PARTNERSHIP ARRANGEMENTS UNDER THE HEALTH ACT 1999 AND CARE TRUSTS - MAIN FEATURES AND IMPLICATIONS

Introduction

In September 1998 the government published a consultation document called Partnership in Action, which contained ideas for improving joint working between health and social services. The intention was to remove barriers in the existing system that prevented vulnerable people receiving integrated, needs led services. By the time the proposals were converted into legislation in the Health Act 1999, they included all health related functions of local government and not just social services.

The Health Act 1999 introduced new powers (from April 2000) to enable local government and the NHS to create new forms of partnership. The Act allows these powers to be used, it does not make them mandatory. However the NHS Plan (published after the Act) indicates that the Government will in future require the powers to be used. The NHS Plan also introduced the concept of Care Trusts, which take the model of partnership further than the Act.

This paper aims to assist those who are interested in developing partnership working. It summarises the relevant parts of the Act, suggests how these might be used in practice and raises important issues for local consideration. It summarises what is known about Care Trusts and suggests some key issues for those interested in their future introduction.

Contents

Part 1

Background

Partnership arrangements can be introduced at any time of year, once they have been registered by the relevant Regional Office. Proposals to introduce the arrangements should be included in the local Health Improvement Programme. The arrangements are designed to improve services in terms of co-ordination, coherence, appropriateness and cost effectiveness. They can be used to commission and provide most NHS services and all health related functions of local authorities including social services. There are three types of arrangements, described as "flexibilities" within Section 31 of the Act:

- Lead Commissioning
- Pooled Budgets/Funds
- Integrated Provision

Lead Commissioning

Key Features:

One agency takes on commissioning for a particular service on behalf of other organisations.

Can be undertaken by Health Authority, Primary Care Trust (PCT) or Local Authority (LA).

Liability/accountability for functions exercised still remains with originating body.

Funds are delegated to the lead commissioner with which to purchase services. These must be spent on services to reflect the financial contribution from each organisation to the commissioning budget i.e. NHS funds must be spent on NHS functions, LA funds on LA functions.

Services can be commissioned from any provider (public, private, voluntary)

Possible Uses:

Where single contracts and contracting process would be advantageous e.g.:

- Leverage with providers on cost
- Leverage with providers on quality e.g. co-ordination of services, flexibility.

Where more innovative services could be designed by having a single organisation specifying the services and having some capacity to reallocate funds between types of service.

In comparatively small specialist service areas where amalgamating commissioning expertise would increase capacity to develop service specifications, agree contracts and evaluate outcomes.

Examples of Options:

The Dept of Health describes this arrangement as similar to joint commissioning, which some authorities already use for learning disability and mental health services. The difference between the two would be that in lead commissioning a multi-agency board would not be required to make decisions.

This arrangement would seem especially relevant to services for well defined client groups with long term needs where the underlying aim is to support people increasingly in social care settings but with a strong health component.

For older people's service there are clear benefits to be gained from joint strategic planning. However it may be difficult to identify commissioning budgets because in many NHS services expenditure is not differentiated by age groups.

Issues to Consider:

Need to be clear about where different levels of commissioning are undertaken and how they relate. The first level is clearly part of lead commissioning and the second will be if funds for purchasing services are held be the lead commissioner. The third is probably too operational to be included.

- strategic commissioning/planning for a population group
- development and monitoring of agreements/contracts with providers
- the assessment of individual need and arrangement of care.

How to make sure that the organisation delegating its responsibilities can effectively monitor the quality and cost of the services commissioned.

Pooled Budgets/Funds

Key Features:

Funds are pooled by organisations to meet specific objectives and each agrees a level of contribution and length of time for the arrangement to operate (including review, extension and termination)

Clear aims and objectives must be agreed at the beginning. The partner organisations will measure the value of their investment against these.

Organisations that can contribute their funds to the pool are Health Authorities, Primary Care Trusts and Local Authorities. Hospital and community health trusts can, with the agreement of relevant health authorities, be contributors to the pool.

