Report To:	**EXECUTIVE CABINET**
Date:	24 March 2016
Executive Member/ Reporting Officer:	Councillor Jim Fitzpatrick – First Deputy (Performance and Finance) Councillor Brenda Warrington – Executive Member (Adult Social Care & Wellbeing) Councillor Gerald P. Cooney – Executive Member (Healthy & Working) Councillor Peter Robinson – Executive Member (Children & Families) Kathy Roe – Chief Finance Officer - Tameside & Glossop Clinical Commissioning Group Stephanie Butterworth – Executive Director of People Angela Hardman – Executive Director of Public Health Peter Timmins - Interim Assistant Executive Director – Finance
Subject:	**TAMESIDE COUNCIL AND TAMESIDE & GLOSSOP CLINICAL COMMISSIONING GROUP – INTEGRATED COMMISSIONING FUND – SINGLE FINANCE AGREEMENT FROM 1 APRIL 2016**
Report Summary:	This report has been prepared jointly by officers of the Council and Tameside and Glossop Clinical Commissioning Group (T&GCCG) as part of the Integrated Care Programme in Tameside. It sets out the key principles required to establish a joint (single) fund between the Council and the CCG managed by a 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 2016. The same report was presented to the Governing body of the CCG on 23 March 2016. 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 was presented to the Tameside and Glossop CCG Governing Body on 23 March 2016. 2. Approve the inclusion of 2016/2017 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 2016/2017 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 a statutory joint committee of both organisations known as the Tameside & Glossop Care Together Single Commissioning Board.

3. Acknowledge that the decisions taken by the Single Commissioning Board (joint committee) relating to the Integrated Commissioning Fund are binding on the Council

4. Approve the principle that during 2016/2017 each organisation will be responsible for the management of their own deficit arising within the level of resources which they contribute to the Integrated Commissioning Fund as stated in **Appendix 1**.

5. Approve that Tameside Council should continue to be the host organisation for the existing Section 75 pooled fund agreement.

6. Note that the terms of the financial framework, which will support the Integrated Commissioning Fund are to be approved by both the Council and CCG by 31 March 2016 and authorise the Executive Director for Governance & Resources to agree this.

7. The terms to be approved will include :

   - Financial regulations
   - Risk management and audit
   - Treatment of over and underspends
   - Reporting on financial and operational performance
   - Conditions of entry to and exit from the ICF
   - Exit strategy

   An extract summary of the proposed terms of the financial framework is provided within **Appendix 3.**

8. Note that the level of resources within **Appendix 1** is 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.

9. Endorse the inclusion of Greater Manchester Transformation Funding within the Integrated Commissioning Fund subject to award confirmation.

10. Endorse the intent to commence joint financial reporting and stringent monitoring in shadow form on the Integrated Commissioning Fund stated in **Appendix 1** to the Executive Cabinet and the Tameside & Glossop Care Together Single Commissioning Board from 1 April 2016 on a monthly basis or

as appropriate within the 2016/2017 reporting governance schedule and agree the approach with both organisations external auditors..

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 seeks to extend the reach of the Better Care Fund to include other service areas within the local health economy. This proposal 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 2016.

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 2016. Recommendation 6 provides a summary of the key terms which will be included within the Financial Framework agreement an extract of which is provided in **Appendix 3**.

The estimated financial gap within the Tameside Economy at 31 March 2017 is summarised below.

Revenue Summary

Estimated Economy Gap at 31 March 2017	**Gross Exp £ m**	**Gross Inc £ m**	**Variation £ m**
Tameside Council			
16/17 Budget	120.349	-57.997	62.352
16/17 Forecast	131.778	-59.995	71.783
Variation	**11.429**	**-1.998**	**9.431**
Tameside & Glossop CCG			
16/17 Budget	374.812	-1.645	373.167
16/17 Forecast	388.312	-1.645	386.667
Variation	**13.500**	**0**	**13.500**
Economy Total			
16/17 Budget	**495.161**	**-59.642**	**435.519**
16/17 Forecast	**520.090**	**-61.640**	**458.450**
Variation	**24.929**	**-1.998**	**22.931**

The Council will be responsible for the delivery of a balanced budget during the 2016/17 financial year and beyond. There is an urgency to implement associated strategies to ensure this is delivered whilst also working in partnership with Health partners on the wider economy financial challenge.

It should be noted that additional non recurrent budget has been allocated to Adult Services (£8 million) and Childrens Services (£4 million) in 2016/17 to support the transition towards the delivery of

	a balanced budget within these services alongside the implementation of the ICO. The additional budget is included in **Appendix 1** and the summary table above. It is essential that the GM Transformation fund bid (as explained in section 3 of the report) is received to commence implementation of service transformation within the economy. 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. Details will be provided within further reports to both the Executive Cabinet and the Tameside & Glossop Care Together Single Commissioning Board during 2016/2017.
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.
Access to Information:	Background papers relating to this report can be inspected by contacting : Stephen Wilde, Head Of Resource Management, Tameside Council Telephone:0161 342 3726 e-mail: stephen.wilde@tameside.gov.uk Tracey Simpson, Deputy Chief Finance Officer, Tameside and Glossop Clinical Commissioning Group Telephone:0161 304 5449 e-mail: tracey.simpson@nhs.net

1. INTRODUCTION

1.1. This report has been prepared jointly by officers of the Council and Tameside and Glossop CCG as part of the joint Care Together Programme in the Tameside area. The same report was presented to the Governing Body of the CCG on 23 March 2016.

1.2. This report seeks to progress the joint commissioning arrangements to optimise congruence of clinical and financial outcomes amongst partners and strengthen resolve beyond funds aligned to the Better Care Fund. This follows the publication of the Contingency Planning Team Report issued by Monitor in September 2015 and demonstrates adoption of the key principles by the Local Health Economy (LHE) representatives at the Board to Board to Board meeting on 23 September 2015.

1.3. Considerable due diligence has been undertaken to ensure risks are mitigated and lessons observed from other organisations operating pooled funding arrangements. Both organisations have worked closely with Damon Palmer (Greater Manchester Integrated Care Programme Office/Public Sector Transformation Network Senior Policy Adviser Health & Social Care Integration), Monitor and DH Better Care Fund Task Force to identify the most appropriate way of doing this acknowledging the current limitations of powers under Section 75 of the National Health Services Act 2006.

1.4. Non-recurrent funds were identified by both organisations in 2015/2016 financial plans, and this was to serve as an investment/contingency fund to facilitate the delivery of the Integrated Care Organisation. The financial framework governing the Integrated Commissioning Fund (financial details within **Appendix 1**) will be approved by both parties by 31 March 2016. 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 The Care Together Programme over the past couple of years has focussed 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 is the transfer of the Tameside and Glossop community staff who are currently hosted by Stockport Foundation Trust into Tameside Hospital Foundation Trust. This process is now underway and will be completed on 1 April 2016.

