hfma briefing

Contributing to the debate on NHS finance
April 2014

The better care fund

Managing the pooled budget

Foreword

The Healthcare Financial Management Association (HFMA) is the representative body for finance staff in healthcare. With a long and established history, it has a track record in providing independent and objective advice, issuing authoritative guidance, delivering training, and helping to spread best practice in financial management and governance.

Launched through the June 2013 spending round and highlighted as a key element of public service reform, the better care fund is being held up to change the way in which health and local government work together by putting the patient at the centre of decisions about health and social care services. Its success depends on effective working across each local health economy – all organisations are involved in and affected by the decisions made now and in the coming months.

This is an exciting and evolving agenda and while this briefing is not meant to be prescriptive, it provides an overview of why and how the better care fund is being established. It looks at some practical considerations to be taken into account when thinking of what to tackle in the coming months ready for go-live on 1 April 2015. It also looks at the accounting treatment required and some top tips for success.

This is an opportunity to achieve a real advantage to patient care, release potential and deliver benefits through the integration of health and social care and strive to improve value for money by working jointly with local authority colleagues. It is also an opportunity for finance professionals to develop personally and professionally.

The HFMA is active at national and local level in raising the awareness of how NHS finance and governance works, influencing policy development and raising the skill base of those involved in financial management. We support NHS organisations and individuals in improving financial management and governance through periods of challenge and change as the new architecture of the NHS becomes established.

We hope it will be helpful to a wide audience and would be delighted to hear your feedback. We would also welcome any suggestions you may have for ways that we might further support you and the development of clinical commissioning groups in the future.

Dawn Scrafield, chair of the HFMA Commissioning Faculty Technical Group

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COVER PHOTOGRAPH: FOTOLIA

Overview

Launched through the spending round in June 2013 and highlighted as a key element of public service reform, the better care fund (the fund) has a primary aim to 'deliver better services to older and disabled people, keeping them out of hospital and avoiding long hospital stays'[1].

A key theme of the government's announcement was the need to drive better cooperation and collaboration between local public services notably clinical commissioning groups (CCGs) and local authorities.

The better care fund, formerly known as the integration transformation fund, will be set up as a pooled budget. Pooled budgets are a type of partnership arrangement where NHS organisations and local authorities contribute an agreed level of resource into a single pot that is then used to commission or deliver health and social care services. In effect, the resource loses its 'badge' when it is put into the fund and should enable patients to experience a seamless service with a single point of access for their health and social care needs.

As well as delivering more effective services, the fund should also facilitate more efficient services crossing over organisational boundaries. The fund is intended to achieve a number of objectives:

- To deliver better services to older and disabled people who have multiple and complex needs
- To keep people out of hospital
- To avoid people staying in hospital for long periods.

Progress towards improved outcomes in these areas will be measured and performance managed.

This briefing looks at the fund from the following perspectives:

- Its foundations
- The component parts and supporting legislation
- The associated planning and performance framework
- The governance and accountability arrangements
- Accounting for pooled budgets
- Top tips for making the fund work well.

It also aims to pull together the guidance that is currently available and references resources for further reading.

Introduction

Seen as 'a key enabler of change', the better care fund is part of a staged process to focus and increase joint working between the NHS and local government. It is not new or additional money but a high-profile transfer of funds already in the health and social care system into a formal arrangement based on existing legislation.

As a result, this means there is less money available for other health activities and money is already tight. There is pressure for the fund to be spent well and for it to deliver the intended outcomes. At the same time, local authorities are facing significant cuts to their budgets, including those for social care.

In 2013/14, £859m[2] of NHS England's allocation has been transferred to local authorities to be used specifically to support adult social care services that also have a health benefit. Although not new, the money could be used to pay for both existing and new services.

In 2014/15, the NHS funds transferred to local authorities from NHS England's allocation will be increased by £241m, bringing the total amount to £1.1bn (£859m plus £241m). This reflects the policy to prepare for April 2015 (when the fund goes live) through increased contributions in 2014/15 – aimed at ensuring that plans identified for 2015/16 are affordable.

The government's aim is that the fund will have a minimum value of £3.8bn in 2015/16 that will be deployed through pooled budget arrangements. From the NHS point of view, the money will come through CCG allocations from NHS England but must then be transferred into the pooled budget, hosted by either a CCG or a local authority.

In preparation for the formal start date on 1 April 2015, CCGs and local authorities have been told how much of their allocations must be transferred to the fund for 2015/16. By supporting collaborative working between the NHS and local government, it is anticipated that the fund will:

- Have a local emphasis
- Support genuine integration

FOOTNOTES

[1] *Spending round 2013*, HM Treasury, June 2013

[2] *Funding transfer from NHS England to social care – 2013/14*, NHS England, June 2013: www.england.nhs.uk/wp-content/uploads/2013/07/funding-transfer-to-sc-letter.pdf

- Be part of an ongoing process – the pool is likely to grow in the future.

