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.)

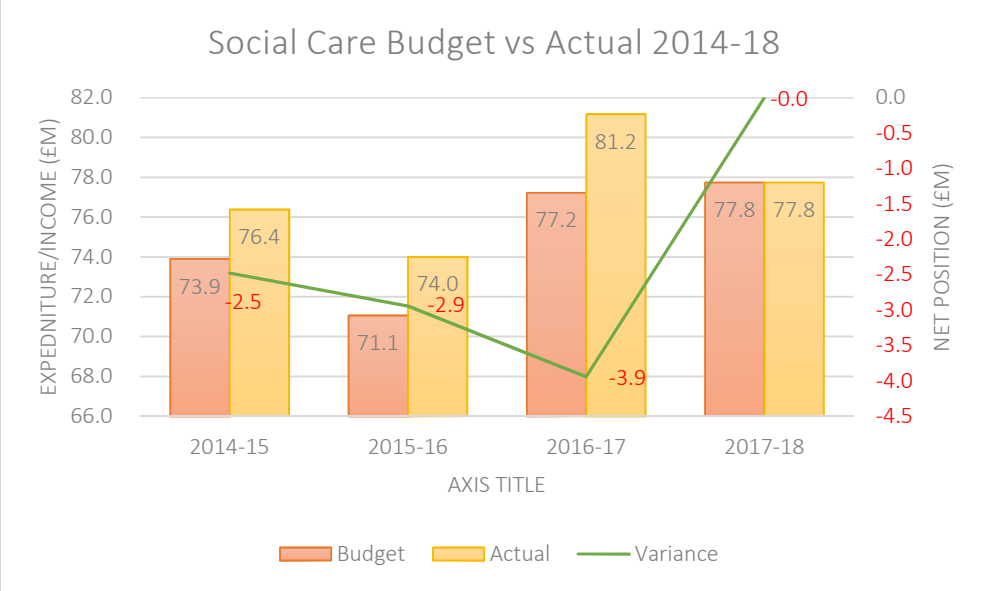
- Fully funded CHC budgets have overspent annually since 2014/15, with a significant overspend of £4.5m delivered against all Out of Hospital care services 2016/17
- Both parties face a significant financial pressure in relation to people with Complex Care needs. Current plans to meet these pressures 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:



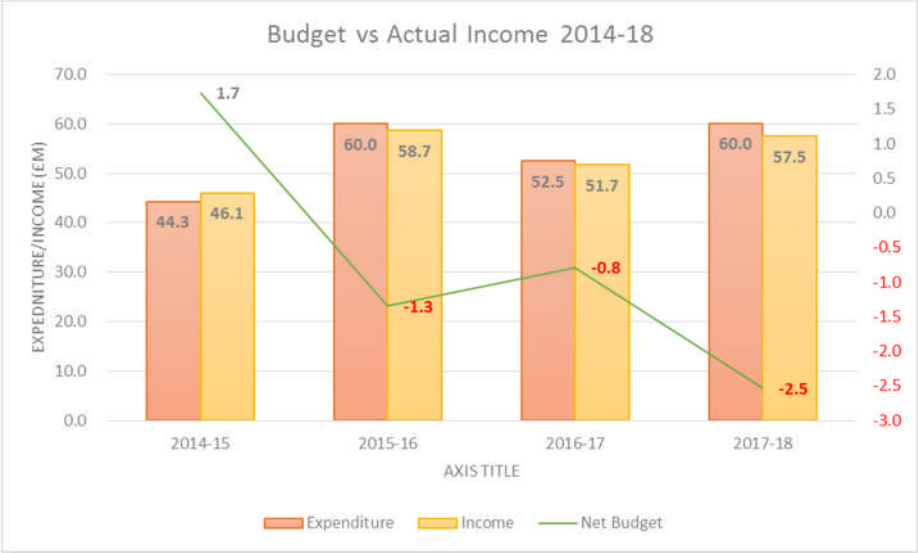
Key observations include:

