Report for: Health and Wellbeing Board – 31 January 2017

Title: Developing the Wellbeing Partnership Agreement

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1. Purpose

This paper seeks direction from the Health and Wellbeing Board (HWB) on the extent of the collaboration that should be reflected and formalised in the Wellbeing Partnership Agreement (a form of Accountable Care Partnership) to be presented to Council Cabinets, Trust Boards and CCG Governing Bodies in April and May 2017.

2. Describe the issue under consideration

Support was given to establish a Haringey and Islington Wellbeing Partnership at the 3rd October 2016 joint meeting of the Health and Wellbeing Boards. This support reflected the strength of collaborative working between organisations in Haringey and Islington and the commitment of local stakeholders. The next stage is to agree the areas for greater joint working and to reflect these in a Wellbeing Partnership Agreement.

This paper suggests seven inter-related areas where we can work together in an even more integrated way:

- Planning: working to a joint Health and Wellbeing Strategy
- Designing: bringing together our work to drive service efficiency and quality improvement
- Scoping services: collective oversight of the services we manage and deliver
- Financial decisions: taking decisions about spend and savings collectively
- Delivering: forming a joint management structure
- Monitoring: reporting together rather than separately
- Decision making: designing a system of decision-making that enables joint working

If the ultimate aim is full collaboration, we might think about each area as a series of stages from limited collaboration to full collaboration. HWB members are asked to discuss each area of joint working and to consider how collaborative we might strive

to become and over what timescale. Similarly, over the next two months Wellbeing Partnership organisations should consider the scale and pace of the changes they wish to achieve.

A series of discussion groups, are exploring in a greater level of detail, how we might extend and develop our level of integrated working. The suggestions from the discussion groups and the HWB discussion will help develop the Wellbeing Partnership Agreement.

3. Recommendation

That the Board consider and give views on the discussion questions in Paragraph 4 below.

4. Discussion Questions

There will be a short presentation at the HWB to help steer the discussion and the members will be asked to consider several questions about the areas of joint working and the pace at which we might integrate. Questions such as:

1. Would the HWB support the move towards a joint health and wellbeing strategy?
2. In which services might we best address our individual organisation's responsibilities through joint service redesign?
3. Our starting point is that all services are included. Are there any exceptions to this?
4. Would the HWB support the development of a partnership board at which significant financial decisions (e.g. savings and investment plans) are discussed and reviewed between organisations and at which delivery is monitored?
5. Can partners see how a single performance monitoring and reporting system could be developed across the Partnership?
6. Would the HWB support the extension of current joint management structures?
7. Does the HWB have specific comments on the governance model set out? Specifically, does it adequately allow us to address social as well as health needs? Does the draft governance model allow appropriate input from the community stakeholders? What might improve this approach?

5. Background

5.1 What is the Haringey and Islington Wellbeing Programme?

Over the past year several organisations in Haringey and Islington have come together to explore the benefits and opportunities to improve the health and wellbeing services for people who live in Haringey and Islington by working more closely together.

The organisations are Haringey and Islington Councils, Haringey and Islington GP Federations, Whittington Health, UCLH, North Middlesex, Barnet, Enfield and Haringey MH Trust, Camden and Islington FT and Haringey and Islington CCGs.

The organisations want to take a 'population approach' to improving health and care provision for the nearly half a million people who live in the two boroughs. This means collectively bringing all the resources of their organisations to bear on reducing ill health and improving health and care.

To begin with the Wellbeing Programme has been working on this approach for specific services e.g. **diabetes and CVD, frailty, learning disabilities, and MSK**. Clinicians and service professionals have met together to review existing services and to propose improvements to the way services are delivered. Our aim is to work together to support people to be and stay healthy, and deliver a preventative approach, strong community services and improved outcomes for people. By December 2016 business cases were beginning to be developed to seek agreement to change how those services might be delivered.

From this joint work and from the experience of working together on previous initiatives such as the Vanguard bid and value based commissioning, the programme has set out a series of objectives.

- To take a whole population approach to health and care delivery.
- To support all of our residents to achieve healthier, happier and longer lives, with a focus on preventing poor health and improving outcomes when people need care and treatment.
- To support people to stay and be healthy, to reduce the level of ill health within our population.
- To simultaneously focus on improving outcomes and reducing costs for population groups who are currently high consumers of health and care.

5.2 How will we do this?

- By bringing together all our resources (budgets), sharing budget information and taking collective decisions about their most effective use.
- By working together to redesign services in a different way using all the skills available to us across our collective workforce recognising that the necessary skills are not vested in one organisation or professional approach.
- By ensuring every organisation is seen to succeed by collective success.
- By developing using our collective information to create insight into how we can improve systems as a whole, where investment needs to go and to drive innovative ways of doing things.
- By bringing teams together, acting on behalf of each other to more efficiently use our staff.

- By collectively taking budget decisions, agreement will be reached on levels of activity and cost so reducing the transaction costs (need for lengthy complex contract negotiations) between organisations
- By working together with our communities and workforce we will accelerate the transformation of our health and care system in Haringey and Islington.

5.3 The need for change

Haringey and Islington populations are 263,386 and 215,667 respectively. The populations are expected to increase by 12% over the next 5 years. This is twice the national average. This rate of growth will put enormous pressure on social care and health services.

Poverty and deprivation are key determinants of poor health and wellbeing outcomes. Islington and Haringey have high levels of deprivation relative to the national picture. Residents are more likely to spend less of their life healthy compared to the England average (approx. 20 years of their life living in poor health).

Funding for social care and health services will not increase to meet the growth in demand on services. Therefore, we must change the way we deliver services, preventing poor health and supporting people to achieve healthier, happier and longer lives. When people need services we must ensure they are delivered effectively and efficiently, improving outcomes.

The Wellbeing Partnership members see an opportunity to achieve this by working more closely together than is possible as separate organisations under the current NHS and local government financial and contracting systems.

5.4 Why Haringey and Islington?

The population demographics in Haringey and Islington have many similarities and these are greater than the variation in health and care needs across the boroughs. This means that the organisations in Haringey and Islington are trying to address broadly similar issues in each borough. There is a simple logic to working together to address these problems.

