



# SCOTTISH EXECUTIVE

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Directorate of Health Policy

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Your ref:

Our ref:

5 September 2001

Dear Colleague

## **JOINT RESOURCING AND JOINT MANAGEMENT OF COMMUNITY CARE SERVICES**

1. This circular gives guidance on the key steps necessary to improve service outcomes through joint resourcing and joint management of community care services for older people (or all community care as appropriate), from 1 April 2002 as set out in the report of the Joint Future Group "Community Care: A Joint Future" (December 2000). It will be supplemented by more detailed practical advice.
2. Many areas are already developing their own systems and management arrangements. This guidance will reinforce and support that progress to deliver integrated services which are more responsive and sensitive to meeting the needs of individuals, and provide a new lead to the areas that are not so far advanced.

### Context

3. NHSScotland and local authorities already have a statutory duty to co-operate, both at the strategic level and when dealing with individuals. In addition, local authorities and NHSScotland can make arrangements between themselves and with others, to assist in the performance of their functions. Ministers want to build on that legislative framework and existing good practice to make joint working between the local partners more effective across the board.
4. It is against this background that the Minister for Health and Community Care, in her Statement of 5 October 2000 in response to the Royal Commission on Long Term Care and again in "Our National Health: a plan for action, a plan for change" (published in December 2000), set out her intention to establish joint resourcing and joint management, initially for services to older people, by 1 April 2002. She indicated that the Executive would legislate if necessary to remove any remaining obstacles to closer joint working. Following consultation on our proposals in "Better Care

JR Guidance Letter

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for all our futures”, this will be taken forward in the Community Care and Health (Scotland) Bill. It will include provisions enabling the transfer of resources, pooling of budgets and delegation of functions between NHSScotland and local authorities. It will also allow for interventions to compel local partners to work jointly where services are judged to be failing.

5. The arrangements for joint resourcing and joint management also reflect the Executive’s policy on managing cross cutting issues generally, which aim for more co-ordinated responses and better results for people who use public services.

### Benefits

6. The case for joint resourcing and joint management was made in the report of the Joint Future Group, and has been widely accepted and welcomed in Parliament and by users, carers and providers of community care services. Joint resourcing and joint management should benefit users, patients and their carers through improved management and delivery of services. It should:

- Promote early assessment and intervention.
- Remove barriers within the individual’s care journey, and have a positive impact on care outcomes and the number of patients waiting for discharge.
- Provide more consistent and integrated services in localities.
- Create more single points of access to community care services.
- Strengthen locality working and the deployment of resources closer to user’s, patients’ and carers’ needs, leading to greater flexibility and responsiveness of services.

7. From a management perspective, the benefits will be :

- For elected and appointed members: the opportunity to take decisions in terms of a much broader range of relevant resources and thus help develop “whole person” approaches to care.
- For senior managers: the opportunity to take a more integrated view of the planning, commissioning and delivery of services; and to develop more “whole person” approaches to service delivery.
- For middle and locality management: the opportunity to see needs and provide services in the round, to manage a broader range of services directly, in a way which is responsive to user’s, patients’ and carers’ needs.
- For professionals: the opportunity to break down cultural and other barriers, to develop a better understanding of others’ skills, and to develop a wider range of personal skills to serve users, patients and carers.
- For front-line staff: the opportunity to develop a wider skill base, to meet more effectively needs of individual users, patients and carers, and support them to live the life they want.

8. There is some evidence that the move to joint resourcing and joint management is welcomed and is already progressing in parts of Scotland. Consultation on the Community Care and Health (Scotland) Bill (“Better Care for all our futures”) and on the Joint Future Group’s recommendations

confirm that the policy has the support of service users, patients and carers, NHSScotland and local authorities.

