



**PRACTICAL ADVICE
ON JOINT RESOURCING AND JOINT MANAGEMENT**
Issued October 2001
Revised February 2003

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Appendix 1: Template for the full Local Partnership Agreement. (This should be completed by the local partnership and sent to the Joint Future Unit by 1 April 2003).



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INTRODUCTION

Why has this Practical Advice been written?

This Practical Advice aims to build on the Scottish Executive Circular on Joint Resourcing and Joint Management issued in September 2001 (CCD7/2001). It explains the ways in which local partners can work together to improve the delivery of services for older people. Local partners means local authorities, NHS Boards (including Trusts and Local Health Care Co-operatives) and Communities Scotland. The Advice also sets out or provides hyperlinks to examples of "Promising Practice" where local partners working at the leading edge of integrated service development have worked together to enable closer integration of housing, social care and health services.

Who has this Practical Advice been written for?

The Advice has been written by the Joint Future Unit and its main audience is senior management teams in health, housing and social work. It also aims to inform key stakeholders, such as people who use services and patients, their carers, staff and trade unions, voluntary and independent providers, together with Councillors and members of NHS Boards about ways of achieving the type of integrated working set out in Circular CCD7/2001.

It is important that in each Agency staff involved in taking forward joint resourcing and joint management are aware that the Practical Advice is available.

How should this Practical Advice be used?

This Advice is not formal Scottish Executive Guidance. It is intended that key decision-makers will find the Practical Advice helpful to:

- Inform themselves more fully of the thinking behind Circular CCD7/2001;
- Assist them to think through the issues facing them locally and to take action;
- Consider the use of new flexibilities outlined in the Community Care and Health (Scotland) Act;

- Learn about areas of Promising Practice, so that they do not need to “re-invent the wheel”.

The Practical Advice can be used equally by partners who are focusing in the first place on joint resourcing and joint management for older people’s services or by partners who are focusing on all community care services.

We expect people will go to the section which interests them most, rather than read the whole document straight through.

The structure of the Practical Advice

This Practical Advice follows the structure of Circular CCD7/2001 and the 6 Action Steps set out in it, with some additional information on partnership working, communication and information sharing. Each section contains:

- Information and advice on implementing the Circular;
- Examples of Promising Practice, or links to them;
- Background information.

We refer to Promising Practice throughout this Advice. Promising Practice is the label we give to leading edge service development that fits the broad direction of travel outlined by new policy. It may not meet all the requirements of policy and it has not been rigorously evaluated as Good Practice or Best Practice. Its value comes from the freshness of the development and the new ground it is breaking.

Where examples of Promising Practice are given, the Joint Future Unit has tried to scrutinise them so that local partners can be reassured of their value. The Nuffield Centre for Community Care Studies www.gla.ac.uk/centres/nuffield/iwp/index.html and its database of good practice continues to welcome nominations of good practice.

This Practical Advice focuses on joint resourcing and joint management. As Practical Advice is developed on other Joint Future Group recommendations , such as the Single Shared Assessment Process or Equipment and Adaptations, this will be added to the Joint Future Unit website www.scotland.gov.uk/health/jointfutureunit.

Many partners have concentrated on service issues such as the Single Shared Assessment Process, rather than on joint resourcing and joint management. In these cases, we recognise that there will not be examples of Promising Practice of joint resourcing and joint management, though there may be many other examples of innovative joint working.

Background Information

“Joint Resourcing and Joint Management of Community Care Services”, CCD7/2001, Scottish Executive, 2001.

<http://www.scotland.gov.uk/health/jointfutureunit/ccd7doc2.PDF>.

“Community Care: A Joint Future”, Report by the Joint Future Group, Scottish Executive, 2000. <http://www.scotland.gov.uk/library3/social/rjfg-00.asp>.

“Our National Health, A plan for action, a plan for change”, Scottish Executive, 2001. <http://www.show.scot.nhs.uk/sehd/onh/onh-oo.htm>.



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1. JOINT MANAGEMENT

Implementing the Circular CCD7/2001

The Circular on Joint Resourcing and Joint Management, issued by the Scottish Executive in September 2001 (CCD7/2001) gave considerable details on possible joint management arrangements.

<http://www.scotland.gov.uk/health/jointfutureunit/ccd7doc2.pdf>

This section focuses on 4 specific issues in more depth:

- Developing a joint management arrangement;
- Joint committees and partnership boards;
- Local management;
- The role of the single manager.

