APPENDIX 3

FINANCIAL FRAMEWORK
Between
Tameside & Glossop Clinical Commissioning Group and
Tameside Metropolitan Borough Council

A. Document Information

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This is version 1 of the Financial Framework signed on 1 April 2016 by:

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Authorised Signatory on behalf of Tameside & Glossop Clinical Commissioning Group

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Authorised Signatory on behalf of Tameside Metropolitan Borough Council

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

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)

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 inaugural Financial Framework will be by:

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

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.

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 objectives and aims of both partner organisations are set out in the terms of reference for the four workstreams :

- Healthy Lives
- Locality Development
- Urgent Single Care
- Planned Care

4.3. The associated terms of reference of the four workstreams are appended at Appendix 1.

4.4. Detailed strategic objectives for acute care are contained within the CCG Contracts; and elements of these overlap into the four 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';

(d) provide and enable brilliant services that strive to exceed customer expectations;

(e) 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 each of the four workstreams are set out within the terms of reference (appendix 1). These 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);
- Standards set by external agencies, e.g. CQC, Ofsted and NICE (regulation).

6.3. Advised objectives include:

- Best practice identified by external agencies, e.g. NICE and GM MMG.

6.4. Locally defined objectives include:

- Living wage for care workers (policy);
- Removal of 'zero hours' contracts for staff of service providers (policy).

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 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' Authorised Officers and Chief Financial Officers

9.1 Authorised Officer

9.1.1. Each Partner is required to appoint a member of the senior management team to be the Authorised Officer for their organisation. Specific roles for the Authorised Officer are identified in guidance to the Better Care Fund:

- 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 these roles will be subject to the delegations approved by each Partner.

9.1.3. Authorised Officers are to be members of the Single Commissioning Board.

9.2 Chief Financial Officer

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

- 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 Council Chief Financial 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 of each Partner will ensure the adequacy of arrangements to deliver new services, programmes and projects.

9.2.4 The Chief Financial Officer of each Partner will report assurance to their respective Audit Committees.

10. Responsibilities of the Host Partner

10.1 The decision on the appointment of the Host Partner is agreed by both Partners, after assessment of the relative merits of each holding the role. For the Pooled Fund the Council has been appointed as the Host Partner. This appointment will be reviewed periodically and may be re-assessed in the light of developments at each Partner or determined by external developments.

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 Pooled Fund Manager;
- 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 Pooled Fund Manager

11.1 The Pool Fund Manager is appointed by the Host Partner in accordance with requirements of the Section 75 Agreement and associated regulations. The appointee is part of the Single Commissioning Board and reports to the Authorised Officer of the Host Partner. The responsibilities of the Pooled Fund Manager, as set out in the legislation and Regulations (7(4)) are limited and specific:

- Managing the Pooled Fund on their behalf

- Submitting bi-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 Partners shall jointly designate an officer whose role will be incorporated within the scope of an existing senior management post in a Partner organisation. The role will report to and is 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.

11.4 The Pooled Fund Manager will oversee the day to day operation and management of the Pooled Fund. The respective Chief Financial Officers of each Partner 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 Pooled Fund Manager 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

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 Funds. 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 and aligned 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 £17,300,756 in 2016/17:

- £1,978,000 Council Disabilities Facilities Grant
- £15,322,756 CCG BCF funding contribution, meeting the minimum specified by DH.
- There is an additional £2,205m 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 2016/17 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:

- 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 of the Pooled Fund and Aligned Fund which it makes sense to plan and manage in a coordinated way. As referenced in Appendix 1.

16.2 The CCG fund elements include (2016/17 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 23 February 2016 and in line with the CCG’s planning submission to NHS England on the 8 February 2016.

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 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 Aligned Fund is 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, but more likely to be addressed through service reviews across the Council during the year.

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 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.

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

- 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 over the next 3 years. The main sources of funding will then be Council Tax and Business Rates;
- NHS funding earmarked for health related services (Better Care Fund) is expected to increase in the next years. 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);

- The size and trend in the gap between the two funding streams over the next 5 years is not certain.
- Both Partners may be required to produce medium term efficiency plans in order to receive multi-year financial settlements.
- GM Devolution imposes 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 is likely to be addressed as additional savings targets

27.2 Mitigations:

- The Partners will agree a protocol for agreeing amendments to the budget setting model in subsequent years. This will include consideration of:
    - Treatment of prior year overspends
    - Treatment of efficiency savings delivered from previous years

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

- Indicative savings targets will be identified by the Partners from time to time.

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. Overspends identified during the year are addressed through service

reviews and rationalisation of the scale of non-mandatory services provided, offsets from underspent directorates, or by allocation from reserves at the year-end.

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.

