NHS
Bury
Clinical Commissioning Group

Meeting: Governing Body (Meeting in Public)

Meeting Date	25 September 2019	**Action**	**Approve**
Item No.	5b	**Confidential**	No
Title	Partnership Agreement including Section 75 Bury Integrated Commissioning Fund		
Presented By	Mike Woodhead Chief Finance Officer		
Author	Carol Shannon-Jarvis Associate Chief Finance Officer		
Clinical Lead	N/A		

Executive Summary

This paper seeks the consideration and agreement of preferred options for an Integrated Commissioning Fund and mechanisms upon which it would be introduced.

The paper follows the agreement of the CCG and Council to establish the Strategic Commissioning Board as a sub-committee of the CCG Governing Body and Council Cabinet. The Strategic Commissioning Board will have wide ranging responsibility for all matters relating to health, social care and the Council's 'health related' functions, which can be delegated to it (subject to reserved matters) under the main legal mechanism set out at Section 75 of the National Health Services Act 2006. It is also proposed that there will be alignment of wider Council, CCG and public services by inclusion so far as legally possible within the role of the SCB and in respect to these matters and aligned budgets.

Recommendations

It is recommended that the Governing Body:

- Consider the options detailed within this paper and agree the preferred options recommended to the CCG Governing Body and Council Cabinet.
- Consider and feedback on the draft Section 75 agreement included at appendix 1 which will be updated to reflect decisions made on the options agreed from this paper
- Consider and feedback on the draft financial framework agreement included at appendix which will be updated to reflect decisions made on the options agreed from this paper

Links to CCG Strategic Objectives

SO1 People and Place To enable the people of Bury to live in a place where they can co-create their own good health and well-being and to provide good quality care when it is needed to help people return to the best possible quality of life	☒

Links to CCG Strategic Objectives	
SO2 Inclusive Growth To increase the productivity of Bury's economy by enabling all Bury people to contribute to and benefit from growth by accessing good jobs with good career prospects and through commissioning for social value	☐
SO3 Budget To deliver a balanced budget for 2019/20	☒
SO4 Staff Wellbeing To increase the involvement and wellbeing of all staff in scope of the OCO.	☐
Does this report seek to address any of the risks included on the Governing Body Assurance Framework? If yes, state which risk below:	
GBAF GB1920_PR_3.5 and GB1920_PR_3.5	

Implications						
Are there any quality, safeguarding or patient experience implications?	Yes	☐	No	☒	N/A	☐
Has any engagement (clinical, stakeholder or public/patient) been undertaken in relation to this report?	Yes	☐	No	☒	N/A	☐
Have any departments/organisations who will be affected been consulted ?	Yes	☒	No	☐	N/A	☐
Finance – CCG and Local Authority colleagues Legal – CCG and Local Authority colleagues Governance – CCG and Local Authority colleagues						
Are there any conflicts of interest arising from the proposal or decision being requested?	Yes	☐	No	☒	N/A	☐
Are there any financial Implications?	Yes	☒	No	☐	N/A	☐
Details noted in the paper						
Has a Equality, Privacy or Quality Impact Assessment been completed?	Yes	☐	No	☐	N/A	☒
Is a Equality, Privacy or Quality Impact Assessment required?	Yes	☐	No	☐	N/A	☒
Are there any associated risks including Conflicts of Interest?	Yes	☐	No	☐	N/A	☒
Are the risks on the CCG's risk register?	Yes	☐	No	☐	N/A	☒

Governance and Reporting		
Meeting	**Date**	**Outcome**
Leader and CCG Chair and CEO Meeting	01/08/2019	Discussed
Joint Executive Team		Discussed
Audit Committee	06/09/19	Noted

Bury Integrated Commissioning Fund

1. Introduction

1.1. This paper seeks the consideration and agreement of preferred options for an Integrated Commissioning Fund and mechanisms upon which it would be introduced.

1.2. The paper provides an options appraisal of the introduction of an Integrated Commissioning Fund for which oversight would be delegated (subject to reserved matters) to the Strategic Commissioning Board as a sub-committee of the CCG Governing Body and Council Cabinet. It considering the risks, mitigations, benefits and costs of each option on the principles and administration of the fund.

2. Background

2.1. In September 2015, NHS Bury CCG and Bury Local Authority signaled their ambition to work more closely to ensure better outcomes for the Borough of Bury through the most economic, efficient and effective use of the Bury pound to improve outcomes for the residents of the Borough. This ambition is very much in keeping with the advent of health and social care devolution

2.2. The Bury Locality Plan for Health and Social Care Transformation 2017-21 further reinforced this ambition and set out the desire to form a 'One Commissioning Organisation' which would have a remit to:

- Bring together health and social care commissioning functions of the CCG and Council into one structure
- Create pooled and aligned budget arrangements for health and social care;
- Develop a single health and social care commissioning strategy;
- Create a shared approach to maximizing social value;
- Strategically commission for outcomes against a wide ranging and dynamic local evidence base; and
- Recognise the role of the new Local Care Organisation as a single provider accountable for delivering all age services at a neighborhood level.

2.3. During the last 18 months, work has been undertaken to progress and develop the arrangements needed to enable this, and a number of significant developments have established a more solid base from which future developments can be shaped, including:

- Co-location of the CCG and Council staff members within the Bury Campus from June 2018;
- Establishment of an OCO Shadow Partnership Board in April 2018 which includes Clinicians, Lay Members, Executives and Elected Members
- Reviewed 4 areas to test how commissioning would work through an integrated model – Mental Health, CHC and LD, Carers and SEND;
- Established a single Joint Executive Team across both CCG and Council;
- Appointed a single CCG Chief Executive and CCG Accountable Officer in October 2018; and
- Appointed a single Chief Finance Officer across both the CCG and LA in June

2019.

- Approval to establish the Strategic Commissioning Board as a sub-committee of the Governing Body and Council Cabinet.

2.4. Key principles that underpin the establishment of the One Commissioning Organisation are that:

- strong and effective clinical and political leadership must be maintained; and
- a place-based approach, focusing on outcomes, engaging communities and using community assets must be embraced;

2.5. As part of the wider Public Service Reform agenda and the devolution arrangements within Greater Manchester there is also a move to integrate public services more widely, joining up not only health and social care services but health services with the full range of Council functions; and together with wider public service and community partners.

2.6. By joining up CCG functions with 'everything the Council does', the Council and CCG will be able to set joined-up objectives to improve further the health and wellbeing of the people of Bury and bring to bear the full powers, influence, resources and capability of the CCG and Council, working together to achieve those objectives.

2.7. Many of the localities in Greater Manchester have made significant progress in integrating health and social care commissioning, and with the wider integration agenda. Our proposals for Bury have learned from their experiences, whilst adapting them to be right for Bury.

2.8. By creating the Bury One Commissioning Organisation the CCG and Council will be able to work together better to:

- Improve health and wellbeing outcomes for and with the people of Bury, and reduce inequalities
- Provide a single and consistent commissioning voice to providers, including the Locality Care Organisation
- Enable commissioning staff to work together to commission more joined up services which are more cost effective and possibly less costly
- Make a real shift towards enabling and supporting people to stay well and independent in their own communities.

2.9. The benefits that it is expected will be gained from the One Commissioning Organisation are a place-based to:

- common strategic and operational business plans;
- making best use of available resources;
- having an efficient means to jointly commissioning services; and
- retaining and building on the key strengths of each respective organisation to further enhance performance and delivery.

2.10. At this stage it is therefore appropriate to review how existing Council and CCG financial arrangements might be developed to support the establishment of the One Commissioning Organisation and changes to governance. This paper sets out the options of an integrated commissioning fund that would underpin the role of the Strategic Commissioning Board.

2.11. It is important to note that each organisation will remain accountable as a statutory body for

discharging its duties, however through changing the way in which both organisations work, and the application of effective and appropriate governance arrangements, the emergence of the One Commissioning Organisation formalises the working arrangements between both organisations

3. Development of an Integrated Commissioning Fund (ICF)

3.1 The development of an Integrated Commissioning Fund (ICF) would bring together the financial resources of the CCG and council into a single fund enabling the Strategic Commissioning Board (SCB) to make decisions (subject to reserved matters) based on the full picture of the One Commissioning Organisations finances. It will end the practice of financial decisions being made in organisational silo's potentially at the expense of other public bodies and ultimately the people of Bury.