Funds can be contributed from main budgets and Partnership Grant allocations.

The fund is meant to cover mainly revenue expenditure. Major capital costs need to be met through Sections 29 or 30 of the Act (see Part 2 of this paper)

One organisation "hosts" the fund and appoints a single manager with responsibility for overall spending and reporting to contributing partners on outputs and outcomes. Host organisations can sub contract the management of funds to another independent organisation.

The host organisation identifies staff who will assess individual need and purchase appropriate care using funds from the pool. Local authority staff can purchase health services, NHS staff can purchase services that would normally be purchased by the local authority.

Once in the pool the funds can be used for any specified services that fall within the functions of the organisations contributing i.e. funds originating in the NHS can be used on LA functions and vice versa. Funds can be used to purchase from independent providers.

Contributing organisations retain responsibility for their **functions** as exercised through the arrangement. They will need to know the extent to which the services resourced through the pooled budget are fulfilling their organisational objectives.

Underspends can be carried forward, unless they are from Partnership Grant.

Possible Uses:

To fund integrated provision (see below)

Services where boundary disputes about responsibility cause problems for users in terms of continuity, delays and appropriateness of response i.e. where deciding on responsibility is difficult but identified needs are obvious.

Where each budget is small but in combination provides a critical mass sufficient to introduce improvements e.g. extended availability, faster responses, higher quality.

Where the mix of health and social care needs experienced by individuals varies over time and is difficult to predict.

Examples of Options

Combining budgets for the purchase and maintenance of equipment that will enable people to stay at home or be discharged into residential/nursing home care e.g. special beds and mattresses, moving and handling equipment, alarm systems.

Allocating funds to employ staff within an integrated service. This would enable the manager of the service to vary the skill mix of the staff group to best meet needs. (see below for examples of integrated services)

Funding the running costs of joint services, for example, one stop shops or customer information services.

Issues to Consider:

Pooled budgets to cover **staffing costs** will be most effective in combination with integrated provision because one manager will control the recruitment, terms and conditions and training. Pooled budgets for the **purchase of services** could be allocated to staff employed in different services but will require effective protocols for purchasing and budget management.

How the organisations contributing to the pool will assess the way that the activity funded from the pool fulfils their objectives.

To respond quickly and flexibly staff need to be able to access budgets quickly. The budget allocation system has to devolve responsibility as much as possible but maintain mechanisms for avoiding overspends.

Integrated Provision

Key Points:

Particular services previously provided by different organisations are integrated by being brought within a single management structure .

Services provided can include the assessment of individual need and care planning.

The role of Integrated Provider, (managing the service), can be taken by NHS Trusts, Primary Care Trusts and Local Authorities.

The Integrated Provider may provide all the services directly or sub–contract with other independent providers where appropriate for some of the service.

The organisations that have transferred their responsibility to the Integrated Provider must monitor the effectiveness of the arrangements.
All staff will be managed by the Provider and can either be seconded from another organisation or directly employed.

Possible Uses:

Where service outcomes could improve because groups of staff previously working within different systems/organisations can be pulled together e.g.:

- Co-ordination of needs assessment and care planning.
- Common information systems.
- Potential for generic roles i.e. one person undertakes health and social care tasks.
- Greater consistency of performance through common procedures/standards.
- Integration of staff training and development.

Where the combination of a larger group of staff and single management structure could lead to more appropriate services e.g. :

- Potential to have greater coverage in terms of hours, geographical area.
- Capacity to effect a more rapid response to emergency needs.
- Availability of wider range of expertise within group.