There is a history of joint working between the organisations in Haringey and Islington, not just within each borough but also between the boroughs.

5.5 What are the benefits of working collaboratively across two boroughs?

<u>For Patients</u>

- A greater focus on prevention and early resolution of problems
- Better health for longer in life
- Maximising individuals' independence

- Care will be more joined up eg Care closer to Home Integrated Networks (CHINs)
- An opportunity to ensure there is a consistent standard of service for everybody
- Better access and availability from the economies of scale in delivering some services over a wider geographical area
- Clinicians and service professionals learn the very best practice from each other

In the way we work

- Creating proper integration across health and social care
- Bringing together people with providing and commissioning skills to work collaboratively to improve services
- Bringing together our collective leadership resource to work together on delivering the best possible health and care
- Developing wider clinical forums eg GP Federations and clinical leader meetings, bringing together more skill, experience and knowledge than previously
- The Joint Wellbeing Programme has been prompted by people choosing and wanting to work together, which is a stronger driver for change than enforced joint working.
- Providers have a real stake in improving delivery of population-wide health and care
- By providers and commissioners engaging differently and planning services and outcomes together, we can collectively achieve the changes to services we need and maximize benefits to service users

Organisational

- Provides democratic engagement and accountability with more local governance and greater transparency for residents and patients through the Health & Wellbeing Board role
- Economies of scale available across the two boroughs increasing efficiency
- Larger ‘clout’ as partner organisations with one voice
- Reduced transaction costs for contracting and multiple performance reviews
- A larger organisation enables retention of high calibre staff and offers opportunity to specialise
- Identifying a single leads for services across organisations improves efficiency and reduces duplication
- Haringey and Islington Councils have made a strong commitment to the programme providing a key local government foundation to the approach

crucial in terms of engaging with the full range of local services and providing local accountability

5.6 Where will the Wellbeing Partnership fit with the NCL Strategic Transformation Plan (STP) and North Central London (NCL) CCG reorganisations?

The STP is a largely NHS financial and service transformation plan developed across the five borough foot print (Barnet, Camden, Enfield, Haringey and Islington) involving NHS providers and commissioners with some limited local authority input. It is a plan for NHS finances and does not yet have social care finance factored in.

The STP service transformation work streams are: **elective care, urgent and emergency care, care closer to home, mental health and prevention**. By taking a 5 borough wide approach covering a population of 1.5 million, it focuses on changes to services which most benefit from standardised approach across a wider geographical and population footprint e.g. elective clinical pathways.

The Wellbeing Partnership has broadly similar objectives as the STP however it has been developed by the two councils social care (adult and children), CCGs and local health organisations seeking benefits from joint work on local delivery of services in two boroughs It is also able to build on the strong local connections to primary care, third sector and community organisations already engaged in the individual boroughs,

Its service transformation initiatives are aligned with several in the STP such as care closer to home, urgent and emergency care, mental health. However, it also includes others of importance in Haringey and Islington, such as Children and Young People and Learning Difficulties which are not a high priority in the NCL STP. The Wellbeing Partnership, with social care as a crucial partner in delivering change, is the way local services will be improved.

Many of the clinical and managerial leads from the Haringey and Islington Wellbeing Partnership are also leading work streams of the NCL STP. Indeed, the STP is looking to Haringey and Islington to test some developments such as an integrated digital database, before rolling them out across NCL.

The Wellbeing Partnership is offering local solutions to national systemic problems. Synergy with the STP will come from clarity about where and at what point in the system demand is best influenced and managed. Its success will depend upon the incentives there are for people to change approach. The STP requirement for collaborative working and a single management structure has accelerated organisational work between the CCGs particularly in moving Haringey and Islington commissioning structures more closely together.

So if those are the benefits, what do we have to change in our current system to be able to make this happen?

5.7 What needs to change?

Operational collaboration

Coming together across boroughs and provider and commissioning organisations requires a range of changes in how we plan; deliver, fund, manage and monitor services:

1. **Planning: working to a joint Health and Wellbeing strategy** - the work of public health teams will come together to help develop a shared population approach with an emphasis on prevention. There are already many similarities in the public health priorities across the boroughs and the potential for the development of a single Joint Strategic Needs Assessment (JSNA).
2. **Designing: bringing together our work to drive efficiency and quality improvement** – alter the current individual organisation service redesign processes to a collaborative process where skills available from all parts of the system are brought to bear on solving problems.
3. **Scoping services**: – considering and prioritising the range of services that will be planned or delivered by the partnership.
4. **Financial decisions: taking decisions about spend and savings collectively** - share budget information to enable decisions to be made collectively, transparently and reduce current transaction (contracting) costs.
5. **Delivering: forming a joint management structure** - identifying roles across organisations to maximise impact, increase efficiency and effectiveness particularly when management resources are scarce.
6. **Monitoring: reporting together rather than separately** - establish a collective, streamlined performance management response on behalf of the partnership organisations rather than each responding separately.
7. **Decision making: designing a system of decision-making that enables joint working**- the changes proposed above require the support of the partnership whose governance enables organisations (Local authority and NHS; commissioners and providers) to work together equitably and transparently, sharing risk and gaining from joint success

Cultural changes

Behaviour change supporting an organisational change

An Organisational Development programme needs to commence to help people in all the organisations become familiar with, build trust in and begin to work differently with colleagues in other organisations. Chief Executives and the most senior managers began this process many months ago in their work on the vanguard bid

