Pooled budgets and the better care fund - update

February 2015

Introduction

The better care fund (the fund) was launched through the Spending Round in June 2013 with a primary aim to '…drive closer integration and improve outcomes for patients and service users and carers'[1]. The fund will 'go live' on 1 April 2015.

Background

Almost as soon as it was launched, the fund was the subject of discussion at the HFMA's Commissioning Technical Issues Group (Commissioning TIG) and the Accounting and Standards Committee. During 2014, the HFMA released three publications in relation to the fund as follows:

1. Managing the pooled budget (member briefing, March 2014)
2. Realising the benefits (member briefing, July 2014)
3. Pooled budgets and the better care fund (guidance for finance staff, October 2014) [2].

The third publication was produced in association with CIPFA as a result of both the HFMA and CIPFA joining NHS England's better care fund finance working group. This publication has resulted in the HFMA being asked to present at a number of workshops:

- Workshop sessions at the HFMA's pre accounts planning conferences (21, 26, 27 January)
- CIPFA in the North/HFMA's Northern Branch health and social care workshop (22 January)
- CIPFA workshops on the better care fund (24, 25 February)
- HFMA webinar on the accounting and assurance arrangements for the better care fund (17 March).

This briefing provides an update to the October publication and draws on the information we have gathered at these workshops. Developments in relation to the fund are on-going and fast moving as we move towards the implementation date.

Summary of the National Position

The planning guidance for 2014/15[3] required that each fund should be supported by a detailed plan to be approved by the local health and wellbeing board (HWB). These plans had to be signed off and submitted to NHS England by 4 April 2014. NHS England undertook an initial review of the plans and as a result, issued additional guidance[4] that required re-submission of all plans by 19 September 2014.

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[1] NHS England Publications Gateway Ref No. 01977, July 2014
[2] hfma.to/pooledbudgetsandthebcfguidance
[3] www.england.nhs.uk/ourwork/forward-view/sop/
[4] www.local.gov.uk/documents/10180/6391705/Better+Care+Fund+-+Revised+Planning+Guidance.pdf/d58c0de0-c283-46f8-adfb-2628e6273b37

The re-submitted plans were again reviewed and were categorised as follows:

Status	Phase 1 October 2014	Wave 1 December 2014	Wave 2 January 2015	Wave 3 February 2015
Approved	6	99	120	147
Approved with support	91	6	4	3
Approved with conditions	48	40	21	0
Not approved	5	5	5	0

[Source: Summary of better care fund powerpoint[5] dated Feb 2015]

Those plans requiring additional work were resubmitted by the 9 January 2015. All plans have now been approved.

Frequently Asked Questions

Since the publication of the guidance in October 2014, we have continued to hold conversations with members and the national bodies[6] about the fund. It is clear that the finance community has questions about the fund, in particular the detailed accounting and assurance arrangements.

This paper summarises those questions and, where possible, provides answers *where this is possible*. However, all questions are raised here (including those without immediate answers) as they are questions which in our view, the bodies involved with the fund should be considering already.

It should be noted that this briefing has been written before the publication of:

- NHS England's operationalisation guidance that is expected to add detail to the existing planning framework and
- The Department's guidance on accounting for pooled budgets.

Those publications will take precedence over this briefing once they are issued.

While every care had been taken in the preparation of this guidance, the HFMA cannot in any circumstances accept responsibility for errors or omissions, and are not responsible for any loss occasioned to any person or organisation acting or refraining from action as a result of any material in it. It is each NHS organisation's responsibility to determine the appropriate accounting treatment based on their circumstances and to agree that accounting treatment with their auditors.

The section 75 agreement

Can our section 75 agreement include aligned commissioning or lead commissioning as well as a pooled budget?

Section 121 of the Care Act 2014 inserts section 223GA into the NHS Act 2006. This section basically requires that any amounts which are designated by NHS England's mandate[7] as having service integration objectives should be pooled under s75(2)(a). The better care fund is specified by the mandate as having service integration objectives and therefore should be set up as a pooled fund.