Examples of Options

At a King's Fund seminar participants identified a range of intermediate care services for older people that might be suitable for integration using the flexibilities. The preference was for multi-disciplinary teams meeting a cluster of health and social care needs and under one management. Some examples of the clusters are shown below:

Rapid Response/Out of Hours service:

Immediate support at home for 24 hours until assessment and other services arranged
Advice and support out of hours and referral if necessary
Up to six weeks rehabilitation/recuperation support at home or in special facility
Assessing A&E attendees for potential to be discharged with support

Care Management Service:

Receives referrals on 'at risk' individuals for further assessment.
Comprehensive assessment of need pre-admission, pre discharge and at home.
Care planning and organisation (including purchase) of services
Undertakes or commissions regular reviews of need

Community Support Service:

Undertakes or co-ordinates first stage screening to identify at risk individuals
Organises housing support, Care and Repair and handyperson
Co-ordinates community alarm systems
Organises low level practical support at home

An integrated service will be part of a larger network of services. Set out below are those that were considered most important for an integrated service to have rapid access to. (In some models, one or more of these services might be part of the integrated service)

- Primary health care team
- Diagnostic services e.g. x-ray, blood tests.
- Community geriatrician
- Specialist medical input
- Transport
- Housing adaptations
- Day care/hospital

There are various options in terms of location of services. How services are organised depends on their function. They are likely to follow one of the following models:

- All services provided in one location
- Some services in central location but with outreach
- Single base for co-ordination, meetings, communication but most services provided outside.
- No base for services/staff, services provided in dispersed locations.

Issues to Consider:

Is the provision of services from a single location important in terms of improving outcomes or is single management the key, irrespective of the location of services/staff. For example, will single management make it easier to develop common assessment procedures and persuade staff to trust each others assessments.

If co-operation between services has failed in the past, in what ways will integration address the causes of this failure?

There will always be services outside your 'core' service. How will effective links be made with these?

What improvements to the service will integration bring that cannot be achieved through other means?

Next Steps

If you believe that a local partnership arrangement could improve service outcomes, you need to consider the following:

The work involved in setting up new arrangements is only worth doing if it will lead to better health and health care. Clear aims and objectives must be agreed at the outset. The arrangements have been developed to provide opportunities for innovation rather than provide identical services within different structures.

What role does your organisation wish to take? i.e. are you proposing that your organisation becomes a lead commissioner, pooled fund manager or integrated provider or do you see another agency taking this role? PCGs need to consider their plans regarding possible Primary Care Trust status. Whereas PCTs could take on any of the three roles, PCGs could only take on lead

commissioning or management of a pooled budget on behalf of the Health Authority. PCGs planning to apply for PCT status may want to start negotiations relating to responsibilities that they will take on in the future.

Partnership arrangements will need to be supported by jointly agreed policies and systems on governance, performance management, staffing, information sharing and financial accountability. Further information on this is included in Part 3 of this paper.

Success in introducing these partnerships will require high levels of trust and genuine consultation, any organisation wishing to propose such changes would need to start local discussions as early as possible. Test out local responses to your ideas before getting too far into the detail.

Part 2

Sections 29 and 30 of the Act

Introduction

These sections provide alternatives to the flexibilities as a way to transfer funds between organisations. The transfers are contributions to specific services, which the receiving authority agrees to provide. The body transferring funds needs to be satisfied that the payment is likely to secure a more effective use of public funds than the deployment of an equivalent amount on its own services. They can be used for revenue expenditure. They should also be used to cover large capital items that both organisations see as essential to a service. This is so that one organisation is the clear owner of the building or equipment. A good example of this would be the transfer of funds to contribute to the purchase or lease of premises for an integrated one stop service.

Section 29

Builds on previous legislation, which enabled health authorities to transfer funds to local authorities and voluntary organisations for certain functions. In the past this was used mainly to fund people with learning disabilities or mental health problems who were coming out of long stay hospital and being cared for in the community. Section 29 extends the powers to cover all health related functions of local authorities and voluntary organisations and also gives these powers to PCTs.

Section 30

In the past there was no reciprocal arrangement allowing local authorities to transfer funds to the NHS. This introduces a new power for local authorities to transfer funds to PCTs and health authorities for certain functions. Some NHS functions are excluded from this e.g. surgical treatments and emergency ambulance services. Local authorities must notify their social care region if intending to use Section 30.

