

Key issues for clinical commissioning groups

March 2016 – Our seventh briefing paper summarises the current key issues facing the sector and the solutions being adopted across the country, drawing on sector insight as the external auditor to 35% of the clinical commissioning groups (CCGs)

We have been discussing many issues with our clients recently which fall in to the following three categories:

- 1 **Emerging issues** – which have emerged during 2015/16 and have risen in importance
- 2 **Stubborn issues** – which have existed from when CCGs were established and have refused to go away
- 3 **Issues on the horizon** – which we are discussing at some clients but are likely to grow in importance in the future

Emerging issues

Co-commissioning of primary healthcare

NHS England gave CCGs the opportunity to assume greater power and influence over the commissioning of primary medical care from April 2015. This was one of a series of changes set out in the 'NHS five year forward view' and is potentially a key enabler in developing integrated out-of-hospital services based around the needs of local populations. It also potentially drives the development of new models of care such as multispecialty community providers and primary and acute care systems.

The document 'Next steps towards primary care co-commissioning' provided three models CCGs could take forward:

- 1 greater involvement in primary care decision-making
- 2 joint commissioning arrangements
- 3 delegated commissioning arrangements.

In 2015/16 64 CCGs were given full approval on their applications for delegation, while 87 CCGs were approved for joint commissioning. 52 CCGs who opted for joint commissioning in April 2015 are now working towards full delegation from April 2016.

Where CCGs have taken on additional responsibility we have seen new governance arrangements develop to help minimise the risk from conflicts of interest.

We have helped CCGs through our conflict of interest workshops which have proven a great way of preparing for ways to deal with this risk.

The challenges we have seen in primary care co-commissioning to date include:

- management capacity due to the need to restructure and build skills and knowledge in the CCG team
- relationships with the membership when the CCG is managing the performance of GPs and resolving any conflicts of interest
- reflecting the inherent risk of primary care budgets within financial plans.

New models of delivery

Commissioners have to balance many competing requirements, one of which is the need to fulfil the vision of the 'Five year forward view'. CCGs were given the opportunity to bid for funding from NHS England to develop and co-design new models of care "Vanguards", creating one of five prototype models.

The different organisations within each pilot need to work more closely, share patient information and remove the need for repeated health assessments. The chosen pilots involved five models:

- 1 **Integrated primary and acute care systems (PACs)** brought together GP, hospital, community and mental health services. Money will be directed from a joint budget to wherever patients are judged to need it most. One example is the Salford Together Partnership which includes the local CCG, City Council and the local acute and mental health foundation trusts. There is also support from the local GP provider consortium
- 2 **Multispecialty community providers (MCPs)** brought specialist services – such as chemotherapy and dialysis – out of the hospital and closer to people's homes. This includes the Vitality Partnership which operates across Birmingham and Sandwell and aims to develop a health and social care system accessible through GP practices
- 3 **Enhanced health in care homes** will enable the NHS and councils to work together to provide more healthcare in care homes and better preventive services

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- 4 **Urgent and emergency care (UEC)** – 8 additional Vanguards were announced in July 2015 to develop new approaches to improve the co-ordination of services and reduce pressure on A&E departments. Examples include the Solihull Together for Better Lives and South Devon and Torbay System Resilience Group
 - 5 **Acute care collaboration** – 13 Vanguards were announced in September 2015 which are designed to link local hospitals together to improve their clinical and financial viability. An example of this is the Salford and Wigan Foundation Chain

We are currently assisting CCGs in many aspects of this process, including the development of a vision and plan for all the organisations involved as well as a financial model. Organisations are identifying learning points all the time and these include the increasing need for new governance arrangements to be developed.

As the Vanguard schemes are established there may be a challenge in having two different models of care being commissioned and delivered by the CCG. A further challenge is that the development of the Vanguard schemes is taking place at the same time as other major developments, for example devolution.

