

# Means to an end

Joint financing across health  
and social care

Health national report

October 2009



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# Summary and recommendations

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## Summary

Councils and NHS bodies must work together to provide responsive services for people who need both health and social care. This report examines how they jointly fund such partnerships and the impact this has on adult service users.

There are a number of statutory and non-statutory options available to local bodies. These range from care trusts (wholly integrated health and social care organisations that provide and sometimes commission services) to aligned budgets, where information is exchanged and joint decisions taken while functions and money remain separate. The most commonly used formal arrangement is the pooling of functions and resources under section 75 of the NHS Act 2006. Pooled funds are mainly used for learning disability, community equipment and mental health services, but rarely for older people's services. Formal joint expenditure accounts for a relatively small amount (3.4 per cent in 2007/08) of total health and social care spend.

Joint financing arrangements are tailored to local circumstances. They can often be considered complex, raising questions of accountability and governance. Formal signed agreements that might provide clarification are not always in place, fully comprehensive or regularly reviewed. Local bodies often do not completely understand the arrangements and the rules governing them. Some have also been deterred by the perceived complexity of the technical requirements for pooled funds, although, once understood, they are less onerous than they may seem. Other barriers to integration include the differences between organisations' information and finance processes, although these can be overcome.

A desire to improve service users' experience often drives joint arrangements. Organisations can usually describe how they now work better together but often not how they have jointly improved user experience. Partnership agreements often fail to include quantifiable outcome measures, and partners rarely monitor them when they do. Analysis of the limited national data available suggests that formal partnership arrangements have had little or no impact on reducing the number of older people who fall and break their hip, or on the length of time they spend in hospital for some common conditions. The same is true for the length of time those with mental health needs stay in hospital.

Central government could do more to support joint working. Research participants identified issues such as conflicting guidance, different sets of priorities and, occasionally, policies that seem to cut across satisfactory local arrangements. They would also welcome a consistent set of performance measures that relate to joint working – drawn from a range of existing indicators – and can be applied equally in both councils and NHS bodies.

Our recommendations address these issues. We also intend to develop a tool to measure outcomes with the Care Quality Commission (CQC), building on existing good practice, to be used locally to assess the benefits of partnership working for users. This will be aligned with CQC's emerging approach to health and social care performance assessment.

NHS and social care organisations increasingly need to work together in partnership to get better value from available resources and improve services and outcomes for users. There are many different approaches and mechanisms available for joint financing, but the focus should always be on value for money and improving the user experience.

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## Recommendations

### **Local NHS bodies and councils should:**

- review their current joint financing arrangements against the advice contained in this report to ensure that they are fit for purpose and use the most appropriate funding and legal framework;
- draw up written joint funding or partnership agreements, as set out in Table 1, and regularly review these in light of performance and changing circumstances;
- set and monitor measurable outcomes for service users for all their partnership agreements, using the checklist in Table 2 to start the process; and
- develop clear and synchronised financial frameworks that cover, for example, budget-setting, governance, financial planning, financial timetables and risk-sharing.

### **The Department of Health (DH) should:**

- identify a consistent set of outcome measures from the existing range available for health and social care, which directly relate to joint working. These should be consistently applied and carry equal weight and legitimacy in both NHS bodies and councils;
- further aid joint financing and integrated care arrangements by developing:
  - a model document for legal arrangements to assist in drawing up partnership agreements; and
  - a robust and accurate method of assessing partnership working to measure Primary Care Trusts' (PCTs') performance for relevant World Class Commissioning competencies; and
- review the success of the NHS operating framework 2007/08 guidance in bringing the NHS planning timetable forward to facilitate effective joint working by identifying barriers and lessons learned from implementation.



# Introduction

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**This report reviews the joint financing and integrated care arrangements between NHS bodies and councils with adult social care responsibilities. It builds on our previous publication (Ref. 1) that explained the practical implications and legislative framework for joint financing. It considers how these arrangements are used, focusing on learning disability, mental health and older people – areas where service users most often need health and social care. The report’s recommendations and examples of notable practice aim to help national and local bodies better understand the options available, how to use them and to achieve better outcomes for service users. Our research methodology is set out in Appendices 1 and 2.**

## **Background**

**1** NHS organisations, particularly PCTs, must work in partnership with councils to jointly commission and deliver services for individuals who need both health and social care. National policies have frequently emphasised partnership working and coordinated processes as a way to achieve improved outcomes for service users.<sup>i</sup> Recent examples include *Strong and Prosperous Communities*<sup>ii</sup> (Ref. 2), *Our Health, Our Care, Our Say* (Ref. 3) and *Putting People First* (Ref. 4), among others (Ref.s 5 and 6). Partnership working is also one of the key competencies of the DH World Class Commissioning (WCC) initiative.

- i** For the purposes of this report, partnership working refers to all joint working arrangements, whether achieved through the integrated provision or management of care or by joining together finances or resources. Where the meaning relates particularly to integration or joint financing, this will be specified.
- ii** This introduced local area agreements (LAAs) to align service planning and provision, underpinned by Joint Strategic Needs Assessments (JSNAs).

**2** Joint financing arrangements – where partners combine their funding for specific health and social care services – are part of this vision and are considered an important mechanism for achieving greater efficiency and better care (Box 1). The NHS Act 2006<sup>i</sup> allows for the delegation and pooling of functions, and the pooling of money between NHS bodies and councils.<sup>ii</sup> Several options (flexibilities) are available to cover a range of circumstances, and can be combined. The statutory and non-statutory options are shown in Appendix 3, although this report does not examine the effectiveness of all these models in detail. Pooled funds, which are considered in depth, are the most commonly used statutory arrangement. Care trusts combine health and social service functions in one statutory body and provide the most integrated approach. Currently, there are ten care trusts that provide services; five are modelled on PCTs and retain their commissioning function and five are based on mental health trusts.<sup>iii</sup>

**Joint financing arrangements are seen as an important mechanism for delivering better and more efficient care**

## **Box 1: Aims of joint working, underpinned by joint financing**

- to facilitate a co-ordinated network of health and social care services, eliminating gaps in provision;
- to ensure the best use of resources by reducing duplication and achieving greater economies of scale; and
- to enable service providers to be more responsive to the needs and views of users, without distortion by separate funding streams for different service inputs.

*Source: Audit Commission*

**3** Two reports have evaluated the use and impact of Health Act flexibilities (Ref.s 7 and 8). We found that, six years on, many of the levers and barriers they identified – such as incompatible finance and information systems – remain.

- i** The NHS Act 2006 consolidated various legislation and now contains the provisions that used to be found in the NHS Act 1977 and Health Act 1999. Section 75 of the 2006 Act covers exactly the same terms as section 31 of the Health Act 1999; and sections 76 and 256 cover the same terms as sections 28BB and 28A respectively of the NHS Act 1977.
- ii** These provisions were previously in the Health and Social Care (Community Health and Standards) Act 2003, which introduced requirements for both the NHS and councils to work together to deliver healthcare improvements. In addition, the Local Government and Public Involvement in Health Act 2007 placed a new duty on health partners, including foundation trusts, to agree shared targets to deliver and achieve health and well-being.
- iii** Four care trusts were established in 2002, three in 2003, and one each in 2005, 2006 and 2007.

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## **Formal joint financing arrangements are only one indicator of integration**

**4** We focused on joint financing across health and social care, although there are other forms of partnership working, such as LAAs and Local Strategic Partnerships (LSPs), and joint financing could be used for other services. Formal joint financing arrangements are only one indicator of integration and partnerships can be successful without them. The Nuffield Trust (Ref. 9) drew on the experience of three localities that have closely integrated health and social care but did not always use Health Act flexibilities. Its conclusions, however, outlining the importance of focusing on users and outcomes and aligning health and social care agendas, are consistent with our findings.

**5** Our research highlighted a number of wider difficulties in joint working between the NHS and councils. While important, they are not within the scope of this study. Examples include the cultural differences in commissioning and funding services: social care tends to focus on the individual and may charge service users, whereas the NHS focuses on the care pathway and provides services free at the point of use. Differences in contracts, pensions, and terms and conditions also create practical difficulties in transferring or seconding staff from one organisation to another in order to provide more integrated services.

## **Report structure**

**6** Chapter 2 reviews the scale and range of joint financing arrangements in England. Chapter 3 looks at local implementation and Chapter 4 comments on the role of both national and local bodies in overcoming identified barriers. Chapter 5 explores how joint financing and integration have made a difference for service users. Chapter 6 summarises the report's conclusions. Examples of notable practice, case studies and checklists are included throughout.

# The national picture – funding and services

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**Formal joint financing arrangements expenditure was £3.9 billion by March 2009**

**7** Formal joint financing represents a small proportion of total health and social care expenditure, despite the national drive to increase partnership working. The majority of councils and PCTs use pooled funds, particularly for learning disability and integrated equipment services. However, it is difficult to gain a complete picture of the range of joint financing arrangements in place regarding money spent and services delivered.

**Identifying joint health and social care expenditure**

**8** DH requests that NHS bodies and councils notify it when they use a Health Act flexibility. In 2004, based on the DH register of flexibility notifications,<sup>i</sup> formally integrated health and social care arrangements accounted for £2 billion. By March 2009, this figure had almost doubled to £3.9 billion, rising at a faster rate than both NHS and adult social care spend over the same period. It was reported to have risen to £4.4 billion by the end of 2008/09 (Ref. 10).<sup>ii</sup> However, formal joint financing expenditure was still only a small proportion – an estimated 3.4 per cent – of the total health and social care expenditure in 2007/08 (Figure 1).

**9** However, the register does not incorporate the full range of statutory approaches, since it excludes arrangements governing care trusts, children's trusts and (until 2008/09) grant arrangements. The DH has struggled to keep the register updated, as organisational and reporting

- i** The register, maintained by the DH since the introduction of the flexibilities in the Health Act 1999, has traditionally been the main source for government figures on joint health and social care expenditure.
- ii** This survey had a response rate from 75 per cent of directors of Adult Social Care. Figures have been extrapolated to the equivalent of all directors responding and show council contributions to joint expenditure for adults and older people totalling £2,074 million and NHS contributions totalling £2,369 million. Learning disability was the service area with the most contributions from both sectors.

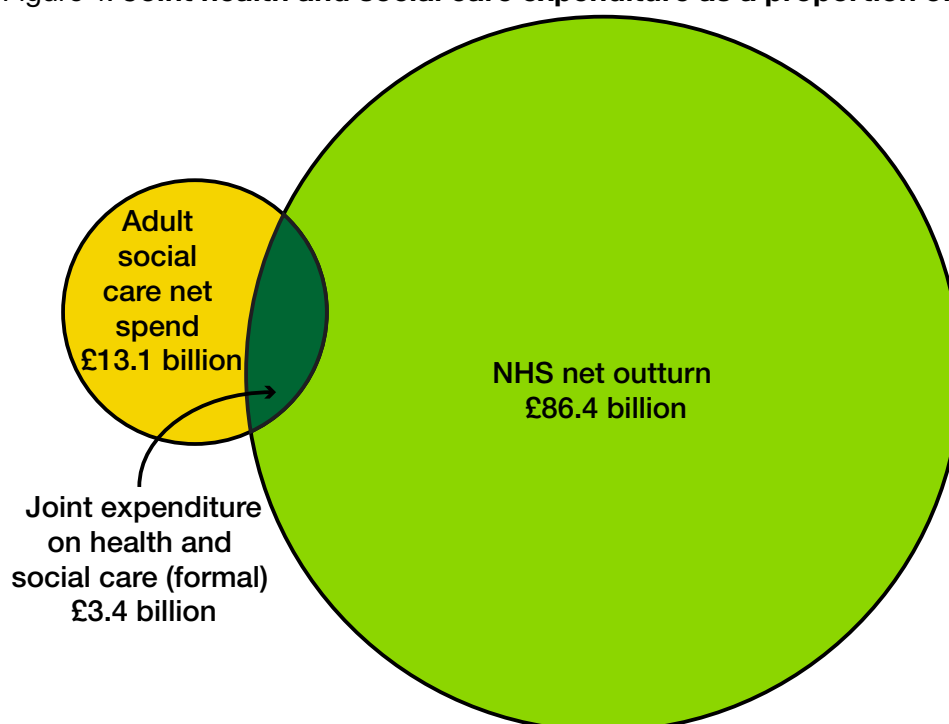
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## The national picture – funding and services

arrangements have changed.<sup>i</sup> Moreover, as our research shows, not all bodies understand the available flexibilities or describe them accurately. Non-statutory financing arrangements, such as aligned budgets, are also commonly used, but not recorded. DH sought to update the register in 2008 but, ten years after the flexibilities' inception, and given the wealth of options now available for joint financing and integration, it is hard to see its purpose. It would be more beneficial to focus on what joint arrangements are achieving rather than on the arrangements themselves.

