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Leading Social Services in Wales

ASSOCIATION OF DIRECTORS OF SOCIAL SERVICES CYMRU

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Advice Note 3 – Practicalities of Partnership Development

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Introduction

1. The purpose of this chapter is to provide advice concerning the development of formal partnerships and pooled budgets.

2. Integration should be based upon local system efficiency and capacity to meet service user needs. This means acting in concert with staff and budgets streamlined towards simpler delivery, not just seeming to plan together.

> **Key Message – Always seek legal advice**
> This and other advice notes in the series, together with any attachments, should not be used as an alternative to obtaining independent legal advice as appropriate. The advice notes are intended as aids to the consideration of what might be required.

Why are formal partnerships necessary?

3. Firstly, the delivery of public sector services requires clearly defined roles and accountabilities. Each agency, NHS and local authority involved in the delivery of support to service users will have a defined set of legal responsibilities.

4. The agencies are not necessarily empowered under such legislation or their insurance arrangements to deliver or coordinate care for the other, or to use their resources for the other agency's responsibilities.

5. Partners should always understand the need to establish whether or not their staff are legitimately enabled to undertake each-other's functions and manage each-other's budgets and assessment related services or not. Part 9 Agreements (or Section 33 Agreements) permit such arrangements if a full written agreement is completed between the partners.

> **Question**
> If you have joint posts (e.g. joint managers) between health and social services (outside of a Part 9 Agreement/Section 33) what are the governance arrangements?
> For example, what are the arrangements for accountability if there is a critical incident?

6. Where the partners and their staff are not specifically enabled without a Part 9 (or Section 33) Agreement to do so, they should not attempt to carry out a function of other partners as they have no acquired authority to do so. Failure to comply with this could lead to significant difficulties for both partners if there were a serious complaint or a critical incident.

7. A Part 9 (or Section 33) Agreement, is a written agreement that must comply with certain statutory directions on content and which, therefore, forces the partners to agree joint priorities and targets, what resources are needed, the types of services required and what outcomes are to be met. They will of course also need to agree how the partnership arrangement is jointly overseen and controlled. (see Advice Note 4 on Governance).

8. The partners can then bring together different funding streams so that providers and their service users do not need to apply separately to different funds or services, ensuring monitoring arrangements are less bureaucratic.

9. Joining up resources for commissioning and provision also ensures that the partners are focusing on meeting the needs of a person, rather than holding discussions on who should pay for what. This is particularly valuable when new models of care ae being introduced and there is a gain for the whole care economy.

What criteria can be used to help decide if a formal partnership and or a pooled fund may help?

10. Here are some simple questions that may help to ask yourselves:

- What are the needs of people in need of care and support?
- Do we have a comprehensive understanding of demand and the drivers of demand across the health and social care system?
- Do we have an understanding of how resources (health, social care, etc) are allocated across the system?
- Does the system work in terms of providing effective services; making effective use of resources; enabling staff to work efficiently and effectively?
- What are service users, carers and other involved bodies telling us about desired improvement?
- Can we achieve the desired change on our own?
- Will we meet agreed needs based upon current ways of operating?
- Do we have a joined-up approach to assessing the needs of individuals in need of care and support and their families?
- Do we have effective mechanisms in place for agreeing joint funded care and support services? Alternatively, do we have a range of separate organisational panels who have to sanction their organisations contribution? How does improve effective timely decision making?
- Will it improve the opportunity to provide a single point of care and contact that is tailored to individual needs?
- Does it make sense to combine our resources to arrange the services?
- Will it be more efficient in terms of offering improved outcomes for users / carers and or make better use of resources?
- Will it reduce bureaucracy?
- Will it generate savings or improved productivity?
- Does it make sense to operate with a single workforce model with an integrated workforce plan to be developed over time?
- Do we want staff to be able to carry out each other’s duties as well as our own, subject to competencies, direction and training?
- Will partnership working improve opportunities for staff?
- Will it aid recruitment, retention and morale?
- Is there a simpler, more effective way than partnership that is safe?
- Will it help to integrate care budgets for staff to manage and arrange care?
- Where are partners interdependent? – e.g. Interdependency of commissioners e.g. funding nursing home placements. Many placements are jointly funded and where many are wholly funded by the NHS (funded via Continuing Health Care) they rely upon the same service providers.
- Will joining together our plans with any of our budgets, staff and contracts help?