3.2 The potential risks and mitigations in the establishment of the ICF are explored in the table below.

3.3 Given the mitigations identified it is recommended that an Integrated Commissioning Fund be established in line with the strategic objectives of the One Commissioning Organisation

Risk	Mitigation
Services included within the ICF are not adequately funded and overspend.	A baseline exercise for all potentially included services is underway to ensure the associated risk is understood. There is already a shared understanding of the financial position of the CCG and council with a joint approach to the management of savings in place.
The interests of the statutory organisations are not aligned with that of the integrated fund.	The fund will be overseen by the SCB whose members are jointly accountable for the two statutory organisations and any pooled funding arrangement.
Arrangements are not sufficient to help respond to changes in circumstance and new events.	Recommended best practice is that the operation of the total pool is subject to twice yearly reviews to ensure that is continues to meet the requirements of all partners
That the establishment of a pooled fund exposes statutory organisations to risks they would not ordinarily be exposed to.	The fund will be overseen by the SCB whose members are jointly accountable for the two statutory organisations and any pooled funding arrangement. Any exposure to risk arising from the pool would therefore be the same as that that members of the SCB would be exposed to in their roles across both statutory organisations.
That the establishment of the integrated pool does not realise any savings to contribute to the locality gap	The establishment of the fund will be done in conjunction with the existing joint CCG and Council £24m savings programme. Potential savings will be

Risk	Mitigation
	identified robustly assessed and their achievement monitored.
Partners cannot meet their contribution due to income reductions	The fund will be overseen by the Bury One Commissioning Partnership Board whose members are jointly accountable for the two statutory organisations and can direct the priorities of the fund in line with available contributions.
Commissioners do not have the skills to manage a pooled fund of this magnitude	The council has experience of hosting pooled budgets and commissioners are experienced in the management of multimillion budgets. The implementation of the ICF follows learning taken from other localities with integrated commissioning funds.
A robust approach to business case prioritisation, development and decision is not in place	Linking in with the wider One Commissioning Organisation work will enable robust processes to be put in place.
The creation of the fund will be resource intensive detracting from the focus on achieving financial sustainability.	An assessment of the resource required to establish and ensure its on-going management will be completed in the next month.
Differences in financial systems and processes in the CCG and Council prevent the smooth operation of an Integrated Fund.	Alongside the establishment of an integrated fund work is underway to integrate the finance departments of the CCG and Council.

4 Governance

4.1 It is proposed that the Integrated Commissioning Fund will be overseen by the Bury Strategic Commissioning Board (SCB) a sub-committee of the CCG Governing Body and Council cabinet. Its membership includes equal representation from the CCG and Council.

4.2 The SCB terms of reference are included at appendix 8.

4.3 Members are asked to approve that the ICF will be overseen by the SCB.

5 Form of an Integrated Commissioning Fund

5.1 The mechanisms by which an integrated commissioning fund could be established have been researched including:

- A pooled fund as set out at Section 75 of the National Health Services Act 2006.
- Power to make payments as set out at Section 256 of the National Health Services Act 2006
- An aligned fund

5.2 The aims of aligned and pooled budgets are broadly the same; To help minimise overlaps/gaps in service delivery, increase efficiency, improve value for money and ensure that services are designed to meet the needs of service users. They can reduce transactions, minimise bureaucracy and improve productivity.

5.3 Aligned budgets involve two or more partners working together to jointly consider their budgets and align their activities to deliver agreed aims and outcomes, while retaining complete accountability and responsibility for their own resources. They tend to be adopted where partnerships are yet to mature, as a step towards pooling, where there are no legal powers to pool or where flexibility to include partners from private and third sectors is required. They tend to be less formalised with less detail than pooled budgets.

5.4 A pooled budget is an arrangement where two or more partners make a financial contribution to a single fund to achieve specified and mutually agreed aims. It is a single budget with a single governance arrangement, managed by a single host with a formal partnership or joint funding agreement that sets out aims, accountabilities and responsibilities. They are used where partners have shared and clearly defined outcomes, objectives and strategies that enable them to sign up to a clear formal agreement which sets out the activities or services to be delivered via the pool. They help to enable faster shared decision making and have shown to be cost effective in planning in the medium and longer term whilst being resource intensive in the short term.

5.5 The power to make payments as set out at section 256 is an arrangement by which a CCG can make payments to a local authority for the provision of services where the transfer will secure more health gain than an equivalent expenditure on the NHS. This mechanism would not be in line with the requirements of a jointly managed integrated fund. It would result in the loss of control by the CCG governing body to the council.

5.6 Of these mechanisms a pooled budget arrangement is most closely aligned to the aims of the One Commissioning Organisation. However, there are restrictions on the functions that can legally be held with a section 75 arrangement as set out in detail at Appendices 2-5.

5.7 Four options are analysed in the table below

- Option 1 Continue as is with minimal pooling arrangements as required by statute (Better Care Fund) and manage all budgets through existing organisational governance.
- Option 2 Creation of an integrated commissioning fund with full pooling of all Council and CCG resources (as permitted under legislation) governed by the SCB.
- Option 3 Creation of an integrated commissioning fund on an aligned only basis governed by the SCB.
- Option 4 Creation of an integrated commissioning fund with the staged transfer of services from aligned to pooled as determined by the SCB.

Option	For	Against
Option 1: Continue as is nothing	• Avoids the resource intensive requirements to set up and manage a pooled budget.	• Does not align with the strategic direction of the Council and CCG to develop a single commissioning function.

Option	For	Against
	• Allows individual organisations to focus solely on their own activities and financial position.	• Disincentivises joint working to improve care. • Reduces ability to achieve efficiencies that reduce duplication and contribute to financial balance.
Option 2 Creation of an integrated commissioning fund with full pooling of all Council and CCG resources	• Aligns with the development of a single commissioning function. • Incentivises joint working focusing all staff on the joint aims of the OCO. • Reduces potential conflict of executive members working jointly across the two statutory organisations due to legal nature of section 75 arrangements. • Provides greatest opportunity to achieve efficiencies that reduce duplication and contribute to financial balance. • Single governance structure allowing fastest possible decision. • Allows the OCO to benefit from the full range of flexibilities available from the pooling of funds i.e. VAT treatment, multi-year investment and access to funding.	• This option exposes the Council and CCG who remain two statutory organisations to risks that currently don't exist and could be greater than any other option. e.g. pool financial overspends. • Current understanding of the full scope of services, budgets and related risk is low. • Budgets may be included for which there are no benefits to be gained from joint management. • Moving to a fully integrated pooled budget mid-year will be complex.
Option 3 Creation of an integrated commissioning fund on an aligned basis.	• Aligns with the development of a single commissioning function. • Informal arrangement reducing statutory organisational exposure to risk arising from the pool. • Goes some way to incentivise joint working and realise efficiencies that reduce duplication and contribute to financial balance. • Allows time for shared understanding of services to be developed.	• Potential conflict for executive members working across the two statutory organisations. • May suggest that the Council and CCG are not as committed to a single commissioning function as other options. • The OCO will be unable to benefit from the flexibilities available from a pooled budget e.g. VAT treatment, multi-year investment and access to funding.

Option	For	Against
	• Less resource intensive than a full pool arrangement in the short term.	
Option 4 Creation of an integrated commissioning fund with the staged transfer of services from aligned to pooled as approved by SCB.	• Aligns with the development of a single commissioning function. • Allows the managed addition of appropriate services and associated exposure to risk arising from the creation of the pool. • Incentivises joint working focusing all staff on the joint aims of the OCO. • Reduces potential conflict of executive members working jointly across the two statutory organisations. • Provides opportunity to achieve efficiencies that reduce duplication and contribute to financial balance. • Allows the OCO to benefit from the of flexibilities available from the pooling of funds i.e. VAT treatment, multi-year investment and access to funding. • Allows for further services to be included as legislation or other circumstances change.	• Potential confusion as to which services are aligned and which pooled. • Element of potential conflict for executive members working across the two statutory organisations. • Most resource intensive and could be most complex if services move mid-year. • Further work required to understand how this option would work in practice. • Delayed benefit in the realisation of pooled budget flexibilities if additions are not prioritised effectively

5.8 Option 4 is recommended for progression on the basis that it closely aligns with the strategic aim of the OCO, allows for the benefits of a pooled budget arrangement to be realised whilst also minimising the risk of pooling a large number of complex services. Option 1 is discounted on the basis that it does not align with the strategic aims of the single commissioning function.