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Figure 1: **Joint health and social care expenditure as a proportion of total outturn, 2007/08**<sup>ii</sup>



Source: Audit Commission (data from DH Departmental Report 2009, PSSEX1 2007/08, DH notification register 2008, Audit Commission pooled fund survey 2008)

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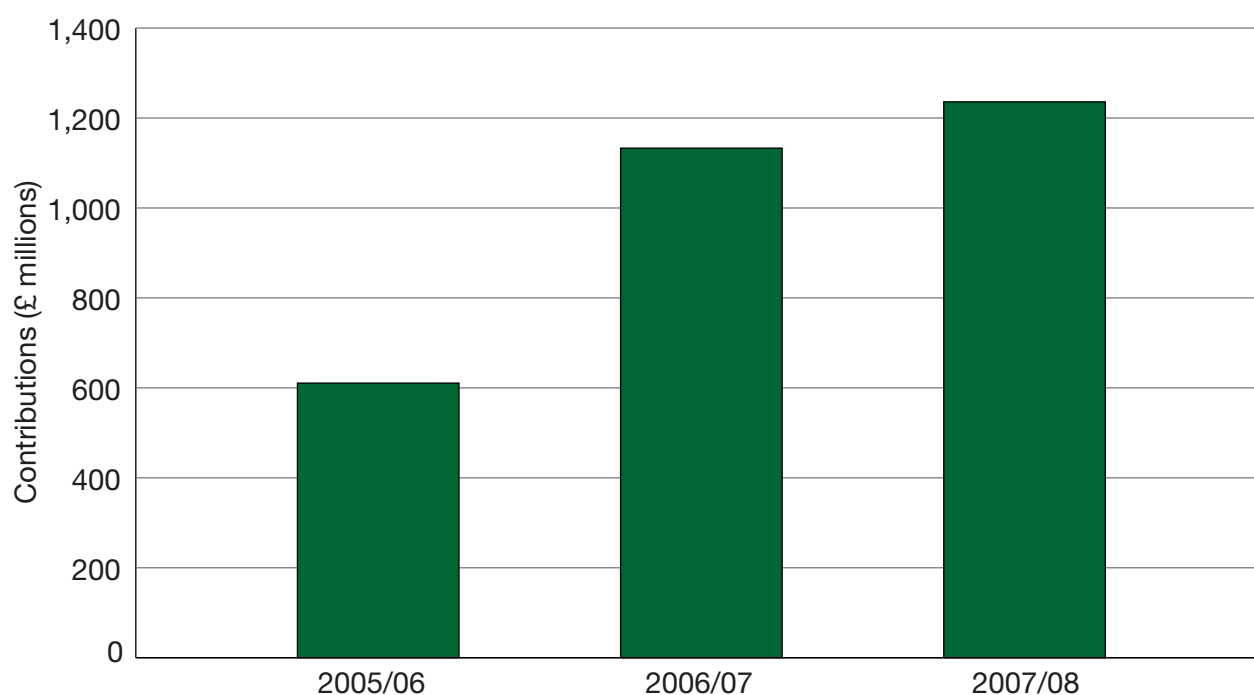
- <sup>i</sup> The last known register still referred to Health Authorities and Primary Care Groups (organisation types that were dissolved in 2002).
- <sup>ii</sup> In July 2008, the DH figure totalled £3.5 billion and our pooled fund survey shows 2007/08 expenditure from section 75 pooled funds at £3.3 billion. We have therefore taken an average of the two figures: £3.4 billion to inform Figure 1.

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**10** Council adult social care expenditure returns (PSSEX1) (Ref. 11) show income from joint arrangements and contributions from the NHS (section 75 and 256 arrangements respectively). NHS contributions to joint arrangements under these sections of the NHS Act 2006 are primarily for learning disability and older people's services. Contributions have risen significantly, by 86 per cent, since 2005/06<sup>i</sup> (Figure 2) but still only accounted for 6 per cent of gross spend on adult social care in 2006/07.

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Figure 2: **NHS contributions to councils, 2005/06 – 2007/08**



Source: Audit Commission (data from PSSEX1, 2005/06 – 2007/08)

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<sup>i</sup> This large increase may be due to the fact that only from 2006/07 onwards have data on 'Income from NHS' (section 256 transfers) been collected separately to expenditure on 'Joint Arrangements' (pooled funds), rather than under a general banner of 'Other Income'.



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## The national picture – funding and services

### Funding specific services – who and what

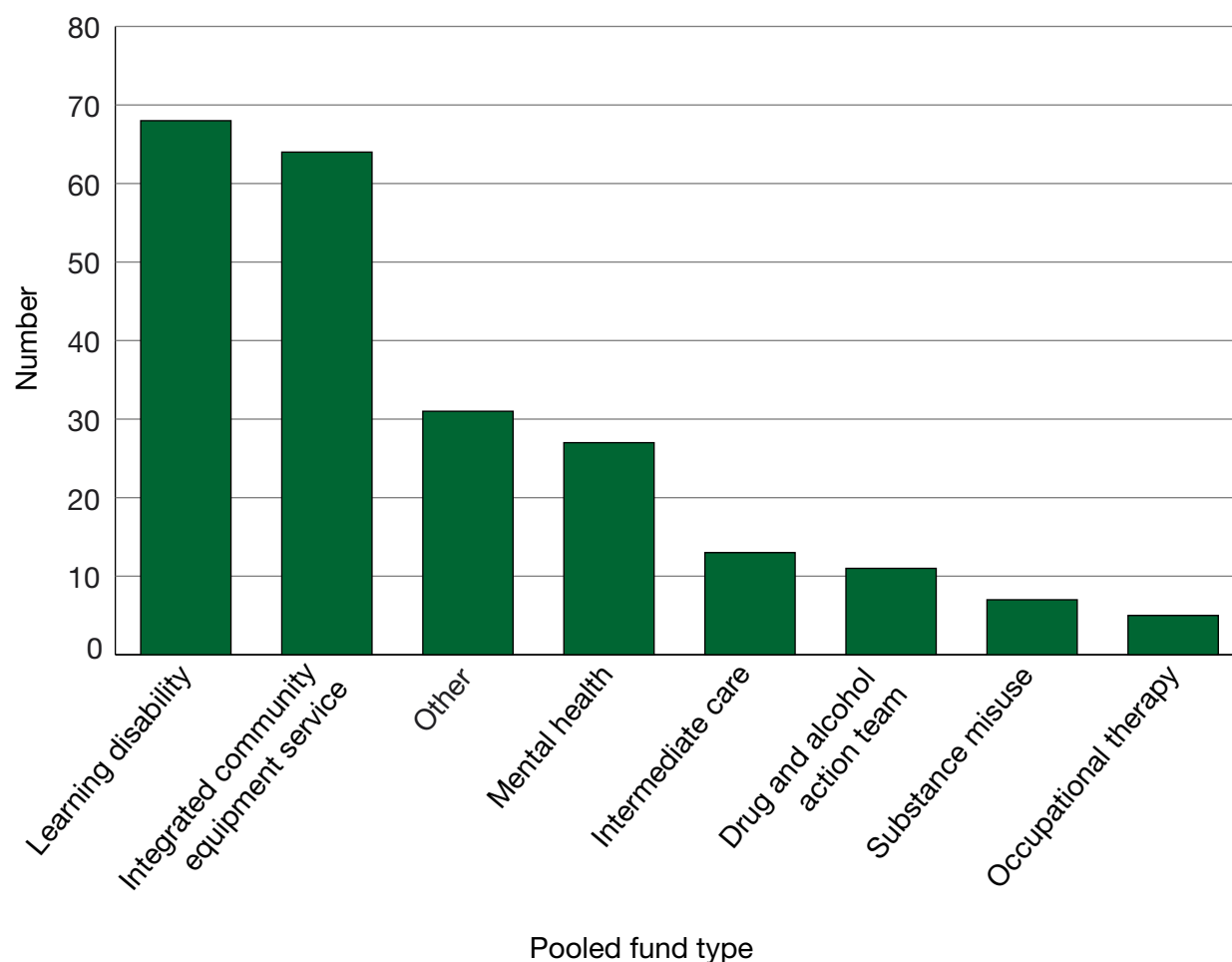
**11** All types of councils with social care responsibilities are involved in partnership arrangements using Health Act flexibilities, and are usually the hosts for pooled fund and lead commissioning arrangements. From our survey, most PCTs, councils and care trusts have some pooled funds. We identified eight mental health trusts involved in one or more pooled funds, mainly with PCTs and councils but in some instances only with their local councils. There may be more scope for the greater involvement of secondary and specialist services in pooled funds and partnership working (Ref. 7), particularly as the DH Integrated Care Pilots (ICPs) progress.<sup>i</sup>

**12** Pooled funds are mainly used for a limited range of services (Figure 3). They are generally allocated from mainstream, recurrent funding and are used predominantly to fund learning disability services (fund expenditure ranging from £95,000 - £87 million per annum); mental health services (£845,000 - £43 million per annum); and community equipment services (£462,000 - £3.8 million per annum).<sup>ii</sup>

<sup>i</sup> Integration can occur vertically within the NHS (for example, across community, primary and secondary care) as well as horizontally with other sectors, such as social care.

<sup>ii</sup> Figures taken from Audit Commission pooled fund survey, 2008.

Figure 3: **Range of pooled fund arrangements<sup>i</sup>**



Source: Audit Commission (data from pooled fund survey, 2008)

## **Around two thirds of PCTs have a joint financing arrangement for learning disability services**

### **Learning disability**

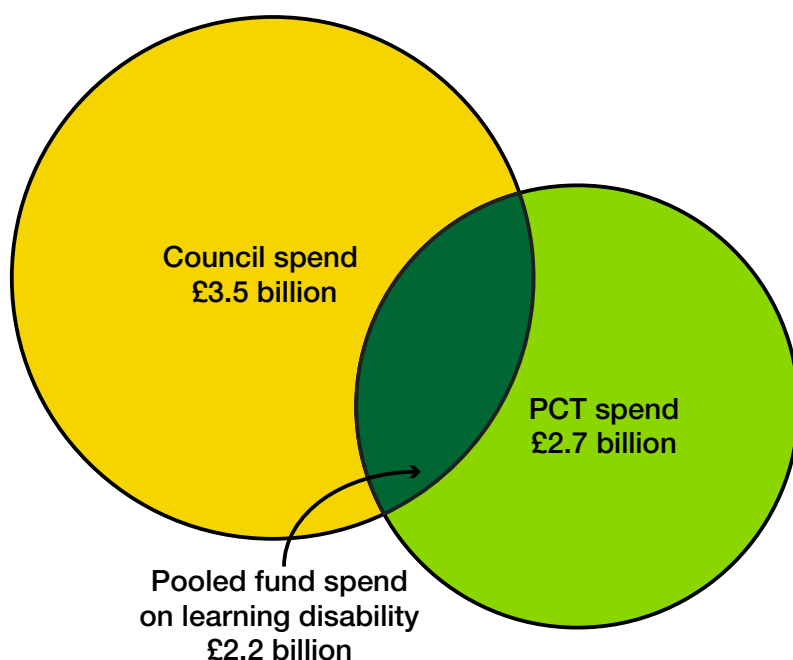
**13** Approximately two thirds of PCTs have a joint financing arrangement covering learning disability services. Figure 4 shows council and PCT spend on learning disability services in 2007/08. In 2008/09, learning disability joint financing expenditure (from sections 75 and 256) was £2.4 billion (Ref. 10). Whether or not learning disability pooled funds are in place has no bearing on the amount spent on local populations.