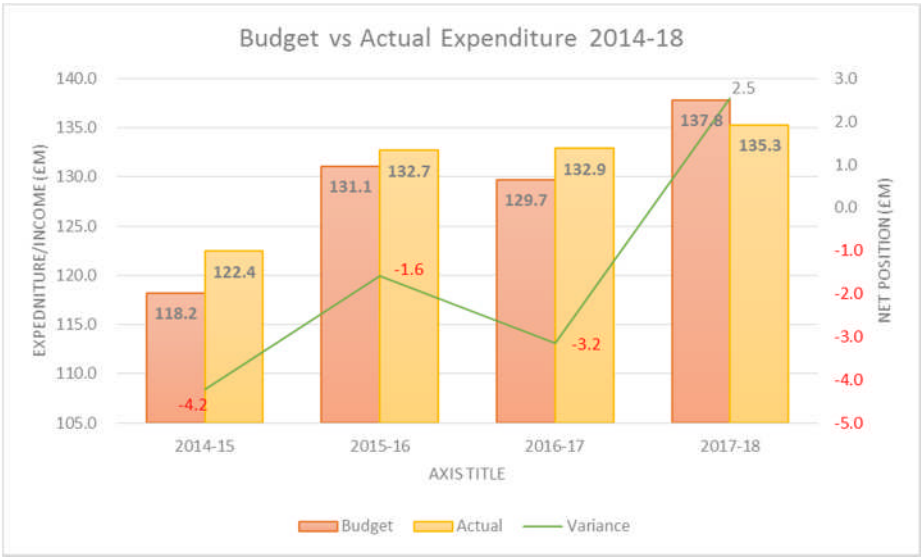
- Social care service expenditure has exceeded budget every year since 2014, with the net annual deficit increasing year on year from £2.5m to £3.9m.
- Net budget and actual social care spend has trended upward between 2014-15 and 2016-17, despite a dip observed in 2015-16 (in part due to savings requirements 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)

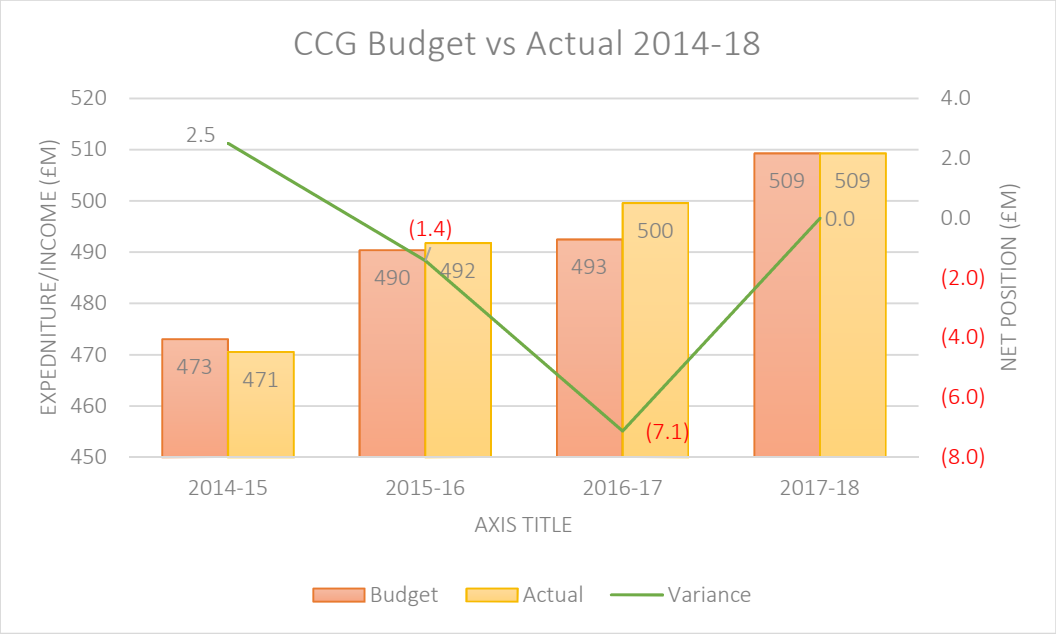
- **Risk to CCG: Despite delivering savings of over 5% of net budget funding annually since 2014/15, social care services have not met their annual saving target since 2014/15, with this target being missed by as much as £7.5m. 'One-off' savings of £2.6m and £1.9 have been required to support savings 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.

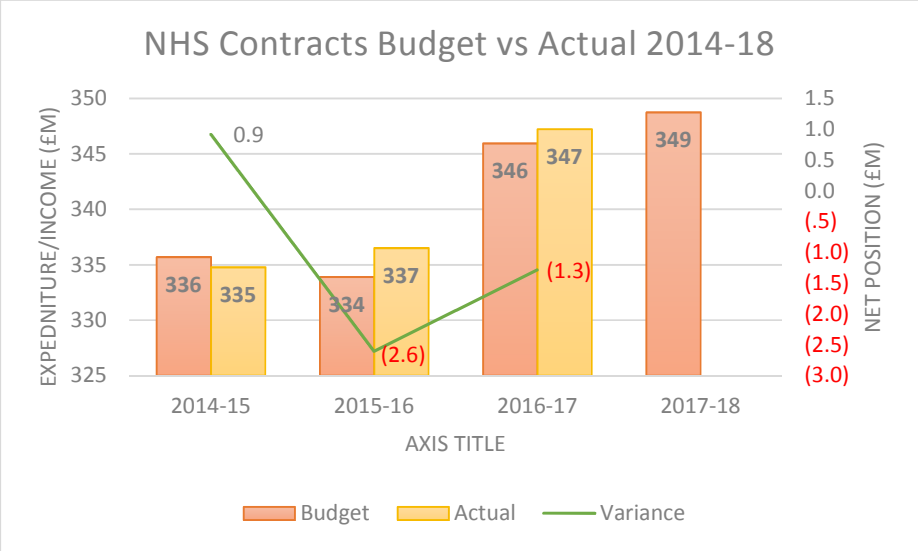
- **Risk to Council: Wirral CCG is forecasting a break-even position for 17/18, despite it reporting annual overspends since 15/16 (£1.4m deficit in 15/16 rising to £7.1m deficit in 17/18)**