2.4 Later this year, GM Devolution is submitting 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 will be based on the following 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 addresses how we locally 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 a joint committee known as the known as the Tameside & Glossop Care Together Single Commissioning Board.

2.9 The purpose of the governance is 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 SETTLEMENT ANNOUNCEMENTS

The Council Settlement

3.1. The Spending Review 2015 and associated local government, health and devolution announcements to date include the following key points:

3.2. The Better Care Fund remains a key government tool in supporting integration of health and social care across the country. £1.5bn of additional funding for an improved Better Care Fund will be allocated directly to local authorities, whilst the existing Better Care Fund will continue to be directed at localities via CCGs. The provisional additional resource allocations for the improved Better Care Fund for Tameside are £1.0m for 2017/18, £5.5m for 2018/19 and £9.4m for 2019/20.

3.3 It should be noted that only 50% of the improved Better Care Fund is new money. The remaining 50% is being funded via savings in the 'new homes bonus scheme,' which local authorities currently receive. The Council has a new homes bonus allocation for 2016/17 but nothing beyond this as there is currently a Government consultation underway on the future arrangements of the scheme (consultation until early March 2016).

3.4 Clearly there is a risk for the Council that the new homes bonus scheme funding may no longer be received in future years due to the announcement that the main sources of funding for Local Authorities will be reduced to business rates and Council Tax by the end of the current financial settlement period.

3.5 Local authorities have the opportunity implement a Council Tax precept for social care to raise additional income to spend exclusively on adult social care services. The provisional estimate of additional revenue for the Council in 2016/2017 is £1.429m. The introduction of this new precept was approved by the Council at the 2016/2017 budget setting meeting on 23 February 2016. It is estimated that the value of this additional income will increase to £5.890m by 2019/2020 should the Council approve an increase of 2% each year during the intervening 3 year period. The estimated cumulative value of social care council tax precept revenue over the four year financial settlement period is stated in the table 1 below:

Table 1

Financial Year	**2016/2017**	**2017/2018**	**2018/2019**	**2019/2020**
	£ m	**£ m**	**£ m**	**£ m**
2% Social Care Precept - Cumulative	**1.429**	**2.887**	**4.374**	**5.890**

3.6 Members should note that any additional revenue generated by the 2% social care precept together with the future year improved Better Care Fund allocations will only contribute towards the additional cost pressures (cumulative details within table 2 below) expected within the Tameside Economy over the spending review period. This is due to cost increases within the economy. Examples include the payment of

the national living wage from 1 April 2016 and the desire to increase this to the foundation living wage rates level at a date to be determined together with contractual price increases and additional demographic demands on service provision.

Table 2

Financial Year	**2016/2017**	**2017/2018**	**2018/2019**	**2019/2020**
	£ m	**£ m**	**£ m**	**£ m**
Estimated Cost Pressure	**8.339**	**15.038**	**21.224**	**27.285**

Public Health Settlement

3.7 The Chancellor's Autumn Statement confirmed that LAs' funding for public health would be reduced by an average of 3.9 per cent in real terms per annum until 2020. This equates to a reduction in cash terms of 9.6 per cent over the same period. The Autumn Statement also confirmed that a central government grant, ring-fenced for use on public health functions, would continue for at least two more years.

3.8 The government will shortly consult on options for fully funding local authorities' public health spending for current public health duties from their retained business rates receipts as part of the move to 100% rates retention. The current ring-fence on public health spending will be maintained in 2016-17 and 2017-18.

3.9 Table 3 below provides details of the grant allocation from 2015/2016 to 2017/18. It should be noted that the 2016/17 and 2017/18 totals include allocations for 0-5 Children's Services which transferred to the Public Health grant during 2015/16 on 1 October 2015.

Table 3

	2015/16	**2016/17**	**2017/18**
	£ m	**£ m**	**£ m**
Public Health Grant	12.520	15.699	15.312
0-5 Children's Services – part year from 1 October 2015 (included in total grant from 16/17)	1.771	-	-
Total	14.291	15.699	15.312
% Reduction			2.47 %

Transformation Funding

3.10 Within the allocation of resources to NHS England, there is a direct allocation of £450m revenue to Greater Manchester, 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.

3.11 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.

3.12 The initial request for transformational funding was submitted to GM Devolution on 29 January 2016. This had been requested by Ian Williamson, Chief Operating Officer and aimed to show how the Tameside & Glossop plans for transformation were developing in line with the emerging GM Devolution workstreams. The request was

an early draft to show the level of funding likely to be required in Years 1 – 3 with the areas for efficiencies highlighted.

3.13 Following submission, the GM Devolution team have agreed to run the Tameside & Glossop request through their initial governance processes to check on direction, ambition and deliverability. The Tameside & Glossop submission will be assessed in parallel with the two GM Vanguards (Salford and Stockport) and will involve a paper based assessment by PwC as well as scrutiny from Carnall Farrar. Following this, the Tameside & Glossop economy will be invited to a Q&A session with Sir Howard Bernstein and Ian Williamson to agree the next steps.

3.14 The informal feedback to date has been largely positive. GM Devolution agree that the economy has ambitious, well developed and tested plans for the future of health and social care which are in line with the GM Devolution agenda. There have been some questions regarding the depth of implementation planning, cross economy financial planning and the level of GP engagement but these are acknowledged locally and work continues accordingly.

3.15 GM Devolution requested a high level implementation plan by the end of February 2016 to complement our earlier submission. It is hoped that by the end of March, the economy will understand what is required further to gain access to the necessary transformational funds to move to implementation of the Locality Plan at scale and pace.

3.16 The transformation revenue investment funding required in 2016/17 is £12m, with a total requirement over the five year period to 2020/21 being £31.4m. These funds are essential to enable the new model of care and ICFT to be implemented at scale and at pace in order to deliver the estimated efficiencies identified of £70.7m.

3.17 There will be additional transitional funding support required during the next 5 years, by way of sustainability funding (Public Dividend Capital (PDC) support) and capital funding.

3.18 The transformation funding represents Value For Money (VfM). For every £1 of transformation funding provided, the return is estimated to be £5.45.