[5] www.local.gov.uk/web/guest/health-wellbeing-and-adult-social-care/-/journal_content/56/10180/4096799/ARTICLE
[6] Department of Health; NHS England; the Audit Commission; the National Audit Office
[7] www.gov.uk/government/uploads/system/uploads/attachment_data/file/386221/NHS_England_Mandate.pdf

Section 75(2)(a) requires:

"….. the establishment and maintenance of a fund:

1. Which is made up of contributions by one or more NHS bodies and one or more local authorities
2. Out of which payments may be made towards expenditure incurred in the exercise of both prescribed functions of the NHS body or bodies and prescribed health-related functions of the authority or authorities."

NHS England requires the *minimum* contribution to the better care fund to be formerly pooled under a section 75 agreement; amounts contributed above this minimum may be subject to other local arrangements.

Taking this guidance together, it is our view that the fund must be managed via a pooled budget rather than other arrangements such as aligned or lead commissioning (see box below for more details).

Our expectation is that a pooled budget will involve members of the arrangement putting resources into a single pot which will be used to fulfil the objectives of the pool. The labels 'NHS' or 'local authority' resource or funding will be lost.

Our expectation of an aligned commissioning arrangement is that all bodies retain control over their commissioning arrangements but work together at a strategic level to ensure that their overall aims are aligned.

In a lead commissioning arrangement, one partner undertakes the commissioning for a number of bodies. Whilst the strategic objectives will be set together the lead commissioning body does the day to day contract management to achieve those objectives. We would expect that the lead commissioner would usually bear the risks of commissioning but will also benefit from any rewards of commissioning. In accounting terms, a lead commissioner would take the role of principal rather than agent.

It is possible for any of these arrangements to exist on their own or together. Therefore, a lead commissioning arrangement can be part of a pooled budget.

In December 2014, the HFMA surveyed its members to better understand whether all better care fund arrangements were going to meet this requirement. The results of the survey can be found on the HFMA's website[8].

Does the section 75 agreement need to be signed by 31 March 2015?

Yes, our understanding is that it does.

What are the consequences if it is not signed?

Under section 223G of the NHS Act 2006 (as amended most recently by the Care Act 2014), NHS England has the power to set conditions around the payment of funds to CCGs; this includes the condition to have a local jointly agreed plan. Where a condition is not met,

[8] www.hfma.org.uk/publications-and-guidance/publications.htm?sort=3&keyword=&categories=info_8

section 223GA of the NHS Act 2006 (as amended most recently by the Care Act 2014) enables NHS England to:

- Withhold the payment (insofar as it has not been made) and use it for purposes relating to service integration or for making payments under section 256 of the 2006 Act
- Recover the payment (insofar as it has been made) and use it for purposes relating to service integration or for making payments under section 256 of the 2006 Act
- Direct the CCG(s) as to the use of the designated amount for purposes relating to service integration or for making payments under section 256 of the 2006 Act.

CCG auditors are required to sign a regularity opinion as part of their opinion on the accounts. The regularity opinion states that in all material respects the expenditure and income have been applied to the purposes intended by parliament and the financial transactions conform to the authorities which govern them. Auditors may need to consider whether they should take any action in relation to their regularity opinion if the section 75 agreement is *not* signed before the fund becomes operational. A qualified regularity opinion would result in the auditor making a referral to the Secretary of State in accordance with section 19 of the Audit Commission Act 1998[9]. Auditors might consider whether there are any value for money implications of an unsigned section 75 agreement.

The accounting

How should our contribution to the fund be accounted for?

The general assumption is that pooled funds under section 75 will be joint operations as defined by IFRS 11. But this assumption needs to be tested in a two stage process.