Although the legislation for pooled budgets already exists, the Care Bill 2013 brings into play the necessary legislative changes to make mandatory the sharing of NHS funding with local authorities. Statutory duties are also in place to support integrated working. The policy for the operation of the fund is set jointly by NHS England and the Local Government Association (LGA).

The fund itself

What it comprises

The better care fund is comprised of a number of existing funding streams (all go into the fund, with only the disabilities facilities grant continuing as it currently is):

- ***The disabilities facilities grant*[3] *(£220m)*:** Capital money made available to local authorities as part of their allocations to award grants for changes to a person's home. The amount of any grant paid is dependent on a household's income and savings. There is a statutory duty for local housing authorities to provide grants to those who qualify. Therefore, although officially part of the fund, the money cannot be used for other things and will be paid back out of the fund to local authorities.
- ***The social care capital grant (£134m)*:** Capital funding made available by the Department of Health to local authorities to support investment in adult social care services.
- ***Carers' break funding (£130m)*:** Funding currently included within CCGs' baseline allocations to support breaks for long-term carers. This money is often pooled with local authorities and is sometimes paid out via personal health budgets.
- ***CCG reablement funding (£300m)*:** Funding currently included within CCGs' baselines to support integrated working with local authorities in order to reduce avoidable hospital admissions and facilitate more timely hospital discharges.
- ***Funding already transferred*** by NHS England from health to support social care in 2013/14 and 2014/15 (£1.1bn).

To these funding streams will be added existing NHS revenue funding from allocations to CCGs in 2015/16 (amounting to £1.9bn) to give a total pooled budget of £3.8bn from 1 April 2015.

The creation of the pooled budget will enable existing funds to be deployed differently and in line with the specific purposes of the fund. In most areas, the fund will include a combination of existing services and new investments. It is likely to become the main mechanism for deciding and approving new community-based services.

When CCGs were notified of their allocations for 2015/16, they were also informed of the minimum amount that must be contributed to the fund, with both parties having the freedom to increase the amount pooled. However, any extension of the pooled fund must be by mutual agreement supported by the relevant health and wellbeing board and in line with the joint health and wellbeing strategy[4].

NHS England has encouraged CCGs to 'have ambition' when it comes to considering their plans for the fund and the amount of any additional investment. Most CCGs recognise that over time, the amounts being commissioned through the fund will significantly exceed the stated 'minimum'.

Some areas have already expressed their intention to go further than the minimum; others are moving at a slower pace, recognising the importance of first establishing the necessary relationships with local authority partners.

Distribution

Routed through NHS England, the better care fund will be created via the CCG and local authority allocations for 2015/16. Unlike the resources supporting integration in 2013/14 and 2014/15, these funds will be transferred to the pooled budget by the CCG and local authority and can then be held by either.

The legislation

The better care fund operates within the context of legislation, the key elements of which are set out below.

Section 256 and section 75(2) arrangements (NHS Act 2006)[5] Currently, funds are transferred to local authorities according to section 256 of the NHS Act 2006, whereby payments can be made by NHS bodies to local authorities for the provision of social care that will have a healthcare benefit. In this situation, a grant is made by a CCG to a local authority. No functions are actually transferred. In other words, it is a contribution to support specific local authority services without a delegation of

FOOTNOTES

[3] *Disabled Facilities Grants (England), House of Commons Library,* April 2014: www.parliament.uk/briefing-papers/sn03011.pdf

[4] A Joint health and wellbeing strategy (JHWS) sets out the issues requiring greatest attention by key commissioners (clinical commissioning groups, local authorities and NHS England) and how they will work together to deliver the agreed priorities

[5] www.legislation.gov.uk/ukpga/2006/41/contents

A new duty will be introduced, requiring NHS England to operate the fund in the joint interests of health and social care

health functions. The transfer must also be made on the basis that it will result in a more efficient use of resources.

The arrangements for the better care fund must comply with section 75(2) of the NHS Act 2006. The Act provides for the establishment and maintenance of a fund based on contributions by one or more NHS bodies and one or more local authorities in relation to health related functions. These are functions that have an effect on the health of individuals or are affected by or connected with the functions of an NHS body – see section 75(8).

In practical terms, this means the 'money invested in a pooled budget can only be spent with the agreement of both parties on activities that benefit both health and social care.'[6]

It also means that a CCG and local authority can have as many section 75 agreements in place as are necessary for the effective operation of the fund. So, it is the better care fund that is the pooled budget, not the individual schemes supported by it.

Health and Social Care Act 2012 The Act sets out CCGs' statutory duties, including a duty to promote integration (section 14Z1). Specifically, this duty requires CCGs to ensure 'that the provision of health services is integrated with the provision of health-related services or social care services' where this would improve the quality of health services, reduce inequalities in the way that patients access services or in relation to the outcomes achieved. Section 14Z3 of the Act allows CCGs to work together to jointly commission or operate pooled budgets.