11. It will be important to ask the questions across a range of client groups e.g. children with a severe disability or chronic illness; people with learning disabilities; older people, people with mental health problems, etc.

Written Agreement

Partners

12. The Partnership Regulations state that for use of any of the flexibilities under Section 33 of the NHS (Wales) Act 2006, the partners' agreement must be in writing and specify:

    - The agreed aims, objectives and outcomes of the partnership;
    - The contributions to be made by each of the partners and how these may be varied;
    - The NHS functions and health related functions of local authorities which are subject of these arrangements;
    - The persons the service is for and the kinds of arrangements they can expect;
    - The staff, goods and services or accommodation that are also to be provided in support of the arrangements;
    - The duration of the arrangement and provision for review or termination of the arrangements;
    - How the arrangements are to be monitored, and in the case of pooled fund arrangements, how they are to be managed.

13. A Part 9 Agreement also requires a written agreement but the guidance is less prescriptive than a Section 33 Agreement. The format of a Section 33 Agreement can be used for a Part 9 Agreement.

14. The written agreement must be between an NHS and local authority body. There is no limit to the number of these statutory partners.

15. Given that the essential feature of such an agreement is that it should delegate functions from one partner to another and in many cases, this may also include delegation of considerable resources, it means that the agreement should have a legal context. Therefore, for both parties, early involvement of their legal advisors is crucial to the drafting.

16. The headline elements of a model Part 9 Agreement are included at the end of this chapter. The National Commissioning Board has also published a draft Partnership Agreement in relation to care homes for older people[i]. Moreover, the Better Care Fund in England has also published model Section 75 Agreement templates.[ii]

Statutory Partners and Functions

17. Partnership regulations govern the use of the flexibilities that are set out in Section 33 of the 2006 Act (See *The National Health Service Bodies and Local Authority Partnership Arrangements (Wales) Regulations 2000* (S.I.2000/2993 (W.193)).[iii] The regulations prescribe the statutory bodies in Wales that can be included in the partnership arrangements. The statutory partners remain the same for an agreement under Section 166 of Part 9 of the Social services & wellbeing (Wales) Act 2014.

18. The statutory partners in Wales can be unitary local authorities, NHS Trusts and Local Health Boards. There is no limit to the number of statutory partners and the partners do not necessarily have to operate in the same adjoining areas. However, if a local authority is in partnership with an NHS body whose boundary extends beyond the boundary of the authority, then the agreement will need to be carefully drawn so that the resources of the authority are applied only to the resident population of that authority. Authorities would not ordinarily spend money on services for citizens who reside outside the boundaries of the authority. In the case of home care services, for example, there is nothing to stop a local authority developing a partnership with its health board. However, its contribution would be confined to its own residents and the health board contribution could also be based upon a share of its budget, based upon individuals resident in that local authority area. The other local authority partners of that health board may not be ready to form such a partnership.

19. However, where a partnership delivers pooled services in one area and the health service straddles local authority boundaries, separate arrangements, according to the scale of the health service at the point of overlap, will be necessary for the NHS to provide care within another local authority's area. Here, there are several possibilities:

    - The NHS could develop similar agreements with that other local authority.
    - Where there are small amounts of activity within a single NHS service, it might agree to identify separately, the non-pooled element of their services that can still be applied to another area.
    - In the case of Care Homes for Older People, RPBs are already adopting a regional partnership approach to the development of contracts, specifications, etc. There is now a requirement for partnership bodies to establish and maintain a regional pooled fund in the exercise of their care home places and family support functions. (See section 'Case Study: Care Homes for Older People' in Advice Note 1 - Introduction to Integration).

20. Similarly, if that other local authority wishes, it could agree to pay for or purchase from another local authority, services to provide to its population alongside the NHS element in a cohesive fashion. The key test is one of reasonableness: lines of accountability should be clear and local authority budgets applied appropriately.

21. The range of functions that can be included is drawn widely and, on the local authority side, goes well beyond social services to embrace other health and care related services. There are, however, important exclusions. The local authority areas not covered by the flexibilities afforded under the legislation include adoption panels. On the health side, the exclusions include surgery, radiotherapy, endoscopies, termination of pregnancies, other invasive procedures and emergency ambulance services.