<sup>i</sup> 'Other' includes, for example, physical disabilities, children's services, public health and rehabilitation.

## The national picture – funding and services

**14** Councils are more likely to take the lead for providing and hosting learning disability services. Indeed, from 1 April 2009, DH formally transferred the management of PCTs' learning disability social care commissioning and funding<sup>i</sup> (not the services themselves),<sup>ii</sup> to councils, as lead commissioners. The transfer is estimated to total £894 million (Ref. 10). Some PCTs reported complications in disaggregating and then re-aggregating their own or pooled funds to facilitate the transfer to councils. As almost all learning disability pooled funds are already hosted by councils, the impact of this change is unlikely to be significant, although it may cause difficulties for councils if future needs have been underestimated.

Figure 4: **Council and PCT funding for learning disability services, 2007/08**



Source: Audit Commission (data from PSSEX1 2007/08, PCT programme budgets 2007/08, pooled funds (2007/08) from Audit Commission survey, extrapolated for all PCTs)

- <sup>i</sup> As set out in a letter to Chief Executives of PCTs and Councils, August 2008, Gateway Reference: 9906.
- <sup>ii</sup> PCTs will retain responsibility for meeting the health needs of this user group, such as treatment or assessment as a hospital inpatient.

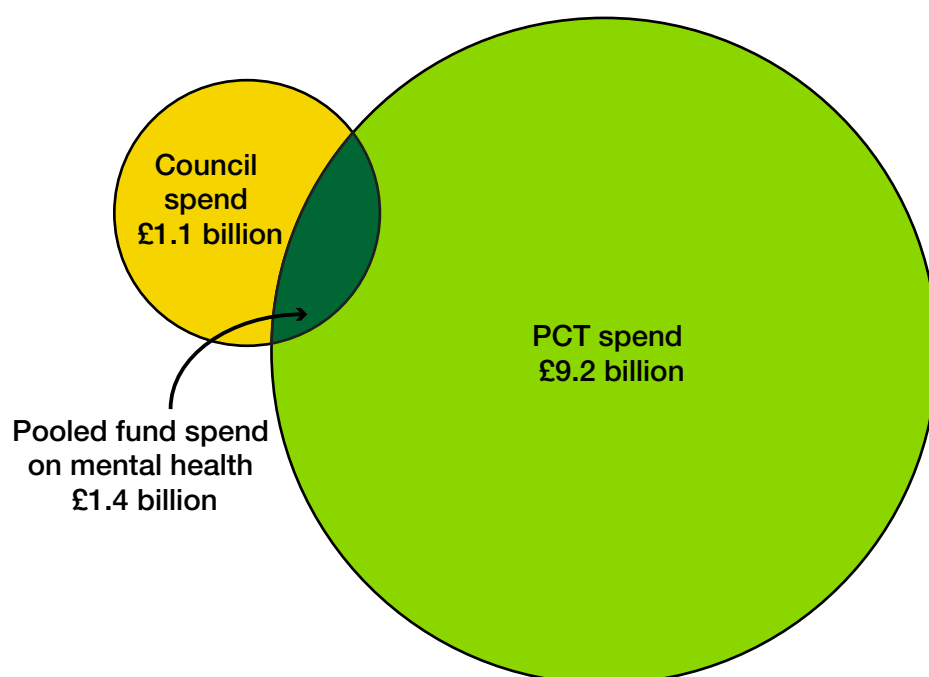
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### Mental health

**15** As the largest funder of mental health services, PCTs and mental health trusts are most likely to be hosts of mental health pooled funds. Figure 5 shows mental health joint financing expenditure as a proportion of total PCT and council spend. Spending under sections 75 and 256 accounted for approximately 15 per cent of mental health spending in 2007/08, decreasing slightly to £1.1 billion (Ref. 10) in 2008/09. Pooling of funds makes little difference to the spend per head of population on mental health, although this expenditure varies widely.

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Figure 5: **Council and PCT funding for mental health services, 2007/08**



Source: Audit Commission (data from PSSEX1 2007/08, PCT programme budgets 2007/08, pooled funds (2007/08) from Audit Commission survey, extrapolated for all PCTs)

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### Older people

**16** In 2007/08, councils spent £8.7 billion on services for older people (those aged over 65) to help them live more independently,<sup>i</sup> increasing by 19 per cent from 2003/04 and more quickly than any other adult client group. However, it is difficult to estimate spend on older people across health and social care as the NHS does not separately collect national expenditure information for older people through their programme budgets.

<sup>i</sup> Services include, for example, home care, day care or residential accommodation.

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## The national picture – funding and services

**17** In 2002, the DH (Ref. 12) advised that shared financial arrangements were vital to help minimise health and social care disputes over older people's services. The Community Care (Delayed Discharges etc.) Act 2003 introduced an incentive system whereby councils are charged should they be found responsible for a patient's delayed hospital discharge. Many older people receive health and social care. Therefore, intuitively, this is the area where the greatest efficiencies and improvement in services are likely to be found.

**18** However, with the exception of integrated community equipment services (ICES) (Figure 3) which are mainly, but not exclusively, used by older people, pooled funds are not common. We identified only 13 examples of pooled funds for intermediate care in our survey. Non-statutory arrangements such as aligned budgets and information-sharing are more common.

**Pooled funds for older people's services are not common beyond ICES**

**19** It is a little surprising that not all PCTs have a pooled fund for ICES and intermediate care services.<sup>i</sup> In 2001 (Ref.s 13 and 14), and again through the 2003 Access and Systems Capacity Grant (Ref. 15), the government allocated funding for intermediate care and ICES requiring that it be pooled using Health Act flexibilities, to encourage integration. It is unclear if this funding was used as directed as there was no monitoring system. The DH removed the grant's terms and conditions after one year, including the need for auditor certification.

**20** One possible reason for the absence of formal joint financing arrangements is that the provision of social care is means-tested. Charging is most common for older people's services. Social care client contributions for older people in 2007/08 totalled £1.8 billion, compared with learning disability, for which user charges totalled £233 million (Ref. 11). Although there is no legislative barrier to service integration where charging for the council element is involved, partners need to be clear on the mechanics of these arrangements.

**i** From our pooled fund survey (July 2008), we found that 69 per cent of respondent PCTs have at least one community equipment pooled fund and only 11 per cent have a pooled fund for intermediate care.

# Joint financing in practice – local implementation

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## Joint financing in practice – local implementation

**21 There are many reasons for local bodies to pursue joint working. Our research highlighted that not all bodies understand the available options or are always able to specify the powers used to enable their joint financing approach. Arrangements can also be complex, requiring careful consideration of accountability and governance frameworks. Partners should review their arrangements and ensure they have signed agreements to establish clarity and accountability within a sound legal framework.**

### Partnership drivers

**22** Organisations enter into joint financing arrangements for a variety of reasons. Our research highlighted cases of pooled funding and care trust arrangements that had evolved from local organisations' experience with, for example, the Joint Finance programme,<sup>i</sup> section 256 (previously section 28A) arrangements, joint commissioning and joint appointments. North East Lincolnshire's experience with a GP-led out-of-hours cooperative and locality commissioning pilots provided strong incentives for the wider integration that now exists. Research participants, however, rarely referred to their partnership arrangements in the wider context of LSPs or LAAs.

**23** The desires to improve service users' experience and to manage resources more efficiently are implicit, and often explicit, drivers to ensure better service integration. For example, pooled funds and partnership flexibilities have been used to prevent disputes over funding responsibilities and protect funding for vulnerable groups, as they effectively ring-fence resources for an agreed time period. West Sussex PCT considered that its integrated budgets for mental health services with the council were particularly crucial in improving user outcomes and helping to deliver targets from the national indicator set (NIS) (Ref. 16).

**Pooled funds are used to prevent disputes over funding responsibilities and protect funding for vulnerable groups**

**24** National policy also has an impact, but not always as intended. For the majority of PCTs in our research, proposals in *Commissioning a Patient-led NHS* (Ref. 17) motivated them to join together with their (often co-terminous) local council, using arrangements such as care trusts, rather than risk a merger with their neighbouring PCTs, with whom they had no shared history or community.

<sup>i</sup> An early financial mechanism, begun in 1976 and now disbanded, that enabled NHS funds to be spent by council social services departments. It provided a financial incentive for joint planning of community services to promote community care and reduce dependence on long-stay hospitals.

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## Clear leadership is vital to engage staff with the new ways of working

**25** Local relationships are a key factor in determining partnership arrangements. Clear leadership, driven by director and assistant director levels, is vital to engage staff with the new ways of working, particularly where there are joint appointments. Conversely, a lack of focus by senior management can lead to the dissolution of joint financing arrangements. We found one example where changing organisational leadership was said to have had a direct result on the decisions to pool, unpool and subsequently re-pool funds, causing confusion for frontline employees. However, paradoxically, where relationships are good, formal joint financing may not always be required, but pooled funds will be difficult to operate where relationships are acrimonious.

**26** PCT and council co-terminosity was reported as being particularly helpful in fostering better partner relations.<sup>i</sup> However, non-co-terminous PCTs were more likely than their co-terminous counterparts to have a pooled fund for mental health and learning disability services.<sup>ii</sup> This perhaps reflects the need to formalise relationships with statutory arrangements where PCT and council boundaries are less aligned. We also identified that there were not better outcomes for older people suffering from stroke, lower respiratory disease, fractured neck of femur (broken hip), or those experiencing delayed transfers of care where councils and PCTs are co-terminous.

## Options for integrated management and provision

**27** Not surprisingly, partnership arrangements are tailored to local circumstances. Care trusts, for example, have all taken different approaches. North East Lincolnshire Care Trust Plus provides a joint public health function (hosted by the council) and integrated children's services (in a Children's Trust hosted by the council) alongside adult social care, mental health and learning disability (hosted by the care trust). Solihull NHS Care Trust, however, has integrated adult social care with PCT functions and has a joint public health director with the council.

<sup>i</sup> 107 PCTs are co-terminous with their local councils (2008/09).

<sup>ii</sup> For learning disability pooled funds, 19 per cent were co-terminous and 24 per cent were non-co-terminous PCTs. For mental health, 43 per cent were co-terminous and 51 per cent were non-co-terminous PCTs.



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## Joint financing in practice – local implementation

**28** Joint senior management posts are increasingly common. For example, in Hammersmith and Fulham there is a joint chief executive with an integrated management team that combines health with all Council services. At the frontline, there are often integrated health and social care teams. Torbay Care Trust has introduced Health and Social Care Co-ordinators as single points of contact for service users. It has established integrated health and social care teams that can commission bespoke care for the individual user, using the full range of services available to the Trust, from health or social care funding streams.