Part 3: Issues to consider if decision is made to introduce partnership arrangements under the Health Act 1999

Introduction

This section summarises the operational and policy issues arising once a decision is made in principle to introduce new partnership flexibilities. Further detail is provided in the Department of Health guidance. HSC/LAC 2000/09 Implementation of Health Act Partnership Arrangements summarises the changes and has details of related documents. (For access via internet: www.doh.gov.uk/jointunit/implementation.htm)

Consultation with:

- Groups who need to support proposed partnership if it is to be successful.
- Staff whose jobs will be substantially affected.
- Other organisations whose income, future plans and relationships will be affected if new arrangement comes into being.
- People who will use services commissioned/provided within the new arrangements, especially where you aim to innovate.

Planning

- Do you need a project manager to oversee the development work?
- What sort of planning group is needed, membership?
- Agreeing the vision, outcomes and targets for service and how to revisit these regularly.
- How success will be evaluated?
- The scope of the service to include, small scale 'pilots' may be attractive in terms of risk but may prove difficult to roll out more widely.
- How to publicise plans, services, influence expectations.
- Decide when to obtain financial and legal advice, from the outset is probably best.

Access to Services

- Criteria for accessing services.
- Assessment protocols
- Multi-disciplinary care plans

Staff Management and Training

- Which arrangements will promote stability and offer career progression?
- Define the competencies needed for different roles.
- Will existing staff need new contracts?
- Is there a need for new posts to be set up?
- Will the arrangement change reporting lines of staff?
- Will staff have to do work they will need new training for?
- If you are creating new ways of working how will staff be supported to take risk and respond to setbacks?
- Are there innovative ways to meet training needs? (secondments, rotation, shadowing)

Information Sharing

- Will there be a need for aggregated info to be shared between the partners e.g. population data?
- Will there be a need to share data on individuals in order to operate the new arrangements effectively?
- Are user held records an option?
- Will the sharing be done using IT or other systems?
- Read Appendix B (Information Sharing) of Dept of Health Guidance on partnership arrangements for more detail on confidentiality, user access to records and Data Protection Act.

Charging

- Are elements of services due to be part of the partnerships charged for at the moment? If yes, are these mandatory or discretionary? Mandatory areas such as places in residential care homes are charged for within a national scheme, policies on discretionary charges are set locally.
- There is no change to the national policy of not charging for NHS services and any income from charges cannot go to NHS services.
- If local authority wants to charge for services purchased through a pooled budget, the LA contribution must be made gross, therefore need for LA to estimate income in advance.
- If charges are to be made, how will these be explained to services users and who will be responsible for ensuring that this happens.

Governance

- New arrangements do not remove the ultimate accountability of each organisation for its functions. They need to know about service objectives, efficiency, quality and outcomes.
- What does each partner currently need to know about the effectiveness of its functions, how can this information be made available within the new arrangements?
- Are there ways of streamlining the systems to minimise duplication of work and systems?
- Consider what sort of decision making body is needed to manage the new arrangements, options include a Partnership Board, existing body if appropriate or an officer group. How much responsibility is each organisation willing to delegate to whatever body is set up?

Performance Management

- What outputs, outcomes and targets will show that the overall objectives of the new arrangement are being met. How will consistent data on these be generated. Targets are expected to encourage continuous improvement.
- How will the experience of service users be included in assessment of the quality of services.
- Ideally complaints from users should be dealt with by the partnership itself and not each agency.
- Do you want to compare the new arrangements with previous ones? How might this influence decisions to continue with the new arrangements in the future.
- If local authority functions are included it will be necessary to include Best Value measures.
- If clinical functions are included it will be necessary to introduce Clinical Governance measures.
- If non clinical NHS functions are included it will be necessary to take account of "Value for Patients", arrangements which will replace compulsory market testing.
- The new arrangements will be subject to inspection by the Department of Health.