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 have to agree to apply accumulated savings;
    - Partners have to agree for one Partner apply their "share" of indicative savings from previous commissioning reconfigurations without the approval of the other.
- 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 seek to 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;
- 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. The CCG is unlikely to be able to report resource balances to carry forward:
    - But, the CCG would report the net position across the whole. The performance of Tameside and Glossop and the rest of the CCG may, in total, allow for shadow reserves to be identified for the Tameside and Glossop element.

37. Governance of service redesign

37.1. The Partners will agree a protocol for developing service re-design. Elements will be delivered within the Integrated Commissioning Strategy of the Single Commissioning Board. It will involve a formal project management procedure for planning significant changes in service delivery design, which:

- Identifies resource implications;
- Identifies staffing implications;
- Assesses the impact on commissioning intentions:
    - And status of agreements with providers;
- Assesses the impact on Service Contracts:
    - Potential differential share of savings between the CCG, the Council and the Provider;
    - Potential for budget shift impact in advance of risk share arrangement;
- Delivers alignment with wider service design agenda.

37.2. Formal approval arrangements will be implemented, involving both Partners and requiring formal sign-off of projects

37.3. The Partners will agree the approach to monitoring of the impact on budget allocations:

- Linked to potential recognition of impact in budget planning;
- Impact on financial risk share.

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 in the first year. This is based on the Partners' budgetary performance in recent years.

39.2. But there is a shared commitment for the maximum resources to be included within the Integrated Commissioning Fund.

39.3. The Partners will be responsible for the management of their own deficit arising within the level of resources which they contribute to the Integrated Commissioning Fund.

39.4. The Partners agree to formalise the risk share agreement for future years during 2016/2017 no later than 30 September 2016.

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:

- Partner organisations will continue to access financial resources in the same way as they currently do: CCG draw down of funds; the Council transfer of cash.

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 Partners agree to assume a "fair proportions" contribution to the input of non-financial resources (staff, premises, equipment, support services etc.), in accordance with the existing arrangements. This assumption will be reviewed during the first year of the Integrated Commissioning approach.

40.7 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 starting principle is that the structure of the budget management and responsibility will evolve during 2016/17, rather than face a major restructuring at the start of the year.

41.2 But, the Partners expect to make clear and consistent progress, from the start of the financial year, towards a more joined up structure of budgetary control.

41.3 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.

41.4 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

41.5 The basic principle is that budget allocations to the Integrated Commissioning Fund will not change (in-year) once they have been agreed however agree that they 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.

41.6 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 the GM Devolution Transformation Fund.

41.7 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

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;
- Monitoring of service backlogs.

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 fund management team, including agreed delegations;
- Process for escalating to the other Partner.

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:

- 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, the Partners will agree:

- The approach to allocating and apportioning risk between the Partners

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. These will include:

- 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:

- 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 Pooled Fund Manager

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 Pooled Fund Manager 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 Pooled Fund Manager 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:

- 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.

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:

- Disabled Facilities Grant

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.

54. Resources contributed by Partners

54.1. Staffing, equipment, accommodation etc. resources provided by each Partner to the management and administration of the Integrated Commissioning Fund will be based, initially, on existing structures.

54.2 The Partners will agree the approach to ensuring a fair share of the cost of administering the Pooled Fund.

54.3 The Partners will identify the savings to be generated through the medium term plan to deliver greater levels of integration of CCG and the Council staff, to identify operational and financial benefits from integration; and will agree the resulting benefit share between Partners.

Appendix One – Workstream Terms of Reference

CARE TOGTHER PROGRAMME
Healthy Lives Work stream – Terms of Reference

1. Aim of the programme

To provide enhanced system leadership for continuing strategy and policy development that will shape outcome based commissioning priorities and intentions to enable the delivery of the Care Together ambition with a focus on early intervention and prevention, asset based community development and enabling self-care as an integrated part of the emergent new model of care.

2. Scope of the work programme

Commissioning:

- Provide system leadership to influence a whole system approach to maintaining and improving population health, working to embed early intervention and prevention, asset based approaches and self-care into all commissioned programmes and models of care.

- Review, develop and finalise a healthy lives (Wellness) early intervention and prevention model that will support people to be and stay well, with a focus on education, skills and support, lifestyle factors and also employment, housing, education and income inequalities with a focus on identifying programme effectiveness and impact on agreed outcomes.

- Review existing support to asset based approaches, creating opportunities for local people and third sector organisations to grow and do more together by valuing assets, skills and strengths and capacity within our communities, through the development of a business model and commissioning strategy, that is underpinned by a comprehensive prioritisation and investment framework.

- Utilise the design and delivery of the Healthy Lives offer as a platform to create and grow a social movement for health and wellbeing across Tameside & Glossop.