5.9 Option 3 is discounted on the basis that it does not allow for the benefits of a pooled budget arrangement to be realised, will not allow for the streamlining of governance and doesn't address the potential conflict it confers to executive members. Option 2 is discounted on the basis that it exposes the Council and CCG to an unnecessary level of risk in the early stages of the ICF.

5.10 For all options there is the consideration of whether staff costs are included within the pool. Where funds are pooled with clear integrated commissioning the rationale for including staff within the pool is clear. As more funds move into the pooled arrangement (under the relevant options above) a case can also be made for staff costs to also move. This therefore precludes all staff costs moving to the pool from day 1.

6 Structure of the Integrated Commissioning Fund

6.1 Whilst the simplest approach would be to pool all health and social care commissioning current constraints of s75 legislation prevents the inclusion of some council and CCG functions. Section 75 is applicable only to prescribed health related functions. CCG's cannot delegate functions related to the commissioning of surgery, radiotherapy, termination of pregnancies, endoscopy, class 4 laser treatments or other invasive treatments, emergency ambulance services or delegated family health services. Meanwhile councils cannot delegate specific functions relating to adoption services, appointment of the director of adult social services, approving MHA mental health professionals, recovery of costs, charging for accommodation and parts of the children's act as set out in detail at Appendices 3 and 5.

6.2 Alongside this there are health and social care services for which the Council and CCG report and hold budgets but the governance arrangement is either collaboratively with other GM organisations or with a lead commissioner e.g. ambulance services and delegated co-commissioning budgets. The SCB would therefore be unable to make a binding decision on these service related funds.

6.3 It is therefore proposed that whilst the Bury Integrated Commissioning Fund comprises of the whole CCG and Council budgets it is made up of 3 categories of budget pooled, aligned and in-view with appropriate governance protocols applied to each.

Category	Description	Governance
Pooled	Formal agreement provided for under Section 75 of the NHS Act 2006	Decisions about the utilisation of the pooled budget is made by the SCB.
Aligned	Covers all other locality health related functions that it is either not currently legally possible to pool or that the locality is not yet in a position to pool.	Recommendations on utilisation of the aligned funds are made by the SCB with decision taken by the appropriate sovereign commissioner.
In View	Areas of health and social care resource that are influenced but not directly commissioned by the locality e.g. the delegated primary care co-commissioning budget, GM ambulance commissioning. Potentially non health related functions elements of the Council to health and social care.	Decisions about the utilisation of in view health and social care budgets are made by committees/bodies outside of Bury e.g. NHSE, GMJCB and lead commissioners. This will be shared for information purposes only with the SCB.

6.4 In summary the SCB will be wholly accountable for the pooled element of the fund, will consider and make recommendations on the aligned element of the pool and will be provided with reports on the in view element of the fund to support the function of the board.

6.5 To note, where a decision is required above service level e.g. at a contract level containing services spanning more than one category of budget it will be taken by the appropriate sovereign commissioner.

6.6 Members are asked to approve the governance protocols described.

7 Financial breakdown of the Integrated Commissioning Fund

7.1 A review of the totality of CCG and Council resource has been undertaken assigning services and related budget to each of the 3 categories of fund based on the criteria below.

Section 75 Pooled Budget

- All CCG healthcare commissioning budgets are assumed to be included within the fund and will be pooled unless a specific rationale for their exclusion can be identified.
  - Community healthcare services
  - Mental Health and Learning Difficulties services
  - Acute non surgical specialty's and points of delivery e.g. A&E, outpatients, direct access, rehab.
  - Continuing Healthcare
  - Intermediate Care
  - Primary Care services Prescribing & Locally Enhanced Services (GP)
- All transformation funded services
- All Better Care Fund budgets
- Adult Social Care expenditure
- Care in the community
- Public Health budgets
- All CCG administration and programme staffing budgets
- Council commissioning staff budgets
- All health and care related childrens budgets are assumed to be included within the fund and will be pooled unless a specific rationale for their exclusion can be identified.

Aligned Budget – Cannot be pooled

- All other healthcare services that cannot be pooled and are under the CCG control are included in the aligned fund.
  - Acute surgical specialty's and points of delivery
  - Safeguarding budgets
- The budget for the post of the Director of Social Services
- Council services related to the Mental Health Act 1983 (detention of people)
- All adoption and fostering services
- All provision of accommodation for children by voluntary organisations, in

Aligned Budget – Cannot be pooled
care homes or independent hospitals. • Charging for accommodation and recovery of costs of providing certain services
Aligned Budget – Could be pooled but suggested aligned at this stage.
• Acute non contract activity • CCG and council reserves • All other childrens services • Civic venues • Communities • Environment, parks and countryside • Housing • Highways and transport • Waste • Sports and leisure • Workforce modernisation & adult education • Business growth • Council non service specific • Council operations • Council regulation and resources

In View

• All other healthcare services that are outside of the CCG control are in the In View Budget.
  ○ CCG delegated co-commissioning budgets (GP services)
  ○ Emergency ambulance services
  ○ Central Drugs.

- Budgets will be included in this fund net of planned savings amounts, therefore requiring that new business models are put in place to secure improved clinical and care outcomes with less money, as part of the journey to delivering a financial sustainable local health economy.
- An analysis of secondary acute Service Level Agreement Monitoring plans carried out at the Point of Delivery (POD) and speciality level indicates 29% of acute contracts would be included in the pooled budget initially.
- At this stage the figures are indicative annual values. A full review will be undertaken during September with due diligence carried out to ensure clarity and appropriate allocation to budgets for the 1st October 2019.

7.2 The table below provides an indication of the value of each category of the fund apportioning budgets based on the criteria in 7.1. This would equate to 50% of CCG budgets being pooled and 35% of council expenditure. A full breakdown of how services and cost centres have been allocated is included at appendix 6 for the CCG and appendix 7 for the Council.

Integrated Commissioning Fund	Section 75 Pooled Budget £000	Aligned Budget £000	In View Budget £000	Total Integrated Commissioning Fund £000
Bury CCG Budgets	155,974	115,509	36,561	**308,045**
Bury LA Budget - Direct Expenditure	127,469	208,523	0	**335,992**
TOTAL Expenditure Resource	**283,444**	**324,033**	**36,561**	**644,037**
Bury LA Budget - Income Budgets	-32,479	-164,651	0	-197,130
TOTAL Income Resource	**-32,479**	**-164,651**	**0**	**-197,130**
NET Resources	**250,964**	**159,382**	**36,561**	**446,907**
Share of ICF	**56%**	**36%**	**8%**	**100%**

7.3 Members are asked to consider the criteria used and either agree the approach or propose amendments for update prior to recommendation at Governing Body and Cabinet.

8 Hosting arrangements

8.1 Under the regulations for a section 75 arrangement either the CCG or Council can act as host. Following a review of case studies in the majority of cases the council was chosen to act as host based on the following.

8.1.1 Firstly, the council has and enjoys greater independence in control of its own balance sheet which lends itself to the management of multi-year projects.

8.1.2 Secondly, the VAT provisions for councils are more generous than those for CCGs enabling increased investment in care, and although being clear that this is not a VAT avoidance approach, however it is a factor in determining how health and care services are commissioned in future.

8.1.3 And lastly, the nationally mandated financial system used by the CCG is inflexible and does not allow local variation. By contrast the Council is in full control of the structure of its financial reporting system, enabling a wider range of analysis and reporting.

8.1.4 In the Bury locality the council also has years of experience in managing pooled funds.

8.2 To note at this stage considerable work will be required to ensure robust financial management of the fund. The resource implications of which will need to be considered in the ongoing review of the corporate core of the One Commissioning Organisation.

8.3 It recommended that the council host any pooled budget arising from the creation of the Integrated Commissioning Fund as this presents more flexibility than hosting by the CCG.