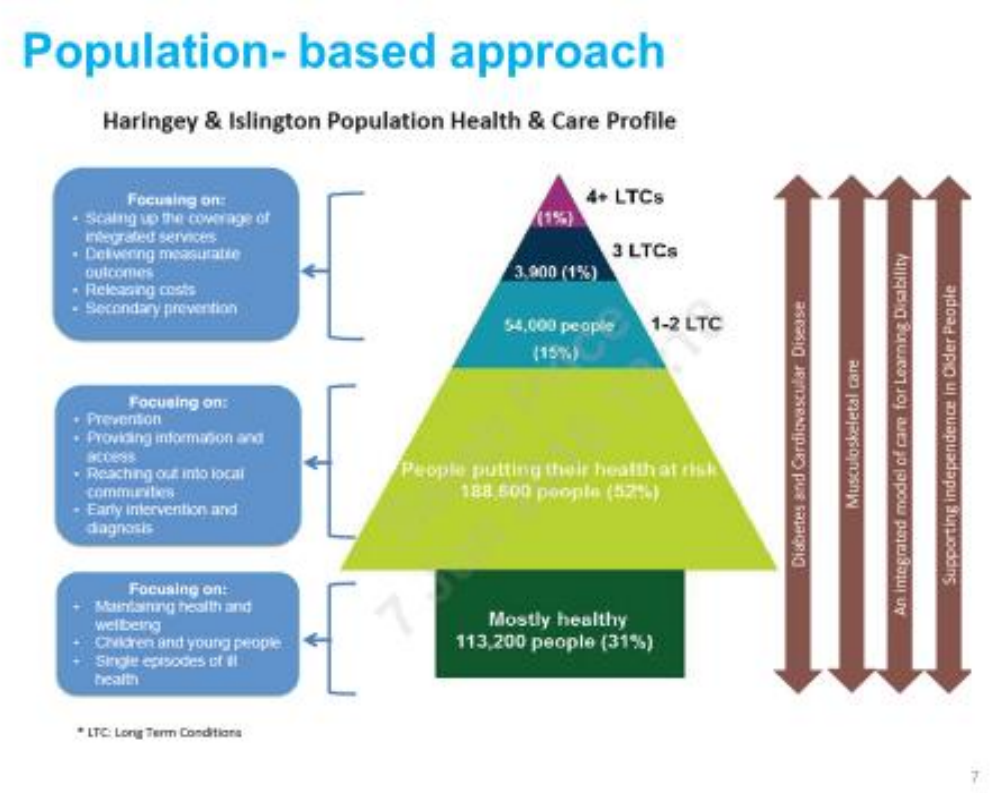
and value based commissioning. Most senior managers in the organisations and few middle managers have had exposure to that emerging collaborative approach and the current system usually mitigates against this behaviour.

There are several way in which the changes identified above might be implemented. Each may be considered on a sliding scale from small levels of collaboration to full collaboration. The ultimate aim is full collaboration. The section below outlines a range of stages to help move from small scale to full collaboration. Over the next two months organisations should consider the scale and pace of the changes they wish to achieve. The stages described should assist Governing Bodies, Council Cabinets and Trust Boards in their commitment to the future development of the partnership.

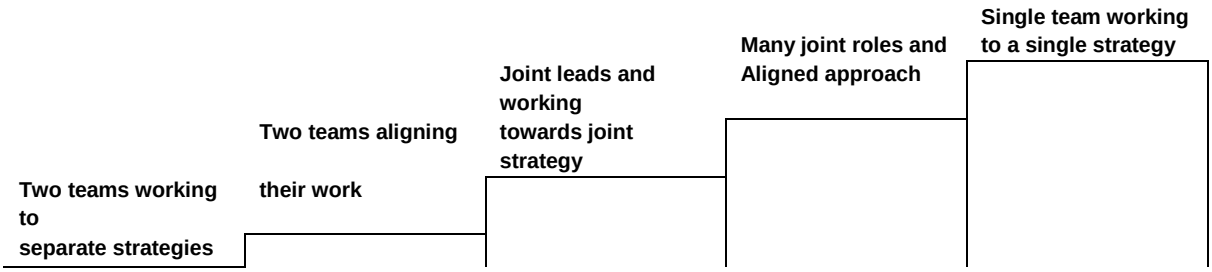
6. Areas for Increased Joint Working

6.1 Planning: working to a Joint Health and Wellbeing Strategy - bring together the work of public health teams to help develop the one population approach and the emphasis on prevention.

The Partnership has emphasised the need for a whole population approach to improving health and care for the people of Haringey and Islington. The public health teams in each borough play a crucial role in developing this approach. The approach has been summarised in the diagram below.



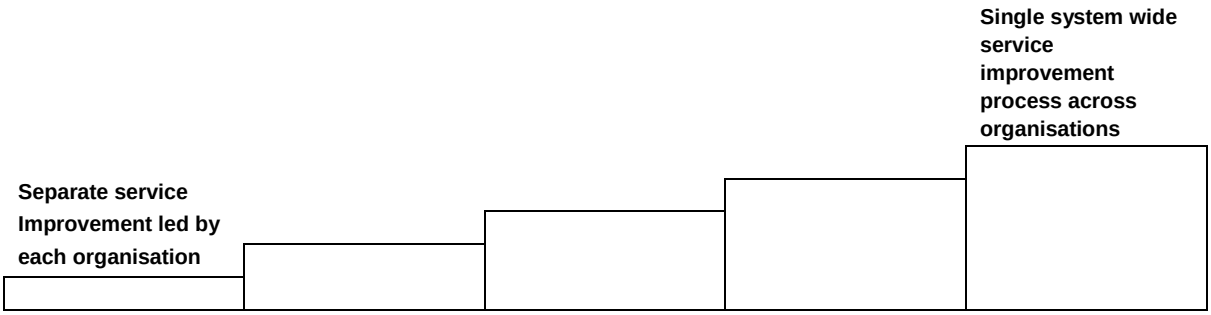
The proposal to establish a joint Health and Wellbeing Board naturally leads to the question of developing a single Joint Strategic Needs Assessment and a joint Health and Wellbeing Strategy. The current Health and Wellbeing Strategies have many similarities in content and structure. An analysis has been undertaken which shows the broadly similar prioritisation given by the separate teams to the common initiatives they are working on. Teams might work together to deliver a joint strategy which might lead to a merging of the teams.