### Action Steps

9. Local partners need to act now on the steps they should take together to achieve joint resourcing and joint management of older people's services by 1 April 2002. We expect them to focus on 6 key action steps. These will be based upon their joint vision of services for older people which they wish to develop and commission over the next 5 years:

- agreement on joint management arrangements;
- agreement on the resources (including staff, money, equipment and property) to be brought under joint management arrangements;
- agreement on outline joint development priorities and the associated organisational and people development plan and targets for the next 3–5 years;
- agreement on joint governance and accountability arrangements;
- agreement on the joint performance management framework; and
- these need to be set out in a Local Partnership Agreement (LPA) by 1 April 2002. It can then form part of existing planning mechanisms such as the community plan, local health plan, community care plan and local housing strategies.

10. Some local partners have already made significant progress on these action steps. The action required of local partners under each key step is set out below. The implications for areas such as human resources are referred to later in this guidance. They will also be covered in more detail in the practical advice.

### Resource Implications

11. The development of joint resourcing and joint management should result, in the longer term, in better use of the overall resources available. There may, however, be transitional additional development costs as agencies re-configure their structures and management arrangements. In the settlement for 2001-04 local authorities can access the additional resources for Modernising Community Care (now £10m per annum) or the uprate in general grant provision. NHS Boards' unified budgets also allow significant headroom for development and improvement of systems and services.

### Conclusion

12. Joint resourcing and joint management is a real opportunity for local partners to deliver better services for older people initially (and subsequently for all care groups). The action steps set out above should help to move the agenda forward while leaving scope for local development of models and approaches. Some agencies are already making good progress. Others will have more to do. The proposed action steps should be set out in Local Partnership Agreements: essentially local documents for local consumption and for guiding local action.

13. The Joint Future Unit proposes to support agencies by providing advice on developing Local Partnership Agreements and on systems for joint resourcing and joint management, and by

promoting “promising practice” in Scotland and elsewhere. This will be made widely available and for example placed on the Joint Future Unit's website and disseminated through regional workshops. We will also ensure wide dissemination of emerging guidance from the Scottish Executive Integrated Human Resources Working Group, Audit Scotland, and professional finance bodies.

#### Action

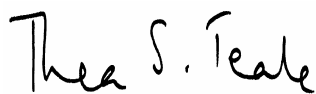
14. Local partners should develop arrangements for joint resourcing and joint management of services for older people by 1 April 2002. They should be set out in Local Partnership Agreements which, though essentially local, should nevertheless be copied to Jenny McNeill, Joint Future Unit, at the address below by 1 April 2002.

#### Enquiries

15. All enquiries relating to this circular should be addressed to Jenny McNeill, Joint Future Unit, Scottish Executive, Health Department, Community Care Division, Room 48C, James Craig Walk, Edinburgh EH1 3BA (telephone: 0131 244 5424). This circular is also available on Scottish Health on the Web: [www.show.scot.nhs.uk/sehd/publications/ccd.htm](http://www.show.scot.nhs.uk/sehd/publications/ccd.htm). Further copies are available by telephoning 0131-244 3523 (or e-mail: [richard.park@scotland.gsi.gov.uk](mailto:richard.park@scotland.gsi.gov.uk) ). It will also be available on the Joint Future Unit website <http://www.scotland.gov.uk/health/jointfutureunit> which will be operational from 12 September and also gives further details of joint resourcing and joint management and the wider joint agenda.

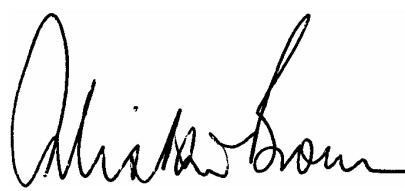
Yours sincerely

3/11/02



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## JOINT RESOURCING AND JOINT MANAGEMENT

This annex sets out more fully the 6 action steps necessary to implement joint resourcing and joint management outlined in paragraph 9 of the circular. Agencies have the option of introducing it for older people's services on their own or for all community care services. This guidance is written for older people, though the principles can apply more widely.