9 Integrated Commissioning Fund Financial Framework

9.1 Whilst a section 75 agreement provides the overarching legal governance requirements of the fund this would need to be underpinned by a detailed financial framework outlining the approach to:

- Financial regulations
- Risk management and audit
- Basis of contribution and contingency
- Treatment of underspends
- Reporting on financial and operational performance
- Conditions of entry and exit from the pool
- Exit strategy
- VAT, insurance & legal implication

9.2 The financial framework applies to the whole ICF and so the approach taken will apply to both the pooled and aligned budgets.

9.3 Some of the areas listed above just require clarification for others there are options which require further consideration below.

9.4 In appendix 1 is the skeleton of a financial framework. Members are asked to approve the clarifications within it and note the other relevant sections will be updated subject to the recommendations within this paper.

10 Financial Framework - Risk Management

10.1 The most suitable approach to financial risk management will depend on a number of factors not least the financial standing of the CCG and Council which can change year on year due to external factors. It is therefore recommended that the approach to risk management is reviewed on an annual basis.

10.2 Four options have been considered for the management of financial risk from the establishment of any fund from 1st October 2019. The options described could be applied consistently across the pool, aligned and in view budgets or bespoke to each.

- Option 1: Financial risk is split 50:50 between the partners. Each further contributing 50% of any budget overspend.

- Option 2: Financial risk is split according to contribution. Each further contributing a percentage of any budget overspend pro rata to the value of their respective financial contribution to that budget.

- Option 3: Financial risk is split based on the total resource of each partner. Each further contributing a percentage of any budget overspend pro rata to the value of their gross expenditure budgets.

- Option 4: Financial risk is split based on an agreed percentage. Each further contributing a fixed percentage of any budget overspend.

- Option 5: Financial risk is split as per one of the options above but with an agreed cap for each partner, above which risk returns to the originating commissioner.

Option	For	Against
Option 1: Financial Risk is split 50:50	• The risk of every pound of potential overspend is borne by organisations equally. • Risk is quick to calculate and easily understood. • For originating partner of service 50% of risk is mitigated by fund partner.	• The partner contributing less to the fund will be disproportionately exposed to risk under this option. • New partner is exposed to 50% of a new risk.
Option 2: Financial Risk is split pro-rata to fund contribution.	• The impact of risk is proportionate to the share of the total partner contribution to the budget. • Easily understood and relatively quick to calculate. • For originating partner of service a share of risk is mitigated by fund partner.	• Partners maybe exposed to risks that currently don't exist.
Option 3: Financial Risk is split pro-rata to total partner expenditure budget.	• The impact of risk is proportionate to the total partner budget. • For smaller partner a higher share of risk is mitigated by fund partner.	• Larger partner maybe exposed to higher risk than if not in a ICF. • Less incentive for smaller partner to prevent risk arising.
Option 4: Financial Risk is split based on a negociated basis	• The impact of risk can be based on a combination of factors. • Flexible to locality need.	• Difficult to ensure all relevant factors are included in the calculation of the split. • One partner maybe exposed to a risks that currently don't exist.
Option 5: Financial Risk split as per an option 1-4 above with the addition of a financial cap for each partner which .	• Maximum exposure of risk from entering pool is clearly understood at outset. • Benefits up to cap as per 1-4 depending on which chosen.	• May resort to silo working if cap is breached.

10.3 The table below provides an indication of the share of the risk each partner would be responsible for under each option.

Split Options For Risk Share	Section 75 Pooled Budget £000	Aligned Budget £000	In View Budget £000	Total Integrated Commissioning Fund £000
Option 1: 50:50 share				
CCG	50%	50%	50%	50%
Council	50%	50%	50%	50%
Option 2a: Pro rata to fund contriburion (gross)				
CCG	55%	36%	100%	48%
Council	45%	64%	0%	52%
Option 2b: Pro rata to fund contriburion (net)				
CCG	62%	72%	100%	69%
Council	38%	28%	0%	31%
Option 3a: Pro-rata to total partner expenditure budget.				
CCG	48%	48%	48%	48%
Council	52%	52%	52%	52%
Option 3b: Pro-rata to total partner net budget.				
CCG	69%	69%	69%	69%
Council	31%	31%	31%	31%
Option 4: Split based on a negociated basis				
CCG	? %	? %	? %	? %
Council	? %	? %	? %	? %
Option 5: Option 1-4 with Cap				
CCG	? %	? %	? %	? %
Council	? %	? %	? %	? %

10.4 The recommendation of this paper to minimise the risk to each statutory organisation for the first 6/18 months of operation of the fund is option 5 being that financial risk is shared based on a 50:50 basis to each budget as per option 1 with a cap agreed.

11 Financial Framework - Basis of Contribution and Contingency

11.1 The creation of an integrated fund allows for the discrete direct link between statutory organisation income and expenditure to be broken. It is recommended that the basis for the contribution to the ICF for each organisation is the budget for the services included in the fund for each partner prior to its establishment uplifted each year in line with total partner budgets.

11.2 However, whether contributions to each budget are as per this basis annually or on average over a period of years with contributions varying for partners year on year is for discussion.

11.3 To allow the maximum flexibility and to take advantage of the financial opportunities available to the partners it is recommended that the total contribution be agreed over a 3 year period. The annual split of contribution should then be agreed to ensure that on

average each partners contribution is as per the value of services included.

11.4 To manage an element of risk within each fund and for development and transformation to ensure the on-going sustainability of the CCG and Council it would be prudent to include a contingency within each fund.

11.5 It is recommended that partners contribute a mutually agreed amount as a contingency for each budget.

11.6 Members are asked to consider whether a contingency should be assigned to each category of fund and what the value of the contingency should be.

12 Financial Framework – Treatment of Underspends

12.1 In the situation where budgets underspend the options open to the partners for the treatment of underspends includes not only those described under risk management but:

- Option 5: Underspends in one budget are assigned to address overspends in another fund budgets.
- Option 6: Underspends are held by the host in an investment or contingency reserve for future years. This option would only be applicable to the pool.
- Option 7: Underspend treated as per options 1-6 to a capped amount after which a second option is applied for the remainder.

Option	For	Against
Option 1: Underspend is split 50:50	• The benefit of every pound of potential underspend is gained equally. • Benefit is quick to calculate and easily understood.	• The partner contributing more to the budget will lose disproportionately more benefit under this option.
Option 2: Underspend is split pro-rata to budget contribution.	• The impact of benefit is proportionate to the share of the total partner budget contributed to the fund. • Easily understood and relatively quick to calculate.	• Benefit generation may be completely unrelated to contribution.
Option 3: Underspend is split pro-rata to total partner expenditure budget.	• The impact of benefit is felt proportionately to the partners.	• There is no relationship between risk and reward.

Option	For	Against
Option 4: Underspend is split based on a negotiated basis	• The impact of benefit can be based on a combination of factors. • Flexible to locality need.	• Difficult to ensure all relevant factors are included in the calculation of the split. • Benefit receipt may be completely unrelated to contribution.
Option 5: Underspends from one budget offset risks in another.	• Mitigates risks across the fund.	• Disincentivises financial balance in each category of the fund.
Option 6: Gain from pool held in investment reserve.	• Provides investment and/or contingency for future years.	• Achieving recurrent underspends is currently unlikely.
Option 7: Underspend split as per an option 1-6 to a capped amount after which a second option is applied.	• This option could be used to maximise the benefits from multiply options.	• Complicated.

12.2 The recommendation of this paper to ensure overall financial balance is option 5. Where underspends are in excess of those needed in other fund budgets any pooled budget underspend should be held by the host in an investment/contingency reserve for future years and in other budgets returned to the sovereign commissioner.

13 Financial Framework - VAT

13.1 A key consideration in setting up an integrated fund are the implications for VAT. For the aligned and in-view budgets there is no change to existing arrangements but the creation of the section 75 pooled budget with associated host does have implications. Holding a pooled budget will end the invoicing of individual items between partners and thus the requirement to charge VAT on a supply of service for items held within the pool. Instead partners will make a single contribution to the pool based on that agreed in the financial framework to cover all items within the pool. The creation of the pooled budget does not require a change in contracting or payment arrangements and so the actual VAT liability of services will continue to be subject to the VAT regime of the organisation that contracts and pays for it.

13.2 It could be that further down the line it makes commissioning sense for one partner to stop contracting a service and for the other to start as part of a jointly agreed service redesign or procurement. At this point the VAT implications for an individual pooled service could

change as it transfers from one organisational VAT regime to the other.