Developing a joint management arrangement

Partners in each area will want to develop their own joint management arrangement to suit local circumstances. The Joint Future Group was very clear that “no one size fits all”.

The process of developing a joint management arrangement will therefore reflect several factors such as:

- Existing good working relationships;
- Positive leadership;
- Co-terminous boundaries;
- Focus on improvements in services for patients/people who use services;
- A history of “success breeds success” in partnership working in the area.

From what the Joint Future Unit has observed, the process of developing a joint management arrangement seems to follow 2 major routes:

- Rapid movement based on a tradition of positive joint working with many joint initiatives already in place or rapid movement based on the necessity to improve services;
- Incremental movement based on the partners coming together to agree and establish joint working more formally and more extensively than previously.

Both routes will involve the initial coming together of senior managers, Councillors and NHS Board members to discuss and obtain commitment to a shared vision of local services. Whenever this happens, it is crucial to the development and effective operation of a joint management arrangement. Involving and getting commitment from professional groups (health, social work and housing) is also crucial.

Partners travelling down the first route may move rapidly to the establishment of a joint committee or partnership board, and the appointment of one or more single managers.

Promising Practice: Highland Joint Committee for Action on Community Care
Glasgow

Both routes (and especially the incremental route) often involve the appointment of a joint project team which has a developmental role. The team usually has a manager, often called the Joint Future Manager, with finance, personnel, organisational development and administrative staff in support.

The team usually has a mix of people from each agency. The team's role is to scope the level and extent of joint resourcing, often known as the joint resourcing pot, and joint management together with the implications, e.g. human resources. It will also take the lead in promoting cultural shifts, acting as a change agent, and generally oiling the wheels in moving forward. The project team members will be empowered to take certain decisions on behalf of their agency but it is recognised that they will usually have to refer back to their respective agencies to either obtain clarification or approval to certain conditions being made within the partnership arrangements.

Some areas may move more rapidly towards partnership arrangements depending on factors such as a well-established tradition of joint working, a local level of commitment to joint working and co-terminosity of local authority and NHS boundaries.

Promising Practice: Fife Council and NHS Fife

Partners might want to be aware that if they set up a project team then that approach needs ongoing management in order to ensure that the agenda does not become marginalised within the project team rather than mainstreamed. It may be better to ask senior and key operational staff to undertake the work so that the Joint Future agenda is owned by senior staff and the people that work for them.

Joint Committees and Partnership Boards

In general, it appears that it is essential to have commitment to the Joint Future agenda by involving Councillors and NHS Board members as early and as fully as possible.

Some partners have said they expect the NHS Board to act as the joint committee or partnership board for joint resourcing and joint management. This is not possible under current local authority legislation and in any event, the NHS Boards already have a very full programme of work. It is more valuable to have the full commitment of all the partners focussed and expressed through a specific committee or partnership board.

Joint resourcing and joint management arrangements could technically be put together without need for a joint committee or partnership board but our experience tells us that this can frustrate single managers, fragment decision making and introduce unhelpful delays. Opportunities for shared learning at Councillor level/NHS Board member level are also lost.

The trend in Scotland is to establish a joint committee or partnership board. Such joint committees and partnership boards are not legal entities and partners will want to have regard to existing local authority legislation which sets out the locus of elected members in decision making.

Some examples have already been developed of joint committees and partnership boards such as Highland Joint Committee for Action on Community Care and the Perth and Kinross "Care Together" Partnership Board. In summary the advantages of a joint committee or partnership board are:

- Highly visible joint leadership - operational managers leading the joint agenda can meet Councillors or NHS Board members and jointly take immediate decisions (within their delegated limit) or make recommendations to parent committees/ NHS Boards giving the benefit of such high level joint counsel.
- Parent committees and NHS Boards can ratify more speedily recommendations from operational managers which fall outwith their day to day delegated responsibilities.
- Badging – a strong sense of identity promotes leadership, teamwork and a focus for organisational development.

<p><i>Promising Practice:</i> Highland Joint Committee for Action on Community Care Perth & Kinross Care Together Partnership Board City of Edinburgh and Lothian Health Joint Committee</p>
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An existing committee or board can be adapted as in the case of the Health, Well-Being and Lifelong Learning Forum, part of the community planning structure in West Lothian.