### What joint resourcing and joint management means

1. It may be helpful to explain what we mean by the above:

**'Joint management'** is the overall term that covers the elements needed to ensure a more co-ordinated and effective approach to services including planning, commissioning and operational management. It can have a number of elements: a high level joint board or committee, a joint senior management group, a new partnership body, a single manager at either high-level or locality level, or both. The critical factor is that the relevant range of services is under single management.

**'Joint resourcing'** is the overall term that covers all aspects of resources brought together to provide a single focus for the planning, commissioning and delivery of services. It encapsulates staff, money, equipment (in its widest sense) and property and any other resources currently made available within each of the existing separate agencies to deliver services.

### Joint Management

2. The Joint Future Group was clear that there is no single model for joint management locally. At the strategic level, between NHS Boards and local authorities, there are three partnership models being developed in Scotland to deliver improved services for older people and community care generally.

#### *2.1 Joint Management Structure*

This involves identifying and bringing together the relevant NHSScotland and local authority resources including staff, money, equipment and property. In this situation, budgets are said to be **aligned**. There will usually be a high level joint committee or board with elected members and senior managers, together with NHS Board representatives and senior health managers. There is also likely to be a joint senior management group, a high level single manager and/or locality level single manager(s) as appropriate for the relevant services. The joint management structure does not, however, constitute an independent legal entity and cannot employ staff. Staff will therefore remain employees of their own agencies but can be seconded, for example, to joint management posts or joint service delivery teams.

#### *2.2 Partnership Body Type A*

This is a development of the first model. It involves setting up a partnership body such as "Care Together" in Perth and Kinross. It brings together staff, equipment, property and **aligned** budgets. This partnership body will, however, have much clearer delegated responsibilities and decision-making powers, and so has a much stronger identity or "badge" than a joint management structure. The partnership body will ensure the appointment of a high level single manager and/or locality level single manager(s) as appropriate. The

partnership body is not an independent legal entity and cannot employ staff in its own right. However, the badging may be so strong that staff, users, patients and carers identify with the partnership body. They remain employees of their own agencies but may be seconded, for example, to joint posts or joint services.

### 2.3 Partnership Body Type P

This involves setting up a partnership body based on bringing together staff, equipment and property and the **pooling** of the relevant health and local authority funds, so should result in more streamlined processes, more flexible use of resources and quicker decision-making. Pooled budgets provide more flexibility than aligned budgets. For legal reasons, one of the statutory authorities must be the "host" for the pooled budget. The partnership body will ensure the appointment of a high level single manager and/or locality single manager(s) as appropriate. But it cannot employ staff in its own right and staff are usually employed by or seconded to the host organisation. These models are illustrated in Appendix I.

3. Local agencies should therefore agree single management for either older people's services (or for all community care services) from the models described above. There may be a single manager at both high-level and one or more at locality levels. These posts will unify the management of services and work under the delegated authority of the joint partners.

4. The role of the high level single manager for services for older people, (or in some cases for all community care services) is primarily to drive the planning, commissioning and management of services. Service delivery at the local level, of course, remains very much for the front line staff, working towards the shared objectives of the local partners. The single manager could come from either a health, housing or social care background, and will manage the basket of jointly agreed services. The crux is that the manager has responsibility across the range of health, social care and housing services, as delegated by the local partners.

5. Models for locality single management may vary from area to area according to local circumstances, such as in rural areas. Involving primary care and community health services in joint resourcing and joint management is an essential part of locality single management. This calls for the full engagement of Local Health Care Co-operatives. LHCCs have the potential to work with social work and other agencies to deliver new and innovative ways of joint working at locality level. LHCCs will obviously be part of the joint management of services to older people and some will see themselves having a more central role. Some are already forging ahead – "Care Together", the Perth and Kinross initiative, now sees itself as one Health and Social Care Co-operative. There is evidence of other LHCCs willing to reconsider their own local boundaries and local management arrangements to embrace this joint agenda. But for others, this will be a significant challenge at present. "LHCC Development: The Next Steps" (Scottish Executive July 2001), identified that only 44% of LHCCs had any form of local authority representation. It went on to say that to assume a wider role LHCCs and their local health care systems need to embrace more vigorously the joint health and social care agenda set out in other strategic documents including the Joint Future Group's Report and particularly its proposals on joint resourcing and joint management.