Procurement regulations Although it is for individual CCGs to decide how to best procure healthcare services for the patients registered with their constituent GP practices, it is important to consider the regulatory framework within which they operate in general, the competition regulations in particular and how they might apply to the services commissioned and delivered through the fund.

As sector regulator, Monitor's core role is to 'protect and promote the interests of patients by ensuring that the whole sector works for their benefit'. There are a number of ways that the regulator aims to do this, one of which is to make sure that choice and competition operate in the best interests of patients. To that end, Monitor published its *Substantive guidance on the procurement, patient choice and competition regulations*[7] at the end of 2013.

Within this context, when identifying how the fund is to be used, it is worth considering answers to the following questions:

- What are the benefits for patients? Can they be clearly articulated and evidenced?
- Does the change to services deliver more or less choice for patients?
- Have commissioners complied with all procurement regulations (National Health Services (Procurement, Patient Choice and Competition) (No 2) Regulations 2013)?
- Are assets likely to transfer (in which case a merger may have taken place)?

It is also important to note that the procurement regulations do not apply to local authorities. More information on this topic is available from Monitor's website.

The Care Bill 2013 Currently passing through the parliamentary process, the Care Bill will provide 'a mechanism that will allow the sharing of NHS funding with local authorities to be made mandatory'.

A new duty will be introduced, requiring NHS England to operate the fund in the joint interests of health and social care. It will also enable NHS England's mandate for 2015/16 to include requirements to allocate resources specifically for the fund, assure local plans for how the fund is to be spent and monitor the performance of CCGs in delivering what was planned. The objectives of the fund will be reflected in the mandate for 2015/16, which is likely to be released in November 2014.

The outcome

The fund will operate as a single budget to deliver specific outcomes at a local level. It is a formal arrangement, governed by legislation and, as such, is subject to formal agreement and processes. This influences the services supported, the way in which the fund is used, how use of the fund is reported and accounted for, and the arrangements that must be in place to ensure that taxpayers' money is used wisely and for its intended purpose.

FOOTNOTES

[6] *The Care Bill – better care fund, Factsheet 19*, Department of Health, 2014

[7] www.monitor-nhsft.gov.uk/sites/default/files/publications/SubstantiveGuidanceDec2013_0.pdf

Planning and performance requirements

Planning

During 2013/14, all NHS organisations prepared five-year strategic plans (2014 to 2019), the first two years of which are at a detailed, operational level. The plans contain a number of sections, one of which relates entirely to the better care fund.

CCGs were required to develop plans for the fund jointly with local authorities, such that they are capable of being stand-alone as well as being aligned to their medium and longer term plans.

CCGs have also been required to demonstrate how the necessary funding for the fund will be made available from their allocations – from where the money will be released. The government anticipates that this will largely come from disinvesting in hospital care through changes to existing contracts with acute hospitals.

Although final signed plans must be submitted to NHS England by 4 April 2014, it is likely that plans developed for the fund this year will be refreshed and refined during the planning process for 2015/16. This will provide more time to discuss and consult on local plans across the whole health economy.

National and local conditions

In order to gauge delivery of outcomes against the objectives of the fund, a number of national and local conditions have been attached to it with associated key performance indicators or metrics.

National conditions The importance of local agreement is set down as one of the six national conditions attached to the fund. The remaining five conditions are as follows:

- Protection for social care services
- Providing seven-day services to support patients on discharge and prevent avoidable admissions at weekends – plans for the fund must be aligned with wider plans for delivering seven-day services[8]
- Improving data sharing between health and social care with a patient's NHS number used as the primary identifier
- Ensuring a joint approach to assessments and care planning
- Agreement on the potential impact of changes to services on the acute sector.

Local conditions In addition to the six national conditions, the CCG and the local authority must identify and agree a local condition and underpinning metric against which progress can be measured, the baseline for which must be established in 2014/15.

Payment for performance As an incentive to meet these conditions, part of the fund (£1bn) is linked to performance measured against both national and local key performance indicators. The assessment will consider how well health and social care in a local area work together to, for example, reduce delayed transfers of care. Detailed workings are yet to be confirmed, although it has been announced that for 2015/16, no monies will be withheld for failure to meet performance targets.

Assurance

The plans As with all taxpayers' money, there is a need to be clear about how the fund is spent. Therefore, the plans and the resulting expenditure will be subject to an assurance process.

At the planning stage, this assurance process is led by NHS England and the LGA. Following local agreement and sign-off, plans are sense-checked by NHS England area teams with input from local government regional peer teams[9]. The central team of NHS England will compile a national summary from this information, which will be subject to ministerial review. Feedback will be communicated at both a local and regional level.