Objectives for Partnership

22. It is important to engage service leads within the public sector agencies, so that there is a clear and unambiguous understanding of what the intended deliverables of the partnership should be and what each partner is capable of delivering. Achieving a seamless, customer focused service, needs clarification in terms of the specific outcomes expected.

23. Once there is an agreement on what is required, then the partners should decide how best to accomplish the outcomes identified. This might mean changing current ways services are delivered by designing new single models for delivery of services. It might also mean the inclusion of:

    - Service improvement objectives – for example, effective mechanisms that can be implemented and evidenced in order to confirm links with other services, and which ensure that the needs of individual service users are met during the transition between services.

    - Objectives to improve quality and standards for services - for example, where relevant clinical / practice policies from partner agencies could be harmonised; this might generate new process design for assessment and delivery of care.

    - Human resources objectives – for example, to address the need for team development which support recruitment, retention, staff training etc.

    - Business objectives – for example, specific targets around activity, finance, identified risk or future change.

24. In removing barriers and achieving a real breakthrough to more user- focused service delivery, the pooling of resources, particularly the pooling of budgets, is one of the best and most underused options.

25. Here the partners should consider identifying a local currency to measure achievement against specific ‘local’ milestones that the partnership was established to deliver. (See section ‘Improving the range and quality of Management Information’ in Advice Note 4 on Governance).

The Pooled Fund Arrangement

26. The first task is to identify and agree the shared aims and outcomes that will be set out in the partnership agreement, regardless of the level of contribution each partner may commit. A pooled budget is a mechanism by which the partners commit to an agreement, with each contributing to the delivery of the outcomes required by creating a discrete fund.

27. The intention must be to enable flexibility in fulfilling the functions that are part of the pooled fund arrangement and therefore, the use of these funds. This is important to enable proper accountability in the use of the pooled fund.

28. The identification of resources that each partner will contribute to the pool is a key element in establishing a pooled fund arrangement and finance leads should agree the framework for financial contributions i.e. what is to be included in any contribution. (See ‘Determining Contributions to the Pooled Budget’ below).

29. Resources that can be contributed are generally those normally used for the services identified in the pooled budget but an essential step is to establish whether the individual contributions are based on past expenditure and if so, whether this is at the out-turn or at budget for spend. Furthermore, there needs to be an explicit understanding between the partners whether the contributions include overheads and other organisational inputs, such as training, IT and other management support.

30. No limit is put on the size of the pooled budget that may be created. However, the likelihood is that each partner will want to consider carefully the proportion of the total budget they feel they should commit, especially when they are using it in conjunction with the delegation of functions. Partners will need to balance the amount of flexibility that they want to enable through the pooled fund against the risk of being able to fulfil all service needs. It is important to remember that a pooled budget can encompass more than one service. It could, for example, encompass all services for people with learning disabilities.

31. The levels of contribution do not have to be equal and could depend on how each partner has historically met its obligations on a particular service or it could be linked, for example, to the relevant population base.

32. The contributions can be used on any of the services agreed as part of the pooled budget.

33. Partners will retain statutory responsibility for their functions carried out under the pooled fund. This means that the partnership agreement is carefully constructed between the partners to cover the governance arrangements, which address accountability, decision taking and how the budget is to work.

34. Comprehensive monitoring arrangements must be put in place that assure partners that their shared aims are being fulfilled.

35. The pooled budget can be hosted and managed by a statutory partner, or it can be hosted by a statutory partner and managed on their behalf by another organisation contracted to do so. The host will provide the financial administrative systems on behalf of the partners, but will not incur any additional liabilities, except those that relate to the management of the budget. Also, the external auditor will expect the same level of internal control to apply to the pooled funds as apply to other parts of the partner organisation. The auditor will also retain full right of access to the financial records and systems and expect a clear audit trail to be maintained for all financial transactions.