partial collaboration *full*
collaboration

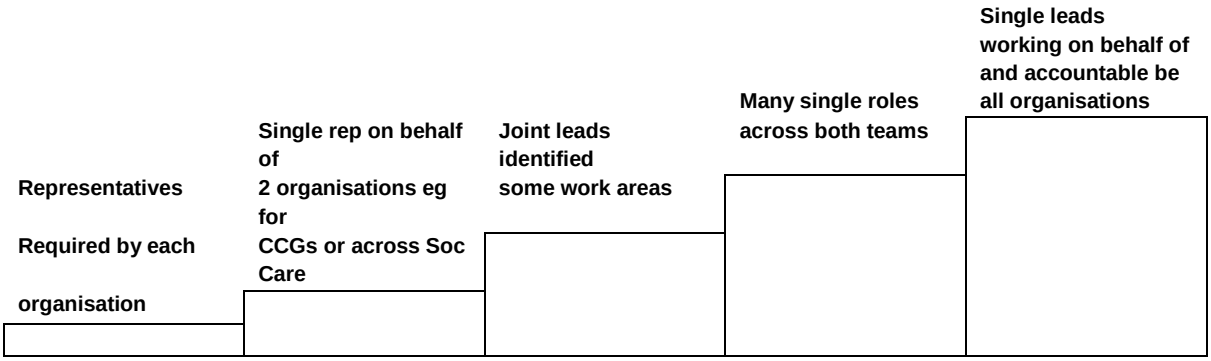
6.2 Designing: bringing together our work to drive efficiency and quality improvement – alter the current separate service redesign processes to a collaborative process where skills available to us from all parts of the system are brought to bear on solving problems. This takes us to agreeing a single service redesign lead acting for all organisations.

We currently have different service improvement processes within separate organisations such as hospital service improvement programmes and CIPs or council MTFS transformation programmes. CCGs operate a commissioning cycle for system service change which usually leads to a potentially divisive contract renegotiation or procurement process. If we bring these separate processes together we can bring all our energy to resolving the service issues rather than managing organisational processes.



partial collaboration *full*
collaboration

Furthermore, we can continue to send one representative from each organisation to collective meetings and so preserve the existing role - health / social care / commissioner / provider - or we can identify leads for individual service changes and give them access and accountability to each organisation to act on behalf of all.

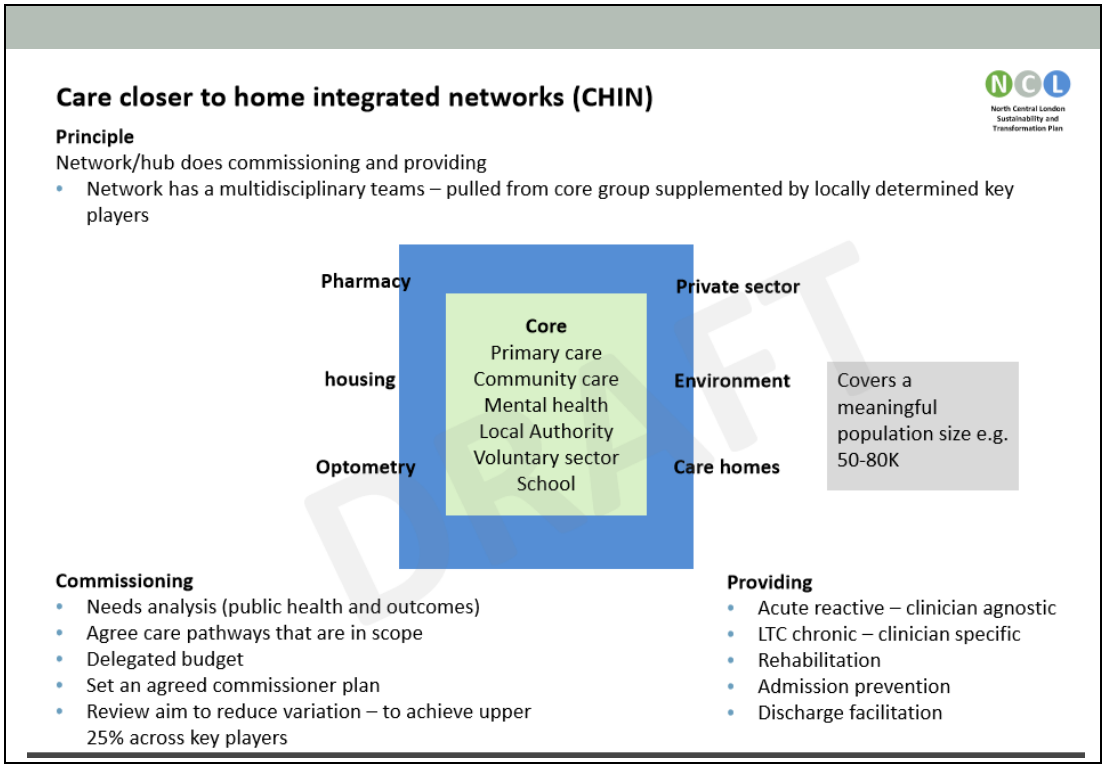


partial collaboration *full collaboration*

Care closer to Home Integrated Networks (CHINs)

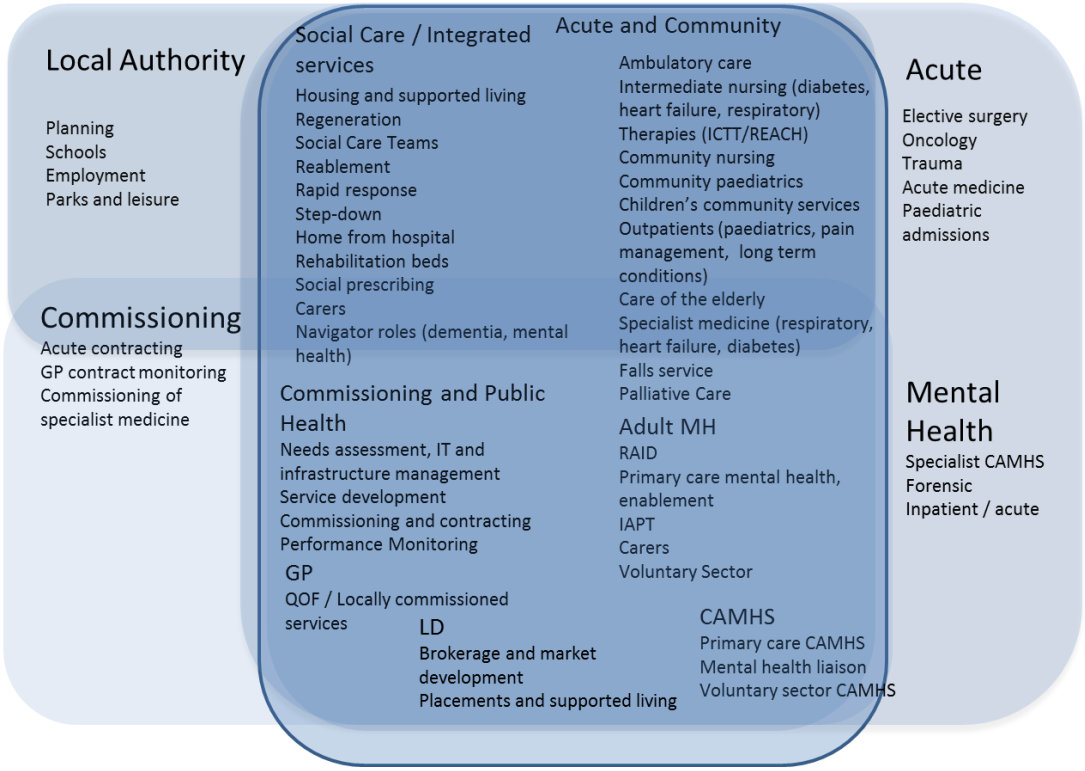
The STP "health and care closer to home" work stream proposes the development of CHINs as set out in the diagram below. CHINs will drive, at a local level, the transformation of care delivery that is required to support many of the changes set out in the STP. They will build stronger local integrated care so that patients are provided with a quality, consistent service across NCL. Furthermore capacity will be built within CHINs to enable a shift of activity from hospital into the community so that patients can be cared for closer to home. They are an opportunity to operationalise a population based approach to health and care provision by staff working in a more integrated way across organisational boundaries.