The assurance process is likely to focus on how national and local conditions will be met and the metrics in place to provide the necessary evidence. Ministers may be involved if a CCG and the relevant local authority fail to produce and agree an acceptable plan.

Health and wellbeing board Once agreed and signed off by the individual NHS and local authorities involved, fund plans must be agreed and signed by the relevant health and wellbeing board (HWB)[10]. The plans must be identifiable at the individual HWB level, even if they relate to more than one HWB – multiple HWBs can plan together providing the data can be disaggregated and signed off at individual HWB level.

During plan development, CCGs are required to identify and engage with those providers that

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FOOTNOTES

[8] *NHS services seven days a week, NHS England*, April 2014: www.england.nhs.uk/wp-content/uploads/2013/12/brd-dec-13.pdf

[9] A lead peer is designated for each region of England. They lead a peer team comprised of highly experienced officers who work with NHS England to ensure that plans are robust in relation to social care

[10] The Health and Social Care Act 2012 introduced health and wellbeing boards to every upper tier local authority. Established as forums 'where key leaders from the health and care system work together to improve the health and wellbeing of their local population and reduce health inequalities', their role is to join up commissioning across the NHS, social care, public health and other services that are directly related to health and wellbeing in the local area

CASE STUDY: NHS WAKEFIELD CLINICAL COMMISSIONING GROUP

NHS England has stipulated the minimum funding each clinical commissioning group must transfer to the better care fund from 2015/16. But many areas plan to go beyond this. In Wakefield, a significant contribution from the district council adult social care funding will be added to the funds from NHS Wakefield Clinical Commissioning Group.

Helen Childs, the CCG interim programme manager for care closer to home, says the local fund was expected to stand at around £26m. But when the CCG and local authority reviewed the adult health and social care service lines they commission, they realised many of them fell within the scope of the better care fund. With these extra services, the better care budget will rise to £42m. And, while not required by NHS England guidance, the council and CCG are keen to have better care fund-style plans for children and family services.

CCG chief finance officer Andrew Pepper echoes this, saying there are three significant numbers in the Wakefield better care fund plan. The first is the scale of the fund - about £26m. The second is £42m – the amount the local partners committed to the better care fund in the draft submitted in February. The third is yet to be decided. 'The question is where else would pooled resources provide an effective catalyst for change,' he says. 'We have been discussing children's and mental health services as two additional components of the better care fund or using a similar mechanism.'

Mr Pepper says the financial context is important. As NHS England set out in its *Call to action*, by 2020/21 there will be a £30bn gap between NHS allocations and the amount needed to meet demand. Local authorities also face challenging financial settlements. The better care fund can help to deliver efficiencies and better care to patients.

'Transformation and partnership provides the best opportunity to improve quality and respond to the need for efficiency,' he says. 'Our local authority faces significant financial pressure but it has recognised in its budget documents that there are benefits in enhancing community provision and efficiencies to be made from the better care fund. As a CFO, I welcome that. The better care fund is not the only game in town but it's the one that offers the most potential to change outcomes.'
The better care fund is about 'gaps and overlaps', he says. 'We all know there are times where services don't join up properly. But with these gaps there are also overlaps – these are all about efficiency. Are we doing the same thing twice, for example? Addressing components of this can make us more efficient.'

Like many areas, services in the Wakefield plan include general community nursing and specialist nursing services, such as the geriatric service. It differs from most in that some intermediate care provision is included. This service provides added capacity and a link between hospital discharge and home as part of a single care pathway. 'We are asking, "Can we ensure there are fully joined-up services with the right services in the right place at the right time and is this efficient?"', Mr Pepper says.

An efficient equipment store – for wheelchairs, for example – tailored to patients' needs is important and is included in the local better care fund plan. 'Demand has grown year-on-year and it's an integral part of getting people home,' he says.

Equipment and reablement provision are two areas where previous pooling arrangements between NHS commissioners and the local authority have been brought into the better care fund plan. Public health funding is also included 'to promote proactive care and prevention so people are able to look after themselves for longer. We can't do that without public health services', Ms Childs says.

As a result, much of the council's adult social care budget is included. The principal exclusion is spending on residential care home services. The CCG is working with mental health partners to understand how the fund can be enhanced through community mental health provision. Ms Childs hopes it will do so before the final plan is submitted in April – increasing the local better care fund to more than its current £42m. 'It's a moving feast,' she says. 'The national guidance said it would be an iterative process, but it's also something we would want to do anyway.'

The ultimate prize is transforming services being commissioned. Wakefield is looking to involve voluntary and third sector organisations in providing some types of care. Ms Childs says: 'Sometimes statutory providers are not being used in the right way. In low-level social care support, the voluntary sector could be used to keep people healthy and offer a variety of support.'
She points to a scheme with Age UK Wakefield as

"The better care fund is not the only game in town but it's the one that offers the most potential to change outcomes"
Andrew Pepper

an example of a voluntary organisation better placed to perform straightforward but necessary work. The scheme places volunteers in A&E to support patients who are not medically unwell but may be vulnerable if sent home on their own. The volunteers accompany the patient home to make sure they have everything they need, such as ensuring their heating is on and there is food.