Part 4

Care Trusts

The concept of Care Trusts (CTs) is introduced in the NHS Plan but very little detail is provided about them. They are described as single, multi-purpose, legal bodies that commission and provide all local health and social care. The Plan says that the first CTs could be in place in 2001. However it would appear that a change to existing legislation would be required to allow them to be established. Given the lack of available detail it is not possible to identify clearly all the implications. Set out below are issues arising from what is already apparent.

Flexibilities or Care Trusts

A key concern for NHS bodies and local authorities is whether by opting for one or more of the flexibilities they will make it more difficult to move to CTs in the future. The key difference between the two options is that CTs are all embracing, whilst the flexibilities are likely to be applied only to some services. They have the same underlying themes of integrating the planning, purchase and provision of services.

Probably the most fruitful way to consider these issues is to look at the purpose of any new way of working. The things that will make a difference to services users and carers will be:

- The use of common assessment systems for health and social care needs.
- Improved co-ordination and integration of services where duplication, gaps and discontinuity occur.
- Faster service responses, especially for those at risk
- Greater involvement of users and carers in decisions about services.
- More integrated and accessible information systems for individual care and service planning.
- Development of services that promote independence and prevent deterioration.
- Development of intermediate care services that enable people to stay in their own homes.

Things that make the flexibilities and CTs potentially compatible include:

- Incentives to focus on the reality of individual need without having to distinguish "health" and "social" needs (pooled budgets and care trusts)
- Encouragement to work co-operatively with other professionals and increase compatibility of policy and practice (integrated provision and care trusts)
- Coherent decisions about the direction of service development and priorities in resource allocation (lead commissioning and care trusts)
- Potential to use resources more efficiently by reducing duplication (all 3 flexibilities and care trusts)

Key Issues/Questions

The NHS Plan makes it clear that introduction of the flexibilities in some way is expected in all localities in the future. It also indicates that where organisations fail to work effectively in partnership, CTs might be imposed. All organisations therefore need to consider the potential benefits of each approach. In considering use of the flexibilities or establishing a CT the following questions are relevant

Where will the critical interfaces be? There will always be services "outside" that you need to link with. The flexibilities can be used in relation to any "health related" function of local government and therefore a lot can be included. The description of CTs in the NHS Plan covers only the "social care" element of local authority services, which appears to be more restrictive than the flexibilities. For example, the flexibilities will allow:

- integration of education, health and social care for children
- inclusion of housing, environmental services, refuse collection, special transport, leisure.

There seems to be no reason in principle why CTs could not be given powers to enter into partnership arrangements within the Health Act. If legislation makes this possible then partnership arrangements set up prior to a CT would not necessarily have to be broken up.

How will local accountability best be served? Care Trusts will be distinct from local authorities and have their own decision making boards. However the NHS Plan indicates that LAs will still be ultimately accountable for social care. Decision making, monitoring and reporting arrangements need to be workable and transparent. The possible benefits of CTs would be having a single board to monitor and report on performance, with less likelihood of attempts to transfer blame.

Possible issues include:

- The fact that local councillors (who would need to be on the CT Board) have different lines of accountability compared to NHS staff or non executives.
- A care trust will control a large budget and wide range of services. The need for different professional groupings/services to be represented will need to be balanced with keeping board membership small enough to be effective.
- The public are usually more interested in how responsive services are than their structure. What impact will any changes have on people's ability to influence services or register complaints.
- Devolved responsibility is likely to lead to more responsive services but also requires effective monitoring systems, the greater the size and complexity of budgets the more sophisticated monitoring may need to be.

How to combine flexibility with stability? Staff recruitment and retention is a pressing issue throughout health and social services. To keep good staff and motivate them to provide quality services requires incentives, for example, they are more likely to take on new roles that offer reasonable security. Introducing the flexibilities or setting up a CT all involve disruption for staff, but the scale of change is different. However, the process of setting up pooled budgets and integrated provision may encourage staff to view integrated working favourably and therefore provide a good basis for further changes in the future.