- In the context of the social value act, adopt a commissioning for social value approach, building capacity and skills within the geography of Tameside & Glossop.

- Maximise opportunities through GM Devolution to align efforts and lever potential investment and support to accelerate progress towards implementation of agreed priorities.

- Building on existing transformation work, scope and evaluate the range of programmes across health, social care and the wider economy in support of improving health and wellbeing of the population with a focus on identifying programme effectiveness and impact on outcomes and develop investment models to support implementation at scale and pace.

- Work collaboratively with the (emergent) Single Commissioning Board to:
    - Evaluate existing commissioned programmes to clarify alignment with the Care Together vision, expected outcomes, impact and value added.
    - Make recommendations on the commissioning and provision of high impact, effective and efficient programmes, aimed at improving population health and wellbeing at scale and pace.
    - Adopt a targeted approach to tackling the key drivers of ill health in Tameside rooted in a more robust use of the evidence base and commissioning against areas where the greatest health impact can be achieved through early

intervention, prevention, self-care and strengthening community resilience through asset based approaches, whilst decommissioning services that are less impacting.
    - Provide expert knowledge, advice and assurance to the model of care group in relation to the economics of prevention /health impact assessment/ evidence based practice and cost effectiveness.

- Influence and provide strategic oversight to the continuing development of the Joint Health and Wellbeing Strategy, Joint Strategic Needs and Asset Assessment and the Pharmaceutical Needs Assessment ensuring the availability and use of high quality intelligence and evidence to shape commissioning priorities and intentions.

- Lead / contribute to the creation of sustainable community and stakeholder communication, engagement and participation strategies, ensuring these are co-ordinated and aligned across the Healthy Lives commissioning and delivery programme.

- Identify potential risks to the delivery of agreed priorities, escalating issues impacting on the delivery, together with recommendations and mitigation plans for consideration by the Commissioning Board / Model of Care Group.

- Lead the development and implementation of an outcome based quality and performance framework.

Provider:

- Review, develop and implement at scale a healthy lives early intervention and prevention offer as an integrated part of the model of care that will support people to be and stay well and live independently in their own homes, with a focus on education, skills and support, lifestyle factors and also employment, housing, education and income inequalities.

- Develop universal and targeted approaches to the delivery of the healthy lives approach in accordance with agreed commissioning priorities.

- Create opportunities for local people and third sector organisations to grow and do more together by valuing assets, skills and strengths and capacity within our communities, through the development of a sustainable and integrated model of delivery.

- Utilise the design and delivery of the Healthy Lives offer as a platform to create and grow a social movement for health and wellbeing across Tameside and Glossop and within individual localities.

- Using MECC as an organisational development platform, ensure early intervention, prevention and asset based approaches are integrated into all delivery models, supported by a robust evaluation framework demonstrating outcomes and impacts.

- Develop a programme of organisational development, audit and evaluation to support and enable the continuing development and implementation of new models of care.

- Contribute to the creation of sustainable communication and social marketing strategies that will underpin programme implementation.

- Contribute to the creation of sustainable community and stakeholder communication, engagement and participation strategies, ensuring these are co-ordinated and aligned across the Healthy Lives commissioning and delivery programme.

- Identify potential risks to the delivery of agreed priorities, escalating issues impacting on delivery, together with recommendations and mitigation plans for consideration by the Commissioning Board / Model of Care Group.

- Ensure that all workforce considerations are translated as required into the workforce transformation programme.

- Develop sustainable partnerships to deliver the workstream.

- Develop and agree a comprehensive implementation plan encompassing all relevant aspects of the workstream.

3. Governance / relationships / accountability

- Accountable to the Model of Care Group
- The Chair will be a member of the Model of Care Group
- The programme group is accountable for:
    - Fostering collaboration across commissioners, providers and stakeholders e.g. via engagement and participation.
    - Removing obstacles to the model of care successful delivery, adoption and use.
    - Maintaining at all times the focus on the agreed scope, outcomes and benefits.
    - Monitoring and managing the factors outside the Healthy Lives programme group's control that are critical to its success.
    - Linking with the other groups and enabling work streams.