Governance

It is fair to say this has been a staple issue since the creation of CCGs and most CCGs have carried out some form of review of their governance arrangements, typically at the end of their first year. However we have seen this emerge recently as a much more significant issue due in part to the attention afforded it by NHS England and the extension of the 'well led' framework to CCGs.

The introduction of co-commissioning has also been a driver to re-look at this area and we have consequently seen a large upsurge in CCGs asking for help. Our own governance review process has provided many CCGs with objectivity, insight and best practice. Our upcoming annual NHS governance review summarises our conclusions on the current state of NHS governance and includes good practice from our client base.

The role of the audit committee is a key forum for good governance. Our recent publication 'Audit committee effectiveness review 2015 : Knowing the ropes' teases out those qualities and actions necessary for an effective audit committee. Above all the role of this committee and how it relates to other committees needs to be understood throughout the organisation.

Sustainability and transformation plans

Following the publication of the 'Five year forward view', the NHS-wide planning guidance for 2016/7 was published on 22 December 2015. The guidance is relevant to all NHS bodies and sets out the national priorities for 2016/17 and longer-term challenges for local systems, together with financial assumptions and business rules.

The NHS England Mandate for 2016/17 sets out the objectives for the NHS as a whole, not just for commissioners with emphasis on planning by place.

All organisations are required to construct and submit two separate but linked plans:

- 1 **A sustainability and transformation plan (STP) by end June 2016** – a five-year plan from October 2016 to March 2021 for the local health and care system. This is a place –based plan for the local population and must reflect local health and well-being strategies
- 2 **An operational plan for 2016/17 draft by 8 February 2016** – this is organisation specific and forms the first year of the STP.

The plans must address three gaps:

- 1 the health and well-being gap
- 2 the care and quality gap
- 3 the finance and efficiency gap

NHS England require each area to set out governance arrangements for agreeing and implementing a plan. This included the nomination of a named person who will be responsible for overseeing and coordinating their STP process – a senior and credible leader who can command the trust and confidence of the system, such as a CCG chief officer.

To access funding in 2016/17 through the Sustainability and Transformation Fund, providers need to meet certain conditions such as delivering an agreed control total in 2016/17, improving access standards and working with commissioners on sustainability and transformation plans which need to be agreed with NHS England and NHS improvement early in 2016/17.





Stubborn issues

Financial pressures and underlying deficits in future years

A greater number of CCGs are reporting potential overspends in 2015/16, some of which are significant. However the large majority of CCGs (around 80%) are still reporting a balanced position in 2015/16, albeit with a heightened risk than last year.

The picture is still much better than in provider trusts where 63% are forecasting a deficit in 2015/16 and in some cases very significant ones. The position also varies nationally, being worse in the Midlands and Eastern Region and better in London.

Our [second bulletin](#) provided detail on good practice financial reporting. Many CCGs continue to struggle to deliver planned QIPP schemes. Typically we see around 20% of QIPP schemes remaining undelivered while in some cases QIPP delivery was only achieved through non-recurrent means. This non-delivery is increasing financial pressures in 2015/16.

CCGs have responded to the QIPP challenge by bolstering project management capacity and putting greater emphasis on real engagement with clinicians. There is some desire to see good practice examples of identifying and managing QIPP schemes more successfully. Some CCGs have highlighted that QIPP has previously been seen to be a 'finance issue'.

A key development this year has been the wider involvement of the CCG as a whole to identify and deliver individual schemes. We have also seen an improvement in project management capacity to deliver schemes. More detail on managing QIPP schemes and ways in which we can assist were set out in our [first bulletin](#). As CCGs develop their QIPP schemes for 2016/17 it is important for CCGs to evaluate the effectiveness of their current QIPP programme and build in lessons for the future.

Given the increasingly challenging financial position all CCGs are facing, it is worth reflecting on what we have found when reviewing CCGs in-year financial reporting. The importance of clear and transparent financial reporting to governing body members has never been greater. Reporting can help in the making of well-informed commissioning decisions as well as highlighting risks to the financial position of the CCG.