6. It is recognised that the move to joint management arrangements may take place in stages – typically there is a developmental or project stage first before moving to comprehensive joint resourcing and joint management arrangements, such as setting up new partnership bodies. This movement is in line with the wider community planning agenda.

7. Some areas may move more rapidly towards partnership arrangements depending on factors such as a well-established tradition of joint working, a commitment to develop more integrated

working, and practical aspects like co-terminosity of local authority and NHS boundaries. However, positive leadership at a number of levels is the most important factor in achieving progress.

8. Decisions on locality structures are for local determination. Local authority members will want to be involved in developing these since there are significant benefits to users, patients and carers by progressing joint management arrangements locally. In this context local authorities will become non executive members of the new unified NHS Boards as they are established. This will strengthen integration.

### **Joint Resourcing**

9. Joint resourcing is more than just the financial contribution of each agency. It includes staff, money, equipment and property put together in the joint resourcing 'pot'. It is also about the active participation and engagement of all relevant players from housing, social work and health, including the interface with acute and mental health services, in a holistic approach to older people's services. For example, an issue such as the increase in emergency admissions to hospital of older people over 75 is a whole systems issue. In this sense, the active participation in and ownership of the agenda by NHS acute services is as much a joint resource and a driver of change as the specific budgets which can be brought to the table. It may not always be feasible in every instance to identify a financial input – but people from these varied backgrounds need to be round the table. However, we do expect the contribution of resources where these can be levered in.

10. We acknowledge that this is a time of transition for the housing players but the inclusion of housing from the start is critical to agreeing a meaningful vision for services and taking a holistic view on the deployment of resources. This applies even when certain funds may be ring-fenced, such as those for Supporting People, or applied to those with special needs more generally, wherever located. We expect adaptations budgets to be included from the outset, and in due course resource envelopes such as Supporting People.

11. We envisage the following elements being part of the joint resourcing 'pot' for older people's services:

- Local authority social work services and budgets for older people – the focus should be on direct services, either provided or purchased.
- Health, social work and housing equipment and adaptation services for older people.
- Supporting People funding (albeit ring-fenced until 2006).
- Dedicated NHS services for older people such as continuing care, assessment and rehabilitation services, day hospitals and services commissioned from the independent sector.
- Relevant services for older people provided by LHCCs such as but not limited to health visitors, district nurses, Professors Allied to Medicine (PAMs).

- Any aspects of acute services that are primarily intended for the care of older people, where local agencies see value in their inclusion. Stroke care pathways, avoidable admissions and delayed discharges are whole systems issues. Services for people with dementia can be categorised either under older people or mental health joint resourcing arrangements. Local partners need to resolve these issues locally and jointly. The essential point is to include resources where there is the possibility of them being used more effectively as part of the holistic approach referred to above.

12. Appendix II sets out a more detailed list of services that we would ultimately expect to be included in joint resourcing and joint management arrangements for older people. We expect agencies to achieve the maximum possible inclusion of services over time, but acknowledge that progress may be incremental. We also support the active participation of other players such as Education, Transport, Social Inclusion agencies, Recreation and Leisure.

13. Once the scope of the joint resourcing pot has been agreed, local agencies will have the option of **aligning their budgets** under existing powers or **pooling their budgets** under the new flexibilities to be offered by the Community Care and Health (Scotland) Bill once enacted.

#### *An Aligned Budget*

14. This involves the grouping together of separate budgets to improve the joint planning and deployment of resources by local partners. Decisions are taken collectively about the aligned budget but the individual funds are still technically held within separate agency budgets to allow them to identify and account for their own contribution. This approach does not require new powers and is a positive, manageable starting point. But some local partners may wish to move directly to a pooled budget.

