Public Document Pack

Adult Care and Health Overview and Scrutiny Committee

Date:	**Tuesday, 27 November 2018**
Time:	**4.00 p.m.**
Venue:	Committee Room 1 - Wallasey Town Hall

This meeting will be webcast at
https://wirral.public-i.tv/core/portal/home

Contact Officer: Patrick Sebastian
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AGENDA

1. APOLOGIES FOR ABSENCE

2. MEMBERS' CODE OF CONDUCT - DECLARATIONS OF INTEREST

Members are asked to consider whether they have any disclosable pecuniary interests and/or any other relevant interest in connection with any item(s) on this agenda and, if so, to declare them and state the nature of the interest.

Members are reminded that they should also declare whether they are subject to a party whip in connection with any item(s) to be considered and, if so, to declare it and state the nature of the whipping arrangement.

3. CALLED-IN BUSINESS - WIRRAL HEALTH AND CARE COMMISSIONING POOLED FUND ARRANGEMENTS

(Pages 1 - 170)

To consider the decision taken by the Joint Strategic Commissioning Board (Cabinet Committee) on 16 October, 2018 relating to 'Wirral Health and Care Commissioning Pooled Fund Arrangements' which has been called-in in accordance with Council Procedure Rule / Standing Order 35.

The following papers are attached:

- Call-in meeting procedure;
- The Call-in Notice;
- Minute Extract – JSCB, 16 October, 2018;
- The report considered by the decision maker.

Audio/Visual Recording of Meetings

Everyone is welcome to record meetings of the Council and its Committees using non-disruptive methods. For particular meetings we may identify a 'designated area' for you to record from. If you have any questions about this please contact Committee and Civic Services (members of the press please contact the Press Office). Please note that the Chair of the meeting has the discretion to halt any recording for a number of reasons, including disruption caused by the filming or the nature of the business being conducted.

Persons making recordings are requested not to put undue restrictions on the material produced so that it can be reused and edited by all local people and organisations on a non-commercial basis.

CALL IN PROCEDURE

Chair's opening remarks (5 minutes)
The Chair will open the special Committee meeting convened to consider the Call-In and set out the procedure as follows:

Explanation of the call in by the lead signatory (5 minutes)
The Chair will invite the lead signatory to set out the reasons for the Call-In.
Members of the Committee will be invited to ask the lead signatory questions.

Overview and explanation of the decision taken by the relevant Cabinet Member (5 minutes)
The Chair will invite the Cabinet Member to explain the reasons for the decision.
Members of the Committee will be invited to ask the Cabinet Member questions.

Evidence from call in witnesses
The Chair will invite the following witnesses to come forward. Witnesses may read out a written statement (not to exceed 5 minutes) if they wish, prior to questions from Members of the Committee. (Running order of witnesses – List of witnesses to be confirmed)

Evidence from decision-taker's witnesses
The Chair will invite the following witnesses to come forward. Witnesses may read out a written statement if they wish (not to exceed 5 minutes), prior to questions from Members of the Committee. (Running order of witnesses – List of witnesses to be confirmed)

Summary of the lead signatory (5 minutes)
The Chair will invite the lead signatory to summarise the key points of evidence given in support of their case.

Summary of the decision-taker (5 minutes)
The Chair will invite the decision-taker to summarise the key points of evidence given in support of the initial decision.

Committee Debate
The Chair will invite comments, observations and discussion from members of the Committee.

Committee Decision
The Committee having considered the evidence and debate may:-

- Refer the decision back to the Cabinet Member setting out in writing the nature of its concerns.

- Refer the matter to the Council. Such a referral should only be made where the Overview and Scrutiny believes that the decision is outside the policy framework or contrary to or not wholly in accordance with the budget. The procedures set out in those rules must be followed prior to any such referral.

- Uphold the decision - If the Overview and Scrutiny Committee agrees with the initial decision the relevant Senior Officer may implement it without delay.

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Elected Members - CALL IN SCHEDULE

We hereby give notice that we wish to Call-In the Joint Strategic Board decision dated 16th October 2018 to approve/sign the contract between Wirral Borough Council and NHS Wirral Clinical Commissioning Group in relation to Wirral Health and Care Commissioning Pooled Fund Arrangements and specifically the Framework partnership agreement relating to the commissioning of Health and Social Care Services.

We wish for this to be called in to both Adult Care and Health Overview and Scrutiny Committee and Children and Families Overview and Scrutiny Committee separately as it involves pooling budgets from both of the above committees.

Call in deadline: 5th November 2018
Submitted: 5th November 2018

Reason(s) for Call In:

1. The contract has been signed with very limited opportunity for Members to consider the scope and extent of this contract.

2. Members have not had sufficient opportunity to explore the scope and specification of this contract and to perform the in-depth scrutiny that is expected of members.

3. Members need to be satisfied that the public consultations that have been alluded to have been adequate and that there is the correct balance in the partnership between the council and CCG.

4. The PWC report commissioned to assess risks and mitigation was not scrutinised by Adult and Social Care Scrutiny and was out of date when eventually made available to Members, thus we need to be satisfied that the mitigated risks within the report have been scrutinised thoroughly by Members.

5. Members also have to be able to scrutinise the explanations as to why pooling local authority funding with that of the CCG is in the best interests of Wirral residents

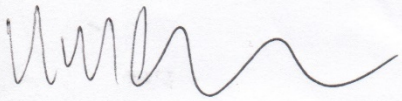
6. Members need to be able to scrutinise the arrangements for meeting the statutory requirements in relation to Adult social care.

7. Members also need to be able to scrutinise the impact of the Framework Partnership Agreement on the democratic accountability of the Council.

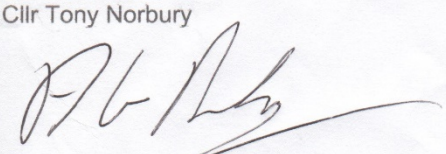
This has been called in by Cllr Tony Norbury, Cllr Kate Cannon, Cllr Jo Bird, Cllr Joe Walsh, Cllr C Muspratt, Cllr T Smith. [Signatures below]

Called in by:

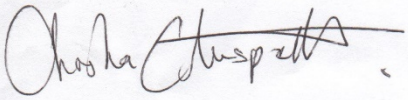
Cllr Kate Cannon



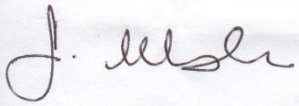
Cllr Tony Norbury



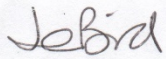
Cllr Christina Muspratt



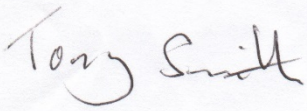
Cllr Joe Walsh



Cllr Jo Bird



Cllr Tony Smith.



MINUTE EXTRACT
JOINT STRATEGIC COMMISSIONING BOARD
16 OCTOBER 2018

22 **WIRRAL HEALTH AND CARE COMMISSIONING POOLED FUND ARRANGEMENTS**

Graham Hodkinson, Director for Adult Care and Health, introduced a report on Wirral Health and Care Commissioning Pooled Funding Arrangements. The report was about the joining up of services to enable people to navigate what was a very complicated system; so that people told their stories only once, potential delays were reduced and people didn't get lost in the system.

Wirral Health and Care Commissioning (WHaCC) had been in operation since May 2018. This was the contemporary name for the Integrated Commissioning Hub referred to in reports dated before May 2018. WHaCC was a formal strategic partnership created on behalf of Wirral Council and Wirral CCG. The partnership was created following agreement to progress into a formal partnership by Wirral Council Cabinet in November 2017 (minute 62 (27/11/17) refers) and NHS Wirral CCG's Governing Body in December 2017.

This report presented the detail of how the agreement to create a single care and health commissioner for Wirral had been taken forward in terms of financial governance and decision making. The Section 75 pooled fund agreement (Appendix 3 to the report) set out the budget areas that were being pooled in 2018. It also referred to a shadow pool which referred to budgets that were not being pooled in 2018, in order to minimise exposure to financial risk. Financial and governance arrangements were included within the Section 75 agreement.

Importantly the key risks and mitigations had been considered and responded to by WHaCC in setting up pooled fund and financial governance arrangements.

He acknowledged that concerns had been expressed from a number of sources and further scrutiny of the risks as well as the benefits would need to happen before any further pooling was considered. The Board were being asked to agree to the pooled arrangements for 2018/19 only after which he proposed that there would be a pause whilst further scrutiny took place on any proposed expansion of the pooled fund.

In September 2017 a due diligence exercise was undertaken by Price Waterhouse Cooper (PWC). The report illustrated the benefits of integrated commissioning and set out their view of potential risks and mitigations on behalf of Wirral Council and Wirral CCG. The report was considered in advance of the decision to create WHaCC, but had not previously been in the public domain. At this stage the report could be read in conjunction with the arrangements that had been put in place to respond to the highlighted risks. He stated that some of the language used in the PWC report in relation to 'accountable care organisations and accountable care systems' was something which had not been adopted in Wirral. Wirral's focus was on integrated care, collaboration and NHS providers working together and was not on the creation of an Accountable Care Organisation.

Mike Treharne, Chief Financial Officer, Wirral NHS CCG then spoke to the report and expanded further on some of its details. He referred to the key risks and mitigations appendix in the report and stated that the risks were well mitigated against. He elaborated further on the financial implications with £129.9m going into the pooled funding for 2018/19 and the need for a more sophisticated risk share arrangement to be developed for future years if additional areas were to be added to the pooled fund.

The Chair then invited questions and comments.

Councillor Bernie Mooney stated that she was pleased any additional pooled fund arrangements beyond those set out for 2018/19 would be halted until more scrutiny had taken place. There had been a number of scrutiny meetings up to now and she was clear that the Council would not take part in any arrangement that would involve the establishment of an Accountable Care Organisation or any form of privatisation. The language used in the PWC report was very unfortunate and very misleading as this was not what the Council would want to be a part of.

Dr Sue Wells assured the Board that for the CCG's part this was about integrating care to help people to have a better health and care experience and was absolutely not about privatisation of the NHS.

The Chair echoed Councillor Mooney's comments, having been a nurse for 40 years the last thing she would be involved with would be privatisation. The NHS had to be free at the point of need and at the point of care, the best quality of care and social care which could be provided.

The NHS Wirral CCG Members and Wirral Borough Council's three Cabinet Members, sitting as a Committee of the Cabinet –

Resolved –

(1) That the Joint Strategic Commissioning Board endorses and supports the approach taken to mitigate financial risk.

(2) That the Section 75 agreement for 2018/2019 is agreed for sign off by Chief Officers on behalf of NHS Wirral CCG and Wirral Council.

JOINT STRATEGIC COMMISSIONING BOARD
Wirral Health and Care Commissioning Pooled Fund Arrangements

Risk **Please indicate**	**High N**	***Medium* Y**	***Low* N**
Detail of Risk Description	*This report deals with how risks are being mitigated against through arrangements that have been put in place for integrated commissioning* *All commissioning activity is subject to appropriate consultation, engagement and impact assessment*		

Engagement taken place	**N**
Public involvement taken place	**N**
Equality Analysis/Impact Assessment completed	**N**
Quality Impact Assessment	**N**
Strategic Themes	
To empower the people of Wirral to improve their physical, mental health and general wellbeing	**N**
To reduce health inequalities across Wirral	**N**
To adopt a health and wellbeing approach in the way services are both commissioned and provided	**N**
To commission and contract for services that: • Demonstrate improved person-centred outcomes • Are high quality and seamless for the patient • Are safe and sustainable • Are evidenced based • Demonstrate value for money	**N**
To be known as one of the leading organisations in the Country	**Y**
Provide systems leadership in shaping the Wirral Health and Social Care system so as to be fit for purpose both now and in five years' time.	**Y**

JOINT STRATEGIC COMMISSIONING BOARD

(Committee in Common)

Meeting Date:	**16 October 2018**
Report Title:	**Wirral Health and Care Commissioning Pooled Fund Arrangements**
Lead Officer:	**Mike Treharne**

1 INTRODUCTION / REPORT SUMMARY

1.1 Wirral Health and Care Commissioning (WHaCC) has been in operation since May 2018. This is the contemporary name for the Integrated Commissioning Hub referred to in reports dated before May 2018. WHaCC is a formal strategic partnership created on behalf of Wirral Council and Wirral CCG. The partnership was created following agreement to progress into a formal partnership by Wirral Council Cabinet November 2017 and Wirral CCG December 2017.

1.2 This report presents the detail of how the agreement to create a single care and health commissioner for Wirral has been taken forward in terms of financial governance and decision making.

1.3 The Section 75 pooled fund agreement (Appendix 3) sets out the budget areas that are being pooled in 2018. It also refers to a shadow pool which refers to budgets that are not being pooled in 2018, in order to minimize exposure to financial risk. Financial and governance arrangements are included within the Section 75 agreement. Current and future risk and gain share arrangements are set out.

1.4 In September 2017 a due diligence exercise was undertaken by Price Waterhouse Cooper (PWC). The report illustrated the benefits of integrated commissioning and set out their view of potential risks and mitigations on behalf of Wirral Council and Wirral CCG. The report was considered in advance of the decision to create WHaCC, but has not previously been in the public domain. At this stage the report can be read in conjunction with the arrangements that have been put in place to respond to the highlighted risks. The report is published in full (Appendix 4).

1.5 Importantly the key risks and mitigations have been considered and responded to by WHaCC in setting up pooled fund and financial governance arrangements. A contemporary view of those risks and mitigations with a revised risk score is provided (Appendix 5).

2 RECOMMENDATIONS

2.1 It is recommended that the Joint Strategic Commissioning Board endorses and supports the approach taken to mitigate financial risk.

2.2 It is recommended that the Section 75 agreement for 2018/2019 is agreed for sign off by Chief Officers on behalf of NHS Wirral CCG and Wirral Council.

3 BACKGROUND INFORMATION

3.1 The direction of travel for integrated commissioning, the business case and proposed integrated arrangements for Wirral Health and Care Commissioning (WHaCC) have been well documented via NHS Wirral Clinical Commissioning Group (CCG) Governing Body meetings on 2 May 2017 and 5 December 2017 and Wirral Council Cabinet meetings on 27 March 2017 and 27 November 2017.

3.2 This paper provides further detail with regard to how the proposals are being implemented and the specifics of the Section 75 legal agreement that is being put in place to support effective integrated commissioning.

3.3 The following key features of integration were outlined as essential to success;

- Pooling resources, intelligence and planning capacity.
- Delivering the Right Care in the Right Place at the Right Time.
- Managing demand and reducing the cost of care.
- Clear accountability and governance arrangements.
- Resilience and flexibility to emerging issues in service delivery.

3.4 Healthy Wirral has been established as the core programme for delivery of key transformational programmes of health and care. WHaCC is the system lead for the delivery of this programme through the Healthy Wirral Partners Board.

3.5 Appendix 1 shows the structure of healthy Wirral in terms of 6 primary programmes 11 enabling programmes and 4 shaping programmes. These have been designed to transform the delivery of health and care in Wirral.

3.6 In order to lead and deliver Healthy Wirral, new governance arrangements have had to be designed. These are in line with the intentions and requirements of Wirral Health and Care Commissioning (Appendix 2). The structure is in 3 sections; integrated commissioning, partnerships, integrated provision. These are all important but for integrated commissioning the key governance arrangements relate to the role of the Joint Strategic Commissioning Board and the Pooled Fund Executive Group that supports the financial aspects of joint strategic commissioning.

Pooled Fund Executive Group;

3.7 The Pooled Fund Executive Group:

- Ensures effective day to day management of the pooled funds under the Section 75.
- Maintains an overview of the use of pooled fund and service delivery.
- Reports on performance of the pooled fund to Joint Strategic Commissioning Board.
- Is accountable for the delivery of objectives to the partners of the pooled fund.

Joint Strategic Commissioning Board;

3.8 The Joint Strategic Commissioning Board has oversight of integrated commissioning arrangements. The Board makes key decisions in relation to commissioning and receives assurance that pooled funds are appropriately used and managed.

Section 75 agreement

3.9 The Section 75 agreement is set out as Appendix 3, and is the culmination of base line work previously established through the better care fund agreements from prior years; the desire to move to an integrated commissioning hub for Wirral Health and Care Commissioning; and a realistic and pragmatic acknowledgement of the appropriate expenditure areas within the pooled fund and associated equitable risk/gain share arrangements.

PWC Due Diligence report

3.10 Price Waterhouse Cooper were commissioned to undertake a due diligence report to focus on the relative benefits and risks of integrated commissioning and the pooling of resources. This report was used to consider how risks could be mitigated and what would need to be in place in terms of financial governance. It was recognised that the report alone would highlight the potential risks rather than to seek to mitigate them it was therefore of critical importance for the document to be published along with the relevant mitigations. See Appendix 4 for the full report.

3.11 The major risks identified were as follows:

- Budget setting, in terms of sufficient resource for both organisations;
- The management of future demand given current experience for both NHS and Social Care services;
- Delivery of efficiency savings and plans for each organisation;
- The management of historical deficits (particularly CCG) and how this would impact the pooled fund arrangements going forward.

3.12 In response to the risks identified, various mitigations were proposed and these are set out in Appendix 5.

3.13 It is also important to recognise that there is no such thing as a risk free option, and the crucial factor is the correct identification of appropriate risks along with proposed relevant, realistic and implementable mitigations.

3.14 The financial challenge for the NHS Wirral CCG and Wirral Council will continue regardless of integration. The key for Wirral will be to ensure that integration of commissioning is seen as an opportunity to help to transform provision to make more effective use of the resources available, (making the most of the “Wirral pound”) rather than the financial challenges being seen as a barrier to integration.

3.15 The risks and mitigations associated with integration will continue to be monitored and updated in the months to come.

Expenditure areas to be included in 2018/19, and shadow areas

3.16 The areas are of expenditure to be included in the pooled funding and shadow arrangements are summarised in the table below.

Description	£m
Adult Social Care	39.7
Public Health	12.4
Children & Young People	2.1
CCG	22.0
Better Care Fund	53.7
	129.9

3.17 The total funds contributed to the shadow pool in 2018/19 amount to £526.3m, as per the table below:

Description	**£m**
Adult Social Care	50.2
CCG	476.1
	526.3

Proposed expenditure areas to be included in the pooled fund in 19/20

3.18 It is proposed for 2019/20 that all of the NHS Wirral CCG expenditure bar the locally commissioned Primary Care development/enhanced schemes will be included within the Pooled Fund budget total and within the relevant governance arrangements. See section 5 for more detail.

4 OTHER OPTIONS CONSIDERED

4.1 Whilst the option of doing nothing was considered, this was not a realistic option given the need to improve collaboration, avoid duplication, and improve cost efficiency and cost effectiveness in commissioning decision and function.

4.2 The explicit options of what expenditure is pooled and what resources are to be shared, in future years beyond 2018/19, are still being fully considered and explored, with certain commissioning functions are already operating under joint leadership. The risks/gain share agreements between the Wirral Council and NHS Wirral CCG are anticipated to be re-visited and agreed each year, depending on the expenditure areas identified and the relative exposure to risk.

5 FINANCIAL IMPLICATIONS

5.1 Following consideration of risks and mitigating factors it was agreed to limit the amount of resources pooled in order to reduce the level of risk that Wirral CCG and Wirral Council would be exposed to. The figures agreed for 2018/19 in respect of the pooled fund amount to £129.9m; the risk and gain share agreement and arrangement is on a 50/50 basis, given the identification of relative risks and opportunities and the need to show improved collaborative working particularly in respect of packages of care.

Description	£m
Adult Social Care	39.7
Public Health	12.4
Children & Young People	2.1
CCG	22.0
Better Care Fund	53.7
	129.9

5.4 A full breakdown of the pool's composition is given below, together with the current forecast:

Area	Category	Budget (£m)	Forecast	Variance
Adult Social Care	Community Care for learning disabilities (LD)	39.3	39.7	(0.4)
	Community Care for mental health (MH)	9.9	10.0	(0.1)
	LD/MH Customer and client receipts	(3.0)	(3.3)	0.2
	Income from LD/MH joint-funded packages	(6.4)	(6.7)	0.3
		39.7	**39.7**	**-**
Public Health	Stop smoking interventions	0.8	0.8	-
	Sexual health services	3.1	3.1	-
	Children's services	6.8	6.8	-
	Health checks	0.3	0.3	-
	Adult obesity	0.2	0.2	-
	Mental health	0.9	0.9	-
	Infection control	0.2	0.2	-
		12.4	**12.4**	**-**
Children & Young People	Care packages	2.1	2.1	-
		2.1	**2.1**	**-**

Area	Category	Budget (£m)	Forecast	Variance
CCG	CHC – adult fully funded continuing care	3.7	3.7	-
	CHC – adult fully funded Personal Health Budgets (PHBs)	0.9	0.9	-
	Funded nursing care	0.8	0.8	-
	Learning disabilities	1.7	1.7	-
	Mental health	9.8	9.8	-
	Adult joint funded	3.8	3.8	-
	CHC – Adult joint funded PHBs	0.3	0.3	-
	CHC children's continuing care	0.9	0.9	-
	Children's PHBs	0.0	0.0	-
		22.0	**22.0**	**-**
Better Care Fund	Integrated services	20.6	20.6	-
	Adult social care services	25.2	25.2	-
	CCG services	2.0	2.0	-
	DFG	3.9	3.9	--
	Innovation fund	0.9	0.9	-
	Known pressures & contingency	1.1	1.1	-
		53.7	**53.7**	**-**
		129.9	**129.9**	**-**

5.5 It is proposed for 2019/20 that all of the Social Care and NHS Wirral CCG expenditure bar the locally commissioned Primary Care development/enhanced schemes will be included within the Pooled Fund budget total and governance arrangements.

5.6 Given that in 2019/20 virtually all NHS Wirral CCG's expenditure is intended to be pooled, a more sophisticated risk share arrangement will need to be developed and agreed, based upon the level of risk brought forward into the annual agreement. Each pooled fund partner will continue to be compliant with their own financial regimes and statutory duties.

5.7 If either organisation has significant residual financial risks, a simple 50/50 share would not be appropriate. In this instance it is essential that a practical and pragmatic approach is adopted based upon the level of risk brought forward from the previous financial year.

5.8 Over time, services which are currently out of scope for Wirral Health and Care Commissioning may be included within the pooled funding arrangements (e.g. further Children's services). The risks of adding these services to Wirral Health and care Commissioning funding arrangement will need to be assessed at the point at which these services are considering being moved into the pooled funding arrangements.

5.9 A proposal will be brought back to Joint Strategic Commissioning Board for the 2019 to 2020 arrangements for that financial year.

18/19 financial risks and challenges

5.10 Achievement of NHS Wirral CCG's £2m surplus control total is clearly not without financial challenge and risk, given the £19.6m savings target required to be delivered. During the planning period and working up of the CCG's financial recovery plan, gross risks and realisable mitigations were identified as follows:

Risks	**Original Plan £m**	**Current Position £m**
QIPP Slippage	£3.5m	£6.5m
Unidentified QIPP	£4.1m	Nil
Acute Over-performance	£2.0m	£2.0m
CHC Excess Growth	£1.0m	£2.5m
Total Gross Risks	**£10.6m**	**£10.9m**
Mitigations	**£m**	**£m**
Contingency	£2.6m	£2.6m
Re-brokerage	£1.0m	£1.0m
RTT Slippage	£0.5m	£0.5m
Other	£0.8m	£1.3m
Total Mitigations	**£4.9m**	**£5.4m**
Overall Net Risks	**£5.7m**	**£5.6m**

5.11 An approved financial recovery is in place to deliver the required mitigations, with further measures to manage net risk identified.

5.12 The financial risks and challenges facing the Social Services budget for 18/19 were as follows:

Description	£m
Adult Social Care	
Demographic growth pressures	1.0
Overspend carried forward from 2017/18	0.5
	1.5

To mitigate these cost pressures, the Council has created savings plans totalling £1.3m, as below:

Description	£	RAG
Extra Care Housing – Balls Road	95,500	Green
Extra Care Housing – Pensby Road	60,000	Red
Outcome-Based Commission - AFG	161,000	Green
SIL – Spital Road	127,500	Amber
Residential Care – Fusion Centre	49,500	Amber
Payment by Actuals	355,500	Green
Payment by Actuals Audit	44,000	Green
Supported Living Reviews	429,000	Red
	1,322,000	

Commissioning plans and activity are in place to deliver against the above savings programme

6 ENGAGEMENT / CONSULTATION

6.1 Documents and discussions in respect of the integration agenda and associated financial risks have been presented and taken place at a variety of Wirral Council and NHS Wirral CCG meetings.

7 LEGAL IMPLICATIONS

7.1 Lawyers acting on behalf of Wirral Council and NHS Wirral CCG have been engaged in, and crucial to the production of the section 75 agreement. The agreement treats each party in an equivalent way, allowing appropriate protections and exit arrangements.

8 RESOURCE IMPLICATIONS: ICT, STAFFING AND ASSETS

8.1 Currently there is no significant impact on resources, ICT, staffing and assets as a result of the integration agenda. As greater integration occurs there are likely to be efficiency savings through economies of scale with appropriate sharing of posts and other assets.

9 EQUALITY IMPLICATIONS

9.1 There are no implications as it is not anticipated that the integration of commissioning functions will have an impact on equality. Rather, potential impacts on equality will come from commissioning decisions for which Equality Impact Assessments (EIA) will need to be produced.

REPORT AUTHOR: **Mike Treharne**
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email: michael.treharne@nhs.net

APPENDICES

Appendix 1 - *Healthy Wirral* Programme structure
Appendix 2 - Wirral Health and Care System Governance
Appendix 3 - Section 75 agreement
Appendix 3a - (Appendix 1 to Section 75 Agreement) Financial Contributions of the Partners in the first Financial Year
Appendix 4 - PWC Due Diligence Report
Appendix 5 - Update response on proposed mitigations in respect of financial risks identified by PWC

REFERENCE MATERIAL

N/A

HISTORY

Meeting	Date

Wirral Health & Care Commissioning

Healthy Wirral

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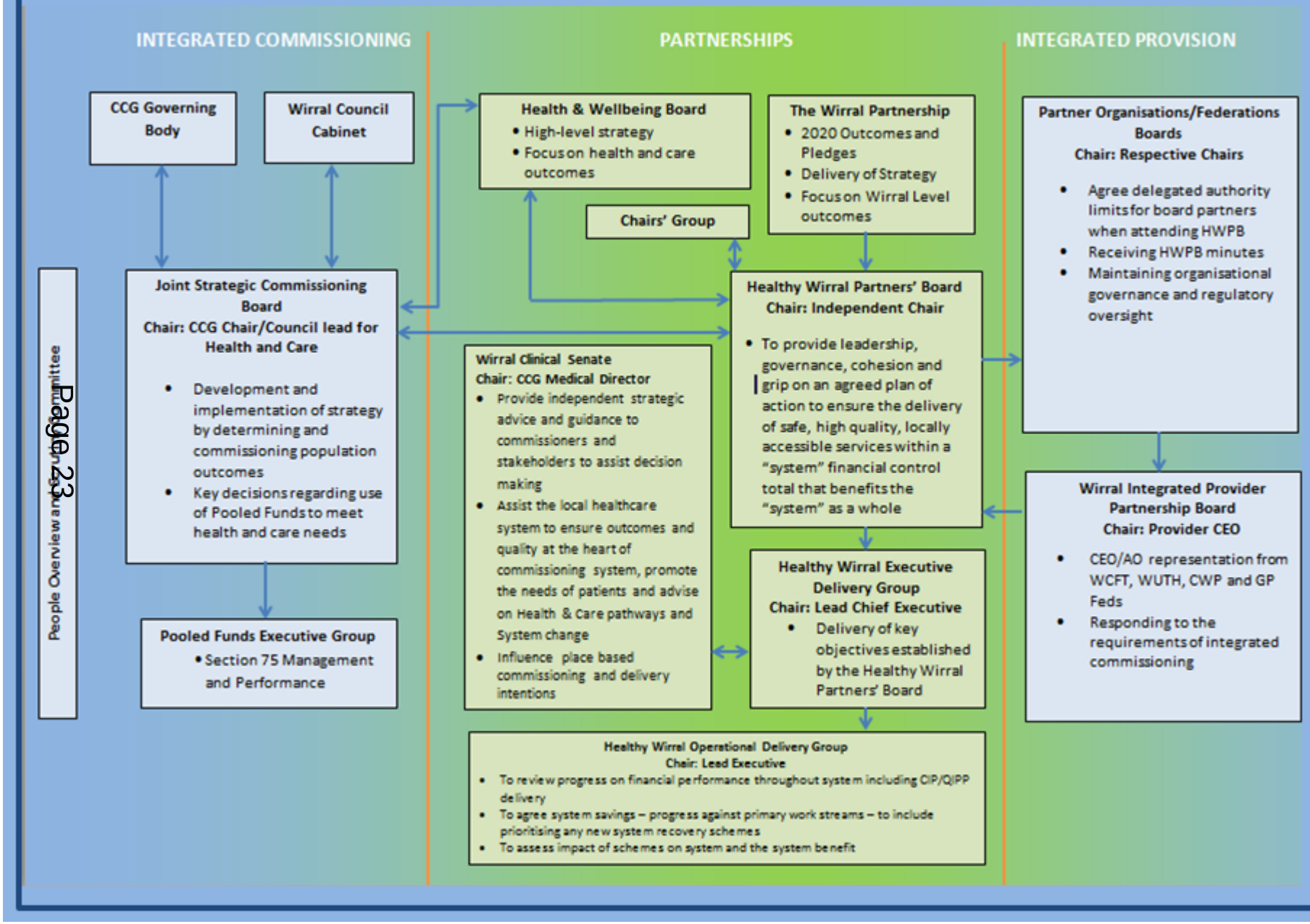
Wirral Health and Care System



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Dated **2018**

WIRRAL BOROUGH COUNCIL

and

NHS WIRRAL CLINICAL COMMISSIONING GROUP

FRAMEWORK PARTNERSHIP AGREEMENT RELATING TO THE COMMISSIONING OF HEALTH AND SOCIAL CARE SERVICES

Head of Legal Services

Wirral Borough Council

(with acknowledgement to

Bevan Brittan LLP, Toronto Square,

7th Floor, Toronto Street,

Leeds LS1 2HJ)

Contents

THIS AGREEMENT is made on day of 2018

PARTIES

(1) **WIRRAL BOROUGH COUNCIL** of Wallasey Town Hall, Brighton Street, Seacombe, Wallasey, CH44 8ED (the **"Council"**)

(2) **NHS WIRRAL CLINICAL COMMISSIONING GROUP** of Marriss House, Hamilton Street, Birkenhead, Wirral, CH41 5AL (the "**CCG"**)

BACKGROUND

(A) The Council has responsibility for commissioning and/or providing social care services and public health services on behalf of the population of the borough of Wirral.

(B) The CCG has the responsibility for commissioning health services pursuant to the 2006 Act in the borough of Wirral.

(C) The Better Care Fund has been established by the Government to provide funds to local areas to support the integration of health and social care and to seek to achieve the National Conditions and Local Objectives. It is a requirement of the Better Care Fund that the CCG and the Council establish a pooled fund for this purpose. The Partners wish to extend the use of pooled funds to include funding streams from outside of the Better Care Fund.

(D) Section 75 of the 2006 Act gives powers to local authorities and clinical commissioning groups to establish and maintain pooled funds out of which payment may be made towards expenditure incurred in the exercise of prescribed local authority functions and prescribed NHS functions.

(E) The purpose of this Agreement is to set out the terms on which the Partners have agreed to collaborate and to establish a framework through which the Partners can secure the future position of health and social care services and public health services through lead or joint commissioning arrangements. It is also the means through which the Partners will pool funds and align budgets as agreed between the Partners.

(F) The aims and benefits of the Partners in entering in to this Agreement are to:

a) improve the quality and efficiency of the Services;

b) meet the National Conditions and Local Objectives;

c) make more effective use of resources through the establishment and maintenance of a pooled fund for revenue expenditure on the Services;

d) support more effective delivery of strategic outcomes through a single planning framework and structure; and

e) commission a more sustainable health and care system for the people of Wirral.

(G) The Partners are entering into this Agreement in exercise of the powers referred to in Section 75 of the 2006 Act and/or Section 13Z(2) and 14Z(3) of the 2006 Act as applicable, to the extent that exercise of these powers is required for this Agreement.

1 DEFINED TERMS AND INTERPRETATION

1.1 In this Agreement, save where the context requires otherwise, the following words, terms and expressions shall have the following meanings:

2000 Act means the Freedom of Information Act 2000.

2004 Regulations means the Environmental Information Regulations 2004.

2006 Act means the National Health Service Act 2006.

Affected Partner means, in the context of Clause 24, the Partner whose obligations under the Agreement have been affected by the occurrence of a Force Majeure Event.

Agreement means this agreement including its Schedules and Appendices.

Annual Report means the annual report produced by the Partners in accordance with Clause 20 (Review).

Approved Expenditure means any expenditure approved by the Partners in writing or as set out in the Scheme Specification in relation to an Individual Scheme above any Contract Price, Permitted Expenditure or agreed Third Party Costs.

Associated Person means in respect of the Council, a person, partnership, limited liability partnership or company (and company shall include a company which is a subsidiary, a holding company or a company that is a subsidiary of the ultimate holding company of that company) in which the Council has a shareholding or other ownership interest; OR any other body that substantially performs any of the functions of the Council that previously had been performed by the Council.

Authorised Officers means an officer of each Partner appointed to be that Partner's representative for the purpose of this Agreement.

BCF Quarterly Report means the quarterly report produced by the Partners and provided to the Health and Wellbeing Board.

BCF 2017 Agreement means the agreement between the Parties in respect of the Better Care Fund for the period commencing 1 April 2017.

Better Care Fund means the Better Care Fund as described in the 2017-2019 Integration and Better Care Fund Policy Framework prepared by the Department of Health and the Department for Communities and Local Government as relevant to the Partners.

Better Care Fund Plan means the plan agreed by the Partners for the relevant Financial Year setting out the Partners plan for the use of the Better Care Fund as attached as Schedule 6.

Better Care Fund Requirements means any and all requirements on the CCG and Council in relation to the Better Care Fund set out in Law and guidance published by the Department of Health.

Better Care Fund Schemes means the schemes referred to in Schedule 1, Part 2, paragraph 5.

Bribery Act means the Bribery Act 2010 and any subordinate legislation made under that Act from time to time together with any guidance or codes of practice issued by the relevant government department concerning the legislation.

Care Act means the Care Act 2014 and any subordinate legislation made under that Act from time to time together with any guidance or codes of practice issued by the relevant government department concerning the legislation.

CCG Statutory Duties means the duties of the CCG pursuant to Sections 14P to 14Z2 of the 2006 Act.

Change in Law means the coming into effect or repeal (without re-enactment or consolidation) in England of any Law, or any amendment or variation to any Law, or any judgment of a relevant court of law which changes binding precedent in England after the Commencement Date.

Commencement Date means 00:01 hrs on 1 April 2018.

Confidential Information means information, data and/or material of any nature which any Partner may receive or obtain in connection with the operation of this Agreement and the Services and:

(a) which comprises Personal Data or Sensitive Personal Data or which relates to any patient or his treatment or medical history;

(b) the release of which is likely to prejudice the commercial interests of a Partner or the interests of a Service User respectively; or

(c) which is a trade secret.

Contract Price means any sum payable under a Service Contract as consideration for the provision of goods, equipment or services as required as part of the Services and which, for the avoidance of doubt, does not include any Default Liability.

Data Protection Legislation this includes the GDPR, the Data Protection Act 1998, the Data Protection Act 2018, the LED, the EU General Data Protection Regulations, the Regulation of Investigatory Powers Act 2000, the Telecommunications (Lawful Business Practice) (Interception of Communications) Regulations 2000 (SI 2000/2699), the Electronic Communications Data Protection Directive 2002/58/EC, the Privacy and Electronic Communications (EC Directive) Regulations 2003 and all applicable laws and regulations relating to processing of personal data and privacy, including where applicable the guidance and codes of practice issued by the Information Commissioner.

Default Liability means any sum which is agreed or determined by Law or in accordance with the terms of a Service Contract to be payable by any Partner(s) as a consequence of (i) breach by any or all of the Partners of an obligation(s) (in whole or in part) under a Service Contract or (ii) any act or omission of a third party for which any or all of the Partners are, under the terms of the relevant Service Contract, liable to a Provider or (iii) the outcome of judicial review proceedings or (iv) the determination of the Local Government and Social Care Ombudsman.

Financial Contributions means the financial contributions made by each Partner to a Pooled Fund in any Financial Year.

Financial Year means each financial year running from 1 April in any year to 31 March in the following calendar year.

First Pooled Fund has the meaning set out in Clause 7.2.

Force Majeure Event means one or more of the following:

(a) war, civil war (whether declared or undeclared), riot or armed conflict;

(b) acts of terrorism;

(c) acts of God;

(d) fire or flood;

(e) industrial action;

(f) prevention from or hindrance in obtaining raw materials, energy or other supplies;

(g) any form of contamination or virus outbreak; and

(h) any other event,

in each case where such event is beyond the reasonable control of the Partner claiming relief.

Functions means the NHS Functions and the Health Related Functions.

GDPR means the General Data Protection Regulation (Regulation (EU) 2016/279).

Health Related Functions means those of the health related functions of the Council, specified in Regulation 6 of the Regulations as relevant to the commissioning of the Services and which may be further described in the relevant Scheme Specification.

Host Partner means for each Pooled Fund the Partner that will host the Pooled Fund and for any Non-Pooled Fund the Partner that will host the Non-Pooled Fund

Health and Wellbeing Board means the Health and Wellbeing Board established by the Council pursuant to Section 194 of the Health and Social Care Act 2012.

Indirect Losses means loss of profits, loss of use, loss of production, increased operating costs, loss of business, loss of business opportunity, loss of reputation or goodwill or any other consequential or indirect loss of any nature, whether arising in tort or on any other basis.

Individual Scheme means one of the schemes which has been agreed by the Partners to be included within this Agreement using the powers under Section 75 as documented in a Scheme Specification.

Integrated Commissioning means arrangements by which both Partners commission Services in relation to an Individual Scheme on behalf of each other in exercise of both the NHS Functions and Health Related Functions through integrated structures.

Joint (Aligned) Commissioning means a mechanism by which the Partners jointly commission a Service. For the avoidance of doubt, a joint (aligned) commissioning arrangement does not involve the delegation of any functions pursuant to Section 75.

Joint Strategic Commissioning Board or JSCB means the committee of the Council responsible for the review of performance and oversight of this Agreement on behalf of the Council as set out in Schedule 2.

Law means:

(a) any statute or proclamation or any delegated or subordinate legislation;

(b) any enforceable community right within the meaning of Section 2(1) European Communities Act 1972;

(c) any guidance, direction or determination with which the Partner(s) or relevant third party (as applicable) are bound to comply to the extent that the same are published and publicly available or the existence or contents of them have been notified to the Partner(s) or relevant third party (as applicable); and

(d) any judgment of a relevant court of law which is a binding precedent in England.

Lead Commissioning Arrangements means the arrangements by which one Partner commissions Services in relation to an Individual Scheme on behalf of the other Partner in exercise of both the NHS Functions and the Health Related Functions.

Lead Partner means the Partner responsible for commissioning an Individual Scheme under a Scheme Specification.

LED means the Law Enforcement Directive (Directive (EU) 2016/680).

Local Objectives means objectives set out and formally agreed by the Partners to be incorporated into a single commissioning strategy.

Losses means all damage, loss, liabilities, claims, actions, costs, expenses (including the cost of legal and/or professional services), proceedings, demands and charges whether arising under statute, contract or at common law but excluding Indirect Losses and "Loss" shall be interpreted accordingly.

Memorandum of Understanding means the memorandum of understanding dated 17 May 2018 between the CCG and the Council in respect of the management of their respective staff working in Wirral Health and Care Commissioning.

Month means a calendar month.

National Conditions mean the national conditions as set out in the National Guidance as amended or replaced from time to time.

National Guidance means any and all guidance in relation to the Better Care Fund as issued from to time to time by NHS England, the Department of Communities and Local Government, the Department of Health, the Local Government Association either collectively or separately.

NHS Functions means those of the NHS functions listed in Regulation 5 of the Regulations as are exercisable by the CCG as are relevant to the commissioning of the Services and which may be further described in the relevant Scheme Specification.

Non-Pooled Fund means the budget detailing the financial contributions of the Partners which are not included in a Pooled Fund in respect of a particular Service as set out in the relevant Scheme Specification.

Non-Recurrent Payments means funding provided by a Partner to a Pooled Fund in addition to the Financial Contributions pursuant to arrangements agreed in accordance with Clause 10.3.

Open Book Accounting means the structured management and sharing of transparent, complete, accurate, current and accessible costing information– including data which would traditionally have been kept confidential – so as to facilitate the joint management of the Pooled Fund and facilitate better use of the resources in commissioning services and exercise of NHS Functions and/or Health Related Functions.

Overspend means any expenditure from a Pooled Fund in a Financial Year which exceeds the Financial Contributions for that Financial Year.

Partner means each of the CCG and the Council, and references to "**Partners**" shall be construed accordingly.

Permitted Budget means in relation to a Service where the Council is the Provider, the budget that the Partners have set in relation to the particular Service.

Permitted Expenditure has the meaning given in Clause 7.4.

Personal Data has the same meaning as set out in the Data Protection Legislation.

Pooled Fund means any pooled fund established and maintained by the Partners as a pooled fund in accordance with the Regulations, including the First Pooled Fund.

Pooled Fund Manager means such officer of the Host Partner which includes a Section 113 Officer for the relevant Pooled Fund established under an Individual Scheme as is nominated by the Host Partner from time to time to manage the Pooled Fund in accordance with Clause 8.

Pooled Fund Executive Group means the executive group as described further at Schedule 1 Part 1 paragraph 13.

Provider means a provider of any Services commissioned under the arrangements set out in this Agreement including the Council or the Associated Person where the Council or an Associated Person is a provider of any Services.

Prohibited Act the following constitute Prohibited Acts:

(a) to directly or indirectly offer, promise or give any person working for or engaged by the Partners a financial or other advantage to:

(i) induce that person to perform improperly a relevant function or activity; or

(ii) regard that person for improper performance of a relevant function or activity;

(b) to directly or indirectly request, agree to receive or accept any financial or other advantage as an inducement or a reward for improper performance of a relevant function or activity in connection with this Agreement;

(c) committing any offence:

(i) under the Bribery Act;

(ii) under legislation creating offences concerning fraudulent act;

(iii) at common law concerning fraudulent acts relating to this Agreement and any other contracts with the Partners; or

(d) defrauding, attempting to defraud or conspiring to defraud the Partners.

Public Health England means the SOSH trading as Public Health England.

Public Health Schemes means the Schemes set out at paragraph 1 of Part 2 of Schedule 1.