4. Chair / Deputy Chair

- Chair - Angela Hardman, Director of Public Health, TMBC
- Deputy Chair - Giles Wilmore, Director of Strategy & Partnerships, TFT

5. Core Membership

- Director of Public Health, TMBC
- Director of Strategy & Partnerships, TFT
- Director of Transformation, CCG
- Head of Health & Wellbeing, TMBC
- Chief Officer, CVAT & Healthwatch
- Principal, Tameside College
- DWP / Job Centre Plus Public Health, Derbyshire – to be confirmed
- Director of Service Development & Sustainability, Pennine Care
- Executive Director of Neighbourhoods, New Charter Housing
- Chief Executive, Active Tameside
- HR & Workforce Development
- Finance, TMBC
- Secretary, LPC – to be confirmed
- GP representation – to be confirmed

<u>Extended membership</u> – to attend on a needs basis

- Consultants in Public Health, TMBC
- Strategic Public Health Manager, TMBC
- Head of Stronger Communities, TMBC
- Assistant Executive Director - Education, TMBC
- Assistant Executive Director - Development & Economic Growth , TMBC
- Assistant Executive Director – Adult Social Care , TMBC
- Executive Director – Place, TMBC

6. Quroum

- A minimum 50% attendance

7. Frequency of meetings

- Monthly

8. Interdependencies

- Single Intelligence
- Single Commissioning Unit
- Public health knowledge
- Economic evaluation / CBA
- GM Devo – PH MOU

9. Measuring Outcomes & Success Criteria

The ultimate objective of this workstream is to improve health and wellbeing outcomes for the people of Tameside and Glossop. For example:

- Fewer people with smoking related conditions / Reduced smoking prevalence
- More people participating in physical activity Reduced nos. that are physical inactivity
- More at risk people included and identified on GP disease registers and actively managed
- No of lives saved each year / reduced premature mortality – CHD, Cancer, Respiratory disease
- Children are school ready
- Improved employment outcomes for long term workless

In seeking to progress these kinds of outcome, the priorities for the workstream's focus and attention should be guided by success criteria. For example:

- Have we demonstrated scalability? Are the actions and projects developed and supported by the workstream replicable so they could be scaled across Tameside & Glossop, as well as wider reach into Greater Manchester and beyond?
- Have we demonstrated sustainability? Are we developing approaches which can be embedded and sustained across the local community and voluntary sector, health and care system in the medium to longer term by being self-sustaining? For example, building the knowledge, skills and confidence of people most in need of health and care services or support.
- Have we maximised impact? Are we concentrating on actions and projects that will bring the optimum benefit to as many people as possible?
- Have health inequalities been narrowed? Has the focus concentrated on delivering a proactive universal offer and those parts of the community currently suffering the worst health and wellbeing outcomes?
- Have we considered the most marginalised? Whilst focusing on high impact and maximum benefit, are we confident that so-called "harder to reach" parts of the population are not being further marginalised?
- Have we demonstrated effectiveness affordability and efficiency? Are we able to present the business case that actions interventions and projects will both be affordable within the available cost envelope, are effective and will deliver efficiencies by releasing pressure on other parts of the health and care system?

10. Capacity Requirements

- Programme Support
- Public engagement/participation support
- Economic evaluation / cost benefit analysis
- Intelligence support
- Academia (AHSN)
- Investment modelling
- Business Planning
- Programme Management

CARE TOGTHER PROGRAMME
Locality Development Work stream - draft terms of reference

1. Context

The Tameside and Glossop Locality Plan has set the bold ambition of raising healthy life expectancy to the North-west average by 2020. For both men and women, this means an increase in healthy life expectancy of 3.3 years over the next five years. Our vision to achieve this ambition is to move quickly to a fully person-centred and integrated model of care, with a much heavier emphasis on prevention, supporting self-care and care closer to home.

A Model of Care Steering Group, led by Karen James, Chief Executive, will be leading the development of the detailed model of care which will achieve our ambition. Beneath this high level steering group are four distinct workstreams; Healthy Lives, Locality Development, Urgent Care and Elective Care. These draft terms of reference will highlight the aims/ objectives for the Locality Development workstream as well as show the process for delivering these.

There are four specific Localities in Tameside and a further one in Glossop. Each have different health and social care needs within their population of which the Locality Development workstream will remain cognisant to ensure the new services provided meet the needs of the specific population.

2. Aims and Objectives

The aim of the Locality Development workstream is to deliver an innovative, ambitious, high quality and financially sustainable locally based integrated health and social care system. This system will work to improve health and social care outcomes, increase healthy life expectancy, reduce duplication, improve patient/service user satisfaction and reduce dependency on the acute sector.

This system will be developed over the next 3 -5 years and in full partnership with patients, staff, voluntary sector, residents and regulators to ensure the model achieves its aims, is well understood and meets the needs of the population.