<p><i>Promising Practice:</i> West Lothian Health, Well-Being and Learning Forum</p>
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The size, membership and remit of the high-level joint committee or partnership board will vary according to factors such as the needs of the area, the vision of services and the joint agreement on what can be reasonably achieved. There is “no one size fits all”. The partners in each area will want to agree what arrangement will facilitate joint working most effectively in their own area.

Local Joint Management

Joint management arrangements are not intended to concentrate management power and resources around a cluster of individuals working between the agencies at a high level. Rather, joint management should be a driver for the devolution of decision making and resources to a level as near to the patient or user of services as possible. Scoping joint management arrangements should therefore consider how devolution of responsibility can be accelerated.

Several areas are moving rapidly to managing services or considering ways of doing so at the level of Local Health Care Co-operatives. The joint resourcing and joint management arrangements set in place at a local level must involve Local Health Care Co-operatives. Primary Care Trusts should be supporting Local Health Care Co-operatives in tackling this very important agenda. The Scottish Executive wishes to see Local Health Care Co-operatives develop as multi-disciplinary and multi-agency organisations. Developments so that equity of responsibility and representation at the local level are clearly visible and owned by the stakeholders such as area social work teams and primary care teams, may be appropriate.

The level of development of Local Health Care Co-operatives varies significantly across Scotland. This makes it impossible to set out a blue print for the role of Local Health Care Co-operatives in joint resourcing and joint management.

However, already some Local Health Care Co-operatives are becoming very involved in the development of joint resourcing. This may be at a local authority wide area, as in East Lothian and Moray.

<p><i>Promising Practice:</i> East Lothian Local Health Care Co-operative and East Lothian Council Moray Council and Moray Local Health Care Co-operative</p>

Joint resourcing and joint management may also be developed at a locality level as in the South East Edinburgh Local Health Care Co-operative and the City of Edinburgh Community Care Social Work Team.

<p><i>Promising Practice:</i> South East Edinburgh Local Health Care Co-operative and City of Edinburgh Community Care Team</p>

It is very important to recognise that the Scottish Executive does not envisage a “take-over” of community care services, either by a Local Health Care Co-operative or a local authority.

Instead partner agencies should work together to develop a joint management arrangement that can deliver improved services to local people. Most Local Health Care Co-operatives, as they are currently constituted, could not become the managerial vehicle for community care services in their area.

Perth and Kinross have developed their form of joint management by taking a fully inclusive approach. They now call their arrangement “Care Together, a Health and Social Care Co-operative.”

Promising Practice: Perth and Kinross Health and Social Care Co-operative

Single Manager

Partners may choose to appoint a single manager at a high level or at locality level or both. Much will depend on the size of the budget, the geography of a given area and whether an incremental approach is adopted. Appointing a high level manager may be the first step towards scoping the joint resourcing and joint management arrangements.

High level managers are likely to be strategic in focus, demonstrating positive leadership but will need support from the outset from specialist colleagues such as Finance Directors and Personnel Directors within the partner agencies and/or from a project team with dedicated time to devote to establishing joint resourcing and joint management arrangements.

Locality managers are more likely to be drawn from an operational background and will inform and interpret high level decisions, placing them in a locality context. Locality managers have a critical role in empowering staff to operate within new systems to achieve better results for patients and clients, demonstrating local leadership and identifying training and development needs.

The factors that influence the overall development of a joint management structure will also affect the creation of single manager posts. For example, a small local authority with a coterminous Local Health Care Co-operative may only need one high level operational manager. A large local authority with a number of Local Health Care Co-operatives may need both a high level operational single manager and several locality single managers.

Promising Practice: See below for job descriptions and person specifications for the following posts in Perth and Kinross Health and Social Care Co-operative. For further details contact:

Alan McGonigle
Tel: 01738 473111 or 476773
Email: AmcGonigle@pkc.gov.uk

OR

Anne Clarke
Tel: 01738 476773
Email: Amclark@pkc.gov.uk

Job Description	Person Specification
Integrated Services Manager	Integrated Services Manager
Learning Disability Manager	Learning Disability Manager
Locality Manager	Locality Manager
Primary Care Manager	Primary Care Manager
Planning and Commissioning Manager	Planning and Commissioning Manager

It is interesting to note the developments in England around single managers at Chief Executive levels, although this is not being advocated in Scotland.