14 What is not being proposed within the Integrated Commissioning Fund

14.1 The proposals do not imply any loss of control for either of the commissioning organisations, Bury Council and Bury CCG. In fact, the aim is that the additional level of control provided by the partnership arrangements increases overall control since each partner will be able to influence more effectively the overall expenditure within the health economy.

14.2 The proposals do not lead to any loss of accountability for the commissioning organisations. Bury Council and Bury CCG must both remain responsible and accountable for their statutory responsibility – whilst these may be delegated to the joint pool, they cannot be transferred.

14.3 These proposals do not imply any intention to transfer risks between organisations to the benefit of one sole partner. The purpose of the pooled fund is to support risk mitigation through joint commissioning.

14.4 Both Bury CCG and Bury Council will retain a responsibility to ensure that the pooled fund can demonstrate that effective arrangements are in place to secure economy, efficiency and effectiveness.

15 Outstanding Issues and Developments

15.1 An example financial report will be developed during September following the outcome of recommendations from this paper.

15.2 A review of the required financial systems, processes, finance team expertise and resource that need to be in place to implement, monitor and report the ICF will be completed and feed into the corporate core review.

15.3 The links between the Integrated Commissioning Fund and the Better Care Fund and between the Strategic Commissioning Board and Health & Wellbeing Board will be further investigated to ensure compliance with statute and national requirements.

16 Recommendations

16.1 That an Integrated Commissioning Fund be established in line with the strategic objectives of the One Commissioning Organisation.

16.2 That the Integrated Commissioning Fund will be overseen by the Strategic Commissioning Board.

16.3 That an Integrated Commissioning Fund be established encompassing a section 75 pooled budget with the staged transfer of services from aligned to pooled as determined by the SCB.

16.4 That the ICF comprises 3 budgets pooled, aligned and in-view which are governed as per the table in section 6.3.

16.5 Members are asked to consider the criteria for apportionment of CCG and Council budgets to fund categories and either agree the approach or propose amendments for update prior to recommendation at Governing Body and Council Cabinet.

16.6 It is recommended that the council host any pooled budget arising from the creation of the Integrated Commissioning Fund as this presents more flexibility than hosting by the CCG.

16.7 To approve the clarifications within the financial framework and note the other relevant sections will be updated subject to the other recommendations within this paper.

16.8 That the financial risk for the first 6/18 months of operation of the fund is shared based on a 50:50 split with an agreed cap for each partner.

16.9 To consider whether the risk share arrangement is applied consistently to the whole ICF or differently to the different fund budgets.

16.10 That the total contribution to the pooled budget be agreed over a 3 year period.

16.11 That a contingency is include in each fund budget of an amount mutually agreed by the partners.

16.12 Where underspends are generated in one budget they should be used to address overspends in another. Where underspends in excess of those needed in other categories of fund are generated the pool budget should be held by the host in an investment/contingency reserve for future years, the aligned and in view budget held by the sovereign organisation.

17 Actions Required

17.1 Members are required to:

- Approve the establishment of an Integrated Commissioning Fund as described to the CCG Governing Body and Council Cabinet.

Carol Shannon-Jarvis
Associate Chief Finance Officer
carol.shannon-jarvis@nhs.net
September 2019

Appendix 1: Financial Framework

Bury Financial Framework - Draft v2.

Appendix 2: Functions of NHS Bodies that <u>can</u> be subject to S75 partnership arrangements

Legislation	Function
Sections 3 & 3A of the NHS Act 2006 (NHS Act) **Note these functions need to be read together with the exclusions in Annex 2*	Duty of a CCG to arrange for the provision of the following to the extent it considers necessary to meet the reasonable requirements of the persons for whom it has responsibility: • hospital accommodation; • other accommodation for the purposes of any service under the NHSA; • medical, dental, ophthalmic, nursing and ambulance services; • such other services or facilities for the care of pregnant women, women who are breastfeeding and young children as the CCG considers are appropriate as part of the health service; • such other services or facilities for the prevention of illness, the care of persons suffering from illness and the after-care of persons who have suffered from illness as the CCG considers are appropriate as part of the health service; • such other services or facilities as are required for the diagnosis and treatment of illness. Power of a CCG to arrange for the provision of such services or facilities as it considers appropriate for the purposes of the health service that relate to securing improvement: • in the physical and mental health of the persons for whom it has responsibility; or • in the prevention, diagnosis and treatment of illness in those persons. NB: This includes rehabilitation services and services intended to avoid admission to hospital.
Section 3B of the NHS Act **Note these functions need to be read together with the exclusions in Annex 2*	Regulations may require NHS England (NHSE) to arrange the provision, to such extent as it considers necessary to meet all reasonable requirements, for the provision as part of the health service of: • dental services of a prescribed description; • services or facilities for members of the armed forces or their families; • services or facilities for persons who are detained in prison or in other accommodation of a prescribed description; • such other services or facilities as may be prescribed.
Section 83 of the NHS Act	From 1 April 2016 the function of arranging the provision of primary medical services where these are commissioned under an APMS contract.

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

Appendix 3: **Functions of NHS Bodies that <u>cannot</u> be the subject of Section 75 partnership arrangements**

Legislation	Function
Sections 3, 3A & 3B of the NHS Act 2006 (NHSA)	The function of arranging the provision of: • surgery; • radiotherapy; • termination of pregnancy; • endoscopy; • the use of Class 4 laser treatments and other invasive treatments; • emergency ambulance services.
Sections 83, 92 & 99 of the NHSA*	The function of arranging the provision of: • primary medical services • primary dental services (*From 1 April 2016 the function of arranging the provision of primary medical services where these are commissioned under an APMS contract will be able to be the subject of a S75 partnership arrangement.)

Appendix 4: Functions of local authorities (Health-Related Functions) that <u>can</u> be the subject of S75 partnership arrangements

Legislation	Function
Schedule 1 of the Local Authority Social Services Act 1970 **Note these functions need to be read together with the exclusions in Annex 4*	This Schedule covers a wide range of social services functions. If you require any further details, please let us know.
Regulation 8A of the Healthy Start Scheme and Welfare Foods (Amendment) Regulations 2005	The function of providing Healthy Start vitamins.
Sections 7 or 8 of the Disabled Persons (Services, Consultation and Representation) Act 1986	• Duty to arrange an assessment for persons on discharge from hospital, having received medical treatment for mental disorder as an in-patient for a continuous period of not less than 6 months, of their needs for healthcare services. (This duty is not yet in force). • Duty of local authority to take into account abilities of a carer
Section 19 of the Local Government (Miscellaneous Provisions) Act 1976	The functions of providing or securing the provision of recreational facilities.
	The functions of local authorities under the Education Acts as defined in section 578 of the Education Act 1996;
Part I of the Housing Grants, Construction and Regeneration Act 1996 and under Parts VI and VII of the Housing Act 1996	Functions of local housing authorities.
Section 126 of the Housing Grants, Construction and Regeneration Act 1996	Functions relating to regeneration and development.
Environmental Protection Act 1990	Functions of waste collection or disposal.
Sections 180 & 181 of the Local Government Act 1972	Functions of providing environmental health services.
Highways Act 1980 and Section 39 of the Road Traffic Act 1988	Functions of local highway authorities.

Legislation	Function
Sections 63 & 93 of the Transport Act 1985	Functions relating to passenger transport and travel concession schemes.
Sections 22, 23(2) & 26 of the National Assistance Act 1948 (NAA)	Where the partners enter into a Section 75 partnership arrangement in respect of the provision of accommodation under S21 or 26 of the NAA the function of charging for that accommodation
Section 17 of the Health and Social Services and Social Security Adjudications Act 1983 (1983 Act)	Where the partners enter into a Section 75 partnership arrangement in respect of the provision of welfare services under any enactment mentioned in Section 17(2)(a) to (c) of the 1983 Act, the function of charging for those services.
Functions under or by virtue of Sections 2B or 6C(1) of, or Schedule 1 to, the NHSA	• Functions relating to the improvement of public health; • Public-health functions of the Secretary of State (where local authorities are required by Regulations to exercise these); • Local authority functions under Schedule 1 of the NHSA, including: - medical inspection and treatment of pupils; and - weighing and measuring of children.

