Fund

40.1 Funding management arrangements, at the transaction level, will be designed in line with the principle of limited change and aim for consistency with the administrative approach of the previous year: Where practicable funds will remain with the respective Partner; and relevant transactions will be handled by them. If required, to fulfil specific s75 Pool rules, recharges will be applied to ensure that the entirety of the Pooled Fund record is accounted for within the Pooled Fund.

40.2 The mechanism of "cash" flow and contribution to the Pooled Fund is managed in accordance with the documented procedure for the Better Care Fund in the Group Accounting Manual (GAM). An extract of this procedure is provided at Appendix 2.

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40.3 Expenditure from the Integrated Commissioning Fund:

- Contractual arrangements will be unchanged from the Partners' existing arrangements, unless evolving integration necessitates redesign.
- A Lead Commissioner will be identified for each contractual arrangement.

40.4 Specific arrangements and rules will be determined for the "direct payments" processes for Service Users (use of a holding bank account and "debit cards").

40.5 Any potential impact of VAT regime differences will be reduced through the planned consistency of approach to:

- Identify the scale and scope of the issue;
- Ensure that the correct VAT regime is applied to each transaction;
- Identify NHS service elements versus health related service elements.

40.6 The governance of transactions will reflect the constitution and financial regulations (SOs, SFIs, SoDA) of the Lead Commissioner, which initiates and processes the expenditure and payment transactions.

40.8 The Partners agree that transactions for Aligned Funds will continue to be undertaken in accordance with the appropriate Partners existing mechanisms and procedures.

Managing Financial Performance

41. Budget management general arrangements

41.1 The Single Commissioning Board will be responsible for decisions to approve the expenditure proposed from the Pooled Fund:

- Each Partner will introduce arrangements whereby the annual allocation of funds to the Pool Fund is agreed in accordance with their Constitution or governance requirements;
- Each Partner will approve commissioning contracts, where it is the Lead Commissioner.

41.2 The financial regulations (SFIs, SoDA) of each Partner will be reviewed for consistency. Where required, the regulations will be amended to enable the proposed structures and responsibilities to be implemented

Review of in-year budget allocation

41.3 The basic principle is that budget allocations to the Integrated Commissioning Fund will not change (in-year) once they have been agreed. However both Partners agree that they will be updated in recognition of national funding decisions of the Government and associated agencies together with funding decisions taken by the Council and CCG.

41.4 Resources, identified during the year, and specific to the services in the agreement and to the population served, will be adjusted accordingly. Examples include:

- Specific grants;
- Funding from DH, NHS England, other government sources;
- Successful bids from Greater Manchester Health and Social Care Partnership.

41.5 The Partners will agree a model whereby they retain the right to revisit allocations during the year

- Risks arising from external sources (protocol for responding to pressures, faced by either partner, from external sources);
- Risks arising from internal sources.

42. In-year financial performance

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Local operating rules

42.1 The Partners will implement administrative arrangements that will be based on existing arrangements, but will be developed, where beneficial, for the Integrated Commissioning function as a whole.

42.2 For individual schemes, the arrangements will reflect:

- Any legislative / funding restrictions or requirements
- strategic priority restrictions

42.3 Reporting of performance (financial, contracts, quality etc.) will be delivered in terms of gross income and expenditure.

42.4 The forecasting approach for the Pooled Fund and the wider Integrated Commissioning Fund will be determined by the Partners.

Monitoring performance

42.5 The Partners will develop a model for monitoring monthly performance of the Integrated Commissioning Fund. This model will include:

- Actual and forecast expenditure and income;
- Arrangements for identified accruals for activity delivered or expected to be delivered;
- Monitoring of service backlogs
- Monitoring against agreed contract outcomes.

43. Responding to overspend trends

Alerting Partners of the likely overspend

43.1 The Partners will develop an agreed approach to addressing trends towards overspending in the Integrated Commissioning Fund. Design of the tool for alerting partners of likely overspend will include:

- Triggers and thresholds;
- Agreed sensitivity measures;
- Trend analysis and alerts;
- Analysis of impact of/on related activities;
- Impact of progress along the annual timeframe – forecasting and sensitivity analysis over the medium term.

43.2 Escalation rules will address

- Scope for managing the situation within the Single Commissioning Management Team, including agreed delegations;
  .

43.3 The Partners' approach to responding to adverse trends will vary, depending on the value of the potential overspend and the progress along the annual timeline:

- differentiating response (scale, threshold etc.) according to progress through the financial year.

Managing potential overspends

43.4 Escalation arrangements for responding to overspends forecast through the year will include assessment of options for:

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- Management of contracts (and contract adjustments);
- Management of demand;
- Service redesign.