Good practice – joint working at senior level

Herefordshire Health Authority and **Herefordshire** Council jointly appointed a single manager as the Chief Executive of the Health Authority and the Director of Social Services and Housing, the first of its kind in England. The Council and the Health Authority agreed the new joint role, with the title of Director of Health, Housing and Social Care, with effect from 1 November 2000, registered under Section 31 of the Health Act 1999.

Barking and Dagenham was a council on special measures where the incoming Director of Social Services set out to rebuild a failing authority, actively involving a range of stakeholders. After successfully achieving removal of the special measures status, the Director was also appointed as Chief Executive of the Barking and Dagenham Primary Care Trust, resulting in Social Services and the Primary Care Trust being jointly managed at chief officer level.

Quoted from “Modern Social Services – a commitment to deliver”, 10th Annual Report of the Chief Inspector of Social Services, 2000/01.

Background Information

“Modern Social Services – a commitment to deliver”, 10th Annual Report of the Chief Inspector of Social Services 2000/01 www.doh.gov.uk/scg/clann_10htm.



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2. JOINT RESOURCING

Implementing the Circular CCD7/2001

Joint resourcing is more than just the financial contribution of each agency. It means bringing together all of the resources, the services, people and their skills, budgets, equipment and property into the joint resourcing “pot” and placing these resources under single management arrangements, jointly agreed by the partners. Not all contributions can be expressed in financial terms, such as the skills and expertise of an A & E consultant in an acute Trust. The resources that can be included in the joint resourcing pot are set out in the Circular. The decision about what to include is for local determination but it can be beneficial to include as much as possible in order to develop a more integrated approach to service delivery. The resources can include:

- Services
- Staff – see Section 7, Human Resources
- Finance
- Property
- Equipment

Services

The guidance sets out in detail the services or elements of services which can be brought into the joint resourcing arrangements for older people’s services, or all community care services.

When local partners are considering which services they can bring together, they should be aware that they will still be accountable for their statutory functions even when these are delegated. These need to be specifically identified, e.g. in the Local Partnership Agreement, or an appendix to it, particularly where a new partnership body is being set up. (See Section 4, Joint Governance and Accountability).

Services and functions that can be included in the local partnership arrangements can be:

- Planning and commissioning;
- Directly provided or purchased services;
- Statutory functions such as the local authorities' statutory responsibility to undertake assessments for community care services under the NHS and Community Care Act (1990).

Bringing together services may take time and a clear view about how this will improve services for older people who use services, but it should not unduly delay the movement towards the integration of services.

For example, equipment and adaptation services involve health, housing and social work resources for people of all ages. The National Strategy Forum for Equipment and Adaptations (established following a recommendation by the Joint Future Group) will report over the next year on the modernisation and improvement of equipment and adaptation services. The Forum will also advise on the best way of incorporating equipment and adaptation services for people into the joint resourcing pot. Another example of work in progress, both nationally and locally, is the development of Supporting People grant funding arrangements and their links with the Joint Future agenda. Local Joint Future groups will therefore want to work closely with local Core Co-ordination/Joint Commissioning Team for Supporting People.

<p><i>Promising Practice:</i> Jointly purchased and provided services NASA (Ayrshire) Community Hospitals (East Lothian) Slow – stream Stroke Rehabilitation (Edinburgh)</p>
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Finance

It is important to involve the partners' finance and audit staff from the outset in developing joint resourcing and joint management arrangements. Setting out the intended outcomes for patients and people who use services in a multi-disciplinary way should assist in meaningful discussions about what budgets can go into the joint pot and how these will be accounted for.

The Joint Future Workshop on Finance issues held in 2001 recommended that it may be helpful for agencies to agree that one senior finance officer should co-ordinate the input from all the local finance and audit community. It is important, too, that each agency is satisfied that any possible risks are identified and managed and that they can meet their own statutory accounting requirements prior to the partnership arrangements being approved.

Our close work with the Department of Health Joint Unit and finance experts tell us that there are no financial accounting show-stoppers to joint resourcing and joint management but that management accounting issues such as budget setting and reporting deadlines need to be worked through locally.

