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Pooled budgets and the better care fund

Guidance

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Contents

Introduction	3
Relevant legislation and regulations	3
Overarching legislation	
Individual funding streams	
Governance arrangements	4
Operational structures	4
Hosting	
Signed agreement	
Information requirements	
In-year changes to plans	
Financial arrangements (in-year)	7
General considerations	
Further considerations for the host	
Further considerations for other parties to the pool	
Financial arrangements (year-end)	8
General considerations	
Further considerations for the host	
Further considerations for other parties to the pool	
Assurance	10
Nature and sources of assurance	
Underlying data	
The outcome	
Appendix 1: Section 75 and the associated regulations (SI 2000/617)	12
Appendix 2: Example financial summary	18
Appendix 3: Accounting for a pooled budget	19
Appendix 4: Essential measures and controls	22
Appendix 5: Pros and cons of sources of assurance	23
Appendix 6: Further reading	23

This guidance looks at the governance and finance issues underpinning the operation of a pooled budget that CCGs and local authorities need to be discussing now to go live on 1 April 2015

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1 Temple Way, Bristol BS2 0BU

T 0117 929 4789

F 0117 929 4844

E info@hfma.org.uk

www.hfma.org.uk

Introduction

1. Launched through the Spending Round in June 2013 and highlighted as a key element of public service reform, the better care fund (the fund) has a primary aim to ‘...drive closer integration and improve outcomes for patients and service users and carers’¹. The fund will be set up as a pooled budget - a type of partnership arrangement whereby NHS organisations and local authorities contribute an agreed level of resource into a single pot (the ‘pooled budget’) that is then used to commission or deliver health and social care services.

2. This guidance looks at the relevant legislation and regulations that underpin the operation of a pooled budget and the governance and finance issues that clinical commissioning groups (CCGs) and local authorities need to be discussing now in order to be ready for ‘go live’ on 1 April 2015. It also considers the accounting arrangements that will apply and need to be thought through in advance of preparing the signed agreement that will underpin the pooled budget.

3. The purpose of this guidance is to provide an overview of the governance and accounting issues associated with the operation of the fund. It is not intended to replace or override statutory guidance, accounting standards or prescribed accounting and governance best practice for both NHS and local authority bodies. It is each body’s responsibility to determine the appropriate governance and accounting treatment for their pooled budget based on their circumstances.

4. This guidance takes account of the information available at the time of writing (September 2014). More detailed guidance will be made available by NHS England over the course of the next few months.

Relevant legislation and regulations

Overarching legislation

5. The better care fund operates within the context of existing legislation, the key elements of which are:

● **Section 256 of the NHS Act 2006**, which allows for a transfer of resource between health and local authorities but not a transfer of functions. A contribution is made to support specific local authority services without a delegation of health functions. This power is used at the national level by the Department of Health to transfer funding from the health vote to local authorities, although it is also available to CCGs to transfer funds.

● **Section 75 of the NHS Act 2006**, which allows local authorities and NHS bodies to operate pooled budgets (directly replacing section 31 of the Health Act 1999). This is the legislation that allows the establishment of pooled budgets between NHS bodies and local authorities at a local level (see Appendix 1).

● **Statutory Instrument 2000 617 (SI 2000/617)**, which sets out the regulations governing pooled budget² arrangements between NHS bodies and local authorities (see Appendix 1).

● **Section 195 of the Health and Social Care Act 2012**, which requires health and wellbeing boards (HWBs) to ‘encourage persons who arrange for the provision of any health or social care services in that area to work in an integrated manner’. In particular, HWBs must provide advice, assistance or other support for the purpose of encouraging services to be provided under section 75 of the NHS Act 2006.

6. It should be noted that section 75 is applicable only to prescribed health-related services and prescribed local authority services. It precludes CCGs from delegating any functions relating to family health services, the commissioning of surgery, radiotherapy, termination of pregnancies, endoscopy, the use of Class 4 laser treatments and other invasive treatments and emergency ambulance services. For

local authorities, the services that can be included within section 75 arrangements are broad in scope although detailed exclusions exist. It is therefore imperative to check that services considered for inclusion in the pooled budget can be incorporated legitimately and that no ultra vires spending is incurred.

Individual funding streams

7. The fund is comprised of a number of existing funding streams (as part of 2014/15 allocations to local authorities and CCGs) with legislation and regulations governing each as follows:

● **Disabilities facilities grant (DFG) – £220m** This is capital money made available to local authorities as part of their allocations to award grants for changes to a person’s home. There is a statutory duty for local housing authorities to provide grants to those who qualify. This part of the fund will be governed by the disabilities facilities grant conditions of grant usage as made by the Department for Communities and Local Government (DCLG) under section 31 of the Local Government Act 2003³. Therefore, although officially part of the fund, the money cannot be used for other things and will be paid back out of the fund to the relevant local authorities.

● **Social care capital grant – £134m** This is capital funding made available by the Department to local authorities to support investment in adult social care services via a direct grant allocation from the DCLG. The Department and the DCLG will issue conditions of use of these grants under section 31 of the Local Government Act 2003⁴.

1 NHS England Publications Gateway Ref No. 01977, July 2014

2 The statutory instrument refers to a ‘pooled fund’ as opposed to a ‘pooled budget’; this guidance uses the term ‘pooled budget’ as this is how such arrangements are known

3 See NHS England planning guidance at tinyurl.com/oe77mhc

4 The conditions of the 2014/15 grants are set out in LASSL(DH)(2014)1 See tinyurl.com/q7lb28f

Given that CCGs and local authorities have different statutory bases, it will be for each partner to consider the regulatory impact of the decisions made

● **Carers' break funding – £130m**

This is funding currently included within CCGs' baseline allocations to support long-term carers. CCGs' general financial duties are set out in sections 223G to K of the NHS Act 2006; section 223GA specifically refers to funding used for integration of health and social care⁵.

● **CCG reablement funding – £300m**

This is funding currently included within CCGs' baselines to support integrated working with local authorities in order to reduce avoidable hospital admissions and facilitate more timely hospital discharges.

● **Funding already transferred by NHS England** to support social care in 2013/14 and 2014/15 (£1.1bn) using section 256 of the NHS Act 2006.

8. To these funding streams will be added existing NHS revenue funding from allocations to CCGs in 2015/16 (amounting to £1.9bn at a national level) to give a total pooled budget of at least £3.8bn from 1 April 2015⁶. Some £135m of this funding is to be used to fund additional costs incurred by local authorities as a result of the new duties imposed by the Care Act 2014. These duties relate to new entitlements for carers, the national minimum eligibility threshold, advocacy services and safeguarding duties.

9. Although the better care fund will operate as a pooled budget, the conditions attached to each funding stream will still have to be met. For example, where funding such as the DFG has been earmarked for a particular purpose, it must be used only for that purpose. This may have implications for the related accounting arrangements.

Governance arrangements

10. Although the pooled budget is created from allocations to CCGs and local authorities, the arrangements do not constitute a delegation of statutory responsibilities. These are retained by the CCG governing body and the local authority cabinet/executive.

11. The governance arrangements for

the better care fund will therefore have to meet the requirements of all partners to achieve economy, efficiency and effectiveness in their use of resources⁷. Each partner will also need to satisfy itself that the pooled budget complies with the requirements of its appropriate code of governance⁸ and annual governance reporting guidance.

12. Each partner must also satisfy itself that all other regulatory requirements are met – for example, that discrete funding streams are only spent appropriately at a local level. Partners therefore need to make arrangements to ensure that that is happening.

13. Given that CCGs and local authorities have different statutory bases, it will be for each partner to consider the regulatory impact of the decisions made. This is likely to be more onerous for the CCGs in the partnership as they work within a tight regulatory framework: they are required to meet both NHS England and the Department's reporting requirements, and their auditors are required to express an explicit opinion⁹ on the regularity of their transactions.

Operational structures

14. It is for each local area to determine the operational structure for their local pooled budget. As it has been required to sign off better care fund plans, the HWB provides the means for ongoing oversight.

15. However, consideration needs to be given as to whether the operation of the pooled budget would be more appropriately managed through a formal subcommittee of the HWB – for example, an 'integrated commissioning executive'. If this model is used, the pooled budget agreement could be prepared by the integrated commissioning executive and ratified by the HWB.

16. Below this 'integrated commissioning executive' could sit a delivery team/programme management office focused on operational and financial delivery supported by work

5 Guidance on CCG allocations can be found here: www.england.nhs.uk/2014/03/27/allocations-tech-guide/

6 More money can be pooled locally than the minimum requirement

7 For local authorities, this requirement is set out in section 3 of the *Local Government Act 1999* and for CCGs, section 14Q of the *NHS Act 2006*

8 For local authorities, the CIPFA/SOLACE *Delivering Good Governance in Local Government: Framework and for CCGs*, HM Treasury's *Managing Public Money* and the UK Corporate Governance Code

9 The regularity opinion states whether in the opinion of the auditor transactions included in the financial statements conform, where appropriate, with the legislation that authorises them; regulations issued by a body with the power to do so; Parliamentary authority; and HM Treasury authority

streams for specific schemes and programmes within the pooled budget.

17. The precise arrangements are likely to vary, depending on whether the local authority is coterminous with a single CCG or has a number of CCGs operating within its area. However, such a structure would allow adequate focus on the detail of the pooled budget at an appropriate level and representation from all local health and social care partners, both commissioner and provider. This structure would need to be accompanied by formal delegation arrangements to enable decisions to be made at an appropriate level.

18. The introduction of the better care fund may also mean significant changes to the agenda for HWBs. Consequently, it may be necessary to revisit the membership and terms of reference of the HWB itself to ensure both are appropriate to support the implementation of the pooled budget from 1 April 2015.

19. The governance and financial reporting arrangements will be heavily influenced by the operational structures, so it is important to think through what approach is likely to work best.

Hosting

20. The regulations require that one of the partners is nominated as the host of the pooled budget and this body is then responsible for the budget's overall accounts and audit. The decision as to which partner is to host the pooled budget should be made locally and based on the most appropriate operational requirements. However, the relevant finance department will also need to consider the impact of issues such as:

- **Value Added Tax (VAT)** The arrangements for NHS and local authority bodies are very different. It is expected that further guidance will be issued by NHS England in relation to VAT arrangements.

- **Accounts closedown timetable** NHS bodies are subject to a short

timeframe for the preparation and audit of their accounts, with final completion by early June. Local authorities have longer to prepare their accounts.

- **Ledger arrangements** Local authorities determine their own financial ledger arrangements, whereas CCGs are required to use the Integrated Single Finance Environment (ISFE) operated by NHS Shared Business Services on behalf of NHS England. Consequently, there is little local flexibility for CCGs to determine their own coding structure.

- **Charging arrangements** Local authorities are able to charge for certain services whereas NHS services are free at the point of delivery.

21. One issue that partners may wish to consider when determining the operational arrangements is the fact that culturally, NHS bodies and local authorities may be different. Care should be taken not to assume that operational arrangements will work in a particular way.

22. The host body will have delegated powers but will need to be able to work within the reporting and management environments of all members of the partnership.