In reviewing financial reports across the country we generally find that they are easy to locate on a CCG's website; they are well-presented with use of graphs and timely with many presented to the governing body within a few weeks of the period under review.

The majority of reports reviewed clearly set out the in-year financial position, but this is rarely linked to the CCG's medium-term financial plans. There is a risk that the delivery of the in-year financial position may be masking underlying budgetary issues which should be raised through the regular reporting of the medium term position.

Typically most of the monthly reports we review set out savings targets and achievement to date. What is not always clearly provided is an explanation as to what is deemed a recurrent or non-recurrent cost saving. Without the quantifiable impact of non-recurrent savings being set out clearly, there may remain some uncertainty on their impact on future years budget plans.

CCG finance reports usually include reference to the risks to in-year financial performance. Some of the better reports include separate sections on the key financial risks, and state the monetary values against those risks identified. Some reports also set out the mitigating actions that are taking place and different sources of finance to cover the risks. It is also good practice to keep the governing body aware of the actions that have taken place to address risks, including whether this action has been successful.

Capacity and ensuring commissioning support services are high quality and deliver value for money.

The demanding agenda CCGs are managing means that their overall capacity is being stretched. CCGs are therefore investigating options to address this capacity gap such as the use of legislative reform order to create 'mergers' or 'joint committees'. Many more are moving to shared management teams between CCGs.

CCGs report differing experiences with their clinical support units (CSUs). A large number of CCGs are still questioning whether CSUs are providing the services they require at the right price, particularly in relation to support provided in continuing healthcare and business intelligence. We have seen many CCGs bring some services in-house whilst re-tendering the bulk of CSU services. In the West Midlands for example this will lead to significant change of provision from April 2016.

The lead provider framework developed by NHS England went live from February 2015 and [our fourth bulletin](#) set out details on what CCGs should be doing and how we can help.





Integration and the Better Care Fund (BCF)

The challenge remains to make the plans work by building positive working relationships between CCGs and councils at a local level. We have used our unique position of working with both bodies to facilitate discussions to assist the process of both building relationships and reviewing plans to manage the transition from existing arrangements to more integrated relationships in a number of areas.

The announcements in the November spending review re-iterated the fact that the BCF is very much a key Government initiative. The review promised to expand the pooled funds. While the NHS mandated contribution will be maintained, councils will be given an additional £1.5 billion by 2019/20 to put into the fund. Councils will also be able to raise an estimated additional £2 billion through a new social care precept which could add up to 2% to their council tax income.

In some areas there is emerging good practice with BCF performance dashboards demonstrating clear improvements in patient outcomes. Although we have seen the inevitable problems of differences in culture and working practices, we are now starting to see benefits and things happening which would probably not have happened otherwise. Trust which has been a major issue between the two sectors seems to be improving but, as yet, it appears that the BCF has made only a limited impact on its key objective of keeping patients out of acute hospital settings unnecessarily.

The BCF is only one aspect of the drive towards greater integration. The integrated personal commissioning (IPC) programme was set out in October 2014 and went live in April 2015 with the first wave of nine demonstrator sites – such as Tower Hamlets – enabling over 10,000 high-need services users to gain control of their own integrated health and social care budgets.

Accounting for the BCF and partnership arrangements could create some fairly complex accounting and governance issues.

In many areas the value of funds committed to pooled budgets is highly material. It is important that both CCGs and local government get the accounting right and agree timetables for sharing financial information that meet the organisations respective reporting arrangements. The risk is that if the accounting is not consistent it could lead to material errors within accounts and also between bodies. This would create difficulties within the NHS agreement of balances exercise, for the whole of government accounts consolidation process and also for the audit of the accounts.

Grant Thornton is running several seminars nationally considering the accounting issues around BCF and pooled budgets, the first of which was in the South West on 13 January 2016. It was well attended by finance officers from councils and CCGs in the South West. By bringing representatives from both sectors together it was possible to facilitate a consistent approach to accounting and to enable some action planning to take place.