Appendix 5: functions of local authorities that cannot be the subject of S75 partnership arrangements

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

Appendix 6 - Bury Integrated Commissioning Fund 19/20 - Current CCG Budgets for inclusion

Directorate	Cost Centre Description	1920 Budget £'000	Section 75 £000	Wider Aligned Budget £000	In View £000
Acute Services	ACUTE COMMISSIONING	147,197,449	42,687	104,510	0
Acute Services	MATERNITY SERVICES	393,557	394	0	0
Acute Services	COLLABORATIVE COMMISSIONING	45,000	0	0	45
Acute Services	CLINICAL ASSESSMENT AND TREATMENT CENTRES	741,095	0	741	0
Acute Services	PLANNED CARE	1,130,372	1,130	0	0
Acute Services	HIGH COST DRUGS	0	0	0	0
Acute Services	NCAS/OATS	2,357,705	0	2,358	0
Acute Services	AMBULANCE SERVICES	8,351,025	0	0	8,351
Acute Services	URGENT CARE	35,000	35	0	0
Acute Services	Winter Resilience	1,179,000	1,179	0	0
Community Health Services	CARERS	38,600	39	0	0
Community Health Services	COMMUNITY SERVICES	21,299,769	21,300	0	0
Community Health Services	HOSPICES	503,134	503	0	0
Community Health Services	INTERMEDIATE CARE	8,907,804	8,908	0	0
Community Health Services	PALLIATIVE CARE	13,217	13	0	0
Continuing Care Services	CHC CHILD PERS HLTH BUD	224,997	225	0	0
Continuing Care Services	CHC CHILDREN	1,709,655	1,710	0	0
Continuing Care Services	CHC AD FULL FUND PERS HLTH BUD	1,444,259	1,444	0	0
Continuing Care Services	CHC ADULT FULLY FUNDED	6,388,505	6,389	0	0
Continuing Care Services	CHC ADULT JOINT FUNDED	1,895,620	1,896	0	0
Continuing Care Services	CONTINUING HEALTHCARE ASSESSMENT & SUPPORT	582,708	0	583	0
Continuing Care Services	FUNDED NURSING CARE	1,712,530	1,713	0	0
Mental Health Services	CHILD AND ADOLESCENT MENTAL HEALTH	50,360	50	0	0
Mental Health Services	DEMENTIA	74,149	74	0	0
Mental Health Services	IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES	51,282	51	0	0
Mental Health Services	LEARNING DIFFICULTIES	199,617	200	0	0
Mental Health Services	MENTAL CAPACITY ACT	105,573	106	0	0
Mental Health Services	MENTAL HEALTH CONTRACTS	23,224,613	23,225	0	0
Mental Health Services	MENTAL HEALTH SERVICES - ADULTS	4,055,702	4,056	0	0
Mental Health Services	MENTAL HEALTH SERVICES - ADVOCACY	46,779	47	0	0
Mental Health Services	MENTAL HEALTH SERVICES - COLLABORATIVE COMMISSIONING	2,334,729	2,335	0	0
Mental Health Services	MENTAL HEALTH SERVICES - NOT CONTRACTED ACTIVITY	55,302	55	0	0
Mental Health Services	MENTAL HEALTH SERVICES - OTHER	186,996	187	0	0
Other Programme Services	CLINICAL LEADS	264,470	0	264	0
Other Programme Services	COMMISSIONING - NON ACUTE	34,380	34	0	0
Other Programme Services	INTERPRETING SERVICES	124,110	124	0	0
Other Programme Services	NON RECURRENT PROGRAMMES	437,230	437	0	0
Other Programme Services	PROGRAMME PROJECTS	337,043	0	337	0
Other Programme Services	RECHARGES NHS PROPERTY SERVICES LTD	803,561	804	0	0
Other Programme Services	SAFEGUARDING	574,728	0	575	0
Other Programme Services	COMMISSIONING RESERVE	-7,106,000	-7,106	0	0
Other Programme Services	GENERAL RESERVE - PROGRAMME	2,641,674	0	2,642	0
Other Programme Services	NON RECURRENT RESERVE	3,140,000	0	3,140	0
Other Programme Services	NHS 111	574,883	575	0	0
Primary Care Co-commissioning	PRC DELEGATED CO-COMMISSIONING	27,218,000	0	0	27,218
Primary Care Services	CENTRAL DRUGS	947,089	0	0	947
Primary Care Services	LOCAL ENHANCED SERVICES	2,215,957	2,216	0	0
Primary Care Services	COMMISSIONING SCHEMES	1,405,000	1,405	0	0
Primary Care Services	GP FORWARD VIEW	722,147	722	0	0
Primary Care Services	MEDICINES MANAGEMENT - CLINICAL	359,825	0	360	0
Primary Care Services	OUT OF HOURS	1,633,703	1,634	0	0
Primary Care Services	OXYGEN	231,877	232	0	0
Primary Care Services	PRESCRIBING	29,405,274	29,405	0	0
Primary Care Services	PRIMARY CARE IT	1,240,946	1,241	0	0
Running Cost	ADMINISTRATION & BUSINESS SUPPORT	366,461	366	0	0
Running Cost	BUSINESS DEVELOPMENT	85,699	86	0	0
Running Cost	BUSINESS INFORMATICS	491,708	492	0	0
Running Cost	CEO/ BOARD OFFICE	580,342	580	0	0
Running Cost	CHAIR AND NON EXECS	176,042	176	0	0
Running Cost	COMMISSIONING	550,122	550	0	0
Running Cost	COMMUNICATIONS & PR	108,473	108	0	0
Running Cost	CONTRACT MANAGEMENT	342,601	343	0	0
Running Cost	CORPORATE COSTS & SERVICES	310,600	311	0	0
Running Cost	EDUCATION AND TRAINING	32,076	32	0	0
Running Cost	EMERGENCY PLANNING	15,432	15	0	0
Running Cost	EQUALITY AND DIVERSITY	34,728	35	0	0
Running Cost	ESTATES AND FACILITIES	129,000	129	0	0
Running Cost	FINANCE	764,366	764	0	0
Running Cost	GENERAL RESERVE - ADMIN	-112,852	-113	0	0
Running Cost	HUMAN RESOURCES	135,924	136	0	0
Running Cost	IM&T	108,990	109	0	0
Running Cost	MEDICINES MANAGEMENT	72,276	72	0	0
Running Cost	PATIENT AND PUBLIC INVOLVEMENT	52,788	53	0	0
Running Cost	PROCUREMENT	58,224	58	0	0
TOTAL CCG		**308,045,000**	**155,974**	**115,509**	**36,561**

Appendix 7 - Bury Integrated Commissioning Fund 19/20 - Current Council Budgets for inclusion