Quarter means each of the following periods in a Financial Year:

1 April to 30 June

1 July to 30 September

1 October to 31 December

1 January to 31 March

and "**Quarterly**" shall be interpreted accordingly.

Quarterly Reports means the reports that the Pooled Fund Manager shall produce and provide to the Joint Strategic Commissioning Board and the CCG Governing Body on a Quarterly basis.

Regulated Activity in relation to children, as defined in Part 1 of Schedule 4 to the Safeguarding Vulnerable Groups Act 2006, and in relation to vulnerable adults, as defined in Part 2 of Schedule 4 of the Safeguarding Vulnerable Groups Act 2006.

Regulated Activity Provider as defined in Section 6 of the Safeguarding Vulnerable Groups Act 2006.

Regulations means the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000 No 617 (as amended from time to time).

Ring-Fenced Monies means the monies ring-fenced to meet the outcomes of the Public Health Schemes as described further in Schedule 3.

Scheme Specification means a specification setting out the arrangements for an Individual Scheme agreed by the Partners to be commissioned under this Agreement.

Sensitive Personal Data has the same meaning as set out in the Data Protection Legislation.

Services means such health and social care services as agreed from time to time by the Partners as commissioned under the arrangements set out in this Agreement and more specifically defined in each Scheme Specification.

Service Contract means an agreement entered into by one or more of the Partners in exercise of its obligations under this Agreement to secure the provision of the Services in accordance with the relevant Individual Scheme.

Service Users means those individuals for whom the Partners have a responsibility to commission the Services.

SOSH means the Secretary of State for Health and Social Care.

Third Party Costs means all such third party costs (including legal and other professional fees) in respect of each Individual Scheme as a Partner reasonably and properly incurs in the proper performance of its obligations under this Agreement and as agreed by the Joint Strategic Commissioning Board and the CCG Governing Body.

Underspend means any expenditure from the Pooled Fund in a Financial Year which is less than the aggregate value of the Financial Contributions for that Financial Year.

Working Day means 8.00am to 6.00pm on any day except Saturday, Sunday, Christmas Day, Good Friday or a day which is a bank holiday (in England) under the Banking & Financial Dealings Act 1971.

1.2 In this Agreement, all references to any statute or statutory provision shall be deemed to include references to any statute or statutory provision which amends, extends, consolidates or replaces the same and shall include any orders, regulations, codes of practice, instruments or other subordinate legislation made thereunder and any conditions attaching thereto. Where relevant, references to English statutes and statutory provisions shall be construed as references also to equivalent statutes, statutory provisions and rules of law in other jurisdictions.

1.3 Any headings to Clauses, together with the front cover and the index are for convenience only and shall not affect the meaning of this Agreement. Unless the contrary is stated, references to Clauses and Schedules shall mean the clauses and schedules of this Agreement.

1.4 Any reference to the Partners shall include their respective statutory successors, employees and agents.

1.5 In the event of a conflict, the conditions set out in the Clauses to this Agreement shall take priority over the Schedules.

1.6 Where a term of this Agreement provides for a list of items following the word "including" or "includes", then such list is not to be interpreted as being an exhaustive list.

1.7 In this Agreement, words importing any particular gender include all other genders, and the term "person" includes any individual, partnership, firm, trust, body corporate, government, governmental body, trust, agency, unincorporated body of persons or association and a reference to a person includes a reference to that person's successors and permitted assigns.

1.8 In this Agreement, words importing the singular only shall include the plural and vice versa.

1.9 In this Agreement, "staff" and "employees" shall have the same meaning and shall include reference to any full or part time employee or officer, director, manager and agent.

1.10 Subject to the contrary being stated expressly or implied from the context in these terms and conditions, all communication between the Partners shall be in writing.

1.11 Unless expressly stated otherwise, all monetary amounts are expressed in pounds sterling but in the event that pounds sterling is replaced as legal tender in the United Kingdom by a different currency then all monetary amounts shall be converted into such other currency at the rate prevailing on the date such other currency first became legal tender in the United Kingdom.

1.12 All references to the Agreement include (subject to all relevant approvals) a reference to the Agreement as amended, supplemented, substituted, novated or assigned from time to time.

2 TERM

2.1 This Agreement shall come into force on the Commencement Date.

2.2 This Agreement shall continue until it is terminated in accordance with Clause 22 or until midnight on 31 March 2021 whichever is earlier.

2.3 The duration of the arrangements for each Individual Scheme shall be as set out in the relevant Scheme Specification or if not set out, for the duration of this Agreement unless terminated earlier by the Partners.

2.4 This Agreement supersedes the BCF 2017 Agreement without prejudice to the rights and liabilities of the Partners under the BCF 2017 Agreement.

3 GENERAL PRINCIPLES

3.1 Nothing in this Agreement shall affect:

(a) the liabilities of the Partners to each other or to any third parties for the exercise of their respective functions and obligations (including the Functions); or

(b) any power or duty to recover charges for the provision of any services (including the Services) in the exercise of any local authority function (including any Health Related Function).

3.2 The Partners agree to:

(a) treat each other with respect and an equality of esteem;

(b) be open with information about the performance and financial status of each; and

(c) provide early information and notice about relevant problems.

3.3 For the avoidance of doubt, the aims and outcomes relating to an Individual Scheme may be set out in the relevant Scheme specification.

4 PARTNERSHIP FLEXIBILITIES

4.1 This Agreement sets out the mechanism through which the Partners will work together to commission services. This may include one or more of the following commissioning mechanisms:

(a) Lead Commissioning Arrangements;

(b) Integrated Commissioning;

(c) Joint (Aligned) Commissioning

(d) the establishment of one or more Pooled Funds

in relation to Individual Schemes (the "Flexibilities").

4.2 Where there are Lead Commissioning Arrangements and the CCG is Lead Partner the Council delegates to the CCG and the CCG agrees to exercise, on the Council's behalf, the Health Related Functions to the extent necessary for the purpose of performing its obligations under this Agreement in conjunction with the NHS Functions.

4.3 Where there are Lead Commissioning Arrangements and the Council is Lead Partner, the CCG delegates to the Council and the Council agrees to exercise on the CCG's behalf the NHS Functions to the extent necessary for the purpose of performing its obligations under this Agreement in conjunction with the Health Related Functions.

4.4 Where the powers of a Partner to delegate any of its statutory powers or functions are restricted, such limitations will automatically be deemed to apply to the relevant Scheme Specification and the Partners shall agree arrangements designed to achieve the greatest degree of delegation to the other Partner necessary for the purposes of this Agreement which is consistent with the statutory constraints.

4.5 At the Commencement Date the Partners agree that there is one Pooled Fund which comprises the schemes set out in Schedule 1 Part 2.

5 FUNCTIONS

5.1 The purpose of this Agreement is to establish a framework through which the Partners can secure the provision of health and social care services in accordance with the terms of this Agreement.

5.2 This Agreement shall include such Functions as shall be agreed from time to time by the Partners as are necessary to commission the Services in accordance with their obligations under this Agreement.

5.3 The Scheme Specifications for the Individual Schemes included as part of this Agreement at the Commencement Date are set out in Schedule 1 Part 2. Where the Partners add a new Individual Scheme to this Agreement a Scheme Specification for each Individual Scheme shall be completed and approved by each Partner in accordance with the variation procedure set out in Clause 30 (Variations). The Scheme Specifications for the First Pooled Fund is set out in Schedule 1 Part 2. Each new Scheme Specification shall substantially follow this format.

5.4 The Partners shall not enter into a Scheme Specification in respect of an Individual Scheme unless they are satisfied that the Individual Scheme in question will improve health and well-being in accordance with this Agreement.

5.5 The introduction of any Individual Scheme will be subject to business case approval by the Joint Strategic Commissioning Board and the CCG Governing Body in accordance with the variation procedure set out in Clause 32 (Variation).

6 COMMISSIONING ARRANGEMENTS

General

6.1 The Partners shall comply with the commissioning arrangements as set out in the relevant Scheme Specification.

6.2 The Joint Strategic Commissioning Board and the CCG Governing Body will report back to the Health and Wellbeing Board as required.

6.3 The Partners shall comply with all relevant legal duties and guidance of both Partners in relation to the Services being commissioned.

6.4 Each Partner shall keep the other Partner regularly informed of the effectiveness of the arrangements including the Better Care Fund and any Overspend or Underspend in a Pooled Fund or Non-Pooled Fund.

6.5 Where there are Integrated Commissioning or Lead Commissioning Arrangements in respect of an Individual Scheme then prior to any new Service Contract being entered into the Partners shall agree in writing:

(a) how the liability under each Service Contract shall be apportioned in the event of termination of the relevant Individual Scheme; and

(b) whether the Service Contract should give rights to third parties (and in particular if a Partner is not a party to the Service Contract to that Partner, the Partners shall consider whether or not the Partner that is not to be a party to the Service Contract should be afforded any rights to enforce any terms of the Service Contract under the Contracts (Rights of Third Parties) Act 1999 and if it is agreed that such rights should be afforded the Partner entering the Service Contract shall ensure as far as is reasonably possible that such rights that have been agreed are included in the Service Contract and shall establish how liability under the Service Contract shall be apportioned in the event of termination of the relevant Individual Scheme.)

6.6 The Partners shall comply with the arrangements in respect of Joint (Aligned) Commissioning as set out in the relevant Scheme Specification, which shall include where applicable arrangements in respect of the Service Contracts.

Integrated Commissioning

6.7 Where there are Integrated Commissioning arrangements in respect of an Individual Scheme:

(a) the Partners shall work in cooperation and shall endeavour to ensure that Services in fulfilment of the NHS Functions and Health Related Functions are commissioned with all due skill, care and attention; and

(b) both Partners shall work in cooperation and endeavour to ensure that the relevant Services as set out in each Scheme Specification are commissioned within each Partner's Financial Contribution in respect of that particular Service in each Financial Year.

Appointment of a Lead Partner

6.8 Where there are Lead Commissioning Arrangements in respect of an Individual Scheme the Lead Partner shall:

(a) exercise the NHS Functions in conjunction with the Health Related Functions as identified in the relevant Scheme Specification;

(b) endeavour to ensure that the NHS Functions and the Health Related Functions are funded within the parameters of the Financial Contributions of each Partner in relation to each particular Service in each Financial Year.

(c) commission Services for individuals who meet the eligibility criteria set out in the relevant Scheme Specification;

(d) contract with Provider(s) for the provision of the Services on terms agreed with the other Partner;

(e) comply with all relevant legal duties and guidance of both Partners in relation to the Services being commissioned;

(f) where Services are commissioned using the NHS Standard Form Contract, perform the obligations of the "Commissioner" and "Co-ordinating Commissioner" with all due skill, care and attention and where Services are commissioned using any other form of contract to perform its obligations with all due skill and attention;

(g) undertake performance management and contract monitoring of all Service Contracts including (without limitation) the use of contract notices where Services fail to deliver contracted requirements;

(h) make payment of all sums due to a Provider pursuant to the terms of any Service Contract; and

(i) keep the other Partner regularly informed of the effectiveness of the arrangements including the Better Care Fund and any Overspend or Underspend in a Pooled Fund or Non-Pooled Fund.

7 ESTABLISHMENT OF A POOLED FUND

7.1 In exercise of their respective powers under Section 75 of the 2006 Act, the Partners have agreed to establish and maintain such pooled funds for revenue expenditure as agreed by the Partners.

7.2 At the Commencement Date there shall be one Pooled Fund (the "First Pooled Fund") into which the following funding streams will be pooled:

(a) the Better Care Fund Plan;

(b) Complex Care Packages, Children and Young People; and

(c) Public Health.

7.3 The First Pooled Fund and any subsequent Pooled Fund shall be managed and maintained in accordance with the terms of this Agreement.

7.4 Subject to Clause 7.5, it is agreed that the monies held in a Pooled Fund may only be expended on the following

(a) the Contract Price;

(b) the Permitted Budget;

(c) Third Party Costs where these are set out in the relevant Scheme Specification or as otherwise agreed in advance in writing by the Joint Strategic Commissioning Board and the CCG Governing Body; and

(d) Approved Expenditure as set out in the relevant Scheme Specification or as otherwise agreed in advance in writing by the Joint Strategic Commissioning Board and the CCG Governing Body,

("Permitted Expenditure").

7.5 The Partners may only depart from the definition of Permitted Expenditure to include or exclude other revenue expenditure with the express written agreement of each Partner.

7.6 For the avoidance of doubt, monies held in a Pooled Fund may not be expended on Default Liabilities unless this is agreed by all Partners in accordance with Clause 7.5.

7.7 Pursuant to this Agreement, the Partners agree to appoint a Host Partner for each Pooled Fund. The Host Partner for the First Pooled Fund is the Council. The Host Partner shall be the Partner responsible for:

(a) holding all monies contributed to the Pooled Fund on behalf of itself and the other Partners;

(b) providing the financial administrative systems for the Pooled Fund;

(c) appointing the Pooled Fund Manager; and

(d) ensuring that the Pooled Fund Manager complies with its obligations under this Agreement.

8 POOLED FUND MANAGEMENT

8.1 When introducing a Pooled Fund, the Partners shall agree:

(a) which of the Partners shall act as Host Partner for the purposes of Regulations 7(4) and 7(5) and shall provide the financial administrative systems for the Pooled Fund;

(b) which officer of the Host Partner shall act as the Pooled Fund Manager for the purposes of Regulation 7(4) of the Regulations.

8.2 The Pooled Fund Manager for each Pooled Fund shall have the following duties and responsibilities:

(a) the day to day operation and management of the Pooled Fund;

(b) ensuring that all expenditure from the Pooled Fund is in accordance with the provisions of this Agreement and the relevant Scheme Specification;

(c) maintaining an overview of all joint financial issues affecting the Partners in relation to the Services and the Pooled Fund;

(d) ensuring that full and proper records for accounting purposes are kept in respect of the Pooled Fund;

(e) reporting to the Joint Strategic Commissioning Board and the CCG Governing Body as required by this Agreement;

(f) ensuring action is taken to manage any projected under or overspends relating to the Pooled Fund in accordance with this Agreement;

(g) preparing and submitting Quarterly Reports (or more frequent reports if required by the Joint Strategic Commissioning Board and/or and the CCG Governing Body) and an annual return about the income and expenditure from the Pooled Fund together with such other information as may be required by the Partners and the Joint Strategic Commissioning Board and/or and the CCG Governing Body to monitor the effectiveness of the Pooled Fund and to enable the Partners to complete their own financial accounts and returns. The Partners agree to provide all necessary information to the Pooled Fund Manager in time for the reporting requirements to be met including (without limitation) comply with any reporting requirements as may be required by relevant National Guidance; and

(h) preparing and submitting reports to the Joint Strategic Commissioning Board, the CCG Governing Body and the Health and Wellbeing Board as may be required and any relevant

National Guidance including (without limitation) supplying Quarterly Reports referred to in Clause 8.2(g) above to the Health and Wellbeing Board.

8.3 In carrying out their responsibilities as provided under Clause 8.2, the Pooled Fund Manager shall:

(a) have regard to National Guidance and the recommendations of the Joint Strategic Commissioning Board and the CCG Governing Body; and

(b) be accountable to the Partners for delivery of those responsibilities.

8.4 The Joint Strategic Commissioning Board and the CCG Governing Body may agree to the viring of funds between Pooled Funds or amending the allocation of a Pooled Fund between Individual Schemes, subject to the restrictions set out in Schedule 3 in respect of the Ring-Fenced Monies.

9 NON-POOLED FUNDS

9.1 Any Financial Contributions agreed to be held within a Non-Pooled Fund will be notionally held in a fund established solely for the purposes agreed by the Partners. For the avoidance of doubt, a Non-Pooled Fund does not constitute a pooled fund for the purposes of Regulation 7 of the Partnership Regulations.

9.2 When introducing a Non-Pooled Fund in respect of an Individual Scheme, the Partners shall agree:

(a) which Partner if any shall host the Non-Pooled Fund; and

(b) how and when Financial Contributions shall be made to the Non-Pooled Fund.

9.3 The Host Partner of the relevant Non-Pooled Fund will be responsible for establishing the financial and administrative support necessary to enable the effective and efficient management of the Non-Pooled Fund, meeting all required accounting and auditing obligations.

9.4 Both Partners shall ensure that any Services commissioned using a Non-Pooled Fund are commissioned solely in accordance with the relevant Scheme Specification.

9.5 Where there are Joint (Aligned) Commissioning arrangements, both Partners shall work in cooperation and shall endeavour to ensure that:

(a) the NHS Functions funded from a Non-Pooled Fund are carried out within the CCG Financial Contribution to the Non-Pooled Fund for the relevant Service in each Financial Year; and

(b) the Health Related Functions funded from a Non-Pooled Fund are carried out within the Council's Financial Contribution to the Non-Pooled Fund for the relevant Service in each Financial Year.

10 FINANCIAL CONTRIBUTIONS

10.1 The Financial Contribution of the CCG and the Council to any Pooled Fund or Non-Pooled Fund for the first Financial Year of operation shall be as set out in Schedule 3.

10.2 The Financial Contribution of the CCG and the Council to any Pooled Fund or Non-Pooled Fund for each subsequent Financial Year of operation shall be subject to review by the Partners which shall each determine their position as required by their constitutional and regulatory framework. The Partners shall meet to discuss and agree their respective contributions no later than 31 January prior to the start of the relevant Financial Year. The Partners shall cooperate in good faith to agree their respective contributions and any dispute in respect of this shall be referred to the Partners' respective chief executives who shall meet in good faith as soon as possible for the purpose of resolving the dispute. If the Partners' respective chief executives cannot resolve the dispute by 31 May in the relevant Financial Year then either Partner may terminate this Agreement by serving 30 days' notice on the other Partner. Clause 23 shall not apply in relation to a dispute arising under this Clause 10.2.

10.3 With the exception of Clause 13, no provision of this Agreement shall preclude the Partners from making additional contributions of Non-Recurrent Payments to a Pooled Fund from time to time by mutual agreement. Any such additional contributions of Non-Recurrent Payments shall be explicitly recorded in Joint Strategic Commissioning Board and CCG Governing Body minutes and recorded in the budget statement as a separate item.

11 NON FINANCIAL CONTRIBUTIONS

Unless set out in a Scheme Specification or otherwise agreed by the Partners, each Partner shall provide the non-financial contributions for any Service that they are Lead Partner or as required in order to comply with its obligations under this Agreement in respect of the commissioning of a particular Service. These contributions shall be provided at no charge to the other Partners or to the Pooled Fund.

12 RISK SHARE ARRANGEMENTS, OVERSPENDS AND UNDERSPENDS

Risk share arrangements

12.1 The Partners have agreed risk share arrangements as set out in Schedule 3, which provide for risk share arrangements arising within the commissioning of services from the Pooled Funds as set out in National Guidance.

Overspends in Pooled Fund

12.2 Subject to Clause 12.3, the Host Partner for the relevant Pooled Fund shall manage expenditure from a Pooled Fund within the Financial Contributions and shall use reasonable endeavours to ensure that the expenditure is limited to Permitted Expenditure.

12.3 The Host Partner shall not be in breach of its obligations under this Agreement if an Overspend occurs PROVIDED THAT it has used reasonable endeavours to ensure that the only expenditure from a Pooled Fund has been in accordance with Permitted Expenditure and it has informed the Joint Strategic Commissioning Board and the CCG Governing Body in accordance with Clause 12.4.

12.4 In the event that the Pooled Fund Manager identifies an actual or projected Overspend the Pooled Fund Manager must ensure that the Joint Strategic Commissioning Board and the CCG Governing Body are informed as soon as reasonably possible and the provisions of the relevant Scheme Specification and Schedule 3 shall apply.

Overspends in Non-Pooled Funds

12.5 Where in Joint (Aligned) Commissioning Arrangements either Partner forecasts an Overspend in relation to a Partners Financial Contribution to a Non-Pooled Fund that Partner shall as soon as reasonably practicable inform the other Partner, the Joint Strategic Commissioning Board and the CCG Governing Body.

12.6 Where there is a Lead Commissioning Arrangement the Lead Partner is responsible for the management of the Non-Pooled Fund. The Lead Partner shall as soon as reasonably practicable inform the other Partner.

Underspend

12.7 In the event that expenditure from any Pooled Fund or Non-Pooled Fund in any Financial Year is less than the aggregate value of the Financial Contributions made for that Financial Year or where the expenditure in relation to an Individual Scheme is less than the agreed allocation to that particular Individual Scheme the Partners shall agree how the monies shall be spent, carried forward and/or returned to the Partners and the provisions of Schedule 3 shall apply. Such arrangements shall be subject to the Law and the Standing Orders and Standing Financial Instructions (or equivalent) of the Partners.

13 CAPITAL EXPENDITURE

13.1 Except as provided in Clause 13.2, neither Pooled Funds nor Non-Pooled Funds shall normally be applied towards any one-off expenditure on goods and/or services, which will provide continuing benefit and would historically have been funded from the capital budgets of one of the Partners. If a need for capital expenditure is identified this must be agreed by the Partners.

13.2 The Partners agree that capital expenditure may be made from Pooled Funds where this is in accordance with National Guidance.

14 VAT

The Partners shall agree the treatment of each Pooled Fund for VAT purposes in accordance with any relevant guidance from HM Customs and Excise.

15 AUDIT AND RIGHT OF ACCESS

15.1 All Partners shall promote a culture of probity and sound financial discipline and control. The Host Partner shall arrange for the audit of the accounts of the relevant Pooled Fund in accordance with the Local Audit and Accountability Act 2014.

15.2 All internal and external auditors and all other persons authorised by the Partners will be given the right of access by them to any document, information or explanation they require from any employee, member of the relevant Partner in order to carry out their duties. This right is not limited to financial information or accounting records and applies equally to premises or equipment used in connection with this Agreement. Access may be at any time without notice, provided there is good cause for access without notice.

15.3 The Partners shall comply with relevant NHS finance and accounting obligations as required by relevant Law and/or National Guidance.

16 LIABILITIES AND INSURANCE AND INDEMNITY

16.1 Subject to Clause 16.2, and 16.3, if a Partner ("First Partner") incurs a Loss arising out of or in connection with this Agreement (including a Loss arising under an Individual Scheme) as a consequence of any act or omission of another Partner ("Other Partner") which constitutes negligence, fraud or a breach of contract in relation to this Agreement or any Service Contract then the Other Partner shall be liable to the First Partner for that Loss and shall indemnify the First Partner accordingly.

16.2 Clause 16.1 shall only apply to the extent that the acts or omissions of the Other Partner contributed to the relevant Loss. Furthermore, it shall not apply if such act or omission occurred as a consequence of the Other Partner acting in accordance with the instructions or requests of the First Partner.

16.3 If any third party makes a claim or intimates an intention to make a claim against either Partner, which may reasonably be considered as likely to give rise to liability under this Clause 16. the Partner that may claim against the other indemnifying Partner will:

(a) as soon as reasonably practicable give written notice of that matter to the Other Partner specifying in reasonable detail the nature of the relevant claim;

(b) not make any admission of liability, agreement or compromise in relation to the relevant claim without the prior written consent of the Other Partner (such consent not to be granted subject to unreasonable conditions, unreasonably withheld or unreasonably delayed); and

(c) give the Other Partner and its professional advisers reasonable access to its premises and personnel and to any relevant assets, accounts, documents and records within its power or control so as to enable the Indemnifying Partner and its professional advisers to examine such premises, assets, accounts, documents and records and to take copies at their own expense for the purpose of assessing the merits of, and if necessary defending, the relevant claim.

16.4 Each Partner shall ensure that they maintain policies of insurance (or equivalent arrangements through schemes operated by the National Health Service Litigation Authority) in respect of all potential liabilities arising from this Agreement and in the event of Losses shall seek to recover such Loss through the relevant policy of insurance (or equivalent arrangement).

16.5 Each Partner shall at all times take all reasonable steps to minimise and mitigate any loss for which one party is entitled to bring a claim against the other pursuant to this Agreement.

Conduct of Claims

16.6 In respect of the indemnities given in this Clause 16:

(a) the indemnified Partner shall give written notice to the indemnifying Partner as soon as is practicable of the details of any claim or proceedings brought or threatened against it in respect of which a claim will or may be made under the relevant indemnity;

(b) the indemnifying Partner shall at its own expense have the exclusive right to defend conduct and/or settle all claims and proceedings to the extent that such claims or proceedings may be covered by the relevant indemnity provided that where there is an impact upon the indemnified Partner, the indemnifying Partner shall consult with the indemnified Partner about the conduct and/or settlement of such claims and proceedings and shall at all times keep the indemnified Partner informed of all material matters; and

(c) the indemnifying and indemnified Partners shall each give to the other all such cooperation as may reasonably be required in connection with any threatened or actual claim or proceedings which are or may be covered by a relevant indemnity.

17 STANDARDS OF CONDUCT AND SERVICE

17.1 The Partners will at all times comply with Law and ensure good corporate governance in respect of each Partner (including the Partners respective standing orders and standing financial instructions).

17.2 The Council is subject to the duty of Best Value under the Local Government Act 1999. This Agreement and the operation of each Pooled Fund is therefore subject to the Council's obligations for Best Value and the other Partners will co-operate with all reasonable requests from the Council which the Council considers necessary in order to fulfil its Best Value obligations.

17.3 The CCG is subject to the CCG Statutory Duties and these incorporate a duty of clinical governance, which is a framework through which they are accountable for continuously improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish. This Agreement and the operation of the Pooled Funds are therefore subject to ensuring compliance with the CCG Statutory Duties and clinical governance obligations.

17.4 The Partners are committed to an approach to equality and equal opportunities as represented in their respective policies. The Partners will maintain and develop these policies as applied to service provision, with the aim of developing a joint strategy for all elements of the service.

18 CONFLICTS OF INTEREST

The Partners shall comply with the agreed policy for identifying and managing conflicts of interest as set out in Schedule 7.

19 GOVERNANCE

19.1 Overall strategic oversight of partnership working between the Partners is vested in the Health and Wellbeing Board, which for these purposes shall make recommendations to the Partners as to any action it considers necessary.

19.2 The Partners have determined arrangements by which they shall meet at the same time and in the same location, in order to govern and facilitate the integration of the commissioning functions of both the Council and the CCG with the objective of delivering a more efficient and effective commissioning of health and social care services. How those arrangements are co-ordinated and chaired is set out in Schedule 2 along with the terms of reference for the JSCB.

19.3 Each Partner has secured internal reporting arrangements to ensure the standards of accountability and probity required by each Partner's own statutory duties and organisation are complied with.

19.4 The Joint Strategic Commissioning Board (for the Council) and the CCG Governing Body (for the CCG) shall be responsible for the overall approval of the Individual Schemes on behalf of the relevant Partner and the financial management set out in Clause 12 and Schedule 3.

19.5 The Health and Wellbeing Board shall be responsible for ensuring compliance with the Better Care Fund Plan and the strategic direction of the Better Care Fund.

19.6 Each Scheme Specification shall confirm the governance arrangements in respect of the Individual Scheme and how that Individual Scheme is reported to the Joint Strategic Commissioning Board (for the Council) and the CCG Governing Body (for the CCG) and Health and Wellbeing Board.

20 REVIEW

20.1 The Partners shall produce a BCF Quarterly Report which shall be provided to the Health and Wellbeing Board in such form and setting out such information as required by National Guidance and any additional information required by the Health and Wellbeing Board or National Commissioning Board. The Partners shall also produce a quarterly report for each other Pooled Fund (other than the Better Care Fund Plan Pooled Fund) which shall be provided to the Joint Strategic Commissioning Board and the CCG Governing Body in such form as they may require.

20.2 Save where the Joint Strategic Commissioning Board and the CCG Governing Body agree alternative arrangements (including alternative frequencies) the Partners shall undertake an annual review ("**Annual Review**") of the operation of this Agreement, any Pooled Fund and Non-Pooled Fund and the provision of the Services within 3 Months of the end of each Financial Year.

20.3 Subject to any variations to this process required by the Joint Strategic Commissioning Board and the CCG Governing Body, Annual Reviews shall be conducted in good faith.

20.4 The Partners shall within 20 Working Days of the annual review prepare an Annual Report including the information as required by National Guidance and any other information required by the Health and Wellbeing Board. A copy of this report shall be provided to the Health and Wellbeing Board, Joint Strategic Commissioning Board and the CCG Governing Body. The report will include a review of Individual Schemes against finance, impact, performance and quality.

20.5 In the event that the Partners fail to meet the requirements of the Better Care Fund Plan and NHS England the Partners shall provide full co-operation with NHS England to agree a recovery plan.

21 COMPLAINTS

The Partners' own complaints procedures shall apply to this Agreement. The Partners agree to assist one another in the management of complaints arising from this Agreement or the provision of the Services.

22 TERMINATION & DEFAULT

22.1 This Agreement may be terminated by any Partner giving not less than 3 Months' notice in writing to terminate this Agreement provided that such termination shall not take effect prior to the termination or expiry of all Individual Schemes.

22.2 Each Individual Scheme may be terminated in accordance with the terms set out in the relevant Scheme Specification provided that the Partners ensure that the Better Care Fund Requirements continue to be met.

22.3 If any Partner ("Relevant Partner") fails to meet any of its obligations under this Agreement, the other Partners (acting jointly) may by notice require the Relevant Partner to take such reasonable action within a reasonable timescale as the other Partners may specify to rectify such failure. Should the Relevant Partner fail to rectify such failure within such reasonable timescale, the matter shall be referred for resolution in accordance with Clause 23.

22.4 Either Partner may terminate this Agreement in accordance with Clause 10.2.

22.5 Termination of this Agreement (whether by effluxion of time or otherwise) shall be without prejudice to the Partners' rights in respect of any antecedent breach and the provisions of Clause 16.

22.6 In the event of termination of this Agreement, the Partners agree to cooperate to ensure an orderly wind down of their joint activities and to use all reasonable endeavours to minimise disruption to the health and social care which is provided to the Service Users.

22.7 Upon termination of this Agreement for any reason whatsoever the following shall apply:

(a) the Partners agree that they will work together and co-operate to ensure that the winding down and disaggregation of the integrated and joint activities to the separate responsibilities of the Partners is carried out smoothly and with as little disruption as possible to service users, employees, the Partners and third parties, so as to minimise the costs and liabilities of each Partner in doing so;

(b) where either Partner has entered into a Service Contract which continues after the termination of this Agreement, both Partners shall continue to contribute to the Contract Price in accordance with the agreed contribution for that Service prior to termination and will enter into all appropriate legal documentation required in respect of this;

(c) the Lead Partner shall make reasonable endeavours to amend or terminate a Service Contract (which shall for the avoidance of doubt not include any act or omission that would place the Lead Partner in breach of the Service Contract) where the other Partner requests the same in writing Provided that the Lead Partner shall not be required to make any payments to the Provider for such amendment or termination unless the Partners shall have agreed in advance who shall be responsible for any such payment.

(d) where a Service Contract held by a Lead Partner relates all or partially to services which relate to the other Partner's Functions then provided that the Service Contract allows the other Partner may request that the Lead Partner assigns the Service Contract in whole or part upon the same terms mutatis mutandis as the original contract.

(e) the Joint Strategic Commissioning Board shall continue to operate for the purposes of functions associated with this Agreement for the remainder of any contracts and commitments relating to this Agreement; and

(f) termination of this Agreement shall have no effect on the liability of any rights or remedies of either Partner already accrued, prior to the date upon which such termination takes effect.

22.8 In the event of termination in relation to an Individual Scheme the provisions of Clause 22.7 shall apply mutatis mutandis in relation to the Individual Scheme (as though references as to this Agreement were to that Individual Scheme).

23 DISPUTE RESOLUTION

23.1 In the event of a dispute between the Partners arising out of this Agreement, either Partner may serve written notice of the dispute on the other Partner, setting out full details of the dispute.

23.2 The Authorised Officer shall meet in good faith as soon as possible and in any event within seven (7) days of notice of the dispute being served pursuant to Clause 23.1, at a meeting convened for the purpose of resolving the dispute.

23.3 If the dispute remains after the meeting detailed in Clause 23.2 has taken place, the Partners' respective chief executives or nominees shall meet in good faith as soon as possible after the relevant meeting and in any event with fourteen (14) days of the date of the meeting, for the purpose of resolving the dispute.

23.4 If the dispute remains after the meeting detailed in Clause 23.3 has taken place, then the Partners will attempt to settle such dispute by mediation in accordance with the CEDR Model Mediation Procedure or any other model mediation procedure as agreed by the Partners. To initiate a mediation, either Partner may give notice in writing (a **"Mediation Notice"**) to the other requesting mediation of the dispute and shall send a copy thereof to CEDR or an equivalent mediation organisation as agreed by the Partners asking them to nominate a mediator. The mediation shall commence within twenty (20) Working Days of the Mediation Notice being served. Neither Partner will terminate such mediation until each of them has made its opening presentation and the mediator has met each of them separately for at least one (1) hour. Thereafter, paragraph 14 of the Model Mediation Procedure will apply (or the equivalent paragraph of any other model mediation procedure agreed by the Partners). The Partners will co-operate with any person appointed as mediator, providing him with such information and other assistance as he shall require and will pay his costs as he shall determine or in the absence of such determination such costs will be shared equally.

23.5 Nothing in the procedure set out in this Clause 23 shall in any way affect either Partner's right to terminate this Agreement in accordance with any of its terms or take immediate legal action.

24 FORCE MAJEURE

24.1 Neither Partner shall be entitled to bring a claim for a breach of obligations under this Agreement by the other Partner or incur any liability to the other Partner for any losses or damages incurred by that Partner to the extent that a Force Majeure Event occurs and it is prevented from carrying out its obligations by that Force Majeure Event.

24.2 On the occurrence of a Force Majeure Event, the Affected Partner shall notify the other Partner as soon as practicable. Such notification shall include details of the Force Majeure Event, including evidence of its effect on the obligations of the Affected Partner and any action proposed to mitigate its effect.

24.3 As soon as practicable, following notification as detailed in Clause 24.2, the Partners shall consult with each other in good faith and use reasonable endeavours to agree appropriate terms to mitigate the effects of the Force Majeure Event and, subject to Clause 24.4, facilitate the continued performance of the Agreement.

24.4 If the Force Majeure Event continues for a period of more than sixty (60) days, either Partner shall have the right to terminate the Agreement by giving fourteen (14) days written notice of termination to the other Partner. For the avoidance of doubt, no compensation shall be payable by either Partner as a direct consequence of this Agreement being terminated in accordance with this Clause.

25 CONFIDENTIALITY

25.1 In respect of any Confidential Information a Partner receives from another Partner (the "**Discloser**") and subject always to the remainder of this Clause 25, each Partner (the "**Recipient**") undertakes to keep secret and strictly confidential and shall not disclose any such Confidential Information to any third party, without the Discloser's prior written consent provided that:

(a) the Recipient shall not be prevented from using any general knowledge, experience or skills which were in its possession prior to the Commencement Date; and

(b) the provisions of this Clause 25 shall not apply to any Confidential Information which:

(i) is in or enters the public domain other than by breach of the Agreement or other act or omission of the Recipient; or

(ii) is obtained by a third party who is lawfully authorised to disclose such information.

25.2 Nothing in this Clause 25 shall prevent the Recipient from disclosing Confidential Information where it is required to do so in fulfilment of statutory obligations or by judicial, administrative, governmental or regulatory process in connection with any action, suit, proceedings or claim or otherwise by applicable Law.

25.3 Each Partner:

(a) may only disclose Confidential Information to its employees and professional advisors to the extent strictly necessary for such employees to carry out their duties under the Agreement;

(b) will ensure that, where Confidential Information is disclosed in accordance with Clause 25.3.1, the recipient(s) of that information is made subject to a duty of confidentiality equivalent to that contained in this Clause 25; and

(c) shall not use Confidential Information other than strictly for the performance of its obligations under this Agreement.

26 FREEDOM OF INFORMATION AND ENVIRONMENTAL INFORMATION REGULATIONS

26.1 The Partners agree that they will each cooperate with each other to enable any Partner receiving a request for information under the 2000 Act or the 2004 Regulations to respond to a request promptly and within the statutory timescales. This cooperation shall include but not be limited to finding, retrieving and supplying information held, directing requests to other Partners as appropriate and responding to any requests by the Partner receiving a request for comments or other assistance.

26.2 Any and all agreements between the Partners as to confidentiality shall be subject to their duties under the 2000 Act and 2004 Regulations. No Partner shall be in breach of Clause 25 if it makes disclosures of information in accordance with the 2000 Act and/or 2004 Regulations.

27 OMBUDSMEN

The Partners will co-operate with any investigation undertaken by the Health Service Commissioner for England or the Local Government Commissioner for England (or both of them) in connection with this Agreement.

28 INFORMATION SHARING

The Partners will work together to document and agree an information governance protocol in respect of the arrangements under this Agreement, and in so doing will ensure that the operation this Agreement complies comply with Law, in particular the Data Protection Legislation.

29 NOTICES

29.1 Any notice to be given under this Agreement shall either be delivered personally or sent by first class post. The address for service of each Partner shall be as set out in Clause 29.3 or such other address as each Partner may previously have notified to the other Partner in writing. A notice shall be deemed to have been served if:

(a) personally delivered, at the time of delivery;

(b) posted, at the expiration of forty eight (48) hours after the envelope containing the same was delivered into the custody of the postal authorities.

29.2 In proving such service, it shall be sufficient to prove that personal delivery was made, or that the envelope containing such notice was properly addressed and delivered into the custody of the postal authority as prepaid first class or airmail letter (as appropriate).

29.3 The address for service of notices as referred to in Clause 29.1 shall be as follows unless otherwise notified to the other Partner in writing:

(a) if to the Council, addressed to the:

Chief Executive
Wirral Borough Council
Town Hall
Brighton Street
Wallasey
Wirral, CH44 8ED

and

(b) if to the CCG, addressed to:

Chief Officer
Marriss House
Hamilton Street
Birkenhead
Wirral
CH41 5AL

30 PROHIBITED ACTS

30.1 Neither Partner shall commit a Prohibited Act

30.2 If either of the Partners commits any Prohibited Act or commits any offence under the Bribery Act with or without the knowledge of the other Partner in relation to this Agreement, the non-defaulting Partner shall be entitled:

(a) to exercise its right to terminate this agreement and to recover from the defaulting Partner the amount of any loss resulting from the termination; and

(b) to recover from the defaulting party any loss or expense sustained in consequence of the carrying out of the Prohibited Act or the commission of the offence.

30.3 Each Partner must provide the other Partner upon written request with all reasonable assistance to enable that Partner to perform any activity required for the purposes of complying with the Bribery Act. Should either Partner request such assistance the Partner requesting assistance must pay the reasonable expenses of the other Partner arising as a result of such request.

30.4 The Partners must have in place an anti-bribery policy for the purposes of preventing any of its employees, agents, servants, consultants or contractors from committing a prohibited act under the Bribery Act and must be enforced where applicable.

30.5 Should either Partner become aware of or suspect any breach of this clause, it will notify the other Partner immediately. Following such notification, the defaulting Partner should respond promptly and fully to any enquiries of the other Partner, co-operate with any investigation undertaken by the non-defaulting Partner and allow the non-defaulting Partner to audit any books, records and other relevant documentation.

31 **SAFEGUARDING**

The Partners shall ensure that all Providers have appropriate Safeguarding policies in place and shall require such policies to be implemented where applicable. Where the services or activities being undertaken with respect to any Individual Scheme are Regulated Activities the Partners shall require Providers to comply with all relevant requirements of the Disclosure and Barring Service.

32 VARIATION

32.1 No variations to this Agreement will be valid unless they are recorded in writing and signed for and on behalf of each of the Partners as set out in this Clause.

32.2 Where the Partners agree that there will be:

(a) a new Pooled Fund;

(b) a new Individual Scheme; or

(c) an amendment to a current Individual Scheme,

the Joint Strategic Commissioning Board and the CCG Governing Body shall agree the new or amended Individual Scheme and this must be signed by the Partners. A request to vary an Individual Scheme, which may include (without limitation) a change in the level of Financial Contributions or other matters set out in the relevant Scheme Specification may be made by any Partner but will require agreement from all of the Partners in accordance with the process set out in Clause 32.3. The notice period for any variation unless otherwise agreed by the Partners shall be 3 Months or in line with the notice period for variations within the associated Service Contract(s), whichever is the shortest.

32.3 The following approach shall, unless otherwise agreed, be followed by the Joint Strategic Commissioning Board and the CCG Governing Body:

(a) on receipt of a request from one Partner to vary the Agreement including (without limitation) the introduction of a new Individual Scheme or amendments to an existing Individual Scheme, the Joint Strategic Commissioning Board and the CCG Governing Body will first undertake an impact assessment and identify those Service Contracts likely to be affected;

(b) the Joint Strategic Commissioning Board and the CCG Governing Body will agree whether those Service Contracts affected by the proposed variation should continue, be varied or terminated, taking note of the Service Contract terms and conditions and ensuring that the Partner(s) holding the Service Contract/s is not put in breach of contract; its statutory obligations or financially disadvantaged;

(c) wherever possible agreement will be reached to reduce the level of funding in the Service Contract(s) in line with any reduction in budget; and

(d) should this not be possible and one Partner is left financially disadvantaged as a result of holding a Service Contract for which the budget has been reduced, then the financial risk will, unless otherwise agreed, be shared as set out in Schedule 3.

33 CHANGE IN LAW

33.1 The Partners shall ascertain, observe, perform and comply with all relevant Laws, and shall do and execute or cause to be done and executed all acts required to be done under or by virtue of any Laws.

33.2 On the occurrence of any Change in Law, the Partners shall agree in good faith any amendment required to this Agreement as a result of the Change in Law subject to the Partners using all reasonable endeavours to mitigate the adverse effects of such Change in Law and taking all reasonable steps to minimise any increase in costs arising from such Change in Law.

33.3 In the event of failure by the Partners to agree the relevant amendments to the Agreement (as appropriate), Clause 23 (Dispute Resolution) shall apply.

34 WAIVER

No failure or delay by any Partner to exercise any right, power or remedy will operate as a waiver of it nor will any partial exercise preclude any further exercise of the same or of some other right to remedy.

35 SEVERANCE

If any provision of this Agreement, not being of a fundamental nature, shall be held to be illegal or unenforceable, the enforceability of the remainder of this Agreement shall not thereby be affected.

36 ASSIGNMENT AND SUB CONTRACTING

The Partners shall not sub contract, assign or transfer the whole or any part of this Agreement, without the prior written consent of the other Partners, which shall not be unreasonably withheld or delayed. This shall not apply to any assignment to a statutory successor of all or part of a Partner's statutory functions nor to an assignment by the Council or transfer of any of its rights or obligations by novation to an Associated Person (to the extent that such an assignment would be consistent with the Council's statutory powers and functions).