The seminar also highlighted the wide variety of pooled budget arrangements that were in operation and also the varying controls that were in place. The pooled budgets reported in 2015/16 need to ensure that they correctly reflect the substance of the agreements that have been signed by the participating bodies. We set out further detail in Appendix 1.

Provider trusts

Concerns continue to grow on the financial stability and performance against contracts of provider trusts. At some trusts very significant deficits are emerging. Not surprisingly, these issues are translating into relationship difficulties in some areas. Many trusts cite poor relationships with their CCGs as a cause for the problems they are having.

Whatever the truth, there is often scope to build on the quality of these relationships. In addition, CCGs are also expressing concerns on the quality of care and performance, such as difficulties achieving the four hour waiting time target for accident and emergency. Many CCGs have raised concerns over the quality of data they receive from the trusts they commission and the uncertainty this presents in managing the contracts.

Issues on the horizon

Devolution

With firm devolution plans in place in nine geographical areas covering a wide range of services, including: health and social care; transport; housing investment; and skills and with more deals to follow, we focus in particular on two of the more advanced devolution areas of Greater Manchester and Cornwall. Both of these 'devolution deals' include health and social care and are therefore of great interest to many CCGs looking to maximise working with local partners.





Greater Manchester – The devolution deal in relation to health and social care continues to develop. The strategic partnership board is made up by representatives from the 12 CCGs, 15 NHS trusts, 10 local authorities, local voluntary services and Healthwatch. The board has been described as the ‘cornerstone’ of the new decision making structure for health and social care in Greater Manchester. Meetings are streamed live, enhancing the transparency of decision making in relation to health and social care within Greater Manchester.

The final draft of the Greater Manchester health and social care strategic plan 'Taking charge of our health and social care in Greater Manchester' was issued in December 2015.

The strategic plan sets out the challenge to be met – that without radical change by 2021 more people will be suffering from poor health within Greater Manchester but the area will be facing a £2billion shortfall in funding for health and social care services. It also recognises that actions should not just be limited to health and social care but across a range of public services to ensure people can 'live well'.

The plan sets out the challenges to be faced and the journey so far, along with early implementation priorities. The main part looks at the 'reimagining' of services across the whole care system in Greater Manchester including:

- upgrading population health prevention
- transforming community based care and support
- standardising acute and specialist care.

The plan, which is part of the overall preparation for the region taking full responsibility for the devolved £6billion health and social care budget, has been built on the ten locality plans submitted jointly by NHS organisations and Councils within the ten boroughs.

Cornwall – In July, Cornwall became the first rural authority in the country to be offered a devolution deal. The Cornwall Devolution Deal, which was signed by the Secretary of State for Communities and Local Government; the Leader of Cornwall Council, the Chair of the Cornwall and Isles of Scilly Local Enterprise Partnership and the Chair of NHS Kernow CCG, gives Cornwall greater powers over public sector funding including health and social care.

The deal sets out that local partners will work with the government, NHS England and other national partners to co-design a business plan to move towards integration of health and social care across Cornwall and the Isles of Scilly bringing together available local resources to improve outcomes for the local population. The deal also highlights that NHS England and local organisations will remain accountable for meeting the full range of statutory duties.

Cornwall Council and NHS Kernow are currently seeking the views of residents to help shape the future of the services for both adults and children. Through an online survey and a series of community events across Cornwall and the Isles of Scilly during March the aim is to help ensure plans being developed are focused on the things that matter to the local populations.

London – In December the 'London Health Devolution Agreement' was published. The London Health and Care Collaboration Agreement sets out how government and national bodies will support the overall vision of transforming the health and care system in the city on a gradual basis. The parties in the agreement are:

- all London CCG's and local authorities
- the Greater London Authority
- a number of national parties including HM Treasury, the Department of Health (DH), Department for Communities and Local Government (DCLG) and NHS England.