36. The partnership regulations note that the partners shall agree that one of them ('the host partner') will be responsible for the accounts and audit of the pooled fund arrangements and the host partner will appoint an officer of theirs (the pool manager) to be responsible for:

    (a) Managing the pooled fund on their behalf; and
    (b) Submitting to the partners quarterly reports, an annual return, about the income of, and expenditure from, the pooled fund and other information by which the partners can monitor the effectiveness of their pooled fund arrangements.

    The partners may agree that an officer of either may exercise both the NHS functions and health related functions, which are the subject of the pooled fund arrangement. The host partner will arrange for the audit of the accounts for the pooled fund arrangements.

37. One of the advantages of the pooled fund will be that health and local authority staff identified in the agreement, will be able to access and take decisions on the use of resources in the pool, according to the process agreed locally between those staff and the pooled fund manager. There will need to be an agreed process to authorise identified staff to do this. There are no legal obstacles to health staff using pool funds in the exercise of local authority functions and vice versa. Also, there is no limit to the number of partners, although each will wish to ensure that their resources are being used for their relevant population.

Determining Contributions to the Pooled Budget

38. Pooled budgets may reduce or even eliminate disputes over funding for packages of care. However, before they can work, the major challenge is to determine and agree the respective contributions of each partner organisation. There are many different approaches that might be adopted. One could begin by examining statutory responsibilities. In respect of nursing home placements, for example, statutory responsibilities are relatively clear with the NHS responsible for 'Funded Nursing Care' and 'Continuing Health Care'. The partners will need to agree responsibilities for funding any intermediate care or respite care commissioned from care homes. In other cases, precedent may be used in terms of looking at who has traditionally funded the service. Alternatively, if you are devising a protocol to determine responsibilities for a new service, it may be helpful to examine the skills and professional expertise required as a means of determining responsibilities and contributions.

39. There is no exact formula for this but a good starting point is to identify what is already being spent and any budgets for it. However, experience suggests that local systems cannot always identify existing spend by a process of pointing to existing fixed budgets already in place. In some cases, budgets may well have been managed in a way that makes expenditure on a particular service to be clearly identifiable. In other cases, expenditure and budgets may need to be disaggregated. When Community Equipment Services were integrated between health and social services (and some education services), it was very difficult to identify expenditure within the NHS because of the complexity of the organisation, with so many different clinics within hospitals and the community issuing equipment. Some form of audit may be required. Care activity can attract expenditure and payments to others that might be managed from different budget lines under different managers even within one organisation. It is therefore crucial that finance officers take an early role in the creation of any partnership arrangements. This is so that they might agree a common approach to budget building and a format for the identification of budgets, targets, reporting and financial governance and to help guide service lead officers into creating clear management information and options for the partnership pooled budget(s) to be developed.

40. Budgets for care arranged through others should be identified in conjunction with service provider information (this may require a jointly managed retrospective activity audit) so that through this, it is possible to track the total organisational spend committed from budget holders that may already be involved.

41. For staff to be placed within proposed integrated teams, it is helpful to start with identification of the staff establishment budgets and any associated care budgets managed by the staff. Budgets should include vacancies so that the full amount of the responsible resource for planning future workforce models is known and is available.

42. Partners should take a view on whether or not to include non-key costs already borne by the organisations but should carefully identify the budgets managed by staff that might migrate with them into a joint integrated service, so as to avoid creating new boundaries and delays in decisions that affect care arranging.

43. In addition to budgets for direct services, there will be a need to consider how the costs of various types of support should be dealt with. Whether they are included in pooled budgets or not will depend on the arrangements for delivery. So, if you are pooling a budget for integrated provision of particular services and the Finance and HR support to that service is clearly identifiable and separable, and the new provider has the capacity to take on the functions, you may benefit from transferring the staff and including their costs in the pooled budgets.

44. In other cases, it may be harder to separate out staff and budgets and a decision may be taken to continue to provide support to the delegated services from the delegating organisation. In this case, the notional costs of this support should properly be included in the pooled budget so that the full cost of services in question is clear, and payment by way of book transfer is made to the providing organisation from the pooled budget. For very small services, it may not be appropriate or practical to add any support costs into the pooled budget.

45. All of this disaggregating activity should lead partners to be able to agree baseline budgets, which should be recorded in the partnership agreement.

46. Each partner will agree a level of contribution. The contributions they commit can be used in any of the services specified in the pooled fund agreement. The pool will be managed to fulfil the agreed outcomes within the budget that may have been allocated.