#### *A Pooled Budget*

15. This is a mechanism by which the agencies contribute to a discrete fund. Within this fund or “pool”, contributions lose their original identity and are committed and accounted for against the joint aims of the partners. To meet their own statutory obligations and justify their contribution to the fund, agencies begin by clearly stating the purpose, scope and outcomes for services within the pooling agreement. For accountability and legal reasons a pooled budget is hosted by one of the partner agencies, in accordance with its standards of financial governance and the requirements of the agencies for monitoring and review.

#### *Host Partners*

16. The precise role of the host agency will be determined by the partners. The role is primarily the vehicle for financial governance and financial accountability, within delegated authority. Strategic management and operational decisions of substance should be taken by the local partners collectively. The host will therefore support the partners and by being host will have no greater authority than the other partners.

#### *Treatment of Capital*

17. Agencies can decide for themselves whether or not to include capital funding in the joint pot. The same broad principles for aligned and pooled budgets apply to the management and control of capital funds. The guidance issued by the Department of Health and CIPFA states that any major capital investment will be best managed by contributions to the host agency if there is a pooled budget. This will ensure clarity of ownership, and liabilities and helps avoid disputes at a later date. Rent overheads and capital charges can be charged through the pooled budget.

18 Partners should agree on the best use of their equipment and property, and what can be put into the joint resourcing pot. For example, it may be more cost effective for one agency to lease or rent accommodation from another partner - for example from a new community school - rather than purchase new property. Or it may be more helpful to users and patients if partners develop or build joint premises.

### **Joint Development Priorities and Targets**

19. These should be clearly identified at the start of the next 3-5 year period, and rolled forward/modified over time. We envisage a mixture of national and local priorities and targets. Agencies will wish to demonstrate their attainment of national priorities such as rebalancing care, tackling delayed discharges, providing more care at home and implementing the recommendations of the Care Development Group. National priorities should be expressed as clear, measurable, local targets for which local partners can be jointly held to account. Other local targets may be derived from the report of the Chief Medical Officer's Expert Group on the Health Care of Older People (which is expected in the autumn) and the implementation of other essential aspects of the Joint Future Group's report, eg single shared assessments and the modernisation of occupational therapy services. Local targets should also include local objectives such as reprovisioning targets, planned service response rates and joint development and training plans.

### **Joint Governance and Accountability**

20. Agencies will need to put in place arrangements that ensure the proper joint governance and accountability of partnership arrangements, and which are open to public scrutiny. These should build on agencies' existing corporate governance arrangements such as those underpinning NHS Boards. There is no one ideal model but effectiveness and simplicity are at their core. Partners locally need to decide what is most appropriate for their local needs and circumstances. But these arrangements must ensure clear statements about decision-making processes, operational and management arrangements, delegation of responsibilities, reporting lines to parent agencies and monitoring.

21. Agencies must also be clear as to how clinical governance, quality assurance and best value will be delivered within the new arrangements. While it is important for agencies to explore these issues and to build ownership of the new arrangements, we do not wish this to be an exhaustive process at the expense of patient and user focussed aspects of the introduction of joint resourcing and joint management. More information will be provided through, for example, the Joint Future Unit's website. We will also direct agencies towards existing examples of joint governance in order that practical solutions can be more rapidly developed by agencies themselves. Our experience suggests that there are no issues that cannot be successfully progressed, if there is joint determination to do so.

### **Joint Performance Management Framework**

22. Agencies will wish to choose measures that demonstrate their improved performance and how they are meeting their objectives. We expect them to draw on measures from existing national frameworks, including the NHS Scotland Performance Assessment Framework (PAF) and to supplement this with the commitment to local targets for joint working. Over time, we expect them to develop jointly agreed performance measures to enable staff and managers to demonstrate their achievements, to consider how they can further improve their performance and ensure that continuous improvement is an integral part of the local partnership agreements. We want to see a range of measures that capture a balanced view of progress, cover the interests of all concerned, with particular emphasis on the outcome measures that are important to the users, patients and carers. The

outcome measures should be developed in consultation with users, patients and carers to determine what is important to them and that they will be satisfied with the service provided. Partners will therefore need to agree locally a framework for performance measurement and its application, which will be part of the Local Partnership Agreement. In addition, some nationally consistent performance measures may be introduced.