3.19 The Tameside economy awaits the outcome of the submitted proposal

The CCG Settlement

3.20 For Health, there has been a real terms increase in funding of £8.4bn nationally (£3.8bn of which is available in 16/17) and this has been agreed over the next 5 years. While this will obviously contribute toward the financial challenges across the economy, it will not close the gap entirely and much of this money will be required to fund new initiatives, both local and national. Specific national commitments which will impact upon the CCG's financial position over the 5 year planning period include:

- £600m funding for mental health,
- 7-day services in primary care and in hospitals,
- £750 million of investment for a new national voluntary contract for GPs,
- a commitment to either diagnose cancer or give the all clear within 4 weeks of referral,
- £300 million per year on diagnostics by 2020 to fund new equipment and additional staff capacity, including 200 additional staff trained to perform endoscopies by 2018

3.21 The CCG's allocations have been made on the basis of 3 years of firm allocations which should not be subject to change. However, the CCG has been given additional

details of a place based allocation for Tameside and Glossop which includes services commissioned by NHSE. These are detailed in table 2 below:

Table 2

Direct CCG Opening Allocations (£000's)	**Actual**	**Firm Allocations**			**Indicative Allocations**	
	2015/16	**2016/17**	**2017/18**	**2018/19**	**2019/20**	**2020/21**
	£ m	**£ m**	**£ m**	**£ m**	**£ m**	**£ m**
Recurrent Programme Allocation	326,912	336,879	343,627	350,455	357,739	370,832
Running Cost Allocation	5,202	5,162	5,155	5,147	5,141	5,135
Total CCG Allocation	**332,114**	**342,041**	**348,782**	**355,602**	**362,880**	**375,967**
Growth		2.99%	1.97%	1.96%	2.05%	3.61%
Primary Medical Services	29,857	30,922	32,075	33,041	34,108	35,485
Drawdown of Surplus		6,746				
Total CCG Budget		**379,709**	**380,857**	**388,643**	**396,988**	**411,452**

Other Allocations	**2015/16**	**2016/17**	**2017/18**	**2018/19**	**2019/20**	**2020/21**
Specialised	61,683	66,301	69,368	72,369	75,513	79,216

These allocations were based on a new ACRA (Advisory Committee on Resource Allocation) formula. On the basis of the local economies overall place based budget our actual allocation is in line with our target allocation.

3.22 The information detailed in the announcements necessitates a requirement to move at pace implementing the strategy and proposals set out in the Tameside Locality Plan. The expansion of the aligned pooled fund is an important enabler and **Appendix 1** provides details of the services for inclusion.

4. JOINT COMMISIONING ARRANGEMENTS

Greater Manchester Joint Commissioning Board

4.1 Within Greater Manchester there will be Greater Manchester Joint Commissioning Board, which will also be a joint committee where each participant makes joint decisions which are binding on each other in the same way as the Tameside & Glossop Care Together Single Commissioning Board will be binding at a local level. It is important that there is clarity regarding the joint commissioning decisions to be taken at the local level and Greater Manchester level respectively.

4.2 Specialised Services Commissioning will take place at Greater Manchester level. As these services cannot be dealt with by way of s75 arrangements without a change in the s75 regulations, any joint commissioning of specialised services will need to be undertaken through a joint committee made up of NHSE, CCGs, GMCA, and local authorities.

4.3 The Greater Manchester Joint Commissioning Board will have significant commissioning decision making responsibility as the largest single commissioning vehicle in Greater Manchester.

4.4 In order to comply with regulatory requirements the Greater Manchester Joint Commissioning Board will function independently of providers.

4.5 Importantly, the key functions of the Greater Manchester Joint Commissioning Board are as follows:

- To develop a commissioning strategy based upon the Greater Manchester Strategic Plan;
- Be responsible for the commissioning of health and social care services on a Greater Manchester footprint;
- Have strategic responsibility for commissioning across Greater Manchester;
- Be responsible for the delivery of the pan Greater Manchester strategy via its commissioning decisions (local commissioning will remain a local responsibility)
- To operate within existing commissioning guidelines following key principles of co-design, transparency and broad engagement.

4.6 The Greater Manchester Joint Commissioning Board will only take on Greater Manchester wide commissioning decisions. Any decision that currently sits with the commissioning responsibilities of LAs and CCGs will stay with these organisations.

4.7 While the core principle of the Greater Manchester Joint Commissioning Board will be that those commissioning decisions which are currently made in localities will remain in localities, there will be mechanisms developed to ensure that the remit of Greater Manchester Joint Commissioning Board can be broadened should localities agree that it is in their best interests to do so.

4.8 It should be noted that Steven Pleasant, Tameside Council's Chief Executive has been appointed by The Greater Manchester Combined Authority and AGMA Executive Board as the co-chair of the Greater Manchester Health and Social Care Commissioning Board.

Criteria for Commissioning at a Greater Manchester Level

4.9 Work is currently underway to identify which services can be more effectively and efficiently commissioned on Greater Manchester footprint and therefore delegated to Greater Manchester. It will be for the Greater Manchester Health and Social Care Commissioning Board and local stakeholders to formally approve and agree what services these are.

4.10 Consideration is also currently being given to whether the commissioning of primary care should be undertaken at a Greater Manchester level, with the exception of General Practice which will be commissioned by CCGs. However, the Greater Manchester Health and Social Care Commissioning Board will have a significant role to play in developing and implementing a Greater Manchester wide framework within which general practice is commissioned.

4.11 The criteria by which existing activity would be commissioned at a Greater Manchester level will focus upon whether decisions taken on a broader footprint achieved a greater benefit for the population, e.g. increased value for money; greater levels of efficiency; or increased clinical sustainability.

Tameside & Glossop Care Together Single Commissioning Board

4.12 Across the Tameside & Glossop locality there will be single place based commissioning body comprising the Tameside & Glossop locality Clinical Commissioning Group and the Local Authority known as the Tameside & Glossop Care Together Single Commissioning Board. The proposals within this report have been developed by the Tameside & Glossop CCG and the Council as a means of

effectively commissioning for the transformation programmes within the locality plan as well as gaining benefits from jointly commissioning existing services.

4.13 As part of previous work undertaken between the CCG and the Council we have defined the role of commissioning as follows:-

- ✓ To define the desired outcomes and service model led by a clear vision and strategy
- ✓ To create the environment for change
- ✓ Soft factors e.g. culture, relationship management, values and behaviours.
- ✓ Hard factors e.g. estates, IMT, finance, contracting, market management etc.
- ✓ To ensure standards are met and improvements are made

4.14 This approach fits with the emergence of an Integrated Care Organisation. The benefits we seek to gain from a single commissioning function are:-

- ✓ Common strategic and operational/business plans
- ✓ To make best use of our collective resources
- ✓ To have an effective means of jointly commissioning services
- ✓ To ensure effective governance within our organisations whilst generating stronger cross system governance arrangements.
- ✓ To retain key strengths of the CCG and the Council approaches to commissioning and local connections.