When any of the flexibilities are used an agreement is made that runs for a specified period of time. Procedures are set up to cover renewal and change. It is not clear whether CTs would have similar time limited agreements or be permanent.

What is local? The NHS Plan describes CTs as commissioning and providing **local** health and social care. The creation of PCGs and PCTs based on patient lists has already required decisions about how to manage any lack of coterminosity with local authorities in terms of liaison and joint planning. The added factor with CTs and the flexibilities is that direct control of social care (for all or part of the LA population) could pass to another organisation. How significant these issues are depends on local service configuration and population needs.

NOTES ON DIAGRAM SHOWING EXAMPLE OF ALTERNATIVE OPTIONS

At the end of this paper is a diagram illustrating the effect of applying alternative options for commissioning, funding and managing services. These notes explain the impact of the options shown.

The diagram uses the example of a one stop service. It shows two different service models, one run on an integrated basis and the other non-integrated. It illustrates the affect of combining one or more of the flexibilities with the two models.

Many existing one stop services are run on a **non integrated** basis characterised by:

- Distinct groups of staff working in one location, often managed separately.
- Staff groups with separate terms and conditions.
- Staff groups using their own organisation's procedures.
- Staff using separate budgets to purchase external services.
- The work of each staff group is defined and monitored separately.
- Complex and difficult negotiations about what each organisation contributes to administrative support, premises maintenance and other running costs.

If the **non-integrated** service is subject to lead commissioning then this will mean the work of the service is defined by one organisation. If the lead commissioner also funds the service then the funds will be labelled as 'health' or 'other' and need to be spent accordingly, whether on staff or services. If funding comes from a pooled budget then those spending the budget will have more flexibility. However if staff groups remain separately managed then a pooled budget for staff costs will not provide much flexibility. A pooled budget for premises and running costs may reduce disputes about who pays for what, but only if one person manages that budget. A pooled budget for purchasing external services will allow individual budget holders to buy services to meet need without worrying about whether the services are health or other.

If the service is set up as **integrated** provision it is possible to operate as a single organisation with common policies, terms and conditions and one overall manager. In this situation, funding staff through pooled budgets will provide the capacity to change the skill mix of the staff group to respond to need. Pooled budgets for purchasing external services will allow budget holders to buy services to meet need without worrying about whether the services are health or other. If the service is commissioned by one organisation through lead commissioning there will be a single plan relating to the service. Where lead commissioning does not exist for this service, several organisations will want to agree plans about how the service will operate.

Although the example chosen here is one stop services, the same factors would apply to other types of community based services where a combination of different skills and facilities is required to meet needs.

Margaret Edwards
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HEALTH ACT 1999
SECTION 26-31 ON "PARTNERSHIPS"

Section 26
Duty of HAs, PCTs and NHS Trusts to co-operate

Section 31

Allows for the setting up of:

- Pooled Budgets
- Integrated Provision
- Lead Commissioning

Section 32
Removes the requirement in 1977 Act to have Joint Consultative Committees