**Integration can be achieved without the structural change needed to be a care trust**

**29** Integration of services with shared aims and resources can be achieved without the structural change required to become a care trust (Box 2).<sup>i</sup> Such approaches may partially explain why relatively few care trusts have been established since 2001.

<sup>i</sup> Ref. 18 proposes a National Care Service that emphasises the importance of joined-up services (with shared aims and resources) between health, social care and housing in order to ensure better user outcomes, without necessarily requiring structural change.

## Box 2: Examples of approaches to integration without structural change

Bath and North East Somerset	Herefordshire	Knowsley
The PCT and council, working in equal partnership, have signed a Joint Working Agreement whereby child and adult health and social care and housing services are integrated using pooled funds combined with a two-way delegation of functions. Partners report to a partnership board that has overall responsibility for implementing and monitoring arrangements, and postholders are accountable to the employer for contractual duties and to the non-employing partner for section 113 duties. <sup>i</sup>	The PCT and Council explored the option of jointly planning, purchasing, designing and integrating all their local public services, but were unable to do so under current legislation. They are currently pursuing the integration of all public services covering strategic health and well-being as Herefordshire Public Services Partnership. There are joint appointments at all management levels with teams that work towards shared objectives and their joint Steering Group reports formally to the Council Cabinet and PCT Board. All section 75 agreements have been updated to reflect these new arrangements.	The PCT and Council have widened their health and social care focus by consciously avoiding the care trust model and using the Health Act flexibilities to support a partnership throughout both organisations. This includes the key leadership role of Chief Executive NHS Knowsley – Executive Director of Council’s Well-being Services (including Social Care and Leisure Services) – to create a health and well-being partnership board in line with its LAA. This has enabled it to jointly plan, commission and deliver services across the locality and use resources more flexibly, for example, reducing duplication in commissioning and procurement.

## To pool or not to pool?

**30** Local bodies have mixed views about the complexities and benefits of implementing the section 75 legislation. Many believe that the technical requirements of the legislation make it too hard to apply.<sup>ii</sup> A key factor has been the accounting requirements (FRS 9) where all pooled fund partners must report their shares of assets, liabilities and cash at the year end in

<sup>i</sup> Section 113 of the Local Government Act 1972 allows staff to be available to ‘non-employing’ partner organisations.

<sup>ii</sup> CIPFA guidance should also help to address any queries about technical requirements (Ref. 19).

## Joint financing in practice – local implementation

the financial statements.<sup>i</sup> This has caused some problems where bodies have not realised this needed to be done or when information has not been available at the right time owing to timing differences between NHS and council final accounts. This may result in shares of overspends leading to a PCT breaching its Revenue Resource Limit. Any cash balances remaining in the pool will also have to be taken into account when reviewing performance against cash limits. Other examples of difficulties cited include risk-sharing and how to recover Value Added Tax (VAT).<sup>ii</sup>

**31** Consequently, partners often choose to align rather than pool budgets. In such cases, information is shared and priorities and strategies discussed and perhaps jointly agreed but management of budgets, monitoring and reporting are kept separate. This approach is often used as an useful interim step to the pooling of functions and resources – for example:

- where a service has historically been funded through aligned budgets;
- when it is difficult for a partner to disaggregate functions, such as adult and children's services, or back office functions;
- while partners need time to understand their budgets and any accounting requirements; or
- where partners are cautious about building relationships and getting the right processes in place before funding identity is entirely lost.

**Aligned budgets are often used as an interim step to pooling**

**32** However, where partners have understood the options and use section 75, pooled funds are seen as critical to the seamless delivery of integrated services. Pooled funds are preferable to aligned budgets where a service is completely integrated (that is, where strategy and outcomes are agreed and it is commissioned as a single service).

**33** The formality and legitimacy afforded by statutory arrangements can be beneficial. Pooled funds, for example, require greater transparency, often prompting reviews of expenditure patterns prior to implementation. They also offer transparency of accountability through delegation of functions and responsibilities. Partners found the process of drawing up agreements helpful in focusing attention and providing a robust framework for operation, particularly where partnership or joint financing objectives

- i** PCTs no longer need to include a memorandum account within the annual accounts. Councils need only do this where disclosure of information is necessary for a proper understanding of the authority's finances.
- ii** NHS bodies can not reclaim VAT on services as they are already recompensed through their funding. The host body's regime applies for a section 75 arrangement, and where a PCT is the host, councils can not recoup payments. There are a number of options available which are detailed in Ref. 1. Partnerships should not be designed to avoid tax.

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## **Pooled funds both require and offer greater transparency**

were linked to intended outcomes. However, our research did not highlight many occasions where these outcomes were subsequently monitored or measured; this is discussed further in Chapter 5.

## **Confusion and complexity**

## **Health and social care partners don't often know about the joint financing options available**

**34** Our research identified that, overall, councils are more likely to be knowledgeable about the statutory arrangements available and better able to handle some of the associated complex reporting and governance arrangements than PCTs. However, health and social care partners often do not know enough about the range of Health Act flexibilities available, particularly beyond pooled funds, and what specific statutory arrangements have been used. Indeed, all the flexibilities are often referred to as pooled funds. For example, we found instances of integrated provision and lead commissioning arrangements or joint appointments that were mislabelled as pooled funds. In addition, some partners declared pooled funds which, upon review of the accounting arrangements, were identified as non-statutory, aligned budgets. Some bodies take a 'lower risk' approach to partnership using aligned budgets within section 75 arrangements, whereby lead commissioning or integrated management arrangements are used but finances are aligned rather than pooled (Appendix 3).

**35** There is also often uncertainty over accountability where section 75 agreements contain both commissioning and providing arrangements. In these circumstances, commissioners and providers should sign separate agreements. Commissioning activities should be accounted for separately from other pooled expenditure in order to provide clarity and remove risk.

### **Ensuring clarity and accountability**

**36** It is important that the most appropriate funding arrangement is selected for each service, and that roles, responsibilities and any relevant performance management or reporting arrangements are clear. This is demonstrated in case study 1.

## Joint financing in practice – local implementation

### Case study 1: ‘Untangling’ the use of Health Act flexibilities in Westminster

City of Westminster Council and NHS Westminster (the PCT) serve more than 244,000 residents in central London. The two bodies work closely in delivering adult and children’s services. Many of their existing section 75 arrangements were the result of a combination of historical factors and incremental decisions.

With some of these agreements due to expire, the PCT and Council jointly hired an external project manager to review the partners’ existing joint agreements for adult services and set up a common framework under which all future agreements would operate.

The review revealed that many finance and non-finance staff had difficulties in understanding the terminology of joint

financing arrangements and Health Act flexibilities, and the differences between the options available. Many pooled funds were actually found to be aligned budgets. The review addressed where such budgets might be better operated as pooled funds. It also found inconsistencies in the way that each partner held data for the different care groups.

All joint commissioning arrangements for services are now in one agreement, under which schedules have been created for each care group. From April 2009, the agreement covered services for mental health, learning disability, older people, physical disability and substance misuse; with two further services to be added during 2009 and 2010. A new partnership management group was set up to oversee implementation and review outcomes of the agreement.

*Source: Audit Commission*

### Signed agreements

**37** Regulations specify that partners using Health Act flexibilities must sign a written partnership or joint funding agreement prior to their commencement. Most, but not all, organisations put such agreements into place.<sup>i</sup> For care trusts, these form part of the overall legal partnership agreement. While some bodies feel this adds bureaucracy, signed partnership or joint funding agreements are essential to ensure mutual understanding and clear accountability and governance arrangements. They can also help to avoid acrimony if the arrangement is dissolved. Table 1 lists the areas that sound joint funding agreements should include.<sup>ii</sup>

- <sup>i</sup> 2007/08 auditor Stewardship and Governance returns for NHS bodies and councils showed that 9 per cent of both PCTs and councils had no signed agreement in place.
- <sup>ii</sup> The various elements to be contained within a robust partnership agreement are also detailed in Ref. 1.

Table 1: **The importance of a signed agreement**

<b>Elements of a joint funding agreement</b>	<b>Reasons for importance – examples:</b>
Annually agreed aims and outcomes.	This provides a focus for the arrangement, allowing partners to plan resources for the year ahead and measure success for the organisation, service and user.
The relevant NHS and council functions covered in the arrangement.	This affirms the relevant functions delegated to each partner and what services are and are not subject to the arrangement.
Identification of the host partner to lead on delivery of the arrangement, and how the other partner(s) will support the host.	This avoids the potential for dispute and allows partners to plan resources for delivery according to an agreed arrangement.
How the arrangements will be managed, including jointly monitoring and reporting progress.	This avoids the potential for dispute by setting out clear expectations within a framework for monitoring performance of the pooled fund or partnership flexibility and reporting financial and management information in a timely way to stakeholders.
Governance arrangements, both financially and corporately, including inter-agency governance structures.	Clear accountability and clarity of roles is critical. This should simplify decision making and avoid the potential for dispute by providing appropriate challenge on financial assumptions and performance.
The client groups for whom the service is funded.	Partners can demonstrate accountability to service users, the range of services available, their intentions and how they can be accessed.
The respective financial contributions and other resources provided in support of partnership (but not necessarily part of the pool), and how surpluses and deficits are dealt with at year-end.	There may be difficulty in costing activity for the vulnerable groups affected by joint financing arrangements. Financial contributions should therefore be specified in any signed agreements, and based, ideally, on assessments of need rather than historical budgets. The approach to financing any overspends arising on the pool should be specified. Failure to agree this at the outset may result in the breakdown of relationships and, ultimately, the arrangements.

## Joint financing in practice – local implementation

Elements of a joint funding agreement	Reasons for importance – examples:
Agreement about the ownership and disclosure of any minor capital items purchased by the pool.	This will help in the division of capital items between partners should the pooled fund arrangement cease to operate.
The duration of the arrangement.	Minimises uncertainty and helps with resource planning for the partners.
The provision and mechanisms for annual review, renewal or termination of the arrangement.	Annual review linked to aims and outcomes and should be updated in light of the risk assessment for the year ahead. Exit strategies outlining how all assets and liabilities would be distributed in the event of partnership dissolution should be agreed early on to help avoid potential acrimony later.
Technical matters such as treatment of VAT, liability, insurance and indemnity, legal issues, complaints, disputes resolution and risk-sharing.	Partners must have a shared view of key risks – for example, shared risk registers for the established partnership arrangement or between commissioners of services for the same service users. The differences in treatment of VAT can be identified.

*Source: Audit Commission*

**38** Although organisations using non-statutory arrangements such as aligned budgets are not required to have joint funding agreements, there is an advantage in having a signed agreement that specifies objectives and includes any governance, performance management and risk-sharing arrangements. Joint posts, while not always established using section 75, should also be the subject of such agreements and must also make clear if any functions have been formally delegated between the authorities. In all cases, agreements need to be regularly reviewed to ensure they are meeting their aims and continue to be appropriate.

# Central and local relationships

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**39** Central government's approach is to support integration and partnership but, in practice, some detailed policies can hamper progress. The numerous policies relating to integration are also not always easy to implement, often owing to the different systems and processes PCTs and councils have in place. The focus has been on process and structures rather than on outcomes, although this is changing.

### Aligning systems

#### Finance and accounting

**40** NHS bodies and councils frequently perceived their different financial regimes to be a barrier to further use of joint financing mechanisms. There are differences in VAT regimes; charging; financial planning and budget-setting timetables; financial reporting arrangements; and accountability and governance arrangements. Many of these are driven by national requirements.