As part of the better care fund development, Wakefield is working with local trusts to ensure all parties understand the consequences of moving money away from hospital-based care. 'This has been an enabler for us, not only to explore the principles around joint commissioning but also to see how we are going to work with our providers,' Ms Childs says. 'We know care for patients is evolving rapidly and hospital is not always the right place for people. The better care fund will help us to develop services that wrap around patients in the community and will support a reduced dependence on hospital beds. We need to reduce activity with acute providers to release funds for community and primary care services and we also need a risk and reward mechanism in place so that everyone knows what's happening, can prepare and work together on the plan.'

The impact of the better care fund on providers has been considered openly and planning assumptions across the area have been aligned, Mr Pepper says. 'We have a common currency when we are talking about changes and trying to quantify them. We found measuring emergency bed days worked best for us in health – so when we are talking about the impact of, say, admission avoidance or early support for discharge schemes, commissioners and providers can see the same impact. It works really well as, once you are measuring on a common basis, you can calculate the financial consequences reasonably easily. The important step now is making sure that the currency is equally adaptable within social care.'

The fund is very much a part of the transformation agenda, he adds. 'Partnership was always going to be on the table. The better care fund puts it on a proper statutory footing. It's a step in the right direction, but putting the budgets together isn't going to mean anything to patients unless they can start to see how services have changed. There is a challenge for us in terms of pace and scale.'

Mr Pepper says the Wakefield partnership is enhanced by a local health and wellbeing board that functions well, including providers and commissioners from health, social care and housing, with representatives from other local organisations and the voluntary sector. 'Everyone is signed up to the same vision of the better care fund. You feel there is alignment between commissioners and providers.'

There is concern among CCGs and local authorities over the performance-related element of the fund. In 2015/16, £1bn was to be held back by NHS England and released on achievement of targets during 2014/15 and the first half of 2015/16. But ministers withdrew the potential for financial penalties in the first year of the fund. The £1bn will still be released in two equal amounts, but areas that fail to achieve targets may be subject to external direction to help address the issues.

Mr Pepper says most of the funding is not new money. 'By putting an element of the funding at risk, you are putting existing resources at risk. This is a concern, as you could be investing the money in the right way and, if you find you don't hit the performance metrics, you will not receive an element of the money you thought you would get.'

Given the need to move at pace and at scale, it was right to waive the financial penalties for 2015/16, he says. 'The question is: "Is it appropriate to have them at all?" It's an open question. For us, it could represent between £6m and £10m – that's a large amount of money to potentially have at risk.'

Performance-related funding is one element of the better care fund that remains to be ironed out. But for Wakefield the better care fund – as part of the wider transformational agenda – offers a huge opportunity to improve the quality of care to patients and increase efficiency. Local bodies appear determined to take that chance.

"The better care fund will help us to develop services that wrap around patients in the community and will support a reduced dependence on hospital beds"

Helen Childs

Wakefield CCG is working with local trusts such as Mid Yorkshire Hospitals (below), to raise awareness about moving funds away from hospital care

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might be affected by the creation and use of the Fund and bring the likely impact to the attention of the relevant HWB. The deployment of the fund should reduce demand for other services commissioned by a CCG and in signing off the plans, the HWB is then also recognising the likely consequences of any planned service change.

Expenditure In terms of how the fund is spent, a CCG must assure itself that the money has been spent as intended and for only the designated purposes. This will include whether or not the CCG and local authority have acted in accordance with their statutory powers and not beyond them.

If the local authority holds the pooled budget, appropriate assurance will need to be obtained and considered by the CCG's audit committee.

Governance and accountability arrangements

A signed joint agreement for the fund must be in place by 1 April 2015. This forms the basis of the arrangement and should set out clearly and precisely what the overall aims are, who is responsible for what, and the associated accountability and reporting arrangements. The agreement should be reviewed regularly to ensure that the arrangement remains relevant to local circumstances and that all those involved are working towards the same goals.

Issues that warrant particular consideration when drawing up the agreement include ensuring that:

- There is a common understanding of the fund's aims.
- Statutory responsibilities are understood and will be met.
- There is clarity over what is and is not covered by the arrangement.
- Decision-making responsibilities are clear. This could mean establishing a separate forum of the relevant governing bodies, with delegated powers to take decisions about the fund or agreeing that the governing bodies of each partnering organisation retain all decision rights. Whatever model is adopted, it is important to bear in mind that each partner remains accountable for their share of the pooled funding.
- If partners decide to use a forum, its membership is well balanced and sufficiently broadly based to cover all key interests with clear rules governing its operation – for example, to ensure objectivity in its proceedings and to record and manage any conflicts of interest).
- There is clarity around which organisation manages the budget(s) and who has the power to commit expenditure (including details of approval levels).
- There is accurate and timely reporting of financial and non-financial information.