Directorate	Cost Centre Description	1920 Budget £'000	Section 75 £000	Wider Aligned Budget £000	In View £000
Acute Services	ACUTE COMMISSIONING	147,197,449	42,687	104,510	0
Acute Services	MATERNITY SERVICES	393,557	394	0	0
Acute Services	COLLABORATIVE COMMISSIONING	45,000	0	0	45
Acute Services	CLINICAL ASSESSMENT AND TREATMENT CENTRES	741,095	0	741	0
Acute Services	PLANNED CARE	1,130,372	1,130	0	0
Acute Services	HIGH COST DRUGS	0	0	0	0
Acute Services	NCAS/OATS	2,357,705	0	2,358	0
Acute Services	AMBULANCE SERVICES	8,351,025	0	0	8,351
Acute Services	URGENT CARE	35,000	35	0	0
Acute Services	Winter Resilience	1,179,000	1,179	0	0
Community Health Services	CARERS	38,600	39	0	0
Community Health Services	COMMUNITY SERVICES	21,299,769	21,300	0	0
Community Health Services	HOSPICES	503,134	503	0	0
Community Health Services	INTERMEDIATE CARE	8,907,804	8,908	0	0
Community Health Services	PALLIATIVE CARE	13,217	13	0	0
Continuing Care Services	CHC CHILD PERS HLTH BUD	224,997	225	0	0
Continuing Care Services	CHC CHILDREN	1,709,655	1,710	0	0
Continuing Care Services	CHC AD FULL FUND PERS HLTH BUD	1,444,259	1,444	0	0
Continuing Care Services	CHC ADULT FULLY FUNDED	6,388,505	6,389	0	0
Continuing Care Services	CHC ADULT JOINT FUNDED	1,895,620	1,896	0	0
Continuing Care Services	CONTINUING HEALTHCARE ASSESSMENT & SUPPORT	582,708	0	583	0
Continuing Care Services	FUNDED NURSING CARE	1,712,530	1,713	0	0
Mental Health Services	CHILD AND ADOLESCENT MENTAL HEALTH	50,360	50	0	0
Mental Health Services	DEMENTIA	74,149	74	0	0
Mental Health Services	IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES	51,282	51	0	0
Mental Health Services	LEARNING DIFFICULTIES	199,617	200	0	0
Mental Health Services	MENTAL CAPACITY ACT	105,573	106	0	0
Mental Health Services	MENTAL HEALTH CONTRACTS	23,224,613	23,225	0	0
Mental Health Services	MENTAL HEALTH SERVICES - ADULTS	4,055,702	4,056	0	0
Mental Health Services	MENTAL HEALTH SERVICES - ADVOCACY	46,779	47	0	0
Mental Health Services	MENTAL HEALTH SERVICES - COLLABORATIVE COMMISSIONING	2,334,729	2,335	0	0
Mental Health Services	MENTAL HEALTH SERVICES - NOT CONTRACTED ACTIVITY	55,302	55	0	0
Mental Health Services	MENTAL HEALTH SERVICES - OTHER	186,996	187	0	0
Other Programme Services	CLINICAL LEADS	264,470	0	264	0
Other Programme Services	COMMISSIONING - NON ACUTE	34,380	34	0	0
Other Programme Services	INTERPRETING SERVICES	124,110	124	0	0
Other Programme Services	NON RECURRENT PROGRAMMES	437,230	437	0	0
Other Programme Services	PROGRAMME PROJECTS	337,043	0	337	0
Other Programme Services	RECHARGES NHS PROPERTY SERVICES LTD	803,561	804	0	0
Other Programme Services	SAFEGUARDING	574,728	0	575	0
Other Programme Services	COMMISSIONING RESERVE	-7,106,000	-7,106	0	0
Other Programme Services	GENERAL RESERVE - PROGRAMME	2,641,674	0	2,642	0
Other Programme Services	NON RECURRENT RESERVE	3,140,000	0	3,140	0
Other Programme Services	NHS 111	574,883	575	0	0
Primary Care Co-commissioning	PRC DELEGATED CO-COMMISSIONING	27,218,000	0	0	27,218
Primary Care Services	CENTRAL DRUGS	947,089	0	0	947
Primary Care Services	LOCAL ENHANCED SERVICES	2,215,957	2,216	0	0
Primary Care Services	COMMISSIONING SCHEMES	1,405,000	1,405	0	0
Primary Care Services	GP FORWARD VIEW	722,147	722	0	0
Primary Care Services	MEDICINES MANAGEMENT - CLINICAL	359,825	0	360	0
Primary Care Services	OUT OF HOURS	1,633,703	1,634	0	0
Primary Care Services	OXYGEN	231,877	232	0	0
Primary Care Services	PRESCRIBING	29,405,274	29,405	0	0
Primary Care Services	PRIMARY CARE IT	1,240,946	1,241	0	0
Running Cost	ADMINISTRATION & BUSINESS SUPPORT	366,461	366	0	0
Running Cost	BUSINESS DEVELOPMENT	85,699	86	0	0
Running Cost	BUSINESS INFORMATICS	491,708	492	0	0
Running Cost	CEO/ BOARD OFFICE	580,342	580	0	0
Running Cost	CHAIR AND NON EXECS	176,042	176	0	0
Running Cost	COMMISSIONING	550,122	550	0	0
Running Cost	COMMUNICATIONS & PR	108,473	108	0	0
Running Cost	CONTRACT MANAGEMENT	342,601	343	0	0
Running Cost	CORPORATE COSTS & SERVICES	310,600	311	0	0
Running Cost	EDUCATION AND TRAINING	32,076	32	0	0
Running Cost	EMERGENCY PLANNING	15,432	15	0	0
Running Cost	EQUALITY AND DIVERSITY	34,728	35	0	0
Running Cost	ESTATES AND FACILITIES	129,000	129	0	0
Running Cost	FINANCE	764,366	764	0	0
Running Cost	GENERAL RESERVE - ADMIN	-112,852	-113	0	0
Running Cost	HUMAN RESOURCES	135,924	136	0	0
Running Cost	IM&T	108,990	109	0	0
Running Cost	MEDICINES MANAGEMENT	72,276	72	0	0
Running Cost	PATIENT AND PUBLIC INVOLVEMENT	52,788	53	0	0
Running Cost	PROCUREMENT	58,224	58	0	0
TOTAL CCG		**308,045,000**	**155,974**	**115,509**	**36,561**

Appendix 8 Strategic Commissioning Board Terms of Reference including governance structure

Strategic Commissioning Board
Terms of Reference

Context

1. As part of the Bury Locality Plan for Health and Social Care Transformation 2017 to 2021 and to progressing the wider public service reform agenda there is a commitment to full alignment and integration between the Council and the Clinical Commissioning Group to form Bury Health and Social Care One Commissioning Organisation.

2. As part of this commitment the statutory bodies have agreed to form a single "Strategic Commissioning Board" in Bury to bring together the integrated governance of health and social care commissioning in its widest sense.

3. The following document sets out the terms of reference for the Strategic Commissioning Board (SCB).

4. Any changes to these Terms of Reference must be approved by the Council Cabinet and the CCG Governing Body

Statutory Framework

5. The SCB is not a statutory body. It is not intended to replace any of the existing statutory bodies in the locality; instead it is a joint committee of the two statutory organisations, Bury Metropolitan Borough Council ("the Council") and NHS Bury Clinical Commissioning Group ("the CCG"). The SCB will have overarching responsibility for all powers as have been delegated to it by the two statutory organisations (subject to any reserved matters) and set out in the associated Scheme of Delegation.

Role of the Strategic Commissioning Board

6. The SCB will be responsible for setting the principles and high-level strategic direction across the full responsibilities of health and care commissioning that is the responsibility of the two partners and will align wider Council, CCG and public services by inclusion so far as possible.

7. The SCB has been established to make decisions on the objectives, priorities, strategic design, commissioning and overall delivery of health and care services, including the oversight of their effectiveness, quality and performance.

8. In performing its role, the SCB will exercise its functions in accordance with duties delegated to it to support the delivery of the Bury Locality Plan for Health and Social Care

Transformation 2017 to 2021, and its successor strategies and plans; including the Bury Strategy.

9. Members of the SCB have a collective responsibility for its operation. In undertaking its role, clinical and democratic accountability will be implicit within all decisions, as will respect for all professional areas of knowledge and expertise. Decisions will be based on achieving better outcomes and experience for the residents of Bury and those that use services within the Borough, better quality and better value.

10. The ethos of partnership working will underpin the programme of work, recognising that on occasion, difficult decisions may be required to benefit the population of Bury.

11. The SCB will have responsibility for providing a Bury response to Greater Manchester commissioning matters.

Core Business

12. As the SCB will operate as a "place based", strategic, outcomes-based commissioner, the items of business for the SCB are likely to be:
    a) Understanding the aspirations, strengths and needs of Bury communities
    b) Leading collaboratively agreement of priorities for improvement
    c) Leading collaboratively the agreement of commissioning and enabling strategies and associated use of financial and other resources
    d) Enabling and supporting others to fulfil their roles within the system
    e) Providing oversight and gaining assurance in respect of outcomes, quality, performance and finance
    f) Providing leadership, oversight and assurance in respect of the development of an effective "One Commissioning Organisation"

13. The items of business for the SCB are unlikely to include detailed plans for operational service design and re-design.

Membership

14. The Strategic Commissioning Board shall consist of the following members:
    - Councillors – Cabinet Members of the Council to include no more than 7 voting Cabinet Members;
    - CCG Governing Body Members – 9 members to include 7 voting members, of which the majority will be clinicians; and 2 non-voting members;
    - The joint Chief Executive and Accountable Officer;
    - The joint Chief Finance Officer (including S151 responsibilities); and
    - The joint Director of Strategic Commissioning.