43.5 The procedure includes arrangements for agreeing the response to; and flexibility allowed within the Integrated Commissioning Fund for changes in allocations, in-year:

- Both Partners options to curtail the Service at any point during the year.

43.6 Where elements of the trend to overspend are specific to one Partner, the Partners will agree:

- The priority of demand on available funds to offset overspends;
- The approach to allocating and apportioning risk (in year and forecast outturn) between the Partners.

43.7 Where elements of the trend to overspend exist within Integrated Commissioning elements i.e. where both Parties would otherwise separately contribute to the Service, contributions between Partners will vary in individual years to meet differing financial pressures in health and social care but the Partners will ensure the Integrated Commissioning Fund is in balance each year and individual Partner contributions will be fully restored and balanced by year ending 2020-21.

43.8 The Partners will agree arrangements for emergency management of any recovery position, including:

- suspension of Host Partner's management of the Integrated Commissioning Fund;
- agreed amendments to the structure of governance and management of the Integrated Commissioning Fund in emergency measures.

44 Responding to annual overspends

44.1 The Partners will develop arrangements for addressing Overspends not recovered at the year-end and/or projected in future years as outlined in paragraph 43.7.

- ~~Escalation thresholds for response, based on the value of the overspend;~~
- ~~Mechanism of carry forward to next year's budget:~~
  - ~~CCG accumulated loss;~~
  - ~~The Council repayment to reserves (but more likely to have been addressed through reduction in service provision during the year);~~
- ~~Apportion according to agreed risk share model for first element of overspend:~~
  - ~~Split by % contribution to Pooled Fund;~~
  - ~~Risk sharing limits set to identify maximum contribution to be made by either Partner;~~
- ~~Allocate remainder according to overspend pattern, to responsible Partner:~~
  - ~~In accordance with risk sharing agreement.~~

44.2 The Council's inability to carry-forward an Overspent position will be addressed through use of reserves, which will be recovered in the subsequent year(s).

45 Responding to annual underspends

45.1 The Partners will identify underspends as generated:

- By whole Pooled Fund;
- By specific Pooled Fund elements;
- By Partner responsibility.

45.2 Options for addressing underspends recorded at the year-end will include:

- Allocate to investment fund;
- Carry forward to next year's budget:
  - Legal restrictions (CCG RAB budgeting);
  - The Council scope to hold balance, but CCG to prove no draw-down in advance of need;
- Off-set against next year's budget;
- Return to Partners:

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- Mechanism for agreeing share of returns.

Other financial Considerations

46 Design of the financial ledger

46.1 Both Partners will design processes that deliver a clear audit trail of each element of the Integrated Commissioning Fund.

- Assurance on the accuracy and completeness of the records will be provided by the Partners;
- Assurance of compliance with s75 may be through a self-assessment and self-certification. But the Partners agree that this will be subject to an IA review, as a minimum.

47 Financial reporting responsibilities of the Host Partner and the Chief Financial Officer(s)

47.1 The Partners will agree the arrangements for administering and managing the financial records of the Pooled Fund. Elements specific to the set-up of financial record include:

- Ledger and consolidations (developing the arrangement for combining the Integrated Commissioning Fund records of the Partners);
- Transactions (delivering the audit trail to show the transactions making up the Integrated Commissioning Fund record);
- Reporting.

47.2 The Partners will agree the financial performance reporting needs of each, including providing analysis and summaries of the financial performance of the Integrated Commissioning function, in accordance with the Partner organisations' requirements

- In accordance with timetables agreed by both Partners;
- Providing the details required by both Partners;
- Designed to meet the needs of the differing audience(s).

47.3 The Chief Financial Officer(s) will ensure the proper treatment specific aspects of the Pooled Fund and its transactions:

- Ring-fenced budgets, specific schemes and funding restrictions:
- VAT;
- Year-end treatment of surpluses;
- Audit.

47.4 The Chief Financial Officer(s) will ensure the provision of the annual return to Partners, identifying separately and in total: BCF and Pooled Fund

- Contributions to the Pooled Fund:
- Expenditure from the Pooled Fund:
- Treatment of the difference / risk share;
- Detail for ring fenced schemes and restricted funds;
- Reporting deadlines.

Requirements of partner organisations

47.5 The Partners will agree their respective requirements for the monitoring and reporting of the financial position:

- Financial contribution to the Integrated Commissioning Fund:
- Expenditure and commitments;
- Contract performance ;
- Overall performance of the Integrated Commissioning Fund.