4.15 The aim of this work is not in the short term to merge organisations, formally restructure or transfer employment of staff from one organisation to another. It is aimed to formalise our working arrangements and organise our resources around key work programmes and work effectively together.

4.16 The Single Commissioning Board has been established as a committee of the two organisations with delegated decision making powers and resources. This will create a unifying group within both the statutory and collaborative governance arrangements for the first time. The key role of this Board will be:-

- ✓ To provide executive leadership for the locality plan from a commissioning perspective.
- ✓ Oversee the management of any delegated commissioning functions and pooled budgets.
- ✓ Lead the development of commissioning as part of statutory and HWBB governance arrangements.

4.18 The Locality plan will be adopted as a shared commissioning strategy and should supersede the relevant parts of existing organisational strategies.

4.19 Together both organisations working with the hospital will develop a common operational/business plan for 2016/17. Led by the priorities for 2016/17 both organisations will organise teams around programmes of work with suitable operational leadership. These will include commissioning for the transformation programmes and also areas of operational commissioning where this adds value.

4.20 The Tameside Economy will also develop and adopt a form of matrix working which will allow us to mobilise our workforce around work programmes in a way which makes best use of our resources, is suitably flexible but also retains a line of sight between commissioning activities and organisational accountabilities.

4.21 The Tameside & Glossop Care Together Single Commissioning Board is not a separate legal body but a Board where each participant makes joint decisions which are binding on each other.

4.22 The bodies delegating functions to the Tameside & Glossop Care Together Single Commissioning Board will remain accountable for meeting the full range of their statutory duties and together will:

- ✓ Commission integrated health and social care services for community based locality teams; and
- ✓ Commission services from the Integrated Care Organisation.

4.23 Key principles will include :

- ✓ A joint committee where decisions are binding on all parties;
- ✓ Members must have delegated authority;
- ✓ Must function independently of providers;
- ✓ Make decisions to support the locality;
- ✓ Will develop a commissioning strategy based upon the agreed Locality Plan;
- ✓ There must be patient engagement on commissioning plans and all decisions must be transparent, reasonable, rational, defendable from Judicial Review challenge;
- ✓ Any decision currently within the commissioning responsibility of the Local Authority/CCG stays with those organisations with oversight by the Single Commissioning Board;
- ✓ From 1 April 2016 the Single Commissioning Board will manage a Tameside & Glossop locality Integrated Commissioning Fund as stated in **Appendix 1**.

5. PROGRESS TO DATE

5.1 The Council and the CCG have made significant progress already in regard to the actions above. These include:-

- Development of the Tameside & Glossop Locality plan.
- Development of a single commissioning team with officers from both organisations to take forward commissioning.
- Appointment of an Independent Programme Chair and Programme Director
- Transfer of the Tameside and Glossop community staff who are currently hosted by Stockport Foundation Trust into Tameside Hospital Foundation Trust. This process is now underway and will be completed on 1 April 2016.
- Pooled budgets and associated financial plans relating to the Better Care Fund.
- Working groups in place to develop contractual arrangements for Single Commissioning and extended pooled budget arrangements.
- Organisational development work relating to commissioning with a focus on movement towards outcome based commissioning.

5.2 By April 2016 the first step towards the new commissioning system will be completed. Both organisations will continue the work programmes and seek to make this way of working more mainstream and more systematic.

5.3 In undertaking this work, both organisations foresee the ability to engage better with the public, patients, communities and community group in our commissioning activities.

5.4 Commissioning across health and social care will allow benefits to identifying risks relating to quality and safety across providers and also to flag risks such as safeguarding incidents or other people in vulnerable positions and work across the public sector to achieve better outcomes efficiently and effectively.

5.5 The Council has commenced a review of the cost of the residential, nursing and homecare provision currently commissioned. The review is supported by additional capacity provided by a Government funded agency (Local Partnerships). The support is provided at nil cost to the Tameside Economy. The key aims are to deliver efficiencies for the economy and ensure there is a long term sustainable community setting provider market with sufficient capacity to provide the additional community care requirements as the ICO develops and patient flow is diverted away from the hospital environment ultimately leading to improved outcomes for residents.

5.6 The Council and CCG are also collating an economy wide database of all existing and planned contracts for review to support the delivery of efficiencies and improved outcomes for residents by improved economy wide commissioning facilitated by the single commissioning function.

5.7 The budget allocations stated in **Appendix 1** will be assigned to each of the four Care Design project leads within the Care Together programme. These lead officers will be accountable for the delivery of services within the level of resource allocated during 2016/2017 and each year thereafter.

6 TAMESIDE & GLOSSOP ECONOMY INTEGRATED COMMISSIONING FUND (ICF)

6.1 The Tameside & Glossop Care Together Single Commissioning Board will be supported by appropriate financial governance arrangements. These will specify authorising officers to act on behalf of the CCG and Council with the appropriate financial scheme of delegation within defined permitted expenditure.

6.2 The Tameside & Glossop Care Together Single Commissioning Board will need to:

- ✓ Prepare a joint financial plan for the totality of the health and care resources including the ICF;
- ✓ Agree a joint approach to prioritisation and development of business cases to access transformation funding;
- ✓ Develop an appropriate and more progressive approach towards risk share arrangements, which make joint prioritisation of resources and spending decisions a necessity;
- ✓ Develop commissioner skills in readiness for the magnitude of the pooled budget envisaged;
- ✓ Sets tolerances to take account of demand variations and agrees appropriate risk reserves; and
- ✓ Agrees the principles by which the financial savings and the impact of investment schemes will be tracked across partners and the whole resource quantum using cost benefit analysis methodology and benefits sharing arrangements.

7 PROPOSALS

Establishment of the Integrated Commissioning Fund.

7.1 **Appendix 1** provides details of the 2016/2017 budget allocations for inclusion in the ICF. Budget allocations are categorised into 3 distinct sections:

Section 75 Services
This relates to the legislation that allows the establishment of pooled funds between NHS bodies and local authorities at a local level.

Aligned Services
Funding contributions for services that cannot be delegated for formal joint provision.

In Collaboration Services
Services which cannot be included within Section 75 arrangements without a change in the legislation. These specialised services are jointly commissioned with NHS England.

7.2 **Appendix 2** provides details of services which can be included in a Section 75 agreement. It also provides details of those services which cannot be included as determined within the existing legislation.