Initially there are five pilots focused on different aspects of health and social care including:

- Lewisham pilot to integrate physical and mental health alongside social care
- Hackney to run a health and social care integration pilot, aiming for full integration of budgets and service provision
- development of an accountable care organisation across Barking and Dagenham, Havering and Redbridge.

The future of clinical commissioning and collaborative commissioning

How clinical commissioning will look going forward is a key issue. Specialised commissioning and co-commissioning are already impacting on how CCGs operate. New care models are seen as an opportunity to address existing barriers and will change how services are commissioned.

The drive to focus on whole pathways of care and outcome-based commissioning aims to transform the way services are provided. All this will change the way services are commissioned and will require CCGs to have the skills, capacity and structures to meet the challenges. Many CCGs will be involved in changes in specialised commissioning. Currently NHS England is responsible for commissioning 147 specialised health services in England and spending £14 billion. These are commissioned by four regions 'The 'Five Year Forward View' talked about specialised providers developing networks of services over an area, integrating services around patients, using innovations such as prime contracting and delegated capitated budgets.





For example in cancer, chemotherapy, support and follow up care could take place in local community hospitals or primary care. This process, referred to as collaborative commissioning, should improve patient experience and access to services. These new collaborative arrangements will be co-designed with CCGs, but CCGs will be able to choose how much involvement they want in the local sub-regional collaborative committees and are not required to invest additional funding. 2015/16 is a developmental year and whereas there are plans to transfer funding and services back to CCGs in the next two years, this is only in a few specialities.

Over the long run there will be a move towards population accountability and lay the basis for “place” based on population budgets which will improve financial incentives and reduce demand.

The future provision of GP services

There are many significant challenges effecting primary care services including reduced funding, workforce recruitment, CQC inspections and increased demand caused, by amongst other things, an ageing population with increased multiple morbidities. As a result many GP practices and CCGs are considering whether current structures are appropriate going forward. This has generated an increased interest in new models of working across boundaries, as discussed earlier, but has also led to the creation of GP federations in many areas. Many of these federations have had financial and other support from the host CCG. This has generated conflicts of interest which needed to be closely managed particularly where GP companies were tendering for contracts with the CCG. One merger in Birmingham has created a particularly large GP practice with over 35 practices.

Grant Thornton has assisted some of the larger practices and federations in developing their arrangements such as business planning and tax management. Grant Thornton is running a roundtable discussion on the future of primary care in our Birmingham office on 11 March 2016. This event will share current thinking and good practice from progressive CCGs. We will share the findings of this event nationally afterwards.

Health HACKs

A HACK is an event over a dedicated period of time where different people are brought together in one place to use their combined knowledge, wisdom and experience to find new solutions to existing problems. Increasingly health organisations in the UK and internationally are using HACKs to consider the delivery of health and social care issues.

A recent example was the Central Cheshire HACK where NHS Vale Royal CCG, NHS South Cheshire CCG and a host of other organisations from the public, private and voluntary sectors looked at the ways that health and social care can work together. The HACK was held over an intensive period of time on Wednesday 27th and Thursday 28th January, starting at 1.30pm and finishing at midnight on day one and then starting again at 7.30am on day two.

The members of the group spent time finding solutions to ways we can move care into the community and keep people out of hospital using the funds and money already available.

This is the first time the CCGs have brought such a broad range of people together, from the CCG's senior management team to occupational therapists working in the community and from innovation experts at companies to representatives from audit and financial services, including Grant Thornton.

The event created a sense of energy and offered different approaches to tackle the challenges faced by the area on health and social care. This alternative way of looking at the issues led to the development of ideas such as a personalised health passport which encourages people to look after themselves through exercise and activity, and a single point of contact for healthcare professionals. This single point of access would provide a ‘one-stop-shop’ of information for health care professionals to ensure the best support for patients both leaving hospital and already in the community.