37 EXCLUSION OF PARTNERSHIP AND AGENCY

37.1 Nothing in this Agreement shall create or be deemed to create a partnership under the Partnership Act 1890 or the Limited Partnership Act 1907, a joint venture or the relationship of employer and employee between the Partners or render either Partner directly liable to any third party for the debts, liabilities or obligations of the other.

37.2 Except as expressly provided otherwise in this Agreement or where the context or any statutory provision otherwise necessarily requires, neither Partner will have authority to, or hold itself out as having authority to:

(a) act as an agent of the other;

(b) make any representations or give any warranties to third parties on behalf of or in respect of the other; or

(c) bind the other in any way.

38 THIRD PARTY RIGHTS

Unless the right of enforcement is expressly provided, no third party shall have the right to pursue any right under this Contract pursuant to the Contracts (Rights of Third Parties) Act 1999 or otherwise.

39 ENTIRE AGREEMENT

39.1 The terms herein contained together with the contents of the Schedules constitute the complete agreement between the Partners with respect to the subject matter hereof and supersede all previous communications representations understandings and agreement and any representation promise or condition not incorporated herein shall not be binding on any Partner.

39.2 No agreement or understanding varying or extending or pursuant to any of the terms or provisions hereof shall be binding upon any Partner unless in writing and signed by a duly authorised officer or representative of the parties.

40 COUNTERPARTS

This Agreement may be executed in one or more counterparts. Any single counterpart or a set of counterparts executed, in either case, by all Partners shall constitute a full original of this Agreement for all purposes.

41 GOVERNING LAW AND JURISDICTION

41.1 This Agreement and any dispute or claim arising out of or in connection with it or its subject matter or formation (including non-contractual disputes or claims) shall be governed by and construed in accordance with the laws of England and Wales.

41.2 Subject to Clause 23 (Dispute Resolution), the Partners irrevocably agree that the courts of England and Wales shall have exclusive jurisdiction to hear and settle any action, suit, proceedings, dispute or claim, which may arises out of, or in connection with, this Agreement, its subject matter or formation (including non-contractual disputes or claims).

IN WITNESS WHEREOF this Agreement has been executed by the Partners on the date of this Agreement

THE COMMON SEAL of)

WIRRAL BOROUGH COUNCIL)

was hereunto affixed in the presence of:)

an authorised signatory:

Signed for on behalf of **NHS WIRRAL**

CLINICAL COMMISSIONING GROUP

_____

Authorised Signatory

SCHEDULE 1 – SCHEME SPECIFICATION

Part 1 – Template Services Schedule

1 OVERVIEW OF SERVICE

1.1 The First Pooled Fund will be made up of a number of funding streams to create a single commissioning First Pooled Fund to the value of £131.1M as set out in the table below. The detail of the specific composition of the First Pooled Fund in relation to currently commissioned schemes and budget lines is given in Schedule 2.

	CCG contribution	Council contribution
BCF Schemes	£25,851,747	£27,886,387
Non-BCF Schemes	£22,000,000	£55.400,000
Total	**£47,851,747**	**£83,286,387**

1.2 The Host Partner for the Pooled Fund is the Council and the Pooled Fund Manager, being an officer of the Host Partner is Director of Care and Health, Deputy Chief Officer.

2 AIMS AND OUTCOMES

2.1 NHS Wirral CCG and the commissioning departments of Adult Social Care, and Public Health of Wirral Council are coming together from April 2018 to form a single commissioning function, Wirral Health and Care Commissioning ("WHaCC"). WHaCC will jointly commission all age health, care and public health services for the Wirral population. This will enable a single cohesive commissioning function to lead the creation of a sustainable model for Health and Care in Wirral.

2.2 WHaCC will be responsible for setting the commissioning agenda and will lead the development of a Place Based Care System (PBCS) in Wirral. The focus will be on people and place, not on organisations. The transformation of service delivery is expected to reduce need for high cost acute care and improve health and wellbeing, reducing the need for long term care. The aim is to improve the outcomes for the people of Wirral and also to deliver sustainable services, both clinically and financially. Placed based care is being developed in response to the challenges the Wirral health and care system faces of constrained funding, increasing demand, fragmentation of services and the need to deliver better health, better care and better value for the people of Wirral.

2.3 The ambition of providing services at the most appropriate local 'place' level has led to development of the '51-9-4-1 model' based on supporting health and delivering care at the most appropriate level. The intention is for services and pathways of care to be delivered through the 51 (as at January 2018) General Practices, nine neighbourhoods, four localities and one district. Development of the nine neighbourhoods is a priority for 2018/19 as this will be the cornerstone of place based care. Neighbourhood teams, with representatives from a variety of health and care disciplines and organisations, will be led by a GP, and will focus on the implementation of care to meet the needs of people within the neighbourhood.

2.4 Pooled funds as identified will enable single commissioning plans to be developed and implemented. The make-up of the Pooled Fund in 2018 will specifically facilitate the further development of BCF schemes and will enable more effective commissioning of services for people with complex needs and learning disabilities.

3 THE ARRANGEMENTS

3.1 The scheme enables the development of a single fully integrated commissioning function (WHaCC). This is a single operating model with a single management and staffing structure to facilitate working

as a single body. The Memorandum of Understanding sets out the terms upon which the Partners intend their respective employees who work in WHaCC to be managed and how the Partners intend to co-operate in relation to the management of their respective employees in order to achieve the objectives of WHaCC.

4 FUNCTIONS

4.1 All health and care related commissioning functions of the CCG and the Council will be undertaken through WHaCC, however the Pooled Fund arrangements have been developed in order to create a stepped change model before full integration of all budgets. This approach has developed further from the original BCF to include finances for care packages and public health services. This is intended to help mitigate risk through pooling those funds most appropriate to the delivery of single integrated commissioning plans.

5 SERVICES

5.1 The First Pooled Fund is made up of a number of elements based on current budget lines and spending requirements:

(a) BCF schemes as set out in Schedule 6 (Better Care Fund Plan). These services are available to the population of Wirral and are intended to assist in reducing pressure on the Hospital through improved access to therapies, early discharge and admission prevention services;

(b) Adult Social care funding for community care packages to include those support packages for people with learning disabilities and mental health problems. The Pooled Fund also includes customer and client receipts as well as other income from jointly funded packages of support as set out in Schedule 2;

(c) CCG Adult fully funded care, personal health budgets, funded nursing care, client group specific care (Learning Disability and Mental Health) joint funded care and continuing care for children as set out in Schedule 2;

(d) Public Health Commissioned services as set out in Schedule 2; and

(e) Children and Young People care packages as set out in Schedule 2.

6 COMMISSIONING, CONTRACTING, ACCESS

Commissioning Arrangements

6.1 A single commissioning strategy will set out key priorities and a single commissioning business plan under the auspices of Healthy Wirral will be delivered through WHaCC.

Contracting Arrangements

6.2 A single contracting team will deliver the contractual requirements of WHaCC. The Lead Partner for each contract within a Scheme is set out in the table in Schedule 6 (Better Care Fund Plan).

7 FINANCIAL CONTRIBUTIONS

7.1 The Financial Contributions of the Partners in the first Financial Year are set out in the spreadsheet in Appendix 1 to this Schedule 1.

8 FINANCIAL GOVERNANCE ARRANGEMENTS

Management of the Pooled Fund

8.1 Financial and performance monitoring is firstly the responsibility of officers of each organisation working together but ultimately is the responsibility of the Joint Strategic Commissioning Board and the CCG Governing Body

8.2 A Pooled Fund Executive Group is in place made up of Directors from the CCG and the Council and is responsible for monitoring and reviewing financial performance of all budgets related to WHaCC and reporting to the Joint Strategic Commissioning Board and the CCG Governing Body.

8.3 The appointed Pooled Fund Manager will report on a regular basis to the Pooled Fund Executive Group on matters regarding performance and sufficient detail regarding the implementation of commissioned services

8.4 Each Partner will also secure internal reporting arrangements as necessary to ensure the standards of accountability and probity required by each Partner's own statutory duties and organisation are complied with.

Audit arrangements

8.5 The audit arrangements for commissioned services will be determined by the organisation accountable for each service. The costs of undertaking audit are Permitted Expenditure for the purposes of the relevant Pooled Fund.

9 VAT

9.1 The Council is the Host Partner for the First Pooled Fund established at inception of this Agreement and will be the Lead Partner in respect of delivering certain activities under the pooled budget arrangement. For other activities the CCG will be the Lead Partner.

9.2 The VAT regime of the Lead Partner will determine the VAT recovery for the partnership.

9.3 Where the CCG is the Lead Partner any VAT incurred in the delivery of the programme can only be recovered to the extent that it relates to services mentioned in the contracting out directions, which are published by the Treasury under Section 41(3) Value Added Tax Act 1994, currently December 2002. This of course only applies to that body's non-business activities.

9.4 Where the Council is the Lead Partner, any VAT incurred in the purchase of goods and services required to deliver the programme can be recovered under Section 33 of the Value Added Tax Act 1994, where the supply has incurred tax and relates to its non-business activities for VAT purposes.

10 GOVERNANCE ARRANGEMENTS

10.1 Overall strategic oversight of partnership working between the Partners is vested in the Health and Wellbeing Board, which for these purposes shall make recommendations to the Partners as to any action it considers necessary.

10.2 The Partners have each determined arrangements by which they meet at the same time and in the same location, in order to govern and facilitate the integration of the commissioning functions of both the Council and the CCG with the objective of delivering a more efficient and effective commissioning of health and social care services. Further detail as to the governance arrangements is set out in Schedule 2 (Governance).

11 NON FINANCIAL RESOURCES

Each organisation will continue to be responsible for their own share of costs in relation to Premises, assets and equipment and central support

12 STAFF

There are no staff transferred or seconded. Each organisation will continue to be responsible for the pay and conditions of staff they employ to support the commissioning for the Individual Schemes.

13 ASSURANCE AND MONITORING

Overall performance will be managed through the Pooled Fund Executive Group who hold responsibility for:

13.1 Assurance and oversight of commissioning and savings programme and their impact against financial performance;

13.2 Monitoring and reviewing actual performance against budget and to suggest actions necessary to ensure that WHaCC remains within agreed budgets. To agree risks and mitigations across the integrated commissioning organisation;

13.3 Monitoring the progress and performance of specific commissioning programmes and other initiatives (QIPP) in delivering agreed financial;

13.4 Receiving specific reports in relation to the BCF programme and performance of the QIPP programme;

13.5 Exploring the efficacy and added value of schemes as necessary in order to recommend changes as necessary;

13.6 Assuring WHaCC that appropriate investments are being made through ensuring due process has been followed i.e. process within Commissioning Decision Policy has been adhered to; and

13.7 Advising the Joint Strategic Commissioning Board and the CCG Governing Body on:

(f) the financial position of the Pooled Fund. The Pooled Fund Executive Group will report on the financial position of each Partner in relation to monies which are not included in the Pooled Fund as at the Commencement Date, but which the Partners contemplate may be included in the Pooled Fund from 1 April 2019 or later during the term of this Agreement;

(g) the overall financial strategy forecasting and potential risks;

(h) an estimate of income and expenditure;

(i) performance of agreed programme of commissioning activity and any proposed significant changes from the plan.

14 LEAD OFFICERS

Council	Graham Hodkinson	Director of Care and Health, Deputy Chief Officer
CCG	Simon Banks	Accountable Officer

15 RISK AND GAIN SHARE ARRANGEMENTS

The risk and gain share in the first Financial Year of the First Pooled Fund is as set out in paragraph 4 of Schedule 3 (Financial Arrangements, Risk and Gains Share and Overspends).

16 DURATION and EXIT STRATEGY

As set out in Clause 22 and each Individual Scheme as appropriate.

Part 2 – Agreed Scheme Specifications

1 PUBLIC HEALTH SCHEMES

The total value of the Public Health Schemes is £12.4 million. These monies are ring-fenced to meet public health related outcomes.

Stop Smoking Interventions

1.1 Stop Smoking Interventions is a multi-faceted programme of tobacco control.

1.2 £0.8 million of the Ring-Fenced Monies are for Stop Smoking Interventions.

1.3 The outcomes of Stop Smoking Interventions are:

(a) a reduction in smoking among adults and young people with a focus on specific vulnerable groups;

(b) a reduction in illegal and illicit tobacco; and

(c) an increased awareness of the risks associated with smoking.

Sexual Health Services

1.4 £3.1 million of the Ring-Fenced Monies are for Sexual Health Services.

1.5 The outcomes of Sexual Health Services are:

(a) a better informed population, with access to differentiated on-line up-to-date information and tools, including for those at highest risk of poor sexual health, as well as signposting to local and national services;

(b) improved access to services among those at highest risk of sexual ill health;

(c) reduced sexual health inequalities;

(d) increased uptake and retention of effective methods of contraception, including rapid access to the full range of contraceptive methods including non-user dependant long acting reversible contraception;

(e) reduced prevalence and transmission of sexually transmitted infections;

(f) increased contraception use among sexually active young people under the age of 19;

(g) a reduction in unwanted pregnancies in all ages as evidenced by teenage conception and abortion rates;

(h) increased diagnosis and effective management of sexually transmitted infections; and

(i) increased uptake of HIV testing with particular emphasis on identified populations, symptomatic service users and repeat testing of those who remain at risk.

Adult Obesity

1.6 Adult Obesity are programmes considering a whole systems approach to tackle obesity.

1.7 £0.2 million of the Ring-Fenced Monies are for Adult Obesity.

1.8 The outcomes of the Adult Obesity programmes are weight loss and healthy weight maintenance in adults aged 16 years and over

Children's Services

1.9 Children's Services includes Healthy Child Programmes for early year's health improvement programme to support young children and their families living in Wirral. Children's Services includes statutory services such as Health Visitors and Family Nurse Partnerships.

1.10 £6.8 million of the Ring-Fenced Monies are for Children's Services.

Health Checks

1.11 Health Checks are a statutory service requiring the provision of health checks check-up for adults in England aged 40-74. Their purpose is to https://www.nhs.uk/conditions/nhs-health-check/what-happens-at-an-nhs-health-check-new of stroke, kidney disease, heart disease, type 2 diabetes or dementia.

1.12 £0.3 million of the Ring-Fenced Monies are for Health Checks.

Mental Health

1.13 Mental Health is the provision of services which improve mental health and wellbeing through the organised efforts and informed choices of society, organisations, public and private, communities and individuals.

1.14 £0.9 million of the Ring-Fenced Monies are for Mental Health.

Infection Control

1.15 Infection Control is the Community Infection Prevention and Control Service, which is responsible for providing:

(a) information, advice and support to the public, professionals and commissioners regarding infection prevention and control (IPC);

(b) health and social care workforce IPC education and development;

(c) prevention, management and control of cases; and

(d) clusters and outbreaks of communicable disease (including health care associated infections) within the community, in partnership where necessary, and following agreed protocols.

1.16 £0.2 million of the Ring-Fenced Monies are for Infection Control.

2 ADULT SOCIAL CARE SCHEMES

2.1 The total value of non–Better Care Fund-funded social care services within the First Pooled Fund in 2018 is £39.8 million after taking account of income against services.

2.2 The contribution to the First Pooled Fund is based upon the cost of statutory services provided to individuals following an assessment under the Care Act contracts are with a broad range of providers and include direct payment awards to individuals.

2.3 The current value of Community Care services for people with learning Disabilities is £39.3 million and for people with mental health problems is £10 million.

2.4 Customer receipts provide income to the value of £3 million.

2.5 Jointly funded care packages bring income of £6.4 million.

3 CHILDREN AND YOUNG PEOPLE'S SCHEMES

3.1 Total value of children's and young people's services £3.2 million.

3.2 The contribution to the First Pooled Fund is based upon the cost of statutory services provided to individuals following an assessment under the Care Act. Contracts are with a broad range of providers and include direct payment awards to individuals.

4 CCG CONTRIBUTION OUTSIDE OF THE BETTER CARE FUND

Total value of CCG contribution for non-BCF services £22M

This figure is made up of

1.	CHC – adult fully funded continuing care	3.7
2.	CHC – adult fully funded Personal Health Budgets (PHBs)	0.9
3.	Funded nursing care	0.8
4.	Learning disabilities	1.7
5.	Mental health	9.8
6.	Adult joint funded	3.8
7.	CHC – Adult joint funded PHBs	0.3
8.	CHC children's continuing care	0.9
9.	Children's PHBs	0.0

5 Better Care Fund Schemes

Total Value of the BCF element of the Pooled Fund £53.7M

This figure is made up of:

6 Integrated services

Services currently commissioned as fully integrated health and care services — £20.6M

7 Adult social care services

The protection of social care services — £25.2M

8 CCG services

Services currently solely commissioned by the CCG — £2.0M

9 Disabled Facilities Grant

Part of the Grant that is pass-ported to Housing for adaptations — £3.9M

10	Innovation fund	
	Part of the Grant set aside for innovative schemes during 2017 to 18 to enable system wide bids	£0.9M
11	Known pressures & contingency	
	Based on the annual forecast part of the Grant set aside to meet expected growth in demand	£1.1M

APPENDIX 1 – FINANCIAL CONTRIBUTIONS OF THE PARTNERS IN THE FIRST FINANCIAL YEAR

[*Appendix 3a to JSCB report 16.10.18*]

SCHEDULE 2 – GOVERNANCE

1 Overall strategic oversight of partnership working between the Partners is vested in the Joint Strategic Commissioning Board (for the Council) and the CCG Governing Body (for the CCG). The JSCB shall for these purposes make recommendations to the Council as to any action it considers necessary.

2 The JSCB and the CCG Governing Body shall arrange to hold a number of meetings together, to be agreed in advance, where matters in relation to this Agreement shall be considered and the JSCB and the CCG Governing Body shall aim to take the same decisions in respect of such matters (but it will be possible and permissible for each to make their own decision). The Partners have agreed a common chairing protocol with which each of the JSCB and the CCG Governing Body shall comply, as set out in Appendix 3 to this Schedule 2.

3 Where decisions are required in respect of this Agreement, decisions shall be taken by each of the JSCB and the CCG Governing Body (whether meeting together or not) and neither may bind the other. Where the JSCB and CCG Governing Body cannot reach the same decision then they may agree to defer their respective decisions to a future meeting to allow reflection by their respective members on the relevant matter. Following any further consideration of a deferred decision at a future meeting, if agreement of both the JSCB and the CCG Governing Body still cannot be obtained, then the matter may be referred to the dispute resolution process set out in this Agreement, provided that the first stage of such process shall be as set out in Clause 23.3, followed by CEDR as set out in Clause 23.4.

4 The JSCB and the CCG Governing Body shall be responsible for the overall approval and strategic direction of the Pooled Funds, ensuring compliance with the national requirements of the Better Care Fund. The terms of reference for the JSCB and procedures as at the date of this Agreement are set out in Appendix 1. The CCG Governing Body Standing Orders shall apply in respect of CCG Governing Body meetings.

5 A group of officers (the Pooled Fund Executive Group) will report to the JSCB and the CCG Governing Body jointly. This board is made up of relevant directors and senior representatives of Wirral Council and Wirral CCG and its purpose is to drive the development and delivery of the WHaCC work/action plans including the delivery of the Better Care Fund. The terms of reference for the Pooled Fund Executive Group are in Appendix 2.

6 It is the responsibility of the JSCB and the CCG Governing Body to ensure that strategic objectives across health and the local authority are aligned. Strategic issues are resolved through this forum.

Post-termination

7 The JSCB and the CCG Governing Body shall following any termination of this Agreement endeavour to ensure that the benefits of any contracts are received by the Partners in the same proportions as their respective contributions at that time.

APPENDIX 1

TERMS OF REFERENCE AND PROCEDURES FOR THE JOINT STRATEGIC COMMISSIONING BOARD CABINET COMMITTEE

1. Purpose

The purpose of the Committee is to make recommendations to and exercise delegated powers of the Executive of Wirral Borough Council (WBC) and suggest what recommendations might be suggested to the Governing Body of the NHS Wirral Clinical Commissioning Group (CCG) in order to bring about the integration of the commissioning functions of both WBC and the CCG to deliver more efficient and effective commissioning of health and social care services.

'Healthy Wirral' sets out a clear set of priorities for the health and care of residents on the Wirral. In order to deliver those priorities and improve services to residents, it is recognised that organisational change will be needed in all parts of the health and social care system.

The JSCB is established to assist in delivery of the integration that will be critical in the move towards commissioning that will deliver outcomes to enhance the quality and consistency of services while moving towards a more holistic approach to health and social care provision.

It is intended that integration will lead to better and more cohesive planning of services, and will be supported by the greater involvement of those people who use the services to help shape the outcomes required in the future.

2. Governance

The CCG and the Cabinet of the Council via the JSCB agree that they will meet at the same time to discuss a common agenda, but each of the Council and the CCG retain their own legal status and arrangements.

Individual arrangements for each body are codified in the Constitutions of each partner and are published on the respective partners' websites. This document provides the legal and procedural requirements of the JSCB Cabinet Committee.

The JSCB Cabinet Committee has a formal status of a Committee of the Cabinet whose members are appointed by the Leader of the Council and whose decisions are taken in consultation with and in the presence of members of the CCG Governing Body.

3. Terms of Reference

The JSCB Cabinet Committee is established to focus on the commissioning, strategic design and performance management of health and care services on Wirral, including the outcomes and quality of those services. The JSCB Cabinet Committee will oversee the development of population based commissioning.

The JSCB Cabinet Committee will undertake the following duties and responsibilities, exercising delegated powers of the WBC Executive and formulating recommendations for adoption by the WBC Cabinet and / or making suggestions to the CCG Governing Body, as the case may be, that seek –

- To promote the integration of health and social services generally across WBC and CCG;
- To approve integrated health and care commissioning strategies;
- To approve large scale health and care transformation programmes;
- To approve and maintain oversight of plans and oversight of delivery for specific areas such as:
  - Better Care Fund Schemes
  - Urgent Care Transformation
  - Commissioning Prospectus
  - Learning Disabilities Plan;
- To ensure effective stewardship of Section 75 pooled monies and address any issues of concern;

- To maintain oversight of health and care system performance and address any issues of concern;
- To ensure the implementation of integrated health and care commissioning strategies and transformation programmes.

In making decisions and / or recommendations to the Cabinet and / or making any suggestion it considers appropriate to do so to the Governing Body, the JSCB Cabinet Committee will look to ensure that those actions will seek in all cases -

- To reduce inequalities;
- To secure greater public involvement;
- To commission services effectively, efficiently and equitably;
- To secure quality improvements;
- To promote choice and inclusion.

The JSCB Cabinet Committee will not consider or deal with any matters relating to individual patients, service users or carers, including complaints or requests for specific treatments or services, which will be managed through existing procedures. The JSCB Cabinet Committee will review service user and patient experience data at an 'aggregate' rather than individual level.

The JSCB Cabinet Committee will make its decisions in accordance with the Budget and Policy Framework of Wirral Council and any matter coming before the JSCB Cabinet Committee that might involve a decision contrary to the Budget and / or Policy Framework shall be referred to the Cabinet for confirmation and, if necessary, referral to the full Council.

4. Membership

The membership of the JSCB Cabinet Committee shall be appointed and varied, as considered necessary, by the Leader of the Council. Membership of the JSCB Cabinet Committee at commencement shall be -

Cabinet Member for Adult Care and Health

Cabinet Member for Children and Families

Cabinet Member for Highways and Transport

The Leader of the Council may appoint deputy or substitute members who shall have voting rights on matters coming before the Board.

Substitution arrangements should be notified to the Clerk prior to the commencement of a meeting.

All the members of the JSCB Cabinet Committee hold a collective responsibility for its operation. The JSCB Cabinet Committee is able to invite additional persons to attend meetings on an ad hoc basis to inform debate, report or answer questions.

* * * * * *

Procedural Arrangements for meetings of the Joint Strategic Commissioning Board Cabinet Committee

The following procedural arrangements represent the statutory requirements of the Local Authorities (Executive Arrangements) (Meetings and Access to Information) (England) Regulations 2012 and the further statutory and procedural requirements contained within the Constitution of Wirral Borough Council as at the date of this agreement . These arrangements will change in line with any changes in statutory requirements and/or the Constitution.

1. Meetings of the Board

1.1 Meetings of the JSCB will be held on a bi-monthly basis.

1.2 Special meetings may, subject to the minimum notice period of five clear working days being given, be convened as provided for in the agreed common chairing protocol in Appendix 3 .

1.3 The JSCB shall meet within ten working days of a meeting of the full Council of WBC in the event of the Council meeting referring back to the JSCB Cabinet Committee a decision subject to call-in to which the Council objects (Rule 110.3 – 11.14 below refers).

2. Chair

2.1 Chairing arrangements will be in line with the Chairing Protocol in Appendix 3.

3. Voting

3.1 Voting shall be in line with the Council's procedural rules and constitution.

4. Notice of Meetings

4.1 Five clear working days' notice of JSCB Cabinet Committee meetings will be given. The notice will comprise the date, time and place at which the meeting is being held, together with an agenda listing all matters for consideration at the meeting and such supporting papers / reports as can be published (see Rule 6.2 – 6.7 below). A copy of the notice and agenda will be forwarded to each JSCB Cabinet Committee member, and the agenda will be published / made available at Wallasey Town Hall and on the Council's website. *Access to Information Procedure Rules 4-5*

5. Business to be considered

5.1 The agenda for all meetings will include

- confirmation of the Chair for the meeting of the JSCB;
- declarations of interest;
- confirmation of the Chair of each Committee for the purpose of voting at the meeting;
- approval of minutes of the previous meeting (if available and circulated prior to the meeting). The minutes are to be submitted only for the purpose of determining accuracy, and shall not otherwise be debated;
- the business to be transacted at the meeting.

5.2 The agenda will not contain an item of 'any other business'. Urgent business can only be considered

(i) at the discretion of the Chair of the meeting and the grounds for urgency being recorded in the minutes of the meeting; and
(ii) in the event of the urgent business being a 'key decision', the special urgency procedures at Rule 5.8 below being followed; and
(iii) in the event of the urgent business being private business, the procedures at Rule 6.11 below for the consideration of private business at less than 28 days' notice being followed.

Key decisions and advance notice of intention to take a key decision

5.3 A key decision is defined in the Council Constitution as –

(a) any decision incurring expenditure or making savings in excess of 10% of the relevant budget head or £500,000, whichever is the smaller, unless

i. the specific expenditure or saving has previously been agreed in full Council, or

ii. it is a decision taken in accordance with the Council's Treasury Management Policy;

or

(b) any decision which, in the view of the Leader of the Council, will have a significant effect on a significant number of people;
or

(c) any decision approving proposals for the making of a plan or budget which requires the approval of full Council.

5.4 If the JSCB Cabinet Committee is to consider business that will require the taking of a 'key decision', that decision shall not be taken unless 28 days public notice of the intention to take a key decision has been taken. This notice is called the 'Executive Forward Plan'.

5.5 The Executive Forward Plan shall contain the following detail insofar as the information is available or might reasonably be obtained:-

(a) the name of the JSCB Cabinet Committee and a list of membership;

(b) the date on which, or the period within which, the decision will be taken;

(c) a list of any documents to be submitted to the decision taker for consideration in relation to the matter and how such documents might be accessed; and

(d) an indication of the Officer responsible for preparing the report and their contact details.

5.6 There is no requirement to disclose confidential or exempt information in such a Notice.

Key decisions – general exception

5.7 If 28 days' notice of a matter likely to be a Key Decision has not been given then the decision may still be taken if:-

- the date by which the decision must be taken makes it impractical to defer until it has been included on a later Notice issued in accordance with the procedures at 5.4 – 5.5 above.

- notice of the matter has been given to the Chair of the Adult Care and Health Overview and Scrutiny Committee, or in their absence to each Member of that Committee, together with an explanation as to why it is impractical to apply procedure 5.5 above,

- this notice is available to the public at the offices of the Council and on the Council website, and

- at least five clear days have elapsed since the notice was given.

Key decisions – special urgency

5.8 If the date by which a decision must be taken means the general exception procedure at 5.7 above cannot be followed, the decision can only be taken

if agreement has been obtained from the Chair of the relevant Overview and Scrutiny Committee that the taking of the decision is urgent and cannot be reasonably deferred. If there is no Chair of the Overview and Scrutiny Committee, then the Mayor, or in his / her absence, the Deputy Mayor shall be consulted. A notice indicating the reasons why the decision is urgent and cannot reasonably be deferred shall be published at the offices of the Council and on the Council website as soon as reasonably practicable.

6. Press and Public

6.1 The press and public shall be entitled to attend and to record or film all meetings of the JSCB Cabinet Committee, except when it is likely that confidential and / or exempt information is likely to be considered and the JSCB Cabinet Committee has resolved to exclude the press and public.

Reports and other documents to be considered by the JSCB Cabinet Committee may likewise be excluded from publication.

Confidential information - requirement to exclude public

6.2 Confidential information means information given to the Council by a Government Department on terms which forbid its disclosure or information which cannot be publicly disclosed by Court Order.

6.3 The public must be excluded from meetings whenever it is likely in view of the nature of the business to be transacted or the nature of the proceedings that confidential information would be disclosed.

Exempt information - discretion to exclude public

6.4 The public may be excluded from meetings whenever it is likely, in view of the nature of the business to be transacted or the nature of the proceedings, that exempt information, as defined below, would be disclosed.

6.5 In all cases, before the public is excluded the meeting must be satisfied that the public interest in maintaining the exemption outweighs the public interest in disclosing the information.

6.6 Where the meeting will determine any person's civil rights or obligations, or adversely affect their possessions, Article 6 of the Human Rights Act 1998 establishes a presumption that the meeting will be held in public unless a private hearing is necessary for one of the reasons specified in Article 6.

6.7 Exempt information means information falling within the following categories (subject to any condition):-

CATEGORY	**QUALIFICATIONS / INTERPRETATION**
1. Information relating to an individual	
2. Information which is likely to reveal the identity of an individual	
3. Information relating to the financial or business affairs of any particular person (including the authority holding the information)	'Financial or business affairs' includes contemplated, as well as past or current, activities. Information is not exempt information if it is required to be registered under either the Companies Acts (as defined in the s2 of the Companies Act 2006); the Friendly Societies Act 1974; the Friendly Societies Act 1992; the Industrial and Provident Societies Acts 1965 to 1978; the Building Societies Act 1986; or the Charities Act 1993. "Registered" in relation to information required to be registered under the Building Societies Act 1986, means recorded in the public file of any building society (within the meaning of that Act).
4. Information relating to any consultations or negotiations, or contemplated consultations or	'Labour relations matters' are as specified in paragraphs (a) to (g) of Section 218(1) of the Trade Unions and Labour Relations

CATEGORY	QUALIFICATIONS / INTERPRETATION
negotiations, in connection with any labour relations matter arising between the authority or a Minister of the Crown and employees of, or office-holders under, the authority	(Consolidation) Act 1992, i.e. matters which may be the subject of a trade dispute within the meaning of that Act, or any dispute about a matter falling within the above. 'Employee' means a person employed under a contract of service. 'Office-holder' means the holder of any paid office appointments which are or may be made or confirmed by the authority or by any joint board on which the authority is represented or by any person who holds any such office or is an employee of the authority.
5. Information in respect of which a claim to legal professional privilege could be maintained in legal proceedings	
6. Information which reveals that the authority proposes (a) to give under any enactment a notice under or by virtue of which requirements are imposed on a person; or (b) to make an order or direction under any enactment	
7. Information relating to any action taken or to be taken in connection with the prevention, investigation or prosecution of crime	

6.8 Information falling within any of paragraphs 1-7 above is not exempt by virtue of that paragraph if it relates to proposed development for which the local planning authority can grant itself planning permission under Regulation 3 of the Town and Country Planning General Regulations 1992.

Advance notice of intention to consider business in private

6.9 If the JSCB Cabinet Committee is to consider business in private, 28 days prior notice must be given by the Council on the Council's website, including a statement as to the reasons for the meeting being held in private. A further notice must be published five clear days before the meeting, including a statement as to the reasons for the meeting being held in private, the details of any representations received about why the meeting should not be held in private, and a statement of response from the JSCB Cabinet Committee to any such representation.

6.10 There is no requirement to disclose confidential or exempt information in such a Notice.

6.11 If the proper notice of private business has not given in accordance with Rule 6.9 above, the decision to hold a meeting or part of a meeting in private may still be taken if the Cabinet Committee has obtained the agreement of the Chair of the Adult Care and Health Overview and Scrutiny Committee

(or in their absence the Mayor or, in the absence of the Mayor, the Deputy Mayor) that the meeting is urgent and cannot reasonably be deferred. As soon as is practicable, a notice shall be published setting out the reasons why the meeting is urgent and cannot reasonable be deferred.

Excluding the press and public

6.12 Where a meeting of the JSCB Cabinet Committee is to resolve to exclude the press and public, the Committee must resolve the following resolution –

> "That, under section 100 (A) of the Local Government Act 1972, the public be excluded from the meeting during consideration of the following item of business on the grounds that it involves the likely disclosure of exempt information as defined by paragraph [*INSERT RELEVANT PARAGRAPH NUMBER*] of Part I of Schedule 12A (as amended) to that Act in that it contains [*INSERT RELEVANT TEXT CONSISTENT WITH QUOTED PARAGRAPH NUMBER*]. The Public Interest test has been applied and favours exclusion".

7. Quorum

7.1 The quorum for a meeting of the JSCB Cabinet Committee is set at two members.

7.2 If a quorum is not present at the conclusion of 15 minutes following the notified commencement time for a meeting of the JSCB Cabinet Committee, the meeting shall not be held and business referred either -

- to a special meeting of the JSCB (if so agreed by the co-chairs); or
- to the next scheduled meeting of the JSCB; or
- exceptionally, direct to the Cabinet and / or the Governing Body if timescales so dictate and such referral is agreed by both the Chief Executive of WBC and the Chief Officer of WCCG

7.3 Business remaining should a meeting in progress become inquorate shall be dealt with in a similar manner.

8. Conflicts of Interest

8.1 Members of the JSCB Cabinet Committee will comply with the requirements of the Members' Code of Conduct as contained in the Council Constitution. It is acknowledged that the Codes of Conduct for each organisation may place different obligations on their Members, but members of the JSCB Cabinet Committee must make whatever declarations of interest at meetings and take such actions as are required by law and by the Council's Members' Code of Conduct, and these shall be recorded in the minutes of the meeting.

8.2 For the avoidance of doubt, should a member of the JSCB Cabinet Committee declare a disclosable pecuniary interest and / or a prejudicial interest they must withdraw from the meeting room in accordance with the Members' Code of Conduct.

9. Minutes

9.1 The minutes of the meeting will include

- a record of attendance, including any substitution arrangements;
- a record of any declarations of interest made and whether any JSCB Cabinet Committee member(s) left the meeting due to a declared interest and at which point in the proceedings; and
- a record of the decision or recommendation, the reasons for the decision or recommendation being forwarded, and any alternative options considered and rejected at the meeting.

9.2 Minutes shall be published for both public and private parts of a JSCB Cabinet Committee meeting. There is no requirement to reveal confidential or exempt information within the published minutes.

9.3 The minutes of meetings of the JSCB Cabinet Committee shall be submitted to the Cabinet regardless of whether or not there are decisions to note or recommendations for approval contained therein. Submission of minutes shall provide surety to the Cabinet of the progress of the JSCB Cabinet Committee towards the agreed objectives of integrated commissioning.

10. Scrutiny and Audit

10.1 The JSCB Cabinet Committee shall be subject to Overview and Scrutiny arrangements through the Adult Care and Health Overview and Scrutiny Committee. The Overview and Scrutiny Committee may

- review the work of the JSCB and performance data of services provided by the JSCB
- exercise the right of call-in in respect of decisions made by the JSCB Cabinet Committee;
- scrutinise recommendations or referrals being made by the CCG JSCB and / or the JSCB Cabinet Committee to the Cabinet and the Governing Body (as appropriate) under a prior-scrutiny arrangement;

10.2 A matter relating specifically to a service provided solely for children may be referred by the Chair of the Overview and Scrutiny Committee to the Children and Families Overview and Scrutiny Committee for consideration.

Call-in

10.3 All decisions of the JSCB Cabinet Committee shall be published and be available at the main offices of the Council within two working days of being made or at the earliest opportunity. All members of the Council will be sent a copy of the decision.

10.4 The Notice will include the date of publication and specify that the decision(s) will come into force and may then be implemented on the expiry of five clear working days (the 'call-in period') after publication, unless the decision is called in for scrutiny by 5:00p.m. on the final day of the call-in period.

10.5 During the call-in period, the WBC Chief Executive shall call-in a decision for scrutiny by the Overview and Scrutiny Committee if so requested by any six members of the Council who have given detailed reasons for the Call-in of the decision. The detailed reasons must be provided by the first or lead signatory by the call-in deadline.

10.6 The Chief Executive shall liaise with the first named or lead Member listed on the call-in schedule to ensure there is sufficient information to enable the call-in to proceed. As long as there is clear reason given, the call-in should be allowed. He / she shall then notify the decision-taker(s) of the call-in and shall call a special meeting of the relevant Overview and Scrutiny Committee, on such date as he / she may determine, where possible and in any case within 15 working days of the decision to Call-in.

10.7 The relevant Chief Officer and all Members of the Council will be notified of a call-in immediately and no action will be taken to implement the decision until the call-in procedure has been completed.

10.8 Other matters relating to the call-in process –

- a decision may be called in only once;
- the meeting of the Overview and Scrutiny Committee to consider the call-in shall be quorate if four or more members are in attendance;
- the meeting of the Overview and Scrutiny Committee to consider the call-in shall commence at 4:00pm unless otherwise agreed by the Chair; and
- should an Overview and Scrutiny Committee meeting be adjourned with a call-in part-heard, it must be convened within seven working days thereafter otherwise it shall be abandoned and a new committee meeting convened within seven working days.

10.9 Having considered the decision, the Overview and Scrutiny Committee may determine to:-

(i) take no action in which case the decision shall take effect on the date of the Overview and Scrutiny Committee meeting

(ii) refer the decision back to the JSCB and / or the JSCB Cabinet Committee for reconsideration, setting out in writing the nature of its concerns or;

(iii) refer the matter to full Council. Such a referral should only be made where the Overview and Scrutiny Committee believes that the decision is outside the Council's policy framework or contrary to or not wholly in accordance with the Council's budget. Procedures set out in the Budget and Policy Framework Procedure Rules at Part 4 of the WBC Constitution must be followed prior to any such referral.

10.10 A decision referred back to the JSCB Cabinet Committee shall be reconsidered by the JSCB Cabinet Committee in the light of the written concerns of the Overview and Scrutiny Committee before a final decision is made.

11.11 If the Overview and Scrutiny Committee does not meet, the decision shall take effect from the date when the Committee should have met.

11.12 If the matter is referred to full Council and the Council does not object to a decision which has been made, then the decision will become effective on the date of the Council meeting.

11.13 If the Council does object the Council may take a decision that would otherwise have been determined by the JSCB Cabinet Committee which is outside the policy and budgetary framework. Otherwise the Council will refer any decision to which it objects back to the JSCB Cabinet Committee together with the Council's views on the decision. The JSCB Cabinet Committee shall determine whether or not to amend the decision before reaching a final decision. A meeting of the JSCB Cabinet Committee (as appropriate) will be convened to reconsider within ten working days of the Council request.

11.14 Call-in should only be used in circumstances where members of the Council have evidence which suggests that the decision was not made in accordance with the principles of decision making in the Constitution.

Call-in and urgency

11.15 The Call-in procedure set out above shall not apply where the decision being taken by the JSCB Cabinet Committee is urgent. A decision will be urgent if any delay likely to be caused by the Call-in process would seriously prejudice either WBC's, CCG's or the public's interest. The record of the decision and the notice by which it is made public shall state whether, in the opinion of the JSCB Cabinet Committee, the decision is an urgent one and therefore not subject to call-in. The Chief Executive must agree both that the decision proposed is reasonable in all the circumstances and to it being treated as a matter of urgency. Decisions taken as a matter of urgency must be reported to the next available meeting of the Council, together with the reasons for urgency.

11.16 Decisions of the JSCB Cabinet Committee not eligible for call-in are those -

- making a recommendation or a referral to the Cabinet or a suggestion to the CCG Governing Body, as appropriate, (the decision of the Cabinet shall be eligible for call-in, unless the matter has received prior scrutiny or been otherwise exempted from call-in); or
- where an Officer or other body has sought guidance on the use of their delegated powers; or
- calling for further information to enable the JSCB Cabinet Committee to determine recommendations or to interrogate performance data; or
- suggesting options for remedial actions in respect of performance reports.

11.17 The decisions and / or activities of the JSCB Cabinet Committee may be subject to review by the Council's external auditors and / or the Audit and Risk Management Committee.

Joint Strategic Commissioning Board

Delegations to the Committee of the Cabinet

The Leader of the Council has generally delegated to all Cabinet Members the power and authority to make decisions, advise upon and deal with all matters falling within their respective Portfolios.

The following powers and authority to make decisions, advise upon and deal with the following matters falling within the Adult Care and Health, Children and Families, and Highways and Transport Portfolios shall lie with the JSCB Cabinet Committee –

- The approval of integrated health and care commissioning strategies;
- The approval of large scale health and care transformation programmes;
- The approval of plans and oversight of delivery for specific areas such as:
  - Better Care Fund Schemes
  - Urgent Care Transformation
  - Commissioning Prospectus
  - Learning Disabilities Plan;
- The effective stewardship of Section 75 pooled monies and make recommendations in respect of any issues causing concern;
- To maintain oversight of health and care system performance and take any remedial actions necessary;
- To ensure the implementation of integrated health and care commissioning strategies and transformation programmes

The Leader of the Council has delegated generally the following powers and responsibilities to the Committee of the Cabinet meeting within the JSCB Cabinet Committee–

(i) approval of the appointment of consultants up to the value of £50,000.

(ii) approval and authorisation of the submission of any formal response on behalf of the Council to Government consultation documents

(iii) determination of grant applications

(iv) approval and authorisation of the submission of grant funding (or other resource) applications on behalf of the Council

(v) approval and authorisation of the extension of contracts for a maximum of up to 2 years where such an extension was an option in the original contract, provided any extension is on advisement of the relevant Chief Officer, the Chief Finance Officer) and the Monitoring Officer.

(vi) authorisation of consultations (whether statutory or otherwise) as considered necessary and appropriate

(vii) approval of the commencement of all procurement exercises in accordance with the Council's Contract Procedure Rules

(viii) acceptance of tenders up to the value of £5,000,000 where the tender is considered the most economically advantageous, the tender complies with all the price, quality, safety, sustainability and any other criteria set out in the tender document; and the tender value is below the figure set out in the relevant budget, on advisement of the relevant Chief Officer, the Chief Finance Officer) and the Monitoring Officer.