Signed agreement

23. The signed agreement for the pooled budget forms the basis of the governance arrangements and needs to set out clearly and precisely what the overall aims are; who is responsible for what and the associated plans for reporting and accountability. Issues that warrant particular consideration when drawing up the agreement include ensuring that:

- There is a common understanding of the pooled budget's aims.
- Statutory responsibilities of all partners are understood and will be met.
- There is clarity over what is and is not covered by the arrangement.
- Decision-making responsibilities are clear.
- The amount of contribution, both financial and non-financial, to be

To support the measuring and reporting of performance, it is necessary to identify information that might be required so that it is collected from the outset

made by each partner is clear, both in terms of amount and the timing of payments.

- The criteria for making payments for performance are determined.

- There is clarity around which organisation manages the pooled budget and who has the power to commit expenditure (including details of approval levels). This should include consideration of the contracting arrangements. For example, when the provider is an NHS body then the standard NHS contract should be used as it meets all contractual requirements, including those of the Commissioning for Quality and Innovation (CQUIN) scheme.

- There is accurate and timely reporting of financial and non-financial information, including the specification of performance metrics, outcome measures, the partner responsible for production and the accompanying deadlines. To that end, the agreement needs to detail the local 'operating rules' for the above in relation to:

- The pooled budget as a whole
- Individual schemes
- In-year reporting of the cumulative/ year to date position
- The year-end forecast
- Cashflows
- The point of recognition for contributions to, expenditure on and subsequent variances in relation to:

- A budget for a whole service where it is part of the better care fund
- Performance-related payments
- Contributions made to larger budgets from the fund, such as in support of nursing or residential homes. For example, if the larger budget overspends, does the fund take a 'hit'?

24. These budgets could be for both revenue and capital expenditure. Where they are for capital expenditure the relevant capital accounting regime must be taken into account.

25. The agreement should be reviewed regularly to ensure that

the arrangement remains relevant to local circumstances and that all those involved are working towards the same goals.

Information requirements

26. To support the measuring and reporting of performance, it is necessary to consider and identify the information that might be required so that it is collected on a regular basis from the outset. This information will be financial and non-financial in nature and is likely to comprise some or all of the following:

- Total emergency admissions (non-elective admissions, general and acute), which is mandatory as it underpins the single pay for performance metric
- Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population
- Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services
- Delayed transfers of care from hospital per 100,000 population
- Patient/service user experience
- The proportion of people feeling supported to manage their (long-term) condition
- Estimated diagnosis rate for people with dementia
- The proportion of patients with fragility (hip) fractures recovering to their previous levels of mobility/ walking ability at 30/120 days
- Social care-related quality of life
- The proportion of adults in contact with secondary mental health services living independently with or without support
- Carer-reported quality of life
- The proportion of adult social care users who have as much social contact as they would like
- The proportion of adults classified as 'inactive'
- Injuries due to falls in people aged 65 and over
- Locally determined quality metrics as set out in the plan
- Spending versus budget by scheme

and provider for the year and the year to date, available on a monthly basis.

In-year changes to plans

27. In-year changes to plans must be subject to appropriate authorisation and approval including final sign off by the relevant HWB.

Financial arrangements (in-year)

28. In-year reporting is governed by the requirements of SI 2000/617 section 7 paragraph 4(b) as follows:

- In-year reporting of the performance of the pooled budget to the parties to the agreement must be undertaken by the host on a quarterly basis.
- The host (through a nominated 'pool manager') must provide quarterly details of income to and expenditure from the pooled budget as well as '...other information by which the partners can monitor the effectiveness of the pooled (budget) arrangements.'

29. In practical terms this means that CCGs and local authorities will need to consider a number of general and specific issues as set out below.

General considerations

- The role of the HWB and the in-year monitoring and reporting required.
- The level at which financial and non-financial performance metrics will be reported. For instance, where there is an agreement that is co-terminus with a single unitary authority and more than one CCG, it may not be possible for the local authority to report certain metrics at the CCG level. This is more likely to be the case with non-financial metrics such as service user experience, where the local authority may not be able to identify the CCG area where the service user lives. Where it is important that metrics are determined at a level other than the pooled budget level this should be identified at an early stage to ensure the appropriate data can be collected.
- NHS bodies should be mindful of the fact that their financial information will be consolidated nationally.

Experience shows that one barrier to smooth consolidation is different accounting treatments, particularly in relation to accounting on a gross or net basis. The default position in IFRS is gross accounting although there are exceptions. With this in mind, parties should consider maintaining all management accounts on a gross basis as it is easier to produce financial reports on a net basis from gross information than the other way around.

- Parties to the pool will need to appropriately reflect the better care fund in their risk register (associated risks including performance reporting). This should be a requirement of the signed agreement. In the first instance, this should be considered by those charged with governance in the CCG and local authority.
- Consider whether the pooled budget arrangement needs to be reflected in the internal audit programme based on materiality and risk. If those charged with governance consider this to be the case, then plans should be put in place for internal audit review of the pooled budget arrangements on an ongoing basis.
- All parties to the pool will need to discuss with their external auditors¹⁰ the assurances that will be required in order to sign off the year end accounts. This will be a particular issue for those bodies that are not hosting the pool because usually auditors will seek to rely on the work of the host body auditor. This is an efficient arrangement but does require co-operation in advance between auditors to determine the work to be performed and any impact on fees¹¹.
- For CCGs, the quality committee may consider the review of the quality of services delivered via the pooled budget.
- The host will be responsible for ensuring that the VAT arrangements are compliant with both NHS and local authority VAT regimes as appropriate.
- The host will be responsible for ensuring that appropriate capital accounting arrangements are applied as required.

10 At this stage, parties to the arrangement must be mindful of the changes to external audit arrangements following the enactment of the *Local Audit and Accountability Act 2014* dissolving the Audit Commission on 31 March 2015

11 Paragraph 5.3.7, *NHS Audit Committee Handbook*, HFMA, 2014

Consider the assurances that may be required in order to be able to sign off the relevant accounts

Further considerations for the host

- Appoint/nominate a pool manager whose role is covered appropriately by standing financial instructions/ prime financial policies and the scheme of delegation.
- Ensure arrangements are in place to deliver the quarterly reporting of:
 - Income
 - Expenditure
 - Performance information as data becomes available (via national and local data collection processes) to ensure that progress is transparent and can be regularly reviewed.
- Ensure the regular and timely receipt of performance reports by the HWB (an example financial summary is shown in Appendix 2).
- Ensure that where elements of the pooled budget are ringfenced for a particular purpose, the necessary supporting information is available to provide assurance that those elements have been used appropriately and to support the accounting arrangement applied.

Further considerations for other parties to the pool

- The CCG governing body and the local authority cabinet/executive needs to be familiar with the following:
 - The level of contribution to the pooled budget
 - What has been spent at a point in time
 - What has been delivered
 - How the pooled budget is performing in overall terms.
- Incorporate consideration of the information expected and received into the body's assurance framework.
- Consider where assurances that the information received in relation to the pooled budget is correct and accurate will come from.
- Identify who will review how the pooled budget is performing against planned outcomes, including the process for alerting the CCG governing body and the local authority cabinet/

executive at the first indication that matters are not as they should be.

- Consider what information is required to gain assurance that ringfenced elements of the pooled budget have been spent appropriately.
- Provide right of access to the records of the pooled budget for the auditors of all parties to the pooled budget. This is only to be exercised in exceptional circumstances as auditors will usually seek to rely on the auditor of the host body to maximise efficiency.

Financial arrangements (year-end)

30. There are various issues relating to the year-end financial processes that parties to a pooled budget need to consider in advance of the year-end itself. Although not an exhaustive list, it is helpful to examine the following:

General considerations

- Include in the signed agreement the deadlines as to what must be shared and by when in order to prepare the accounts recognising the difference in NHS and local authority year end reporting requirements.
- The accountable officer/section 151 officer¹² needs to consider the assurances that may be required in order to be able to sign off the relevant accounts that include the transactions relating to the pooled budget arrangement.
- The nature of a pooled budget in accounting terms (see Appendix 3 for more details) – it may be that it is a joint operation in accordance with IFRS 11 but it may be that the substance of the arrangement means it does not meet the standard's criteria for a joint operation. If the arrangement is not a joint operation then its substance should determine the accounting. It may be a lead commissioning or aligned commissioning arrangement.
- The likely impact on the governance statements of the parties to the pooled budget (these will differ depending on whether the organisation is the host or a contributing partner). For CCGs, the exact requirements for the governance statement will be for NHS England to identify. It is expected that CCGs will be

12 This officer is responsible for ensuring that his or her organisation operates effectively, economically and with probity; makes good use of their resources and keeps proper accounts

required to identify if there have/have not been significant issues relating to the operation of the pooled budget during the period covered by the statement. For example, if the pooled budget overspends during the year, this would be a significant control issue. However, other parts of the governance statement, such as those relating to internal control and risk management frameworks, may need to reference the pooled budget where it is high risk and material in nature.

● While records must be kept on a gross basis at the year end, it is envisaged that there will be one calculation setting out the net balance in the pooled budget and the ownership of this balance. Parties to the better care fund must agree its treatment in advance. CCGs cannot carry forward cash balances nor make payments in advance¹³. Therefore it is important that likely year-end balances are accurately forecast, so that action can be taken if necessary. If the partners envisage any surpluses to be held in the local authority accounts, so that they can be carried forward, the arrangement must be set up in such a way as to allow this to happen while not breaching the regulatory or accounting requirements with which all partners are required to comply.

● All parties will need to agree the information required by NHS bodies to undertake the annual agreement of balances exercise. As pooled budgets are not entities in their own right, no balances or transactions are with the pooled budgets; they are with the parties to the pooled budget. Guidance on 2015/16 agreement of balances will be issued by the Department and NHS England in due course.

● Consider the role of the auditor and the information they require to be able to give their opinion on the financial statements. The auditors of the parties to the pool will usually seek to rely on the host's auditor for this purpose.

Further considerations for the host

● **SI 2000/617 paragraph 7(4)** states that the host is responsible for:

- Managing the pooled budget

- Submitting an annual return to the partners about the income of, and expenditure to the pooled budget and any other relevant information.

● **SI 2000/617 paragraph 7(6)**

currently requires that the host body arranges for their Audit Commission appointed auditor to certify the pooled budget accounts. It is expected that this requirement will be repealed once the Audit Commission ceases to exist in March 2015. This should be kept under review.