Key objectives for the workstream are to:

- Determine what services should be provided as a minimum in all 5 Localities
- Agree how each locality can incorporate additional services also required to meet the specific needs of their population
- Determine the cost envelope for the Locality model
- Determine how services within a Locality can be effectively incentivised/ aligned with an ICO
- Lead the transformation of Primary Care services, and deliver closer alignment and joint working of general practices within the Locality model
- Determine if new categories of staff are required to support the new ways of working and if so, to liaise with the Human Resource Enabling workstream to ensure these can be created/sourced
- Agree the prioritisation of the work programme
- Challenge and drive the progress of the work programmes
- Clarify interdependencies with the other workstreams, agreeing where each starts and ends
- Consider emerging Greater Manchester Devolution programmes and incorporate relevant work within the overall Locality Development programme
- Lead the commissioning/decommissioning of services to deliver the new model of care, turning it into 'business as usual' by 2018/19
- Harness opportunities for innovation and new ways of working to improve the health and well-being of people in Tameside and Glossop.

3. Scope and Responsibilities

To ensure delivery of the roles and responsibilities the workstream will:

- Ensure the patient and service user voice is at the heart of the Locality model

- Remove obstacles to the successful delivery of the locality model and its interdependencies
- Maintain the focus on the agreed scope, outcomes and benefits to residents across Tameside and Glossop
- Proactively address factors outside the workstream's control that are critical to its success
- Work closely with other Clinical and Enabling workstreams to ensure a cohesive, innovative, high quality, clinically and financially sustainable overall Model of Care is delivered
- Promote corporate citizenship and social value within the locality, supporting local providers

4. Governance and Accountability

The Locality Development workstream will be accountable to the Model of Care Steering Group which is in turn accountable to the Care Together Programme Board. A structure chart of the governance arrangements is attached at Annex A.

The Chair of the Locality Development workstream will be held accountable for the progress made and will also report to and feedback from the Model of Care Steering Group.

5. Membership and Meetings

Meetings of the workstream will be held on a monthly basis, with secretariat support provided by the CCG. Meetings will require a minimum of 50% of members to be quorate however for the sake of pragmatism, work can continue without quoracy should those present and those offering apologies agree.

Core membership

- Director of Transformation, T&G CCG, Chair
- Medical Director, Tameside NHSFT, Deputy Chair
- Deputy Director of Transformation, T&G CCG, workstream lead
- Governing Body Lay Nurse, T&G CCG
- Tameside NHSFT – representatives to be confirmed but to include lead manager for Community Services and others to ensure integration with urgent/acute services
- Tameside MBC – (Adult and children social care representatives to be confirmed)
- Derbyshire County Council – representatives to be confirmed
- Community Services (plus others TBC) Tameside & Glossop Community Healthcare
- Director of Public Health (or nominated deputy)
- Director of Operations or Director of Development, Pennine Care NHS FT
- GP leads (Drs S Ahmed, J Douglas, N Riaz)
- Head of Primary Care, T&G CCG
- Mental Health, Children & LD Commissioning Lead, T&G CCG
- Chief Executive of CVAT/Healthwatch, Tameside
- Chief Executive, Glossop Volunteers Centre
- Member of Estates workstream
- Member of IM&T workstream
- Member of the HR & OD workstream
- Member of the Finance workstream
- Project Support I Administration

6. Linkages and Interdependencies

This workstream has significant links with all three of the other workstreams and the majority of the enabling task and finish groups.

7. Milestones and Impact

The Locality Development workstream will need to develop a programme plan for consideration by the Model of Care steering Group by March 2016. This plan will need to include a description of how high quality health and social care will be provided closer to

home in the future, what the milestones are, the key deliverables and defined cost efficiencies.
The impact of the work of the Steering Group will be assessed via a number of different measures and KPIs. These will be worked up over the forthcoming months alongside the detailed development of the locality model. However, where possible these KPIs will be derived from a single data source, be transparent, accurate and not increase the administrative burden within the current performance management system.

CARE TOGTHER PROGRAMME

Planned Care Work stream – Terms of Reference

1. Context

The Tameside and Glossop Locality Plan has set the ambition of raising healthy life expectancy to the North-west average by 2020. For both men and women, this means an increase in healthy life expectancy of 3.3 years over the next five years. Our vision to achieve this ambition is to move quickly to a fully person-centred and integrated model of care, with a much heavier emphasis on prevention, supporting self-care and care closer to home.

The Locality Plan is clear that delivering this ambition will be enabled through four priority work streams, which together constitute our approach to integrated care.

Planned Care is the planning, development, commissioning and delivery of non-urgent health services which meet the needs of our local community, offering choice and convenient access as well as achieving excellent health outcomes for our local population. For the purposes of the Care Together Programme, those planned care services which are likely to be provided from the hospital site will be within the remit of this Planned Care work stream. Planned care services outside of the hospital, in community, primary, mental health or social care will fall under the remit of the Locality work stream.