### **Local Partnership Agreement**

23. Central to the development of joint resourcing and joint management for older people is setting out how it will work in a Local Partnership Agreement, (LPA), to be drawn up by 1 April 2002. It may be necessary for some agencies to develop more than one Local Partnership Agreement, eg if a NHS Board covers more than one local authority area. Agreements should cover all of the other key action steps described above to be taken by the local partners. We recognise that this is a high hurdle for some agencies to clear, but others will already have the key elements in place or under consideration. The LPA will also set out broadly how local partners intend to progress joint resourcing and joint management for the rest of community care, if starting with older people's services only from 1 April 2002.

### **Human Resources Issues**

24. The change agenda in community care generally gives rise to a wide range of human resources issues. The same is true for developing joint resourcing and joint management. We do not believe, however, that significant upheaval of staff is necessary to progress joint resourcing and joint management from 1 April 2002.

25. It is important to stress that all of the possible joint working arrangements, including the new partnership bodies, ensure that staff would, in the first place, be employed by their current employer and should only be seconded or transferred to another agency following consultation.

26. We believe it is important that agencies, as part of the local partnership arrangements offer a strong lead and establish joint Local Staff Partnership Forums, such as that in Dumfries and Galloway. Agencies should also offer their staff a clear statement of intent that signifies their wish to support staff as fully as possible, and to develop good joint human resources policies such as secondment, joint training etc. That could include agreement on a local, comprehensive development and training plan at the outset of joint resourcing and joint management.

27. A national Integrated Human Resources Working Group has been established by the Scottish Executive, led by Peter Bates, Chair, NHS Tayside to examine the longer-term issues in relation to joint working. It will report, in the first instance, by April 2002. It will cover issues such as harmonising conditions of service and pay, pensions, disciplinary/grievance procedures, development training and qualifications.

28. Thus, in the short term, human resources issues should not, of themselves, be a barrier to developing joint resourcing and joint management. And while there are a range of grading/pay and conditions issues these will be resolvable only in the longer term under the auspices of the relevant bodies and by legislative change. One instance is occupational therapy staff who are currently employed by NHS Scotland and local authorities in a variety of settings. It is likely that occupational therapy staff in both agencies, although performing different roles will be included in the joint resourcing and joint management arrangements for services for older people. Careful consideration will need to be given to the appropriate roles and resultant human resources issues.

## **Finance Issues**

29. Those delivering and managing new ways of working need support through good financial information and clear lines of accountability. We believe that there are no technical financial issues to prevent joint resourcing and joint management being taken forward in Scotland. As already stated, the Community Care and Health (Scotland) Bill will include new powers to enable the pooling of budgets, while the aligning of budgets can take place within existing powers. Guidance has already been issued by the Department of Health, CIPFA and the Audit Commission to support similar changes in England. The Local Government Finance and Health Finance Divisions of the Scottish Executive are consulting agencies on whether any additional material is required here. In addition, Audit Scotland will consider the need for specific guidance to support implementation of joint resourcing and joint management.