Changes to the Levels of Contribution

47. It is usual for a Section 33 Agreement to state how contributions are made, how they can be varied and the timescales for notice of change of a contribution that is required unless both partners mutually agree a change. For a pooled fund, this is often cited as a minimum of 6 months or sometimes, one year. For a non-pooled (delegated contributions) this may often be cited as one month. The same principles apply to a Part 9 Agreement.

48. The agreement will state separately how any change in contributions in-year will not affect proportionality on surplus (if an increased contribution is made) and also will not affect any existing inherent liabilities towards contracts for service or employment liabilities already agreed in the course of the partnership.

49. The *Pooled Budgets Toolkit*,[iv] produced by the Department for Education and Skills, notes that the agreement also needs to set out how contributions to the pooled budget will be agreed in subsequent years. Key factors to consider include:

   - How the inflation factor to be applied to budget contributions will be determined. This does not have to be the same for all contributors to the pool but there needs to be an agreement about how each partner will determine that rate to be applied.
   - How pressures on the budget, other than inflation, will be dealt with.
   - How growth in budgets will be handled. This is from two perspectives, one where a partner wishes to contribute more to the budget to deliver particular new services and the other where growth in expenditure is required and the respective contributions of partners to that growth have to be agreed.
   - How the need for any partner to reduce their contribution to the budget in real terms will be dealt with.
   - End of year arrangements (e.g. agreeing year-end position, reporting requirements, etc). It is good practice to review (against agreed targets and resources) the performance of the partnership annually and to use this as an opportunity to confirm continuation with an update to any targets and resources for the next year ahead.

Financial Framework Consideration – Income from Charges

50. Income from charges to service users should also be considered when identifying budgets and it should be agreed whether or not the proposed pooled fund contribution is to be affected (positively as well as negatively) by income variation from charges or separated from the risk/opportunity when identifying the proposed operational pooled budget

51. Each partner is obliged to identify their contributions within the Partnership Agreement. For local authorities, this may include budgets where the spending commitment is dependent upon the level of income collected through charges which can create uncertainty and complicate financial management.

52. Commissioning through block contracting on a long-term basis or implementation of new service design arrangements needs to operate within an environment that is fairly secure for planning purposes. There are several ways to deal with this at the outset when the Partnership Agreement is drafted:

    - The local authority can predict, with norms, the level of income expected and budget for its contribution up to an acceptable level. It can absorb any risk internally and simply not refer to income collection, whilst committing a firm sum of money within the Partnership Agreement.
    - The local authority could then either then retain any opportunistic accrual of additional income it receives or pass that on to the partnership on a non-recurring basis as and when, such occasions occur.
    - The local authority can commit to a fuller contribution from the outset, at a risk of income collection. This seems unlikely.
    - The local authority can commit a basic contribution net of expected income and indicate the expected position on income for planning purposes but with arrangements to pass that additional income into partnership on a regular basis as it is collected.

53. The last may appear the most attractive but will require agreement between the partners on how they will deliver maximum strategic advantage without risk of shortfall in income.

Links to Financial Risk Management

54. The budget setting process will also need to link to any arrangements within the Partnership Agreement about the management of financial risk and the methodology for calculating relative shares of responsibility in any scenario.

55. The risk faced by each partner can be managed separately where, for example, a single partner is managing the social care budget and the health care budget alongside each other, according to separate but complementary targets. Here, any commitments made from one budget would be made with the agreement of the donor according to an agreed set of targets and objectives. Hence the risk can be tracked to that budget commitment formally. That budget could not be used for the other partner’s purposes without a pooling arrangement, as only in a pool can the barrier between the NHS and local authority duties be fully removed.

56. In a pooled budget, the normal assumption is that financial risk is proportionate to the overall contributions made. If the plan is to vary from that principle, that should be tested with auditors in advance in order to avoid local dispute or difficulties of accounting compliance later.