In line with the recent Healthier Together consultation and Greater Manchester Devolution plans, we will ensure our patients have access to the very best clinical support. This will be through ensuring our local hospital works with other hospitals to provide consistently high quality treatment and care which meets best practice standards and provides the best outcomes and experience for patients. We will share services across a number of hospitals and ensure concentrated expertise in clinical teams delivering the "once-in-a-lifetime" specialist care. This may mean that for some services, people will have to travel further for particular types of treatment but we will continue to develop opportunities for day case treatment by reducing overnight stays in hospital and increasing the amount of outpatient care in our communities.

The Planned Care work stream will take forward the recommendations from the Greater Manchester Healthier Together Programme to deliver planned care as part of wider clinical networks. Healthier Together is one part of an overall public sector service transformation programme led by Greater Manchester Local Authorities and the NHS, alongside other partners.

2. Aims and Objectives

Our ambition for planned care is for when people need pre-arranged treatment, they will have access to care that delivers the best health outcomes and returns them to independence as quickly as possible.

Key objectives are to:

- Provide seamless and timely care with appropriate levels of access, supported by strong clinical ownership, by removing traditional health and social care boundaries to improve clinical pathways and manage patient care as locally as possible.
- Improve patient experience and health outcomes through the delivery of high quality, responsive and proactive care within a financially stable health economy.
- Identifying the operating model for planned care service delivery and the associated workforce requirements, making recommendations to the Model of Care Steering Group.
- Use benchmarking in the delivery of good outcomes and excellent patient experience, in sharing best practice across the NHS and other health and social care services.
- Develop a programme of work which clearly outlines key milestones, timescales and accountability/responsibility for delivery and progress against this programme.

- Identify potential risks to the programme reporting to the Model of Care Steering Group plans for mitigation.

- Consider the work programme developed by this group in conjunction with those developed by other work-streams to maintain the integrity of the strategy and avoid duplication/omission.

- Ensure that co-dependencies with other work-streams are identified and referenced within the work programme.

- Ensure that governance arrangements are reviewed and appropriately reflect the new models of service delivery.

- Ensure that existing regulatory and statutory obligations are clearly identified and considered within the service redesign.

- Ensure the voice of staff, patients, service users and local people are incorporated into the work-stream.

- Build strong partnerships in designing and delivering the work programme across other parts of the public sector, the voluntary/community sector (VCS) and commercial sector.

- Ensure involvement / representation of all relevant professionals, organisations and agencies

- Consider how the vision for the new services and ongoing progress with the work will be communicated to staff involved in delivery and the wider community.

- Assess workforce demand and supply, identifying opportunities for role redesign that supports the delivery of seamless care and improved efficiency.
- Provide advice and input into the Communication and Engagement Plan, and internal or external communications (as required).
- Support the development of protocols and pathways which are evidenced based and facilitate a standardised approach across partner organisations.

- Identify where required the need for specific, time limited, action focussed task & finish groups in order to support the programme of work.

- Establish task & finish groups ensuring that their work is monitored and evaluated at agreed regular intervals and reports produces as necessary.

3. Scope and responsibilities

The scope of the Planned Care Group's responsibilities is to design, develop and implement the model for planned care in the hospital setting, taking into account the synergies with the other three work streams, and also the cross-cutting work streams.

To get into the level of detail of service design necessary for the new models of care, it is likely that a number of Task and Finish groups, with a focus on particular patient/service user groups or defined services, will need to be formed to support the work of the four work streams. They are likely to be particularly active in supporting the work of the Planned Care and Locality work streams. It will not be possible to run task and Finish Groups for all service areas simultaneously, so there will need to be some phasing and prioritisation. Early priorities for task and Finish groups might include the following areas:

- Ear, Nose & Throat (ENT) Services (work already in progress with Care UK)
- Musculoskeletal (MSK) Services (work already in progress with Care UK)
- Ophthalmology (work already in progress)
- Integration of Community Services
- Children and Young People's Community Services
- Healthier Together Programme & Elective Services

4. Constitution

4.1 Meetings & Membership

Work stream meetings will be held on a monthly basis, with secretarial support provided by Tameside Hospital NHS Foundation Trust (THFT) Corporate Secretariat.
Meetings will require a minimum of 50% of members to be quorate. Every effort should be made by members to attend meetings, but in the event of members being unable to attend they should notify the secretariat in advance of a named deputy.
The Director of Strategy & Partnerships shall be the Chair of the meeting.