**41** However, these differences need not be barriers. In many cases, joint arrangements are not material to the overall budget process for individual organisations. Consequently, decisions can be made away from the central budgeting process, although the joint fund will be subject to local political priorities. Alternatively, the joint arrangement may be so significant – for example, if a section 75 arrangement covers a whole care trust – that the partners have resolved the issues upfront.

**42** DH has recognised the need for alignment of financial, performance management and assessment systems. In 2007/08 it brought forward the NHS planning timetable (Ref. 20) to facilitate effective joint working with local government. Case study 2 shows how progress can be made in synchronising financial systems.

**Progress can be made in aligning NHS and council financial systems**

## Case study 2: Synchronising financial systems in Bath and North East Somerset

Bath and North East Somerset Council and NHS Bath and North East Somerset (the PCT) are co-terminous public bodies that serve a population of over 190,000. There is a history of strong partnership working that existed prior to the introduction of the Health Act flexibilities in 1999. There are good relationships both between the two organisations and key senior people within the PCT and unitary authority. They started to integrate their services and structures in 2006, setting up Integrated Project and Joint Commissioning Boards. There are currently pooled funds for adult learning difficulties; integrated community equipment services; education and social care for children; and for drug and alcohol misuse services. Joint governance arrangements were implemented in April 2008.

As part of their Joint Working Agreement, an Integrated Financial Policy Framework consistent with each partner's financial frameworks was drawn up in April 2009 as a lever to successful joint financing. It outlines how the PCT and council will unify and, where this is not practicable, synchronise their financial management processes and

systems including ledgers. This means that a joint approach will be taken for medium-term financial planning, reporting, monitoring, risk-sharing, audit and governance, for all pooled and aligned social care and community health funds. The aim is to synchronise budget-setting processes and timetables to ensure funding contributions are set within the context of each organisation's wider priorities (such as LSPs) and financial demands. All budgets for a service will be managed by the same manager to meet agreed objectives. Budget statements will be simpler and, fundamentally, set out on the same ledger, with separate cost centres for each partnership budget. Standing orders and financial instructions are also aligned where possible. The system will be 'live' by October 2009.

The chairs of the Joint Partnership Boards are responsible for managing significant partnership budgets (whether pooled or aligned). They ensure that pooled funds receive the correct contributions, partnership funding is reprioritised where necessary and service levels and resources amended should the partners wish to change, merge or increase the number of pooled funds in the future.

*Source: Audit Commission*

## Information and data

**43** Integrated services require joint approaches to data collection, information-sharing, record-keeping and management information to inform commissioning and expenditure decisions. However, alignment and synchronisation of data systems is not always easy in practice. As a minimum, partners should ensure that protocols on each of these aspects are incorporated into agreements and any relevant contracts or service level agreements.

### Aligning policies

#### World Class Commissioning

**44** The WCC programme has set out to transform PCT commissioning. It uses 11 competencies to help improve commissioner capability, including partnership working within and outside the NHS. Although WCC recognises the importance of partnership working, councils participating in our research feel that it is too focused on the NHS, without fully recognising the need to engage councils and others if service transformation is to be successful, or the implications for social care.

**45** Two indicators were used in the first round of assessment to help measure PCT collaborative working (Competency 2): PCT involvement in section 75 pooled funds for adult mental health; and adult mental health council expenditure as a percentage of PCT spend. Not only is this a narrow focus, but the data used were not wholly reliable. Evidence for the first indicator, based on WCC data from 2006/07, is informed by the DH Health Act flexibilities notification register<sup>i</sup> and, as discussed in paragraph 9, is unlikely to be accurate. Neither indicator is a robust measure of partnership working, although the competency narrative does refer to the use of JSNAs, formal and informal partnership arrangements, information-sharing protocols and assessments of the strength of the partnerships.

#### PCT provider arm development

**46** The DH requires that PCTs separate their provider functions into arm's length bodies or new organisations so they can concentrate on commissioning. Research participants expressed concern about the possible impact on current contracts and partnership arrangements with social care, including pooled funds, especially where there is also integrated provision. Current council and PCT contractual agreements may have to be dissolved and redrawn where the partnership agreement is with the PCT provider arm, which may require legal assistance. Care trusts formed from a PCT are particularly anxious about whether they can continue their provision. These issues are so far unresolved. Although the move towards a greater PCT focus on commissioning is important, implementation of the policy should not undermine joint service provision.

**The move towards a greater focus on commissioning should not undermine joint service provision**

<sup>i</sup> Audit Commission data are consistent with the WCC data on only two occasions and are inconsistent on 11 occasions. We have a nil response from our pooled fund survey for seven PCTs. WCC data shows that 13 per cent of PCTs have at least one mental health pooled fund whereas our research shows that 28 per cent of all respondent PCTs have at least one mental health pooled fund.

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## **Pooled funds may need to be separated to allow personal budgets for social care**

**47** Some have seen this as an opportunity however. Bath and North East Somerset Council, for example, has sought to maximise benefits and ensure that PCT and council integrated structures accommodate this reform. It plans to mirror the PCT provider arm divestment by integrating adult health, social care and housing service provision into a separate delivery arm, under an overall partnership working agreement.

### **Joint financing and personalisation**

**48** Personalisation allows service users to shape their local services according to their needs and priorities, giving them greater choice and control over their care – for example – in adult social care. The approach includes development of social capital, early intervention and prevention as well as use of individual budgets or direct payments. Greater use of individual budgets and direct payments may bring about significant changes to joint financing arrangements because of the need to separate health and social care funds and disaggregate block contracts so that an individual can be given a budget for the social care element. The DH is exploring the introduction of personal health budgets. However, work on pilot sites has only just started and there are significant obstacles to be overcome in joining a single health and social care budget together, not least because NHS services are free at the point of use whereas social care is subject to charges.

### **Aligning priorities**

## **Partnership working is often not reflected in central government practice**

**49** Despite the policy drive towards local joint working, neither NHS bodies nor councils feel that this is reflected in practice by central departments (particularly DH and Communities and Local Government (CLG), although others were also cited). For example, participants referred to numerous sets of joint commissioning guidance issued at similar times by different government departments and other national organisations.<sup>i</sup> They also pointed to different priorities, contract monitoring processes and performance indicators, which can lead to duplication and a lack of shared outcomes. Separate local arrangements were partly driven by the need to make separate health and social care returns to government which would

<sup>i</sup> For example, Department for Children, Schools and Families (DCSF) relating to Every Child Matters; the Home Office relating to drug action teams; DH relating to health and well-being; Chartered Institute of Public Finance and Accountancy (CIPFA) relating to social care; and the Improvement and Development Agency (IDeA) and Audit Commission relating to partnerships and integrated services.

require activity data from a pooled fund to be disaggregated. Participants considered that departments could provide clearer and more consistent direction which would improve implementation locally.

**50** There are relatively few national outcome measures that focus on integrated services and commissioning. Of the 76 proposed indicators for measuring community services transformation (Ref. 21), some do have a social care element, but only two clearly relate to the provision of integrated services (referring to delayed hospital discharge). Local bodies reported their desire for the DH to set outcome measures for users that reflected joint working between health and social care and that carried equal weight and legitimacy in both organisations. This approach would offer advantages.

**51** The move towards a single national indicator set, the establishment of the Care Quality Commission (CQC) (particularly welcomed by our research participants) and the development of Comprehensive Area Assessment (CAA) will also help align performance assessment and performance management arrangements for PCTs and councils.

**Outcome measures should reflect joint working and carry equal weight in councils and PCTs**

# Making a difference

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Measuring outcomes nationally	44

**52** Identifying where joint financing arrangements have made a difference is often easier at a local rather than national level. Partners often focus on the administrative processes of establishing joint arrangements rather than the direct benefits for users. Locally, outcomes are rarely quantified and monitored, although anecdotal evidence shows joint financing to be beneficial. Nationally, the use of specific arrangements does not appear to impact on outcomes.<sup>i</sup> Analysis shows wide variation across PCTs and councils for admissions for fractured neck of femur, stroke and respiratory disease, and also delayed transfers of care. As the pressure increases to deliver more efficient and productive services within available resources, local bodies should improve value for money by working together, using joint financing as a mechanism to improve the user experience.

### Operating costs and savings

**53** Organisations involved in our research considered that establishing integrated organisations and funding arrangements carried a cost, although this was rarely quantified. The main burden relates to administrative and legal time and costs. Examples cited included agreeing financial contributions, writing and agreeing partnership and joint funding agreements and resolving human resources issues in transferring or seconding staff. Additional, unquantified, costs are also incurred where joint teams duplicate existing processes in the separate organisations. A number of research participants, particularly care trusts, stated that a standard legal document, developed by the DH, might help reduce both time and costs in this area, and assist others such as those in the ICP programme. However, the DH has removed guidance on section 75 from its website.

**54** Research participants rarely referred to savings in operating costs arising from joint financing agreements or joint posts. If there are value-for-money gains, they come from improved use of resources and better, more efficient services.

<sup>i</sup> DH work on use of resources in adult social care supports this finding (Ref. 22).

**It is important to take joint responsibility for identifying problems and finding solutions**

**Partnership benefits**

**55** Participants in our research identified many intangible, qualitative outcomes from joint working, including sharing skills such as contracting for services, gaining trust and sharing responsibility for achieving outcomes. The recognition of working together towards better outcomes for service users – for example, achieving cost savings – also led many to appreciate the importance of taking joint responsibility for identifying problems and finding solutions. Partners commented on the improved understanding and transparency of partners’ finances, budgets and financial pressures that joint working arrangements offered, reportedly resulting in fewer funding disputes and negotiations. Box 3 describes an area where pooled funds have allowed partners to address difficulties where joint health and social care is required to improve outcomes.

**Box 3: Continuing care – where pooled funds can make a difference**

PCTs and councils both report experience of delays in providing the best care for people who need continuing care due to disputes over funding responsibility.

Although we found very few examples of continuing care pooled funds,<sup>i</sup> those with them in place were keen to share how the pooled funds had helped to address such difficulties. In Oxfordshire, joint financing for continuing

care has enabled a single assessment process for end-of-life care, resulting in fewer disputes and tensions between health and social care partners. North East Lincolnshire Care Trust Plus has used section 75 to develop an integrated approach for continuing care where specialist mental health input has been vital in placing older people with mental health needs in care homes. It allowed it to sensibly link both NHS and council funding with the contracts for the mental health service and care home and reduce transaction costs, making the arrangements less complex to manage.

<sup>i</sup> Five examples of PCTs and councils jointly funding continuing care or free nursing care through pooled funds (Audit Commission pooled fund survey, 2008).



**56** Some bodies perceive that pooled funds impose restrictions by effectively ring-fencing resources, whereas others regard section 75 flexibilities as a tool for improvement. Many consider that pooled funds are an ideal method of setting a strategy and outcomes and, subsequently, releasing resources for that work from the joint fund. West Sussex PCT believes that a pooled fund arrangement gave greater predictability in managing its large learning disability and mental health pools which, historically, had been poorly managed financially. There are also examples where pooled funds acted as a springboard for further joint work. In Herefordshire, the transfer of responsibility for learning disability social care resources to the Council had been made easier, owing to their previous experience of joint working and implementation requirements for pooled funding and partnership flexibilities for learning disability services.