15. In addition, other Officers and representatives will be invited to the SCB, and will be recognised as in attendance, enabled to participate fully in discussions to inform the decisions of the SCB, but will not hold voting rights. This will include, but is not limited to:

- 2 opposition party representatives;
- additional members of the CCG Governing Body (who are not members of the SCB)
- additional members of the CCG/Council Joint Executive Team or any such equivalent successor team (who are not members of the SCB)

Chair

16. The SCB will be jointly chaired by the Council's Leader on behalf of the Council and the CCG Chair on behalf of the CCG, with chairing responsibility rotated between meetings.

17. In the event of the Chair of the SCB being unavailable for all or part of the meeting, the following deputising arrangements will apply:
    - The Deputy Council Leader will deputise for the Council Leader; and
    - The CCG Chair will nominate a deputy drawn from the CCG members of the SCB.

Quorum

18. The meeting will achieve quoracy if the following requirements are satisfied:
    - A minimum of 3 elected members, of which 1 must be the Leader or Deputy Leader of the Council;
    - A minimum of 3 Governing Body representatives, of which 2 must be practicing clinicians; and
    - At least one joint Officer.

Voting

19. It is anticipated that decisions will be made by consensus, however in the event that this cannot be achieved, a vote will be undertaken. Each voting member of the SCB will have one vote and a simple majority vote will be sufficient to carry the decision. In the event that the vote is tied, the presiding Chair of the SCB meeting in session will have a casting vote which will be exercised in such a way that is respectful of the partnership arrangements under which the SCB is established.

Deputies

20. Deputies are only permitted in respect to the Chairing of the SCB or Officer members.

21. With the exception of deputising arrangements for the Chair of the SCB, nominated deputies will not hold a vote nor will they count towards quoracy.

Frequency of meetings

22. The SCB will routinely meet at monthly times; a schedule of pre-arranged meeting dates will be distributed on an annual basis with a proposed annual calendar of business.

23. The meetings of the SCB shall be held in public:
    a) subject to any exemption provided by law

    b) the SCB may resolve to exclude the public from a meeting that is open to the public (whether during the whole or part of the proceedings) whenever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings or for any other reason permitted by both the Public Bodies (Admission to Meetings) Act 1960 (as amended or succeeded from time to time) and the Local Government Act 1972.

Attendance

24. Members are expected to attend every meeting.

25. Where a member is unable to attend a meeting, apologies should be notified in advance to the Chair of the meeting.

Conduct of Meetings

26. The SCB will give no less than five clear working days' notice of its meetings.

27. The agenda and supporting papers will be published at least 5 clear working days in advance of the meeting, not including the publication day and the day of the meeting. Authors of papers presented must use the required template. Papers must be received by the committee secretary in line with the published deadlines unless, in exceptional circumstances, explicit agreement has been reached with the SCB Chair.

28. The SCB will be appropriately resourced to ensure the timely distribution of papers, production of minutes, action and decision tracking, and the maintenance of the formal record and documentation of the business of the SCB.

29. Presenters of papers can expect all SCB members to have read the papers and should keep to a summary that outlines the purpose of their paper/report and key issues arising since the time of publication which may materially influence the decision or actions of the SCB. SCB members and others in attendance may question the presenter.

Conflict of Interest

30. As a statutory Joint Committee formed by the two statutory organisations, the SCB must comply with the standards set by the Local Government Act 2000 as set out in Part 5(a) of

the Council's Constitution and Section 140 of the National Health Service Act 2006 (as amended) as set out in Section 6 of the CCG Constitution.

31. In addition, the Register of Interests will be maintained for the members of the SCB and published on the Council and CCG websites.

Reporting

32. A highlight report from the SCB will be submitted to the Governing Body and Cabinet meetings, drawing the attention of the respective Statutory Committee to any items where further action is required. The SCB minutes will be included as an appendix to this report.

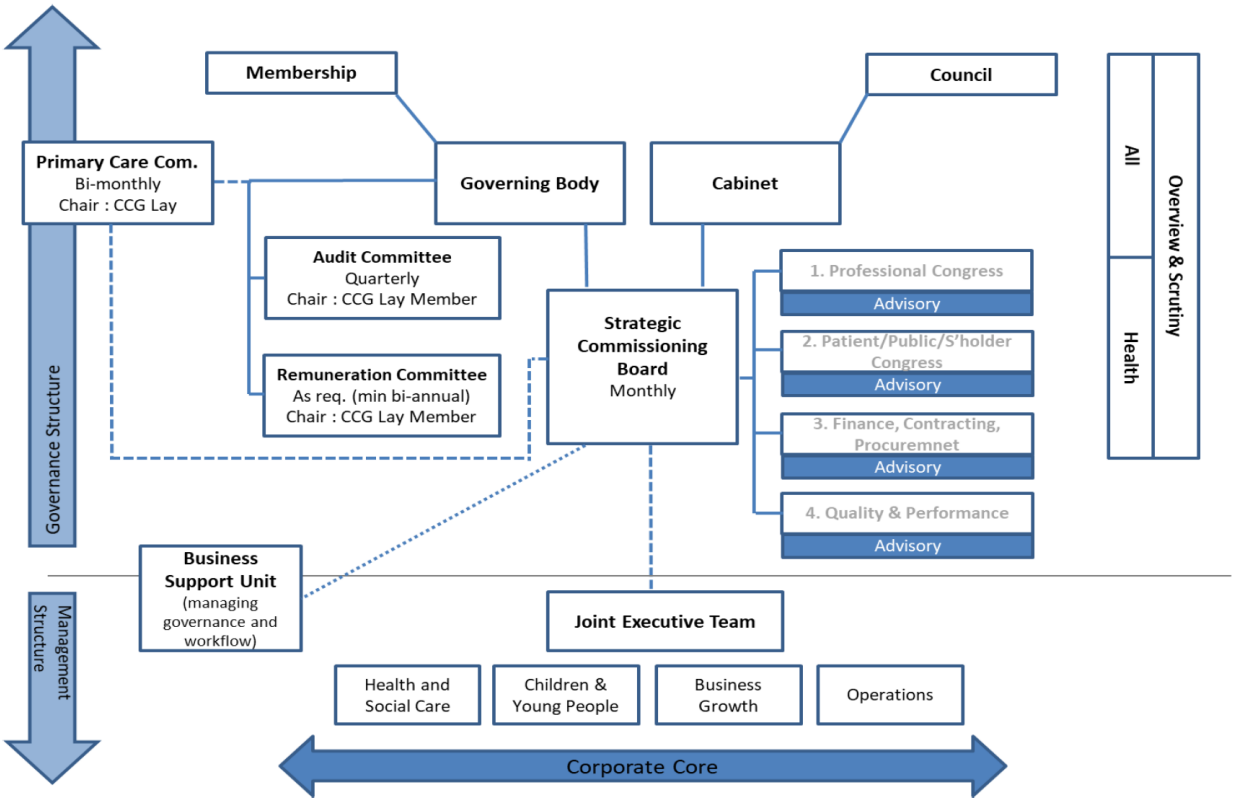
Monitoring Compliance

33. Meetings of the SCB shall be conducted in accordance with the provisions of both bodies Constitutions, Standing Orders, Scheme of Reservation and delegation of the respective partners and the duties delegated.

34. The SCB shall submit an annual report to the Governing Body and Council, incorporating progress, reporting arrangements, frequency of meetings and membership attendance. A summary of which will be included within the respective Governance Statements.

35. A review of effectiveness of the SCB will be undertaken at the end of the first year of operation and at further intervals as agreed appropriate.

36. The Terms of Reference of the SCB will be reviewed at least annually and submitted through the appropriate Governance arrangements for approval.


Membership
Council
Primary Care Com.
Bi-monthly
Chair : CCG Lay
Governing Body
Cabinet
All
Overview & Scrutiny
Health
Audit Committee
Quarterly
Chair : CCG Lay Member
Remuneration Committee
As req. (min bi-annual)
Chair : CCG Lay Member
Strategic Commissioning Board
Monthly
1. Professional Congress
Advisory
2. Patient/Public/S'holder Congress
Advisory
3. Finance, Contracting, Procuremnet
Advisory
4. Quality & Performance
Advisory
Governance Structure
Business Support Unit
(managing governance and workflow)
Management Structure
Joint Executive Team
Health and Social Care
Children & Young People
Business Growth
Operations
Corporate Core