Core membership:

- Director of Strategy & Partnerships, THFT (Chair)
- Executive Director of Operations, THFT
- Deputy Director of Operations, Surgery, Women & Children's Services, THFT
- Deputy Director of Operations, Medicine and Clinical Support Services, THFT
- Clinical Director, Surgery, THFT
- Clinical Director, Women & Children's Services, THFT
- Director of Governance, THFT
- Assistant Chief Nurse, THFT
- Directorate Managers, (relevant specialties) THFT
- Radiology Directorate Manager, THFT
- Out-patient & Health Records Directorate Manager, THFT
- Director of Transformation, T&G CCG
- GP lead
- Voluntary sector representative
- IM&T Lead
- Finance Lead
- HR Lead
- Service Transformation Lead, THFT
- Participation and engagement Lead
- Tameside MBC social care lead
- Estates Lead

4.2 Governance & Accountability

The Planned Care work stream is accountable to the Model of Care Steering Group, which is in turn accountable to the Care Together Programme Board (see diagram 1, page 1).
The Chair of the work stream will be held accountable for the programme of work and progress made, and will provide update reports to the Model of Care Steering Group.

5. Linkages and interdependencies

The Planned Care work stream has significant links and interdependencies with the other three work streams, and a number of cross-cutting work streams, in addition to the Healthier Together Programme. Cross cutting work streams include:

- Estates
- IT infrastructure and systems
- Information (data and business intelligence)
- Finance
- Workforce and Organisational Development
- Participation, engagement and communications.

Links with other work streams will focus on:

- *Healthy Lives* (the role of voluntary/community organisations in supporting better knowledge, skills and confidence for self-care out of hospital.)

- *Locality Development* (the interface between hospital and out of hospital services, for instance the role of consultants in supporting locality based activity as part of a multi-disciplinary approach.)
- *Urgent Integrated Care* (the role of planned hospital services as part of an integrated pathway with crisis, out of hours and emergency care).

6. Key performance metrics

- Improved patient experience
- Sustained improvement in the delivery of the Referral to Treatment Standard
- Sustained improvement in the delivery of the Cancer Waiting Times Standard
- Sustained improvement in the delivery of the Diagnostic Waiting Times Standard
- Reduced length of stay for elective patients
- New to follow-up ratio for out-patient attendances in line with national benchmarking best practice
- Reduced readmissions
- Metrics associated with better self-care, such as the Patient Activation Measure (PAM), which will link with the Healthy Lives and Locality work streams.

CARE TOGTHER PROGRAMME
Urgent Integrated Care Services Work stream – Terms of Reference

1. Main authority & limitations

- The Model of Care Steering Group expects that each of the four transformational work streams lead upon the redesign of services. The overall aim of this work-stream is to provide multi-disciplinary strategic direction and guidance across the local health economy to ensure that the shared strategic vision for the provision of integrated urgent care services is realised.

- The Urgent Care Integrated Services work-stream has delegated authority from the Steering Group to request information, individuals/ groups to attend to address any emerging concerns as part of its discussions.

- Standing Financial Instructions to be agreed with the Steering Group.

2. Main priority and objective

The work stream aims to ensure that people receive timely and convenient access to unscheduled care through changing the way in which services are managed and delivered.

The objective of the work-stream is to develop and deliver a differentiated model of emergency/urgent care provision the characteristics of which include, where clinically appropriate and safe, the provision of care closer to people's home and the development of a single access point for the delivery of emergency and urgent care.

It will develop and deliver an urgent integrated care system across Tameside & Glossop which is responsive to the needs of people in crisis, or who require urgent clinical or social intervention/support which is aimed at avoiding a rapid deterioration in their health status. The system will align urgent care services, creating an emergency village which has the capacity and capability to ensure that peoples can access high quality emergency and urgent care. Service provision will be consolidated with the aim of ensuring accessibility, improving efficiency and concentrating expertise resulting in seamless access to a range of services.

3. Scope

This work-stream will ensure plans for the provision of emergency/urgent care services consider the whole service user experience and will include enhancing primary and community care services and avoiding unnecessary admission to hospital.
The scope of the work will include; the development of the emergency village on the THFT site, the redesign of urgent care response to the community, including where appropriate and safe the provision of care closer to people's home.

This work-stream will be responsible for identifying and recommending to the Steering Group; the operational model for service delivery, the workforce requirements associated with this, the quality and performance metrics against which service provision will be monitored and the financial consequences of redesign and delivery.

The proposed UICS will draw together all of the resources that need to be able to respond to urgent needs under a single operational management- including A&E, Medical Assessment Unit, urgent primary care as well as some key mental health, social care and other support that needs to be deployed rapidly.

The UICS will have unequivocal responsibility for looking after local people who experience a crisis whether medical or social. It will respond to needs from the onset that difficulties are reported, through the diagnostic and treatment phase, supporting and rehabilitating until the person is able to live independently or with the help of the LCCT.

If the recommendations of this work-stream are accepted it will move to an implementation phase, within the timescales outlined by the Steering Group.