(ix) Approval of additional or replacement items for the current year's Capital Programme, where the amount of the estimate does not exceed £5,000,000 and does not increase the overall total of the Departmental Capital Programme, on advisement of the relevant Chief Officer, the Chief Finance Officer) and the Monitoring Officer.

(x) the award of contracts of up to 5 years, where the contract value does not exceed £5,000,000, where the tender is the most economically advantageous, the tender complies with all the price, quality, safety, sustainability and any other criteria set out in the tender document; and the tender value is below the figure set out in the relevant budget, on advisement of the relevant Chief Officer, the Chief Finance Officer) and the Monitoring Officer.

(xi) approval of variations to contract values post-tender where the value of the variation, or series of variations exceeds £20,000.

(xii) the fixing, variation or amendment of fees and charges for services (as permitted).

All executive functions / matters may be referred by the JSCB Cabinet Committee to the Cabinet for consideration, determination and / or decision. Only those executive functions / matters that fall into one or more of the following categorises should be referred to Cabinet -

(i) the matter under consideration is a high profile matter;

(ii) the decision has a significant budgetary impact;

(iii) there is a need or it is considered prudent to engage the public and/or raise public awareness; and / or

(iv) The function / matter provides important performance management information.

The JSCB Cabinet Committee is authorised to give whatever agreements are necessary to proposals of the CCG in pursuance of the objectives of integration and improvement of health and care service delivery.

APPENDIX 2 – POOLED FUND EXECUTIVE GROUP TERMS OF REFERENCE

Constitution and Purpose

The Pooled Fund Executive Group (PFEG) is a sub group reporting to the JSCB Cabinet Committee and the CCG Governing Body.

Remit

The PFEG shall undertake the following activities and make recommendations to the JSCB and the CCG Governing Body as appropriate:

1. Monitor and review financial performance of all budgets related to Wirral Health and Care Commissioning.

2. This includes those funds pooled under Section 75 and those running in shadow for 2018/19.

3. Assurance and oversight of commissioning and savings programme and their impact against financial performance.

4. To triangulate activity and performance against allocated budget and ensure appropriate progress against agreed budgetary plans is made including the taking of any necessary mitigating steps to the extent permitted within agreed budgets, and making recommendations to the JSCB and the CCG Governing Body where further actions are necessary to ensure that Wirral Health and Care Commissioning remains within **agreed** budgets .

5. Monitor the progress and performance of specific commissioning programmes and other initiatives (QIPP) in delivering agreed financial plans.

6. Receive specific reports in relation to the BCF programme and performance of the QIPP programme. To request further details of a specific programme if concerns are raised in relation to performance and/or spend.

7. To explore the efficacy and added value of schemes as necessary in order to recommend changes as necessary to the JSCB and the CCG Governing Body.

8. To provide assurance to the JSCB and the CCG Governing Body that appropriate investments are being made through ensuring due process has been followed i.e. process within Commissioning Decision Policy has been adhered to.

To advise/assure the Joint Strategic Commissioning Board and the CCG Governing Body on the:

1. Financial position of Wirral Health and Care Commissioning Pooled Funds. To report the financial position of each Partner in relation to the broader shadow pooled fund

2. Overall financial strategy forecasting and potential risks

3. Provide estimate of income and expenditure

4. Performance of agreed programme of commissioning activity and any proposed significant changes from the plan

Membership

Director Health and Care, Deputy Chief Officer (chair)

Director Health and Wellbeing (Council)

Chief Finance Officer (CCG)

Director of Commissioning (CCG)

Director of Quality and safety (CCG)

Nominee for children's services (Council)

Director of Public Health (Council)

Director of Children's Services (Council)

Quorum

Quorum - One of either the Director Health and Care (DCO), Chief Finance Officer or Deputy plus two other members from the organisation which is not chairing the meeting.

Chair

Director Health and Care

Vice chair - Chief Finance Officer

Frequency

Monthly should be 10 meetings per year.

Agenda and papers will be circulated 7/5 days prior to the meeting.

minutes will be circulated 7 days post meeting

In Attendance

Assistant Director Integrated Commissioning / Urgent Care

Assistant Director Care and Health Outcomes

Assistant Director Programme Management

Other officers of WHaCC will be co-opted as necessary in order to offer reports

Confidentiality

All records of meetings and decisions made will be disclosable unless specifically exempted under the FOI Act

Reporting Procedures

Minutes of the meeting will be noted at meetings of the JSCB and the CCG Governing Body.

Reports will be made available to the JSCB and the CCG Governing Body as required. This must include finance and performance update.

The minutes of this meeting will be noted at the CCG Governing Body, the CCG's finance committee and relevant council committee.

It is acknowledged during 2018 there will be some elements of overlap between PFEG and CCG Finance Committee whilst there are shadow pooled fund arrangements in place. The role of the CCG's finance committee will be reviewed as the pool grows.

Matters may require escalation to the JSCB and the CCG Governing Body and/or to the Council cabinet as appropriate.

Actions To Be Taken; align these with GBB/other committees

- **Note**
- **Receive**
- **Consider**
- **Support**
- **Approve**
- **Recommend**
- **Reject**
- **Escalate**

Resources

The Agenda will be agreed with the Chair and PA support.

The meeting will be minuted by Commissioning Administration.

Finance reports will be provided through the joint accountancy service.

APPENDIX 3 – COMMON CHAIRING PROTOCOL

NHS Wirral CCG Governing Body and Wirral JSCB Cabinet Committee

Common Chairing Protocol: Key Principles for Implementation

Context

In August 2018, NHS Wirral CCG (the "CCG") Governing Body and Wirral Borough Council (the "Council") Cabinet decided that the CCG Governing Body should hold certain meetings at the same time, and in the same location around one table with the Council Cabinet committee known as the "JSCB Cabinet Committee," as part of an aligned decision-making model. These meetings would be in furtherance of the objective to integrate the CCG's and the Council's commissioning functions (underpinned by a Section 75 Agreement) to ultimately improve outcomes for the Wirral population.

The aim of this alignment is to further the collaboration between the two organisations whilst still respecting the legal reality that there remain two sovereign organisations.

Key points:

- There are two separate bodies meeting at the same time, which are part of two separate organisations (the CCG and the Council respectively).

- The Governing Body and the JSCB Cabinet Committee will arrange to hold certain meetings (a schedule of which will be agreed in advance between the organisations) in the same place at the same time around the same table.

- For each such meeting, the Governing Body and the JSCB Cabinet Committee will have their own individual agendas although they will, insofar as possible, be identical to help meetings run smoothly.
- The Council must give a statutory 28 day notice of the intention of the JSCB Cabinet Committee to make a 'key decision' and / or consider business in private. Procedures do exist for permission to be granted for shorter notice on urgency grounds. The grant of such permission is not guaranteed.

- The Governing Body and the JSCB Cabinet Committee must each make its own decision and their decision together with the discussion leading up to the decision must be recorded in their own respective minutes. It is acknowledged that sections of the minutes recording discussions of each organisation will often be similar given that the meetings are taking place at the same time. It is further acknowledged that the minutes of one organisation may require procedural content or steps not required in the minutes of the other. In some cases, the Governing Body and the JSCB Cabinet Committee may make the same decision – although it is possible and permissible for each to make their own, different decision.

- Each organisation retains its own individual accountability for the matters discussed; decisions made and discharge of its individual responsibilities.

- A decision taken by the JSCB Cabinet Committee may be subject to the Council's 'call-in' procedure and be subject to review by an Overview and Scrutiny Committee. A relevant decision of the JSCB Cabinet Committee may only be implemented if (i) it is exempted from call-in; or (ii) the call-in period expires without the decision being called in; or (iii) in the event of the decision being called-in, the Council's call-in procedures are concluded (which may include referral back to the JSCB for re-consideration).

- Any disputes between the Governing Body and the JSCB Cabinet committee shall be referred to the Chief Executive of the Council and Chief Officer of the CCG, and, if they cannot be resolved at this level, they must be referred to the mediation stage of the dispute resolution procedure set out in the Section 75 Agreement between the Council and the CCG.

Chairs

The Governing Body and the JSCB Cabinet committee will each continue to have its own respective chair and the two (or 'dual') chairs shall chair their meetings jointly in accordance with the following principles:

1. The dual chairs agree that in accordance with the integrated commissioning strategy agreed on behalf of both the CCG and the Council it is in the best interests of the organisations to collaborate more closely and seek to align working to deliver greater benefits and outcomes for the Wirral population.

2. To that end, the dual chairs agree that a consensus approach between two chairs should be adopted where possible, without prejudice to the need to properly discharge their individual rights and responsibilities.

3. Before each meeting to be held together, the dual chairs shall meet to discuss and plan for the forthcoming meeting including addressing any issues as to meeting agenda and papers, attendees and who will be the 'primary' chair of that meeting. In general, the dual chairs should agree to take it in turn to be the 'primary' chair of each meeting. A primary chair may agree that for certain part(s) or agenda item(s) of meetings he/she is leading, the other chair should take over and chair that part of the meeting/agenda item.

4. Where a chair is unable to attend a meeting held together, or to undertake a specific action relating to planning for such a meeting by reason of illness or absence for any other cause, references to the 'chair' shall be taken to refer to the deputy chair as per the relevant standing orders of the CCG Governing Body or terms of reference of the JSCB Cabinet committee as applicable.

5. Where possible, identical but separate agendas and papers will be used for meetings held together and they will be served on behalf of each organisation at the same time.

6. The 'primary' chair shall:

    a. Open the meeting;

    b. Keep the meeting focussed on the agenda;

    c. Ensure proper order at the meeting including but not limited to who is entitled to speak and ask questions;

    d. Ensure that only one agenda item may be discussed at any one time;

    e. Facilitate discussions at each meeting;

    f. Ensure the meeting follows proper process including when making decisions;

    g. Ensure there is clarity as to what decision/action is agreed on behalf of which organisation;

    h. Ensure appropriate arrangements for the meeting minutes to be taken; and

    i. Closes the meeting.

    In doing so, the other chair may assist the primary chair as agreed between the two chairs.

7. Quorum and Voting

    For the avoidance of doubt, acting as primary chair does not affect or amend either the membership of or the requirements as to quorum for either the Governing Body or the JSCB Cabinet Committee and each chair only has the voting rights given to him/her by his/her own organisation in respect of decisions being made, even if acting as primary chair.

On the occasion of a vote, the Governing Body and the JSCB Cabinet Committee will vote in turn using the following process:

- The 'primary' Chair shall first preside over the vote of the Governing Body or JSCB Cabinet committee of which he / she is a member.

- The primary Chair shall then defer to the other co-chair (or the person appointed to act as chair in the absence of the co-chair, as the case may be) to preside over the vote of the other organisation (i.e. the Governing Body or the JSCB Cabinet Committee as the case may be) of which that co-chair (or such other person appointed to act as chair) is a member.

8. The primary chair can seek the views of the other chair during the course of the meeting as he or she sees fit. The other chair may also raise queries/concerns with the primary chair as to proper conduct and procedure of the meeting as they see fit, which the two chairs shall seek to resolve by consensus wherever possible.

9. If at any time in the course of a meeting, there arises a dispute between the two chairs which it is not possible to resolve, either chair may decide to call a halt to the meeting and to request that the two meetings continue separately with their individual membership and chairmanship. Where such a step is taken, it shall be reported by each chair to their respective Chief Executive or Chief Officer.

10. At any time in the preparation for a meeting or during a meeting, either or both chairs may seek the advice and support of the governance leads for both organisations as to process, procedure and/or facilitating an agreed way forward.

11. Special meetings of the JSCB Cabinet Committee may, subject to the minimum notice period of five clear working days being given, be convened with the agreement of both co-chairs.

12. Each committee must have its own meeting minutes approved in accordance with each organisation's governance practices. However, in recognition of the above points and principles, the dual chairs acknowledge that it is reasonable and appropriate for minutes of such meetings to often largely mirror each other, save for any requirement for procedural content to be included in one set of minutes, but not the other.

These principles are to be reviewed by the CCG Governing Body and the Leader of the Council or the Council Cabinet (as may be determined by the Leader of the Council) six months after initial adoption and then annually thereafter. These principles may be refreshed by agreement between the CCG and the Council at any time, including on any such review.

SCHEDULE 3 – FINANCIAL ARRANGEMENTS, RISK AND GAINS SHARE AND OVERSPENDS

1 Unless the context otherwise requires, the defined terms used in this Schedule shall have the same meanings as set out in Clause 1 of the main body of Agreement.

2 Subject to any contrary provision in the relevant Scheme Specification, the Parties agree that Overspends or Underspends shall be managed in accordance with this Schedule 3.

2A References in this Schedule 3 to decisions made by the JSCB and the CCG Governing Body shall mean that each of the JSCB and the CCG Governing Body shall consider the relevant matter and aim to make the same decisions in line with the governance procedures as set out in Schedule 2.

Financial Contributions

3 Payment of contributions into a Pooled Fund will be made by both Partners on a quarterly basis as follows:

3.1 June 2018;

3.2 September 2018;

3.3 December 2018; and

3.4 March 2019.

Payments from the Pooled Fund will be made to the respective Partners in arrears on agreement of the Joint Strategic Commissioning Board and the CCG Governing Body as set out below:

3.5 July 2018 (based on Q1 2018/19 performance);

3.6 October 2018 (based on Q2 2018/19 performance);

3.7 January 2018 (based on Q3 2018/19 performance); and

3.8 March 2019 (based on Month 11 2018/19 performance).

Risk Share

4 Both the CCG and the Council agree that subject to any decision of the JSCB and the CCG Governing Body otherwise as to the treatment of any Overspend or Underspend in accordance with paragraphs 5 to 10 (inclusive) of this Schedule 3:

4.1 the risk share in respect of Overspends in relation to the Schemes contained within this Agreement shall be made on the basis of 56% for the CCG and 44% for the Council, based upon a calculation of relative risk and investment, except in the case of:

4.1.1 the Better Care Fund Plan, where the risk share shall be made on the basis of 50% for the CCG and 50% for the Council; and

4.1.2 the Ring-Fenced Monies, where Overspends cannot be attributed elsewhere and no virement can take place. The risk share in respect of Overspends on the Ring-Fenced Monies shall therefore be made on the basis of 0% for the CCG and 100% for the Council;

4.2 the gain share in respect of Underspends in relation to the Schemes contained within the Agreement shall be made on the basis of 50% for the CCG and 50% for the Council, except in the case of the Ring-Fenced Monies, where no Underspend can be attributed elsewhere and no virement can take place. Any gain in respect of the Ring-Fenced Monies must therefore be reinvested for the purposes of the Public Health Schemes).

Pooled Fund Management

5 Out-turn will be reported on a monthly basis to the JSCB and the CCG Governing Body. Any variances will be scrutinised by the JSCB and the CCG Governing Body and corrective or mitigating action identified and agreed by the JSCB and the CCG Governing Body. The relevant Lead Partner will be requested to attend the JSCB and the CCG Governing Body to account for any Overspend.

Overspends

6 Once the JSCB and the CCG Governing Body agree that there is no alternative other than to Overspend then the risk share arrangements set out in paragraph 4 will be triggered.

7 It shall be a general principle that any Overspend will be determined by the JSCB and the CCG Governing Body jointly in a just and equitable manner. If the JSCB and CCG the Governing Body identify poor management by the Lead Partner as a contributing factor to an Overspend they will give due consideration to that poor performance and the extent of it to the contribution to the Overspend when determining the division of the Overspend.

8 Where both the JSCB and the CCG Governing Body agree, in relation to the division of Overspends the JSCB and the CCG Governing Body may:

8.1 determine that Partners should agree an action plan to reduce expenditure;

8.2 identify Underspends that can be vired from any other Scheme maintained under this Agreement

8.3 ask for more money from the respective Partners; and

8.4 if no more money is available agree a plan of action, which may include decommissioning all or any part of the Individual Scheme or service to which the Overspend relates.

9 Decisions regarding Overspends will be mindful of Better Care Fund guidelines outlined in Schedule 6.

Underspends

10 Underspends should be considered by the JSCB and the CCG Governing Body regardless of who commissions the Scheme or where the Underspend is reported. In doing so the JSCB and the CCG Governing Body may, where they both agree:

10.1 identify the reason for underspend and impact on the overall performance targets;

10.2 review if further investment would benefit the overall outcomes defined within the Agreement;

10.3 if there are any other Schemes contained within this Agreement for which an Overspend has been identified that can be negated by Underspend on other schemes; and

10.4 if there are Schemes that will run into the following financial year and would benefit from the funding being carried forward.

10.5 Decisions regarding Underspends will be mindful of Better Care Fund Guidelines outlined in Schedule 6.

Risk Management Framework

11 A comprehensive risk register and monitoring arrangements have been developed between the Council and the CCG to manage or mitigate known and emerging risks associated with the development and implementation of this Agreement.

12 This register includes an assessment of risk both financial and system impact for each scheme and is RAG rated. This will be monitored by the JSCB and the CCG Governing Body monthly and will include

a clearly defined escalation protocol to feed into both Partners' reporting frameworks. The risk register will be maintained and reported to the JSCB and the CCG Governing Body.

Risk Escalation Protocol

13 The Out-turn will be monitored on a monthly basis alongside the risk register. In the event of adverse performance the Lead Partner will report directly to the JSCB and the CCG Governing Body on Scheme performance and mitigating actions.

14 If the JSCB and the CCG Governing Body identify that adverse performance cannot be contained within the funding contributions set out within this Agreement then each Partner shall report significant risks to its governing executive and Health and Wellbeing Board as appropriate.

15 An example of how risk share is intended to operate is:

15.1 A gain (Underspend) or loss on the Better Care Fund Schemes of £1 million would be split as follows:

15.1.1 the Council £0.5 million; and

15.1.2 the CCG £0.5 million.

15.2 A gain (Underspend) on Schemes other than the Public Health Scheme of £1 million would also be split as set out in paragraph 15.1.

15.3 A loss (Overspend) of £1 million on Schemes other than the Public Health Schemes and the Better Care Fund Schemes would be split as follows:

15.3.1 the Council £0.44 million; and

15.3.2 the CCG £0.56 million.

A loss (Overspend) of £1 million on the Better Care Fund Schemes would be split as follows:

15.3.3 the Council £0.5 million; and

15.3.4 the CCG £0.5 million.

A loss (Overspend) of £1 million on the Public Health Schemes would be split as follows:

the Council £1 million; and

the CCG £0.

SCHEDULE 4 – JOINT WORKING OBLIGATIONS

Part 1 – LEAD PARTNER OBLIGATIONS

Terminology used in this Schedule shall have the meaning attributed to it in the NHS Standard Form Contract save where this Agreement or the context requires otherwise.

1 The Lead Partner shall notify the other Partners if it receives or serves under a Service Contract:

1.1 a Change in Control Notice;

1.2 a Notice of an Event of Force Majeure;

1.3 query; or

1.4 a notice indicating breach of contract or notice requiring remedial actions

and provide copies of the same.

2 The Lead Partner shall provide the other Partners with copies of any and all:

2.1 CQUIN Performance Reports;

2.2 monthly activity reports;

2.3 remedial action plans; and

2.4 Service Quality Performance Report.

3 The Lead Partner shall consult with the other Partner before attending:

3.1 a contract management meeting; or

3.2 a contract review meeting;

and, to the extent the Service Contract permits, raise issues reasonably requested by a Partner at those meetings.

4 The Lead Partner shall not:

4.1 permanently or temporarily withhold or retain monies pursuant to any payment provisions or other provisions in a Service Contract;

4.2 vary any service specifications

4.3 agree (or vary) the terms of a joint investigation or a joint action plan undertaken in respect of a Service Contract;

4.4 give any approvals under a Service Contract;

4.5 agree to or propose any variation to the Service Contract (including any Schedule or Appendices);

4.6 suspend all or part of the Services;

4.7 serve any notice to terminate the Service Contract (in whole or in part);

4.8 serve any notice; or

4.9 agree (or vary) the terms of a Succession Plan,

without the prior approval of the other Partner (such approval not to be unreasonably withheld or delayed).

5 The Lead Partner shall advise the other Partners of any matter which has been referred for dispute and agree what (if any) matters will require the prior approval of one or more of the other Partners as part of that process.

6 The Lead Partner shall notify the other Partners of the outcome of any Dispute that is agreed or determined by Dispute Resolution.

7 The Lead Partner shall share copies of any reports submitted by the Service Provider to the Lead Partner pursuant to the Service Contract (including audit reports).

Part 2 – OBLIGATIONS OF THE OTHER PARTNER

1 Each Partner shall (at its own cost) provide such cooperation, assistance and support to the Lead Partner (including the provision of data and other information) as is reasonably necessary to enable the Lead Partner to:

1.1 resolve disputes pursuant to a Service Contract;

1.2 comply with its obligations pursuant to a Service Contract and this Agreement; and

1.3 ensure continuity and a smooth transfer of any Services that have been suspended, expired or terminated pursuant to the terms of the relevant Service Contract.

2 No Partner shall unreasonably withhold or delay consent requested by the Lead Partner.

3 Each Partner (other than the Lead Partner) shall:

3.1 comply with the requirements imposed on the Lead Partner pursuant to the relevant Service Contract in relation to any information disclosed to the other Partners; and

3.2 notify the Lead Partner of any matters that might prevent the Lead Partner from giving any of the warranties set out in a Service Contract or which might cause the Lead Partner to be in breach of warranty.

SCHEDULE 5 – PERFORMANCE ARRANGEMENTS

An Outcomes Framework is in the process of being drafted, which will be linked to the Healthy Wirral programme. The KPIs contained within it will be monitored by the Council's Business Intelligence Team and the CCG's Performance Team and reported to the JSCB and the CCG Governing Body on a monthly basis.

SCHEDULE 6 – BETTER CARE FUND PLAN

The BCF is intended to transform local Health and Social Care services, driving integration at a local level. Nationally driven by NHS England and Central Government to bring resources from both the NHS and Local Authorities into a single pooled budget.

Fundamentally, we believe that the Better Care Fund should be used for a genuine transformation of the health and social care system in Wirral. However, this transformation is not just about reducing admissions to hospital, but rather about changing the whole system so that it is focused on supporting people wherever possible with person-centred and professionally-led primary, community and social care, with the goal of living as independently as possible for as long as possible. A key part of this will be to ensure that access and response times of all services will meet the needs of the population and that capacity also meets demand across the range of services. This aligns with the principles set out by Government, NHS England and LGA, is consistent with the priorities set out in Wirral's Joint Strategic Needs Assessment, NHS Wirral CCG's Strategic Plan and the Council's Corporate Plan and Commissioning Intentions.

The BCF closely aligns to the Urgent Care strategy, and supports the Urgent Care commissioning priorities.

We already have a programme of work which is working towards:

- Development of Integrated Care Coordination Teams (ICCTs)
- Investing in Community health and social care services, accessible 7 days a week, with a focus on hospital admission avoidance.
- More effective joint commissioning of key services
- Developing a sustainable and responsive market with the independent and 3rd sector
- Developing more effective community interventions such as falls response and prevention services, assistive technology, community equipment, appropriate mental health and dementia interventions
- Redesign of existing services to effectively target resources to deliver key outcomes, re-commissioning where appropriate
- Supporting flow and capacity in acute care

Key components of this programme of work include:

- Rapid community MDT providing a 4 hour response at home for GP's and NWAS
- Investment and expansion of the intermediate and transitional care service
- Development of a single front door and gateway
- Transformational redesign of our discharge pathways to improve LOS and patients experience and outcomes

These will all require a much closer level of integration and collaboration between the Acute sector (consultants and nursing /therapies), primary health (GPs), community health (e.g. district nursing, physiotherapy) and social care (support to live independently), so that these services can identify, support and intervene much earlier to prevent a crisis occurring or someone feeling they are unable to access the support they need.

An effective communication strategy and focus upon changing workforce culture across all organisations underpins the success of this transformational change in Wirral.

Information technology will play a key role in facilitating new ways of working, streamlining information sharing and reducing duplication.

Our priority focus will be to ensure appropriate investment in a range of community services and to see a reduction in demand on acute care and long term residential/nursing placements. This will result in both an improved experience and outcomes for patients.

In addition we will aim to invest in new schemes, particularly to support 7 day working across health and social care and information technology. We are also working with public health colleagues to retain a focus on early intervention and prevention and to ensure that a range of requirements are delivered through existing investments, for example supporting self-care and falls prevention.

The value of individual schemes is as follows, with the final column indicating commissioning responsibility for individual schemes.

Scheme Name	2017/18 Total	2018/19 Total	Contract with (CCG or Council)
1. Assistive Technologies			
Innovation bid scheme 9 - Medequip/Falls	69,000	69,000	Council
Known Development Pressures (TeleHealth, TeleTriage)	0	58,387	CCG
Tele-triage - Single Gateway/7 Day Response	100,000	100,000	CCG
Tele-triage role out across Care Homes	110,820	226,705	CCG
Whole System VSA for frail and elderly support at home	15,000	0	Council
Wirral Independence Service	4,295,000	4,295,000	Council
1. Assistive Technologies Total	4,589,820	4,749,092	
2. Care navigation / coordination			
Brokerage	27,000	27,000	Council
Clinical Streaming at the front door	200,000	300,000	CCG
Comms - Home First	12,000	12,000	Council
IMC - WCT existing schemes	1,445,762	1,445,762	Council
Integrated Assessments Training & Implementation	8,250	0	De-commissioned
Street triage	152,000	152,000	CCG
2. Care navigation / coordination Total	1,845,012	1,936,762	
3. Carers services			

Carers Service	653,912	653,912	Council
3. Carers services Total	653,912	653,912	
4. DFG - Adaptations			
DFG	3,591,765	3,858,041	Council
4. DFG - Adaptations Total	3,591,765	3,858,041	
6. Domiciliary care at home			
Dom Care	200,000	200,000	Council
Home First Capacity - supporting growth in dom care, reablement, mobile nights	66,955	73,651	Council
Mobile Night Service	536,600	536,600	Council
Trusted Assessor - Dom Care	110,000	110,000	Council
6. Domiciliary care at home Total	913,555	920,251	
7. Enablers for integration			
BCF Scheme Lead/ROI Evaluation	24,000	48,000	Council
Communication and Engagement Lead Role	30,000	0	CCG
Transformation Programme Manager Role	60,000	60,000	CCG
Whole System Acute/Community Capacity and Demand Model (WI Posts)	91,000	0	CCG
Whole System Modelling Senior Performance Analyst	40,000	40,000	CCG
7. Enablers for integration Total	245,000	148,000	
8. Healthcare services to Care Homes			
Care Homes Scheme/Quality Improvement Nurse	40,000	40,000	CCG
8. Healthcare services to Care Homes Total	40,000	40,000	
9. High Impact Change Model for Managing Transfer of Care			
Additional MDT support, including clinical cover for extra beds (10)	106,343	106,343	

			CCG
Home First - Clinical Support/Discharge Capacity	540,808	540,808	CCG
Home First - MDT	399,657	399,657	Council
Primary Care & Therapies for T2A Beds	967,428	967,428	CCG
Ward Discharge Coordinators - Additional 2fte	116,250	0	CCG
9. High Impact Change Model for Managing Transfer of Care Total	2,130,486	2,014,236	
10. Integrated care planning			
7 Day Community Offer (ASC)	3,932,992	3,932,992	Council
7 Day Community Offer (CCG)	854,011	854,011	CCG
10. Integrated care planning Total	4,787,003	4,787,003	
11. Intermediate care services			
10 x T2A Residential Beds - core funding	260,520	273,546	Council
86 x T2A Nursing Beds - core funding	3,358,472	3,526,396	Council
Adapted Flats (temporary accommodation for people awaiting major adaptation	40,000	35,643	Council
Growth in T2A Beds (Nursing)	178,625	164,460	Council
Reablement - Commissioned Care	1,162,249	1,162,249	Council
T2A - 10 beds - Cover for Pressure periods (Nursing)	230,012	241,513	Council
Winter Pressure Beds	284,396	0	Council
11. Intermediate care services Total	5,514,274	5,403,807	

12. Personalised healthcare at home			CCG
IV Antibiotics	562,300	562,300	
12. Personalised healthcare at home Total	562,300	562,300	
13. Primary prevention / Early Intervention			
Age UK - Discharge lounge/home of choice/single gateway presence/falls army	55,000	110,000	Council
Complex Needs Service	250,000	250,000	Council
Crisis Response	150,576	150,576	CCG
Dementia LES	71,400	71,400	CCG
Dementia Nurse	150,580	150,580	CCG
Early Intervention & Prevention	1,090,169	1,090,169	Council
Early onset Dementia	146,000	146,000	Council
Joint Posts - Mental Health	474,587	474,587	CCG
13. Primary prevention / Early Intervention Total	2,388,312	2,443,312	
14. Residential placements			
Known Development Pressures (Enhancing Health in Care Homes)	0	50,000	Council
Trusted Assessor - Care Homes	71,000	71,000	Council
14. Residential placements Total	71,000	121,000	
16. Other			
Care & Support Bill Implementation	497,180	497,180	Council
CCG Third Sector	485,378	485,378	CCG
Green Car	357,786	357,786	Funding to be Re-allocated
Homeless Service	93,279	93,279	Council
Maintaining Social Care	9,697,189	13,265,830	

			Council
Mental Health detention transport	52,500	70,000	CCG
Protection of Out of Hospital Services	0	482,000	CCG
Public Health - Drugs & Alcohol	7,312,913	7,093,526	Council
Stabilising the Market	1,414,337	1,414,337	Council
Street Triage - enhanced hours of operation	84,501	112,668	CCG
Street Triage for NWAS	131,064	174,752	CCG
Winter Planning & Contingency	529,814	529,814	CCG
16. Other Total	20,655,941	24,576,550	
Grand Total	47,988,380	52,214,265	

SCHEDULE 7 – POLICY FOR THE MANAGEMENT OF CONFLICTS OF INTEREST

Both the Council and the CCG have established and practised Conflicts of Interest policies in place. The following principles will apply:

1. Doing business appropriately. If commissioners get their needs assessments, consultation mechanisms, commissioning strategies and procurement procedures right from the outset, then conflicts of interest become much easier to identify, avoid and/or manage, because the rationale for all decision-making will be clear and transparent and should withstand scrutiny;

2. Being proactive, not reactive. Commissioners should seek to identify and minimise the risk of conflicts of interest at the earliest possible opportunity, for instance by:

    - considering potential conflicts of interest when electing or selecting individuals to join the governing body or other decision-making bodies;

    - ensuring individuals receive proper induction and training so that they understand their obligations to declare conflicts of interest; and

    - establishing and maintaining registers of interests, and agreeing in advance how a range of possible situations and scenarios will be handled, rather than waiting until they arise;

3. Individuals will seek to act ethically and professionally, but may not always be sensitive to all conflicts of interest. It is assumed people will volunteer information about conflicts and, where necessary, exclude themselves from decision-making, but there will be prompts and checks to reinforce this;

4. Following proper procurement processes and legal arrangements, including even-handed approaches to providers; and

5. Ensuring sound record-keeping, including up to date registers of interests.

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Org	Commissioner	Category	SubCategory		17/18 Budget (£)
WMBC	Adult Social Care	Community Care for Learning Disabilities	Day Care	6,653,200	
			Direct Payments	4,047,800	
			Domiciliary Care	349,800	
			Nursing Long Term	433,400	
			Nursing Short Term	500	
			Res Long Term	9,929,900	
			Res Short Term	1,145,400	
			Shared Lives	281,000	
			Supported Living	17,310,400	
		Total Community Care for Learning Disabilities			**40,151,400**
		Community Care for Mental Health	Day Care	48,500	
			Direct Payments	305,100	
			Domiciliary Care	555,800	
			Nursing Long Term	2,841,200	
			Nursing Short Term	30,500	
			Res Long Term	2,416,000	
			Res Short Term	200,300	
			Shared Lives	44,100	
			Supported Living	3,853,300	
		Total Community Care for Mental Health			**10,294,800**
		Customer & Client Receipts	Mental Health Service User Contributions	-884,100	
			Learning Disability Service User Contributions	-2,186,900	
		Total Customer & Client Receipts			**-3,071,000**
		Income from Joint Funded Packages	Joint Funded Income - Mental Health	-1,677,100	
			Joint Funded Income - Learning Disabilities	-4,796,900	
		Total Income from Joint Funded Packages			**-6,474,000**
	Total Adult Social Care				**40,901,200**
	Public Health	Stop Smoking Interventions	Stop Smoking Interventions	764,399	
		Sexual Health Services	Sexual Health Services	3,109,729	
		Children's Services	Children's Services	6,847,694	
		Healthchecks	Healthchecks	309,600	
		Adult Obesity	Adult Obesity	200,000	
		Mental Health	Mental Health	895,659	
		Infection Control	Infection Control	227,787	
		Infection Control Total			**12,354,868**
	Total Public Health				**12,354,868**
	CYPD	Care Packages	Children's Social Care	2,028,990	
			Education	1,133,449	
			Growth	386,156	
			Saving	-332,513	
		Care Packages Total			**3,216,082**
	Total CYPD				**3,216,082**
TOTAL WMBC					**56,472,150**
CCG	CCG	CHC - Adult fully funded Continuing Care	CHC - Adult fully funded Continuing Care	3,726,145	
		CHC - Adult Fully funded PHBs	CHC - Adult Fully funded PHBs	889,004	
		Funded Nursing Care	Funded Nursing Care	826,304	
		LD - 100% funded not CHC	LD - 100% funded not CHC	281,079	
		LD - Section 117	LD - Section 117	1,416,727	
		MH - Adults under 65 100% funded not CHC	MH - Adults under 65 100% funded not CHC	3,145,395	
		MH - Adults over 65 100% funded not CHC	MH - Adults over 65 100% funded not CHC	1,019,547	
		MH - Section 117	MH - Section 117	5,635,932	
		Adult Joint funded	Adult Joint funded	3,827,975	
		CHC - Adult Joint funded PHBs	CHC - Adult Joint funded PHBs	274,250	
		CHC Children's Continuing Care	CHC Children's Continuing Care	908,034	
		Childrens PHBs	Childrens PHBs	11,228	
	Total CCG				**21,961,620**
TOTAL CCG					**21,961,620**
TOTAL NON-BCF					**78,433,770**
BCF	Better Care Func	Integrated Services	Wirral Independence Service	4,205,200	
			Care Homes Scheme - Nurse	40,000	
			Tele-triage recurrent costs	207,812	
			Adapted Flats	35,643	
			Trusted Assessor - Dom Care	110,000	
			Trusted Assessor - Care Homes	71,000	
			BCF Scheme Lead/ROI Evaluation	35,000	
			8b Post	35,000	
			Home First Capacity - dom care, reablement, mobile nights	78,955	
			Home First - MDT (Enhanced Rapid Response Service)	399,657	
			Home First - Clinical Support/Discharge capacity	540,808	
			Acute Visiting Service (AVS)	709,920	
			10 x T2A Residential Beds - core funding	273,520	
			86 x T2A Nursing Beds - core funding	3,471,472	
			Growth in T2A Beds	219,625	
			T2A - 10 beds - Cover for Pressure periods	223,812	
			Additional MDT support, including clinical cover for extra beds (10)	106,343	
			Primary Care & Therapies for T2A Beds	967,428	

Org	Commissioner	Category	SubCategory		17/18 Budget (£)
			Community Offer (ASC)	3,972,292	
			Community Offer (CCG)	854,011	
			Reablement - Commissioned Care	1,231,249	
			Dom Care	412,000	
			Enhanced Dom Care (Dom Care Plus)	143,000	
			Joint Posts - Mental Health	474,587	
			Homeless Service	93,279	
			Existing Schemes	1,019,526	
			ICCT - WCT	426,236	
			Comms - Home First	12,000	
		Total Integrated Services			**20,369,375**
		Adult Social Care Services	Early Intervention & Prevention	1,199,000	
			Carers Service	818,512	
			Mobile Night Service	694,394	
			Care & Support Bill Implementation	497,180	
			Drugs & Alcohol	7,093,526	
			Protection of Social Care	14,880,901	
			Brokerage	27,000	
		Total Adult Social Care Services			**25,210,513**
		CCG Services	CCG Third Sector	485,378	
			IV Antibiotics	562,300	
			Street triage	152,000	
			Dementia LES	71,400	
			Early onset Dementia	146,000	
			Complex Needs Service	250,000	
			Crisis Response	150,576	
			Dementia Nurse	150,580	
		Total CCG Services			**1,968,234**
		Other	DFG	3,858,041	
		Total Other			**3,858,041**
		Innovation Fund	Transformation Programme Manager Role	60,000	
			Whole System Modelling Senior Performance Analyst	40,000	
			Mental Health detention transport	70,000	
			Street Triage - enhanced hours of operation	112,668	
			Street Triage for NWAS	174,752	
			Ward Discharge Coordinators	155,000	
			Primary Care Bid - Clinical Streaming at Front Door	300,000	
		Total Innovation Fund			**912,420**
		Known Pressures & Contingency	Winter Planning & Contingiency	529,814	
			Known Development Pressures (TeleHealth, TeleTriage)	58,387	
			Known Development Pressures (Enhancing Health in Care Homes)	50,000	
			Allocation of increase in CCG minimum allocation	482,000	
		Total Known Pressures & Contingency			**1,120,201**
	Total Better Care Fund				**53,438,784**
TOTAL BCF					**53,438,784**
GRAND TOTAL					**131,872,554**

Wirral Council and NHS Wirral Clinical Commissioning Group
Integrated Commissioning Hub: Financial Risks and Mitigations

September 2017

pwc

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Executive Summary

Overview

Health and care services in the Wirral are facing increasing demand at a time of national constraints. This is creating financial challenges and pressures on the resources of Wirral Council ('the Council') and Wirral CCG ('the CCG'), the two main Commissioners of health and care services across the health economy.

Both the Council and the CCG (together 'the Commissioners') would like to extend their current pooled budget arrangements to incorporate the majority of the total health and social care funding within the health economy. The services that fall under the scope of these new pooled arrangements will be formally commissioned by the Integrated Commissioning Hub (ICH). By pooling the budgets and jointly commissioning services, the Commissioners hope to achieve a number of objectives, including:

- A single, **joint commissioning approach** using shared resources for all in-scope service areas;
- A single provider framework and commissioning gateway that offers **assurance and value for money**;
- Developing and shaping the care supply market through a **single market management strategy** in order to reduce the likelihood of market failure;
- **Meeting the cost of care and demand management pressures** in the system;
- **Reduced duplication** of effort and service provision; and
- Facilitation of the **integrated operating model** for services across the Wirral (through the implementation of a new model of care)

Our Scope

PwC have been commissioned to provide an independent assessment of the potential risks and benefits to each Commissioner from pooling the budgets in the ICH. PwC were asked to undertake our assessment through 'two lenses' whereby we:

- Assessed the risks to the Council from integrating with and sharing responsibility for the CCG's budget and obligations; and
- Assessed the risks to the CCG from integrating with and sharing responsibility for the Council's budget and obligations.

Alongside this, we were also asked to provide indicative, high level guidance regarding the potential VAT implications of pooling the budgets via a Section 75 agreement.

Our assessment

Based on our assessment of the ambitions for the ICH, the risks and mitigations identified from pooling the budgets and the potential benefits which could be delivered, we believe that the move to the ICH is the correct approach.

It is clear that increasing demand, in the face of limited funding, will require new ways of working in order for financial balance to be sustained. The pooling of budgets in the ICH should stimulate new joint ways of commissioning services across the Wirral and allow Commissioners to focus their efforts on improving services for their citizens. In order to build trust and confidence, shared demand management and care assessment and planning initiatives should be identified and pilot tested in 2017/18 (if possible). These should focus on the key areas of recurring pressure highlighted by a detailed review of the drivers of prior year performance.

The Commissioners and providers in the Wirral are at a very early stage in the move towards an Accountable Care System. Consequently, the governance and operational arrangements for the ICH, and the potential clinical model which is to be put in place by providers, are not yet agreed. We have therefore been unable to provide any recommendations regarding the future health and care commissioning and delivery models in the

Wirral. However, the move to an ACS and the associated changes in demand management and accountabilities should further promote increased financial stability and outcomes across the Wirral. The implementation of the ICH is likely to be a key first step in this process.

Key benefits identified

It is important to recognise that due to demographic pressures, increasing demand and an increasing complexity of need, that there is no risk-free option for the future commissioning of services. However, integration is the direction of travel in many areas of the country, and the implementation of the ICH is anticipated to deliver a range of benefits to the health and care system.

The Commissioners have already begun to identify the range of clinical, operational and financial benefits which could be delivered through a move to the ICH. The detail behind these workstreams and the associated benefits are described outside of this report, and we have therefore not analysed the benefits of moving to the ICH in substantial detail within this report.

Despite this, we believe that pooling budgets within the ICH could deliver health and care system benefits including:

1. **Aligned incentives across the system**

   Pooled budgets will allow the Commissioners to align contractual and financial incentives of health and care providers across the Wirral. This will help to ensure that commissioner's outcomes and priorities are increasingly likely to be met, through the incentivisation of aligned, patient/client-centred care across health and social care services.

2. **Increased likelihood of value for money of the Wirral £**

   The ICH will focus on an integrated commissioning approach to the provision of health and care services across the Wirral. A joint commissioning function would be able to facilitate changes from traditional service models, promoting cross-provider working and responsibilities and improving outcomes and system performance.

3. **Reduction in Commissioner time, effort and spend**

   Commissioners at both the Council and CCG expend a significant amount of time negotiating and agreeing the use of the BCF and CHC/Packages of Care costs, in order to ensure the most efficient and effective utilisation of their own organisation's budgets. A single integrated commissioner would remove these transaction costs, allowing ICH members to focus on system transformation and increasing the value for money of services.

4. **Single planning process, financial plan and shared responsibilities**

   The Council and CCG currently commission separate parts of patient pathways, which has led to duplication of work and a potential for the commissioning of a disjointed pathway. Duplication of effort would therefore be reduced by the agreement of a single financial plan with providers, regulators and others providing oversight across the Wirral. Commissioners will be able to work closer together, sharing information and insight in order to achieve their shared financial responsibilities and obligations.

5. **Primary Care incentivisation is in the ICH and could help with elective and social care referrals**

   The CCG intends to pool the funding which it has available for the incentivisation of primary care providers across the system. The ICH will be able to take a system-wide health and care perspective for the use of this funding, ensuring that referrals for elective care and social care services align with the wider strategic objectives of the ICH and demand management interventions in place across the Wirral.

6. Facilitates introduction of ACS

The introduction of an integrated commissioner with a single pool of funds will facilitate the introduction of a wider Accountable Care System / Accountable Care Organisation across the Wirral. Without the ability for Commissioners to ultimately let a single contract for services through the ICH, the ability to move to an ACS would be impaired due to complexity which multiple contracts, budgets and accountabilities would bring.