Even after the formal event had closed, the HACK continued with conversations and ways to share ideas through social and digital media, including Twitter #CCSRGHACK and the Central Cheshire HACK 2016 page on Facebook.





Technology in health care

The role of technology in improving health care is an on-going issue. Often discussions focus on large scale projects such as paperless NHS records and the role of big data. Increasingly there is an opportunity to make better use of simple technology. For example NHS Liverpool CCG found that a ‘telehealth’ scheme reduced unscheduled admissions by 20%. Smartphones and other handheld devices are becoming increasingly affordable and health monitoring apps are becoming more advanced. Taken together there is an opportunity for governing body discussions to include asking how can technology support our change. As governing bodies consider the role of technology, the discussions may assist completing their local digital roadmaps and understanding their digital maturity index which is due to be published in March 2016.

One of the key steps in identifying where technology can support clinical pathways is to engage clinicians in the re-design of the pathway. Where technology works well there are improvements in the work experience for the clinician as well as the smooth delivery of care to the patient. Challenges remain such as how to create a seamlessly integrated care record that is accessible to all health workers treating the patient including those in community settings.

Department of Health/HFMA guidance on auditor panels

In September 2015 DH published guidance – jointly prepared with the HFMA – advising NHS trusts and CCGs on meeting their statutory duties in relation to auditor appointments under the Local Audit and Accountability Act 2014. The guidance confirms that

2017/18 will be the first year for which auditor panels will appoint the external auditor at NHS trusts and CCGs. Larger local government bodies appointing from 1 April 2018.

The guidance explains the legal requirements in relation to auditor panels and gives advice on how CCGs can fulfil their responsibilities and summarises the regulations which state that:

- an auditor panel member may receive remuneration
- the quorum is two members or 50% of the membership of the panel (whichever is the greater)
- the auditor panel should advise the health service body on the purchase of non-audit services from the auditor
- an auditor panel must have at least three members, including a chair who is an independent non-executive member of the health service body’s governing board/body
- the governing board/body must assess a prospective auditor panel member’s independence by considering whether his or her circumstances could affect his or her judgement.

As appointments for 2017/18 must be made by the end of 2016, your auditor panel needs to be in place early in 2016 so that it can fulfil its responsibilities in relation to the procurement and appointment of auditors.

Nationally we have seen CCGs just start to consider how they are approaching this. Most are looking at working together with other CCGs to procure jointly. Where this happens all CCGs need to separately look at what they want from their external auditors and ensure that each CCG’s viewpoint is covered in the procurement process. The terms of reference of the audit committee may need to be adjusted for this.

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Accounting for Better Care Fund

The better Care Fund is a significant development in the Government's aim to integrate health and social care. Local arrangements may be complex and CCGs need to consider their specific arrangements in determining the correct accounting treatment

The Better Care Fund (BCF) was implemented under The Care Act 2014 (the Act) and came into operation on 1 April 2015 for the 2015/16 financial year. The BCF originally envisaged a single local pooled budget to facilitate NHS organisations and local government working more closely around people, by placing their well-being at the centre of health and care services. The aim of the fund is move care from hospitals into the community to improve clinical care, provide a better patient experience and reduce costs.

The Act requires CCGs to establish joint arrangements with local authorities to operate a pooled budget, established under section 75 of the NHS Act 2006 (a s75 agreement). BCF pooled budget arrangements can be complex and varied. It is important for all members of the pooled budget to have a clear understanding of the contractual arrangements as well as their own and other parties' accounting and reporting arrangements.

Accounting considerations

The BCF accounting requirements depend on the nature of the s75 agreement and where the control for the individual funds lie. 'International Financial Reporting Standard (IFRS) 10 Consolidated Financial Statements' sets out a definition of control. A body controls arrangements if it has:

- power over the arrangement
- exposure or rights to variable returns (including contribution to service objectives)
- ability to use its power over the arrangement to affect the amount of the investor's returns (including contribution to service objectives).