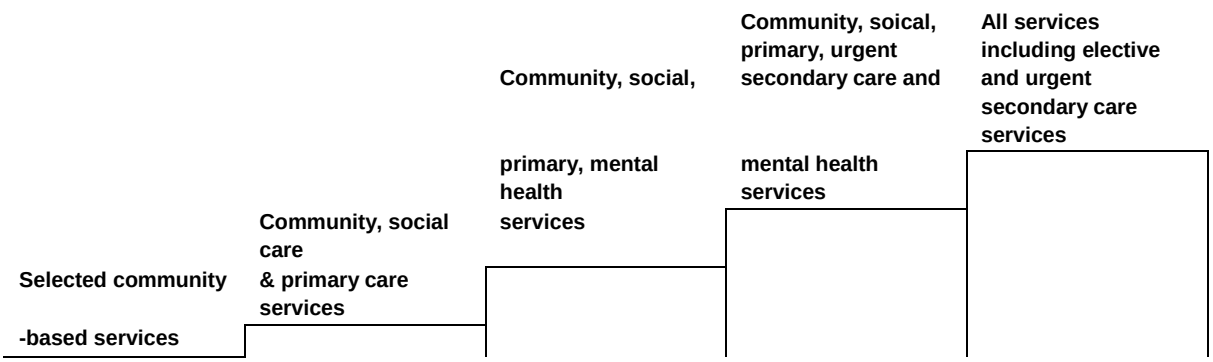
In Haringey and Islington this model is being adopted as a practical way in which we can test out cross organisational working to deliver services close to people in their community.



6.3 Scoping services: considering what range of services will be planned or delivered by the partnership.

The diagram below show the services organisations currently provide or fund – we will need to work out which of these are to be covered by the partnership. There will be some services which are best planned and consistency achieved over a larger geographical footprint. A good example are many elective clinical services where consistent referral and treatment criteria help ensure high quality of care. Other services fit well within local delivery and are best planned and delivered by the Partnership within the local boroughs.



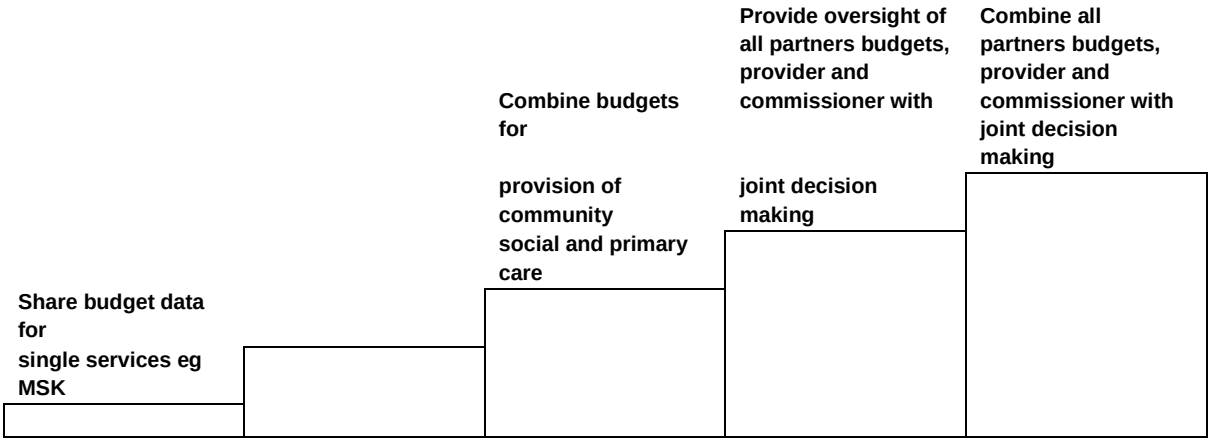


partial collaboration *full*
collaboration

6.4 Financial decisions: taking decisions about spend and savings collectively - share budget information to enable decisions to be made collectively, transparently and reduce current transaction (contracting) costs

One interpretation of 'a whole population approach' suggests the collective oversight of the total funding available to health and care statutory organisations in Haringey and Islington. The budget allocations of the two CCGs and both boroughs' adult and children's social care departments would be managed together with clarity on how that funding is used in local providers. The critical question is how prioritisation decisions are taken across the system and how these are enacted in a budget setting rather than contracting process within the Partnership?