Key risks identified

The following summarises the key risks we have identified concerning the pooling of funds in the ICH (the full list of risks identified is included within the report).

The potential mitigations identified present a longlist of available options to the ICH – not all of these could or may be able to be implemented at this time.

Table 1: Key risks and potential mitigations of pooling budgets

Potential Risk	Which organisation presents this risk?	Potential impact	Potential mitigations	Where risk should sit in the ICH
Budget setting risk				
• The Council may be unable meet its efficiency requirement of £3.4m in 2017/18 (4.4% of total budget), resulting in an in-year deficit • Despite delivering savings of over 5% of net budget funding annually since 2014/15, social care services have not met their annual saving target since 2014/15, with this target being missed by as much as £7.5m. 'One-off' savings of £2.6m and £1.9 have been required to support savings in 2015/16 and 2016/17	Council	> The ICH would begin with a financial deficit, with funding insufficient to meet the required expenditure, prior to any additional budget pressures being experienced from 2018/19 onwards > Additional contingency/deficit funding would be required to be repaid in 2018/19 > Savings plans are still under discussion with community trust to identify and deliver further savings	> Prior year deficits to be kept out of the pooled funding arrangements > Deficit repayments to be made solely by the original organisation > Effective, joint saving plan required and implemented to reduce demand and take cost out of the system > Risk share arrangements to incentivise joint working > Open book accounting > "One-off" actions to be reviewed if required > Single population health budget implemented over the longer term	Council
• The CCG may be unable meet its efficiency requirement of £12.3m in 2017/18, resulting in an in-year deficit (2.4% of total budget), resulting in an in-year deficit. This could result in the CCG being placed in the Capped Expenditure Process in 2018/19 • The CCG did not meet its QIPP requirement in 2016/17, missing its £8.8m target by £5.0m	CCG	> The ICH would begin with a financial deficit, with funding insufficient to meet the required expenditure, prior to any additional budget pressures being experienced from 2018/19 onwards > Additional contingency/deficit funding would be required to be repaid in 2018/19 > CCG could be entered into the Capped Expenditure Process and/or Turnaround	> Prior year deficits to be kept out of the pooled funding arrangements > Deficit repayments to be made solely by the original organisation > Effective, joint saving plan required and implemented to reduce demand and take cost out of the system > Robust contractal arrangements with providers regarding QIPP > Risk share arrangements with providers > Risk share to incentivise joint working > Open book accounting introduced > Single population health budget implemented over the longer term	CCG

Potential Risk	Which organisation presents this risk?	Potential impact	Potential mitigations	Where risk should sit in the ICH
Forecasted spend risk				
• Brought forward pressures from 16/17 could in fact be recurrent and could place ongoing pressure on the budget • Social care services are forecasting a break-even budget position this year, despite social care services overspending its budget each year since 2014 (a £2.5m deficit in 14/15 rising £3.9m in 16/17) • For the last three years the Council have overspent on its expenditure budget, with these overspends varying between £1.6 and £4.2m	Council CCG	> Based on previous trends a breakeven position for ASC would be difficult to achieve in 17/18. This could result in underfunded services being pooled in the ICH > Additional contingency/deficit funding would be required to be refunded in 2018/19 > Risk of cumulative deficits and cost pressures becoming unmanageable if pressures in-year are not mitigated. > However, significant government intervention has changed the dynamics of funding to begin to offset these pressures	> Prudent assumptions regarding performance in 17/18 made > Prior year deficits to be kept out of the pooled funding arrangements > Deficit repayments to be made solely by the original organisation > Effective, joint planning required and implemented to reduce demand and take cost out of the system > Re-baselining of service provision and cost in 2018/19 in risk share arrangements > Open book accounting	Council (for non-recurring soclail care elements) Shared for recurring elements
• Funding pressures in 2018/19 include the repayment of deficits and contingency drawdowns used to fund prior year budget deficits • CCG allocation will be top-sliced in future years in order to repay deficits incurred in the years prior to 2017/18. This is likely to result in the CCG's budget being top-sliced by £9.8m in 2018/19	Council CCG	> ICH budget would contain pressures unrelated to service delivery in 2018/19, which are unmanageable by the ICH > CCG funding allocation is top-sliced by NHS England to repay prior-year debt drawdowns	> These pressures and repayment obligations are not pooled and remain with their original organisations > Organisation must pay its debt obligations back through a surplus made through the funding pool as part of a risk share arrangement > Council to be party to any negotiations with NHSE regarding deficit repayments > Open book accounting	Council CCG

Recommendations

Based on the identified risks, and the available mitigations available to the Council and CCG, the following list summarises our recommendations, which could be implemented in order to minimise the identified risks to the ICH:

1. Joint review of prior year performance

Our piece of work has looked at the high level organisational performance at a budget line level. We recommend that the Council and CCG jointly undertake a more granular review of the drivers behind prior year budget volatility, in order to allow both parties to have a joint understanding of the drivers of deficits, and begin to mitigate these risks through integrated working arrangements. This should isolate the recurring and non-recurring elements of prior year financial performance.

2. Joint planning and working

The ICH budget and contract should start from a net nil position in 2018/19 (i.e. prior deficits of either organisation should not be included within the Year 1 budget position of the ICH). Any deficits or contingency funding required to be repaid by either commissioner should be funded through efficiencies and benefits achieved by the ICH or through risk share arrangements (as per Recommendation 3 below).

Consequently, the Council and CCG should begin to work closely together as soon as possible (prior to pooling the budgets if possible) in order to minimise the likelihood of a deficit for either organisation being recorded in 2017/18 and therefore pressures being placed on the ICH budget in 2018/19. Joint planning, forecasting and working will be a key approach through which risks can be shared and mitigated in the ICH. This could include the joint agreements, over a three year time horizon, of:

- Demographic, demand and inflation pressures affecting health and care services;
- Feasible efficiency targets which can be delivered by both Commissioners;
- Forecasting assumptions (including a shared view on the cost pressures affecting the health economy and the mitigations available to reduce those pressures); and
- Integrated demand management plans in order to reduce cost pressures in social care services and deliver the QIPP requirements of the CCG.

Additionally, the CCG should become active participants in the Council's budget setting process, and the Council active participants in the CCG's contract negotiations, so that funding requests, contract negotiations and drivers of efficiency targets are fully understood and agreed to by both parties. This would support both parties formulating common supply side market management efficiencies.

Public health budgets are currently ring-fenced for use on public health services. These successful delivery of these services successful will be essential for the long term reduction of demand across the Wirral. Joint planning for public health services should be undertaken by the Council and CCG, however it is proposed that this funding remain ring-fenced for the short term in order to meet current public health objectives.

3. Gain/risk share arrangements

A key mitigation of many of the risks posed by the pooling of the Commissioners budgets is the introduction of a gain/risk share arrangement between the Council and CCG. A risk share arrangement will allow both Commissioners to appropriately share any benefits and risks as a result of the financial performance of the ICH. However, the formulation and introduction of a gain/risk share arrangement is a complex process, particularly for risk sharing arrangements around large or complex budgets. The Council and CCG will therefore be required to undertake a significant programme of work in order to determine an appropriate gain/risk share arrangement for the ICH (potential approaches are discussed in more detail within this report). This work will be supported by the joint analysis and shared negotiations described above.

4. ICH governance and reporting arrangements

Clear governance and reporting arrangements should be introduced in the ICH, in order to allow it to deliver the anticipated benefits across the system whilst maintaining the delivery of the Council's and CCG's statutory obligations. This could include the appointment of a joint Commissioning Director and the introduction a Joint Board, comprised of representatives from the Council and CCG. Appropriate delegated authority from the Council and CCG to this Joint Board would be a pre-requisite. However, we understand that revised governance arrangements are currently being considered in the current operating model design work for the ICH.

Governance arrangements concerning the use of funding and budget management will also be required, in order to provide assurance to both organisations. This could include approval mechanisms for the agreement of investment decisions and joint monthly reporting of the financial performance of the ICH to the respective organisation boards. Open book accounting would further provide assurance to the Council's and CCG's Boards on the transparency of decision making in the ICH.

5. Continuing Healthcare position review and joint commissioning

Prior to the introduction of the ICH we recommend that both parties review the current CHC and joint package of care activity and cost across the system before a baseline budget for these services are agreed. We believe that the current distribution of funding is significantly different from relevant peers and that the ICH may want to introduce a redistribution of joint vs fully funded packages of care over an agreed period of time in order to closer resemble the proportions achieved by benchmarked peers. A review of the assessment and approvals process for care support is also currently being undertaken, and a combined assessment process should be implemented where relevant. This should allow the ICH to jointly agree the appropriate combined funding required for CHC and complex care needs across the health economy.

Upon the completion of the review, the ICH should jointly agree the appropriate combined funding required for CHC and complex care needs across the health economy, and begin the joint contracting and commissioning for CHC and complex care placements across the area. This would allow the Commissioners to deliver value for money and drive quality and safety, whilst managing future market demand. Risk share arrangements could also be introduced in order to appropriate share gains and losses with regards to complex care costs, in line with the new baselined spend.

6. Budget exclusions reviewed

Two significant areas of budget may end up being out of the initial scope of the ICH – client income from the Council (£18.9m) and the prescribing budget (£59.5m) from the CCG. We recommend that the definition of 'out of scope' and implications of these budgets being out of scope for the ICH should be jointly discussed by the Council and CCG before a final decision is made.

We understand that client income being kept out of the pooled funding arrangement would result in the ICH having no direct control over the receipt of this income. The ICH would therefore need to ensure that realistic income receipt forecasts are agreed with the Council, and that the ICH is shielded from any risk of under-collection of income, as it would have no control over the Council's performance in this regard. We recommend that if client funding is not included within the ICH budget then the risk of any under-collection of income should lie centrally with the Council.

The implications of excluding the prescribing budget should also be agreed between the Council and CCG. For example, the CCG will need to ensure that any overspends in the prescribing budget do not negatively affect the sum available in future years to pool in the ICH (e.g. through the repayment of deficit funding or contingency reserves). The CCG should consider ways through which this risk could be mitigated and/or if this budget could be jointly managed through its introduction into the ICH.

7. Upcoming policy review and contingency planning

An ongoing challenge for the ICH will be its response to national and local policy changes. We recommend that known policy intentions are reviewed and shared between both organisations in order to agree a shared view on the impact that these changes may have. This includes the Government's proposal to reform social care funding from 2020/21, and the likely impact on the ICH if the CCG is entered in the NHS Capped Expenditure Process.

This will allow the ICH to scenario plan and agree contingency arrangements if policy changes result in significant pressures and/or changes for service provision across the Wirral. Over time, contingency funding should try to be built up by the ICH in order to mitigate the effect of unanticipated pressures over the longer term. The outcome of such a review should be reflected in the risk and gain share arrangements in the ICH.

8. Strong branding and cultural identity

In order to facilitate the integration of the commissioning function in the ICH, and promote new ways of working both internally and externally with providers, the ICH should ensure it had a strong brand which is publicised across the Wirral. Joint development and integration events could be introduced in order to facilitate collaboration and integration within the ICH, and a shared strategy should be published, integrating the Wirral 2020 Vision and the CCG's commissioning intentions, in order to align the goals and objectives of health and social care across the Wirral.

9. Performance monitoring metrics

In light of the identified risks and recommendations, we have considered potential performance monitoring metrics which could be used to monitor the impact and benefits of moving to the ICH. These metrics should be reported upon in any shadow running/transition period for the ICH in 2017/18:

- Improvements in the ICH financial position
- Combined contingency funding and debt obligations cleared
- Publication of joint strategies and reports
- Number of jointly commissioned services implemented and demand management interventions put in place
- Staff satisfaction scored, including staff association with working for ICH (as opposed to their own organisations)
- Joint benchmarks and performance metrics in which both organisations have influence, including reducing the number of DTOC, reduction in hospital admissions, number of patients admitted to long term residential care
- Reduction in health inequalities across the Wirral
- Ultimately the letting of a single contract with a single set of outcomes for providers, as part of an Accountable Care System.

VAT implications

The pooling of budgets, implementation of a single commissioning function through the ICH and the ultimate move into an ACS is likely to have VAT implications for the Commissioners. Positive steps will therefore need to be taken to ensure that additional VAT costs are not incurred when compared to the existing arrangements across the system.

Given that the plans are still in their formative stages some initial thoughts on the VAT implications of the move to the ICH have been provided, in order to inform the decision making process. Importantly however, where the Commissioners act together, they will need to consider whether in doing so they create a relationship that could be treated as a separate entity for VAT purposes, e.g. a partnership. Any such entity is unlikely to enjoy the VAT recovery regime that currently applies to NHS bodies or local authorities.

VAT liability

The VAT liability of the services commissioned by the Commissioners depends on the nature of the services, which depends, in turn, on how the services are defined in the respective agreements.

In broad terms, supplies of health care are exempt for VAT purposes and as such, do not attract a VAT charge. The treatment of social care services generally follows the same principles, although the VAT liability may in some cases differ. It is therefore likely that there will be no VAT charge on the supplies made to the Commissioners.

The VAT implications of other services, such as contract management, supplier selection, quality assurance, financial control, systems and data management, etc. would typically be standard rated for VAT purposes, however this will only be able to be confirmed through the analysis of the relevant contracts, once available.

In addition, NHS bodies in England are broadly within the same divisional VAT registration, so that supplies between these bodies are usually disregarded for VAT purposes. Consequently, supplies from an NHS body / provider to the CCG will be outside the scope of VAT.

ICH organisational arrangements

The Commissioners will need to consider the VAT implications of the way in which they come together and the impact that VAT costs may have on the funds pooled. The recovery of VAT in relation to any pooled funds will depend on how the agreement is structured. The comments below are based on the treatment of Section 75 agreements:

- Where a lead commissioner is responsible for delivering the service and receives funding from the other commissioner(s) in order to carry out those responsibilities, the recovery of any VAT incurred in the delivery of the service will follow the regime of the lead commissioner.
- Where a lead commissioner is acting under the instruction of another commissioner and is appointed to manage funds on behalf of that commissioner, and so is effectively acting as an agent, VAT recovery will ultimately be determined by the VAT regime of the principal. The parties will need to ensure that the appropriate administrative arrangements are in place to provide the principal with the evidence necessary to recover VAT where possible, to deal with costs that need to be apportioned and to ensure VAT is applied correctly to any management charges made by the lead commissioner.

Even where there is a Section 75 agreement, the Commissioners will need to consider the VAT implications of charges between them (such as for staff) and be aware that VAT costs can still arise where there is no monetary consideration paid for services provided by one to the other.

The ability of the Council and the CCG to recover any VAT on costs incurred by them as Commissioners is as follows:

The Council

A local authority can usually recover all the VAT it incurs in relation to its activities, as long as the VAT it incurs in relation to what are treated as exempt supplies for VAT purposes remains within the 5% partial exemption de minimis limit.

The Council's activities in its role as commissioner should be regarded as non-business rather than exempt in nature from a VAT perspective. Consequently, the Council should be able to recover any VAT on costs incurred in this role and there should be no impact on its partial exemption calculation in this respect.

The CCG

An NHS body can recover VAT incurred in relation to its normal statutory non-business healthcare activities where that VAT relates to certain contracted-out services.

The CCG will need to ascertain whether the third party costs incurred in relation to its activity as commissioner are on the list of contracted-out services, in respect of which VAT recovery is permitted. Unless the CCG intends to procure additional goods or services as a consequence of the contract and alliance arrangements, there should be no additional irrecoverable VAT costs arising. One potential proviso in this respect is where staff are provided / seconded by the Council to the CCG. A supply of staff is generally subject to VAT at the standard rate, VAT which is unlikely to be recoverable by the CCG under the contracted-out services rules.

ACO Alliance host / providers

The VAT implications for providers in the system will also depend upon the structuring of service and contractual arrangements across the Wirral. Again, detailed analysis will need to be undertaken once further plans and arrangements for the future provision of services across the Wirral have been agreed.

Scope and process

This section summarises the scope of PwC's support and the work which has been undertaken to assess the risks of integrating the commissioner budgets

Scope of Works

We have undertaken a limited scope engagement and have had good access the management and support from the Council and CCG. A summary of our process is as follows:

Our scope  Limited Extensive	PwC were asked to review the proposed budget, forecasting arrangements and the historic performance of the Council and CCG in order to identify key risks and potential gains for the Council and the CCG, through a two lenses approach (i.e. independent review of the Council budget for the CCG and the CCG budget for the Council). Our work only assessed the figures provided to us by the Council and CCG – it does not include provider corroboration or an assessment of the services out of scope for the ICH. We were also asked to provide an early view on the potential VAT implications of pooling the budgets in a Section 75 agreement.
Access to management  None Good	Our access to the key financial team and wider commissioning members from both organisations has been good. Meetings were coordinated by Simon Rice (Council – Transformation Project Manager), providing access to Andrew Roberts (Council – Head of Finance), Mathew Gott (Council – Principal Accountant), Graham Hodkinson (Council – Director of Health and Care), Jacqui Evans (Council – Assistant Director of Integrated Care), Mike Treharne (CCG – Director of Finance), Emma Edwards (CCG – Finance), Paul Edwards (CCG – Director of Corporate Affairs) and Andrew Cooper (CCG – Assistant Director of Planned / Unplanned Care).
Access to information  Limited Extensive	Access to information has generally been good, and the information provided has given us a reasonably timely basis on which to analyse the general risks of the budgets anticipated to be in scope for the ICH. However, the Council's budget continued to flex throughout our engagement as funding requirements were agreed. Equally, detailed forecasting assumptions for the Council's budget pressures were not available until late in the engagement. Finally, we did not receive initial comments from the CCG on the accuracy of our interpretation of their information until very shortly prior to the issuing of our draft report.
Clarity of information  Poor Good	The information provided, alongside our access to management, has allowed us to gain some insight into some of the more significant risks and benefits of pooling commissioner funds. However, some of the forecasting assumptions and historic performance information could have been more detailed and clearer to allow richer analysis. Additionally, we encountered some difficulties in assessing the Council's budgets for in-scope services, with historic performance in 2015/16 having to be re-baselined during our work.
Important scope comments	We have not carried out anything in the nature of an audit nor, except otherwise where stated, have we subjected the financial or other information contained within this report to checking or verification procedures. Accordingly we assume no responsibility and make no representation with respect to the accuracy and completeness of the information in this report, except where otherwise stated.

Benefits of pooling commissioner budgets

Although there are a number of potential risks to Commissioners from pooling their budgets in the ICH, it is important to recognise that due to demographic pressures, increasing demand and an increasing complexity of need, that there is no risk-free option for the future commissioning of services. However, the implementation of the ICH is anticipated to deliver a range of benefits to the health and care system, in lie with the widely accepted view across the country that integration is the required direction of travel to mitigate these risks. The Commissioners have already begun to identify the range of clinical, operational and financial benefits which could be delivered through a number of workstreams, including:

- Finance
- Contacts & payments
- Governance
- Data & Commissioning Tools (Business Intelligence)
- HR and Organisational Development
- IT and Estates

The detail behind these workstreams and the associated benefits are described outside of this report. We have therefore not analysed the benefits of moving to the ICH in substantial detail within our analysis. Despite this, we believe that pooling budgets within the ICH could deliver health and care system benefits including:

1. **Aligned incentives across the system**

   Pooled budgets will allow the Commissioners to align contractual and financial incentives of health and care providers across the Wirral. This will help to ensure that commissioner's outcomes and priorities are increasingly likely to be met, through the incentivisation of aligned, patient/client-centred care across health and social care services. For example, this could include revised/shared contractual terms with Wirral Community Trust for health and care services, shared quality outcomes and targets, and risk share arrangements between the ICH and providers.

2. **Increased likelihood of value for money of the Wirral £**

   The ICH will focus on an integrated commissioning approach to the provision of health and care services across the Wirral. This will include assessing inefficiencies, duplications of care and opportunities to integrate and deliver services closer to home. A joint commissioning function would be able to facilitate changes from traditional service models, promoting cross-provider working and responsibilities and improving outcomes and system performance. For example, this could include clinical support being provided to the domiciliary care market or having domiciliary care nurses changing patient's dressings, rather than district nurses having to visit patients to do this instead.

3. **Reduction in Commissioner time, effort and spend**

   Commissioners at both the Council and CCG expend a significant amount of time negotiating and agreeing the use of the BCF and CHC/Packages of Care costs, in order to ensure the most efficient and effective utilisation of their own organisation's budgets. This effectively places the Council and CCG at opposition with one another, particularly with regard to the balance of fully funded vs jointly funded packages of care across the system. A single integrated commissioner would remove these transaction costs, allowing ICH members to focus on system transformation and increasing the value for money of services.

4. Single planning process, financial plan and shared responsibilities

The Council and CCG currently commission separate parts of patient pathways, which has led to duplication of work and a potential for the commissioning of a disjointed pathway. Duplication of effort would therefore be reduced by the agreement of a single financial plan with providers, regulators and others providing oversight across the Wirral. Commissioners will be able to work closer together, sharing information and insight in order to achieve their shared financial responsibilities and obligations. A shared financial plan will further prevent Commissioners having to act in opposition to one another in order to maintain financial balance.

5. Primary Care incentivisation is in the ICH and could help with elective and social care referrals

The CCG intends to pool the funding which it has available for the incentivisation of primary care providers across the system. The ICH will be able to take a system-wide health and care perspective for the use of this funding, ensuring that referrals for elective care and social care services align with the wider strategic objectives of the ICH and demand management interventions in place across the Wirral.

6. Facilitates introduction of ACS

The introduction of an integrated commissioner with a single pool of funds will facilitate the introduction of a wider Accountable Care System / Accountable Care Organisation across the Wirral. This is due to the integrated commissioner being able to eventually procure all health and social care services through a single contract and a single budget across the system, which an accountable, integrated provider could manage and deliver. Without the ability for Commissioners to let a single contract for services, the ability to move to an ACS would be impaired due to complexity which multiple contracts, budgets and accountabilities would bring.

Key risks and mitigations

Based on the information received and our analysis of the riskse, this section presents the key risks to the Council and CCG from the pooling of their budgets, and identifies a range of possible mitigations available in order to reduce these risks.

The potential mitigations identified present a longlist of available options to the ICH – not all of these could or may be able to be implemented at this time.

Risks have been rated as follows:

Very Low Risk	**0-9**
Low Risk	**10-14**
Moderate	**15-19**
High Risk	**20+**

Table 2: Identified risks and potential mitigations of pooling budgets

Potential Risk	Which organisation presents this risk?	Potential impact	I	L	RAG rating	Potential mitigations	Where risk should sit in the ICH
Income risk							
• Council revenues are variable in nature and are more short term than CCG funding. Wider scale funding reform for social are services has been proposed by Central Government from 2021 onwards, however no detail on what this may look like is available at present. • Available sources of income to mitigate cost pressures are variable each year, with a number of grants expected to be time-bound and council tax rate increases to fund social care capped by Central Government	Council	> The annual budgeting process will be less predicatble each year for the ICH until the point at which grants and funds are confirmed > Unless alternative funding sources are sufficient to replace those being removed and/or reductions in expenditure are obtained, future budgets are at risk of deficit	2	4	**8**	> Defined process in place to agree budget and income > CCG active participant in discussions and agreement of grant funding request > CCG actively informed of any potential policy and funding changes proposed by the Government and Council > Contingency planning undertaken > Joint 3 year plan to be reviewed annually > Joint 3 year budgeting	Shared
• Delays in receiving income or deferred payments may result in lower than anticipated free cash flow available for the ICH	Council	> There may be lower than budgeted cash flow available when required	3	3	**9**	> Joint 3 year plan to be reviewed annually > Joint 3 year budgeting > Council acts in a 'cash management / banking' role, funding short term cash requirements until anticipated income is received > Risk of non-collection remains with the Council, agreed through an MOU and the Section 75 agreement	Council

Potential Risk	Which organisation presents this risk?	Potential impact	I	L	RAG rating	Potential mitigations	Where risk should sit in the ICH
Income risk							
• Client income can be under-collected by the Council, placing pressures on the budget • Since 2015/16 the Council has under-recovered its budgeted income figure, with under-receipt of income varying between £0.8m and £1.3m per year • The Council significantly under-collected income across a range of service lines in 2016/17 compared to budget	Council	> Reductions in income compared to budget will place pressures on the ICH budget beyond any pre-existing efficiency requirement targets	3	5	**15**	> Robust SLA with Personal Finance Unit for income collection, with penalties if required > Managed through the current budget setting approach > Realistic income targets set > The Council could fund any deficits against collection > Prudent bad debt allowances assumed annually > Contingency fund built up in order to account for any shortfall > Risk share arrangements could be implemented > Council undertakes a 'banking' role for income collection of deferred income	Council
• Linked to the Medium Term Financial Planning process, retention of Business Rates is expected to be a large contributor to social care services in future years (as part of national business rates reform), which could be challenging for the Wirral	Council	> Business Rates recovered across the Wirral will be insufficient to substantively replace grant and other funding no longer provided by the Government/Council	3	3	**9**	> Defined process in place to agree budget and income for social care services > Top ups / no loss policy in place for now > CCG active participant in discussions and negotiations on income receipt > Joint three year budgets and plans agreed > CCG actively informed of any potential policy and funding changes proposed by the Government and Council	Shared
Demand risk							
• CCG is unable to negotiate any additional allocation of funds at the start of the year if it feels its budget is underfunded • Non-recurrent funding for unanticipated pressures is unpredictable and may be insufficient to meet non-recurrent pressures in the system	CCG	> Budget deficit for the ICH	3	4	**12**	> Joint agreement of likely budget requirement for healthcare services (inc. increased QIPP target) > Risk share arrangements put in place to incentivise joint working > Joint working between the Council, CCG and providers to plan for and implement solutions to manage demand and pressures at those times > Contingency funding put in place in light of unexpected pressures > Open book accounting introduced	Shared

Potential Risk	Which organisation presents this risk?	Potential impact	I	L	RAG rating	Potential mitigations	Where risk should sit in the ICH
Demand risk							
• Increases in patient and service user demand may not be mitigated fully by social care services and additional iBCF funding available, resulting in further budget pressures • The CCG only received an additional net 0.1% increase in funding for demographic growth, and therefore must be able to manage demand across the health economy to remain in budget	Council CCG	> Pooled budget is underfunded, likely to result in a deficit for the ICH > Without significant intervention cumulative deficit likely to increase annually as prior-year demand is unmet	4	4	**16**	> Joint working between the Council, CCG and providers to plan for and implement solutions to manage demand and pressures at those times > Investment in effective demand management, integrated and contractual management and care assessment schemes > Contingency funding put in place in light of unexpected pressures > Joint agreement of the forecasting assumptions by both parties	Shared
• Managing demand has been a challenge for the CCG, due to a number of factors including patient demographics and a need to ensure statutory targets are met	CCG	> Additional expenditure may be required by the CCG in order to pay alternative providers so that treatment targets are met	4	4	**16**	> Joint working to closely monitor the performance of their providers in meeting RTT targets and other demand pressures, inc. care assessment and management. > Risk share arrangements with providers in order to contribute to additional demand related costs. > Joint demand forecasting and planning in order to manage demographic pressures across the Wirral. > Commissioning for outcomes (not activity) > Ultimately a move to the Capped Expenditure Process would limit CCG expenditure	Shared
• CCG has reverted to an activity-based (PbR) contract with its main acute provider WUTH, as opposed to a block arrangement (as was the case in 2016/17). Efficiency (QIPP) savings within this contract total £5.8m	CCG	> Potential for significant contractual overspend if demand is higher than anticipated and is unable to be managed by the Trust and the CCG	4	4	**16**	> Joint demand management schemes including effective discharge planning and readmissions avoidance > Robust contract management to remain at agreed activity plan with associated contractual terms (e.g. cap/collar) > ASC involved in contract negotiations > Contractual penalties between the commissioner and the Trust > Ongoing movement towards introducing an ACS	Shared
• Poor provider performance in the system could result in regulatory intervention in order to meet performance targets. Such an intervention would have to be funded by the CCG	CCG	> ICH will be required to fund the costs of any other providers which are required to intervene in order to meet RTT targets > Likely budget deficit	3	2	**6**	> Effective management of providers through contractual terms and arrangements > Joint working with providers to manage flow and demand across the system > Effective market management > Risk share arrangements with providers put in place > Ongoing movement towards introducing an ACS	Shared

Potential Risk	Which organisation presents this risk?	Potential impact	I	L	RAG rating	Potential mitigations	Where risk should sit in the ICH
Budget setting risk							
• The funding allocated for social care services is through the council in its budget setting allocation process, as opposed to a predetermined figure such as % of central funding received	Council	> There will be uncertainty for the ICH as to its total budget each year, and associated efficiency requirements, until close to the start of the new financial year > The budget available to the ICH is likely to be influenced by external pressures and factors affecting the Council and its range of services	3	4	**12**	> CCG actively part of the budget setting process > Joint three year budget plans put in place > Risk share arrangements to incentivise joint working > Open book accounting > Council may take 100% risk on a real terms cut in budget plans where it is the sole determinant	Shared
• Council has limited scope to make expenditure savings through reducing the price it pays providers – alternative approaches to meeting efficiency requirements will need to be identified	Council	> ICH may have difficulties in reducing its expenditure base if required (particularly as prices are going up due to NLW) > Alternative approaches to meeting efficiency requirements will need to be taken	3	5	**15**	> Single commissioning plan for outcomes > Opportunities to bring commissioning together to allow better outcomes > Joint discussions and agreements for ways to reduce the cost of social care services if required	Shared
• Prescribing budget overspends (which is outside of the scope of the ICH) could restrict the sums of money the CCG is able to pool to the ICH	CCG	> Prescribing overspends will need to be funded through surpluses elsewhere or through deficit funding > This will limit the budget available to pool in the ICH	3	3	**9**	> Detailed saving plan in place with GPs who are actively incentivised to reduce prescribing spend and are managing this budget > Both parties should agree what happens in the event of an overspend so that pooled funds remain unaffected > Open book accounting should be introduced.	CCG
• Savings negatively impact on the ICH for ASC services based on the overarching performance of the Council rather than ASC's ability to deliver those savings	Council	> The ICH may be unable to meet the required savings targets, resulting in budget overspends and financial deficits	4	3	**12**	> Joint planning and implementation of ICH interventions > Savings already in the plan require transparency > Joint negotiations with Cabinet where possible on savings targets > Risk share arrangements to incentivise joint working	Shared
• The Council may be unable meet its efficiency requirement of £3.4m in 2017/18 (4.4% of total budget), resulting in an in-year deficit • Despite delivering savings of over 5% of net budget funding annually since 2014/15, social care services have not met their annual saving target since 2014/15, with this target being missed by as much as £7.5m. 'One-off' savings of £2.6m and £1.9 have been required to support savings in 2015/16 and 2016/17	Council	> The ICH would begin with a financial deficit, with funding insufficient to meet the required expenditure, prior to any additional budget pressures being experienced from 2018/19 onwards > Additional contingency/deficit funding would be required to be repaid in 2018/19 > Savings plans are still under discussion with community trust to identify and deliver further savings	4	5	**20**	> Prior year deficits to be kept out of the pooled funding arrangements > Deficit repayments to be made solely by the original organisation > Effective, joint saving plan required and implemented to reduce demand and take cost out of the system > Risk share arrangements to incentivise joint working > Open book accounting > "One-off" actions to be reviewed if required > Single population health budget implemented over the longer term	Council

Potential Risk	Which organisation presents this risk?	Potential impact	I	L	RAG rating	Potential mitigations	Where risk should sit in the ICH
Budget setting risk							
• The CCG may be unable meet its efficiency requirement of £12.3m in 2017/18, resulting in an in-year deficit (2.4% of total budget), resulting in an in-year deficit. This could result in the CCG being placed in the Capped Expenditure Process in 2018/19 • The CCG did not meet its QIPP requirement in 2016/17, missing its £8.8m target by £5.0m	CCG	> The ICH would begin with a financial deficit, with funding insufficient to meet the required expenditure, prior to any additional budget pressures being experienced from 2018/19 onwards > Additional contingency/deficit funding would be required to be repaid in 2018/19 > CCG could be entered into the Capped Expenditure Process and/or Turnaround	4	5	**20**	> Prior year deficits to be kept out of the pooled funding arrangements > Deficit repayments to be made solely by the original organisation > Effective, joint saving plan required and implemented to reduce demand and take cost out of the system > Robust contractal arrangements with providers regarding QIPP > Risk share arrangements with providers > Risk share to incentivise joint working > Open book accounting introduced > Single population health budget implemented over the longer term	CCG
Forecasted spend risk							
• Wirral CCG is forecasting a break-even position for 17/18, despite it reporting annual overspends since 15/16 (£1.4m deficit in 15/16 rising to £7.1m deficit in 17/18) • Expenditure on acute and non-acute NHS contracts has, overall, over-spent against the target activity and financial plan for the last three years. These overspends have included contracts with a range of key NHS providers	CCG	> Based on previous trends a breakeven position for the CCG would be difficult to achieve in 17/18. This could result in underfunded services being pooled in the ICH > Additional contingency/deficit funding would be drawndown and would be required to be refunded in 2018/19	4	4	**16**	> Prudent assumptions regarding performance in 17/18 made > Proactive management of contracts > Prior year deficits to be kept out of the pooled funding arrangements > Deficit repayments to be made solely by the original organisation > ASC involved in contract negotiations > Effective, joint planning required and implemented to reduce demand and take cost out of the system > Re-baselining of service provision and cost in 2018/19	CCG (for non-recurring elements)
• Brought forward pressures from 16/17 could in fact be recurrent and could place ongoing pressure on the budget • Social care services are forecasting a break-even budget position this year, despite social care services overspending its budget each year since 2014 (a £2.5m deficit in 14/15 rising £3.9m in 16/17) • For the last three years the Council have overspent on its expenditure budget, with these overspends varying between £1.6 and £4.2m	Council CCG	> Based on previous trends a breakeven position for ASC would be difficult to achieve in 17/18. This could result in underfunded services being pooled in the ICH > Additional contingency/deficit funding would be required to be refunded in 2018/19 > Risk of cumulative deficits and cost pressures becoming unmanageable if pressures in-year are not mitigated. > However, significant government intervention has changed the dynamics of funding to begin to offset these pressures	4	5	**20**	> Prudent assumptions regarding performance in 17/18 made > Prior year deficits to be kept out of the pooled funding arrangements > Deficit repayments to be made solely by the original organisation > Effective, joint planning required and implemented to reduce demand and take cost out of the system > Re-baselining of service provision and cost in 2018/19 in risk share arrangements > Open book accounting	Council (for non-recurring soclail care elements) Shared for recurring elements
• National and local policies changes can result in annual fee uplifts and cost pressures (e.g National Living Wage increases)	Council CCG	> Requirement for additional expenditure reductions and/or income being raised in order to counteract unexpected pressures	4	3	**12**	> Joint agreement and implementaion of activites to reduce the impact of policy changes > Over time contingency funding built up to mitigate pressures	Shared

Potential Risk	Which organisation presents this risk?	Potential impact	I	L	RAG rating	Potential mitigations	Where risk should sit in the ICH
Forecasted spend risk							
• Funding pressures in 2018/19 include the repayment of deficits and contingency drawdowns used to fund prior year budget deficits • CCG allocation will be top-sliced in future years in order to repay deficits incurred in the years prior to 2017/18. This is likely to result in the CCG's budget being top-sliced by £9.8m in 2018/19	Council CCG	> ICH budget would contain pressures unrelated to service delivery in 2018/19, which are unmanageable by the ICH > CCG funding allocation is top-sliced by NHS England to repay prior-year debt drawdowns	4	5	**20**	> These pressures and repayment obligations are not pooled and remain with their original organisations > Organisation must pay its debt obligations back through a surplus made through the funding pool as part of a risk share arrangement > Council to be party to any negotiations with NHSE regarding deficit repayments > Open book accounting	Council CCG
Budget management risk							
• The CCG has been issued formal directions by NHS England, requiring the CCG to improve its financial and governance weaknesses	CCG	> Additional oversight and scrutiny from NHS England > If performance doesn't improve the CCG could be placed in the capped expenditure process	4	3	**12**	> Strengthening the CCG's financial and governance arrangements through the ICH > CCG and Council should begin considering governance and reporting requirements with this in mind. > Section 75 financial framework in place	Shared
• Residual funding remaining in separate original organisations (e.g. prescribing budget, funding which cannot be delegated), alongside the pooled ICH budget, will prevent joint, integrated realignment and maintain original organisational identities	Council CCG	> Current behaviours and cultures maintained > New ways of working disincentivised > Potential biases towards original organisations maintained	1	2	**2**	> Clear governance arrangements e.g. new joint board > Strong branding and joint organisational development > Integration of workforace	Shared
• The lead ICH Commissioner could innately or overtly prioritise the funding of services from their 'old' organisation rather than for the benefit of the ICH overall, preferentially redirecting funding back to its old organisation	Council CCG	> Independent assessments of the best funding allocations for services and service investments not obtained > Potential conflicts between ICH members > Financial performance reported with respect to services offered by the original commissioning organisations will be skewed, unfairly affecting any risk share arrangements	2	3	**6**	> Strong governance arrangements required e.g. new joint board > Clear accounting treatment should be put in place, with joint recommendations for investment > Strong cultural identity in the ICH > Open book accounting	Shared
• If the decision to integrate commissioning is reversed, disbanding the ICH could lead the Council being left with the residual costs of new interventions, without joint funding to support these recurrent costs	CCG	> ASC will experience large funding pressures as there will be insufficient income and Council budget to meet the additional recurrent costs in place in the system	5	2	**10**	> Contractual provisions to manage exit arrangements from the ICH which consider the Council's statutory position to fund ASC	Shared

Potential Risk	Which organisation presents this risk?	Potential impact	I	L	RAG rating	Potential mitigations	Where risk should sit in the ICH
CHC / complex care risk							
• Large discrepancies in joint vs fully funded packages of care compared to peer benchmarks means a re-baselining of CHC costs is likely to be required • Both parties face a significant financial pressure in relation to people with Complex Care needs. Current plans to meet these pressures are not aligned, leading to disputes for individual cases	Council CCG	> Current CHC working practices, assessment practices and/or classifications are inappropriate > CCG will experience an overspend in its CHC costs in 17/18 if ASC is to meet its efficiency saving requirements > Additional savings may have to be made from elsewhere, which might not be achievable > CHC budget may be underfunded	3	3	**9**	> Assessment and funding approvals process and criteria should be reviewed, with joint assessment implemented where relevant > Re-benchmarking of joint vs fully funded packages of care may be required in line with benchmarked peers, in order for an appropriate baseline to be passed into the ICH > Risk share arrangements to incentivise joint working > Open book accounting > Open discussions had between commissioners > Budget adjustments made if necessary	Shared
• Fully funded CHC budgets have overspent annually since 2014/15, with a significant overspend of £4.5m delivered against all Out of Hospital care services 2016/17	CCG	> Current CHC working practices and/or CCG budget management for CHC are inappropriate and require revision	5	3	**15**	> Joint review of CHC and other Out of Hospital costs to determine why overspends have been delivered > Agreement on realistic recurrent cost pressures with regards to these services	Shared

Recommendations

Based on the information we received and our analysis of the risks, this section summarises our main recommendations for the Council and CCG in order to mitigate the key risks relating to the pooling of funds in the Integrated Commissioning Hub.

1. Joint review of prior year performance

Our analysis has highlighted a number of pressures within the budgets of the Council and CCG, and how these pressures have resulted in deficit financial positions for both parties since 2014/15. This piece of work has looked at the high level performance at a budget line level, and we now recommend that the Council and CCG jointly undertake a more granular review of the drivers behind prior year budget volatility relating to income receipt, expenditure overspends and the potential recurrent impact of these drivers in the future ICH budget. This should isolate the recurring and non-recurring elements of prior year financial performance. Although this could be a significantly more detailed piece of work over a period of time (e.g. working with providers to assess why QIPP schemes have not delivered, assessing causes for a non-receipt of income from clients), it would allow both parties a joint understanding of the drivers of deficits, in order to mitigate these risks through a combined approach.

2. Joint planning and working

The ICH budget and contract should start from a net nil position in 2018/19 (i.e. prior deficits of either organisation should not be included within the Year 1 budget position of the ICH). Any deficits or contingency funding required to be repaid by either commissioner should be funded through efficiencies and benefits achieved by the ICH or through risk share arrangements (as per Recommendation 3 below). Consequently, the Council and CCG should begin to work closely together as soon as possible (prior to pooling the budgets if possible) in order to minimise the likelihood of a deficit for either organisation being recorded in 2017/18 and therefore pressures being placed on the ICH budget in 2018/19.

In the first instance, both parties should keep the other informed in their ongoing performance in meeting their efficiency requirement targets throughout 17/18, so that any deficits likely to be recorded in 2017/18 are known by all parties. Open book accounting would be beneficial in this regard.

Additionally, joint planning, forecasting and working will be a key approach through which risks can be shared and mitigated in the ICH. This could include the joint agreements, over a three year time horizon, of:

- Demographic, demand and inflation pressures affecting health and care services;
- Feasible efficiency targets which can be delivered by both Commissioners;
- Forecasting assumptions (including a shared view on the cost pressures affecting the health economy and the mitigations available to reduce those pressures); and
- Integrated demand management plans in order to reduce cost pressures in social care services and deliver the QIPP requirements of the CCG.

Integrated demand management plans could include encouraging providers to implement new ways of working in their clinical models, a closer integration of services, and reviewing of the appropriateness and effectiveness of services currently in place. It could also include facilitating the introduction of Accountable Care System arrangements in the Wirral (in line with the system's current intentions) and the introduction of risk share arrangements with providers.

Additionally, the CCG should become active participants in the Council's budget setting process so that they are able to assist social care services in their funding request and have full visibility of the Council cabinet's rationale though which the social care funding allocation is awarded.

Similarly, the Council should become active participants in the CCG's contract negotiation discussions with providers, in order to assist in the setting of QIPP targets for each provider and to have full visibility on the final contract sums agreed across the system. This would support both parties formulating common supply side market management efficiencies.

Both the Council and CCG should then work together to monitor provider performance across the Wirral (e.g. QIPP delivery, RTT performance) in order to jointly respond where necessary.

Public health budgets are currently ring-fenced for use on public health services. These successful delivery of these services successful will be essential for the long term reduction of demand across the Wirral. Joint planning for public health services should also be undertaken by the Council and CCG, however it is proposed that this funding remain ring-fenced for the short term in order to meet current public health objectives.

3. Gain/risk share arrangements

A key mitigation of many of the risks posed by the pooling of the Commissioners budgets is the introduction of a gain/risk share arrangement between the Council and CCG. A risk share arrangement will allow both Commissioners to appropriately share any benefits and risks as a result of the financial performance of the ICH.