Firstly, whether the fund is a joint arrangement under IFRS 11 needs to be considered. IFRS 11 defines a joint arrangement as follows:

- An arrangement of which 2 or more parties have joint control:
- The contractually agreed sharing of control of an arrangement, which exists only when decisions about the relevant activities require the unanimous consent of the parties sharing control.

Once it has been determined that there is a joint arrangement, the second part of the process is to identify what type of joint arrangement it is. The standard defines two types of joint arrangement – joint ventures and joint operations. The legislative requirements around pooled budgets mean that it will be a joint operation as long as the IFRS 11 tests for a joint arrangement are met.

The Department will be issuing detailed guidance which will set out the accounting principles which bodies need to consider.

At this stage, we think that the considerations to determine whether the fund is a joint operation include:

- Do any elements of the fund fall outside of any joint operations? This would be where joint control does not exist due to the restrictions on what the elements can be spent on (for example, the capital grants)

- What are the relevant activities covered by the fund? IFRS 11 focuses on how those activities are managed so it is important to understand what activities the fund covers and therefore what activities are included in the joint operation

[9] To be replaced by section 30 of the Local Audit and Accountability Act 2014

- Where does the decision making authority lie and who is making the key decisions about those activities? Can any one party over-ride the decisions of other parties to the fund? Or do all parties need to agree? This will be part of the IFRS 11 consideration. Consideration should be given to whether the membership of the health wellbeing board (HWB) affects the control. Also, to the delegation of decision making responsibility. Are members of the fund acting as agents and simply passing payments through the pool or as principals which involves taking an element of risk? This assessment is key and the Department are working with NHS England to define control in the context of the fund
- What are the key decisions? It may be that this is not the decision about the detail in the contract or even the management of the contract. It may be that the key decision is the decision to enter into a contract with a particular body for specified services.

If the decision about who to contract with and for what services is critical to managing the relevant activities and all members have to agree then it may be that there is a joint operation even though the contracting is done by one party to the pool. However, if the decisions about who to contract with and the services to commission are made by one member of the pool (who are taking risks and rewards) then it may be that the arrangement is not a joint operation.

If there is a joint operation in place then the question is how is each party's share identified of the assets, liabilities, income and expenditure? Is this based on the contracts which are in place or the share of contributions as set out in the section 75 agreement? If the arrangement is critical to determining that there is a joint operation in place then, logically, it is key to determining the share of assets, liabilities, income and expenditure – it sets out the substance of the transaction (the contracting arrangements are simply a practical mechanism for moving cash around).

As a CCG, we are contributing 91% of the funding to the better care fund. Does the proportion of contribution to the pooled budget influence the right of control for accounting purposes?

If a CCG is putting in 91% of the funding then it may be logical for the CCG to host the pool. If nothing else, the pool is likely to be material to the CCG and may not be to the local authority. However, the level of contribution has no bearing on the 'right of control' and the tests as set out in IFRS 11 must be applied. The section 75 agreement should provide the answers to these tests, as it sets out the way the fund will be managed.

What disclosures will I have to make in my 2014/15 accounts?

As the fund 'goes live' on 1 April 2015, it is unlikely to be an event after the reporting period (IAS 10). However, given the focus on the fund, it may be appropriate to include reference to it in the annual report including the assurance arrangements put in place during the year.

How will over/underspends on the fund be accounted for? How can I make sure there are no last minute surprises?

This will follow the section 75 agreement in terms of the sharing of assets and liabilities at the year end. Last minute surprises can be avoided by good in-year reporting and regular communication.

CCGs need to be very aware of their cash position. Where the local authority is the host body but the CCG is the major contributor to the fund, the CCG may need to make payments into the fund ahead of the authority paying for services. CCGs must ensure that they are not

drawing down cash in advance of need[10] so payments must only be made into the pool once it is known that the host body is going to be making payments from the pool. Historically, auditors have qualified regularity opinions in the NHS where cash has been drawn down in advance of need. A qualified regularity opinion will result in a referral to the Secretary of State for Health as the transaction will be viewed as unlawful.