4. Constitution

4.1 Membership and attendance

The membership of the group will be inclusive of all partner organisations who are currently involved in the delivery of emergency/urgent care services and those parties whose future involvement would be of benefit. Other stakeholders will be co-opted at the most appropriate point in the work programme.

The Executive Director of Operations shall be the Chair of the Meeting, with the Executive Assistant Director of Adults (TMBC) as vice chair

The Membership shall be as follows:

- Executive Director of Operations (Chair) – Trish Cavanagh
- Executive Assistant Director of Adults (TMBC) (Vice Chair) – Sandra Whitehead
- Service Transformation Lead – Grace Wall
- Divisional Director – Medicine and Urgent Care – Sara Derbyshire
- GP leads – Richard Bircher. Simon Rushton
- Clinical Director – Urgent Care – Nasreen Contractor & Martin Patrick
- Director of Human Resources – Amanda Bromley
- Director of Estates & Facilities – Gillian Parker
- Associate Director of Finance - Suzanne Holroyd
- GoToDoc – Jane Pugh
- NWAS - TBA
- CVAT – Ben Gilchrist
- Assistant Chief Nurse – Lindsay Stewart
- Service Leads – Community Services & Allied Health Professionals
- Chief Information Officer - Colin Skoyles
- Stockport Community Services – John Schooling
- Derbyshire County Council – Mike Peers
- Pennine Care – Karen Maneely
- New Charter – Tony Powell
- Care Homes – Representative to be confirmed.

Each member is required to nominate a deputy to attend in his/ her absence as agreed with the Chair. In addition, other members will be asked to co-opt in as appropriate.

In order for decisions taken by the group to be valid, the meeting must be quorate. This will consist of the Chair or the Vice Chair and at least five members or their deputies to be in attendance.

4.2 Frequency

The work-stream shall meet monthly in the week before the Steering Group.

4.3 Reporting

The work-stream shall report to the Steering Group and provide an update on progress against the agreed work programme and areas where risks are emerging which may impact on the delivery of objectives.

4.4 Organisation

The meeting arrangements and administration will be serviced by the Executive Director of Operation's office. Information shall be circulated before each meeting in a timeframe that gives members sufficient time to prepare for the meeting.

5 Aims

- Develop a differentiated model of emergency/urgent care the characteristics of which include; where clinically appropriate and safe the provision of care closer to people's home and the development of a single access point for the delivery of emergency and urgent care.

- Ensure that in the development of the future service model consideration is given to the operational aspects of delivery, the workforce requirements associated with this, the quality and performance metrics against which service provision will be monitored and the financial consequences of redesign and delivery.

- Develop a programme of work which clearly outlines key milestones, timescales and accountability/responsibility for delivery and progress against this programme.

- Identify potential risks to the programme reporting to the Steering Group plans for mitigation.

- Consider the work programme developed by this group in conjunction with those developed by other work-streams to maintain the integrity of the strategy and avoid duplication/omission.

- Ensure that co-dependencies with other work-streams are identified and referenced within the work programme.

- Ensure that governance arrangements are reviewed and appropriately reflect the new models of service delivery.

- Ensure that existing regulatory and statutory obligations are clearly identified and considered within the service redesign.

- Ensure the views of service users and key stakeholders are incorporated into the work-stream.

- Ensure involvement / representation of all relevant professionals, organisations and agencies

- Consider how the vision for the new services and ongoing progress with the work will be communicated to staff involved in delivery and the wider community.

- Assess workforce demand and supply, identifying opportunities for role redesign that supports the delivery of seamless care and improved efficiency.

- Support the development of protocols and pathways which are evidenced based and facilitate a standardised approach across partner organisations.

- Identify where required the need for specific, time limited, action focussed task & finish groups in order to support the programme of work.

- Establish task & finish groups ensuring that their work is monitored and evaluated at agreed regular intervals and reports produces as necessary.

6 Linkages and Interdependencies

- The model developed within this work-stream will need to be congruent with that being developed in the locality based service programme.
- The development of IT systems which facilitate sharing of people records will also be a critical element of this work-stream and others.
- The Estate development will need to link with other work programmes.
- There may be some synergy/conflict with other partner organisations strategies e.g NWAS/GTD which is currently not apparent.

7 Key Performance Metrics

Responsive, safe and cost effective services evidenced by;

- Reduction of emergency admissions by 36%
- Reduction in LOS – impact of complex cases needs to be factored in
- Reduction in the number of hospital beds
- Delivery of access standards for people requiring urgent care
- Reduction in re-admission rates to hospital and intermediate care
- Reduction in ambulance delays
- Service provision across 7 days
- Reduction in system costs

Version control	Date	Comments
V0.1	18/11/2015	For consultation prior to meetings
V0.2	19/12/15	Amendments following meeting of 16th Dec

APPENDIX 2

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**