However, the formulation and introduction of a gain/risk share arrangement is a complex process, particularly for risk sharing arrangements around large or complex budgets. The Council and CCG will therefore be required to undertake a significant programme of work in order to determine an appropriate gain/risk share arrangement for the ICH. This work will be supported by the joint analysis and shared negotiations described above.

That being said, there are a number of principles which can be considered in order to facilitate early discussions regarding risk share arrangements. There are three fundamental stages that will need to be navigated to design a risk share arrangement:

Agree the services for which risks are to be shared

The ICH will need to agree which services they will share the financial risks and benefits of, as a result of their underlying financial performance. In principle the Commissioners should, in the first instance, share risks around services for which both Commissioners are able to influence and/or for services where an integrated approach is likely to deliver financial benefits. Over time, as the Commissioners and services become more integrated and the ICH matures, risks and benefits around additional services can be shared.

For example, CHC and complex care costs are borne by both the Council and CCG, the performance of which has placed financial pressure on both organisations over recent years. A risk share arrangement, whereby both Commissioners are working to deliver the same, integrated, budgeted spend (as opposed to their own individual budget targets for complex care needs), is more likely to result in an overall improvement in the financial performance of complex care costs in the near term and could be considered for an immediate risk share arrangement in 2018/19.

Agree the baseline budgeted spend for shared services ("Risk Pool")

Once the services for risks and benefits will be shared have been agreed, the Commissioners will need to estimate the budgeted baseline spend for that service in 2018/19 and the associated cost pressures for which the risks of non-delivery will be pooled. This baseline spend will be the benchmark against which financial performance, and the sharing of benefits and risks, will subsequently be assessed.

One potential approach to determine the baseline budget and cost pressures would be to simply utilise the budgeted net expenditure of the ICH as the baseline budget, and the identified savings as the cost pressures to be pooled (i.e. the "risk pool"). For illustrative purposes, a baseline budget for 2017/18 for the ICH (based on if the total budgets for the Council and CCG were included in the ICH)) could have looked like:

2017/18 Budget (£m)	Council	CCG	ICH
Baseline budgeted spend	77.7	509.3	587.0
Budget pressures (risk pool)	5.4	12.3	16.4
Total potential expenditure	**81.8**	**521.6**	**603.4**
Note: risk pool includes			
Contingency repayment	*3.4*	*2.6*	*6.0*
Other net pressures	*2.0*	*9.7*	*10.4*

Total risk pool	***5.4***	***12.3***	***16.4***

This risk pool will contain within in it cost pressures relating to prior year deficits, as well as current year budget pressures. As recommended throughout this report, prior year deficit obligations should remain with the original commissioner and not be shared in the ICH. Consequently these obligations should not be shared via gain/risk share mechanism. One potential approach to doing this would be to agree that any pooled overspends are initially utilised to repay any deficits or contingency drawdowns from prior years, before additional overspends are shared between the parties.

Agree gain/risk sharing mechanism

Depending upon the delivery of a surplus or deficit against the baseline spend, the Council and CCG will share the saving or loss, depending on the apportionment approach agreed concerning contingency funding and budget pressure risks. This gain/risk sharing mechanism will be used to distribute gains and losses between the Council and CCG from the ICH, once any prior year deficits and drawdowns have been repaid.

There are a number of potential gain and risk share mechanisms which could be utilised by the ICH. Agreeing a suitable mechanism is a challenging process, as different mechanisms have a number of advantages, disadvantages and could have unintended consequences. A substantial period of scenario modelling will need to be undertake prior to selecting an appropriate risk share mechanism for the ICH. Some potential mechanisms, and their relative benefits, are as follows (this list is not exhaustive):

Risk share option	Advantages	Disadvantages
50/50 split of gains and losses	• Simple • Easy to understand and implement	• Does not take into account influence and control • Ignores relative size of host budgets and ability to bear losses
Gains and losses shared in line with size of contribution to pooled fund	• Takes into account relative size of hosts and ability to bear losses • Easy to understand and implement	• Would consistently favour/penalise CCG due to its size • Does not reflect actual performance or influence of each organisation • Could lead to no change / feels like the status quo
Gains and losses shared in lie with organisations 'influence' in meeting budget	• Takes into account host performance • Incentivises those in control to deliver aims	• Determining relative influence and control is extremely difficult • Does not take into account relative size of host
Gains and losses shared in line with size of savings made by each host organisation	• Simple and easy to understand • Takes into account host performance	• Could be difficult to determine which organisation has made the savings

4. ICH governance and reporting arrangements

Clear governance and reporting arrangements should be introduced in the ICH, in order to allow it to deliver the anticipated benefits across the system whilst maintaining the delivery of the Council's and CCG's statutory obligations. This could include the appointment of a joint Commissioning Director and the introduction a Joint Board, comprised of representatives from the Council and CCG, which can make strategic commissioning decisions on behalf of the ICH. Appropriate delegated authority from the Council and CCG to this Joint Board would be a pre-requisite. However, we understand that revised governance arrangements are currently being considered in the current operating model design work for the ICH.

Governance arrangements concerning the use of funding and budget management will also be required, in order to provide assurance to both organisations. This could include approval mechanisms for the agreement of investment decisions and joint monthly reporting of the financial performance of the ICH to the respective

organisation boards. As previously mentioned, open book accounting would further provide assurance to the Council's and CCG's Boards on the transparency of decision making in the ICH.

5. Continuing Healthcare position review and joint commissioning

From our discussions with both organisations it has been clear that the Council and CCG have historically disagreed on the appropriateness of the current balance of fully CCG funded and jointly funded packages of complex care. The introduction of the ICH will remove many of the transaction costs currently incurred by both organisations in the funding of these packages of care.

However, prior to the introduction of the ICH we recommend that both parties review the current CHC and joint package of care activity and cost across the system before a baseline budget for these services are agreed. We believe that the current distribution of funding is significantly different from relevant peers and that the ICH may want to introduce a redistribution of joint vs fully funded packages of care over an agreed period of time in order to closer resemble the proportions achieved by benchmarked peers. A review of the assessment and approvals process for care support is also currently being undertaken, and a combined assessment process should be implemented where relevant.

Upon the completion of the review, the ICH should jointly agree the appropriate combined funding required for CHC and complex care needs across the health economy, and begin the joint contracting and commissioning for CHC and complex care placements across the area. This would allow the Commissioners to deliver value for money and drive quality and safety, whilst managing future market demand. Risk share arrangements could also be introduced in order to appropriate share gains and losses with regards to complex care costs, in line with the new baselined spend.

6. Budget exclusions reviewed

Two significant areas of budget may end up being out of the initial scope of the ICH – client income from the Council (£18.9m) and the prescribing budget (£59.5m) from the CCG. We recommend that the definition of 'out of scope' and implications of these budgets being out of scope for the ICH should be jointly discussed by the Council and CCG before a final decision is made.

We understand that client income being kept out of the pooled funding arrangement would result in the ICH having no direct control over the receipt of this income. The ICH would therefore need to ensure that realistic income receipt forecasts are agreed with the Council, and that the ICH is shielded from any risk of under-collection of income, as it would have no control over the Council's performance in this regard. We recommend that if client funding is not included within the ICH budget then the risk of any under-collection of income should lie centrally with the Council.

The implications of excluding the prescribing budget should also be agreed between the Council and CCG. For example, the CCG will need to ensure that any overspends in the prescribing budget do not negatively affect the sum available in future years to pool in the ICH (e.g. through the repayment of deficit funding or contingency reserves). The CCG should consider ways through which this risk could be mitigated and/or if this budget could be jointly managed through its introduction into the ICH.

7. Upcoming policy review and contingency planning

An ongoing challenge for the ICH will be its response to national and local policy changes. A number of recent policy introductions have placed pressures on both the Council's and CCG's budgets, such as the introduction of the National Living Wage and the NHS's commitment to increase the amount of funding spent on mental health services.

We recommend that known policy intentions are reviewed and shared between both organisations in order to agree a shared view on the impact that these changes may have. This includes the Government's proposal to reform social care funding from 2020/21, and the likely impact on the ICH if the CCG is entered in the NHS Capped Expenditure Process. This will allow the ICH to scenario plan and agree contingency arrangements if policy changes result in significant pressures and/or changes for service provision across the Wirral. Over time,

contingency funding should try to be built up by the ICH in order to mitigate the effect of unanticipated pressures over the longer term. The outcome of such a review should be reflected in the risk and gain share arrangements in the ICH.

Specifically with regards to the CCG's oversight from NHS England (as part of its formal directions guidance), the ICH will be required to evidence how the new commissioning arrangements will strengthen the CCG's financial and governance arrangements. With this in mind, the Council and CCG should therefore begin considering governance and reporting requirements as soon as possible.

8. Strong branding and cultural identity

In order to facilitate the integration of the commissioning function in the ICH, and promote new ways of working both internally and externally with providers, the ICH should ensure it had a strong brand which is publicised across the Wirral. Joint development and integration events could be introduced in order to facilitate collaboration and integration within the ICH, and a shared strategy should be published, integrating the Wirral 2020 Vision and the CCG's commissioning intentions, in order to align the goals and objectives of health and social care across the Wirral.

9. Performance monitoring metrics

In light of the identified risks and recommendations, we have considered potential performance monitoring metrics which could be used to monitor the impact and benefits of moving to the ICH. These metrics should be reported upon in any shadow running/transition period for the ICH in 2017/18:

- Improvements in the ICH financial position
- Combined contingency funding and debt obligations cleared
- Publication of joint strategies and reports
- Number of jointly commissioned services implemented and demand management interventions put in place
- Staff satisfaction scored, including staff association with working for ICH (as opposed to their own organisations)
- Joint benchmarks and performance metrics in which both organisations have influence, including reducing the number of DTOC, reduction in hospital admissions, number of patients admitted to long term residential care
- Reduction in health inequalities across the Wirral
- Ultimately the letting of a single contract with a single set of outcomes for providers, as part of an Accountable Care System.

VAT implications

The pooling of budgets, implementation of a single commissioning function through the Integrated Commissioning Hub and the ultimate move into an Accountable Care System is likely to have VAT implications for the Commissioners. Positive steps will therefore need to be taken to ensure that additional VAT costs are not incurred when compared to the existing arrangements across the system.

The VAT position is complex and will need careful consideration. Given that the plans are still in their formative stages some of the comments below are general in nature, in order to inform the decision making process. Additional advice will be needed as and when specific proposals are made.

The information that follows in this section is based on the following assumptions, in relation the planned to move to an Accountable Care System:

- Wirral CCG and Wirral MBC will enter into a s.75 agreement
- A single contract will ultimately be let for health and social care services
- It is not yet known as to which of Wirral CCG and Wirral MBC will be the lead commissioner under the s.75 agreement, and thus which will let the single contract
- No staff will transfer between Wirral CCG and Wirral MBC
- The providers will form an alliance through a contractual joint venture
- The alliance will be hosted by one of the providers
- It is not yet known which of the providers will be the counterparty to the single contract let by one of Wirral CCG and Wirral MBC

VAT considerations from the perspective of the Council and CCG as Commissioners

The VAT liability of the services commissioned by the Commissioners depends on the nature of the services, which depends, in turn, on how the services are defined in the respective agreements.

In broad terms, supplies of health care are exempt for VAT purposes and as such, do not attract a VAT charge. The treatment of social care services generally follows the same principles, although the VAT liability may in some cases differ. It is therefore likely that there will be no VAT charge on the supplies made to the Commissioners.

Other services, such as contract management, supplier selection, quality assurance, financial control, systems and data management, etc. would typically be standard rated for VAT purposes. The key question is likely to be whether there are any such services that are separate supplies from a VAT perspective or whether such services are ancillary to the single provision from a VAT perspective of health care and social care services.

This analysis will be heavily influenced by the content of the relevant contracts, the drafts of which should be reviewed from a VAT perspective when they are available.

In addition, NHS bodies in England are broadly within the same divisional VAT registration, so that supplies between these bodies are usually disregarded for VAT purposes. Consequently, supplies from an NHS body / provider to the CCG will be outside the scope of VAT.

The Commissioners will need to consider the VAT implications of the way in which they come together and the impact that VAT costs may have on the funds. The recovery of VAT in relation to any pooled funds will depend on how the agreement is structured. The comments below are based on the treatment of s.75 agreements:

- Where a lead commissioner is responsible for delivering the service and receives funding from the other commissioner(s) in order to carry out those responsibilities, the recovery of any VAT incurred in the delivery of the service will follow the regime of the lead commissioner.
- Where a lead commissioner is acting under the instruction of another commissioner and is appointed to manage funds on behalf of that commissioner, and so is effectively acting as an agent, VAT recovery

will ultimately be determined by the VAT regime of the principal. The parties will need to ensure that the appropriate administrative arrangements are in place to provide the principal with the evidence necessary to recover VAT where possible, to deal with costs that need to be apportioned and to ensure VAT is applied correctly to any management charges made by the lead commissioner.

Even where there is a s.75 agreement, the Commissioners will need to consider the VAT implications of charges between them (such as for staff) and be aware that VAT costs can still arise where there is no monetary consideration paid for services provided by one to the other.

The ability of the Council and the CCG to recover any VAT on costs incurred by them as Commissioners is discussed below.

The Council

A local authority can usually recover all the VAT it incurs in relation to its activities, as long as the VAT it incurs in relation to what are treated as exempt supplies for VAT purposes remains within the 5% partial exemption de minimis limit.

The Council's activities in its role as commissioner should be regarded as non-business rather than exempt in nature from a VAT perspective. Consequently, the Council should be able to recover any VAT on costs incurred in this role and there should be no impact on its partial exemption calculation in this respect.

The CCG

An NHS body can recover VAT incurred in relation to its normal statutory non-business healthcare activities where that VAT relates to certain contracted-out services.

The CCG will need to ascertain whether the third party costs incurred in relation to its activity as commissioner are on the list of contracted-out services, in respect of which VAT recovery is permitted. Unless the CCG intends to procure additional goods or services as a consequence of the contract and alliance arrangements, there should be no additional irrecoverable VAT costs arising. One potential proviso in this respect is where staff are provided / seconded by the Council to the CCG. A supply of staff is generally subject to VAT at the standard rate, VAT which is unlikely to be recoverable by the CCG under the contracted-out services rules.

Where the Commissioners act together, they will need to consider whether in doing so they create a relationship that could be treated as a separate entity for VAT purposes, e.g. a partnership. Any such entity is unlikely to enjoy the VAT recovery regime that applies to NHS bodies or local authorities.

VAT considerations from the perspective of the alliance host / prime provider

The VAT position for providers in an ACS is complex and will need careful consideration. The main issues to be considered in relation to the VAT position of the alliance host / prime provider are:

- What is the VAT liability in respect of the supplies the alliance host / prime provider is making?
- What is the status of the alliance host / prime provider?
- What is the status of the commissioner?
- Can the alliance host / prime provider recover VAT it incurs on costs?

If the alliance host / prime provider is responsible for providing services as a principal, such services that relate to supplies of medical care are unlikely to attract a VAT charge. The same usually also applies to welfare services, but not always. In the case of local authorities and NHS bodies, such supplies made as part of their statutory non-business activities are not liable to VAT.

Other services provided by the alliance host / prime provider, such as contract management, supplier selection, quality assurance, financial control, systems and data management, etc. would typically be standard rated for VAT purposes. The key question is likely to be whether these services are separate supplies or are ancillary to the provision of medical care or welfare in a single contract.

If the alliance host / prime provider and the commissioner are both NHS bodies in England, supplies between these bodies are usually disregarded from a VAT perspective, as they are within the same divisional VAT registration, and no VAT is charged.

Where the alliance host / prime provider does not make standard rated supplies, the status of the alliance host / prime provider will have a direct impact on its ability to recover VAT on its costs. So, for example:

- An NHS body can recover some VAT, but only VAT incurred in relation to its normal non-business healthcare activities and only where that VAT relates to certain contracted-out services. Where an NHS alliance host / prime provider is commissioned to provide healthcare services by a non-NHS body, these services may not qualify as non-business activities from a VAT perspective, which means that the NHS alliance host / prime provider will not have access to VAT recovery under the contracted-out services rules.
- An alliance host / prime provider which is a private sector organisation, including GP practices, is unlikely to be able to recover VAT.

The alliance host / prime provider is unlikely to incur VAT on the healthcare services sub-contracted to the alliance partners but may incur VAT on other costs; it will be necessary to confirm the nature and potential scale of these costs in order to assess the extent of any potential additional irrecoverable VAT that may arise as a consequence of the proposed arrangements.

It will also be necessary to analyse the costs that the alliance host / prime provider will incur as host of the alliance and whether these are likely to be liable to VAT. This will include recharges made by the alliance partners as well as costs incurred by the alliance host / prime provider directly. VAT will only be recoverable on these costs if the alliance host is an NHS body and to the extent they relate to supplies of healthcare to another NHS body, and then only to the extent that VAT recovery is provided for under the COS rules. General costs will need to be apportioned in accordance with the NHS body's partial exemption method.

As mentioned above, other services, such as contract management, supplier selection, quality assurance, financial control, systems and data management, etc. would typically be standard rated for VAT purposes. The key question is likely to be whether there are any such services that are separate supplies from a VAT perspective or whether such services are ancillary to the single provision from a VAT perspective of health care and social care. This analysis will be heavily influenced by the content of the relevant contracts, the drafts of which should be reviewed from a VAT perspective when they are available. To the extent that the alliance host / prime provider is making taxable supplies, it will be able to recover as input tax the VAT it incurs on costs attributable to these taxable supplies.

The status of the alliance host / prime provider may also have an impact on the extent of irrecoverable VAT in the supply chain. This is discussed further below.

VAT considerations from a provider's perspective

Again, the VAT position is complex and will need careful consideration. The main issues to be considered in relation to the VAT position of the provider are:

- What is the VAT liability in respect of the supplies the provider is making?
- What is the status of the provider?
- What is the status of the body commissioning the services of the provider?
- Can the provider recover VAT it incurs on costs?

In broad terms, supplies of medical care will not attract a VAT charge. The same usually also applies to welfare services, but not always. In the case of local authorities and NHS bodies, such supplies made as part of their statutory non-business activities are not liable to VAT.

The VAT liability of other services will depend on the nature of these services and the status of the provider.

NHS bodies in England are broadly within the same divisional VAT registration, so that supplies between these bodies are usually disregarded from a VAT perspective and no VAT is charged.

Providers that make standard rated supplies will be able to recover the VAT incurred on costs that relate to these standard rated supplies.

Where the provider does not make standard rated supplies, the status of the provider will have a direct impact on its ability to recover VAT on its costs.

- A local authority can usually recover all of the VAT it incurs in relation to its activities, as long as the VAT it incurs in relation to exempt supplies it makes for VAT purposes remains within certain limits.
- An NHS body can recover VAT that relates to its normal non-business healthcare activities but only where that VAT relates to certain contracted out services.
- A provider which is not a local authority or an NHS body is unlikely to be able to recover VAT. This would be the case for private providers, including GP practices.

There is currently uncertainty as to whether and the extent to which the status of the body commissioning the services of the provider has an impact on the nature of the supply by the provider for VAT purposes. HMRC has stated that an NHS provider being commissioned under a contract by a non-NHS commissioner / ACO is providing its services under a commercial contract and is no longer carrying on non-business activity, with the result that the NHS provider is making exempt business supplies for VAT purposes and may no longer recover VAT on contracted out services.

Where the providers act together, they will need to consider whether in doing so they create a relationship that could be treated as a separate entity for VAT purposes, e.g. a partnership. Any such entity is unlikely to enjoy the VAT recovery regimes that apply to local authorities and NHS bodies. This is also the likely outcome if a separate entity is formally created.

Applying this analysis to the bodies that may be part of the alliance:

NHS provider

The VAT position in relation to the healthcare services provided by an NHS provider is unaffected only where the services are provided to an NHS alliance host / prime provider.

GPs and charities

These bodies may not be registered for VAT. It will be necessary to review the relevant alliance contracts to confirm the nature of the supplies these organisations will make and the VAT treatment thereof. If the supplies are taxable and the value of such supplies will exceed the VAT registration threshold, these providers will have to register for and charge VAT.

If, as is probably more likely, the core supplies by these organisations are not taxable, they will not be able to recover the VAT incurred on costs attributable to these supplies. This is similar to the VAT position that currently prevails for both of them.

A small allowance is available for the recovery of VAT on exempt supplies; specifically the providers will be able to reclaim their VAT costs if the VAT cost relating to exempt supplies is less than c.£7,500 per annum. Due to the scale of this project, however, we expect that the VAT costs incurred by providers will far exceed this threshold, and that any VAT costs attributable to their exempt supplies will, therefore, be irrecoverable.

Alliance agreement

If the alliance is intended to be a pure contractual joint venture, it will not be registerable for VAT purposes in its own right. Transactions between the partners, such as, for example, the recharging of back-filling costs or charges for the secondment of staff, will need to be analysed to establish whether they are liable to VAT and whether any VAT charged can be recovered by the recipient of the supply in line with the VAT recovery position set out in the preceding sections of this paper.

It will be necessary to establish whether, in entering into contractual relationships or in incurring costs that relate to the alliance, the party concerned is acting as principal, as an agent for the alliance host or as an agent for another alliance partner.

It will also be necessary to analyse the proposed alliance costs and the extent to which there may be irrecoverable VAT costs that relate to them.

Appendix

The following sections describe the information we received regarding the processes the Commissioners undertake in order to set their budgets, and our analysis of the historic budget volatility and forecast budget performance of the Council and CCG. Throughout this analysis we have outlined the risks identified and the mitigations which could be implicated in order to reduce this risk.

Strategic Context

This section outlines the current commissioning landscape within the Wirral Peninsula and the ambitions for the Integrated Commissioning Hub and the pooled budget arrangements.

Summary of key risks

Key Risks to the Council

- If the decision to integrate commissioning is reversed, disbanding the ICH could lead the Council being left with the residual costs of new interventions, without joint funding to support these recurrent costs

Key Risks to Both Parties

- Residual funding remaining in separate original organisations (e.g. prescribing budget, funding which cannot be delegated), alongside the pooled ICH budget, will prevent joint, integrated realignment and maintain original organisational identities
- The lead ICH Commissioner could innately or overtly prioritise the funding of services from their 'old' organisation rather than for the benefit of the ICH overall, preferentially redirecting funding back to its old organisation

Wirral Health Economy Background

The Wirral Peninsula ('Wirral' or 'the Wirral') is an area comprising of over 321,000 people, within a relatively small area of 60 square miles. Despite its small area, the health and wellbeing of people within the Wirral is extremely varied, both across the peninsula itself, and when compared to the England average[1].

The Wirral is one of the 20% most deprived districts within England, with significant problems relating to alcohol usage in both adults and children. Life expectancy is 11.7 years lower for men and 9.7 years lower for women in the most deprived areas of Wirral than in the least deprived areas, with average life expectancy for both sexes lower than the England average. The number of obese children, and the percentage of physically active adults across the Wirral, are both significantly lower than the England average. These issues present a difficult challenge for public health, Commissioners and providers of health and care services across the region.

Consequently, health and social care services across the Wirral are, in line with the rest of England, experiencing a period of sustained financial pressure. Demand for health and care services are increasing, at the same time that the funding for health and care services remains flat (or is decreasing in real terms).

Drivers of increasing demand for services include:

- **Demographic growth:** The overall Wirral population is forecast to increase by approximately 3,000 residents between 2015 and 2020, many of whom will require the support of health and care services.

[1] Public Health England: Wirral Health Profile 2017.

- **Ageing population:** Wirral has an older population (aged 60+) than the England average. An older population is associated with increased health demands and needs, and a greater prevalence of illnesses such as cancer.
- **Increasing complexity of health and care need:** A growing and ageing population results in more patients having multiple medical co-morbidities and care needs, often resulting in the provision of long term support and/or treatment for patients and service users.

This increasing demand, at a time of resource constraint (across health and social care), is creating financial challenges and pressures for the Commissioners of health and care services across the Health Economy.

Commissioning arrangements within the Wirral

By far the largest majority of Health and Social Care services for the Wirral population are purchased by two statutory Commissioners:

Wirral Council

Wirral Council ("the Council") has a statutory responsibility to provide and commission Adult and Children's Social Care services, and Public Health services, on behalf of the local population. Social Care services are predominantly provided through the commissioning of 'packages of care' (funding for support services which are tailored to meet the specific needs and requirements for individual service users). These services often support older adults (who may be frail and/or suffering from dementia), people with mental health issues and people with learning disabilities, through residential care, domiciliary care and day services. Additionally, children's services includes targeted and early support services for vulnerable young people.

Public health services focus on the entire population, aiming to increase the overall health of the population through interventions to reduce incidence of disease arising from obesity, alcohol usage and smoking.

Wirral Council has allocated a net budget of £77.8m (gross budget £139.8m) to social services, comprising of £75.8m funding plus £2.0m additional contingency funding. Additionally, £29.9 million of funding has been budgeted for public health in 2017/18.

NHS Wirral CCG

Wirral CCG ("the CCG") is responsible for the commissioning of all adult and children's NHS funded healthcare services across the Wirral. That includes acute, community, mental health, prescribing and continuing healthcare services for the Wirral population. These services are commissioned from a range of healthcare providers across the Wirral, including Wirral University Teaching Hospital (WUTH), Wirral Community NHS Foundation Trust (WCT) and Cheshire and Wirral Partnership NHS Foundation Trust (CWP). Demand for these services is primarily driven through elective and non-elective patient demand and choice.

The CCG has a budget allocation of £509.3m for the commissioning of healthcare services in 2017/18.

Jointly commissioned services

Through the Better Care Fund (BCF) Wirral Council and the CCG successfully jointly commission a range of health and care services for the Wirral population. This is achieved through the pooling of a proportion of each organisation's budget. The BCF has been used to fund a wide range of services including Transfer to assess bed capacity, community officers and additional community dementia services.

The BCF has a total budget of £47.9m for 2017/18, with £22.5m being contributed by Wirral Council and £25.4m being contributed by the CCG.

Primary care commissioning

Currently Primary Care services are commissioned by NHS England. The CCG is responsible for commissioning enhanced primary care services to the total of £2.1m in 2017/18.

Ambitions for the Integrated Commissioning Hub

Both the Council and the CCG would now like to extend the current pooled budget arrangements to incorporate the majority of the total health and social care funding within the region. The services that fall under the scope of these new pooled arrangements will be formally commissioned by the Integrated Commissioning Hub (ICH).

The Wirral Plan, and the Healthy Wirral programme, provide the strategic frameworks through which the Commissioners anticipate managing rising demand, greater focus on public health and increased expectations against a backdrop of decreasing real terms funding. Achieving the aims of these programmes requires a better understanding of the needs of the population, an improvement in the effectiveness of the services commissioned within the Wirral, and even better value for money. The joint commissioning of health and social care services, through a formal pooled budget arrangement, is expected to be an important step towards achieving this ambition.

The implementation of an Integrated Commissioning Hub is anticipated to result in:

- A single, **joint commissioning approach** using all resources for areas such as older people, mental health and advocacy, for people with complex needs, and for carers;
- A single provider framework and commissioning gateway in order to ensure clarity for providers, and provide a single cohesive approach that offers **assurance and value for money**;
- Developing and shaping the care supply market through a **single market management strategy**, with Commissioners working together to shape the market and take joint responsibility for quality, in order to reduce the likelihood of market failure;
- **Meeting the cost of care and demand management pressures** in the system through an integrated commissioning approach;
- **Reduced duplication** of effort and service provision; and
- Facilitation of the **integrated operating model** for services across the Wirral (through the implementation of a new model of care), for all age disability services, mental health and community care teams.

In order to deliver these ambitions, the sum of funding in Pot A in the table below is anticipated to be included within the pooled budget arrangement of the Integrated Commissioning Hub (note: the net budget position of Wirral Council, i.e. after the receipt of income, is presented below):

Organisation	Pot A (£m)	Pot B (£m)	Pot C (£m)	Pot D (£m)	Total (£m)
Wirral Council	91.8	(18.9)	-	4.8	77.8
Wirral CCG	420.2	73.2	0.2	15.7	509.3
Public Health	14.7	8.0	-	7.2	29.9
Total	**526.7**	**62.3**	**0.2**	**27.7**	**616.9**

The pot arrangements outlined above can be described as follows:

- **Pot A:** Services which are anticipated to be pooled under a Section 75 arrangement in the ICH (including those services already pooled within Section 75 arrangements)
- **Pot B:** Services not anticipated to be pooled for formal joint provision
- **Pot C:** Funding which cannot legally be pooled for formal joint provision without a change in existing legislation, as they are currently jointly commissioned with NHS England
- **Pot D:** Services which will not be pooled and will remain entirely in control of the original parent organisation. In the main these refer to safeguarding service costs.

Over time, services which are currently out of scope for the ICH may be included within the pooled funding arrangements (e.g. Children's Social Care services). The risks of adding these services to the ICH's funding

arrangement will need to be assessed at the point at which these services are considering being moved into the pooled funding arrangements.

- **Risk to Both Parties: Residual funding remaining in separate original organisations (e.g. prescribing budget, funding which cannot be delegated), alongside the pooled ICH budget, will prevent joint, integrated realignment and maintain original organisational identities**

  We recommend: *A strong brand for the ICH should be developed and organisational development work should be undertaken in order to promote allegiance to the new organisation. This should be supported by new governance arrangements (e.g. a Joint Board) which assesses staff satisfaction, joint working and identity over time.*

- **Risk to Both Parties: The lead ICH Commissioner could innately or overtly prioritise the funding of services from their 'old' organisation rather than for the benefit of the ICH overall, preferentially redirecting funding back to its old organisation**

  We recommend: *Funding allocations should be agreed by a joint team of individuals, overseen by strong governance arrangements (e.g. a Joint Board). A strong brand for the ICH should be developed and joint organisational development work should be undertaken in order to promote allegiance to the new organisation. Open book accounting should be introduced.*

- **Risk to Council: If the decision to integrate commissioning is reversed, disbanding the ICH could lead the Council being left with the residual costs of new interventions, without joint funding to support these recurrent costs**

  We recommend: *Contractual arrangements and provisions are agreed by the Council and CCG in advance of the pooling of funds, which outline how service arrangements and funding should continue if either party chooses to exit the ICH.*

Public Health funding and analysis

Wirral Council is responsible for the commissioning of Public Health activities, for which it receives annual ring-fenced grant funding. This funding will be included within the scope of the ICH and the pooled budget, however on discussions with the Council and an assessment of historic budget performance it is clear that this budget does not pose any significant risks to either party or the ICH at the current time.

Although there are suggestions that public health grants may be reduced in future years to be replaced by business rates, expenditure on public health services are not demand led – funding is spent as available and, where funding is reduced, public health activities which do not have funding are no longer commissioned. Furthermore, public health funding is currently ring-fenced, with the delivery of many public health services are also a statutory responsibility for the Council. Therefore it is unlikely that public health service grants will be removed completely in the near term for a large subset of public health services, however this is still quite uncertain and plans will need to be made by the Council to mitigate risks if this funding is ultimately removed.

Of course, the ICH will need to ensure that public health services are supported and maintained wherever possible in order to minimise additional pressures to health and care services which are currently avoided through the delivery of public health interventions. However, due to the limited risks public health pose no analysis of this budget is included within this report. Furthermore, as Public Health funding is ring-fenced, any underspends in this budget would be unavailable for use by the ICH to subsidise other services. Consequently this report focuses only on the risks concerning the Council's funding for adult social care services.

Setting the budget

The annual budgeting approach for each commissioner is different in nature. Both Commissioners fund demand-driven services and are therefore required to estimate the annual demand and expenditure they are likely to incur in future financial years. This section outlines how the forecast annual budget for each organisation is set and is funded. Risks concerning forecast demand and the Commissioners' ability to fund these services are discussed in subsequent sections of the report.

Summary of key risks

Key Risks to CCG

- Council has limited scope to make expenditure savings through reducing the price it pays providers – alternative approaches to meeting efficiency requirements will need to be identified
- Council revenues are variable in nature and are more short term than CCG funding. Wider scale funding reform for social are services has been proposed by Central Government from 2021 onwards
- Delays in receiving income or deferred payments may result in lower than anticipated free cash flow available for the ICH
- Client income can be under-collected by the Council, placing pressures on the budget
- Linked to the Medium Term Financial Planning process, retention of Business Rates is expected to be a large contributor to social care services in future years (as part of national business rates reform), which could be challenging for the Wirral
- The funding allocated for social care services is determined by the Council in its annual budget setting process, as opposed to a predetermined figure such as % of central funding received.

Key Risks to the Council

- CCG is unable to negotiate any additional allocation of funds at the start of the year if it feels its budget is underfunded
- Non-recurrent funding for unanticipated pressures is unpredictable and may be insufficient to meet non-recurrent pressures in the system
- CCG allocation will be top-sliced in future years in order to repay deficits incurred in the years prior to 2017/18
- Prescribing budget overspends (which is outside of the scope of the ICH) could restrict the sums of money the CCG is able to pool to the ICH

Wirral Council

Planned expenditure

Expenditure at Wirral Council for social care services is primarily driven through two main routes:

1. The commissioning of packages of care and other social care-related activities (e.g. drop-in centres) for service users
2. In-house social care workers who undertake eligibility assessments and referrals for services on behalf of the Council.

Budgets for both of these activities are to be included within the pooled funds allocated to the ICH.

The annual budgeting process for social care services begins in summer each year, with the final budget agreed in the February prior to the new financial year. The process begins by estimating the full outturn for the year, based on the month 10 position. This is done via a straight line estimate of the cumulative variance ("slippage") from budget at that time.

This forecast full year outturn is then adjusted based on known pressures and uplifts in the coming financial year. These pressures include demographic, inflationary and fee rate growth and associated service changes (the assumptions used within the 2017/18 budget are described in the "Forecast Budgets" section of this report).

This forecasting process results in an overall gross expenditure budget for social services for the year, prior to the agreement of savings and efficiency requirements set by the council's cabinet.

The main budgets which drive social care expenditure, and their associated net expenditure for 2017/18 (including any saving requirements, as at May 2017) are:

Budget Area	Gross value (£m)	Net value (£m)
DA411 - Birkenhead / South Wirral Locality	25.8	18.2
DA412 - Commissioning & Transformation - Health & Care	10.0	7.6
DA413 - Day Services	6.2	5.4
DA414 – Delivery	8.7	(7.7)
DA415 - Independence	6.4	0.4
DA416 - Integrated Disability Service	34.4	26.2
DA417 - Integrated Health Provision	9.5	7.5
DA420 - Wallasey / West Wirral Locality	26.3	14.3
Social Care Workers and other employees	11.3	4.7
Other	1.2	1.0
Total	**139.8**	**77.8**

The Council has in recent years focused on developing the local supply for social care services and reducing the unit cost of provision of care services across the Wirral. This focus has been successful, with the Council now benchmarking in the middle of peers with respect to the cost of provision of services. However, the success in reducing the costs of provision now means that there is limited additional scope within the current model for further reductions, particularly as prices are expected to increase in the coming years (due to pressures such as national living wage increases, discussed later in this report). This limits the ability of the ICH to further manage cost pressure in the future through cost reductions, without prejudicing the quality of care. Additional approaches to reducing cost must therefore be considered in future years.

- **Risk to CCG: The Council has limited scope to manage future cost pressures through a reduction in the price it pays for local social care services. Alternative approaches may need to be identified.**

  We recommend: *The Council and CCG jointly discuss and agree ways to reduce the cost of social care services if required, resulting in single commissioning plan for outcomes. This could include encouraging providers to implement new ways of working in their clinical models, a closer integration of services and the reviewing of the appropriateness and effectiveness of services currently in place.*

Funding Availability

Funding to the Council for the delivery of these social care services currently arises from a diverse range of sources:

Funding source	Description	Value for 2017/18

BCF and iBCF	Contributions from the CCG and a local government grant which is used to support adult social care services, the ASC market and the reduction of pressures on NHS services	£29.3m
Client Self-funding	Income from service users towards the cost of the packages of care utilised. This includes Residential, Non-Residential and Nursing Charges	£20.9m
Joint Funded Income	Recharges to the CCG for the funding of Joint Packages of Care	£7.7m
Other Grants and Recharges	Grant received by the Council for use in the delivery of social care services, such as the Adult Social Care grant (£1.8m)	£2.7m
Retained Business Rates	An allocation of the business rates raised by Wirral Council to ASC	£1.4m
Total		£62.0m

This available income of £62.0m contributes to the gross social care expenditure budget of £139.8m, resulting in a net expenditure budget for the department of £77.8m

Grant funding

The size and availability of a number of these funding sources can be variable in nature year on year, and values may be determined late in the year (although allocations tend to cover multi-year periods). For example, the Adult Social Care Grant may only be available in 2017/18 and not beyond. Equally, the ability for the Council to maintain and increase its generation of business rates could affect the income available for ASC in future years, particularly if the guarantee of top-up funding available within the Liverpool City Region Pilot is removed. This risk is increased by the Government's proposal to reform social care funding from 2020/21 which could see a divestment in Revenue Grant Funding from 2020 onwards, despite alternative sources of income not yet being decided upon.

- **Risk to CCG: Council revenues are variable in nature and are more short term than CCG funding. Wider scale funding reform for social are services has been proposed by Central Government from 2021 onwards**

  We recommend: *The CCG become active and work with social care colleagues in the agreement of funding and grant value requests from cabinet. Joint three year budgets and plans agreed by the Council and CCG. Current national and local policies are reviewed and shared with the CCG in order to assess the likelihood of receiving various income sources over the coming years. Contingency planning and/or alternative funding arrangements are assessed in case alternative funding arrangements from 2021 onwards are insufficient to replace those grants being removed.*

- **Risk to CCG: Linked to the Medium Term Financial Planning process, retention of Business Rates is expected to be a large contributor to social care services in future years (as part of national business rates reform), which could be challenging for the Wirral**

  We recommend: *Joint three year budgeting and planning undertaken by the Council and CCG. Top up funding is anticipated to remain in place in the near future. The Council undertakes a piece of analysis to identify current sources and size of Business Rates funding in the Wirral, and forecast Business Rates to be received in the years to come. In the event that Business Rates appear insufficient in future years contingency planning and/or alternative funding arrangements should be assessed.*

However, there are control mechanisms in place which ensure that hypothecated care funding, such as the Social Care Precept and Adult Social Care Grant, is used solely for care purposes. This provides assurance that dedicated health and care funding received by the Council is directed to social care services and not alternative services areas. New build housing initiatives across the Wirral could provide opportunities for increases in care funding through additional tax revenues and the Social Care Precept, however this housing could also result in additional health and care demand across the system, mitigating to some degree these additional revenues.

Client income

Client income is collected in two ways. The first is through direct collection from clients via the Council's charging policy. Payment rates are generally good, however the Council does make provisions for bad debts and writes off a number of bad debts each year.

The second collection approach is through deferred payment. In this approach the Council levies a charge against the value of a client's estate, which is then collected upon the selling of the client's estate. With this approach there is no cash income until the client realises the value of their estate, however as the deferred payment approach is contractually binding the ultimate receipt of payment is relatively low risk to the Council.

- **Risk to CCG: Delays in receiving income or deferred payments may result in lower than anticipated free cash flow available for the ICH**

  We recommend: *The Council and CCG jointly prepare a 3 year budget and plan which should be reviewed annually and take into account historic cash flow performance. The Council should act in a 'cash management / banking' role, funding short term cash requirements until anticipated income is received. Consequently, the risk of non-collection remains with the Council, agreed through an MOU and the Section 75 agreement.*

- **Risk to CCG: Client income is under-collected by the Council**

  We recommend: *The risk regarding the collection of client income remains with the Council, through a robust SLA with Personal Finance Unit for income collection, with penalties if required. Realistic forecasts of client income should be agreed by the Council and CCG. The Council could agree to fund any deficits against anticipated income values.*

Savings requirements and final budget agreement

Upon the identification of the forecast expenditure and budgeted income (and the subsequent funding gap), the social care director then submits a funding request to the Council's cabinet for a sum of the central government funding and grants which have been allocated to the Council. This can an iterative process. Through balancing its competing demands, a funding allocation and savings requirement for social care service are agreed, which covers the remaining funding requirement for services, net of the savings requirement for social care services.

- **Risk to CCG: The funding allocated for social care services is determined by the Council in its annual budget setting process, as opposed to a predetermined figure such as % of central funding received**

  We recommend: *The CCG become an active participant in the budget setting process and works with social care colleagues in the agreement of funding requests from cabinet. Joint 3 year budgets put in place. Risk share arrangements are put in place between the Council and CCG if the budget appears difficult to achieve without the joint working of both parties. Open book accounting should be introduced.*

The budget for social care services in 2017/18 and the associated savings requirement are as follows:

Funding source	Description	Value for 2017/18
Central Government funding and grants	An allocation from the Council's central Government funding and grants made to ASC – agreed via negotiation with the Council. This includes £3.7m Social Care Precept funding and an additional £2.0m of contingency funding made available by Cabinet for ASC services in 2017/18.	£77.8m
Savings requirement	Savings required to be made by ASC services in 2017/18 in order to meet budget	£5.4m

More detail concerning the budget pressures which have resulted in a savings requirement of £5.4m can be found in the budge forecasting section of this report.

Current budget control mechanisms

The department's budgets are monitored closely on an ongoing basis by a team of chartered accountants and accounting technicians. Monthly monitoring reports are produced for the Director and the senior leadership team, which summarises the overall budget position and highlights areas that warrant further discussion. A monthly forecast is also produced for corporate Council monitoring, which is shared with Cabinet and elected members for scrutiny and challenge.

Where savings targets are set at the start of the year, these are monitored on an ongoing basis and updates are produced for the Director, as well as corporately. Regular meetings are held with the officers responsible for making these savings to ensure any risk of non-achievement is identified early, so that corrective actions can be planned and compensatory savings found. This also applies to any situation where a forecast overspend is anticipated.

Wirral CCG

Planned expenditure

The CCG funds a wide range of healthcare services delivered by a number of different providers, with funding used to commission:

- **NHS contracts:** including acute, community, mental health and ambulance services
- **Non-acute contracts:** Non-NHS providers delivering healthcare services, such as Spire – Murrayfield and Locally Commissioned Services
- **Prescribing:** Primary care and central drugs prescribing
- **Out of hospital services:** Continuing healthcare, joint funded services and funded registered nursing care
- **Primary care:** Enhanced service payments and other development costs for primary care
- **Better Care Fund:** NHS contribution to social care services in order to reduce demand on NHS services
- **Other:** Reserves, contingency balances and other miscellaneous expenditure
- **Running costs:** the CCG's internal running costs

Budget setting at the CCG begins before December each year, with an estimate of the full year's expenditure made based on the month 9 outturn. These projected outturn figures are then forecast forward based on anticipated activity and cost growth to produce a gross expenditure assumption for the year (the assumptions used within the 2017/18 budget are described in the "Forecast Budgets" section of this report).