7.3 Budgets are included in the ICF net of planned savings amounts, therefore requiring that new business models are put in place to secure improved clinical and care outcomes with less money, as part of the journey to delivering a financially sustainable local health economy

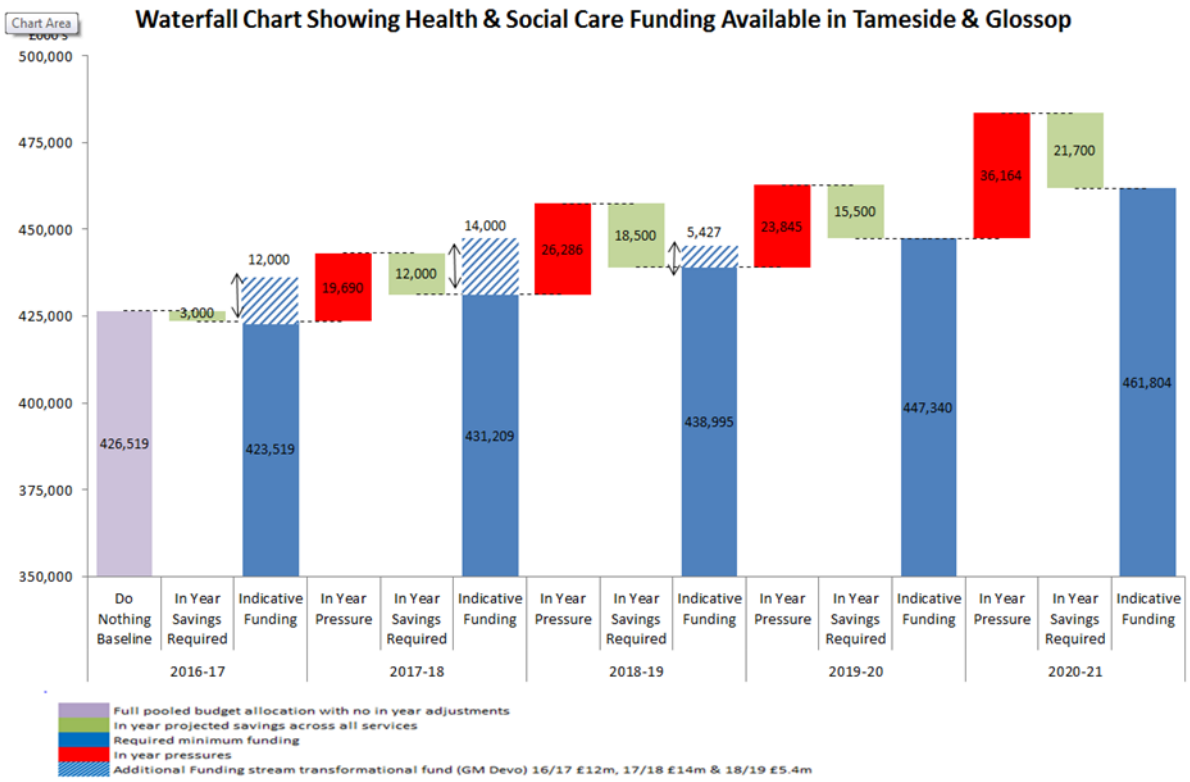
7.4 Separate to the direct budgets for service commissioning, a number of enabling functions (such as finance, IT, administration, or workforce development) will also be considered. Work is already in progress regarding these enabling functions, with the intention that a single support framework is established. It is not intended that this will create a new support team or teams, but rather existing officers within the organisations affected will be redirected to support single commissioning activity.

Balancing The Projected Economy Financial Gap

7.6 The Tameside and Glossop locality plan submitted to GM Devolution during October 2015 provided details of the strategies to balance the £70.7m financial gap which is expected to materialise by 2020/21. It should be noted that the estimated economy gap by this date is currently under review and is being updated in response to the recent financial settlement announcements for both organisations.

7.7 It should be emphasised that during 2016/2017 each organisation will be responsible for the management of their own deficit arising within the level of resources which they contribute to the integrated commissioning fund.

7.8 **Chart 1**



The waterfall chart shown in chart 1 demonstrates the total health and social care funding in Tameside and Glossop and how the net efficiencies will be generated over the five year period to 2020-21:

7.9 **Chart 2**

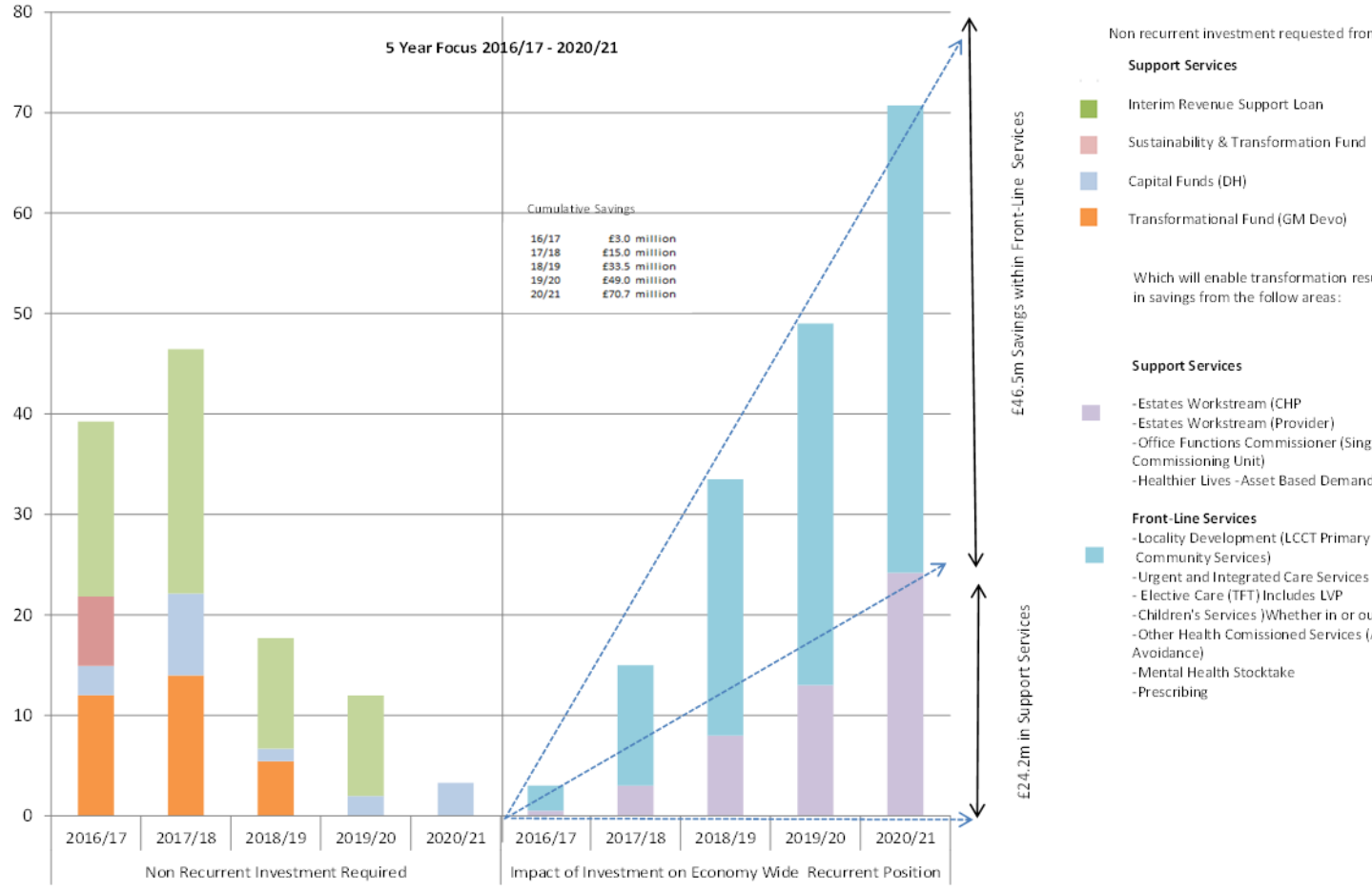


Chart 2 further demonstrates how the different components of non-recurrent investment are planned to be deployed to generate efficiencies across the different areas of transformation.

Capital Investment

7.10 In addition to the revenue funding detailed in **Appendix 1**, the Council is proposing capital investment within Tameside Economy Care Together services. The associated details are included in table 3 below.

Table 3

COUNCIL CAPITAL PROGRAMME	16/17	17/18	18/19	TOTAL
	£'m	£'m	£'m	£'m
Children's Services - In Borough Residential Properties	0.912	0.000	0.000	0.912
Public Health - Leisure Estate Reconfiguration	5.203	9.072	2.891	17.166
Adult Services - Disabled Facilities Grant - Adaptations	1.978	0.000	0.000	1.978
Total	**8.093**	**9.072**	**2.891**	**20.056**
FINANCING				

Grant	1.978	0.000	0.000	1.978
Prudential Borrowing	6.115	9.072	2.891	18.078
Total	**8.093**	**9.072**	**2.891**	**20.056**

7.11 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 investment in table 3 will be £ 1.808 million. This will be an associated cost to be financed within the Integrated Commissioning Fund.

Single Non Recurrent Investment Fund

7.12 Members should also note that the Council and CCG have committed 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 7.9 table 3.

The contributions from each organisation are stated in table 4 below:

Table 4

Organisation	**£ m**
CCG	3.00
TMBC – Earmarked Reserve	3.38
Total	**6.38**

7.13 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 will be agreed by the Single Finance Management Team and will be subject to the approval of a robust business case. (pro-forma in place). It should be noted that there will be an estimated remaining balance of £ 4.28 million on 1 April 2016.

Governance of the Integrated Commissioning Fund

7.14 The clinical and care principles by which the pool will be operated will be overseen by the Tameside & Glossop Care Together Single Commissioning Board. Membership includes representatives from the T&G CCG Governing Body and the Executive Cabinet of the Council and has joint chairmanship. As such the Care Together Commissioning Board will constitute a Joint Committee of the CCG and the Council in compliance with the Local Government act 1972 and the NHS Act 2006, which permits the creation of a joint committee.

7.15 The Tameside & Glossop Care Together Single Commissioning Board represents the interests of both partners, T&G CCG and the Council, in securing improved operation of the local health economy. As such it is proposed that they have equal voting rights and so an equal stake in securing better outcomes. Any other balance of voting rights will effectively create the pool as a subsidiary of one or other commissioner, eroding the trust that has been built up between them.

7.16 The Tameside & Glossop Care Together Single Commissioning Board will set out the key priorities and principles for the pool through which improvements to clinical and care outcomes and to financial sustainability will be secured. The Tameside & Glossop Care Together Single Commissioning Board will be wholly accountable for the pooled fund and delegate day to day management of the pool to the Care Together Programme Single Finance Management Team and hold them responsible for this. Decisions to pool funding and management of service or commissioning areas will be made by the Tameside & Glossop Care Together Single Commissioning Board.

7.17 Decisions by the Care Together Programme Single Finance Management Team to deploy funds from the risk pool and the investment reserve will require authorisation by the Tameside & Glossop Care Together Single Commissioning Board. Further summary details on the planned management of the pool are included at Appendix 3. It should be noted however that the detailed financial framework to support the management of the ICF will be approved by both the Council and CCG by 31 March 2016.

7.18 The management of the ICF is facilitated via the Single Finance Management Team via formal delegation from the Tameside & Glossop Care Together Single Commissioning Board. This an officer group including the CFOs of each of the commissioners, or their nominated deputies. Monthly financial and performance monitoring reports to the Tameside & Glossop Care Together Single Commissioning Board, T&G CCG and the Council, will be provided by the Single Finance Management Team.

7.19 As the Health and Wellbeing Board includes representatives of a number of organisations (including providers) who are not statutory commissioners of local health and care services, it is not appropriate to require the Health and Wellbeing Board to take decisions on the pooled fund. The Health and Wellbeing Board will however be kept informed of the performance of the ICF.

7.20 **Appendix 1** provides details of the 2016/2017 budget and the estimated projected outturn for the resource allocations from both the Council and CCG within the ICF.

Better Care Fund and Care Act considerations

7.21 It should be noted that the pooled funds will not replace our Better Care Fund (BCF) plans, nor supersede the preparations for the implementation of the Care Act. Both organisations will ensure that the requirements of both can still be met and that relevant measures can be collected from services inside and outside the pool and be reported appropriately. This will be a responsibility of the Single Finance Management Team.

Hosting

7.22 It is proposed that the pooled fund is hosted (reported) within the accounts of the Council on behalf of the Tameside & Glossop Care Together Single Commissioning Board.

7.23 Local control within the Council over financial reporting systems allows more flexible reporting that can be achieved through the nationally defined NHS financial systems. This is of vital important in meeting Better Care Fund and Care Act requirements. The Council also has greater balance sheet control than the CCG, which is more closely aligned to the delivery of multi-year projects.

Risk Pool

7.24 Beyond 2016/2017 it is proposed that a joint 'risk pool' is created for unforeseen liabilities accruing to the services included within the pool. It is proposed that his pool will be funded by a percentage of funds from each organisation (contribution levels to be confirmed). Where this reserve is used and so depleted in one year, the pooled funds must make provision to instigate remedial action to bring the expenditure back on plan.

7.25 During 2016/2017 however, each organisation will be responsible for the management of their own deficit arising within the level of resources which they contribute to the single commissioning pooled fund.

What is not being proposed

7.26 Loss of control. The proposals do not imply any loss of control for either of the commissioning organisations. In fact, the additional level of control provided by the partnership arrangements increases overall control since each partner will be able to influence more effectively the overall expenditure within the local health economy.