Under IFRS 11 where there is a joint operation, the CCG will account for its own share of any assets. Therefore, cash paid into the pool will continue to be the CCG's cash until it is paid out of the pool on services provided. Accurate reporting will be especially important at the year end when NHS England is managing the out-turn position against the year-end cash limit.

How will differing timescales to close CCG and LA accounts impact on accounting for the fund and appropriate disclosures?

It is impossible to tell what the impact might be. However, CCGs are required to submit their final accounts to NHS England on 29 May 2015 for 2014/15. It is expected that the timetable will be about the same in 2016. Local authorities are required to close their accounts by the end of July[11].

Where the local authority is the host body, the agreement must include deadlines for the provision of information to allow the CCG to meet its reporting deadline.

Agreement of balances

Should the pool host notify each party to the pool of its year end position?

Yes. This is essential and should also be done on a quarterly basis (monthly if possible).

Should the host tell NHS providers how the money paid over to them is split between each contributor?

Yes. This is essential to ensure that all parties can agree on the transactions and balances. It should also be done on a quarterly basis (monthly if possible).

This is another area that the Department and NHS England are currently considering. In the meantime, all parties should keep as much information relating to the fund as possible.

Audit/ assurance

How can we best involve our external auditors at this point?

This will depend on the working relationship with your auditors. It is not for the auditors to work out how the arrangement should be accounted for.

However, they will usually be happy to discuss your conclusions on accounting at an early stage and the better care fund should be part of the discussions for audit planning.

In order to reach your own conclusions on accounting for the fund, you will need to have read the section 75 agreement as well as any supporting contracts. You should also consider the cash flows for the fund. This information should allow you to reach an initial conclusion on the accounting treatment as you answer the questions set out above.

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[10] See paragraphs A4,8.5 and onwards in HM Treasury's Managing Public Money www.gov.uk/government/uploads/system/uploads/attachment_data/file/212123/Managing_Public_Money_AA_v2_-_chapters_annex_web.pdf

[11] www.legislation.gov.uk/uksi/2015/234/contents/made

It is likely that your auditors will want to see the same documentation as you in order to reach their own conclusions. However, it will be worth discussing the fund with them at an early stage to understand their expectations.

How do we work out who needs what assurance? How do we work out where the assurance is coming from or what we need to have in place?

This will depend on the local arrangements in place. However, the fund does not override any statutory duties of its member bodies. Therefore, each body will need to prepare its own accounts so if information in those accounts is produced by another body then assurance will be required. Also, each body will need to prepare a governance statement so assurance over the fund's controls will be required.

When do we need assurances from third parties? What do we do if it not forthcoming?

Assurance is not simply a year end requirement. During the year, the fund will be on the agenda of the HWB; we expect that it will be on the agenda of most governing body meetings as well.

Therefore, where third parties are hosting the fund, information and assurances over the way that the money paid into the fund has been spent and performance against budgets will be essential. This assurance may come from the third party, their internal auditor or it may be that external assurance is required. This should be discussed and agreed as the operational plans are put in place.

In the worst case scenario, if information or assurance is not forthcoming at the end of the financial year, the accounts submission could be delayed with consequences for the preparation of consolidated accounts by NHS England and the Department. If assurance cannot be obtained then the auditors could qualify the accounts or the regularity opinion. However, it is more likely that they would wait until the assurance or information was available.

Will all CCG auditors need to agree so that a national approach is taken? Is this possible?

The Audit Commission and National Audit Office are discussing this issue with local auditors. However, as each fund is different, each auditor will need to assess the arrangements in place locally and act on that basis.

Operational arrangements

Is there any reason why a CCG can't be the host for the pooled budget?

There is no reason in the legislation why the CCG can't host the pooled budget. The decision as to which body should host should be made on operational grounds alone.

Are the VAT advantages materially better if the local authority hosts rather than the CCG?