57. Thus, where the maximum possible local authority contribution is not clear and committed at the outset, partners may choose to limit the contribution they make to a pool or not adopt a pooling arrangement but instead have a Lead Commissioning or Integrated Service ‘management’ arrangement to be hosted by one partner. This would also then avoid any later risk of concerns about cross subsidisation within a pool because of income shortfall. Cross subsidisation can be addressed with the careful identification of contributions to the pool described above. As these arrangements become established, the funding will lose its label. It will not be a health fund or a social care fund but a pooled fund to allocate to meet the needs of individuals without doing battle about who pays.

Over and Underspends

58. The partners should consider and define at the outset, not just the contributions but also the process for reporting on and managing surpluses and deficits, including relative responsibilities where a deficit that might occur.

59. Then the responsibility of the host partner is to manage the fund resources according to what has been agreed and within the resources available plus, delivering the reporting for that function.

60. It does not necessarily follow that because there is a deficit that each partner will bear a liability proportionate to their original contribution of cash to the pool, neither does it follow that each partner will automatically derive a share proportionate to their original contribution of cash to the pool if there is a surplus. In both cases, proportionality should be the first point of agreement and the relative shares for this should be set out in the original agreement at the outset, along with any variation to reflect contributions adjusted over time.

61. If the money has simply all been expended on prior agreed forms of activity, then any further activity that needs to be met must either be covered by additional contributions from partners (if they discuss and agree to do so) or by the partner responsible for the statutory assessed needs and clients as yet unfunded. **Unfunded care is not the responsibility of the pool or the host if the money is not available within the pool.** The pool needs to be managed like any other budget, to provide services whilst staying within the resources available. If each organisation has to budget for a contingency that the pool will overspend, then the pool is not working properly.

62. **No pooled fund can be used to transfer (or cap) any additional statutory liabilities from one partner to another for any care and cost not fully resourced.**

63. The fund is limited to what can be afforded within the available resources the partners have committed to its design for operating.

64. In managing the fund, it is important to provide regular forward reporting on spend and projected out-turn along with governance arrangements that allow the two partners to meet regularly and review expenditure, targets and outcomes and discuss projected demands. Monitoring requirements should specify that any projected overspends or underspends should be drawn to the attention of the partners at the earliest possible opportunity, with reasons for their occurrence and options to address them. Dialogue at the earliest possible stage will enable partners to manage this before financial year-end.

65. Sometimes partners may agree in advance as part of the Part 9 Agreement, some level of permissible overspend ('risk') that will be accepted automatically and retrospectively, in the circumstances where an urgent decision about client care has been required and where it was difficult to make contact between the partners immediately at the time required. However, such circumstances will be extremely rare, and any such pre-agreed budget tolerances might be limited to say, an agreed small percentage of the overall budget. Such a policy will also need to accord with individual partner organisational risk management and financial governance policies and should never be assumed without agreement.

66. Where an unforeseen overspend arises at year-end, the partners will need to consider how best to fund this and its implications for future years. Such additional funding will be in proportion to the partners respective contributions to the pooled fund unless agreed differently.

67. Unforeseen or fortuitous underspends at year-end will normally be available to the partners in the first instance if required by them, in proportion to their contributions to the pooled fund, or, if not required, will be managed into the following year by the host authority, pending agreement by the partners on future use of the funds.

68. Where an underspend is planned and agreed with the specific aim of carrying it forward for a stated purpose in the following year, then it is for the partners to agree if, and how, this can be achieved within their cash control mechanisms.

69. The partners may wish to agree arrangements for the planned withdrawal of funds e.g. due to budgetary pressures elsewhere the partners may wish for an underspend in the pooled budget, for transfer back into mainstream budgets. Such arrangements should be set out explicitly in the agreement. The partners will need to agree whether such withdrawals are recurrent or non-recurrent in nature.

Access to Funds – Authorisation of Expenditure

70. One of the advantages of a pooled budget is that local partners identified in the agreement can access and take decisions on the use of resources in the pool, according to the process agreed locally between those staff and the pooled fund manager.

71. There will need to be an agreed process to authorise identified staff to do this. They will assess each individual case in line with the eligibility criteria for services which are part of the agreed functions to be fulfilled. There are no real obstacles, for example, to health staff using pooled funds in the exercise of local authority functions, and vice versa, and this needs to be clearly outlined in the agreement.

Annex 1 – Draft Partnership Agreement

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[iv] Department for Education and Skills, *Pooled Budgets Toolkit*, 2006.