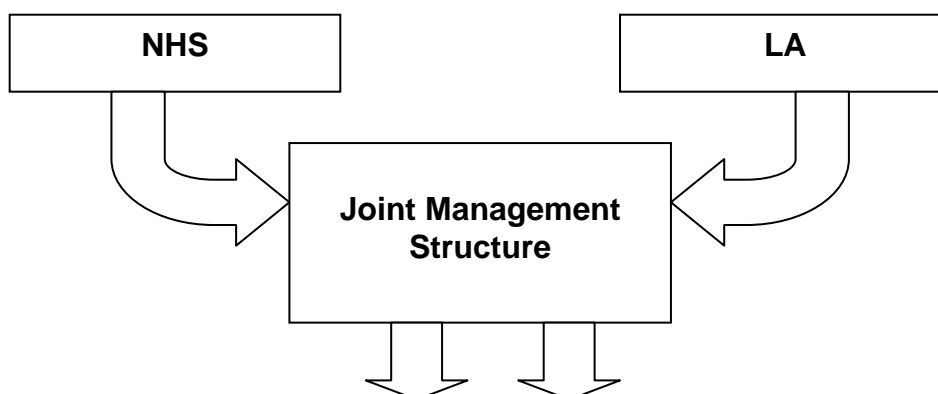
30. We encourage those establishing joint resourcing and joint management arrangements to actively engage finance and audit colleagues from the outset in developing governance arrangements. Agencies also will wish to consider designating one senior finance officer to co-ordinate the local partners' finance and audit interests and to liaise as necessary with professional bodies.

### **Further advice**

31. This guidance will be supplemented by further practical advice later in the year and indicated elsewhere in the text.

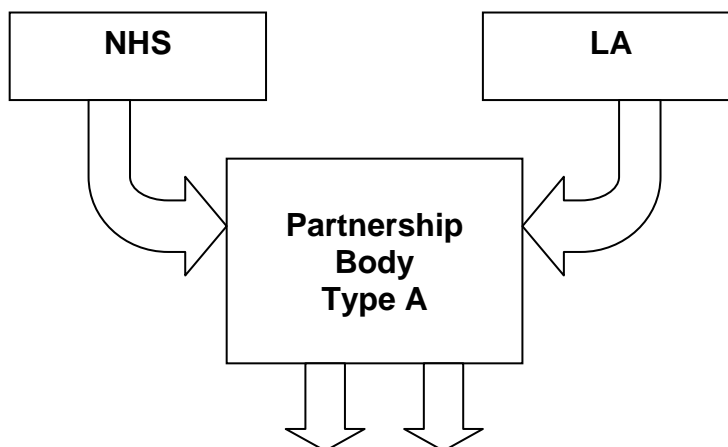
**PARTNERSHIP ARRANGEMENTS POSSIBLE UNDER JOINT RESOURCING AND JOINT MANAGEMENT.**