The host should be determined on operational grounds in the interest of the patient/ service user rather than to gain a VAT advantage.

There is very little guidance available on the VAT implications of hosting. However, as we understand it, local authorities are able to reclaim most of the VAT they incur whereas NHS bodies can only reclaim a limited amount of VAT in accordance with the contracted out services rules. However if the care being provided forms part of a personal care budget or goods are for the sole personal use of an individual then recovery by the local authority may be blocked as the supply is deemed to be to the end-user.

We understand that the VAT guidance[12] published when pooled budgets were launched under section 31 of the Health Act 1999 is still extant. Collectively, make the decision that makes most operational sense and then work out the practicalities. VAT could be an issue when the fund is used to purchase equipment.

The VAT implications of all arrangements need to be carefully considered to ensure that the contracts reflect what is actually being done.

HMRC is currently reviewing their guidance on the fund with the Department of Health.

Surely, the CCG should contract with NHS providers and the local authority with social care providers?

Again, this decision has to be made on operational grounds. It may be that NHS providers prefer to work with CCG commissioners as they know each other and understand the NHS contract. Equally, social care providers will be used to working with local authorities. However, it may be agreed that the host of the fund should enter into all of the contracts or that all contracts should be jointly signed.

The contracting arrangements may need to be considered when determining the accounting arrangements but it is the decision making process which is the key determinant under IFRS 11. Therefore, the arrangement will need to be considered in its entirety (from the section 75 agreement and the composition of the HWB to the contracting arrangements) when looking at the accounting treatment.

I'm an NHS provider; my only concern is that my income will go down as a result of the planned reduction in emergency admissions.

This may be a valid concern. It is critical to understand the nature of the local agreements made and how your organisation may be affected. It should be noted that provider bodies themselves can be parties to a section 75 agreement. If this is the case, you will need to understand exactly what you have signed up to and what the impact might be on your financial position.

The fund isn't material to me so I don't need to worry about it, do I?

Yes you do. Each organisation retains its statutory responsibilities in relation to the use of public monies including its contribution to the fund. The accountable officer will be required to sign the accounts for 2015/16 including the governance statement which will require knowledge and understanding of how the better care fund was used and the arrangements put in place to ensure that the organisation's objectives are achieved. This will include those of the fund.

My non-executive directors (NEDs)/ lay members are not interested in the fund – should they be?

Absolutely! Those charged with governance (normally the audit committee) play a key role and need to be involved. Discuss matters with them from the start of the year. NEDs/ lay members should be looking for evidence that their organisation is 'on top' of matters and the overall position with regard to the fund and equally that matters have been escalated if things are not going to plan. The role of the audit committee is:

- To take a view of the system of integrated governance, risk management and internal control

[12] Follow this link: http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4076384 , click on download the guidance and select view the item in the UK Government Archive

- To consider performance based on accurate information
- To consider if the information can be relied on
- To consider the implications for the achievement of the fund’s objectives
- To consider how to best use internal and external sources of assurance to determine if things are working as they should.

The fund should also feature in the board assurance framework as well as any key risks and mitigations.

Outstanding Questions February 2015

Audit/ assurance

1. How do we work out where the assurance is coming from or what we need to have in place?
2. What will the effect on the value for money conclusion be? Both the 2014/15 conclusion and the 2015/16? If our arrangements are not in place by 31 March 2015, will this affect this year's value for money conclusion?

Other

1. Are there any issues relating to the operation of ISFE that are still outstanding? Are cost centres/ codes appropriately set up?
2. What, if anything, needs to be included about the fund in the 2014/15 governance statement? What will the 2015/16 statement include?
3. Will NHS England require CCGs to disclose the amount of their allocation which was earmarked for the fund and the amount actually spent on the fund as well as any money which was given as a result of meeting performance measures and how much had to be diverted to spend on emergency admissions?
4. If the CCG hosts, are the costs of hosting the pool a programme or admin cost? Presumably, spend into the pool is programme?