- The host must review other requirements specified in the signed agreement and ensure compliance.
- To meet the requirements in relation to an annual return the host must prepare and publish a full statement of spending, signed by the accountable officer/section 151 officer to provide assurance to all other parties to the pooled budget. This is likely to include:

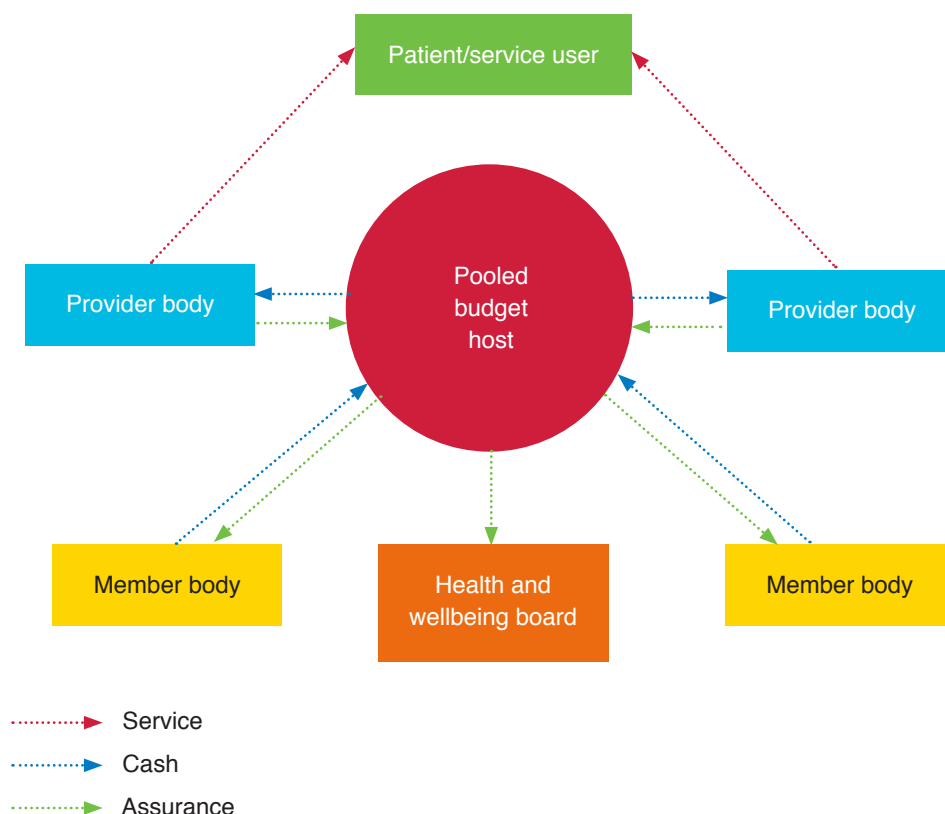
- Contributions to the pooled budget – cash or kind
- Expenditure from the pooled budget
- The difference
- The treatment of the difference
- Any other agreed information.

- The host should also liaise with other partners to identify if there is any other information they require for their year-end reporting and the corresponding date that it is required in order to meet external reporting deadlines.

Further considerations for other parties to the pool

- Where the better care fund is material (recognising that the pooled budget may be material to some organisations but not others), disclosure in the annual accounts will be necessary and this will be in the format required by the relevant accounting guidance for 2015/16. Partners will need to liaise with the host body to ensure that the relevant information is available in time to meet external reporting deadlines.
- NHS bodies may be required to provide information for consolidation

¹³ If the agreement states that any surplus on the pooled budget is held by the local authority at the year end, then CCGs need to satisfy themselves and their auditors that they have not drawn down cash in advance of need

Which bodies need to provide assurance to whom?

purposes even where the better care fund is not material to their own accounts. Therefore all CCGs will need to consider what information may be required for consolidation purposes and maintain their records accordingly.

- The signed agreement needs to reflect when the memorandum account will be available to the parties to the arrangement in line with the external reporting deadlines for each body.

Assurance

31. The better care fund is a high-profile policy. Key stakeholders include:

- The general public
- CCGs and local authorities, both as statutory organisations reporting to their own governing bodies but also reporting to the HWB
- NHS England and the Local Government Association
- Ministers from the Department and the DLGC.

32. In order to demonstrate the appropriate use of public sector money and the extent to which the pooled budget has achieved its aims, it is necessary to identify at an early stage which bodies will need to provide assurance to whom, as suggested in the diagram above.

Nature and sources of assurance

33. Those charged with governance in each statutory organisation identified above need to be able to obtain the right information and rely on it. This is particularly important for parties to the pooled budget (other than the host), where key information will come from another organisation.

34. It can be helpful to consider assurances in three broad categories:

- **First line** Management assurance from 'front line' or business operational areas

● **Second line** Oversight of management activity, separate from those responsible for delivery but not independent of the organisation's management chain – for example, the accountable officer or the section 151 officer

● **Third line** Independent and more objective assurance, including internal audit and from external bodies¹⁴.

35. The assurances themselves can take a number of forms (for example, outcome data, process data or reports from reviews carried out) and can be derived from sources that are both internal and external to the organisation concerned. These may include some or all of the examples in the table below¹⁵:

36. The pros and cons associated with internal and external sources of assurance can be found in Appendix 5.

Underlying data

37. Those charged with governance will need to assure themselves that the data underpinning the above assurances is robust. This involves looking beyond the messages received, critically reviewing the underlying data and ascertaining the source's reliability. Any gaps in assurance will need to be identified

and addressed. To that end, the following can be used to evaluate a data source:

- Is the data source valid?
- Is the data complete?
- Is the data up to date?
- Are the messages consistent with other information?
- How is data viewed by the organisation – is it trusted?

The outcome

38. Having identified the assurance and its source, and established the reliability of the underlying data, those charged with governance must then consider the results and their implications for the achievement of the pooled budget's objectives. It can be helpful to consider:

- Whether the overall objective of the pooled budget (or individual scheme if appropriate) is being met
- Whether the main controls are operating as expected
- Any agreed actions for improvement are being implemented.

39. A summary of the essential measures and controls considered as necessary in supporting the successful delivery of the better care fund as set out in this guidance is included as Appendix 4.

Different forms of assurances

Internal sources	External sources
Internal audit (financial and non-financial)	External audit
National and local metrics*	National and local metrics*
Performance reports	External benchmarking (review against local and national peers – as data becomes available)
Clinical audit	National and regional audits
Results of internal investigations	Peer reviews
Patient/ service user experience surveys and reports	Feedback from service users
NHS contract monitoring information	NHS contract monitoring information
Staff satisfaction surveys	Feedback from other partners
	Service auditor report (ISAE 3402)



***Note:** the performance of national and local metrics could be internal (for the host) or external (for other parties to the pool)

¹⁴ NHS Audit Committee Handbook, HFMA, 2014

¹⁵ NHS Audit Committee Handbook, HFMA, 2014

Appendix 1: Section 75 and the associated regulations (SI 2000/617)

Section 75 of the NHS Act 2006 allows the secretary of state for health to set out in regulations the arrangements that NHS bodies and local authorities can enter into to exercise their health related functions. Together the section and associated regulations set out the bodies that can enter into such arrangements. As this is the legislation that underpins all pooled budget arrangements it is important to understand what it says. Both the section of the Act and the regulations are copied below¹⁶.

Section 75 of the NHS Act 2006: Arrangements between NHS bodies and local authorities

(1) The secretary of state may by regulations make provision for or in connection with enabling prescribed NHS bodies (on the one hand) and prescribed local authorities (on the other) to enter into prescribed arrangements in relation to the exercise of:

- (a) Prescribed functions of the NHS bodies
- (b) Prescribed health-related functions of the local authorities, if the arrangements are likely to lead to an improvement in the way in which those functions are exercised.

(2) The arrangements that may be prescribed include arrangements:

- (a) For or in connection with the establishment and maintenance of a fund:
 - (i) Which is made up of contributions by one or more NHS bodies and one or more local authorities
 - (ii) Out of which payments may be made towards expenditure incurred in the exercise of both prescribed functions of the NHS body or bodies and prescribed health-related functions of the authority or authorities
- (b) For or in connection with the exercise by an NHS body on behalf of a local authority of prescribed health-related functions of the authority in conjunction with the exercise by the NHS body of prescribed functions of the NHS body
- (c) For or in connection with the exercise by a local authority on behalf of an NHS body of prescribed functions of the NHS body in conjunction with the exercise by the local authority of prescribed health-related functions of the local authority
- (d) As to the provision of staff, goods or services in connection with any arrangements mentioned in paragraph (a), (b) or (c)

- (e) As to the making of payments by a local authority to an NHS body in connection with any arrangements mentioned in paragraph (b)
- (f) As to the making of payments by an NHS body to a local authority in connection with any arrangements mentioned in paragraph (c).

(3) Regulations under this section may make provision:

- (a) As to the cases in which NHS bodies and local authorities may enter into prescribed arrangements
- (b) As to the conditions which must be satisfied in relation to prescribed arrangements (including conditions in relation to consultation)
- (c) For or in connection with requiring the consent of the secretary of state to the operation of prescribed arrangements (including provision in relation to applications for consent, the approval or refusal of such applications and the variation or withdrawal of approval)
- (d) In relation to the duration of prescribed arrangements
- (e) For or in connection with the variation or termination of prescribed arrangements
- (f) As to the responsibility for, and the operation and management of, prescribed arrangements
- (g) As to the sharing of information between NHS bodies and local authorities.

(4) The provision that may be made by virtue of subsection (3)(f) includes provision in relation to:

- (a) The formation and operation of joint committees of NHS bodies and local authorities
- (b) The exercise of functions that are the subject of prescribed arrangements (including provision in relation to the exercise of such functions by joint committees or employees of NHS bodies and local authorities)
- (c) The drawing up and implementation of plans in respect of prescribed arrangements
- (d) The monitoring of prescribed arrangements
- (e) The provision of reports on, and information about, prescribed arrangements
- (f) Complaints and disputes about prescribed arrangements
- (g) Accounts and audit in respect of prescribed arrangements.

(5) Arrangements made by virtue of this section do not affect:

- (a) The liability of NHS bodies for the exercise of any of their functions
- (b) The liability of local authorities for the exercise of any of their functions

¹⁶ Note: the extract from the Act has been taken from www.legislation.gov.uk/ukpga/2006/41/section/75 – it may not include all of the most recent changes to legislation

(c) Any power or duty to recover charges in respect of services provided in the exercise of any local authority functions.

(6) The secretary of state may issue guidance to NHS bodies and local authorities in relation to consultation or applications for consent in respect of prescribed arrangements.

(7) The reference in subsection (1) to an improvement in the way in which functions are exercised includes an improvement in the provision to any individuals of any services to which those functions relate.

(8) In this section:

● “health-related functions”, in relation to a local authority, means functions of the authority which, in the opinion of the secretary of state:

- (a) Have an effect on the health of any individuals
- (b) Have an effect on, or are affected by, any functions of NHS bodies
- (c) Are connected with any functions of NHS bodies

● “NHS body” does not include a special health authority.

(9) Schedule 18 makes provision with respect to the transfer of staff in connection with arrangements made by virtue of this section.

The regulations that govern pooled budgets are SI 2000/617. This SI has been amended over the years by other legislation; this version includes all of the changes, as set out on the government website¹⁷.

2000 No. 617

NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000

Made: 10 March 2000

Laid before parliament: 10 March 2000

Coming into force: 1 April 2000

The secretary of state for health, in exercise of the powers conferred upon him by section 126(4) of the *National Health Service Act 1977*¹⁸ and section 31 of the *Health Act 1999*¹⁹ and all other powers enabling him in that behalf hereby makes the following regulations:

Citation, commencement and extent

1. (1) These regulations may be cited as the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000 and shall come into force on 1 April 2000.

(2) These regulations extend to England only²⁰.