Early warning systems to identify when matters veer off course are needed, as well as contingency plans to rectify the situation

Assessing risk

Planning guidance requires local areas to agree a shared risk register that 'should include an agreed approach to risk sharing and mitigation covering, as a minimum, the impact on existing NHS and social care delivery'.

It is important, therefore, to think through what may pose a risk to the delivery of the plans for the fund, as well as what would happen if plans fail to achieve their aims. Early warning systems to identify when matters are beginning to veer off course are needed, as well as contingency plans to rectify the situation.

This process of identifying and managing risks (and taking any necessary corrective action) is well established within NHS organisations and underpins each governing body's assurance framework – a document that sets out the organisation's principal objectives and identifies the key risks that could prevent their achievement.

It also identifies:

- Key controls intended to manage these risks
- Arrangements for obtaining assurance on the effectiveness of these controls
- The reliability of the assurances identified and any gaps
- Plans to take corrective action.

A process will also be needed should a recovery plan be required.

It is also important to think through a strategy for dealing with a situation where a partner organisation or one providing a service is subject to formal intervention or is unable to deliver the service. The CCG must ensure all its obligations are met, even if the partner organisation is unable to deliver its part of the service.

Given that the arrangements for the fund involve cross-boundary working and co-operation, partners' governing bodies (and audit committees) need to be alert to the possibility of risks arising at the borders between one organisation and another, particularly if a CCG is party to more than one fund.

This can be exacerbated if the respective roles and responsibilities of the partners are not clearly defined, understood and written down. Although the potential exists for the governance arrangements to be complicated, this is an area that it is important to get right.

Accounting for pooled budgets

The accounting treatment will be determined by the substance of the arrangements in place. In order to establish the right treatment, it may be helpful to ask the following questions:

- Has the funding been transferred to local authorities by NHS England?
- Who is commissioning the service(s)?
- Are several commissioning organisations involved?
- Which organisations are providing resources?
- Who is providing the services?
- Who are parties to the contract?
- Which organisations bear the risk of overspends?
- Which organisations benefit from any cost savings?
- Are staff transferred between organisations?
- Are other assets to be shared or moved between organisations?
- Is a merger involved?

Accounting for funding transfers

For 2013/14 and 2014/15, Department guidance published in December 2012 in relation to a funding transfer from NHS to social care[11] applies.

Accounting for commissioning and lead commissioning

Where a CCG is commissioning healthcare-related services for a local authority using its powers under section 256 of the NHS Act 2006, this will be recorded by the CCG as expenditure in the statement of comprehensive net expenditure.

Where a number of CCGs are working together and one acts as a lead commissioner[12] then the accounting will be on a gross basis. This means that the lead CCG will show the total expenditure with the provider body in its statement of comprehensive net expenditure and the contributions from the other CCGs as miscellaneous income in the same statement.

The other CCGs will show their contributions to the lead CCG as expenditure in their statement of comprehensive net expenditure.

Any balances at the end of the financial year will be accounted for in accordance with the signed agreement. An example is shown in Appendix 1 on page 12.

Accounting for pooled budgets

Usually, in accounting terms, a pooled budget is considered to be a joint arrangement that is not an entity in its own right. Rather, it is a mechanism to allow the signatory bodies to work together. The accounting standards that apply have been revised with standards effective from 1 April 2014:

2013/14	2014/15
IAS 27 *Separate financial statements*	IAS 27 *Separate financial statements as amended in 2011*
IAS 28 *Investments in associates and joint arrangements*	IAS 28 *Investments in associates and joint arrangements*
IAS 31 *Interests in joint ventures*	IFRS 10 *consolidated financial statements*
	IFRS 11 *joint arrangements*
	IFRS 12 *disclosure of involvement with other entities*

The fund is jointly controlled by two or more parties – depending on the number of CCGs and local authorities involved. In terms of IFRS 11, joint control is defined as involving 'the contractually agreed sharing of control'. In practical terms, this means that all parties to the agreement must give unanimous consent to any decisions affecting the fund.

There are two types of joint arrangements:

- A joint venture where the parties have a right to a share of net assets
- A joint operation where the parties have rights to assets and obligations for liabilities that are recognised in the CCG's own accounts.