**Fig 1: Joint Management Structure, eg Glasgow Learning Disability Service**



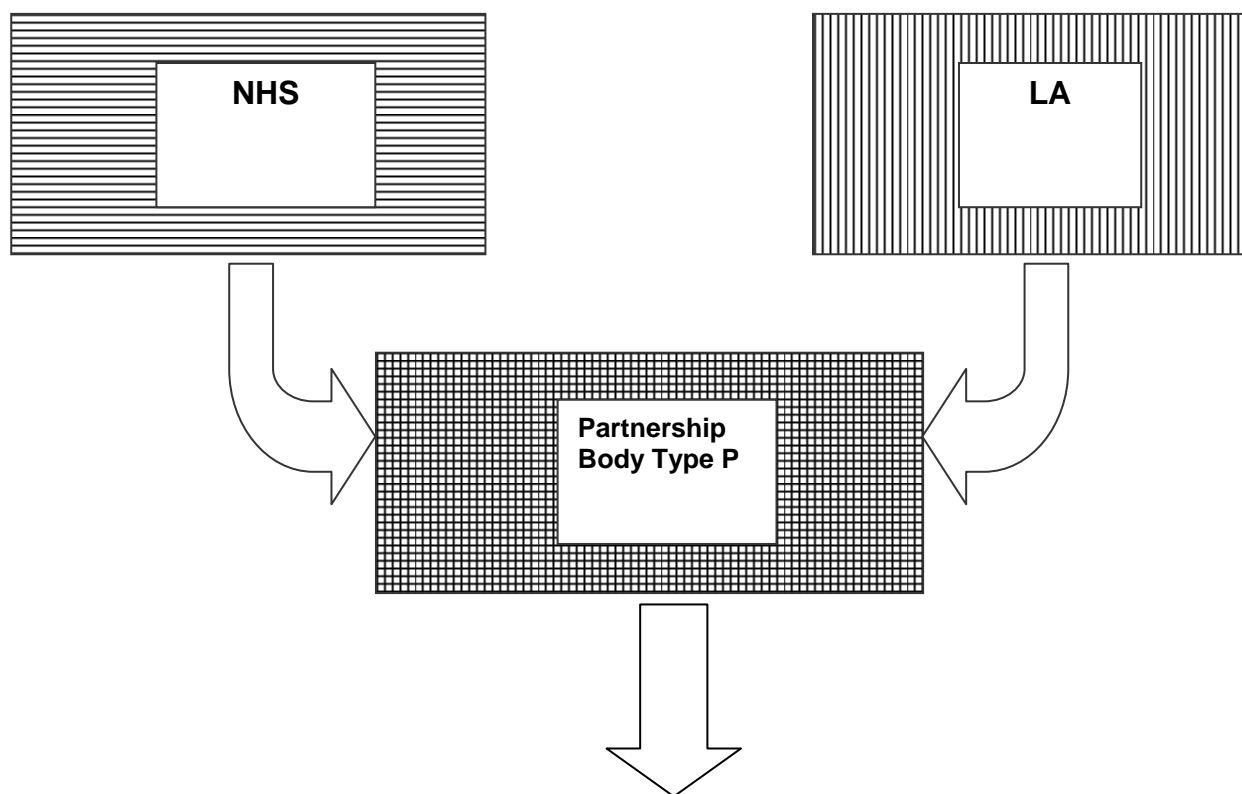
1. **Aligned budgets, staff and services**
2. Not an independent legal entity
3. Staff employed by own agency but both agencies share joint management arrangements, eg committee/board, management group, single manager.

**Fig 2. Partnership Body Type A, (aligned budgets) eg Perth and Kinross**



1. **Aligned budgets, staff and services.**
2. Has a distinct “badge” or identity; but not an independent legal entity
3. Cannot employ staff in its own right.
4. Streamlined decision making through increased delegation.

**Fig 3. Partnership Body Type P, (pooled budget) eg Manchester Mental Health Partnership**



1. **Pooled budget – host partner holds it.**
2. Has distinct “badge” or identity, but not an independent legal entity.
3. Staff employed by one or other statutory agency, usually the host agency. Cannot employ staff in its own right.
4. Main benefits include:
  - flexible use of resources
  - streamlined processes
  - quicker decision making

**SERVICES AND ASSOCIATED FUNDING WHICH COULD BE INCLUDED IN JOINT RESOURCING AND JOINT MANAGEMENT FOR OLDER PEOPLE.**

- Domiciliary services, e.g. meals, laundry, shopping services, household maintenance
- Assessment and care management services
- Places, or funding for places, in residential care homes and nursing homes
- Housing support for older people
- Continuing care (long stay) NHS beds including NHS nursing home places
- Health, social work and housing equipment and adaptation services for older people.
- Rehabilitation and intermediate care services
- Crisis care services
- Community hospitals
- Advocacy services
- Relevant services provided by LHCCs, such as but not limited to health visitors, district nurses, Professions Allied to Medicine (PAMs)
- Care and Repair services
- Community alarms
- Mental health services for older people (including both those with dementia and with functional mental disorder)
- Respite and day care services, whether LA/NHS purchased and / or provided e.g. day centres, NHS day hospitals
- NHS assessment /rehabilitation beds for older people
- Hypothecated funding e.g. resource transfer, winter beds / delayed discharge
- Grant funding of organisations (as opposed to contractual purchase of services for older people)

In the first place, agencies may wish to select services or parts of services that are easily identifiable.