CCG Funding

NHS services commissioned by the CCG are in the main funded by an annual allocation from NHS England. This allocation is determined through a national formula based on population size and demographics, with allocations of funding determined for three years (and indicative allocations provided for a further two years), giving the CCG a degree of certainty of its available financial resources. However, the CCG is unable to negotiate additional funding before the start of the financial year if it feels its allocation is less than its anticipated budgeted spend for the year.

- **Risk to Council: CCG may be unable to negotiate any additional allocation of funds at the start of the year if it feels its budget is underfunded**

  We recommend: *The Council and CCG jointly agree a likely budget requirement for healthcare services, including a realistic assessment of QIPP requirements and deliverability. Risk share arrangements are put in place between the Council and CCG if the budget appears difficult to achieve without the joint working of both parties.*

Funding for core primary care services are also passed through the CCG. Currently these services are commissioned by NHSE and the CCG is not therefore responsible however the CCG is currently not responsible for any associated over/under performance of these services. It is anticipated the CCG will move to a level 3 commissioning arrangement with NHS England in 2018/19, whereby it will be jointly responsible for the

commissioning and budget responsibility of primary care services. At this time there are no plans for the budget for primary care commissioning to come into scope of the ICH.

Additionally, non-recurrent funding is allocated to the CCG through the year for specific items of expenditure (e.g. winter pressures monies). These monies are expected to be spent against the services or pressures to which they have been allocated. However, whether or not these monies will be available each year, and if they will be sufficient to cover the cost of the anticipated financial pressure, is by its nature unpredictable.

- **Risk to Council: Non-recurrent funding for unanticipated pressures is unpredictable and may be insufficient to meet the pressures in the system**

  We recommend: *Joint working is undertaken by the Council and CCG upon the identification of unanticipated system pressures in order to mitigate the impact of the pressures and allocate the available funding in the best possible manner. Over time contingency funding should try to be built up by the ICH in order to mitigate the effect of unanticipated pressures over the longer term. Open book accounting should be introduced.*

The planned availability of funds for the CCG between 2017/18 and 20/21 is as follows (funds for 19/20 and 20/21 have been determined from indicative NHS England allocations to the CCG and are subject to change):

CCG Allocation £	2017/18	2018/19	2019/20	2020/21
Recurrent base allocation	486.8	496.8	-	-
Growth allocation	9.9	9.9	-	-
Allocation adjustments	5.5	5.5	-	-
Running cost allowance	7.1	7.0	-	-
Prior year deficit to return	-	(9.8)	-	-
Total	**509.3**	**509.5**	**516.6**	**535.5**

The return of prior year deficits are technically 'one-off' repayments made in light of overspends in previous financial years. These deficit returns will remain 'one-off' if QIPP plans are sufficient to reduce the demand and pressures in the system so that further overspends are avoided. The pressures anticipated by the CCG are described later in this report.

- **Risk to Council: CCG allocation will be top-sliced in future years in order to repay deficits incurred in the years prior to 2017/18**

  We recommend: *As the Council was not party to these prior year deficits, deficit repayment obligations should remain out of scope for the ICH. Risk share and/or other arrangements should be put in place which outline the terms through which the CCG and Council can pay back historic deficits and contingency drawdowns. The Council should be kept informed of deficit repayment obligations and should be party to any negotiations with NHS England on this matter. Open book accounting should be introduced.*

Savings requirements and budget agreement

Upon the identification of the forecast expenditure and budgeted income, the Commissioning Director at the CCG negotiates to agree a final contract value with each provider. Based on the allocation it has received, these contract values will contain within them a savings QIPP target for the year (note: these targets may not always be agreed by the providers or included within their contracts). The budgeted figures for 2017/18 and the associated QIPP values relating to those services are as follows:

Budget Area	Contract/Budget Value (£m)	QIPP saving within contract (£m)
NHS contracts	349.7	(5.6)
Non-acute contracts	16.8	-
Prescribing	59.5	(2.6)
Out of hospital services	38.0	(1.4)
Primary care	4.4	-
Better Care Fund	25.4	-
Other	8.4	(2.6)
Running costs	7.1	-
Total	**509.3**	**(12.3)**

More detail concerning the budget pressures which have resulted in a savings requirement of £12.3m and current performance in meeting this target can be found in the budge forecasting section of this report.

Budgets to be pooled within the Integrated Commissioning Hub

Both the Council and the CCG anticipate pooling the majority of their funds into the Integrated Commissioning Hub, in order to facilitate transformational change across the system. However, there are a number of notable exclusions and/or inconsistencies of approach between the two organisations:

1. **Net budget position presented by the Council:** The Council's figures included within 'Pot A' are net of the receipt of grants and other income sources (except self-funding income mentioned above). Although the Council not receiving this funding within the year is relatively low risk, it is important to be aware that the gross expenditure requirement for social care services is higher than the 'net' figures presented by the Council.
2. **Running costs:** The Council and CCG have taken alternative approaches to the inclusion of running costs within the ICH pooled budget; the Council has chosen to include running costs within the budget, whilst the CCG has chosen to exclude these from the budget.

   We recommend: *A consistent position is taken by both the Council and CCG on the inclusion or not of running costs in the pooled budget arrangements.*
3. **Prescribing:** The CCG has chosen to exclude the prescribing budget (£59.5m) from the pooled budget arrangements. This is a significant area of funding, which has historically overspent its budget. The Council will need to ensure that any overspends in the prescribing budget to not affect the CCG's contribution to the pooled budget.

- **Risk to Council: Prescribing budget overspends (which is outside of the scope of the ICH) could restrict the sums of money the CCG is able to pool to the ICH**

  We recommend: *Detailed saving plan in place with GPs who are actively incentivised to reduce prescribing spend and are managing this budget. The implications of excluding the prescribing budget are agreed between the Council and CCG. The CCG should ensure that any overspends in the prescribing budget do not negatively affect the sum available in future years to pool in the ICH (e.g. through the repayment of deficit funding or contingency reserves). Open book accounting should be introduced.*

Current budget control mechanisms

The CCG's budgets are monitored monthly by a team of accountants, who report to the CFO any significant monthly variances, the drivers of which are then identified through an internal investigation. Monthly budget performance is discussed with budget holders, who alert the finance team to any identified pressures to their budgets, so that action can be taken. The CCG also reports financial performance monthly to its Finance

Committee, focusing on the main on risks to the CCG and current performance in the delivery of QIPP targets. The CCG's Governing Body also receives a copy of these monthly reports.

The CCG also currently operates an Activity Management Group, which undertake deep dive investigations if contract management policies or criteria are triggered, which are overseen by a Financial Recovery Group. These ensure the CCG delivers on its financial obligations and requirements, as per the agreed Financial Recovery Plan.

Forecast Budgets

This section will present the forecasting assumptions included within the 2017/18 budget and relevant benchmarks where available for those services anticipated to be pooled.

Summary of Key risks

Key Risks to CCG

- The Council may be unable meet its efficiency requirement of £3.4m in 2017/18 (4.4% of total budget), resulting in an in-year deficit
- Brought forward pressures from 16/17 could continue to place ongoing pressure on the Council's budget
- National and local policies changes can result in annual fee uplifts and cost pressures (e.g National Living Wage increases)
- Savings negatively impact on the ICH for ASC services, based on the overarching performance of the Council rather than ASC's ability to deliver those savings
- Funding pressures in 2018/19 include the repayment of deficits and contingency drawdowns used to fund prior year budget deficits
- Increases in patient and service user demand may not be mitigated fully by social care services and additional iBCF funding available, resulting in further budget pressures
- Available sources of income to mitigate cost pressures are variable each year, with a number of grants expected to be time-bound and council tax rate increases to fund social care capped by Central Government

Key Risks to Council

- The CCG may be unable meet its efficiency requirement of £12.3m in 2017/18 (2.4% of total budget), resulting in an in-year deficit. This could result in the CCG being placed in the Capped Expenditure Process in 2018/19
- The CCG has to repay its prior year funding deficits back to NHS England and will begin this in 2018/19. This is likely to result in the CCG's budget being top-sliced by £9.8m in 2018/19
- Brought forward pressures from 16/17 could continue to place ongoing pressure on the CCG's budget
- The CCG only received an additional net 0.1% increase in funding for demographic growth, and therefore must be able to manage demand across the health economy to remain in budget
- Managing demand has been a challenge for the CCG, due to a number of factors including patient demographics and a need to ensure statutory targets are met
- CCG has reverted to an activity-based (PbR) contract with its main acute provider WUTH, as opposed to a block arrangement (as was the case in 2016/17). Efficiency (QIPP) savings within this contract total £5.8m
- Poor provider performance in the system could result in regulatory intervention in order to meet

Wirral Council

Forecast budgets

The department of Adult Social Services has forecast its budget for 2017-18 with an indicative budget created until 2020-21. These budgets, and their associated assumptions, are as follows:

Net Budget position

Budget adjustment (£m)	2017/18	2018/19	2019/20	2020/21	Rationale
16/17 Net Budget b/f	77.2				
Base net budget	77.2	77.7	84.6	89.0	
Adult social care precept	3.7	4.0	0.4	0.2	3% increase in council tax in 17/18 and 18/19
Retention of business rates	1.3	6.9	6.0		
LD/Mental Health savings	(1.0)	(2.0)	(2.0)	(2.0)	As per Council's Medium Term Financial Plan
Contingency payback (15/16 overspend)	(2.4)				Repayment of corporate funding based on 15/16 overspend
Contingency payback (Living Wage impact - NLW)	(1.0)	(2.0)			Repayment of corporate funding for Living Wage pressures in 15/16
Other adjustments	(0.1)				Consultancy fees
Adjusted Net Budget	**77.7**	**84.6**	**89.0**	**87.2**	

The above budget figure is net of identified cost pressures, mitigations and the resulting efficiency requirement for social care services. This includes any cost pressures anticipated from increased demand for services or inflationary cost pressures. A summary of the cost pressures expected over the next four years, their funding mitigations and the resulting efficiency requirement for social care services is as follows:

Expenditure

Budget adjustment (£m)	2017/18	2018/19	2019/20	2020/21	Rationale
Non-demographic pressures					
16/17 pressures c/f	(5.9)				16/17 overspend and one-off costs
Framework fee rate increases (NLW)	(2.9)	(2.4)	(2.4)	(2.4)	National Living Wage and other fee rate increases
Non-framework fee rate increases	(1.0)	(1.0)	(1.0)	(1.0)	Council assumptions
LD/Mental health savings	(1.0)	(2.0)	(2.0)	(2.0)	MTFP assumptions
BCF innovation fund	(2.0)			2.0	Funded from supplementary iBCF
Hospital discharge costs	(1.3)			1.3	Funded from supplementary iBCF
One-off integration costs	(0.5)				Actual costs & loss of flexibility

Budget adjustment (£m)	2017/18	2018/19	2019/20	2020/21	Rationale
Contingency payback (15/16 overspend)	(2.4)				Repayment of corporate funding based on 15/16 overspend
Contingency payback (Living Wage impact - NLW)	(1.0)	(2.0)			Repayment of corporate funding for Living Wage pressures in 15/16
Non-demographic pressures	**(18.0)**	**(7.4)**	**(5.4)**	**(2.1)**	
Demographic growth					
Young people with disabilities	(1.7)				
Older people (65+)	(0.8)				
Demographic growth pressures	**(2.5)**	**(2.7)**	**(2.8)**	**(2.9)**	DASS forecasts
Mitigations					
Supplementary iBCF (£2bn)	8.3	(3.2)	(2.5)	(2.6)	Funding reduces each year until 2020/21
Retention of business rates	1.3	6.9	6.0		Funding increases each year until 2019/20
Adult Social Care Grant	1.8	(1.8)			Available in 17/18 only
Social Care Precept	3.7	4.0	0.4	0.2	
Corporate contingency	2.0				
Total mitigations	**17.1**	**5.9**	**3.9**	**(2.4)**	
Total financial pressures identified	**(3.4)**	**(4.2)**	**(4.3)**	**(7.4)**	
% of net budget	*4.4%*	*5.0%*	*4.8%*	*8.5%*	

The Council and CCG take a similar approach in the setting of their budget, uplifting prior year expenditure in light of known pressures and service/policy changes. Within reason this seems a sensible approach, in light of activity-driven nature of the health and care system.

Key observations from the above forecasts include:

- **Brought forward pressures:** In 2017/18 social care services are required to fund £5.9m of unfunded pressures which were realised in 2016/17 – including the reported £3.9m overspend and an additional £2.9m of pressures mitigated by 'one-off' cost reductions in 2016/17 (e.g. write-offs of aged creditors, revision of forecasting assumptions). This is prior to any additional pressures anticipated to be identified in-year. This leads to a potential risk of cumulative deficits and cost pressures becoming unmanageable if adult social care services are unable to fund or reduce its pressures in-year.

- **Risk to CCG: Brought forward pressures from 16/17 could continue to place ongoing pressure on the Council's budget**

  We recommend: *The Council and CCG review prior year brought forward pressures to determine the recurrent and non-recurrent nature of these and the likelihood of these pressures existing in future budgets. Joint ways of working, between the commissioner and with providers, should be agreed in order to reduce these pressures where possible. Open book accounting should be introduced.*

- **Annual fee uplifts:** The Council has committed to working with its providers to review its standard fee rates annually to meet any unanticipated cost pressures they have experienced. In 2017/18 £2.9m of pressures are anticipated to be experienced due to the introduction of the National Living Wage across the region. Additionally sleeping night rates for elderly patients were also required to be reassessed in order to deliver value for money. Social Care services will continue to be at risk from future policy changes which result in cost pressures to its providers and/or the Council itself.

- **Risk to CCG: National and local policies changes can result in annual fee uplifts and cost pressures (e.g. National Living Wage increases)**

  We recommend: *The Council and CCG should remain aware of likely policy changes and scenario plan for the impact of their introduction where possible. Joint working is undertaken by the Council and CCG upon the identification of unanticipated policy changes in order to mitigate the impact of the changes in the best possible manner. Over time contingency funding should try to be built up by the ICH in order to mitigate the effect of unanticipated pressures over the longer term.*

- **Imposed Council savings:** The Council centrally determines savings which ASC services are expected to deliver over the next four years and the phasing of these savings, in line with its own funding pressures (rather than adult social care's ability to deliver those savings). Consequently, from 2017/18 onwards, ASC is required to deliver £7.0m of LD/mental health savings by the end of 20/21. We believe this may be a challenging ask for the social care directorate.

- **Risk to CCG: Savings negatively impact on the ICH for ASC services, based on the overarching performance of the Council rather than ASC's ability to deliver those savings**

  We recommend: *Plans currently in place should be shared with the CCG. The CCG become an active participant in these negotiations and works with social care colleagues in the agreement of funding and grant values from cabinet. The Council and CCG should jointly agree a likely budget requirement for social care services, including a realistic assessment of the deliverability of savings requirements. Risk share arrangements are put in place between the Council and CCG if the budget appears difficult to achieve without the joint working of both parties (principally around demand management).*

- **Contingency payback:** Social Care is required to repay £3.4m of contingency funding back to the Council from its 2017/18 budgets and an additional £2.0m of funding in 2018/19. This contingency was drawn down in order to fund the unanticipated cost pressures arising in 2016/17. In the event that ASC services is unable to fund its budgets this year, further contingency funding (and repayments) will have to be made to the Council. The CCG should be shielded from the repayment of these contingency costs as these pressures will have arisen prior to the integration of commissioning services.

- **Risk to CCG: Funding pressures in 2018/19 include the repayment of deficits and contingency drawdowns used to fund prior year budget deficits**

  We recommend: *As the CCG was not party to these prior year deficits, deficit repayment obligations should remain out of scope for the ICH. Risk share and/or other arrangements should be put in place which outline the terms through which the CCG and Council can pay back historic deficits and contingency drawdowns. The CCG should be kept informed of deficit repayment obligations agreed in the planning process and should be party to any negotiations with cabinet on this matter. Open book accounting should be introduced.*

- **Demographic growth:** Social care services are required to mitigate any demographic and inflationary costs which they experience between years (i.e. the Council does fund additional demographic growth in excess of the funding for demographic growth provided through the iBCF). Demographic growth is recognised an issue across the Wirral, with ASC forecasting an increase in demand of 1.7% for older peoples (65+) services (including a 3% increase in those adults aged 85+), and a 5% increase in young people with disabilities requiring support. These demographic growth projections are determined by the independent computer-based POPPI forecasting model for older persons activity, and via a retrospective analysis of the last five years of activity with respect to younger peoples services. These pressures are anticipated to increase further by 2020/21 and therefore sustainable interventions will need to be put in place to mitigate the impact of these increases in demand where these are not offset by grant funding.

- **Risk to CCG: Increases in patient and service user demand may not be mitigated fully by social care services and additional iBCF funding available, resulting in further budget pressures**

  We recommend: *The Council and CCG jointly agree likely demographic and growth pressures in the annual funding submission to cabinet, and jointly plan for ways to manage demographic pressures, care assessment and management across the Wirral. This could include encouraging providers to implement new ways of working in their clinical models, a closer integration of services and the reviewing of the appropriateness and effectiveness of services currently in place. Investments in effective demand management, integrated and contractual management and care assessment schemes should be made. Over time contingency funding should try to be built up by the ICH in order to mitigate the effect of unanticipated pressures over the longer term.*

  - **Mitigations arising from additional income:** New sources of income, solely for use on social care services, have been received in 2017/18, helping to mitigate a number of the pressures on the Council's budget. However, the receipt of such mitigations are variable each year, with some income sources (such as the iBCF and Adult Social Care Grant funding) anticipated to be replaced within the next few years through a revised Government approach for the funding of social care services. Furthermore the Council can only increase the Social Care Precept funding by 3% for an additional two years. This uncertain future regarding the sources of social care income provide complexities for the budgeting of social care services and place risks towards the future sustainability of services, unless replacement national or local income streams are sufficient to replace those lost.
  - **Risk to CCG: Available sources of income to mitigate cost pressures are variable each year, with a number of grants expected to be time-bound and council tax rate increases to fund social care capped by Central Government**

  We recommend: *The CCG become active and work with social care colleagues in the agreement of grant funding requests from cabinet. Jointly agreed three year budgets and plans should be produced. Current national and local policies are reviewed and shared with the CCG in order to assess the likelihood of receiving various income sources over the coming years. Contingency planning and/or alternative funding arrangements are assessed.*

The above pressures have resulted in a £3.4m efficiency requirement saving for the Council, which is 4.4% of the net social care budget in 2017/18. The Council have indicated that early progress on efficiency savings performance has been good, with the total amount of savings identified and expected to be delivered in year, through efficiencies of partnership working with the CCG, partnership working with the Community Trust and a rebalancing of the funding of packages of care. We believe that although savings have been identified the actual achievement of these savings could be difficult to achieve in-year and there is therefore a risk that social care services may report a deficit in 2017-18.

- **Risk to CCG: The Council may be unable meet its efficiency requirement of £3.4m in 2017/18 (4.4% of total budget), resulting in an in-year deficit**

  We recommend: *The Council and CCG should jointly work together in the planning and delivery of efficiency requirements across the Wirral (and should begin working together as soon as possible). Cost reduction schemes should be jointly assessed and agreed by both parties, including introducing increasing accountabilities and risk share arrangements with providers. Both parties should keep the other informed of their performance in the delivery of their savings targets throughout the financial year. Risk share arrangements are put in place between the Council and CCG in order to identify a realistic budget baseline against which under and over performance can be assessed, particularly for services which require the joint working of the Council and CCG. Open book accounting should be introduced. A single population health budget should be implemented over the longer term.*

Wirral CCG

Forecast budgets

The CCG has forecast its budgets for 2017/18 and 2018/19, based on current NHS planning assumptions. These summary of these budgets, and their associated assumptions, are as follows:

Sources of funds

	2017/18			2018/19		
Expected source of funds (£m)	**Recurrent**	**Non-Recurrent**	**Total Funds**	**Recurrent**	**Non-Recurrent**	**Total Funds**
Recurrent Base	486.8	-	486.8	496.8	-	496.8
DH Growth Allocation 2%	9.9	-	9.9	9.9	-	9.9
Allocation Adjustment (IR Rules, Tariff changes)	-	0.3	0.3	-	-	0.3
Allocation Adjustment (HRG 4+)	-	5.2	5.2	-	5.3	5.3
Running Cost Allowance	7.1	-	7.1	7.0	-	7.0
Prior year deficit returned non recurrently (drawdown/ drawup)	-	-	-	-	(9.8)	(9.8)
Total Resource	**503.8**	**5.5**	**509.3**	**513.6**	**(4.2)**	**509.5**

The funding received by the CCG in 17/18 and 18/19 has been adjusted based on a number of policy changes, including:

- **IR Rules and tariff changes:** Increases in funding for specialised services due to revisions to the identification rules (IR) for patients
- **HRG4+ adjustment:** The activity (Payment by Results) tariff for a range of NHS services has been revised again for 2017/18, resulting in an increase in payments to providers, and a subsequent non-recurrent increase in allocations to Commissioners to account for these costs.
- **Prior Year deficit returns:** The CCG is expected to return any additional funding it received in prior years which was used to fund a financial deficit in that year. Although no funding is anticipated to be returned in 2017/18 whilst the CCG returns to financial balance, the CCG is expected to begin to return this funding in 2018/19 onwards. The Council should not be expected to contribute to these returns as well as being protected from any risks in a failure to return this funding.

- **Risk to Council: The CCG has to repay its prior year funding deficits back to NHS England and will begin this in 2018/19. This is likely to result in the CCG's budget being top-sliced by £9.8m in 2018/19**

  We recommend: *As the Council was not party to these prior year deficits, deficit repayment obligations should remain out of scope for the ICH. Risk share and/or other arrangements should be put in place which outline the terms through which the CCG and Council can pay back historic deficits and contingency drawdowns. The Council should be kept informed of deficit repayment obligations and should be party to any negotiations with NHS England on this matter. Open book accounting should be introduced.*

Expenditure

	2017/18			2018/19		
Planned application of funds (£m)	**Recurrent**	**Non-Recurrent**	**Total Funds**	**Recurrent**	**Non-Recurrent**	**Total Funds**
16/17 Brought Forward Baseline Expenditure	**494.2**	**-**	**494.2**	**492.2**	**-**	**492.2**
Planning Guidance 1% Non-Rec Spend	**-**	**2.5**	**2.5**	**-**	**2.5**	**2.5**
Inflation, Efficiency and Growth (net)	-	-	-	-	-	-

	2017/18			2018/19		
Planned application of funds (£m)	**Recurrent**	**Non-Recurrent**	**Total Funds**	**Recurrent**	**Non-Recurrent**	**Total Funds**
Tariff Prices 0.1% Net	0.4	-	0.4	0.4	-	0.4
Prescribing Inflation (3.1%) Net	1.9	-	1.9	1.8	-	1.8
CHC / FNC Inflation (2.1%) Net	0.8	-	0.8	0.8	-	0.8
Inflation, Efficiency and Growth (net)	**3.0**	**-**	**3.0**	**3.0**	**-**	**3.0**
Strategic Investment Plan / Planning Guidance	**-**	**-**	**-**	**-**	**-**	**-**
Primary Care £3 per head of population	-	0.5	0.5	-	0.5	0.5
Mental Health 5 Year View	-	1.6	1.6	-	3.3	3.3
CNST	1.4	-	1.4	-	0.0	0.0
Strategic Investment Plan / Planning Guidance	**1.4**	**2.1**	**3.5**	**-**	**3.8**	**3.8**
QIPP savings	**(12.3)**	**-**	**(12.3)**	**(7.1)**	**-**	**(7.1)**
Contract offer cost pressures	**3.3**	**-**	**3.3**	**(0.1)**	**-**	**(0.1)**
Corporate Running Costs	**7.1**	**-**	**7.1**	**7.0**	**-**	**7.0**
Contingency / Headroom						
Contingency reserve (0.5%)	2.6	-	2.6	-	0.0	0.0
Risk Reserve (0.5%) of the 1% Non Rec Reserve	-	-	-	-	2.5	2.5
Other Reserves (Spend for IR and HRG4+)	-	5.5	5.5	-	5.6	5.6
Contingency / Headroom	**2.6**	**5.5**	**8.1**	**-**	**8.1**	**8.1**
Total Applications of Funds	**499.2**	**10.1**	**509.3**	**495.0**	**14.4**	**509.5**
Total Resource	**503.8**	**5.5**	**509.3**	**513.6**	**(4.2)**	**509.5**
Interim Forecast Cumulative (Surplus) / Deficit	**4.6**	**(4.6)**	**0.0**	**18.6**	**(18.6)**	**0.0**
QIPP saving % of revenue			*2.4%*			*1.4%*

Key observations from the above forecasts include:

- **Brought forward pressures:** The CCG is bringing forward a baseline expenditure value of £494.2m, which contains within it demand pressures which were unmet by QIPP plans in 2016/17. This is prior to any additional pressures anticipated to be identified in-year. This leads to a potential risk of cumulative deficits and cost pressures becoming unmanageable if adult social care services are unable to fund or reduce its pressures in-year.

- **Risk to Council: Brought forward pressures from 16/17 could continue to place ongoing pressure on the CCG's budget**

  We recommend: *The Council and CCG review prior year brought forward pressures to determine the recurrent nature of these and the likelihood of these pressures existing in future budgets. Joint ways of working, between the commissioner and with providers, should be agreed in order to reduce these pressures where possible. Open book accounting should be introduced.*

- **Strategic investments and planning guidance:** CCGs receive specific guidance concerning the uses of their allocations and the funding of reserve and contingency balances. This includes an annual risk reserve of 1% of base allocation and a 1% contingency funding requirement from the CCG's total allocation. Alongside this, NHS England also determine strategic investments which the CCG must

fund on behalf of their populations from their recurrent allocation. This includes investments in mental health and primary care services in 2017/18 and 2018/19. This guidance therefore restricts (to some extent) the CCG's flexibility to fund local investments and initiatives which it deems important from its population.

- **Risk to Council: The CCG must implement unanticipated national NHS policy initiatives from its budget, often without additional funding allocation from NHS England**

We recommend: *The Council and CCG should remain aware of likely policy changes and scenario plan for the impact of their introduction where possible. Joint working is undertaken by the Council and CCG upon the identification of unanticipated policy changes in order to mitigate the impact of the changes in the best possible manner. Over time contingency funding should try to be built up by the ICH in order to mitigate the effect of unanticipated pressures over the longer term.*

- **Demand, inflation and growth:** Increases in funding allocations to meet additional demand, inflation and growth are annually set against a central 'tariff deflator' efficiency requirement from NHS England, which is passed through to providers. The CCG has utilised central planning benchmarks in forecasting their inflationary cost pressures for 2017/18 and 2018/19:

Cost pressure	Growth	Tariff Deflator	Net increase in cost	Matches NHSE guidance
Tariff inflation	2.1%	(2.0)%	0.1%	Yes
Prescribing inflation	6.0%	(2.9)%	3.1%	Local estimate based on historic performance and national pressures
CHC inflation	2.1%	(2.0)%	0.1%	Local estimate

In order to contain activity growth at 2.1% the CCG needs to ensure that demand is robustly managed across the health economy, as any additional demand above 2.1% will not be able to be funded from tariff. In prior years the CCG as had difficulties in managing demand, with Spire –Murrayfield having to be substantively contracted with in order to meet elective referral to treatment and demand targets. Over 2016/17 the CCG, with the support of GPs, has improved its demand management approach. However, there is a residual risk to the Council and CCG that demand management interventions are insufficient to meet demand and therefore that tariff increases will not meet these costs, placing budget pressures on the ICH.

- **Risk to Council: The CCG only received an additional net 0.1% increase in funding for demographic growth, and therefore must be able to manage demand across the health economy to remain in budget**

We recommend: *The Council and CCG jointly agree likely demographic pressures in the annual funding submission to cabinet, and jointly plan for ways to manage demographic pressures across the Wirral. This could include encouraging providers to implement new ways of working in their clinical models, a closer integration of services and the reviewing of the appropriateness and effectiveness of services currently in place. Open book accounting should be introduced.*

- **Risk to Council: Managing demand has been a challenge for the CCG, due to a number of factors including patient demographics and a need to ensure statutory targets are met**

We recommend: *The Council and CCG should continue to closely monitor the performance of their providers in meeting RTT targets and other demand pressures. Risk share arrangements could be put in place with providers in order to contribute to additional demand related costs. The Council and CCG should jointly forecast demand and plan for ways to manage demographic pressures across the Wirral, and should work to harmonise care assessment, planning and management. Ultimately a move to the Capped Expenditure Process would limit CCG expenditure on services.*

- **Contract offer cost pressures:** Contracts with healthcare providers are negotiated and adjusted annually based on actual patient demand, provider cost pressures and other factors. The main driver of contract offer pressures in 2017/18 is additional funding for WUTH, in light of its move to an activity-

based (PbR) contract in 2017/18. The CCG will need to ensure that this contract is managed effectively and that any overspends are identified and mitigated early, through demand management programmes and contractual penalties where appropriate.

- **Risk to Council: CCG has reverted to an activity-based (PbR) contract with its main acute provider WUTH, as opposed to a block arrangement (as was the case in 2016/17). Efficiency (QIPP) savings within this contract total £5.8m**

  We recommend: *The Council should become active participants in the contract negotiation process with providers. The Council and CCG should continue to closely monitor the performance of WUTH in relation to activity levels and QIPP scheme delivery, so that the agreed activity plan is delivered. Cap and Collar / risk share arrangements should be jointly agreed by the Council and CCG and negotiated with WUTH if these are not already in place. The Commissioners should continue to consider the move to an Accountable Care System arrangement across the Wirral over the longer term in order to allow providers to manage future demand risk. Ultimately a move to the Capped Expenditure Process would limit CCG expenditure on services.*

  - **Provider performance results in cost risk:** The CCG has limited scope to mitigate clinical financial difficulties caused by providers in the system. For example, if WUTH fails to meet its referral to treatment (RTT) targets there is potential for regulatory intervention, through which patients will be referred to alternative providers to meet the target. This will result in an unanticipated cost to the CCG, who will have to fund the costs of any additional providers treating Wirral patients.

- **Risk to Council: Poor provider performance in the system could result in regulatory intervention in order to meet performance targets. Such an intervention would have to be funded by the CCG**

  We recommend: *The Council and CCG should continue to closely monitor the performance of their providers in meeting RTT targets and other demand pressures. Joint working with providers to manage flow and demand across the system. Risk share arrangements could be put in place with providers in order to contribute to additional demand related costs. Ongoing move towards an ACS/ACO in the Wirral.*

  In order to achieve financial balance in 2017/18 and 2018/19 the CCG is required to deliver £12.3m and £7.1m of QIPP savings respectively. Based on historic QIPP delivery performance we believe these targets are likely to be challenging for the CCG, which could result in financial deficits being reported for the next two financial years, contravening the intentions of the CCG's published Financial Recovery Plan. Evidence for this comes from the CCG failing to meet QIPP targets in prior years and the fact that only £5.2m (42%) of savings had been identified at the start of the 2017/18 financial year and upon discussions with the CCG, we believe that early QIPP delivery performance indicates that this QIPP target may be missed this year by as much as £6m.

  This could ultimately result in the CCG being placed into a Capped Expenditure Process by NHS England, which would result in a 'hard expenditure cap' for the commissioner and therefore an inability to fund contractual overspends or other pressures in the system. Financial deficits in 2018 and 2019 would also result in the CCG pooling the budgets what would effectively be an underfunded healthcare system. The Council would therefore need to be aware of these risks and work with the CCG to reduce this deficit and/or insulate itself from these risks.

- **Risk to Council: The CCG may be unable meet its efficiency requirement of £12.3m in 2017/18, resulting in an in-year deficit (2.4% of total budget), resulting in an in-year deficit. This could result in the CCG being placed in the Capped Expenditure Process in 2018/19**

  We recommend: *Both parties should keep the other informed of their performance in the delivery of their savings targets throughout the financial year. The Council and CCG should begin to work closely together as soon as possible (prior to pooling the budgets if possible) in order to minimise the likelihood of a deficit being recorded in 2017/18. Cost reduction schemes should be jointly assessed and agreed by both parties, including introducing increasing accountabilities and risk share arrangements with providers. Risk share arrangements are put in place between the Council and CCG in order to identify a realistic budget baseline against which under and over performance can be assessed, particularly for services which require the joint working of the Council and CCG. Open book accounting should be introduced. Single population health budget implemented over the longer term. The implications of a move into the*

Capped Expenditure Process should be discussed with the Council, particularly with regards to the potential implications for service provision across the Wirral, strict financial controls likely to be implemented on Commissioners and providers and the potential removal of additional central deficit funding.

Historic Budget Performance

This section will provide financial analysis and conclusions regarding the historic budget volatility of each organisation.

Summary of Key Risks

Key Risks to CCG

- Social care services are forecasting a break-even budget position this year, despite social care services overspending its budget each year since 2014 (a £2.5m deficit in 14/15 rising £3.9m in 16/17)
- Social care services are budgeting a reduction in net social care expenditure of £3.4m in 2017/18, despite actual net budget expenditure annually trending upwards between 14/15 and 17/18
- Since 2015/16 the Council has under-recovered its budgeted income figure, with under-receipt of income varying between £0.8m and £1.3m
- For the last three years the Council have overspent on its expenditure budget, with these overspends varying between £1.6 and £4.2m
- The Council significantly under-collected income across a range of service lines in 2016/17 compare to budget
- Despite delivering savings of over 5% of net budget funding annually since 2014/15, social care services have not met their annual saving target since 2014/15, with this target being missed by as much as £7.5m. 'One-off' savings of £2.6m and £1.9 have been required to support savings in 2015/16 and 2016/17
- Large discrepancies in joint vs fully funded packages of care compared to peer benchmarks means a re-baselining of CHC costs is likely to be required
- Social care services hope to make efficiency savings in current year through a redistribution of complex care packages from joint funded to fully funded packages, however the CCG has not budgeted for this
- Both parties face a significant financial pressure in relation to people with Complex Care needs. Current plans to meet these pressures are not aligned, leading to disputes for individual cases

Key Risks to Council

- Wirral CCG is forecasting a break-even position for 17/18, despite it reporting annual overspends since 15/16 (£1.4m deficit in 15/16 rising to a £7.1m deficit in 17/18)
- Expenditure on acute and non-acute NHS contracts has, overall, over-spent against the target activity and financial plan for the last three years. These overspends have included contracts with a range of key NHS providers
- The CCG did not meet its QIPP requirement in 2016/17, missing its £8.8m target by £5.0m
- The CCG has been issued formal directions by NHS England, requiring the CCG to improve its financial and governance weaknesses

Key Risks to Council (Cont.)

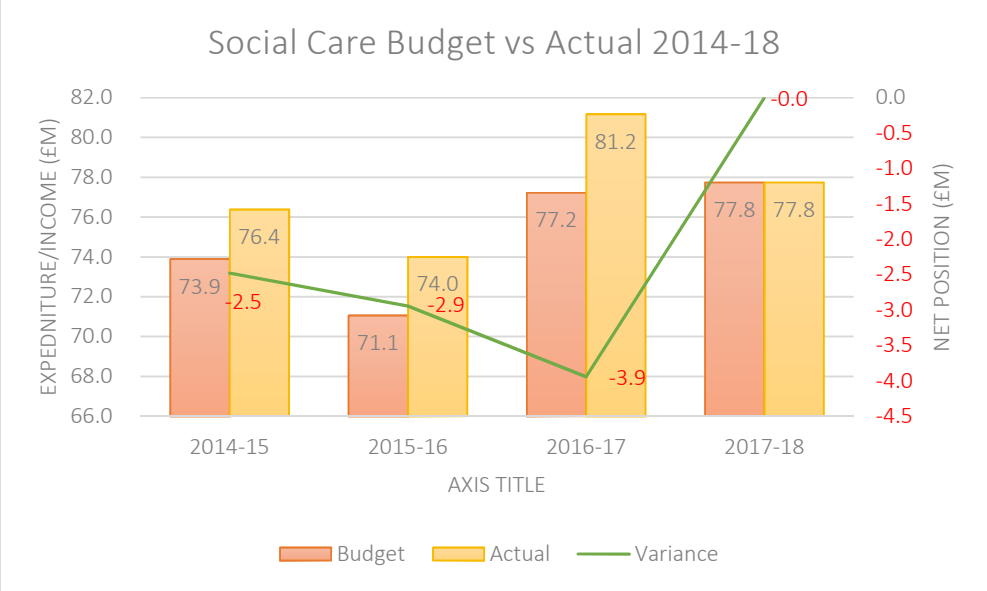
- Fully funded CHC budgets have overspent annually since 2014/15, with a significant overspend of £4.5m delivered against all Out of Hospital care services 2016/17
- Both parties face a significant financial pressure in relation to people with Complex Care needs. Current plans to meet these pressures are not aligned, leading to disputes for individual cases

Wirral Council

Budget Volatility and Performance

The Council's social care financial performance since 2014 has been assessed. To do this income and expenditure against budgeted levels has been compared across the social care budget lines for the last three financial years.

The overall budget performance for social care services from 2014/15 to 2017/18 (forecast) is highlighted below:



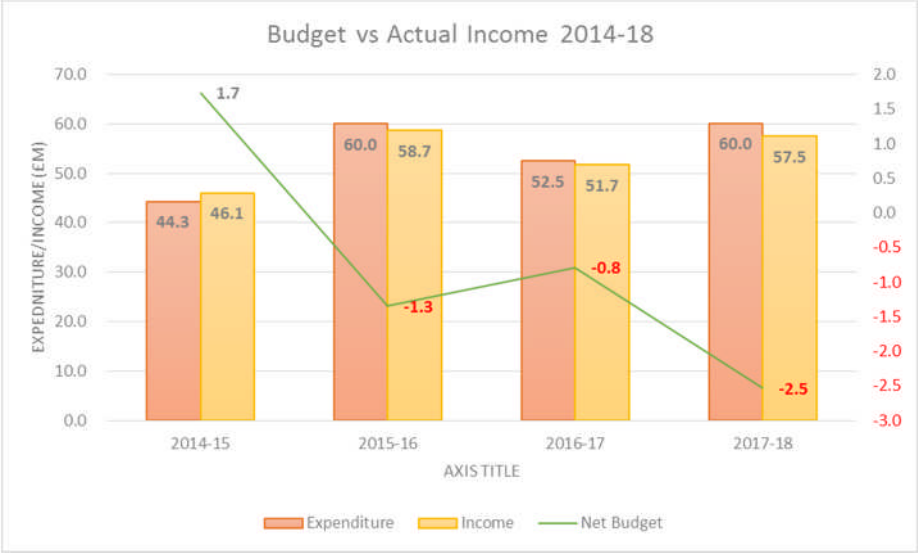
Key observations include:

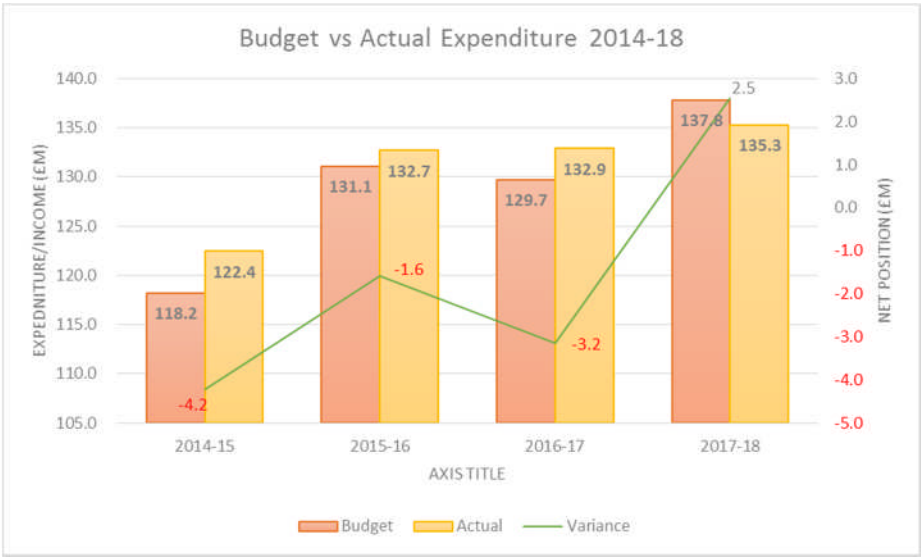
- Social care service expenditure has exceeded budget every year since 2014, with the net annual deficit increasing year on year from £2.5m to £3.9m.
- Net budget and actual social care spend has trended upward between 2014-15 and 2016-17, despite a dip observed in 2015-16 (in part due to savings requirements in 2015/16)
- Despite these trends, the Council in forecasting a break even position on its budget in 2017/18. This is anticipated to be driven in part by the social care efficiency savings of £5.4m.

- **Risk to CCG: Social care services are forecasting a break-even budget position this year, despite social care services overspending its budget each year since 2014 (a £2.5m deficit in 14/15 rising £3.9m in 16/17)**

  We recommend: *Both parties prudently anticipate that based on historic performance a break-even budget position will not be delivered in 2017/18, and pooled funding plans are made with this in mind. Both parties should keep the other informed of their performance throughout the financial year. Risk share arrangements are put in place between the Council and CCG in order to identify a realistic budget*

baseline against which under and over performance of the ICH can be assessed, particularly for services which require the joint working of the Council and CCG. Open book accounting should be introduced.





Underlying the net outturn position of social care services over the last three years is a general under-receipt of forecast income (with income received each year varying considerably over the last three years, potentially due to the nature of the mixed funding approach for social care services), alongside an annual overspend against forecast expenditure budgets, which have trended upwards since 2014-15. The Council have sensibly increased their forecast expenditure in 2017/18 in line with this upward trend in expenditure.

- **Risk to CCG: Since 2015/16 the Council has under-recovered its budgeted income figure, with under-receipt of income varying between £0.8m and £1.3m**

We recommend: *The Council and CCG should agree the income target for social care services in future years. Work should be undertaken to identify why income has been under-recovered and joint mitigations agreed and implemented where possible. Risk share arrangements should be put in place where necessary, or collection risk passed over to the central Council where possible. Over time contingency funding should try to be built up by the ICH in order to mitigate the effect of unanticipated pressures over the longer term.*

- **Risk to CCG: For the last three years the Council have overspent on its expenditure budget, with these overspends varying between £1.6 and £4.2m**

We recommend: *The Council and CCG should agree the expenditure target for social care services in future years. Work should be undertaken to identify why overspends have been delivered and joint mitigations agreed and implemented where possible.*

At the time of writing this report there was £2.5m of BCF income which was unallocated, with an associated £2.5m of unallocated expenditure, resulting in the forecast budget variances anticipated for 2017/18. This again highlights the iterative nature of the setting of the Social Care budget.