Interpretation

2. (1) In these regulations:

- “the Act” means the *Health Act 1999*
- “the 1948 Act” means *National Assistance Act 1948*
- “the 1983 Act” means the *Health and Social Services and Social Security Adjudications Act 1983*
- “the 2006 Act” means the *National Health Service Act 2006*
- “the Board” means the National Health Service Commissioning Board
- “health-related functions” means the functions of local authorities prescribed under regulation 6
- “local authority” means a body to which regulation 3(2) applies
- “NHS body” means a body to which regulation 3(1) applies
- “NHS contract” has the meaning given in section 9 of the 2006 Act²¹
- “NHS functions” means the functions of NHS bodies prescribed under regulation 5
- “partners”, in relation to partnership arrangements, means one or more NHS bodies and one or more local authorities
- “partnership arrangements” means arrangements prescribed under regulations 7, 8 and 9.

(2) In these regulations, unless the context otherwise requires, any reference to a numbered regulation is a reference to the regulation bearing that number in these regulations, and any reference to a numbered paragraph is a reference to a paragraph bearing that number in that regulation.

Prescribed NHS bodies and local authorities

3. (1) The NHS bodies prescribed for the purposes of section 31 of the Act are:

- (c) An NHS trust²²
- (d) An NHS foundation trust

¹⁷ www.legislation.gov.uk/changes/affected/ukxi/2000/617

¹⁸ 1977 (c. 49); section 126(4) is applied by virtue of section 62(4) of the *Health Act 1999* and was amended by the *National Health Service and Community Care Act 1990* (c. 19), section 65(2) and the *Health Act 1999*, Schedule 4, paragraph 37(5)

¹⁹ 1999 (c. 8); see section 31(8) for the definition of “prescribed”

²⁰ The functions of the secretary of state under section 3(1) are, so far as exercisable in relation to Wales, transferred to the National Assembly for Wales by the National Assembly for Wales (Transfer of Functions) Order 1999 SI 1999/672 as amended by section 66(4) and (5), *Health Act 1999*

²¹ Section 9 was amended by the 2008 Act, Schedule 5, paragraph 82 and by the 2012 Act, Schedule 4, paragraph 6, Schedule 7, paragraph 18, Schedule 14, paragraph 4, Schedule 17, paragraph 10(2), Schedule 19, paragraph 9(2), and Schedule 21, paragraph 6

²² See section 5 of the *National Health Service and Community Care Act 1990* as amended by paragraph 69 of Schedule 1 to the *Health Authorities Act 1995* and section 13(1) of the *Health Act 1999*

- (e) A clinical commissioning group
- (f) The Board.

(2) The local authorities prescribed for the purposes of section 31 of the Act are:

- (a) A district council
- (b) A county council
- (c) A county borough council
- (d) A London borough council
- (e) The Common Council of the City of London
- (f) The Council of the Isles of Scilly.

Partnership arrangements between NHS bodies and local authorities

4. (1) Subject to paragraphs (2) and (3), the partners may enter into any partnership arrangements in relation to the exercise of any:

- (a) NHS functions
- (b) Health-related functions, if the partnership arrangements are likely to lead to an improvement in the way in which those functions are exercised.

(2) Subject to paragraph (2A), the partners may not enter into any partnership arrangements unless they have consulted jointly such persons as appear to them to be affected by such arrangements.

(2A) Paragraph (2) does not apply where the partnership arrangements have been consulted

23 2005 c.9. Schedule A1 was inserted into the *Mental Capacity Act* by Schedule 7 of the *Mental Health Act 2007* (c.12)

24 1970 (c. 42); Schedule 1 was amended (by repeal, substitution, or insertion of entries) by the following: section 78 of, and Schedule 7 to, the *Charities Act 1992* (c. 42); section 78 of, and Schedules 2 and 3 to, the *Public Health (Control of Disease) Act 1984* (c. 22); the *Statute Law (Repeals) Act 1978* (c. 45); the *Statute Law (Repeals) Act 1993* (c. 50); section 73(3) of, and Schedule 4 to, the *Adoption Act 1976* (c. 36); section 57 of, and Schedule 5 to, the *National Health Service Reorganisation Act 1973* (c. 32); section 148 of, and Schedule 4 to, the *Mental Health Act 1983* (c. 20); section 108(5) of, and Schedules 13 and 15 to, the *Children Act 1989* (c. 41); section 89(2) of, and Schedules 2 and 3 to, the *Domestic Proceedings and Magistrates' Courts Act 1978* (c. 22); section 127(1) of, and Schedule 3 to, the *Mental Health (Scotland) Act 1984* (c. 36); section 54 of, and Schedules 2 and 3 to, the *Matrimonial Causes Act 1973* (c. 18); section 35(2) and (3) of, and Schedules 7 and 8 to, the *Supplementary Benefits Act 1976* (c. 71); section 129 of, and Schedule 16 to, the *National Health Service Act 1977* (c. 49); section 66(1) of, and Schedule 9 to, the *National Health Service and Community Care Act 1990* (c. 19); section 20(1) of, and Schedule 4 to, the *Social Security Act 1980* (c. 30); sections 3 and 4 of, and Schedules 1 and 2 to, the *Housing (Consequential Provisions) Act 1985* (c. 71); section 57 of, and Schedule 1 to, the *Registered Homes Act 1984* (c. 23); section 216(3) of, and Schedule 17 to, the *Housing Act 1996* (c. 52); section 582(1) and (2) of, and Schedules 37 and 38 to, the *Education Act 1996* (c. 56); section 1(7) of the *Carers (Recognition and Services) Act 1995* (c. 12); section 3(1) and (3) of the *Community Care (Direct Payments) Act 1996* (c. 30); and section 15(1) of, and Schedule 2 to, the *Adoption (Intercountry Aspects) Act 1999* (c. 18)

25 1948 (c. 29)

upon pursuant to section 77(1A)(b) of the 2006 Act and regulation 4 of the *NHS Bodies and Local Authorities (Partnership Arrangements, Care Trusts, Public Health and Local Healthwatch) Regulations 2012* (consultation requirements).

Functions of NHS bodies

5. The NHS functions are:

- (a) The functions of arranging for the provision of services under sections 3, 3A and 3B of, and paragraphs 9 to 11 of Schedule 1, to the 2006 Act, including rehabilitation services and services intended to avoid admission to hospital but excluding surgery, radiotherapy, termination of pregnancies, endoscopy, the use of Class 4 laser treatments and other invasive treatments and emergency ambulance services
 - (aa) The functions of providing the services referred to in paragraph (a), pursuant to arrangements made by a clinical commissioning group or the Board
- (b) The functions of arranging for the provision of services under section 117 of the *Mental Health Act 1983*
 - (ba) The functions of providing services referred to in paragraph (b) pursuant to arrangements made by a clinical commissioning group or the Board
 - (bb) The functions of making direct payments under:
 - (i) Section 12A(1) of the *National Health Service Act 2006* (direct payments for health care)
 - (ii) The National Health Service (Direct Payments) Regulations 2013
- (bc) The function of arranging the provision of Healthy Start vitamins under regulation 8A of the Healthy Start Scheme and Welfare Foods (Amendment) Regulations 2005
- (c) The functions under Schedule A1 of the *Mental Capacity Act 2005*²³.

Health-related functions of local authorities

6. The health-related functions are:

- (a) Subject to sub-paragraph (k), the functions specified in Schedule 1 to the *Local Authority Social Services Act 1970*²⁴ except for functions under:
 - (i) Sections 22, 23(3), 26(2) to (4), 43, 45 and 49 of the 1948 Act²⁵
 - (ii) Section 6 of the *Local Authority Social Services Act 1970*
 - (iii) Sections 1 and 2 of section 3 of the *Adoption and Children Act 2002*
 - (iv) Sections 114 and 115 of the *Mental Health Act 1983*

- (iva) Subject to sub-paragraph (1), section 17 of the 1983 Act
- (vi) Parts VII to IX and section 86 of the *Children Act 1989*²⁶
- (aa) The function of providing Healthy Start vitamins under regulation 8A of the Healthy Start Scheme and Welfare Foods (Amendment) Regulations 2005
- (b) The functions under sections 7 or 8 of the *Disabled Persons (Services, Consultation and Representation) Act 1986*
- (c) The functions of providing or securing provision of recreational facilities under section 19 of the *Local Government (Miscellaneous Provisions) Act 1976*²⁷
- (d) The functions of local authorities under the Education Acts as defined in section 578 of the *Education Act 1996*²⁸
- (e) The functions of local housing authorities under Part I of the *Housing Grants, Construction and Regeneration Act 1996*²⁹ and under Parts VI and VII of the *Housing Act 1996*³⁰
- (f) The functions of local authorities under section 126 of the *Housing Grants, Construction and Regeneration Act 1996*
- (g) The functions of waste collection or waste disposal under the *Environmental Protection Act 1990*³¹
- (h) The functions of providing environmental health services under sections 180 and 181 of the *Local Government Act 1972*³²
- (i) The functions of local highway authorities under the *Highways Act 1980*³³ and section 39 of the *Road Traffic Act 1988*³⁴
- (j) The functions under section 63 (passenger transport) and section 93 (travel concession schemes) of the *Transport Act 1985*³⁵
- (k) Where partners enter into arrangements under regulation 7(1) or 8(1) in respect of the provision of accommodation under sections 21 or 26 of the 1948 Act, the function of charging for that accommodation under section 22, 23(2) or 26 of that Act or
- (l) Where partners enter into arrangements under regulation 7(1) or 8(1) in respect of the provision of a service under any enactment mentioned in section 17(2)(a) to (c) of the 1983 Act, the function of charging for that service under that section
- (m) The functions of local authorities under or by virtue of sections 2B or 6C(1) of, or Schedule 1 to, the 2006 Act.

Pooled fund arrangements

7. (1) Subject to the following provisions of this regulation, the partners may enter into arrangements for or in connection with the establishment and maintenance of a fund ("pooled fund arrangements"), which is made up of contributions by the partners and out of which payments may be made towards expenditure

incurred in the exercise of any NHS functions or health-related functions.

- (2) A partner which is an NHS trust may not enter into pooled fund arrangements with a partner which is a local authority unless it obtains the consent of each clinical commissioning group with which it has an NHS contract for the provision of services for persons in respect of whom the functions which are the subject of the pooled fund arrangements may be exercised.

- (3) Where the partners have decided to enter into pooled fund arrangements the agreement must be in writing and must specify:

- (a) The agreed aims and outcomes of the pooled fund arrangements
- (b) The contributions to be made to the pooled fund by each of the partners and how those contributions may be varied
- (c) Both the NHS functions and the health-related functions the exercise of which are the subject of the arrangements
- (d) The persons in respect of whom and the kinds of services in respect of which the functions referred to sub-paragraph (c) may be exercised
- (e) The staff, goods, services or accommodation to be provided by the partners in connection with the arrangements
- (f) The duration of the arrangements and provision for the review or variation or termination of the arrangements
- (g) How the pooled fund is to be managed and monitored, including which body or authority is to be the host partner in accordance with paragraph (4).