Section 27
Duty of co-operation between NHS Bodies and Local Authorities

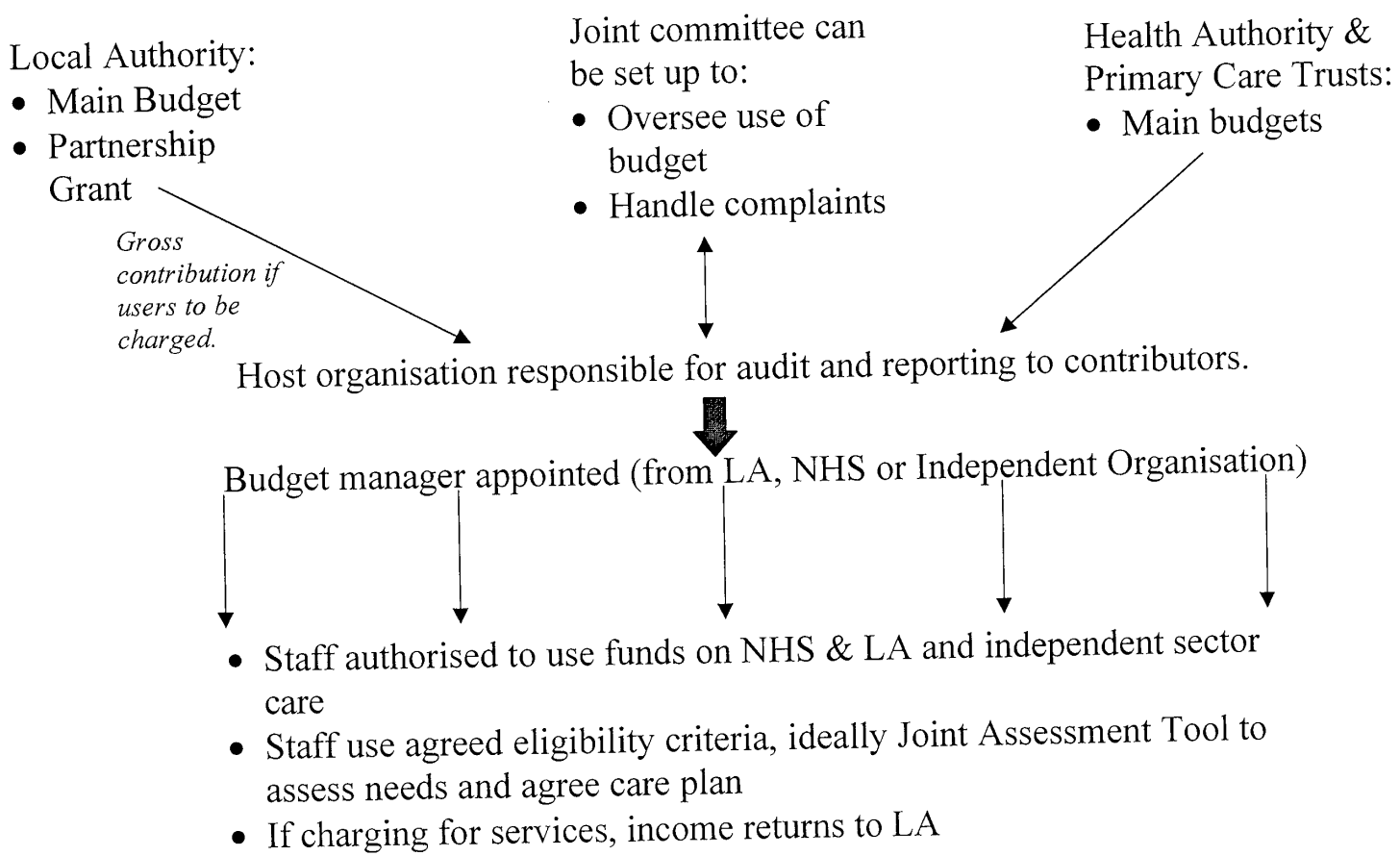
Section 28
Duty of HAs to prepare Health Improvement Plans in co-operation with other NHS Bodies and LAs

Section 29
Amends S28A of 1997 Act so that NHS bodies can make payments to LAs and voluntary organisations towards expenditure on any health related functions

Section 30
Creates S28BB in 1977 Act to allow LAs to make payments to HAs or PCTs towards expenditure on certain* NHS functions

* Note – some functions are excluded as shown in Statutory Instrument 2000 No 618

POOLED BUDGET



LEAD COMMISSIONING

HA, LA, PCT
Delegate responsibility for commissioning a service they would have previously commissioned

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Single commissioning Body making decisions on what should be commissioned.
Can commission from public, private and voluntary sector

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Funds are transferred from organisations that are delegating responsibility