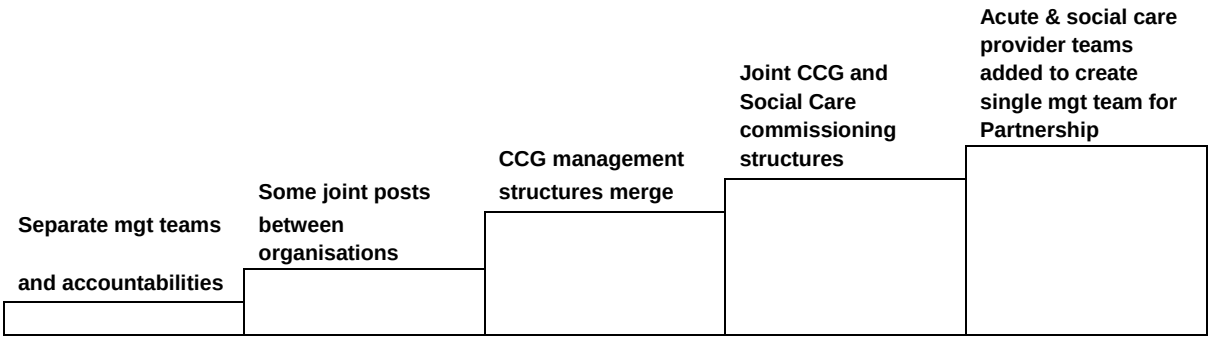
Alternatively, the partnership could begin working together and sharing four or five individual service budgets eg MSK, LD budgets. As the number of services managed in this way increases so the scale of the jointly managed budget increases.



6.5 Delivering: forming a joint management structure - identifying roles across organisations reduces duplication, increasing efficiency and effectiveness when management resources are scarce.

Economies of scale in support services such as HR, IT, procurement & legal services should also be considered in this area of collaborative working.

Closer working gives us the opportunity to review the efficiency of our use of management resources. The CCG changes are prompting an early consideration of management structures but we could use this to go further in developing a virtual management structure for the future partnership. Changes in joint commissioning at Haringey and current arrangements at Islington could also be reviewed. A further significant step would be to consider the implications of including management resource at the providers.

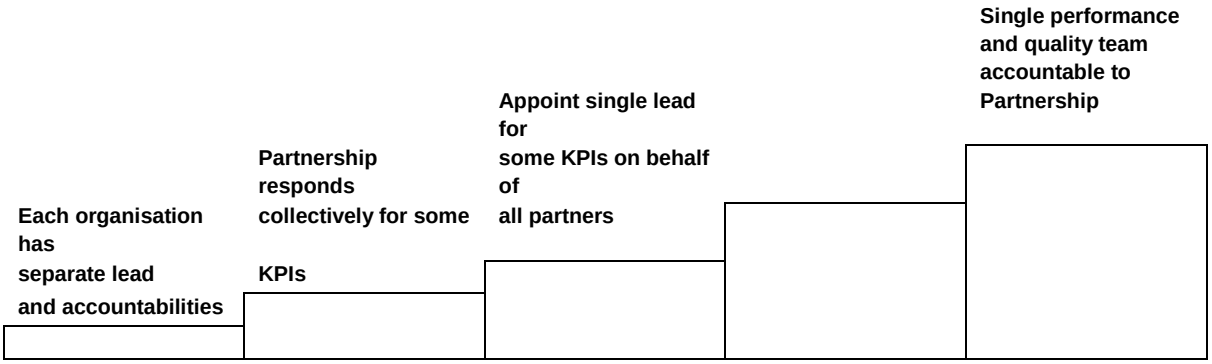


Clinical Commissioning Group (CCG) management arrangments

Following the development of the North Central London Sustainability and Transformation Plan (NCL STP), agreement has been reached to appoint a single CCG Accountable Officer for NCL. In Haringey and Islington there is agreement to bring together the management teams in the two CCGs. This process is at an early stage but is intended to progress within the next few weeks. This offers an opportunity to consider management structures within the Partnership and how lead arrangements for service redesign might be developed.

6.6 Monitoring: reporting together rather than separately - establish a collective performance management response on behalf of the partnership organisations rather than each responding separately.

NHS England, NHS Improvement, CQC and other regulatory and monitoring organisations currently hold each of the partnership members to account. We each provide a lead to represent us to these bodies. Alternatively we could appoint one lead for certain performance areas to act on behalf of all organisations. This would be more efficient, reducing duplication and present the partnership as a single body with one 'position' on issues. The opportunity for a blame culture is reduced. An added benefit is that all organisations can reflect in the collective success of the group in the same way that all share in the risks.



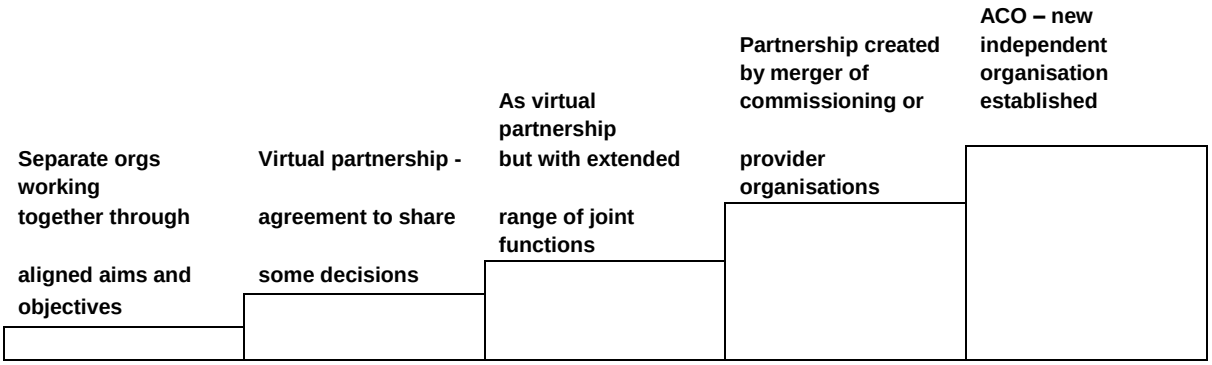
6.7 Decision making: designing a system of decision-making that enables joint working - the changes proposed above require the support of a partnership whose governance enables organisations to work together equitably and transparently, sharing risk and gaining joint success**.**

A governance structure is required for organisations to commit to sharing and making joint use of budgets within which **service providers** can seek efficiencies through joint working to deliver services more effectively. There are several models broadly termed Accountable Care Organisations.