- (4) 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 shall appoint an officer of theirs ("the pool manager") to be responsible for:

- (a) Managing the pooled fund on their behalf
- (b) Submitting to the partners' quarterly reports, and 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 the pooled fund arrangements.

- (5) The partners may agree that an officer of either may exercise both the NHS functions and

26 1989 (c. 41)

27 1976 (c. 57)

28 1996 (c. 56)

29 1996 (c. 53)

30 1996 (c. 52)

31 1990 (c. 43)

32 1972 (c. 70)

33 1980 (c. 66)

34 1988 (c. 52)

35 1985 (c. 67)

health-related functions which are the subject of the pooled fund arrangements.

- (6) The host partner shall arrange for the audit of the accounts of the pooled fund arrangements and shall require the Audit Commission to make arrangements to certify an annual return of those accounts under section 28(1)(d) of the *Audit Commission Act 1998*³⁶.

Exercise of functions by NHS body

8. (1) Subject to the following provisions of this regulation, the partners may enter into arrangements for the exercise by NHS bodies of health-related functions in conjunction with the exercise by such bodies of their NHS functions.
- (2) Where the partners have decided to enter into arrangements under paragraph (1) the agreement must be in writing and must specify:
- (a) The agreed aims and outcomes of the arrangements
 - (b) The payments to be made by local authorities to the NHS bodies and how those payments may be varied
 - (c) The health-related functions and NHS functions the exercise of which are the subject of the arrangements
 - (d) The persons in respect of whom and the kinds of services in respect of which the functions referred to in sub-paragraph (c) may be exercised
 - (e) The staff, goods, services or accommodation to be provided by the partners in connection with the arrangements
 - (f) The duration of the arrangements and provision for the review or variation or termination of the arrangements
 - (g) The arrangements in place for monitoring the exercise by the NHS bodies of the functions referred to in sub-paragraph (c)
 - (h) In the case of the exercise of functions mentioned in regulation 6(k) or (l), the arrangements in place for determining the services in respect of which a user may be charged and for informing users about such charges
 - (i) The arrangements in place for the sharing of information between NHS bodies and local authorities.
- (3) The NHS bodies shall report to the local authorities, both quarterly and annually, on the exercise of the health-related functions which are the subject of the arrangements.

Exercise of functions by local authorities

9. (1) Subject to the following provisions of this regulation, the partners may enter into arrangements for the exercise by local authorities of NHS functions in conjunction with the exercise by such authorities of their health-related functions.
- (2) A partner which is an NHS trust may not enter into arrangements under paragraph (1) unless it obtains the consent of each clinical commissioning group with which the trust has an NHS contract for the provision of services for persons in respect of whom the functions which are the subject of the arrangements may be exercised.
- (3) Where the partners have decided to enter into arrangements under paragraph (1) the agreement must be in writing and must specify:
- (a) The agreed aims and outcomes of the arrangements
 - (b) The payments to be made by the NHS bodies to the local authorities and how those payments may be varied
 - (c) The NHS functions and the health-related functions the exercise of which are the subject of the arrangements
 - (d) The persons in respect of whom and the kinds of services in respect of which the functions referred to in sub-paragraph (c) may be exercised
 - (e) The staff, goods, services or accommodation to be provided by the partners in connection with the arrangements
 - (f) The duration of the arrangements and provision for the review or variation or termination of the arrangements
 - (g) The arrangements in place for monitoring the exercise by the local authorities of the functions referred to in sub-paragraph (c)
 - (h) In the case of the exercise of functions mentioned in regulation 6(k) or (l), the arrangements in place for determining the services in respect of which a user may be charged and for informing users about such charges
 - (i) The arrangements in place for the sharing of information between NHS bodies and local authorities.
- (4) The local authorities shall report to the NHS bodies, both quarterly and annually, on the exercise of the NHS functions which are the subject of the arrangements.

Supplementary

- 10. (1)** In connection with any partnership arrangements a partner may agree to provide staff, goods, services or accommodation to another partner.
- (2)** Partners may form a joint committee to take responsibility for the management of partnership arrangements including monitoring the arrangements and receiving reports and information on the operation of the arrangements.
- (2A)** Where a local authority in England is operating executive arrangements, a joint committee formed under paragraph (2) may include any person who is a member of that authority whether or not he is also a member of the executive of that authority.
- (3)** Without prejudice to any complaints procedures under the *Hospital Complaints Procedures Act 1985*³⁷ or under section 7B of the *Local Authorities Social Services Act 1970* or otherwise, where partners have formed a joint committee under paragraph (2) in respect of partnership arrangements they may agree that a sub-committee, or a member of the joint committee, may consider complaints about the partnership arrangements if the complaints are made by or on behalf of users of services provided under the partnership arrangements.
- (4)** In paragraph (2A), “executive” and “executive arrangements” have the same meaning as in Part II of the *Local Government Act 2000*.

*Signed by authority of the secretary of state for health
Gisela Stuart, parliamentary under secretary of state
10 March 2000, Department of Health*

Explanatory note (not part of the regulations)

These regulations make provision for certain NHS bodies and local authorities to enter into arrangements (“partnership arrangements”) for specified functions.

Regulation 3 prescribes the NHS bodies and local authorities (“the partners”) which may enter into the arrangements.

Regulation 4 sets out the conditions which must be satisfied before the partners may enter the partnership arrangements.

Regulations 5 and 6 prescribe the NHS functions and local authority functions which may be the subject of partnership arrangements.

The regulations also define the nature of the partnership

arrangements. They provide for the establishment of a fund made up of contributions from the partners, out of which payments may be made towards expenditure incurred in the exercise of their functions, for the exercise by NHS bodies of local authority functions, and require the partners to set out the terms of the arrangements in writing (regulations 7, 8 and 9).

Regulation 10 makes supplementary provisions.

Explanatory note for SI 2003/629

These regulations further amend the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2001 (“the principal regulations”). These make provision for certain NHS bodies and local authorities to enter into specified arrangements (partnership arrangements) in relation to specified functions.

Regulation 3 adds the Council of the Isles of Scilly to the list of local authorities who can enter into partnership arrangements.

Regulation 4 disapplies the consultation requirement in regulation 2 of the principal regulations in respect of partnership arrangements entered into where those arrangements have been consulted upon in connection with an application for care trust designation pursuant to section 45 of the *Health and Social Care Act 2001*.

Regulation 5 makes amendments to regulation 6 of the principal regulations. The amendments relate to charging for community care services. In particular it adds section 17 of the *Health and Social Services and Social Security Adjudications Act 1983* to the list of functions which, generally, cannot be the subject of partnership arrangements. It also adds sub-paragraphs (k) and (l) to regulation 6 of the principal regulations which enable the specified functions to be part of partnership arrangements provided the function to which the charging function relates also forms part of those partnership arrangements.

Regulations 6 and 7 make amendments to regulations 8 and 9 of the principal regulations so that, where the partnership arrangements include charging functions, the partnership agreement must specify what arrangements are in place for determining the services in respect of which a user may be charged and for informing those users about such charges.

³⁷ 1985 (c. 42)

Footnote to para 21 of SI 2010/1000

SI 2000/617 (“the 2000 regulations”). Following the consolidation of enactments relating to the health service by the *National Health Service Act 2006* (c. 41), the 2000 regulations have effect as if made under section 75 of that Act, by virtue of paragraph 1 of Part 1 of Schedule 2 to the *National Health Service (Consequential Provisions) Act 2006* (c. 43)

Appendix 2: Example financial summary

Service area	Plan value (£)	Year to date actual expenditure (£)	Forecast Oct-Dec expenditure (£)	Forecast Jan-Mar expenditure (£)	Forecast outturn expenditure (£)
Community, equipment and adaptations	£		£		
Telecare					
Integrated crisis and rapid response services					
Maintaining eligibility criteria					
Reablement services					
Bed-based intermediate care services					
Early supported hospital discharge schemes					
Mental health services					
Housing projects					
Employment support					
Learning disabilities service					
Dementia services					
Support to primary care					
Integrated assessments					
Integrated records or IT					
Joint health and care teams/ working					
Other preventative services (please specify)					
Other social care (please specify)					
Other intermediate care (please specify)					
Overall totals					

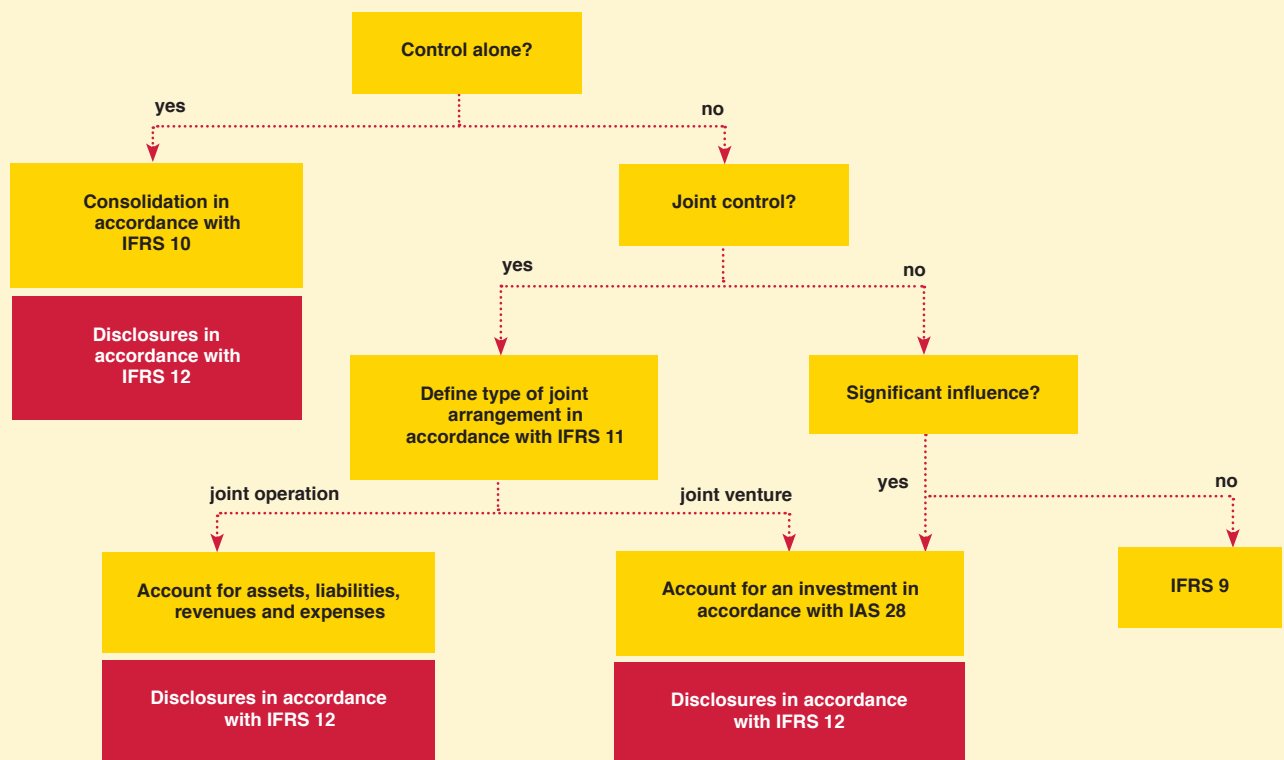
Appendix 3: Accounting for a pooled budget

The accounting standards that apply to pooled budgets are new and revised and effective from 1 April 2014:

- IAS 28 *Investments in Associates and Joint Arrangements*
- IFRS 10 *Consolidated financial statements*
- IFRS 11 *Joint arrangements*
- IFRS 12 *Disclosure of Involvement with Other Entities*³⁸.