### Measuring outcomes locally

**57** Research participants generally recognised the need to improve how service user needs are addressed. Torbay Care Trust and Torbay Council, for example, in response to poor Comprehensive Performance Assessment and adult social care assessment ratings, joined forces and resources to improve their organisational performance and outcomes for local people. Their test for service integration was to identify a fictional older person, 'Mrs Smith', and how they could overcome service fragmentation and lack of co-ordination to meet her needs. They assessed how she fitted into the jigsaw of health, social care, the PCT and council, and how integrated staff and innovative joint financing arrangements would improve services for her and other users. Since 2006, urgent (a quarter of all) intermediate care cases can see therapists within four hours. In 2008, 99 per cent of community equipment was delivered within seven days and 97 per cent of care packages were in place within 28 days of assessment (an increase of 9 and 30 per cent respectively since 2006).

**58** However, although partners could often point to improvements in their mutual understanding and process, few could identify improvements in outcomes for service users. Broad outcomes for service users are generally set out in partnership and pooled fund agreements but these are often neither specific nor measurable – for example, proposals to 'create a seamless care experience'. We found that where outcome measures are in place, regular, systematic monitoring of outcomes against plan is not common. Partners should routinely set agreed performance measures, carry out an annual review that includes an evaluation of performance against these and review targets and priorities for the forthcoming year.

**Few partners  
can identify  
improvements in  
user outcomes**

**59** Table 2 provides performance measures and indicators that local bodies can use in their agreements. They combine key health and social care activity and performance indicators from a range of data sources that are currently available and should already be routinely collected. These include the social care performance assessment framework (PAF) (Ref. 23), Public Service Agreement (PSA) targets (Ref. 24), NIS (Ref. 16) and department strategic objectives (DSO) for DH and CLG. Ideally, each outcome measure should specify who (partner body or individual) is leading delivery, when each is to be delivered by, the source of the data to confirm evidence and how it is linked to local priorities.<sup>i</sup>

Table 2: **Checklist to measure performance of joint funding arrangements**

	<b>Detail</b>	<b>Current targets/ sources (where relevant)</b>
<b>Overview measures</b>	<ol style="list-style-type: none"> <li>1 The extent to which agreed outcomes are being fulfilled and targets met.</li> <li>2 How far integrated care arrangements or the aims of joint financing are being achieved.</li> <li>3 The extent to which the use of NHS Act 2006 section 75 flexibilities or integrated care arrangements have contributed to improved (or reduced) performance of the service.</li> </ol>	
<b>Performance indicators</b>	<b>Admissions</b> <ul style="list-style-type: none"> <li>■ Reduction in hospital admissions as a result of falls (that is, fractured neck of femur admissions for patients over 65 years; over 75 years; and over 85 years old).</li> <li>■ Reduction in avoidable emergency admissions/bed days for patients over 65 years.</li> <li>■ Reduction in delayed transfers of care, particularly for patients over 65 years.</li> </ul>	PAF D41, NI 131, DH DSO

<sup>i</sup> For example, *The Health Service Journal* (The hard fact on falls, 14 May 2009) reported that each SHA could save net £3 million per annum from reduced NHS costs if they invested in falls and bone health early intervention services.

	Detail	Current targets/ sources (where relevant)
Performance indicators	<b>Access and appropriateness of services</b>	
	<ul style="list-style-type: none"> <li>■ Shared use of support services and facilities promoting one point of contact (where appropriate).</li> <li>■ Reduction in duplication of client contacts.</li> <li>■ Single processes agreed for joint teams – for example, assessment.</li> <li>■ Reduction in people receiving services ‘out of area’.</li> <li>■ Improved times from referral to agreement of care packages.</li> <li>■ Improved times from agreement to delivery of care.</li> </ul>	
	<b>Achieving independence</b>	
	<ul style="list-style-type: none"> <li>■ An increase in the number of vulnerable adults (mental health, physical disability, learning disability, those over 65 years) helped to live at home/supported to live independently/achieving or maintaining independent living.</li> </ul>	PAF C29-32, NI 136, NI 141, NI 142, PSA 17, 18, CLG DSO NI 125, PSA 18
	<ul style="list-style-type: none"> <li>■ An increase in the number of patients over 65 years achieving independence through rehabilitation/ intermediate care.</li> </ul>	PAF D54
	<ul style="list-style-type: none"> <li>■ Increased percentage of items of equipment and adaptations delivered within seven days and an increase in the number of people benefiting from this provision.</li> </ul>	NI 150, NI 146, PSA 16
	<ul style="list-style-type: none"> <li>■ An increase in the number of vulnerable adults (mental health and learning disability) in contact with services in employment.</li> </ul>	
	<b>Skills</b>	
	<ul style="list-style-type: none"> <li>■ Staff skill mixes reviewed, to reduce duplication where it exists and secure better use of scarce professional skills and time.</li> <li>■ Improvements in staff recruitment, retention and morale.</li> </ul>	

Detail		Current targets/ sources (where relevant)
Performance indicators	<b>Satisfaction</b>	
	<ul style="list-style-type: none"> <li>■ Raised service user satisfaction in terms of access to services, compared with a baseline year.</li> </ul>	NHS Patient Survey Programme; CQC national surveys of local health services and community mental health services; SCIE annual social care user experience survey.

Source: Audit Commission

**60** Some partners have been working together to develop a robust framework for measuring their performance. Case study 3 describes the section 75 integrated balanced scorecard approach developed by Oxfordshire and Buckinghamshire Mental Health NHS Foundation Trust, with Oxfordshire County Council and Buckinghamshire County Council, that measures the aims of both the partnership and their integrated services.<sup>i</sup> We intend to further develop this framework beyond mental health services, working in partnership with CQC, to assess the success of wider health and social care integration.

<sup>i</sup> Prepared in association with Lorimer Consultants Ltd.

### Case study 3: Oxfordshire and Buckinghamshire Integrated Balanced Scorecard for adult mental health

Between 2006 and 2007, Oxfordshire and Buckinghamshire County Councils and Oxfordshire and Buckinghamshire Mental Health NHS Foundation Trust entered into three section 75 agreements for mental health provider services for adults of working age and older people, for which the total expenditure was £38.6 million (excluding Oxfordshire older people's services). Oxfordshire older people's services have always worked in close partnership with social care and a section 75 agreement was entered into from July 2008. To monitor performance and outcomes for the mental health provider services, the local Joint Management Groups (JMGs) of the Councils and the Foundation Trust (in association with two independent consultants) developed an Integrated Balanced Scorecard in each county which is specifically linked to their section 75 agreement.

The scorecard is made up of a range of indicators that reflect a combination of key national guidance and local assessment reporting, which are also linked to the themes identified in *High Quality Care for All* (Ref. 5). The indicators are weighted towards the service user and carer perspective and a risk rating is used to forecast whether targets will be achieved by year-end. Performance and outcomes are reviewed on a quarterly basis.

The scorecards were implemented from 1 April 2008 and the JMGs use them to measure the key aspirations of the partnership and to satisfy organisational requirements for reporting on the performance management of its integrated services. This is divided into the following four domains:

- 1 Service users and carers (customer) – for example, promoting choice and supporting carers.
- 2 Internal business process (processes) – for example, governance, service co-ordination and public health.
- 3 Resources (finance) – for example, finance, workforce and capacity.
- 4 Learning and growth (people) – for example, workforce capability and organisational learning.

The scorecard is also important for reporting performance to commissioners, that is, it helps to raise the profile and the value of local discussions on commissioning outcomes. The scorecard has been converted into Excel spreadsheets, so that not only can the overall performance statement be used in local discussion between partners and their performance leads, but also specific sections analysed in more detail. In this way, the partners use it to assess Trust capacity, performance of the service and, critically, outcome targets for service users.

*Source: Audit Commission*

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## Measuring outcomes nationally

**61** Assessing the impact of partnership working is not straightforward given the absence of meaningful national indicators covering both health and social care. Consequently, the data selected for analysis are used as proxy measures and caution should be exercised with their interpretation. We have analysed hospital activity and expenditure and social care indicator data relating to mental health and older people's services and have drawn on our pooled fund survey and where the PSSEX1 indicates that councils and NHS bodies have joint arrangements. We aimed to identify whether formal joint arrangements are improving outcomes and if PCTs and councils are making a real difference in areas often regarded as tests of joint working. As activity data and outcome measures for learning disability services are limited, we have not included these in our analysis.

### Mental health

**62** Using bed days (length of stay) as a proxy for efficiency, analysis shows that mental health length of stay has decreased from 2005/06 to 2007/08, with little apparent relationship with total NHS mental health spend. However, those areas with joint financing arrangements<sup>i</sup> do appear to have slightly lower lengths of stay, although this is not statistically significant. It is therefore hard to say if joint financing – and pooled funds in particular – have had an impact on efficiency using this measure. More detailed knowledge of local service delivery arrangements would be needed to get a more reliable picture.

### Older people

**63** The majority of data relating to outcomes and efficiency in health and social care is associated with services for older people, for which there are few formal joint financing arrangements. We have used emergency bed days as the proxy efficiency measure, despite older people often experiencing better quality of care and life when hospital admissions are avoided in the first place. This measure features in the NIS and is in line with the POPPS evaluation (Ref. 25) findings. We focused on lower respiratory disease, fractured neck of femur (which relates to falls) and stroke rehabilitation, which have a high incidence among older people, accounting for approximately one-sixth of the bed days for those aged 65 years and above. They also relate to areas where health and social care services must work together, and therefore, where joint financing can be valuable. Data were analysed by PCT and council for all three indicators and showed the same picture of variation for both organisation types.

<sup>i</sup> As evidenced by both the social care expenditure returns and our pooled fund survey.

**64** Lower respiratory disease and stroke both show a reduction in emergency bed days from 2005/06 to 2007/08; for 2008/09<sup>i</sup> the emergency bed days increased for lower respiratory disease. Care trusts, as fully integrated organisations, might be expected to show the most reduction in bed days, but this was not evident in 2007/08. We have correlated emergency bed days data with known instances of intermediate care pooled funds<sup>ii</sup> to show where outcomes may link to the funding arrangements in place. This demonstrates that the performance of those with joint financing arrangements for older people is no better than for those without.

**65** Falls in older people often result not only in fractures – accounting for over one million bed days each year – but also in reduced mobility, fear of falling, loss of independence and isolation. *The National Service Framework for Older People* (Ref. 26) encouraged the development of local falls prevention programmes to reduce the number of older people falling and being admitted to hospital. Analysis of the PCT fractured neck of femur rates<sup>iii</sup> over three years shows no clear downward trend for those aged 65 years and above; 75-84 years (who account for 40 per cent of bed days for this condition for those aged 65 years and over); or those aged 85 and over (who account for approximately half of the bed days). Overall, emergency bed days continue to rise. As for the previous two conditions, analysis of the 2007/08 data shows care trusts conforming to the overall PCT trend, with no difference between provider and commissioner-based care trusts.

### Joint equipment

**66** One way of measuring service efficiency is to review the speed of access to community equipment, such as wheelchairs, particularly as the majority of PCTs and councils are likely to have ICES. It is also a good measure of user satisfaction, with over two thirds of community equipment services survey respondents saying it had improved their quality of life (Ref. 27). Such services, which are generally financially marginal to the core business of each organisation, are most commonly accessed by older people. They help to support people to live independently at home and are often needed urgently in preparation for hospital discharge to prevent delayed transfers of care. In 2007/08, the service operated efficiently, with only 3 per cent of delayed transfers of care for those aged 65 years

<sup>i</sup> Using provisional Hospital Episode Statistics data for 2008/09.

<sup>ii</sup> There are few intermediate care pooled funds in place, as demonstrated in our pooled fund survey.

<sup>iii</sup> For which there appears to be no relationship with deprivation.

and over due to waiting for community equipment or home adaptations.<sup>i</sup> However, where ICES are used and the teams delivering the community care are also integrated, it can be difficult to differentiate those items that are solely council or PCT responsibility. This is an area where pooling funds and joint responsibility are valuable (case study 4), although the key point is how well ICES work, whether or not they are financed by a pooled fund.