An ACO brings together a number of providers to take responsibility for the cost and quality of care for a defined population within an agreed budget. ACOs take many different forms ranging from fully integrated systems to looser alliances and networks of hospitals, medical groups and other providers.
The Kings Fund 22 March 2016

The Wellbeing Partnership Agreement might be viewed as an ACO but where the agreement between parties, rather than forming a new organisation, is based upon a legally binding partnership agreement and explicitly involves commissioners and providers.

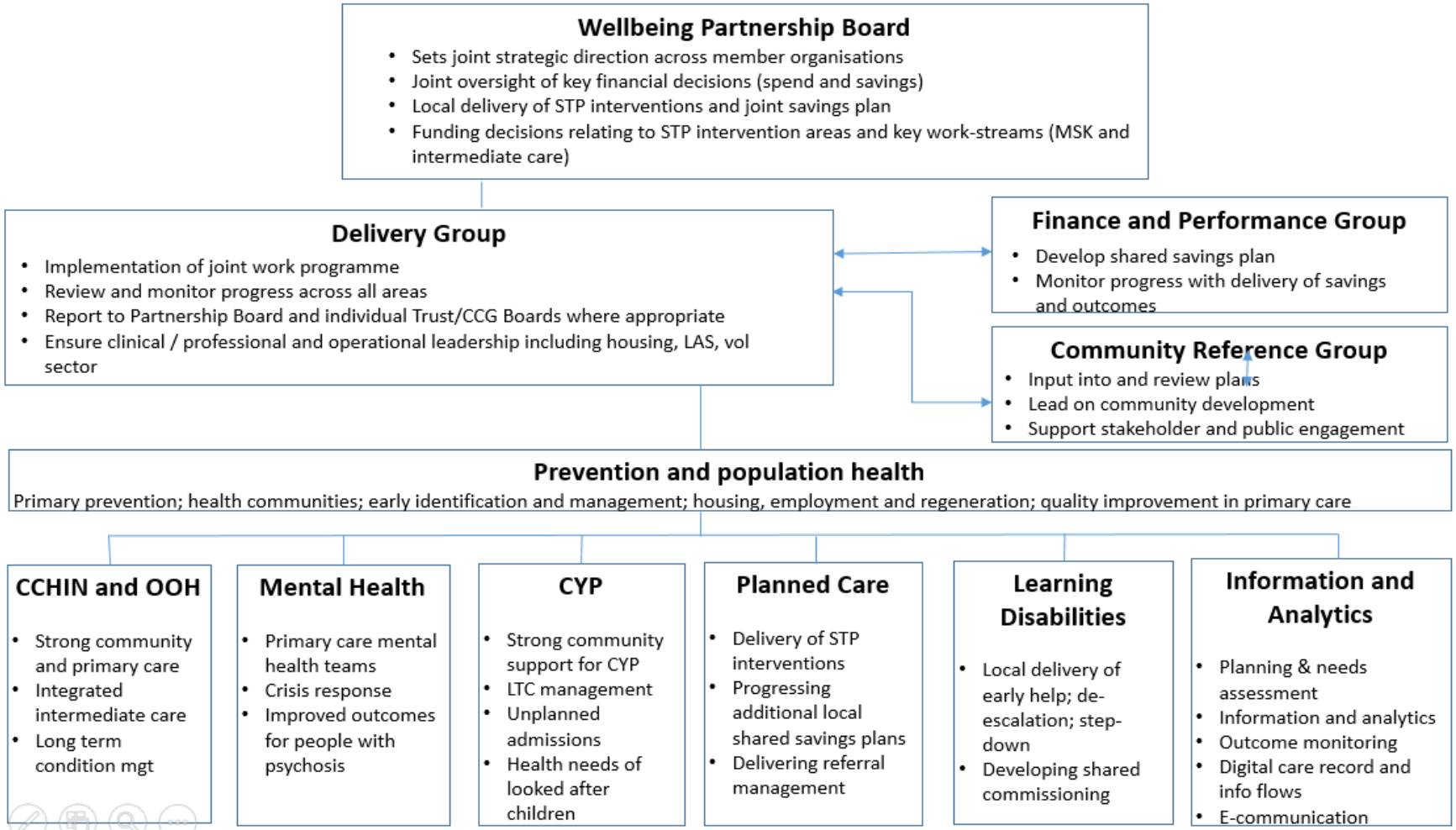
The form of the MCP and PACs models described in previous papers to the Joint Health and Wellbeing Board are predominantly developments of NHS provider organisations and do not fully involve social care. Whilst elements of each might be helpful, the Wellbeing Partnership has set out a vision which brings together commissioning organisations with providers and social care in a central role.



At the Joint Health and Wellbeing Board in October, there was agreement that a virtual partnership might be the most useful arrangement for 2017-18. During the year further close working would lead organisations to accept a more formal partnership agreement for a future phase of collaboration.

A draft governance structure for 2017-18 is outlined in the table below. This describes the functions for each of the committees as the functions will help define membership for the governance arrangements. The current Wellbeing Programme workstreams have been grouped under each of the NCL STP service transformation groups. This is deliberate to reduce confusion about service change over different geographical footprints but does not prejudice the Wellbeing Partnership's priorities.

Draft governance structure for 2017-18



7. Evaluation

In the Wellbeing Partnership agreement which goes to the various Governing Bodies in April and May, we need to include a section on how we will evaluate the success of the Partnership approach. This should primarily be focussed on service and efficiency improvements prompted by a collaboration between partners but should also include lessons learnt in the partnership development process itself. This will require a properly established evaluation process. There are several organisations who are experts in this area who can be engaged for this work.

Several success factors have been identified in developing ACPs elsewhere. These include:

- Taking responsibility for the full budget associated with a population, with a risk / gain share in place to create incentives to address need, manage demand and share the risks of population growth or activity increases
- Using information and analysis about the population to predict health and care need and inform planning
- Developing strong and clear links between primary care physicians who can coordinate all medical care for high-risk patients and community services and specialist teams
- Focusing on the small proportion of people who account for a high proportion of use and targeting interventions
- Developing case management programmes for people with multiple chronic illnesses
- Sharing access to the clinical information about the patient, regardless of where previous treatments and care was delivered.