The links between the standards have been illustrated by the IASB:

Interaction between IFRS 10, 11, 12 and IAS 28



Previously, in accounting terms, a pooled budget has been considered a joint arrangement that is not an entity in its own right. Under the new accounting standards, pooled budgets (including the better care fund) may meet the definition of a joint operation. However, this will need to be considered on a case by case basis based on the signed agreement and the working practices in operation.

Control alone

In accordance with IFRS 10, there will be control if one body (the investor) has all of the following:

1. Power over the other body (the investee) – power arises from rights, in particular, the rights to direct the investee's activities. The rights may come from voting rights or from contracts and they do not have to have been exercised to exist
2. Exposure or rights, to variable returns from its involvement with the investee (returns may be positive, negative or both)
3. The ability to use its power over the investee to affect the amount of its returns.

³⁸ Local authorities are required to follow the requirements of chapter 9 of the Code of Practice on Local Authority Accounting in relation to pooled budgets. The Code's requirements are based largely on the accounting standards identified. References to IFRS 11 requirements set out here are consistent with the Code's requirements for local authorities

Where there is more than one investor and no one investor can direct the investee's activities without the co-operation of the other investors, then there is no individual control and the answer to the 'control alone' question would be no. Where 'joint control' exists, the following test needs to be applied.

Joint control

IFRS 11 defines joint control as '...the contractually agreed sharing of control of an arrangement, which exists only when decisions about the relevant activities require the unanimous consent of the parties sharing control'. Joint control requires that all the parties, or a group of the parties, must act together to direct the activities that significantly affect the returns of the arrangement – the relevant activities. This means that:

- No single party controls the arrangement on its own
- Any one of the parties in the arrangement can prevent any of the other parties from controlling the arrangement.

The examples provided in the standard (paragraph B8) are as follows:

Example 1

Assume that three parties establish an arrangement: A has 50% of the voting rights, B has 30%, C 20%. The contractual arrangement between A, B and C specifies that at least 75% of the voting rights are required to make decisions about the relevant activities of the arrangement. Even though A can block any decision, it does not control the arrangement because it needs the agreement of B. The terms of their contractual arrangement requiring at least 75% of the voting rights to make decisions about the relevant activities imply A and B have joint control of the arrangement because decisions about the arrangement's relevant activities cannot be made without A and B agreeing.

Example 2

Assume an arrangement has three parties: A has 50% of the voting rights, B and C each have 25%. The contractual arrangement between A, B and C specifies that at least 75% of the voting rights are required to make decisions about the relevant activities of the arrangement. Even though A can block any decision, it does not control the arrangement because it needs the agreement of either B or C.

In this example, A, B and C collectively control the arrangement. However, there is more than one combination of parties that can agree to reach 75% of the voting rights (either A and B or A and C). In such a situation, to be a joint arrangement the contractual arrangement between the parties would need to specify which combination of the parties is required to agree unanimously to decisions about the relevant activities of the arrangement.

Example 3

Assume an arrangement in which A and B each have 35% of the voting rights, with the remaining 30% widely dispersed. Decisions about the relevant activities require approval by a majority of the voting rights. A and B have joint control of the arrangement only if the contractual arrangement specifies that decisions about the relevant activities of the arrangement require both A and B agreeing.

Structure of joint arrangements

A joint arrangement not structured through a separate vehicle is a joint operation. In such cases, the contractual arrangement establishes the parties' rights to the assets and obligations for the liabilities (relating to the arrangement) and their rights to the corresponding revenues and obligations for the corresponding expenses (*IFRS 11, para B16*).

A joint arrangement in which the assets and liabilities relating to the arrangement are held in a separate vehicle can be either a joint venture or a joint operation. Whether a party is a joint operator or a joint venturer depends on the party's rights to the assets and obligations for the liabilities relating to the arrangement that are held in the separate vehicle (*IFRS 11, paras B19 and B20*).

Better care fund pooled budgets and IFRS 11

It is anticipated that all parties to a better care fund pooled budget agreement will have joint control. However, this will be dependent on the exact terms of the signed agreement and the nature of the funding streams covered by the agreement and should therefore be assessed on a case by case basis. As no separate vehicle is created in such an arrangement, where joint control exists it is classified as a joint operation (in accordance with IFRS 11 requirements).

As the better care fund pooled budget is a joint arrangement solely for the purpose of working together, it is anticipated that no single body will have power of control over the other parties to the agreement.

The signed agreement for a better care fund pooled budget should set out the nature of the activities that are the subject of the agreement (as required by SI 2000/617) as well as how the parties intend to operate those activities together. This will enable each party to identify its share of the assets and liabilities for accounting purposes.

Accounting for a joint operation in the financial statements

IFRS 11 paragraph 20 sets out how a joint operation should be accounted for:

- a) Each joint operator to the joint operation will recognise (in relation to its interest in that joint operation):
 - (i) Its assets, including its share of any assets held jointly
 - (ii) Its liabilities, including its share of any liabilities incurred jointly
 - (iii) Its revenue from the sale of its share of the output arising from the joint operation
 - (iv) Its share of the revenue from the sale of the output by the joint operation
 - (v) Its expenses, including its share of any expenses incurred jointly
- b) Each joint operator shall account for the assets, liabilities, revenues and expenses relating to its interest in a joint operation in accordance with IFRSs applicable to the assets, liabilities, revenues and expenses (*IFRS 11, para 22*)
- c) When accounting for transactions such as the sale, contribution or purchase of assets between an entity and a joint operation in which it is a joint operator, the entity will recognise the gains and losses resulting from such a transaction only to the extent of the other parties' interests in the joint operation (*IFRS 11, paras B34-B37*).

If a party to a better care fund pooled budget does not have joint control but has rights to the assets and obligations for the liabilities relating to the joint operation, it shall also account for its interest in the arrangement in accordance with paragraphs a) to c) above.

Disclosure

All of the arrangements above are covered by the disclosure requirements set out in IFRS 12. The standard requires the disclosure of information about significant judgements and assumptions made by the entity in determining whether or not it has joint control over another entity.

Also required is the disclosure of information that enables users of its financial statements to evaluate the nature, extent and financial effects of interests in joint operations [better care fund pooled budget arrangements], including the nature and effects of its contractual relationship with the other investors with joint control. For material joint operations, the following will need to be disclosed:

- The name of the joint arrangement
- The nature of the entity's relationship with the joint arrangement (could include description of the nature of activities)
- The principal place of business of the joint arrangement
- The proportion of ownership interest or participating share held by the entity and, if different, the proportion of voting rights held (if applicable).

If any critical estimates or accounting judgements have been made in relation to the joint operation, these should be disclosed in accordance with IAS 1. One judgement which should be considered is whether transactions are made on an agency basis and therefore accounted for net rather than gross. It is expected most transactions will be accounted for on a gross basis but for the financial accounts it may be determined that net accounting is appropriate where payments are simply passed through an organisation. However, management accounts information should be maintained on a gross basis as it is simpler to produce net results from gross information than produce gross from net.

In the event that joint control does not exist, there is no specific requirement for the above disclosures to be made. However, it is recommended that where a party to a better care fund pooled budget does not have joint control but has rights to the assets and obligations for the liabilities relating to the joint operation, any risks associated with those interests should be disclosed.

Appendix 4: Essential measures and controls

Summary of the measures and controls in this guidance and the relevant paragraph reference

Governance arrangements	Paragraph
The governance arrangements for the pooled budget should meet the requirements of all partners	12
Each partner must satisfy itself the pooled budget complies with requirements of its appropriate code of governance	12
Each partner must satisfy itself that all other regulatory requirements are met	13
In-year changes to plans must be subject to appropriate authorisation/approval inc final sign-off by relevant HWB	28
In-year financial reporting must comply with the requirements of SI 2000/617 section 7 paragraph 4(b)	29
Parties to the pooled budget will need to reflect the better care fund in their risk register	30
Risks of pooled budget arrangements must be assessed and as necessary be subject to ongoing internal audit review	30
Supporting assurance must be obtained that the information received in relation to the fund is correct and accurate	30
There must be a process for alerting the CCG governing body and local authority cabinet/executive of concerns about delivery of better care fund projects	30
CCGs will probably be required to identify if there have/have not been significant financial issues relating to the pooled budget for the period of the governance statement	31
Other than the host, parties to the pooled budget must identify what assurance information they require on the projects from other organisations	34
Those charged with governance need to assure themselves that the data underpinning the above assurances is robust, then consider the results and the implications for the achievement of the fund's objectives	38 and 39
Operational structures	
Each local area must determine the operational structure for their pooled budget	15
The HWB must sign off pooled budget plans	15
The HWB must implement measures for the on-going oversight of better care fund projects	15
The operational structure must include formal delegation arrangements	18
The membership and terms of reference of the HWB must be appropriate	19
Hosting	
The decision on which partner hosts the pooled budget should be made locally	21
While the host body will have delegated powers it will need to work within the reporting and management environments of the partnership	23
Signed agreement	
The signed agreement must set out precisely what the overall aims are; who is responsible for what and the associated plans for reporting and accountability	24
The agreement should be reviewed regularly	26
Information requirements	
The information required to support performance monitoring and reporting must be identified in advance and collected on a regular basis from the outset	27
Financial arrangements	
Parties to the pool will need to discuss with their external auditors the assurances that will be required in order to sign off the year-end accounts	30
The pooled budget host must ensure that VAT arrangements are compliant with NHS and local authority VAT regimes	30
The pooled budget host will be responsible for ensuring that appropriate capital accounting arrangements are applied as required	30
Regular and timely performance reports must be provided for the HWB, the CCG governing body and the local authority cabinet/executive	30
All parties to a pooled budget must understand and consider the various issues relating to the year-end financial processes in advance of the year end itself	31
The accountable officer/section 151 officer must consider the assurances that may be required to sign off accounts that include pooled budget transactions	31
For joint operations, parties should account for their share of as the assets, liabilities, income and expenditure in accordance with IFRS 11	31
Under SI 2000/617 paragraph 7(4), hosts must submit an annual return to the partners about the income and expenditure of the pooled fund	31
The annual return must include a full statement of spending, signed by the accountable officer/section 151 officer	31

Appendix 5: Pros and cons of sources of assurance

Table 1: internal sources

Pros	Cons
<ul style="list-style-type: none"> • Less costly • Testing and reporting determined by the entity so tailored to the system 	<ul style="list-style-type: none"> • Testing and reporting determined by the entity so: <ul style="list-style-type: none"> o No consistency between organisations o Additional work for each body to develop the work programme o Additional work for each body to review and agree the work programme

Table 2: external sources

Pros	Cons
<ul style="list-style-type: none"> • Prescribed testing and reporting structure • Known output • Consistency of work and output • Independent 	<ul style="list-style-type: none"> • Can be costly • Can only be used for certain systems