The fund is most likely to be a jointly controlled operation as there will be no separate legal entity and all parties to the agreement share control. By considering the substance of the transaction

FOOTNOTES

[11] www.gov.uk/government/uploads/system/uploads/attachment_data/file/213223/Funding-transfer-from-the-NHS-to-social-care-in-2013-14.pdf

[12] One party exercises the other party's functions for them

How are local healthcare providers likely to be affected by the plans? Don't assume they will know what is going on

How to make the better care fund work well: top tips

Holding the fund

Working out who will hold the fund is a key decision and involves the consideration of a number of questions[14] depending on whether it is a service to be commissioned or one that is already delivered.

Using the fund

At this stage in the planning of and preparation for the fund, it may be useful to consider answers to the following practical questions:

- Who is best placed to hold the pooled budget: health or local government?
- Which services (new and existing) are to be resourced by the fund? This is an opportunity to review what is provided currently and how things can be better delivered for patients.
- Which staff are involved? Are joint posts appropriate with officers holding contracts with both bodies?
- Could the powers under section 113 of the Local Government Act 1972 (which deals with the supply of staff between CCGs and the local authority through 'deemed officer status') be helpful?
- What is the role of NHS England, particularly in terms of related primary care services in the local health economy? As NHS England commissions primary care services, early discussions with the local area team may be helpful.
- Are the necessary relationships with local authority colleagues already in place or is urgent discussion needed?
- Are other section 75 arrangements already in place? What can be learned from them?
- Which partner is responsible and able to make which decisions and in what circumstances?
- Which powers are to be delegated and how does this affect the prime financial policies and scheme of delegation? What changes must be considered by the audit committee and governing body? How does this fit with national timescales?
- Do the services being considered meet the needs of identifiable cohorts of patients?
- Are QIPP[14] schemes already in place and how are they affected? How are savings to be shared?
- How are local healthcare providers likely to be affected by the plans? Don't assume that they will know what is going on or how their organisations may be affected in the short, medium or longer term. Without a seat on the local health and wellbeing board, chief executives and chief finance officers may not be aware of the decisions pending or made
- What are the 'enablers' that can help the arrangements develop smoothly?

and the nature of the agreement in place, the CCG's rights and obligations can be clarified. This will determine the accounting and reporting treatment. An example is shown in Appendix 2 on page 12.

The Department's *Manual for accounts* currently states that each member body must recognise its share of a pooled budget in its accounts[13]. The share is determined on the basis set out in the signed agreement governing the fund's use. The proportion of the contribution made to the fund is the likely basis for this.

It is for each of the signatories to the pooled budget to decide whether a memorandum account will be included in its statutory accounts as a separate note. The materiality of the contribution to the fund will be a key criterion. If it is included, then it will be subject to further scrutiny by the signatory body's external auditors.

Value added tax

Local authorities and NHS organisations are subject to different funding regimes and value added tax (VAT) treatment. In essence, NHS organisations are treated as government bodies

FOOTNOTES

[13] Paragraph 4.66, *Manual for Accounts 2013/14*, Department of Health, 2014

[14] Paragraph 141, *Pooled budgets: a practical guide for local authorities and the National Health Service,* fully revised second edition, CIPFA, 2009

[15] Quality, innovation, productivity and prevention (QIPP), a programme designed to identify savings that can be reinvested in the health service and improve the quality of care

and therefore cannot recover VAT on services for which they are already recompensed through direct funding arrangements. However, local authorities can reclaim most of the VAT they incur in carrying out their functions.

As partnerships cannot be designed to avoid tax, the host partner's VAT regime applies. VAT recovery is not permitted when a local authority delegates its functions and budgets to an NHS organisation. However, local authorities can recoup all VAT payments incurred in undertaking an NHS organisation's functions and budgets.

Conclusion

The primary consideration for services to be resourced through the fund should be those where it makes sense to commission jointly along a care pathway through a pooled arrangement.

An important role for finance staff is to ensure that the focus is on the patient and the service rather than the money.

Be clear about the functions to be transferred and how the patient pathway is affected – will the patient benefit? Do the proposals deliver more or less choice for patients? Look for genuine opportunities and outcomes and explain the intended benefits to everyone involved. Be practical: think through how the service will work on a day-to-day basis and draw on what is already in place.

Consider how the fund can best be used to achieve better patient care. It is easy to be cynical, as the fund is created from existing funding streams and is not new money, but this is a real opportunity to be innovative.

It is also vitally important to keep both acute and community providers up to date with plans for the fund. It is an opportunity to encourage system-wide planning and service design. This is particularly important where a CCG contributes to and is involved in plans for more than one fund.

Finally, consider the money available – but don't let the numbers dictate how services should be designed and delivered. ■

Don't let the numbers dictate how services should be designed and delivered

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Appendices

APPENDIX 1: LEAD COMMISSIONER ARRANGEMENTS

A group of three CCGs has agreed that CCG A will commission healthcare-related services from local authority X on their behalf. CCG A's budget for these services is £2m, CCG B's is £1.5m and CCG C's is £2.5m.