8. Next steps

During January, February and March a series of discussion groups are underway to develop more detail about the steps required to move from partial to full collaboration. This detail will be reflected in the final Partnership Agreement. The Partnership Agreement will aim to clarify the degree of integrated working to which partners commit. It will also signal the pace at which movement to fuller collaboration might occur.

If there is another meeting of the Health and Wellbeing Board before the end of March 2017 the draft agreement can be shared for discussion. The intention is to take the final Partnership Agreement to the Council Cabinets, Trust Boards and CCG Governing Bodies for signature during April and May 2017 so that the Partnership governance arrangements can begin formally from June 2017.

A ‘heads of terms’ for the Partnership Agreement is included in Appendix 1 below for comment.

9. Contribution to strategic outcomes

These proposals support the strategic principles and outcomes of the Haringey and Islington Wellbeing Partnership as well as priorities in the key strategic plans of all partners to the arrangements.

10. Statutory Officer Comments (Legal and Finance)

Legal

Accountable Care Partnerships are relatively new organisational forms intended to bring together commissioners and providers to take responsibility for the cost and quality of care for defined population, in this case Haringey and Islington, and within an agreed budget. Information available, suggest that accountable care partnerships may take many different forms including a fully integrated care systems with an opportunity to break down traditional barriers between organisations and to improve the quality of services. This form of system wide integration under a collectively defined and managed budget would require partners to sign an Accountable Care Partnership Agreement to affirm their collective accountability for outcomes, define their mutual responsibilities to deliver integrated care and to formally agree a joint governance structure to make decisions, allocate and manage funds, manage performance, share resources, risk and rewards and hold each other accountable for delivering outcomes. There may also be individual agreements between commissioners and providers that sits alongside or are aligned with the Accountable Care Partnership Agreement.

Section 195 of the Health and Social Care Act 2012 (duty to encourage integrated working) provides that, a Health and Wellbeing Board must, for the purpose of advancing the health and wellbeing of the people in its area, encourage persons who arrange for the provision of any health or social care services in that area to work in an integrated manner. The recommendation to the Haringey and Islington Health and Wellbeing Board to endorse the move towards an accountable care partnership falls within the function of the respective Boards to encourage integrated working across health and social care. The same also apply to the proposal that partners agree a memorandum of understanding on principles, outcomes, expectations and responsibilities and as a prelude to the accountable care partnership arrangements.

In scoping out the work required to move towards this new partnership model, partners should, amongst other matters, consider whether there is likely to be changes to services provided to residents of the respective boroughs. If so, the

nature and extent of the changes and the need for public consultation, in particular, if there is likely to be an adverse effect on services delivered to residents. Partners should also consider the implications on existing contractual and other partnership arrangements for example Section 75 Health and Social Care Partnership Agreements and how this can be aligned with the proposed accountable partnership arrangements. Partners must ensure that they seek the required authority of their respective decision making body to enter into the proposed partnership arrangement. For the local authorities, this would require a report to their respective Cabinet for a decision.

Chief Finance Officer

The creation of an Accountable Care Partnership that potentially could involve the budgets for Adults Social Care and Health in LB Haringey, Haringey CCG, LB Islington, Islington CCG and partner healthcare trusts is a major undertaking. While it may provide significant opportunities for synergies and efficiencies across the partnership, there are also risks about individual organisations having less direct financial control of parts of their finances at a time of financial constraint. Moreover, there are likely to be significant resources required to bring such a partnership into being.

At this stage, the report is seeking an agreement in principle to the concept and to carry out more work to establish the practical steps that would be necessary. The Haringey and Islington Health and Wellbeing Partnership should ensure that it has access to sufficient resources to undertake this activity.

11. Environmental Implications

There are no significant environmental implications arising directly from this report.

12. Resident and Equalities Implications

The council must, in the exercise of its functions, have due regard to the need to eliminate discrimination, harassment and victimisation, and to advance equality of opportunity, and foster good relations, between those who share a relevant protected characteristic and those who do not share it (section 149 Equality Act 2010). The council has a duty to have due regard to the need to remove or minimise disadvantages, take steps to meet needs, in particular steps to take account of disabled persons' disabilities, and encourage people to participate in public life. The council must have due regard to the need to tackle prejudice and promote understanding.

A resident impact assessment has not been completed because an assessment is not necessary in this instance.

13. Appendices

Appendix 1 - Content of the Partnership Agreement

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The table below outlines some of paragraphs which might need to be set out within the Partnership Agreement. The list is not meant to be definitive or comprehensive but is intended to prompt consideration as to how arrangements will be articulated.

Heads of Terms

1	**Duration of the Agreement** The initial agreement may be for the period to 31 March 2018 by which time more collaborative work will be underway and an updated agreement necessary for April 2018	
2	**Summary of Partnership Arrangements** Broad details of what the partners have agreed to work together to achieve in the context of the organisations overall corporate objectives	
3	**Shared & Aligned Budget Arrangements** To specify the budget sharing arrangements, perhaps providing transparency, single management of smaller budgets (a version of a S75?), collective decision making on larger budgets.	
4	**Joint Savings Plans; Overspends and Underspends** The Partnership is exploring joint development of savings plans. These will require collective monitoring and clarity on management variation in achievement.	
5	**Lead Management Arrangements** To specify the responsibilities and accountabilities for any lead management arrangements or posts on behalf of partnership members	
6	**Staffing Arrangements** This section will clarify the joint management structure arrangements and the terms of any secondment or accountability agreements required	
7	**Financial Contributions and Cross Charging** There will be a need for contributions (monetary or in kind) to the running of the Partnership. This and the agreed basis of any recharges between partners will be specified.	

8	**Non-Financial Contributions** As above	
9	**Information Sharing** Current and new information sharing protocols will be required to remove barriers to joint working.	
10	**Performance Monitoring and Reporting**	
11	**Risk Management And Risk Sharing Arrangements** Crucial to developing joint work is agreement on how to manage risks between and on behalf of other partners	
12	**Governance Arrangements** Details of membership and associate membership will be specified as well as agreements on quorate voting requirements	
13	**Dispute Resolution**	
14	**Complaints**	