Appendix 6: Further reading

- *Introductory guide for clinical commissioning groups: pooled budgets and integrated care*, CIPFA, June 2011
www.cipfa.org/-/media/files/policy%20and%20guidance/panels/health%20panel/lib_07_cipfa_intro_guide_pooling_budgets.pdf
- *Pooled budgets: a practical guide for local authorities and the National Health Service*, fully revised second edition, CIPFA, 2009
- *Code of practice on local authority accounting in the United Kingdom*, CIPFA (annual publication)
- *Code of practice on local authority accounting in the United Kingdom: guidance notes for practitioners*, CIPFA (annual publication)
- S75 NHS Act 2006 partnership agreements, Commissioning Support Programme, July 2010
- Local Government Association
www.local.gov.uk/web/guest/health-wellbeing-and-adult-social-care/-/journal_content/56/10180/4096799/ARTICLE
- NHS England better care fund web pages
www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/
- Template section 75 agreement
www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/risk-sharing/
- The National Health Service (Conditions Relating to Payments by NHS Bodies to Local Authorities) Directions, 2013
www.gov.uk/government/uploads/system/uploads/attachment_data/file/200460/s256_257_conditions_-_Payments_by_NHS_bodies_to_LAs.pdf



About CIPFA

CIPFA, the Chartered Institute of Public Finance and Accountancy, is the professional body for people in public finance. Our 14,000 members work throughout the public services, in national audit agencies and major accountancy firms, anywhere where public money needs to be effectively and efficiently managed. As the world's only professional accountancy body to specialise in public services, CIPFA's qualifications are the foundation for a career in public finance. We also champion high performance in public services, translating our experience and insight into clear advice and practical services. Globally, CIPFA shows the way in public finance by standing up for sound public financial management and good governance.

About the HFMA

The Healthcare Financial Management Association (HFMA) is the UK representative body for finance professionals working in the NHS and the wider healthcare sector. Our aim is to support the NHS finance function, to promote good practice in financial management and to improve the general understanding of NHS finance issues.

Our work is informed by a number of committees and special interest groups made up of healthcare finance practitioners. We publish numerous guides and briefings aimed at finance professionals, non-executive directors and non-finance staff. We also provide training and development opportunities – including a suite of web based learning modules – across all of these groups.

HFMA

1 Temple Way
Bristol BS2 0BU

T 0117 929 4789

F 0117 929 4844

E info@hfma.org.uk

www.hfma.org.uk

Healthcare Financial Management Association (HFMA) is a registered charity in England and Wales, no 1114463 and Scotland, no SCO41994. HFMA is also a limited company registered in England and Wales, no 5787972. Registered office: 110 Rochester Row, Victoria, London SW1P 1JP

Better Care Fund

Heads of Terms

**Agreement under Section 75 National
Health Service Act 2006 for the pooled
fund between Medway Council and
Medway Clinical Commissioning Group**

1 The Parties

- NHS Medway Clinical Commissioning Group
- Medway Council

2 Agreement Date

- 1 April 2015.

3 Background

- (A) The Council has responsibility for commissioning and/or providing social care services on behalf of the population of the borough of Medway .
- (B) The CCG has the responsibility for commissioning health services pursuant to the 2006 Act in the borough of Medway
- (C) The Better Care Fund has been established by the Government to provide funds to local areas to support the integration of health and social care and to seek to achieve the National Conditions and Local Objectives. It is a requirement of the Better Care Fund that the CCG and the Council establish a pooled fund for this purpose. [The Partners wish to extend the use of pooled funds to include funding streams from outside of the Better Care Fund.]¹
- (D) Section 75 of the 2006 Act gives powers to local authorities and clinical commissioning groups to establish and maintain pooled funds out of which payment may be made towards expenditure incurred in the exercise of prescribed local authority functions and prescribed NHS functions.
- (E) The purpose of this Agreement is to set out the terms on which the Partners have agreed to collaborate and to establish a framework through which the Partners can secure the future position of health and social care services through lead or joint commissioning arrangements. It is also means through which the Partners will seek to pool funds and align budgets as agreed between the Partners.
- (F) The aims and benefits of the Partners in entering in to this Agreement are to:
 - a) improve the quality and efficiency of the Services;
 - b) meet the National Conditions and Local Objectives;[and]

¹ Consider whether this will be the case or whether the services that will initially be commissioned using Better Care Fund monies will not have supplemental funding from 'non Better Care Fund' resources.

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

d) [INSERT AIMS]²

(G) The Partners have jointly carried out consultations on the proposals for this Agreement with all those persons likely to be affected by the arrangements.³

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

4 **Clause 1 – Defined terms and interpretation**

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

1998 Act means the Data Protection Act 1998.

2000 Act means the Freedom of Information Act 2000.

2004 Regulations means the Environmental Information Regulations 2004.

2006 Act means the National Health Service Act 2006.

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

Agreement means this agreement including its Schedules and Appendices.

[Approved Expenditure] means any additional expenditure approved by the Partners in relation to an Individual Service above any Contract Price and Performance Payments.]

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

Better Care Fund means the Better Care Fund as described in NHS England Publications Gateway Ref. No.00314 and NHS England Publications Gateway Ref. No.00535 as relevant to the Partners.

Better Care Fund Plan means the plan attached at Schedule 6 setting out the Partners plan for the use of the Better Care Fund.

² Consider and provide any additional aims/objectives.

³ The CCG/Council will need to be satisfied that consultation occurred as stated (and as required by the Regulations).

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

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

Commencement Date means 00:01 hrs on [].⁴

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

- (a) which comprises Personal Data or Sensitive Personal Data or which relates to any patient or his treatment or medical history;
- (b) the release of which is likely to prejudice the commercial interests of a Partner or the interests of a Service User respectively; or
- (c) which is a trade secret.

Contract Price means any sum payable to a Provider under a Service Contract as consideration for the provision of Services and which, for the avoidance of doubt, does not include any Default Liability or Performance Payment].⁵

Default Liability means any sum which is agreed or determined by Law or in accordance with the terms of a Services Contract to be payable by any Partner(s) to the Provider as a consequence of (i) breach by any or all of the Partners of an obligation(s) in whole or in part under the relevant Services Contract or (ii) any act or omission of a third party for which any or all of the Partners are, under the terms of the relevant Services Contract, liable to the Provider.⁶

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

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

Force Majeure Event means one or more of the following:

- (a) war, civil war (whether declared or undeclared), riot or armed conflict;
- (b) acts of terrorism;
- (c) acts of God;
- (d) fire or flood;
- (e) industrial action;

⁴ Partners to confirm. This should be no later than 1 April 2015 but may be earlier

⁵ TBC

⁶ Further consideration will always be needed on this.

- (f) prevention from or hindrance in obtaining raw materials, energy or other supplies;
 - (g) any form of contamination or virus outbreak; and
 - (h) any other event,
- in each case where such event is beyond the reasonable control of the Partner claiming relief

Functions means the NHS Functions and the Health Related Functions

Health Related Functions means those of the health related functions of the Council, specified in Regulation 6 of the Regulations as relevant to the commissioning of the Services and which may be further described in the relevant Scheme Specification.⁷

Host Partner means for each Pooled Fund the Partner that will host the Pooled Fund [and for each Aligned Fund the Partner that will host the Aligned Fund]

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

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

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

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

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

Law means:

- (d) any statute or proclamation or any delegated or subordinate legislation;
- (e) any enforceable community right within the meaning of Section 2(1) European Communities Act 1972;
- (f) any guidance, direction or determination with which the Partner(s) or relevant third party (as applicable) are bound to comply to the extent that the

⁷

Here and in the definition of NHS functions the widest definition is used; this needs to be cut down in the relevant specification so that the purpose must be fulfilled by use of the function

same are published and publicly available or the existence or contents of them have been notified to the Partner(s) or relevant third party (as applicable); and

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

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

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

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

Month means a calendar month.

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

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

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

Non-Recurrent Payments means funding provided by a Partner to a Pooled Fund in addition to the Financial Contributions pursuant to arrangements agreed in accordance with Clause [8.4].

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

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

Partnership Board means the Joint Commissioning management Group (executive partnership board) responsible for review of performance and oversight of this Agreement as set out in Schedule 2.

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

Permitted Expenditure has the meaning given in Clause [7.3].

Personal Data means Personal Data as defined by the 1998 Act.

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

Pooled Fund Manager means such officer of the Host Partner which includes a Section 113 Officer for the relevant Pooled Fund established under an Individual Scheme as is nominated by the Host Partner from time to time to manage the Pooled Fund in accordance with Clause [10].

Provider means a provider of any Services commissioned under the arrangements set out in this Agreement.

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

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

1 April to 30 June

1 July to 30 September

1 October to 31 December

1 January to 31 March

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

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

Performance Payment Arrangement means any arrangement agreed with a Provider and one of more Partners in relation to the cost of providing Services on such terms as agreed in writing by all Partners.⁸

Performance Payments means any sum over and above the relevant Contract Price which is payable to the Provider in accordance with a Performance Payment Arrangement.

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

Sensitive Personal Data means Sensitive Personal Data as defined in the 1998 Act.

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

Services Contract means an agreement for the provision of Services entered into with a Provider by one or more of the Partners in accordance with the relevant Individual Scheme.

⁸

The Performance Payment Arrangements and how they will be addressed in this Agreement will need to be revisited once the Performance Payment arrangements have been considered.

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

SOSH means the Secretary of State for Health.

[Third Party Costs means all such third party costs (including legal and other professional fees) in respect of each Individual Scheme as a Partner reasonably and properly incurs in the proper performance of its obligations under this Agreement and as agreed by the Partnership Board.]⁹

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

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

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

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

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

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

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

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

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

⁹

For discussion between the Parties.

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

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

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

5 Clause 2 - Term

Whilst a longer term (5years ?) may be agreed between the parties, due to the fact that funding via the Better Care Fund is not confirmed beyond 31 March 2016, this agreement may terminate on march 2016.

6 Clause 3 – General Principles¹⁰

Nothing in this Agreement shall affect:

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

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

The Partners agree to:

treat each other with respect and an equality of esteem;

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

provide early information and notice about relevant problems.

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

7 Clause 4 – Partnership Flexibilities

¹⁰ Consider any overarching principles for insertion here. We have provided a list for consideration, however, this will be varied on the basis of the principles agreed between the Partners.

- Whilst this Agreement sets out a range of flexibilities to incorporate a Framework approach, involving lead commissioning, integrated commissioning and joint commissioning, together with the essential Pooled Funds, the parties will have to decide which of the options they wish to put in place, and indeed whether they wish to put in place more than one in order to meet the requirements for the Pooled Fund under the BCF.
- This clause also provides for the delegations between the Council and the CCG to the extent that it is necessary for the delegations to be in place so that the parties can exercise each other's functions.

8 Clause 5 – The Functions which can be included within the Section 75 Agreement are set out in the 2000 Regulations

- The initial specification can be set out, as in an Agreement in a Schedule. But this highlights also how the Agreement can establish a Framework which can then incorporate other schemes and funding arrangements should this be desirable. The same provisions in relation to the importance of health and wellbeing will apply to only subsequent functions put within the Section 75 Agreement.