#### **Case study 4: Herefordshire joint equipment pooled fund**

Herefordshire Council and Herefordshire PCT are co-terminous public bodies serving a population of 178,000, of which older people account for one-fifth. They are separate legal entities, but have a history of partnership working, a number of jointly-appointed senior management posts and are working towards a more formal integrated structure.

In 2004, they set up a section 75 arrangement for an integrated community equipment store, using a pooled fund, lead commissioning arrangements and a joint manager with joint accountability. The arrangement covers adult, children, health and social care budgets. Total expenditure is £564,000 (2007/08), contributions are 50:50 from April 2009 and risk and responsibility for outturn is shared.

The arrangement enables a central and immediate access point to aids and adaptations for health and social care. It helps to facilitate prompt hospital discharge and independent living in people's own homes, and support disabled children at school. Accessed by district nurses, occupational therapists and social workers, it has enabled more effective and efficient use of equipment across the county, supporting service development and delivery of improved health and social care outcomes. Savings include management costs and greater efficiencies derived from joint purchasing power.

Performance is regularly measured against the national indicator (currently 97 per cent). The DH's national ICES User Experience Survey (February 2008) demonstrated favourable local results in user-defined outcomes and experience compared with national results: 78 per cent of respondents were extremely or very satisfied with the services; and two thirds reported that their quality of life had improved as a result.

*Source: Audit Commission*

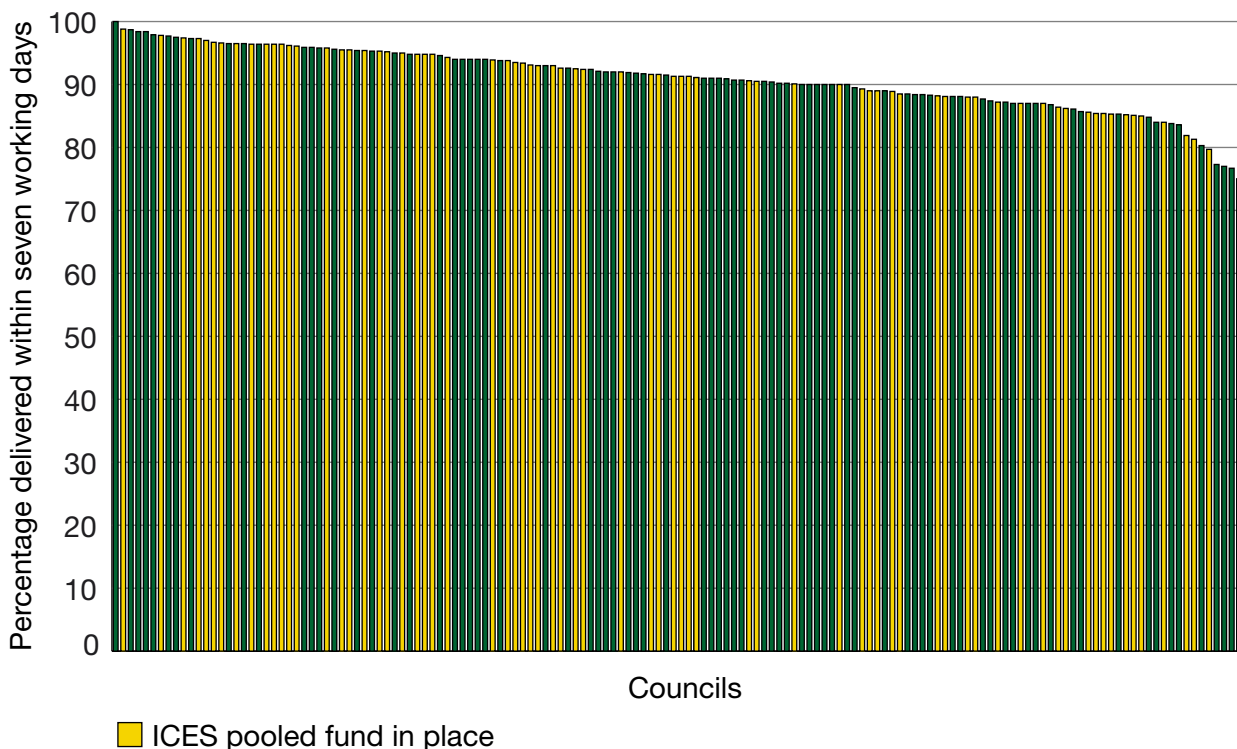
<sup>i</sup> PAF indicator D41 – delayed transfers of care (Ref. 23).



**67** Figure 6 shows the percentage of equipment delivered by councils within seven working days, using data drawn from PAF indicator D54.<sup>i</sup> Nationally, 91 per cent of equipment items or minor adaptations were delivered on time in 2007/08, which accounts for over 2.1 million items. While this only shows a 1 per cent increase since 2006/07, it demonstrates a 22 per cent increase since 2003/04 and a very positive picture overall. However, there is no apparent relationship between this indicator and the performance of commissioning care trusts, nor any clear relationship with efficiency where PCTs and councils are co-terminous or for those councils whom we know have ICES pooled funds.

**91%**  
of equipment items  
were delivered on  
time in 2007/08

Figure 6: **Linking pooled funds with delivery of community equipment**



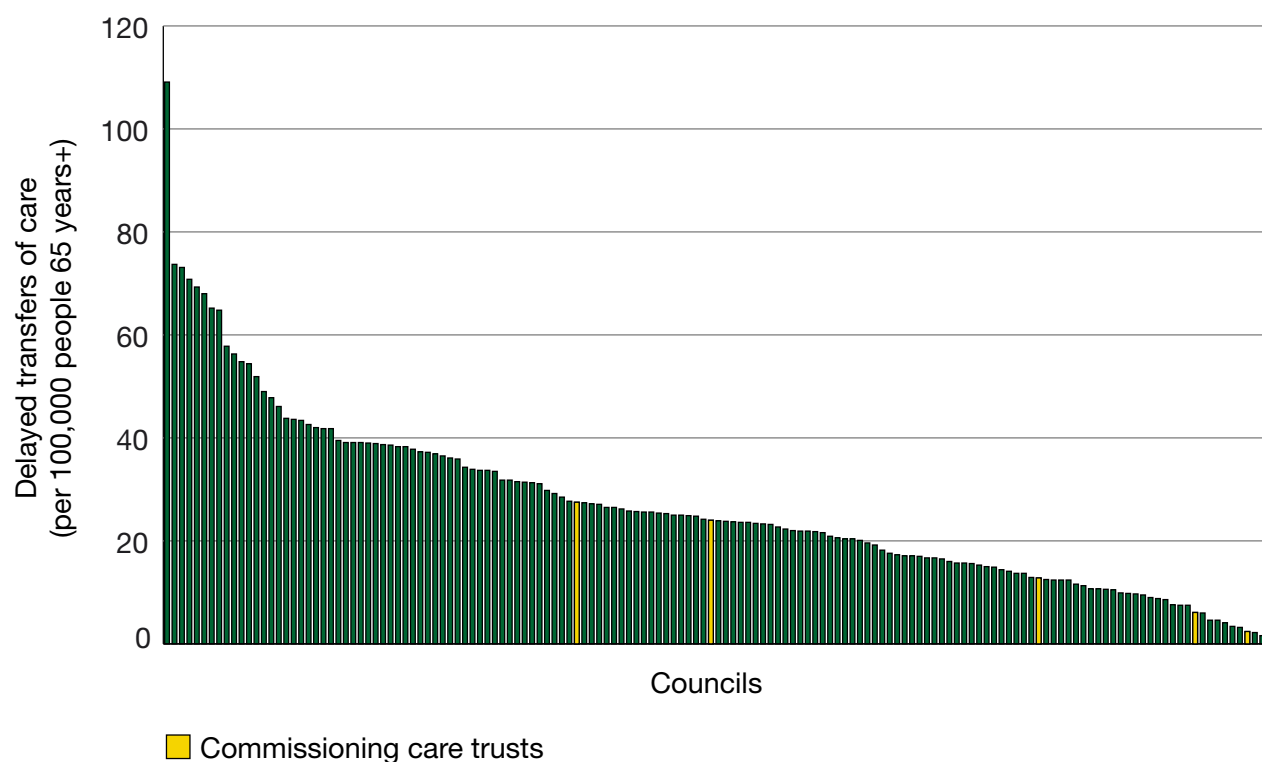
Source: Audit Commission (PAF indicator D54 2007/08 and pooled fund survey, 2008)

<sup>i</sup> PAF indicator D54 – percentage of items of equipment and adaptations delivered within seven working days (Ref. 23).

### Delayed transfers of care

**68** There is a relationship between delayed transfers of care and the availability of intermediate care, rehabilitation services and social care that help people to live independently at home. Delayed transfers may indicate poor joined-up working between health and social care services. Indeed, reducing these delays requires that community, primary, acute and social care bodies work together. In theory, joint financing arrangements may help to overcome some of the problems encountered. On average, just over 1 percent of those aged over 65 experienced delayed transfers of care in England in 2007/08. This is in line with the national trend of reductions over the last three years, which reduced from 29 per 100,000 in 2006/07 to 27 per 100,000 in 2007/08. Figure 7 shows that there is wide variation in the performance by PCT, including care trusts, demonstrating that there is room for improvement in some areas. Leicester University (Ref. 8) also found that the use of Health Act flexibilities did not appear to make any difference to delayed transfers of care or to residential and nursing home admissions.

Figure 7: **Delayed transfers of care for those aged over 65 years**



Source: Audit Commission (data from PAF indicator D41 2007/08)

# Conclusion

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## Conclusion

**69** Central government has always endorsed pooled funds and partnership working as a way of ensuring that services are designed around users' needs and that decisions are not distorted by separate funding streams for different services or disputes over funding responsibilities. Implementation of these arrangements is tailored to local circumstances and approaches vary. However, the different statutory and non-statutory approaches available are often not fully understood by NHS organisations and councils.

**70** Pooled funds have helped organisations improve partnership working, particularly where formality and legitimacy are needed and where services may already be integrated. However, the arrangements can be complex, leading to problems of governance and accountability. Written partnership agreements are not always in place or comprehensive. Some bodies have also been deterred by technical problems of implementation, although these can be less complex than they appear once fully understood.

**71** Organisations point to intangible benefits such as better partnership working and improved mutual understanding. However, it is difficult to identify the extent to which pooled funds and other joint financing arrangements have directly achieved better value for money or have made a tangible difference for service users. Outcome measures are rarely quantified in partnership agreements or subsequently monitored. Nationally, there are weak relationships between individual factors and specific joint outputs or outcomes. The national and local focus has tended to be on process rather than outcome.

**72** NHS and social care organisations will increasingly need to work closely together in order to get better value from the money available and improve services and outcomes for users. Many different approaches to financing and partnership arrangements can be used, although they are not always well understood and implementation could be more rigorous. However, the focus should be on outcomes and efficiency gains achieved rather than the process of partnership working or the method by which the service is financed.

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## Appendix 1

### Research methodology

The methodology involved a combination of qualitative and quantitative, and primary and secondary research methods.

Desk-based contextual research was undertaken to ensure that the research was well-grounded in an understanding of the relevant policy and legislation. We reviewed literature on an ongoing basis throughout the study.

In summer 2008, a survey was sent to the Audit Commission's appointed auditors for all PCTs, Metropolitan Borough Councils, County Councils, London Borough Councils and Unitary Authorities in England to obtain a national picture of the health and social care pooled fund arrangements. Auditors were asked whether their audited bodies were involved in pooled funding arrangements and if so, to identify the host partner and provide details regarding activities covered by the fund; duration of the arrangement; partner contributions for 2006/07 and 2007/08; and any other joint financing arrangements in place. Responses covered 69 per cent of these organisations. Both the survey responses and the literature review informed our choice of fieldwork sites.