7.27 Loss of accountability. The proposals do not lead to any loss of accountability for the commissioning organisations. T&G CCG and the Council must both remain responsible and accountable for their statutory responsibilities. These may be delegated to the single pool, but cannot be transferred.

7.28 Loss of oversight. The oversight arrangements within both commissioning organisations will continue, and will include oversight for the single pool. However, the Tameside & Glossop Care Together Single Commissioning Board may wish to create a joint scrutiny function specifically for the activities of the pooled fund through the existing vehicles available to the CCG and the Council, in order to streamline this area of work and ensure effort is deployed to best effect.

7.29 Risk transfer. These proposals do not imply any intention to transfer risks between organisations to the benefit of one sole partner. Risks are already identified and logged within each commissioning organisation and for the ICO partnership. The purpose of the pooled fund is to support risk mitigation via single commissioning.

7.30 Loss of Value for Money (VFM). Both the T&G CCG and the Council will retain a responsibility to ensure that the pooled fund can demonstrate effective arrangements are in place to secure economy, efficiency and effectiveness (VFM). This will be further assured and endorsed by the external auditors to both organisations. It is also suggested that VFM in relation to the pooled fund appears in the audit plans for both organisations.

8 RECOMMENDATIONS

8.1 As detailed on the report cover.

Appendix 1

SUMMARY OF SERVICES INCLUDED WITHIN THE INTEGRATED COMMISSIONING FUND 2016-17

SECTION 75 SERVICES

Service Area	Net 2016/17 Budget £'000	Net 2016/17 Forecast £'000
TMBC		
Adult Social Care	25,682	40,170
Adults Early Intervention	1,287	1,272
Childrens Social Care - Youth Offending Team	136	134
Public Health	1,571	2,342
Capital Investment - Revenue	0	1,808
2% Social Care Precept	0	-1,429
Non Recurrent Transitional Budget (16/17) - Adult Services	8,000	0
TMBC Total	**36,675**	**44,296**
TMBC - Efficiencies To Deliver Financial Balance		
Adult Social Care	0	-14,488
Non Recurrent Transitional Budget (16/17) - Adult Services	0	8,000
Adults Early Intervention	0	16
Childrens Social Care - Youth Offending Team	0	2
Public Health	0	-772
Capital Investment - Revenue	0	-1,808
2% Social Care Precept	0	1,429
TMBC Total inc Efficiencies	**36,675**	**36,675**
CCG		
Tameside FT Contract (excludes community transfer)	73,372	73,372
CCG Commissioned Primary Care	6,198	6,198
Continuing Care	13,902	13,902
Mental Health	28,150	28,150
Acute (excludes Tameside FT)	14,179	14,179
Community	27,579	27,579
Corporate	5,151	5,151
BCF - Derbyshire Only - Tameside Included Wihin Adult Social Care	2,205	2,205
Other	8,989	8,989
CCG Total	**179,725**	**179,725**
Grand Total Section 75 Services including Efficiencies/QIPP	**216,400**	**216,400**

ALIGNED SERVICES

Service Area	Net 2016/17 Budget £'000	Net 2016/17 Forecast £'000
TMBC		
Adult Social Care	1,413	1,374
Childrens Social Care	18,435	24,184
Childrens Strategy & Early Intervention	1,828	1,929
Non Recurrent Transitional Budget (16/17) - Childrens Services	4,000	0
TMBC Total	**25,676**	**27,486**
TMBC - Efficiencies To Deliver Financial Balance		
Adult Social Care	0	40
Childrens Social Care	0	-5,749
Non Recurrent Transitional Budget (16/17) - Childrens Services	0	4,000
Childrens Strategy & Early Intervention	0	-101
TMBC Total inc CIP	**25,676**	**25,676**
CCG		
Tameside FT Contract (excludes community transfer)	59,451	60,451
CCG Commissioned Primary Care	41,933	41,933
Acute (excludes Tameside FT)	54,132	55,132
Mental Health	0	500
Other	6,333	17,333
CCG Total	**161,850**	**175,350**
CCG - QIPP To Deliver Financial Balance		
CCG QIPP	0	-13,500
CCG Total inc QIPP	**161,850**	**161,850**
Grand Total Aligned Services including Efficiencies/QIPP	**187,526**	**187,526**

IN COLLABORATION SERVICES

Service Area	Net 2016/17 Budget £'000	Net 2016/17 Forecast £'000
CCG		
Safeguarding	1,148	1,148
Co-Commissioned Primary Care	30,445	30,445
CCG Total	**31,593**	**31,593**
Grand Total In Collaboration Services including Efficiencies/QIPP	**31,593**	**31,593**

Grand Total Integrated Commissioning Fund Efficiencies/QIPP	**435,519**	**435,519**

Note: QIPP (Quality Innovation Productivity and Prevention)

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.

APPENDIX 3

EXTRACT OF PROPOSED TERMS OF THE INTEGRATED COMMISSIONING FUND

(Please note the detailed Financial Framework to support the ICF will be approved by the Council and CCG by 31 March 2016)

Service elements to be included within the pool

1.1. The services and budget lines included within the pooled fund with effect from 1 April 2016 are aligned to the vision for in-scope services proposed by the CPT and endorsed by both the Executive Cabinet and CCG Governing Body. Any subsequent changes to budgets will be supported by a clear business case setting out the following:

- Total budget spending planned (recurrent and non-recurrent) by year
- Contributions to this amount from the Council and Tameside & Glossop CCG (T&G CCG)
- The service area or commissioning area affected.
- The clinical and financial improvements to be achieved and how this will be done (an implementation or mobilisation plan would be appropriate).
- The reasons why commissioning from the pool is an appropriate solution to achieve these improvements
- The contracting rules which apply. Some services must always be procured via an NHS contract. Responsibility for this will sit with the lead commissioner.
- Safeguarding arrangements affecting the service; whether Local Authority or NHS arrangements are being applied; who the named responsible officers will be for these arrangements. All commissioned activity will include provisions to explicitly promote safeguarding; responsibility will be joint and several amongst commissioners and providers.

1.2. Further services may also be included in compliance with legislation.

1.3. Decisions to include new elements in the pool will require agreement from the Tameside & Glossop Care Together Single Commissioning Board. Amounts included in the pool will be confirmed in advance of each financial year by the Council and T&G CCG.