9 Clause 6 – Commissioning Arrangements

Integrated Commissioning

- 9.1 Where there are Integrated Commissioning arrangements in respect of an Individual Scheme, both Partners shall work in cooperation and shall endeavour to ensure that the NHS Functions and Health Related Functions are commissioned with all due skill, care and attention.
- 9.2 Both Partners shall be responsible for compliance with and making payments of all sums due to a Provider pursuant to the terms of each Service Contract.
- 9.3 Both Partners shall work in cooperation and endeavour to ensure that the relevant Services as set out in each Scheme Specification are commissioned within each Partners Financial Contribution in respect of that particular Service in each Financial Year.
- 9.4 The Partners shall comply with the arrangements in respect of the Joint (Aligned) Commissioning as set out in the relevant Scheme Specification.

- 9.5 Each Partner shall keep the other Partners and the Joint Adult Commission Board regularly informed of the effectiveness of the arrangements including the Better Care Fund and any Overspend or Underspend in a Pooled Fund or Non Pooled Fund.
- 9.6 The Partnership Board will report back to the Health and Wellbeing Board as required by its Terms of Reference.

Appointment of a Lead Commissioner¹¹

- 9.7 Where there are Lead Commissioning Arrangements in respect of an Individual Scheme the Lead Commissioner shall:
- 9.7.1 exercise the NHS Functions in conjunction with the Health Related Functions as identified in the relevant Scheme Specification;
 - 9.7.2 endeavour to ensure that the NHS Functions and the Health Related Functions are funded within the parameters of the Financial Contributions of each Partner in relation to each particular Service in each Financial Year.
 - 9.7.3 commission Services for individuals who meet the eligibility criteria set out in the relevant Scheme Specification;
 - 9.7.4. contract with Provider(s) for the provision of the Services on terms agreed with the other Partners;
 - 9.7.5. comply with all relevant legal duties and guidance of both Partners in relation to the Services being commissioned;
 - 9.7.6. where Services are commissioned using the NHS Standard Form Contract, perform the obligations of the “Commissioner” and “Co-ordinating Commissioner” with all due skill, care and attention and where Services are commissioned using any other form of contract to perform its obligations with all due skill and attention;
 - 9.7.7. ¹²undertake performance management and contract monitoring of all Service Contracts;¹³
 - 9.7.8. make payment of all sums due to a Provider pursuant to the terms of any Services Contract
 - 9.7.9. keep the other Partner and the Joint Adult Commission Board regularly informed of the effectiveness of the arrangements including the Better Care Fund and any Overspend or Underspend in a Pooled Fund or Non Pooled Fund.

¹¹ Parties should consider overarching obligations on Lead Commissioners, including whether any further duties will be assigned to the Lead Commissioner.

¹² Consider adding in further obligations around contract management and the requirement of the Lead Commissioner to take enforcement action.

¹³ How will the Parties deal with performance monitoring and accountability/assurance frameworks?

10 Clause 7 – Establishment of Pooled Fund

- The BCF arrangements require a Pooled Fund, and the Care Act 2014, Section 121 provides for this. There are various ways in which Pooled Funds can be managed but this clause provides for what the monies held in the Pooled Fund may be expended upon. The Clause also provides for the option to appoint a host partner for each pooled fund and outlines the responsibilities of the host partner in relation to the Pooled Fund.

11 Clause 8 – Pooled Fund Management

- This clause outlines the agreement in relation to who is to be the host partner and which officer will then act as the Pooled Fund Manager, and the duties and responsibilities of the Pooled Fund Manager. Where there is more than one Pooled Fund, this clause also provides for virement between Pooled Funds in accordance with the governance arrangements agreed.
- This clause also makes reference to a Partnership Board (the board responsible for review of performance and oversight of this Agreement).

12 Clause 9 – Non Pooled Funds

- These are optional between the parties and indeed can be Notional Funds with contributions identified but held separately. Transfers between partners for non-Pooled Funds will be made by Section 76 or Section 256 of the 2006 Act. The template provides for the host partner to have responsibilities for establishing the support needed to enable the effective and efficient management of the non-Pooled Fund, as there may well be funds used towards the BCF that is not part of the pooled funds.

13 Clause 10 – Financial Contributions

- This incorporates the Template Services Schedule. It is included in Schedule 1 to the Agreement and parties need to agree the various items indicated within that Schedule. There are detailed financial governance arrangements with a considerable number of questions which will need to be answered in relation to each scheme which is included within the Agreement. These could cover such issues as premises, IT support, staff, etc, which are necessary for the parties to perform their obligations pursuant to the Agreement and will need to be considered on a scheme by scheme basis. It may however be the case that the parties are able to agree some overarching principles which will apply to such non-financial contributions.

14 Clause 12 – Risk Share Arrangements, Overspends and Underspends

- The risk share arrangements are set out in detail in Schedule 3 and deal with overspends and underspends in both Pooled and non-Pooled Funds. The parties will need to identify the process by which potential overspends are identified, reported and the decision is taken as to the action to deal with the overspend and how this will be dealt with in an equitable manner. Parties can agree to apportion overspends, for example, in agreed or variable proportions.
- The Council currently maintains a risk log.

15 Clause 13 – Capital Expenditure

- This provides that neither Pooled nor non-Pooled Funds would normally be applied towards Capital Expenditure unless this is specifically agreed by the partners. There are problems in using Pooled funds for capital on the termination of the fund.
- It may be agreed that where there is capital, it would revert back to the source upon termination.

16 Clause 14 – VAT

- Local Authorities and the NHS have different VAT treatments and the parties must consider their positions relating to VAT as it may make some difference.

This should be considered when the parties are deciding on the commissioning arrangements.

17 Clause 15 – Audit & Right of Access

- The parties will each have responsibilities for audit and so the arrangement needs to provide for the responsibilities of the host partner relating to audit and the right of internal and external auditors to be given access to anything they need to carry out their duties.

18 Clause 16 – Liabilities & Insurance & Indemnity

- The parties will need to consider and agree what will happen in relation to the acts and omissions of each other which contribute to losses or give rise to a claim for liability. The parties will also have a requirement to consider their respective insurance position and take advice from their own insurance providers. There are particular issues about the availability of NHSLA cover for Health Bodies who perform Council health related functions and Councils will need to take their own insurance advice on this. The clause also provides for the parties to always take reasonable steps to mitigate any loss for which one party may be entitled to bring a claim against the other in relation to the Agreement.

19 Clause 17 – Standards of Conduct & Service

- This sets out the statutory duties of both Local Authorities and the CCG and also relates to the approach the parties will take in relation to Equality and Equal Opportunities.

20 Clause 18 – Conflicts of Interest

- Given the range of responsibilities of both parties to the Agreement it is desirable for the parties to agree a policy as to how these are managed and set it out in a Schedule.

21 Clause 19 – Governance

- The parties will have to agree their own approach to governance which relates back and is agreed by the Health and Wellbeing Board as an integral part of delivering the Better Care Fund. There are a number of different variations to provide the appropriate governance arrangements. The template sets out one approach with an officer working group structure. This is the Partnership Board but whatever governance structure is chosen, the parties will need to determine carefully the terms of reference of the Governance Body, its particular functions and objectives and any delegation which is made from the parties to the representatives who sit on the Governance Bodies.

22 Clause 20 – Review

- The template provides for an annual review of the Agreements and this will need to be tied into the overall governance arrangements referred to above, and of course to the Health and Wellbeing Board and the requirements of the BCF plan.

23 Clause 21 – Complaints

- The parties will need to consider whether they develop a joint complaint procedure to apply to the services delivered under the Agreement, or if they agree to use their own complaints procedure.
- In the light of Robert Francis' recommendations this area may be subject to further legislative change

24 Clause 22 – Termination & Default

- This provides the arrangements for termination and default, and in the template it also provides for individual schemes to be terminated but the BCF requirements continuing to be met. This is a very important clause, and the parties will need to take care to identify both the arrangements between themselves, and the

arrangements which will have apply to any service contract which are held by a lead Commissioner in relation to services which apply to the other party's functions. This would ideally be dealt with by a novation to the other party, or by the other party agreeing to act as an agent and the contract remaining in place; in any case the contractor must be brought into the discussion.

25 Clause 23 – Dispute Resolution

- The template sets out a sample dispute resolution procedure; the parties will need to consider whether they are willing to consider arbitration, it incorporates the model CEDR Mediation procedure. However, the parties may agree other ways for dispute resolution.

26 Clause 24 – Force Majeure

- This provides for neither party providing for liability to the other in respect of a force majeure event and incorporates a provision for the parties to act in good faith towards each other.

27 Clause 25 – Confidentiality

- This provides for the parties to keep confidential information strictly confidential and not disclosing it to other parties. The Clause also provides for when the parties may disclose such confidential information and for the parties not to use confidential information other than for the performance of their obligations under the agreement.

28 Clause 26 – Freedom of Information Act and Environmental Information Regulations

- This provides for cooperation between the parties upon the receipt of requests for information under the respective Acts.

29 Clause 27 – Ombudsman

- The parties agree to cooperate with investigations undertaken by either the LGO or the Health Service Commissioner for England in connection with the Agreement.

30 Clause 28 – Information Sharing

- A protocol for information governance should be agreed and set out in Schedule 8 to ensure that the Agreement complies with the law.

31 Clause 29 – Notices

- This provides for the service of any Notice required to be served under the Agreement.

The Remaining Clauses – 30-39 are technical legal clauses dealing with matters such as change in law, the entire Agreement and the governing law, etc

The Schedules

Because the Schedules set out the specific relationship between the parties, and are necessarily more detailed to relate to their specific Agreement, many of the Schedules in this template are not populated. The template does contain some suggested drafts where it is felt this would be of most use.

Schedule 1 – Scheme Specification

The template is designed so that the individual service specifications are set out in appendices. In many ways, as can be seen from the template this repeats many of the provisions within the main Section 75 Agreement, but goes into more detail in relation to such matters as the individual service specification, etc. It may be the case that where many services are included within the Agreement, different appendices relating to each scheme are required.

Schedule 2 - Governance

The template relates to the particular Partnership Board approach adopted in the main Agreement but this is purely an example and there are many other approaches which the parties could agree.

Schedule 3 – Risk, Share and Overspends

The parties will need to consider carefully what they do in relation to both overspend and indeed any underspends that may apply and whether these are to be dealt with on a case by case basis or via a general apportionment approach. The particular example in the template includes an agreement with an acute provider, in which case it would be sensible to include the acute provider as a party to the Agreement for these purposes.

Schedule 4 – Joint Working Obligations

The template provides some illustrative examples of what the parties may wish to agree to that they require to have reported, etc. Once again the parties will need to decide for themselves what they wish for the obligations to be on the lead Commissioner and the other parties.

Schedule 5 – Performance Arrangements

Schedule 6 – Better Care Fund Plan

Schedule 7 – Policy for the Management of Conflicts of Interest

Schedule 8 – Information Governance Protocol

There may of course be other Schedules which the parties require as a result of their Agreement.