CCG A contracts for £6m with local authority X (LA X) for the patients who form part of all three CCGs' areas. At the end of the year, payments under the contract total £6.5m. Cash payments have been made in accordance with the budget. Based on the contract monitoring information, the volume of patient activity can be identified as follows:

- Patients in CCG A's population: £2.2m (a difference of £0.2m)
- Patients in CCG B's population: £1.9m (a difference of £0.4m)
- Patients in CCG C's population: £2.4m (a difference of £0.1m).

The year end balances are recorded as follows:

CCG A	CCG B	CCG C
Payable of £0.2m with LA X Receivable of £0.4m with CCG B Payable of £0.1m with CCG C	Payable of £0.4m with CCG A	Receivable of £0.1m with CCG A

APPENDIX 2: ACCOUNTING FOR A POOLED BUDGET

CCGs A, B and C enter into a pooled budget arrangement with local authority X. An agreement is put in place which says that the pooled budget will be hosted by CCG A. The parties to the agreement decide that they will contribute the following resources to the pooled budget:

- CCG A: £2m, which they have transferred to the pooled budget in full
- CCA B: £1.5m – they have paid £1.8m into the pooled budget in the year
- CCG C: £2.5m, which they have transferred to the pooled budget in full
- Local authority X: £1m, of which they have paid more than £0.8m

The budget will be used to commission healthcare-related services from local authority X and community trust Y. Contracts are placed for £5m with local authority X and £2m with community trust Y.

The actual spend on the contracts is £5.5m with local authority X and £1.8m with community trust Y. Both provider bodies have been paid the contracted amount at the year-end.

The agreement states that any overspends or underspends will be split between the signatories in the same proportion as the numbers of individuals treated for whom they are responsible.

At the end of the year, the individuals treated are identified as the responsibility of each member of the pool in the following proportions:

- CCG A: 29%
- CCG B: 21%
- CCG C: 36%
- LA X: 14%

The pooled budget memorandum account will be as follows:

	Memorandum account (£000)
Income	7,000
Expenditure	7,300
Surplus/(deficit) to be shared across parties to the pooled budget	(300)
Total spend	7,000
Surplus/(deficit)	**0**

The deficit on the fund was apportioned between the members of the pool in the same proportion as the numbers of people treated for whom they were responsible.
The CCGs' accounts will look as follows:

	CCG A accounts (£000)	CCG B accounts (£000)	CCG C accounts (£000)
Expenditure – original contribution	(2,000)	(1,500)	(2,500)
Share of surplus/(deficit)	(86)	(64)	(107)
Total spend	**(2,086)**	**(1,564)**	**(2,607)**
Cash	(2,000)	(1,800)	(2,500)
Receivables		236	
Payables	(86)		(107)
Cumulative surplus/(deficit)	**(2,086)**	**(1,564)**	**(2,607)**

Note: the statement of financial position entries show the movement in these balances in the year, as it is assumed that the bodies start with a zero opening balance.

GUIDANCE AND FURTHER READING

- *Strategic and operational planning 2014 to 2019*, NHS England: www.england.nhs.uk/ourwork/sop/

- *NHS England – better care fund planning*: www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/

- *Local Government Association – better care fund guidance*: www.local.gov.uk/web/guest/health-wellbeing-and-adult-social-care/-/journal_content/56/10180/4096799/ARTICLE

- *Substantive guidance on the procurement, patient choice and competition regulations*, Monitor, 2013: www.monitor-nhsft.gov.uk/sites/default/files/publications/SubstantiveGuidanceDec2013_0.pdf

- *CIPFA introductory guide for clinical commissioning groups: pooling budgets and integrated care*, June 2011

- *Pooled budgets: a practical guide for local authorities and the National Health Service,* fully revised second edition, CIPFA, 2009

- *Clarifying joint financing arrangements*, Audit Commission, 2008: archive.audit-commission.gov.uk/auditcommission/sitecollectiondocuments/AuditCommissionReports/NationalStudies/ClarifyingJointFinancing4Dec08REP.pdf

- *Means to an end*, Audit Commission, 2009: http://archive.audit-commission.gov.uk/auditcommission/sitecollectiondocuments/AuditCommissionReports/NationalStudies/meanstoanend291009repv2.pdf

- *S75 NHS Act 2006 partnership agreements, Commissioning Support Programme*, July 2010: www.commissioningsupport.org.uk/pdf/20_Partnership_and_pooled_budgets.pdf

- *Partnership working in the NHS*, HFMA, May 2013: www.hfma.org.uk

- *Procurement regulations, Monitor, 2013*: www.monitor.gov.uk/s75

Appendices

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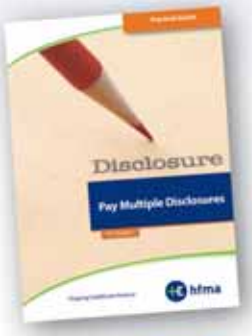

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