1.4. The operation of the pool:

- The Single Finance Management Team will provide day-to-day oversight of the pooled fund, and receive appropriate monthly financial and performance reports.
- The financial regulations and procurement rules of the host body will apply but these will be adapted where necessary to comply with the statutory requirements of the individual organisation, e.g. the annual accounts process where T&G CCG timelines are earlier than those of the Council.
- The CFOs will retain responsibility for statutory reporting and liaise with the Auditors to ensure this is completed in a professional manner for both organisations, and that such information as is necessary for the accounts of each organisation is made available in good time and to a high quality. Disputes between the funders are to be resolved initially through the Single Finance Management Team. If resolution is not achieved it will be incumbent on the CFOs to recommend a course of action for determination by the Single Commissioning Board.

Risk management

1.5. Key known risks include significant financial variation to plan, poor clinical or care performance or adverse inspection outcomes.

1.6. Lead commissioners will be named for each area of single activity and they will be accountable for the clinical and care outcomes in those areas. Reporting on performance in all areas will be as necessary, with monthly formal reports to the Single Finance Management Team and the Tameside & Glossop Care Together Single Commissioning Board.

1.7. Safeguarding. Safeguarding arrangements will be the responsibility of the Single Finance Management Team and the Lead Commissioner for each service, who must ensure that safeguarding requirements are written into all commissioned services, and in place within each provider. To ensure the effective management of safeguarding matters, it is expected that as far as possible the safeguarding arrangements will be based upon existing safeguarding arrangements, so avoiding duplication and confusion and be monitored discreetly in collaboration with but outside of the integrated commissioning fund.

1.8. The integrated commissioning fund should be included on the risk register of each of the commissioners. It should also be included on the internal audit review programme.

1.9. Audit risks have already started to be discussed with the internal and external auditors of the Council and T&G CCG. The audit teams have been briefed on the planned scope of the integrated commissioning fund and their advice will continue to be sought on matters relating to governance, reporting, audit and financial regulation of the fund.

1.10. VAT regulations. These are different between the NHS and local government. Advice will be sought and adhered to, to ensure that appropriate treatment, accounting and reporting of VAT transactions.

Treatment of over and underspends

1.11. Underspending may emerge where investment is delayed or where cost is driven by demand and demand is lower than anticipated. Variations will be managed within the pool during the year. There is scope for underspends to be managed between years, by agreement of the CFOs from the Council and T&G CCG.

1.12. Overspends may emerge where demand is higher than anticipated or investment is able to be made sooner than planned and therefore ahead of savings being realised. There could similarly be an overspend if transformation does not occur at the planned pace. Overspends will be retained within the integrated commissioning fund. Each organisation will be responsible for the management of their own deficit arising within the level of resources which they contribute. Recovery plans will need to be agreed with the CFOs from the Council and T&G CCG and reported to the Tameside & Glossop Care Together Single Commissioning Board, T&G CCG Governing Body and the Executive Cabinet of the Council.

1.13. Appropriate measures to track recurrent and non-recurrent expenditure from the pool against budgets will be implemented. This is to ensure that non-recurrent funding is not used to support recurrent service expenditure, the rules relating to the treatment of capital and revenue expenditure are adhered to and the management of recurrent and non-recurrent expenditure is agreed with CFOs from the Council and T&G CCG.

Hosting of the pool

1.14. It is proposed that the Council continues to host the Section 75 pooled fund, as this presents more flexibility than hosting by the T&G CCG. The rationale for the fund to be hosted by the Council is that the Council has years of experience of managing pooled funds and enjoys greater independence in control of its own balance sheet. Also, the VAT provisions are more generous, and there is local control of the financial reporting system. The financial management system required to be used by all CCGs is inflexible and does not allow local variation. By contrast the Council is in full control of the structure and analysis of its finance system, enabling a wider range of analysis and reporting to be automated. This will support the need for transparency within the use of the pooled fund more effectively.

Exit from the pool

1.15. Service exit or organisation exit and triggers. Decisions to remove service areas or a whole organisation from the pool will be made by the Tameside & Glossop Care Together Single Commissioning Board. Triggers for an exit will be significant failure to achieve clinical safety, care or financial objectives which cannot be addressed adequately while the service remains pooled. Recommendation to withdraw from the pool may be made to the relevant CFO by agreement within the Single Finance Management Team.

1.16. Ongoing liabilities. In the event of a partial or complete exit from the pool some liabilities arising from the activities of the pool may need to be liquidated. It is not anticipated that supplier or provider break clauses will need to be activated since services will continue to be required.

1.17. In the case of capital or tangible assets these will revert to the organisation with the statutory responsibility for the service, or in the case of groups or classes of assets, be divided in proportion to respective funding levels where this is possible. Where it is sensible to do so, some assets may be sold on with the resulting funds being returned to the lead organisation or allocated between the organisations pro-rata to funding contributions.

1.18. Any carried forward underspend or remaining risk pool funds will be returned to the Council and T&G CCG in proportion to the overall level of their respective contributions at the point of exit from the pool in the case of an organisation level withdrawal, or proportionate to the level of funding for the affected services in the case of a service level withdrawal.

1.19. Any remaining investment funds in the investment pool will be returned to the Council and the T&G CCG in accordance of contributions made, taking into account the investments made in property and other assets.

Internal & External Audit Arrangements

1.20. CFOs will retain responsibility to ensure sufficient and accurate accounts are prepared for audit in accordance with statutory requirements

1.21. The Council and CCG currently have separate internal audit arrangements; the Council has a dedicated internal provision whilst the CCG commission the service via a third party. Both organisations currently have their external audit opinion provided by the same third party organisation. It should be noted that the provision of external audit services to both the Council and CCG are delivered via a contract which will be due for re-commissioning during the term of the current Government.

1.22. The arrangements for the provision of the internal and external audit services relating to the associated systems, controls and management of the Integrated Commissioning Fund are under consideration and will be confirmed in the financial framework.

Reporting

1.23. Reporting arrangements of the ICF, e.g. to the local economy, Greater Manchester Devolution, NHSE or to Department of Communities and Local Government or Department of Health will be undertaken by the host organisation, with support from both CFOs and liaison with other agencies, as at present.

Other considerations

1.24. Better Care Fund. The pooled fund is intended to supplement the Better Care Fund requirements and not to supersede them. Better Care Fund commitments will still be required to be achieved. The Single Finance Management Team will be required to ensure that both partnership/pooled fund objectives and BCF objectives are achieved and can be reported accurately as such. The Single Finance Management Team will be responsible to the Tameside & Glossop Care Together Single Commissioning Board for this requirement.

1.25. Care Act. In a similar way to the BCF, some requirements of the Care Act may be achieved via the integrated commissioning fund. However, other requirements will not be part of the pool. The Single Finance Management Team will be required to ensure that both the objectives of the pool and those of the Care Act are delivered, and will be responsible to the Tameside & Glossop Care Together Single Commissioning Board for this requirement.