In January to March 2009, we held workshops with representatives from NHS bodies and councils in eight localities that had made varying progress with joint financing and integration. This included 12 PCTs, 13 councils, three mental health trusts and three care trusts. In addition, we conducted semi-structured interviews with two further councils, one PCT and one mental health trust (see Appendix 2 for a full list). Workshop participants included director and senior levels of staff from finance, commissioning,

policy and performance roles. The focus of this primary research was to determine how joint financing works in practice and explore areas for improvement. Participants were also asked to complete a data template outlining their current joint financing arrangements, the funds involved and any changes in outcome as a result of implementation. The pooled fund survey and local data collection from fieldwork sites gave us data coverage of 72 per cent of (110) PCTs and 67 per cent of (99) councils. Only six PCTs and four councils – all but one with co-terminous boundaries – were not involved in any pooled funds. Following the workshops, many participants were contacted to provide case studies to highlight examples of notable practice.

We analysed expenditure and activity data, drawing primarily on the PCT programme budgets, social care expenditure (PSSEX1) returns and Hospital Episode Statistics. In addition, we analysed other nationally and locally available data, such as social care indicator data relating to learning disability, mental health and older people's services. While financial data are more readily available for learning disability and mental health services, the majority of activity and outcomes-based data are available for older people. In reviewing the national picture on outcomes, we have also drawn on the pooled fund survey and where the social care expenditure returns indicate where councils and NHS bodies have joint arrangements.

With thanks also to Robin Lorimer and Ed Harding, formerly of the Care Services Improvement Partnership at the DH Integrated Care Network, who have provided technical support and advice during the study.

## Appendix 2 Organisations involved in the research for this study

### Primary Care Trusts

Barking and Dagenham PCT  
Bath and North East Somerset PCT  
Brighton and Hove City PCT  
Buckinghamshire PCT  
East Sussex Downs and Weald PCT  
Hastings and Rother PCT  
Herefordshire PCT  
Islington PCT  
Lambeth PCT  
Oxfordshire PCT  
Swindon PCT  
West Sussex PCT  
Westminster PCT

### Care Trusts

North East Lincolnshire Care Trust Plus  
Solihull NHS Care Trust  
Torbay Care Trust

### Mental Health Trusts

Camden and Islington NHS Foundation Trust  
Central and North West London NHS Foundation Trust  
Oxfordshire and Buckinghamshire Mental Health NHS Foundation Trust  
Sussex Partnership NHS Foundation Trust

### Councils

Bath and North East Somerset Council  
Brighton and Hove City Council  
Buckinghamshire County Council  
East Sussex County Council  
Herefordshire Council  
London Borough of Barking and Dagenham  
London Borough of Bexley  
London Borough of Lambeth  
North East Lincolnshire Council  
Oxfordshire County Council  
Solihull Metropolitan Borough Council  
Swindon Borough Council  
Torbay Council  
West Sussex County Council  
Wiltshire Council

A seminar outlining our emerging research findings was held with a wider selection of 16 organisations that had previously not been involved in the research, to validate our findings. This included representatives with interest of and/or experience in the field of joint financing from four PCTs, four councils, the DH, four voluntary sector organisations, two private providers and one independent consultancy.

## Appendix 3 Options available for joint financing and integration

Arrangement	Description	Legislative basis: NHS Act 2006	Further detail
<b>Lead commissioning</b>	One partner takes the lead (and acts as the host) in commissioning services on behalf of another to achieve a jointly agreed set of aims.	section 75	<ul style="list-style-type: none"> <li>■ Suitable option depending on size and make-up of the service to be commissioned.</li> </ul>
<b>Integrated management or provision</b>	One partner delegates their duties to another to jointly manage service provision; or partners combine (pool) resources, staff and management structures to help integrate provision of a service from managerial level to the frontline. One partner acts as the host to undertake the other's functions.	section 75	<ul style="list-style-type: none"> <li>■ Helps to ensure cooperation and prevent duplication where the same person is responsible for services for both bodies.</li> </ul>
<b>Pooled funds</b>	Each partner makes contributions to a common fund to be spent on pooled functions or agreed NHS or health-related council services under the management of a host partner organisation.	section 75	<ul style="list-style-type: none"> <li>■ Shared resources and responsibility to meet specific local needs is acknowledged.</li> <li>■ Flexibility, as expenditure and service response is based on users' needs rather than financial contributions, helping to prevent disputes over funding responsibilities.</li> <li>■ Essential where a service is, or moving towards being, fully integrated.</li> <li>■ Associated processes, e.g. financial management and technical requirements of the pool seen to be bureaucratic.</li> </ul>



Arrangement	Description	Legislative basis: NHS Act 2006	Further detail
<b>Combination of section 75 flexibilities</b>	Combination of any or all of the above, for example, pooled funds with lead commissioning arrangements, pooled fund with integrated provision or delegated (or lead) funds with pooled funds.	section 75	<ul style="list-style-type: none"> <li>■ Allows flexibility and seamless provision of care.</li> </ul>
<b>Aligned budgets</b>	Partners align resources (identifying their own contributions) to meet agreed aims for a particular service, with jointly monitored spending and performance but separate management of, and accountability for, NHS and council funding streams.	Non-statutory	<ul style="list-style-type: none"> <li>■ Flexibility around the use and monitoring of funds.</li> <li>■ Retained ownership of funds and responsibility of budget management.</li> <li>■ Interim step to pooling.</li> <li>■ Not ideal where a service is already integrated.</li> </ul>
<b>Aligned budgets with section 75 flexibilities</b>	One partner takes the lead in the management of jointly commissioned or provided services, but NHS and council funds are not pooled.	section 75	<ul style="list-style-type: none"> <li>■ Flexibility around the use and monitoring of funds against a jointly agreed set of aims.</li> <li>■ Retention of specialist knowledge by lead partner about specific service area.</li> </ul>
<b>Care trusts</b>	NHS and council health-related responsibilities are combined (via council delegation) within an NHS body under a single management. Can be formed from an existing NHS trust or PCT (in the latter case, the PCT is both a commissioner and provider).	section 77 section 75	<ul style="list-style-type: none"> <li>■ Joint planning, commissioning and delivery of health and social care services across a local area.</li> </ul>

Arrangement	Description	Legislative basis: NHS Act 2006	Further detail
<b>PCT grants to councils</b>	PCTs make transfer payments (service revenue or capital contributions) to councils to support or enhance a particular council service. This is not a partnership and there is no delegation or pooling of functions.	section 256	<ul style="list-style-type: none"> <li>■ Can be used to provide funding from one partner to another in order to offer a more effective use of resources and provide a greater level of care where necessary.</li> </ul>
<b>Council grants to PCTs</b>	As above, but for council transfers to PCTs.	section 76	

Source: Audit Commission

# Glossary

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### **Aligned budgets**

Partners align resources (identifying their own contributions) to meet agreed aims for a particular service, with jointly monitored spending and performance but separate management of, and accountability for, NHS and council funding streams.

### **Avoidable admissions**

People being admitted to hospital with conditions that in theory should never require hospitalisation.

### **Care Quality Commission (CQC)**

The Care Quality Commission is responsible for the independent regulation of health and social care in England, whether provided by the NHS, local authorities, private companies or voluntary organisations. It also protects the rights of people detained under the Mental Health Act. CQC was established on April 2009 from the Healthcare Commission, Commission for Social Care Inspection and the Mental Health Act Commission.

### **Comprehensive Area Assessment (CAA)**

From April 2009, CAA is the mechanism for assessing locally-delivered public services, bringing together judgements from six inspectorates into one coordinated view of public services in an area. The primary focus is on the place (outcomes achieved for the community and assessing the risk to future improvement) rather than on organisations and their past performance. The inspectorates will publish an annual joint assessment for every area covered by an LAA on the CAA website.

### **Continuing Care / Continuing Healthcare**

Continuing care is care provided to an adult / older person with long-term conditions or following hospital discharge to meet

physical or mental health needs arising from disability, accident or illness. It often requires a combination of health and social care and can be provided in home, care or nursing home settings. If the main need for care relates to health, care is arranged and funded solely by the NHS (known as NHS Continuing Healthcare) rather than the service user paying for local authority community care support.

### **Delayed Transfer of Care / Delayed discharge**

These are delays that can occur as patients are discharged from hospital and the responsibility for their care shifts from the NHS acute sector to providers of community services (delivered either by the NHS or council social care).

### **Delegation of functions**

The functions (statutory powers or duties) of one partner can be delivered day-to-day by another partner, subject to agreed terms of delegation, to more easily meet the shared partnership objectives.

### **Integrated Care Pilots (ICPs)**

These are organisations taking part in a DH programme to test and evaluate new models of integrated care that cross the boundaries of primary, community, secondary and social care. The 16 pilot sites were announced on 1 April 2009.

### **Intermediate care**

Intermediate care provides short-term, flexible and targeted rehabilitation, primarily for older people, using services across health and social care. It aims to reduce the number of avoidable admissions to acute care, secure earlier discharge from hospital where appropriate and help service users live independently.

## **Joint Strategic Needs Assessment (JSNA)**

Section 116 of the Local Government and Public Involvement in Health Act 2007 requires PCTs and local authorities to produce a JSNA to describe the future health, care and well-being needs of their local community, and the strategic direction of service delivery to meet those needs.

## **Local area agreement (LAA)**

LAAs are agreements that identify local priorities for key partners (central and local government and their delivery partners) via Local Strategic Partnerships (LSPs) as set out in the Sustainable Community Strategy, to improve services and the quality of life in a place. Provisions relating to LAAs were enacted in section 106 of the Local Government and Public Involvement in Health Act 2007.

## **Local Strategic Partnership (LSP)**

LSPs are a collection of organisations and representatives voluntarily agreeing to work in partnership, thereby helping NHS bodies and councils to co-operate with one another to improve the health and welfare of their population through identifying priorities in Sustainable Community Strategies and LAAs. As non-statutory bodies, they are enabled by section 82 of the NHS Act 2006 and also by the Local Government and Public Involvement in Health Act 2007.

## **Pooled funds**

Each partner makes contributions to a common fund to be spent on pooled functions or agreed NHS or health-related council services under the management of a host partner organisation.

## **PSSEX1 (Council adult social care expenditure returns)**

PSSEX1 returns show expenditure incurred and the associated income and activity report each year by councils. Refinements are currently being made to better reflect, for example, the role of intermediate care and the fact that older people's lines cover all those aged 65 years and over but, for example, learning disabilities covers all ages which may also be for those aged 65 years and over.

## **Revenue Resource Limit**

A body's approved limit on revenue expenditure for a given year, applicable to both Strategic Health Authorities and PCTs.

## **The Social Care Institute for Excellence (SCIE)**

An independent charity funded by the DH that identifies and disseminates good practice in all aspects of social care.

## **Sustainable Community Strategy (SCS)**

A Sustainable Community Strategy (SCS) sets the overall strategic direction and long-term vision for the economic, social and environmental well-being of a local area, backed by clear evidence and analysis.

## **World Class Commissioning (WCC)**

This DH programme was set up in 2007 to help transform the commissioning of health and care services by improving PCT commissioner capability focusing on 11 competency areas. It aims to deliver a more strategic and long-term approach to commissioning services, with a clear focus on delivering improved health outcomes and better value for money. It has been developed jointly by the DH and the wider health and care community and will be delivered locally by the NHS.

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