Drivers of volatility

Income

Even though social care services recorded £0.8m less of income than budgeted in 2016/17, this overall picture hides a wide range of income receipt volatility across the various social care budget lines:

Budget line (£m)	Budgeted income	Actual income	Variance	*From self-funding*	*From other*
Birkenhead and S Wirral	9.6	8.0	-1.6	*-0.8*	*-0.8*
Wallasey and W Wirral	9.9	7.8	-2.2	*-1.4*	*-0.7*
Mental Health/IHP	1.9	1.3	-0.6	*0.7*	*-1.3*
Learning Disability/IDS	6.4	10.6	4.2	*0.4*	*3.8*
In House Day Services	0.8	0.4	-0.4	*0.0*	*-0.4*
Delivery	8.7	9.9	1.2	*-0.6*	*1.8*

2016/17 was the first year in which the Council appears to have received a significant under-receipt of client self-funded income across a number of budget lines, counterbalanced by substantial over-receipts towards Integrated Disability Services (LD) and Delivery services. The Council will need to ensure that this under-receipt of client funding income does not continue into 2017/18 and beyond as it could result in additional budget pressures for social care services.

- **Risk to CCG: The Council significantly under-collected income across a range of service lines in 2016/17 compared to budget**

  We recommend: *The Council and CCG should agree the income target for social care services in future years. Work should be undertaken to identify why income has been under-recovered and joint mitigations agreed and implemented where possible. Risk share arrangements should be put in place where necessary, or collection risk passed over to the central Council where possible.*

Expenditure

Social care services have overspent against budget for each of the last three financial years. These overspends are not constrained against one or two budget lines; overspends have occurred against a wide range of budget lines as follows (the list below only highlights service lines with a significant variance, not all social care service lines):

	2014-15		2015-16		2016-17	
Budget line (£m)	Budgeted spend	Variance	Budgeted spend	Variance	Budgeted spend	Variance
Birkenhead and S Wirral	26.7	-1.1	29.9	2.5	22.9	-1.5
Wallasey and W Wirral	28.4	1.6	26.0	2.0	20.4	-2.6
Mental Health/IHP	8.7	-1.9	10.0	-0.9	8.7	-1.5
Learning Disability/IDS	29.7	-1.5	35.7	-3.4	32.9	-1.7

	2014-15		2015-16		2016-17	
Budget line (£m)	**Budgeted spend**	**Variance**	**Budgeted spend**	**Variance**	**Budgeted spend**	**Variance**
In House Day Services	7.5	-0.6	6.0	-1.3	5.9	-0.3
Delivery	-	-	-	-	7.6	1.4
Total	**101.0**	**(3.5)**	**107.6**	**(1.1)**	**98.4**	**(6.1)**

Social care services reported a £7.5m deficit against its five largest budget lines in 2016-17 (and a £1.4m underspend on delivery services), in the main due to unanticipated budget and funding pressures within the year (total overspend for 16/17 was £3.9m however). These pressures are recurrent in nature and are therefore likely to affect budget performance in 2017/18, again placing pressure on expenditure budgets within the year.

Savings requirement: anticipated performance

In 2017-18 social care services have been challenged to deliver £5.4m of efficiency savings.

Historically the Social Care service has struggled to deliver all of its annual savings requirement, with 'One-off' funding (e.g. write-offs of aged creditors, revision of forecasting assumptions) used in 2015/16 and 2016/17 to increase the savings achieved within the year. This is summarised in the table below.

Savings requirement (£m)	Target Recurrent Savings	Recurrent Savings	'One-off' Savings	Total savings delivered *(% net budget)*	Variance
2014/15 efficiency requirement	11.8	4.3		4.3 *(5.4%)*	(7.5)
2015/16 efficiency requirement	9.0	4.0	2.6	6.5 *(9.1%)*	(2.5)
2016/17 efficiency requirement	6.4	3.8	1.9	5.7 *(7.4%)*	(0.7)

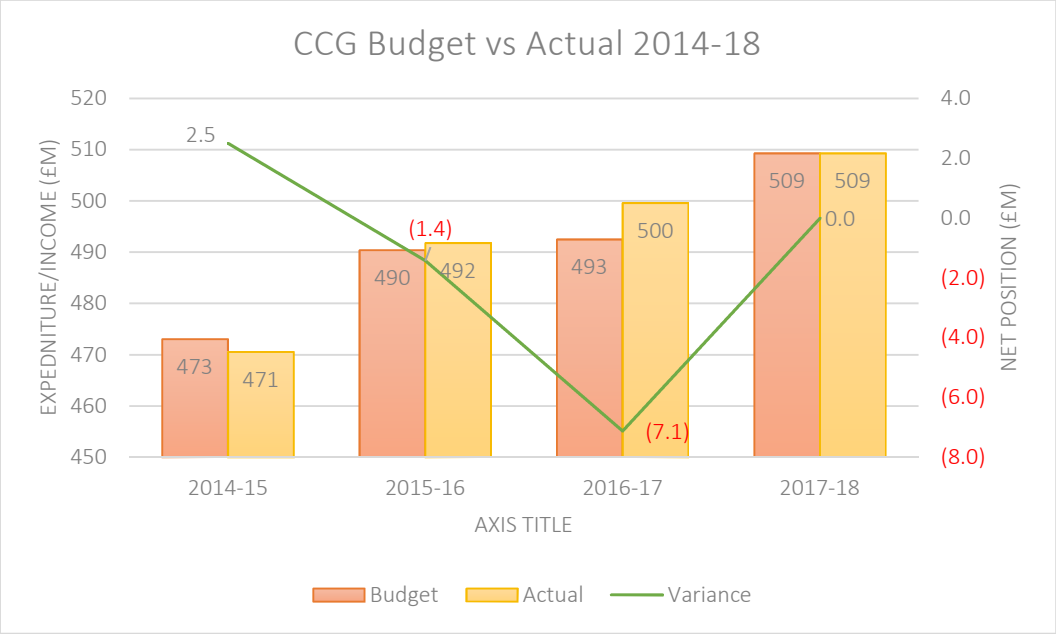
- **Risk to CCG: Despite delivering savings of over 5% of net budget funding annually since 2014/15, social care services have not met their annual saving target since 2014/15, with this target being missed by as much as £7.5m. 'One-off' savings of £2.6m and £1.9 have been required to support savings in 2015/16 and 2016/17**

  We recommend: *Both parties should keep the other informed of their performance in the delivery of their savings targets throughout the financial year. The nature of the 'one-off' savings should be identified in order to agree an underlying recurrent cost pressure for the Council and therefore the financial baseline which can be pooled in the ICH. The Council and CCG should jointly work together in the planning and delivery of efficiency requirements across the Wirral. Cost reduction schemes should be jointly assessed and agreed by both parties, including introducing increasing accountabilities and risk share arrangements with providers. Risk share arrangements are put in place between the Council and CCG in order to identify a realistic budget baseline against which under and over performance can be assessed, particularly for services which require the joint working of the Council and CCG.*

Wirral CCG

Budget Volatility and Performance

An assessment of the CCG's financial performance since 2014 has also been undertaken. CCG expenditure against contract values and budget allocation has been undertaken for the last three financial years. The outcome of this assessment is as follows:



Key observations include:

- Both healthcare funding and associated healthcare expenditure has increased year on year since 2014-15. In line with this NHS Wirral's allocation of funds has increased this year to £509m.
- However, expenditure has exceeded funding each year, with the annual commissioning performance shifting from a £2.5m surplus in 2014-15 to £7.1m deficit in 2016-17.
- Despite this, the CCG is forecasting a breakeven position this year, with any increased in expenditure expected to be funded through an additional £9m of funding allocation in 2017-18 and the achievement of £12.3m of QIPP savings.

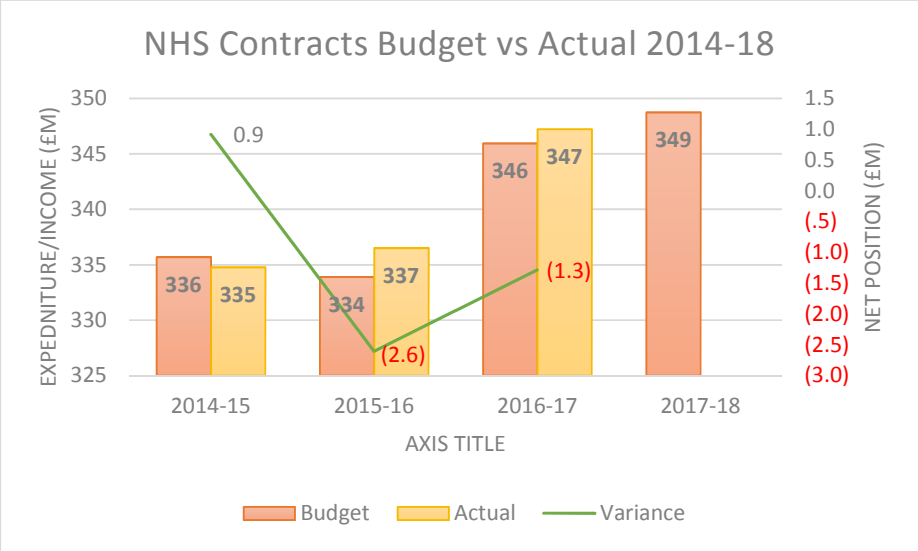
- **Risk to Council: Wirral CCG is forecasting a break-even position for 17/18, despite it reporting annual overspends since 15/16 (£1.4m deficit in 15/16 rising to £7.1m deficit in 17/18)**

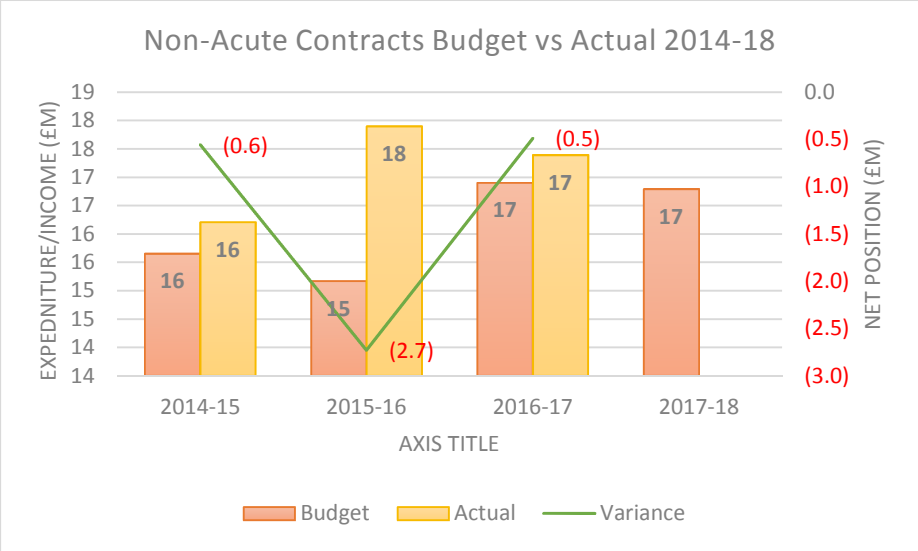
  We recommend: *Both parties prudently anticipate that based on historic performance a break-even budget position will not be delivered in 2017/18, and pooled funding plans are made with this in mind. Both parties should keep the other informed of their performance throughout the financial year. Risk share arrangements are put in place between the Council and CCG in order to identify a realistic budget baseline against which under and over performance of the ICH can be assessed, particularly for services which require the joint working of the Council and CCG. Open book accounting should be introduced.*

Drivers of volatility

Expenditure

Due to the CCGs block contract arrangements with its providers between 2014-15 and 2016-17, patient demand and provider over-performance has to some extent been contained. Despite this, expenditure on acute and non-acute NHS contracts has, overall, over-spent against the target activity and financial plan for the last three years.





The main drivers of these overspends and CCG budget volatility have historically included a number of key contracts and/or providers:

	2014-15		2015-16		2016-17	
Budget line (£m)	**Budgeted spend**	**Variance**	**Budgeted spend**	**Variance**	**Budgeted spend**	**Variance**
Wirral Uni. Teaching Hospital	222	3.3	219	(1.9)	228	0.0
RLBUHT	6	(0.8)	7	(0.7)	7	(0.3)
Wirral Community Trust	47	(0.7)	43	0.2	43	(0.3)
Spire - Murrayfield	5	(0.1)	5	(1.1)	6	(0.7)
Locally Commissioned Services	1	(0.2)	2	(1.4)	0	(0.0)

These overspends are anticipated to be reduced through the delivery of QIPP schemes in 2017/18.

- **Risk to Council: Expenditure on acute and non-acute NHS contracts has, overall, over-spent against the target activity and financial plan for the last three years. This has included overspends on contracts with a range of key NHS providers**

We recommend: *The Council and CCG should agree the expenditure target for healthcare services in future years. The Council should be involved in contract negotiations with providers. Work should be undertaken to identify why overspends have been delivered in both acute and non-acute contracts and joint mitigations agreed and implemented where possible. This could include risk share arrangements with providers or new demand management programmes where possible.*

Savings requirement performance

Due to the well-reported financial constraints in NHS funding, the CCG have been required to make Quality, Innovation, Productivity and Prevention (QIPP) efficiency savings in the delivery of their services in order to achieve financial balance.

However, the CCG has failed to deliver its required QIPP savings for a number of years. In 2016-17 the CCG was required to deliver £8.8m of QIPP savings, however only £3.8m of these savings were delivered in year, resulting in a QIPP deficit of £5.0m at year end.

- **Risk to Council: The CCG did not meet its QIPP requirement in 2016/17, missing its £8.8m target by £5.0m**

  We recommend: *Both parties should keep the other informed of their performance in the delivery of their savings targets throughout the financial year. The nature of any non-recurrent savings in the delivery of prior year performance should be identified in order to agree an underlying recurrent cost pressure for the CCG and therefore the financial baseline which can be pooled in the ICH. The Council and CCG should jointly work together in the planning and delivery of efficiency requirements across the Wirral. Cost reduction schemes should be jointly assessed and agreed by both parties, including introducing increasing accountabilities and risk share arrangements with providers. Risk share arrangements are put in place between the Council and CCG in order to identify a realistic budget baseline against which under and over performance can be assessed, particularly for services which require the joint working of the Council and CCG.*

As a result of this significant deficit, NHS England intervened and have issued formal directions to the CCG, requiring it to resolve its financial and governance weaknesses. This has resulted in the CCG agreeing to deliver £12.3m of QIPP savings in 2017-18, and act within its financial budget.

- **Risk to Council: The CCG has been issued formal directions by NHS England, requiring the CCG to improve its financial and governance weaknesses**

  We recommend: *Section 75 framework put in place. The ICH will be required to evidence how the new commissioning arrangements will strengthen the CCG's financial and governance arrangement and the Council and CCG should begin considering governance and reporting requirements with this in mind.*

CHC and Joint Funding Packages of Care

Budget Volatility and Performance

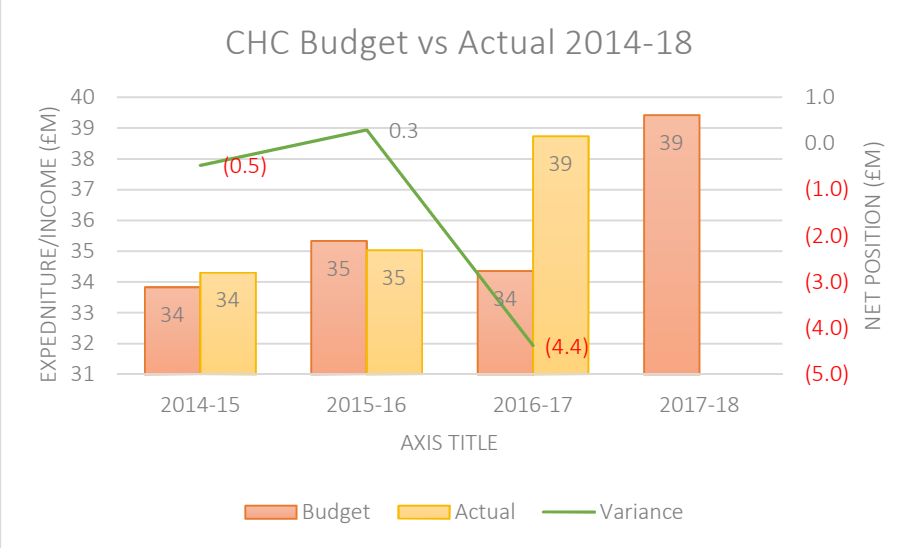
The Council and CCG both contribute to the long term care needs of clients and patients across the Wirral, through the funding of Joint Packages of Care (equally funded by the Council and CCG) and Continuing Healthcare services (fully funded by the CCG). Complex and long term care services expensive for both Commissioners, and therefore the balance between joint funded and CCG-only funded care packages currently has important implications for the financial performance of both organisations.

	2014-15		2015-16		2016-17	
Budget line (£m)	**Budgeted spend**	**Variance**	**Budgeted spend**	**Variance**	**Budgeted spend**	**Variance**
CCG Fully Funded CHC	10	(0.5)	9	(0.5)	9	(2.0)
Joint Funded Packages of Care	17	(0.1)	19	0.7	19	(0.9)
Funded Registered Nursing	5	0.1	5	0.1	5	(1.6)
Total	22	(0.5)	33	(0.2)	33	(4.5)

It is clear that fully funded CHC faces significant financial challenges having overspent in each of the last three years, with a significant variance (22%) delivered in 2016/17. Furthermore, the CCG also recorded significant overspends against its joint funded and funded registered nursing budgets in 2016/17 (the registered nursing deficit arising as a result of national cost pressures). The management of CHC and Joint Funded Care will therefore be an important challenge for the ICH.

- **Risk to Council: Fully funded CHC budgets have overspent annually since 2014/15, with a significant overspend of £4.5m delivered against all Out of Hospital care services 2016/17**

  We recommend: *The Council and CCG should review CHC and other Out of Hospital costs to determine why overspends have occurred, particularly those in 2016/17, in order to determine the realistic recurrent cost pressures with regards to these services and how these pressures can be mitigated in the ICH.*



The CCG spends almost twice as much on joint packages of care than it does on fully funded CHC costs (with an equivalent sum of funding for Joint Packages of care also being spent by the Council). At present, benchmarking analysis suggests that the distribution between fully funded and joint packages of care is different in the Wirral than comparable CCGs across Cheshire and Merseyside; specifically that the CCG fully funds approximately 40% fewer packages of care than comparable CCGs. In contrast, jointly funded packages of care far exceed peer packages by as much as 4x (suggesting that the Council is contributing too much towards CHC costs under the current arrangements). Based on current benchmarks, the CCG estimates that it currently spends approximately £2m per annum less than its peers on CHC services for its population.

- **Risk to CCG: Large discrepancies in joint vs fully funded packages of care compared to peer benchmarks means a re-baselining of CHC costs is likely to be required**

  We recommend: *The Council and CCG should review the current CHC and joint package of care activity and cost across the system before a baseline budget for these services are agreed in the ICH. The assessment process and criteria for funding approvals should also be reviewed, with a joint assessment process implemented where relevant. An agreed position should be obtained regarding a targeted redistribution of joint vs fully funded packages of care over an agreed period of time, in order to closer resemble the package proportions achieved by benchmarked peers. Risk share arrangements should be introduced in order to share the gains and losses of under or over performance with regards to CHC costs, in line with the newly re-baselined spend. Open book accounting should be introduced.*

Analysis over the last two financial years indicates that these packages of care are consistently allocated over the financial year, with no significant variation is the number of care packages allocated within each quarter of the financial year between 2015/16 and 2016/17.

Under the current separation of commissioning functions there is therefore a risk to the CCG of increased fully funded CHC costs in the coming years, which may not be offset by an associated reduction in jointly funded packages of care costs. Indications of this have come from the Council, which, as part of their efficiency saving

ambitions, hope to reallocate some £2m of the jointly funded packages of care as fully CCG-funded CHC packages. The CCG does not appear to have budgeted for this cost pressure within their 2017/18 budgets.

- **Risk to Both Parties: Both parties face a significant financial pressure in relation to people with Complex Care needs. Current plans to meet these pressures are not aligned, leading to disputes for individual cases**

  We recommend: *The Council and CCG should have open discussions regarding current savings plans and the role of CHC costs in these. Budget amendments and/or savings plans should be adjusted if required.*

However, upon the move to the ICH, this approach to the allocation of funding for care packages and the associated transaction costs will cease to exist, reducing the bureaucracy and negotiations required between both Commissioners. The focus will instead need to be on managing the demand and under arching cost base for these packages of care.

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Key risks and mitigations

Based on the information received and our analysis of the risks, this section presents the key risks to the Council and CCG from the pooling of their budgets, and identifies a range of possible mitigations available in order to reduce these risks.
The potential mitigations identified present a longlist of available options to the ICH – not all of these could or may be able to be implemented at this time.
Risks have been rated as follows:

Very Low Risk Low Risk	**0-9**
Moderate	**10-14**
High Risk	**15-19**
	20+

Table 2: Identified risks and potential mitigations of pooling budgets

Potential Risk	Which organisation presents this risk?	Potential impact	I	L	RAG rating	Potential mitigations	Where risk should sit in the ICH	WHaCC response	I	L	RAG rating
Income risk											
• Council revenues are variable in nature and are more short term than CCG funding. Wider scale funding reform for social are services has been proposed by Central Government from 2021 onwards, however no detail on what this may look like is available at present. • Available sources of income to mitigate cost pressures are variable each year, with a number of grants expected to be time-bound and council tax rate increases to fund social care capped by Central Government	Council	> The annual budgeting process will be less predictable each year for the ICH until the point at which grants and funds are confirmed > Unless alternative funding sources are sufficient to replace those being removed and/or reductions in expenditure are obtained, future budgets are at risk of deficit	2	4	**8**	> Defined process in place to agree budget and income > CCG active participant in discussions and agreement of grant funding request > CCG actively informed of any potential policy and funding changes proposed by the Government and Council > Contingency planning undertaken > Joint 3 year plan to be reviewed annually > Joint 3 year budgeting	Shared	Minimum exposure to risk in 2018/19. Longer term will require continued focus as settlement from central government grants becomes clearer. Mitigations as outlined are judged to be robust.	2	2	
• Delays in receiving income or deferred payments may result in lower than anticipated free cash flow available for the ICH	Council	> There may be lower than budgeted cash flow available when required	3	3	**9**	> Joint 3 year plan to be reviewed annually > Joint 3 year budgeting > Council acts in a 'cash management / banking' role, funding short term cash requirements until anticipated income is received > Risk of non-collection remains with the Council, agreed through an MOU and the Section 75 agreement	Council	Mitigations outlined are judged to be robust and partners in agreement with approach.	3	2	
Potential Risk	**Which organisation presents this risk?**	**Potential impact**	**I**	**L**	**RAG rating**	**Potential mitigations**	**Where risk should sit in the ICH**	**WHaCC response**	**I**	**L**	**RAG rating**
Income risk											
• Client income can be under-collected by the Council, placing pressures on the budget • Since 2015/16 the Council has under-recovered its budgeted income figure, with under-receipt of income varying between £0.8m and £1.3m per year • The Council significantly under-collected income across a range of service lines in 2016/17 compared to budget	Council	> Reductions in income compared to budget will place pressures on the ICH budget beyond any pre-existing efficiency requirement targets	3	5	**15**	> Robust SLA with Personal Finance Unit for income collection, with penalties if required > Managed through the current budget setting approach > Realistic income targets set > The Council could fund any deficits against collection > Prudent bad debt allowances assumed annually > Contingency fund built up in order to account for any shortfall > Risk share arrangements could be implemented > Council undertakes a 'banking' role for income collection of deferred income	Council	Mitigations outlined are judged to be robust and already in place. Deemed not to be a material risk.	3	1	
• Linked to the Medium Term Financial Planning process, retention of Business Rates is expected to be a large contributor to social care services in future years (as part of national business rates reform), which could be challenging for the Wirral	Council	> Business Rates recovered across the Wirral will be insufficient to substantively replace grant and other funding no longer provided by the Government/Council	3	3	**9**	> Defined process in place to agree budget and income for social care services > Top ups / no loss policy in place for now > CCG active participant in discussions and negotiations on income receipt > Joint three year budgets and plans agreed > CCG actively informed of any potential policy and funding changes proposed by the Government and Council	Shared	The Council strategy of increasing business rates with active leadership with the chamber of commerce is well publicised. Potential risk is not attracting new but a reduction in business rate income through close of businesses. Mitigations as stated sound.	3	1	

Demand risk											
• CCG is unable to negotiate any additional allocation of funds at the start of the year if it feels its budget is underfunded • Non-recurrent funding for unanticipated pressures is unpredictable and may be insufficient to meet non-recurrent pressures in the system	CCG	> Budget deficit for the ICH	3	4	**12**	> Joint agreement of likely budget requirement for healthcare services (inc. increased QIPP target) > Risk share arrangements put in place to incentivise joint working > Joint working between the Council, CCG and providers to plan for and implement solutions to manage demand and pressures at those times > Contingency funding put in place in light of unexpected pressures > Open book accounting introduced	Shared	Manifestation of funding CCG deficits not necessarily reflected in additional funding. This issue is usually dealt with, with a revised (deficit) control total as per 15/16, 16/17 and 17/18. New risk is integration of health economy wide deficits and system control totals. This will need to be worked through in the medium to longer term. Partners agree with the mitigations.	3	1	
Potential Risk	**Which organisation presents this risk?**	**Potential impact**	**I**	**L**	**RAG rating**	**Potential mitigations**	**Where risk should sit in the ICH**	**WHaCC response**	**I**	**L**	**RAG rating**
Demand risk											
• Increases in patient and service user demand may not be mitigated fully by social care services and additional iBCF funding available, resulting in further budget pressures • The CCG only received an additional net 0.1% increase in funding for demographic growth, and therefore must be able to manage demand across the health economy to remain in budget	Council CCG	> Pooled budget is underfunded, likely to result in a deficit for the ICH > Without significant intervention cumulative deficit likely to increase annually as prior-year demand is unmet	4	4	**16**	> Joint working between the Council, CCG and providers to plan for and implement solutions to manage demand and pressures at those times > Investment in effective demand management, integrated and contractual management and care assessment schemes > Contingency funding put in place in light of unexpected pressures > Joint agreement of the forecasting assumptions by both parties	Shared	Increases in patient and service user demand are a national issue. It is anticipated that more 'real money' will be coming to the NHS, although this will come with caveats for improved delivery of constitutional standards. The improved integrated commissioning will lead to a better understanding of demand levers and influencers, as will the pooled arrangements in terms of packages of care. Mitigations are supported. Need to be further supplemented by sensitivity analysis at planning assumptions stage, and also explicit contingency plans if budgets start to overspend.	4	2	
• Managing demand has been a challenge for the CCG, due to a number of factors including patient demographics and a need to ensure statutory targets are met	CCG	> Additional expenditure may be required by the CCG in order to pay alternative providers so that treatment targets are met	4	4	**16**	> Joint working to closely monitor the performance of their providers in meeting RTT targets and other demand pressures, inc. care assessment and management. > Risk share arrangements with providers in order to contribute to additional demand related costs. > Joint demand forecasting and planning in order to manage demographic pressures across the Wirral. > Commissioning for outcomes (not activity) > Ultimately a move to the Capped Expenditure Process would limit CCG expenditure	Shared	Mitigations are sound accompanied by more explicit modelling and more sensitivity analysis to ensure demand forecasting is robust.	4	2	
• CCG has reverted to an activity-based (PbR) contract with its main acute provider WUTH, as opposed to a block arrangement (as was the case in 2016/17). Efficiency (QIPP) savings within this contract total £5.8m	CCG	> Potential for significant contractual overspend if demand is higher than anticipated and is unable to be managed by the Trust and the CCG	4	4	**16**	> Joint demand management schemes including effective discharge planning and readmissions avoidance > Robust contract management to remain at agreed activity plan with associated contractual terms (e.g. cap/collar) > ASC involved in contract negotiations > Contractual penalties between the commissioner and the Trust > Ongoing movement towards introducing an ACS	Shared	Mitigations are sound as stated and need to be supplemented by demand forecasting as outlined above. Further mitigated by an 'in principle' agreement to adopt system budget.	2	4	
• Poor provider performance in the system could result in regulatory intervention in order to meet performance targets. Such an intervention would have to be funded by the CCG	CCG	> ICH will be required to fund the costs of any other providers which are required to intervene in order to meet RTT targets > Likely budget deficit	3	2	**6**	> Effective management of providers through contractual terms and arrangements > Joint working with providers to manage flow and demand across the system > Effective market management > Risk share arrangements with providers put in place > Ongoing movement towards introducing an ACS	Shared	Low risk and mitigations acknowledged. To be set in the context of system budget of £600m .	2	2	

Potential Risk	Which organisation presents this risk?	Potential impact	I	L	RAG rating	Potential mitigations	Where risk should sit in the ICH	WHaCC response	I	L	RAG rating
Budget setting risk											
• The funding allocated for social care services is through the council in its budget setting allocation process, as opposed to a predetermined figure such as % of central funding received	Council	> There will be uncertainty for the ICH as to its total budget each year, and associated efficiency requirements, until close to the start of the new financial year > The budget available to the ICH is likely to be influenced by external pressures and factors affecting the Council and its range of services	3	4	**12**	> CCG actively part of the budget setting process > Joint three year budget plans put in place > Risk share arrangements to incentivise joint working > Open book accounting > Council may take 100% risk on a real terms cut in budget plans where it is the sole determinant	Shared	Mitigations ok. Key will be open book counting and reconciliation of in year and prior year spend v proposed budget and any changes. MTFP within Council agreed with no further budget cuts.	3	2	
• Council has limited scope to make expenditure savings through reducing the price it pays providers – alternative approaches to meeting efficiency requirements will need to be identified	Council	> ICH may have difficulties in reducing its expenditure base if required (particularly as prices are going up due to NLW) > Alternative approaches to meeting efficiency requirements will need to be taken	3	5	**15**	> Single commissioning plan for outcomes > Opportunities to bring commissioning together to allow better outcomes > Joint discussions and agreements for ways to reduce the cost of social care services if required	Shared	Mitigations ok. Would anticipate increased shared purchasing power to allow for some reduction in volume.	3	2	
• Prescribing budget overspends (which is outside of the scope of the ICH) could restrict the sums of money the CCG is able to pool to the ICH	CCG	> Prescribing overspends will need to be funded through surpluses elsewhere or through deficit funding > This will limit the budget available to pool in the ICH	3	3	**9**	> Detailed saving plan in place with GPs who are actively incentivised to reduce prescribing spend and are managing this budget > Both parties should agree what happens in the event of an overspend so that pooled funds remain unaffected > Open book accounting should be introduced.	CCG	Mitigations ok.	3	1	
• Savings negatively impact on the ICH for ASC services based on the overarching performance of the Council rather than ASC's ability to deliver those savings	Council	> The ICH may be unable to meet the required savings targets, resulting in budget overspends and financial deficits	4	3	**12**	> Joint planning and implementation of ICH interventions > Savings already in the plan require transparency > Joint negotiations with Cabinet where possible on savings targets > Risk share arrangements to incentivise joint working	Shared	Mitigations ok.	4	1	
• The Council may be unable meet its efficiency requirement of £3.4m in 2017/18 (4.4% of total budget), resulting in an in-year deficit • Despite delivering savings of over 5% of net budget funding annually since 2014/15, social care services have not met their annual saving target since 2014/15, with this target being missed by as much as £7.5m. 'One-off' savings of £2.6m and £1.9 have been required to support savings in 2015/16 and 2016/17	Council	> The ICH would begin with a financial deficit, with funding insufficient to meet the required expenditure, prior to any additional budget pressures being experienced from 2018/19 onwards > Additional contingency/deficit funding would be required to be repaid in 2018/19 > Savings plans are still under discussion with community trust to identify and deliver further savings	4	5	**20**	> Prior year deficits to be kept out of the pooled funding arrangements > Deficit repayments to be made solely by the original organisation > Effective, joint saving plan required and implemented to reduce demand and take cost out of the system > Risk share arrangements to incentivise joint working > Open book accounting > "One-off" actions to be reviewed if required > Single population health budget implemented over the longer term	Council	Mitigations ok. Key again is agreeing contingency and recovery for the pooled budget and plan actions at budget setting, such that the recovery actions are explicit and clear to all as to what happens when efficiency savings are not met.	4	2	

Potential Risk	Which organisation presents this risk?	Potential impact	I	L	RAG rating	Potential mitigations	Where risk should sit in the ICH	WHaCC response	I	L	RAG rating
Budget setting risk											
• The CCG may be unable meet its efficiency requirement of £12.3m in 2017/18, resulting in an in-year deficit (2.4% of total budget), resulting in an in-year deficit. This could result in the CCG being placed in the Capped Expenditure Process in 2018/19 • The CCG did not meet its QIPP requirement in 2016/17, missing its £8.8m target by £5.0m	CCG	> The ICH would begin with a financial deficit, with funding insufficient to meet the required expenditure, prior to any additional budget pressures being experienced from 2018/19 onwards > Additional contingency/deficit funding would be required to be repaid in 2018/19 > CCG could be entered into the Capped Expenditure Process and/or Turnaround	4	5	**20**	> Prior year deficits to be kept out of the pooled funding arrangements > Deficit repayments to be made solely by the original organisation > Effective, joint saving plan required and implemented to reduce demand and take cost out of the system > Robust contractual arrangements with providers regarding QIPP > Risk share arrangements with providers > Risk share to incentivise joint working > Open book accounting introduced > Single population health budget implemented over the longer term	CCG	Mitigations ok. 17/18 has seen significant increase in QIPP delivery and performance. Culture of accountability and delivery still needs to improve, and the CCG has been set a challengingly ambitious Control Total of a £2m surplus, by NHSE, requiring savings of £19.6m. Net risks are currently estimated at £5.6m, with further actions identified to mitigate these risks. Ultimate delivery of financial balance for the CCG and WHaCC will depend as much on prudent financial and budget management as the delivery of QIPP.	2	3	

Forecasted spend risk											
• Wirral CCG is forecasting a break-even position for 17/18, despite it reporting annual overspends since 15/16 (£1.4m deficit in 15/16 rising to £7.1m deficit in 17/18) • Expenditure on acute and non-acute NHS contracts has, overall, over-spent against the target activity and financial plan for the last three years. These overspends have included contracts with a range of key NHS providers	CCG	> Based on previous trends a breakeven position for the CCG would be difficult to achieve in 17/18. This could result in underfunded services being pooled in the ICH > Additional contingency/deficit funding would be drawn down and would be required to be refunded in 2018/19	4	4	**16**	> Prudent assumptions regarding performance in 17/18 made > Proactive management of contracts > Prior year deficits to be kept out of the pooled funding arrangements > Deficit repayments to be made solely by the original organisation > ASC involved in contract negotiations > Effective, joint planning required and implemented to reduce demand and take cost out of the system > Re-baselining of service provision and cost in 2018/19	CCG (for non-recurring elements)	Mitigations ok. The 2018/19 CCG Control Total of £2m surplus, and require QIPP target of £19.6m is acknowledged as very challenging. Internally CCG reporting for the last 2 years has been sound and accurate. Any potential deficit position will not affect resources going in to WHaCC, but crucial to the long term sustainability of WHaCC and the health and social care economy will be the delivery of a robust 3 year financial recovery plan.	3	2	
• Brought forward pressures from 16/17 could in fact be recurrent and could place ongoing pressure on the budget • Social care services are forecasting a break-even budget position this year, despite social care services overspending its budget each year since 2014 (a £2.5m deficit in 14/15 rising £3.9m in 16/17) • For the last three years the Council have overspent on its expenditure budget, with these overspends varying between £1.6 and £4.2m	Council CCG	> Based on previous trends a breakeven position for ASC would be difficult to achieve in 17/18. This could result in underfunded services being pooled in the ICH > Additional contingency/deficit funding would be required to be refunded in 2018/19 > Risk of cumulative deficits and cost pressures becoming unmanageable if pressures in-year are not mitigated. > However, significant government intervention has changed the dynamics of funding to begin to offset these pressures	4	5	**20**	> Prudent assumptions regarding performance in 17/18 made > Prior year deficits to be kept out of the pooled funding arrangements > Deficit repayments to be made solely by the original organisation > Effective, joint planning required and implemented to reduce demand and take cost out of the system > Re-baselining of service provision and cost in 2018/19 in risk share arrangements > Open book accounting	Council (for non- recurring social care elements) Shared for recurring elements	Mitigations ok. LA now declaring balance for 18/19 deficit on social services budget.	3	2	
• National and local policies changes can result in annual fee uplifts and cost pressures (e.g. National Living Wage increases)	Council CCG	> Requirement for additional expenditure reductions and/or income being raised in order to counteract unexpected pressures	4	3	**12**	> Joint agreement and implementation of activities to reduce the impact of policy changes > Over time contingency funding built up to mitigate pressures	Shared	Pay increases for the NHS are fully funded. There is an acknowledgement of social care providers and staff feeling the pressure of increasing wages to ensure future supply. This needs to be factored into assumptions and discussions with appropriate mitigating strategies.	3	1	
Potential Risk	**Which organisation presents this risk?**	**Potential impact**	**I**	**L**	**RAG rating**	**Potential mitigations**	**Where risk should sit in the ICH**	**WHaCC response**	**I**	**L**	**RAG rating**
Forecasted spend risk											
• Funding pressures in 2018/19 include the repayment of deficits and contingency drawdowns used to fund prior year budget deficits • CCG allocation will be top-sliced in future years in order to repay deficits incurred in the years prior to 2017/18. This is likely to result in the CCG's budget being top-sliced by £9.8m in 2018/19	Council CCG	> ICH budget would contain pressures unrelated to service delivery in 2018/19, which are unmanageable by the ICH > CCG funding allocation is top-sliced by NHS England to repay prior-year debt drawdowns	4	5	**20**	> These pressures and repayment obligations are not pooled and remain with their original organisations > Organisation must pay its debt obligations back through a surplus made through the funding pool as part of a risk share arrangement > Council to be party to any negotiations with NHSE regarding deficit repayments > Open book accounting	Council CCG	Mitigations ok. There has been a change to allocation policy and adjustments from previous years such that the historic deficit is no longer automatically top sliced off CCG allocations. The historic cumulative deficit still appears as a note within the reporting system, but this will be repaid through future CCG surpluses. There is a recognition nationally of the perilous financial situation of the NHS and no desire nationally to worsen CCG financial positions by including the payment of historic of cumulative deficits. System control totals based on place are likely to be future way forward and therefore a resolution will need to be found to the funding of both commissioner and provider historic deficits.	4	2	
Budget management risk											
• The CCG has been issued formal directions by NHS England, requiring the CCG to improve its financial and governance weaknesses	CCG	> Additional oversight and scrutiny from NHS England > If performance doesn't improve the CCG could be placed in the capped expenditure process	4	3	**12**	> Strengthening the CCG's financial and governance arrangements through the ICH > CCG and Council should begin considering governance and reporting requirements with this in mind. > Section 75 financial framework in place	Shared	Mitigations ok. Whilst formal process carries with it an increased level of scrutiny by regulators, the Wirral system is likely to volunteer to enter a system budget process which should bring the benefits of the CEP process without increased formal regulation.	3	2	
• Residual funding remaining in separate original organisations (e.g. prescribing budget, funding which cannot be delegated), alongside the pooled ICH budget, will prevent joint, integrated realignment and maintain original organisational identities	Council CCG	> Current behaviours and cultures maintained > New ways of working disincentivised > Potential biases towards original organisations maintained	1	2	**2**	> Clear governance arrangements e.g. new joint board > Strong branding and joint organisational development > Integration of workforce	Shared	Mitigations ok. Joint OD programme will be key.	1	2	
• The lead ICH Commissioner could innately or overtly prioritise the funding of services from their 'old' organisation rather than for the benefit of the ICH overall, preferentially redirecting funding back to its old organisation	Council CCG	> Independent assessments of the best funding allocations for services and service investments not obtained > Potential conflicts between ICH members > Financial performance reported with respect to services offered by the original commissioning organisations will be skewed, unfairly affecting any risk share arrangements	2	3	**6**	> Strong governance arrangements required e.g. new joint board > Clear accounting treatment should be put in place, with joint recommendations for investment > Strong cultural identity in the ICH > Open book accounting	Shared	Mitigations ok. Early work from WHaCC/ Strategic Joint Commissioning Board, appears to show levels of transparency, honesty and integrity which will sustain the organisation through challenging times.	2	3	
• If the decision to integrate commissioning is reversed, disbanding the ICH could lead the Council being left with the residual costs of new interventions, without joint funding to support these recurrent costs	CCG	> ASC will experience large funding pressures as there will be insufficient income and Council budget to meet the additional recurrent costs in place in the system	5	2	**10**	> Contractual provisions to manage exit arrangements from the ICH which consider the Council's statutory position to fund ASC	Shared	Mitigations ok. Legal advice for both parties would need to be sought on exit arrangements, reconcile to Memorandum of understanding agreements.	4	2	

Potential Risk	Which organisation presents this risk?	Potential impact	I	L	RAG rating	Potential mitigations	Where risk should sit in the ICH	WHaCC response	I	L	RAG rating
CHC / complex care risk											
• Large discrepancies in joint vs fully funded packages of care compared to peer benchmarks means a re-baselining of CHC costs is likely to be required • Both parties face a significant financial pressure in relation to people with Complex Care needs. Current plans to meet these pressures are not aligned, leading to disputes for individual cases	Council CCG	> Current CHC working practices, assessment practices and/or classifications are inappropriate > CCG will experience an overspend in its CHC costs in 17/18 if ASC is to meet its efficiency saving requirements > Additional savings may have to be made from elsewhere, which might not be achievable > CHC budget may be underfunded	3	3	**9**	> Assessment and funding approvals process and criteria should be reviewed, with joint assessment implemented where relevant > Re-benchmarking of joint vs fully funded packages of care may be required in line with benchmarked peers, in order for an appropriate baseline to be passed into the ICH > Risk share arrangements to incentivise joint working > Open book accounting > Open discussions had between commissioners > Budget adjustments made if necessary	Shared	Since November 2017, greater collaboration and understanding of the commissioning of packages of care has taken place between the CCG and the LA. Increased resources have been put into this area, and whilst there is still a significant savings challenge, efforts are now centred on appropriateness of the packages and associated costs, as opposed to who pays.	1	3	
• Fully funded CHC budgets have overspent annually since 2014/15, with a significant overspend of £4.5m delivered against all Out of Hospital care services 2016/17	CCG	> Current CHC working practices and/or CCG budget management for CHC are inappropriate and require revision	5	3	**15**	> Joint review of CHC and other Out of Hospital costs to determine why overspends have been delivered > Agreement on realistic recurrent cost pressures with regards to these services	Shared	Mitigations ok, see above.	3	3	

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