47.6 Assurance framework requirements:

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- Sources of assurance;
- Specific funding and ring fencing requirements in respect of appropriateness of spend.

47.7 Overview of management of the Integrated Commissioning Fund:

- Review arrangements;
- Access to records, including audit access;
- Ad hoc reviews.

47.8 And year-end requirements:

- Deadlines specific to NHS/LG and specific reporting requirements;
- Accountable Officer / s151 Officer assurance requirements;
- IFRS reporting requirement;
- Governance statement requirements.

48 Managing the cash position

48.1 The Host Partner will:

- Hold monies contributed to the Pooled Fund that are required for transactions generated from the Host Partner:
  - The timing of contributions will align to payment obligations;
- Administer the payment processes for its own transactions;
- Administer the consolidation of the financial records of the Pooled Fund.

48.2 The Partners will adhere to the rules and restrictions applying to them:

- The CCG is required to limit cash draw-down to the monies required, when they are required:
  - Not allowed to draw excess cash;
  - Not allowed to earn interest, or investment income;
  - Not allowed to have a cash balance at the year-end;
- The Council is allowed to invest available cash to earn income on its own resource allocation:
  - The Council will determine how interest income is used; and is not obliged to include any part of that interest income in the Integrated Commissioning Fund.

48.3 Banking arrangements will reflect existing arrangements.

48.4 Transaction payments from the CCG and the Council will be unchanged from current arrangements. The Council should not suffer a reduced capacity to generate investment income from retained cash and investment balances. But, the Council will not be able to derive investment advantage through early draw-down of CCG funds.

49 Payment mechanisms

49.1 The Partners acknowledge responsibility for paying all sums due to Providers, in compliance with contract terms.

49.2 The Partners will agree arrangements for making payments to Providers, such that Providers are not affected by any changes to the structure of commissioning from the Integrated Commissioning Fund.

49.3 The design of payment mechanism will ensure that the Integrated Commissioning Fund structure delivers the full process of receipt of invoice, confirmation of service delivery and standards compliance, confirming amount due to invoice amount, instructing payment.

49.4 Providers will not be affected adversely by any specific rules that apply to certain services managed through the Integrated Commissioning Fund.

49.5 Any specific arrangements for LG and NHS to comply with will be identified and addressed, as necessary.

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50 Direct Payments

50.1 The Partners recognise the growing importance and impact of direct payments to Service Users for purchasing their own agreed packages of care.

50.2 The design of the resource allocation arrangements will deliver:

- Discipline over approval of proposed care plans and direct payments approach;
- Security of funding ahead of spend by Service Users (e.g. "debit card", pre-approved spend)
- Approach to recovering unused funding from individual Service Users.

51 Income opportunities

51.1 Grants and sponsorship

51.1.1 The partners will seek to maximise uptake of opportunities of funding offered, including:

- Government Grant funding:
  - As an annual allocation;
  - Through one-off projects;
- Grants from other organisations;
- Sponsorship;
- Opportunities to charge for enhanced services commissioned.

51.2 Chargeable health related services

51.2.1 The Council will retain responsibility for assessing the contribution (to a provided social service) to be paid by Service Users.

51.2.2 The Council will retain responsibility for collecting the assessed contribution.

52 Insurance and VAT

52.1 Insurance

52.1.1 The NHS element of the Integrated Commissioning function will continue to be risk-shared by the NHS Litigation Authority.

52.1.2 The Council will maintain its approach to insuring its service commissioning role.

52.1.3 Providers will be contractually required to prove that they have adequate and sufficient insurance cover for the services that they deliver.

52.2 VAT

52.2.1 The Partners will set out the details of the treatment of VAT in respect of the Services commissioned through the Integrated Commissioning Fund:

- Identify range of services for which VAT is reclaimable;
- Identify charged services which have to be subject to VAT;
- Identify controls for ensuring that VAT is treated correctly.

53 Capital investment

53.1 The financial arrangements for the Integrated Commissioning Fund will recognise and allow for the Council approach to delivering future service improvement through capital grants to achieve improved quality, lower cost accommodation for services e.g.

- Disabled Facilities Grant

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53.2 The Council will retain ownership of any assets that are to be retained.

53.3 The Council has the option to arrange on behalf of both Partners unsupported borrowing to support capital investment in the Tameside and Glossop economy.