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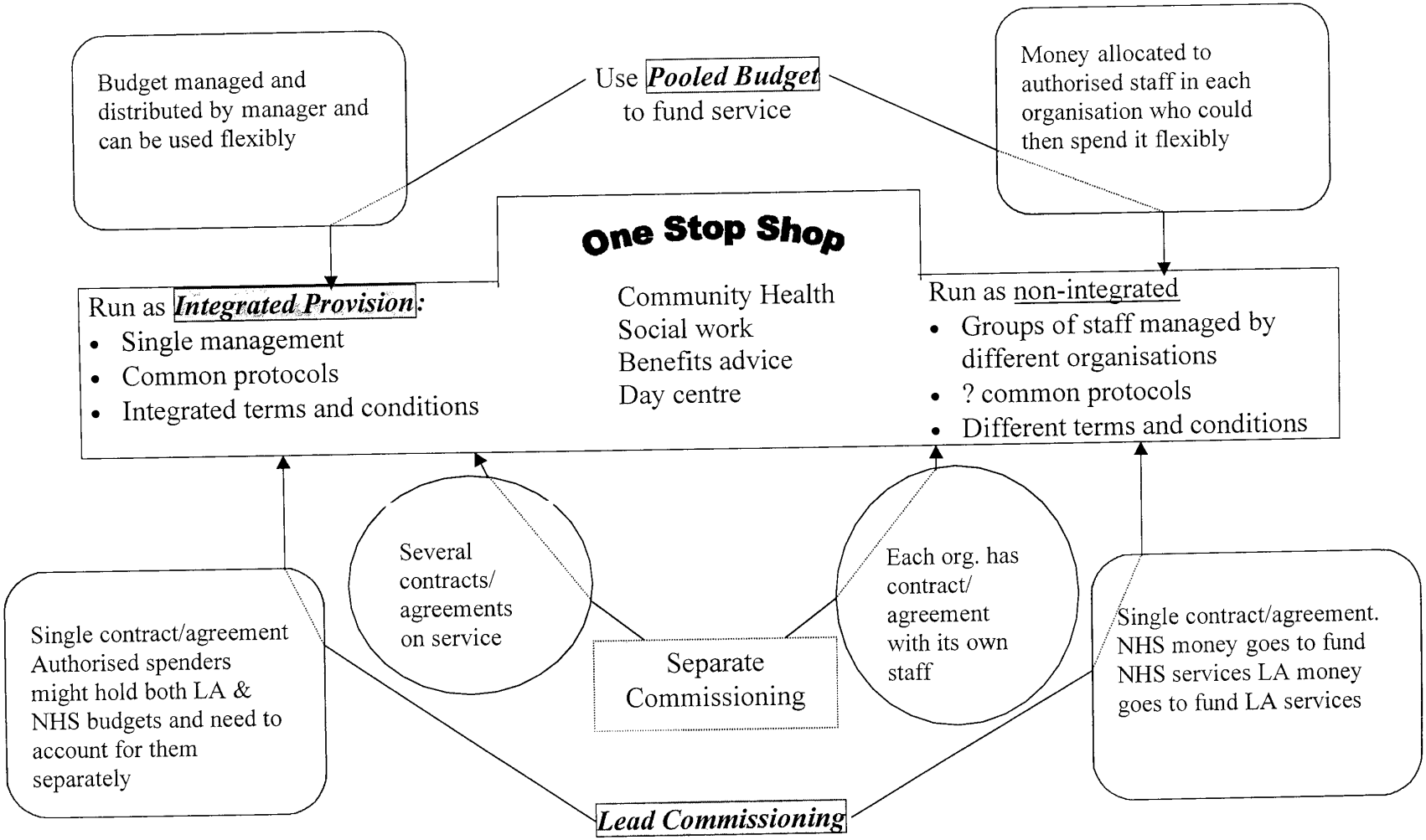
- Spending funds to purchase services
- Spending in proportion to contributions
  - NHS £ on NHS functions
  - LA £ on LA functions

APPLICATION OF DIFFERENT OPTIONS TO A PARTICULAR SERVICE



INTEGRATED PROVISION