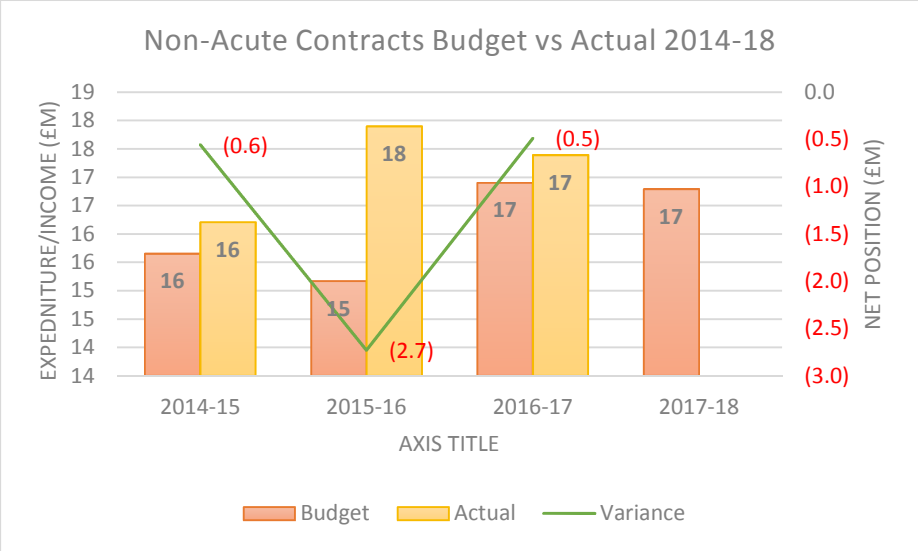
  We recommend: *Both parties prudently anticipate that based on historic performance a break-even budget position will not be delivered in 2017/18, and pooled funding plans are made with this in mind. Both parties should keep the other informed of their performance throughout the financial year. Risk 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

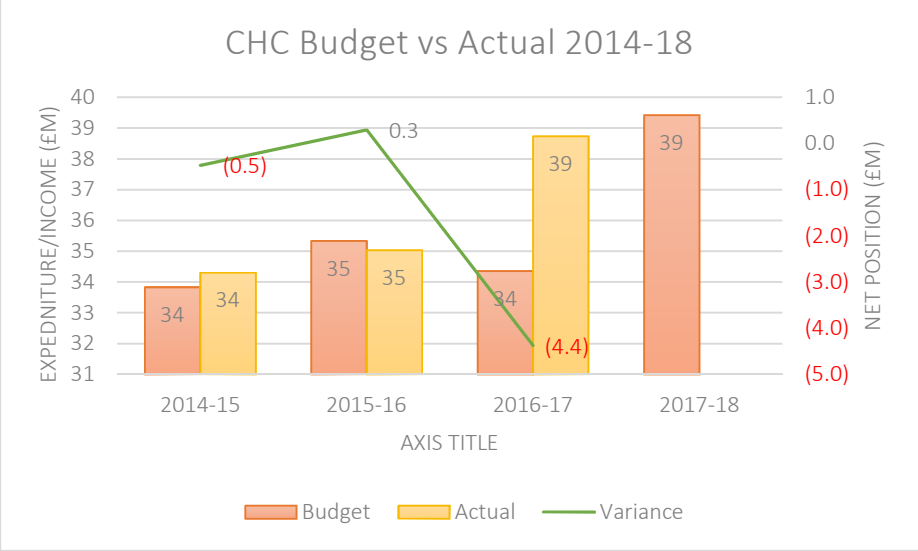
The Council and CCG both contribute to the long term care needs of clients and patients across the Wirral, through the funding of Joint Packages of Care (equally funded by the Council and CCG) and Continuing Healthcare services (fully funded by the CCG). Complex and long term care services expensive 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.