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C. **Sign off**

Appendix 1 – Appendix from Cabinet/CCG GB Report

£000's	2017/18			
	Section 75	Wider Aligned Budget	In Collaboration	Total
ICO Contract	88,242	66,003	430	154,675
ACUTE	33,982	32,062	0	66,044
MENTAL HEALTH	29,596	0	0	29,596
PRIMARY CARE	9,722	41,148	31,988	82,857
CONTINUING CARE	13,247	0	0	13,247
COMMUNITY HEALTH SERVICES	3,639	0	0	3,639
CORPORATE	4,018	0	0	4,018
OTHER	18,810	7,870	734	27,414
ADULT SOCIAL CARE	43,459	1,081	0	44,540
CHILDRENS SERVICES	185	34,925	0	35,110
PUBLIC HEALTH	16,708	0	0	16,708
Grand Total	**261,609**	**183,089**	**33,151**	**477,849**

Savings which are incorporated into and assumed met in the figures above	
CCG	23,900
ADULT SOCIAL CARE	336
PUBLIC HEALTH	436
TOTAL	**24,672**

Please note the Council resource allocations within the above table may be subject to further savings allocations prior to the Council budget setting meeting on 28 February 2017

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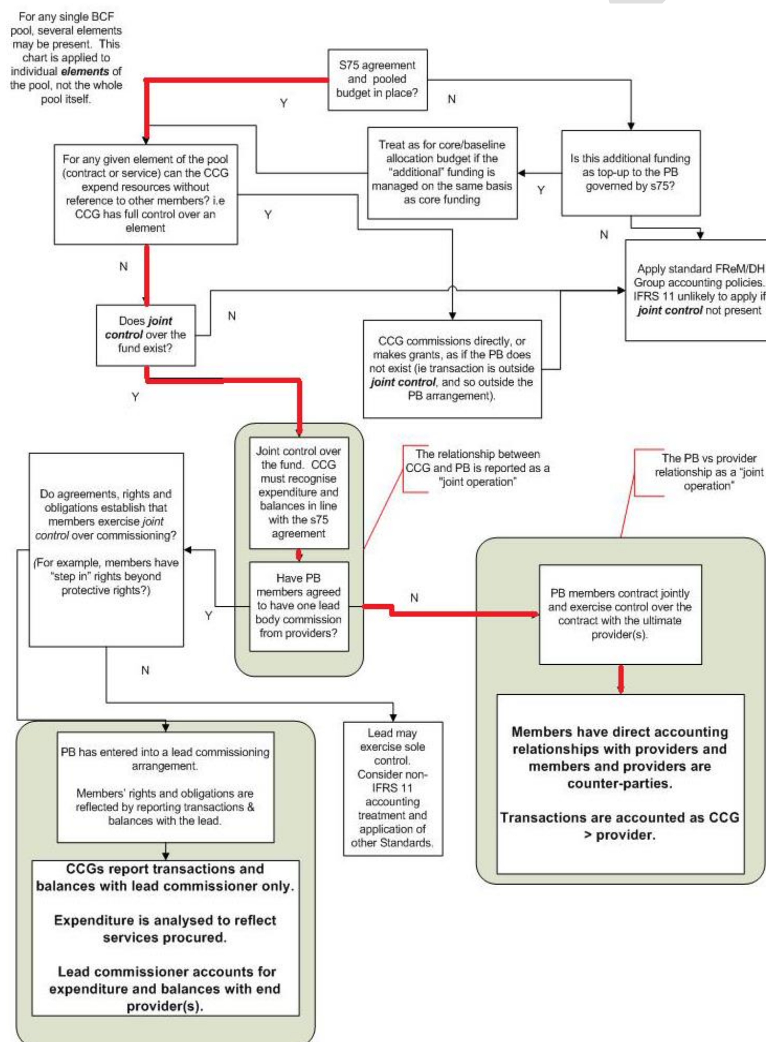
Appendix 2 – Extract from the Group Accounting Manual (formerly Manual for Accounts)

Accounting for Section 75 agreements

The DH manual for accounts (MfA) recently superceded by the Group Accounting Manual (GAM) but underpinned by the same accounting principles reports:

There is no requirement to physically transfer cash from any entity to the host in order to have a pooled budget arrangement under s75. The Pooled budget is an accounting concept that does not have to be represented by the creation of a pooled cash resource.

Given the above, and based on the decision tree extract, from the DH Manual For Accounts, members will have direct accounting relationships with providers. This will eliminate the CCG risk associated with NHS England consolidation, as well as simplify the Agreement of Balances process, and ensure that each member accounts for its own share of assets and liabilities.
This will, however, result in the requirement of a memorandum to each of the members accounts, detailing the consolidation of the 'pooled' funds



Transfer of cash will only take place where services are commissioned on behalf of a member, by another member eg, BCF, and staff recharges, and will only be transacted as required, supported by detailed cash flow information, and not in advance of need.

C. Sign off

DRAFT