'IFRS 11 Joint Arrangements' refers to the definition of control in IFRS 10. The pooled BCF budget could consist of a number of funds under one s75 agreement with differing arrangements. Each fund within the pool needs to be considered separately to determine where control lies.

Lead commissioner arrangements – where one party has all the control

Indicators that one party has been given control (and is acting as a principal rather than an agent):

- host/lead selects providers and can agree/vary contracts unilaterally
- host/lead holds providers to account, other parties hold host/lead to account
- host/lead subject to greater risks than other members.

Joint arrangement – where there is shared control

Indicators of joint control (one party, the host, acts as agent for the others):

- unanimous decisions – any member can veto any agreement with a provider
- all members hold providers to account for delivery
- risks are borne equally (in line with s75 agreement).

The type of risks that may be considered are inventory risks, credit risk and provider price fluctuation. It is important that all parties agree where control lies and the resulting accounting treatment.

Accounting requirements

Lead Commissioner – host as principal

If there is a lead commissioner arrangement, members of the pool will have agreed to pass decision making on relevant activities to one body. If this is the case the lead commissioner would account for all income, expenditure, receivable balances and payable balances with other parties and with providers. Other parties to the fund would record income, expenditure, receivable balances and payable balances with the lead commissioner/host.

Joint arrangement – host as agent

Accounting for a fund as a pooled budget with joint control will follow 'International Financial Reporting Standard (IFRS) 11 Joint Arrangements'. Under IFRS 11 the host doesn't account for contributions into the pool as income and other members do not account for contributions to the pool as expenditure. All parties account for their share only of income and expenditure with the provider and account for their share of receivable and payable balances with the provider.

Where cash is held in the pool, members account for their share of cash held by host as a debtor receivable and the host accounts for others' share of cash in pool as payables. In terms of cash balances, CCGs should not draw down significant amounts of cash in advance of need, so should not pay cash into the pool in advance of its expenditure. Having a working cash balance in the pool is acceptable, the Manual for Accounts says members will wish to keep such balances at a minimum but discusses a working balance of one month. Cash held by the host is accounted for as cash by the host and if the host is a CCG it will count towards their cash balances.



Disclosures

The disclosures for the BCF come under 'IFRS 12 Disclosure of Involvement with Other Entities'. Members should disclose information that enables users of its financial statements to evaluate the nature of, and risks associated with, its interests in other entities and the effects of those interests on its financial position, financial performance and cash flows.

Where material to the understanding of the accounts, members should disclose:

- significant judgments concerning relationships and control
- identity of partners
- purpose of the partnership
- gross income and expenditure of any pool
- their share of income and expenditure of any pool.

Other considerations

Where there is a joint arrangement with joint control the individual members are responsible for the regularity of their share of expenditure. The other members will therefore need assurance from the host that appropriate procedures have been followed and supporting information is made available. The host will also need to notify the other members of risks, incidents and improvements to the pool arrangements that need to be reflected in the individual members' governance statements.

The deadline for local authority accounts is 30 June, so where the host is a local authority, members will need to work with the host to obtain the required information in good time to achieve the NHS closedown timetable. A memorandum account should be maintained by the host and provided to all members with appropriate working papers. Members can include the memorandum account in their financial statements if they wish to do so.

How else can we help?

To assist with managing BCF pooled budgets we:

- **provide joint workshops for CCGs and local authorities** – these help CCGs and local authorities within an area to develop a shared understanding of the different structures for pooled budgets and the accounting requirements in each case. We help you to determine what actions are required to account correctly for the pooled budget and what NHS and LG partners need from each other
- **act as a critical friend** to provide support to CCGs in assessing BCF related governance arrangements.

Our experience

Combining our wealth of experience in the areas of good governance and health, drawn from working with 33% of public sector health bodies, we understand the importance of supporting CCGs to use their autonomy and flexibilities effectively in a way that also shows integrity, reassures the public and secures value for money for patients.

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