Promising Practice: Perth and Kinross Heads of agreement
Manchester Mental Health Partnership on Pooled Budgets

The following list is a sample of the type of finance issues/arrangements to cover in any partnership agreement:

- Details on the resources each partner will contribute. This can include accommodation, information systems, personnel, goods and services and capital and revenue funding. Any specific conditions and reporting arrangements attached to these resources should be stated, especially as ring-fenced funding e.g. Supporting People is included in the joint pot;
- The level of budget variation, both in-year and between years, acceptable to the partners;
- Details on how underspends, overspends and virements are to be reported on and dealt with;
- Details on how inflationary pressures will be managed;
- Details of the devolved budget arrangements to local areas and front-line staff;
- Financial monitoring and reporting arrangements during the year and at year-end which have been agreed by partners;
- Details of any significant contracts already in existence for the delivery of services entered into by the partnership;
- Charging policy of the local authority and how this will be administered within the partnership;
- Local authorities and the NHS are governed by different VAT regimes. Liaison is currently underway between Department of Health and HM Customs and Excise about the arrangements which will apply where pooled budgets are being operated by the partners in order to ensure no loss of funding to the community care system as a result of closer working; www.doh.gov.uk/jointunit/vat.htm;
- The financial arrangements to cover any exit strategies, disputes and termination of the agreement, e.g. reallocation of assets and resources and responsibility of outstanding debts;
- The internal and external audit arrangements.

A number of finance and audit issues have naturally been raised on the proposed new joint resourcing arrangements. A specific and detailed Finance Q & A *section* www.scotland.gov.uk/health/jointfutureunit/financeQA.pdf is shown on this website - this contains significant practical detail and will be regularly updated to take account of issues as they are raised by partners.

To assist with the smooth introduction of joint resourcing and joint management and to support the finance communities within health and local government, CIPFA Scotland have established a Joint Resourcing Advisory and Network Group to offer advice on issues raised by the Circular (CCD7/2001) and the new flexibilities which underpin it contained in the Community Care and Health (Scotland) Act and to identify Promising Practice. The Act will include new powers to enable the transfer of resources between agencies for agreed functions, the delegation of statutory functions and the pooling of budgets.

CIPFA Network: www.scotland.gov.uk/health/jointfutureunit/cipfaremit.pdf

Community Care and Health (Scotland) Act:
www.scottish.parliament.uk/parl_bus/legis.html#34

Guidance has already been issued by the Department of Health and CIPFA to support the pooled budget arrangements in England. In addition, Audit Scotland will consider the need for any specific guidance in Scotland.

CIPFA publications www.cipfa.org.uk/

Department of Health guidance www.doh.gov.uk/jointunit.

Successful examples of financial arrangements have demonstrated that some “thinking out of the box” is required. Viewing risk as a joint responsibility within longer term partnership arrangements may help partners find a way around individual issues.

<i>Promising Practice:</i> Lincolnshire Learning Disabilities Services
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Staff – see Section 7, Human Resources

Property

The inclusion of property in the joint resourcing pot is designed to ensure that the cost and appropriateness of premises is taken into account from the outset. It also ensures that resources currently tied up in existing models of service provision are available to the partners when planning new models of provision. Once partnership arrangements are established, agencies may also wish to consider the added value of joint premises to create single points of access to community care services.

Agencies can decide for themselves whether or not to include the purchase or construction of new properties to enable the delivery of services. It may be cost effective for one agency to lease accommodation from another partner- for example from a new community school - rather than purchase new property. Or it may be more helpful to people who use services if the partners develop and build new jointly shared premises.

Promising Practice: Ayrshire (Dalmellington), NHS Ayrshire and Arran
Kinlochbervie (Highland), NHS Highland

However, inclusion of properties within a partnership arrangement - particularly where pooled budgets are concerned - is more complex because of the different capital regimes within which health and local government bodies work. Consequently, the partners may agree that one agency (the host, as required for a pooled budget) acquires and develops the property on behalf of the partnership and accounts for it in accordance with the capital regime within which it normally operates. Capital contributions, including receipts from the disposal of existing sites and properties, can however be made by the other agencies to fund new properties in accordance with their normal procedures and legal security arrangements. It is important to have clarity of ownership to avoid disputes at a later date.

Promising Practice: Homelink – The Joint Capital Funding of Housing Projects

Rent, overheads and capital charges on the properties being used by the partnership can be charged through the joint resourcing arrangements.

Equipment

Agencies should agree on the best use of their existing and prospective equipment, such as IT, to assist the partnership with the delivery of services. It should not only be cost effective but should improve services. For example, for shared IT systems and developments it may be necessary to change the procurement, location, type of information technology hardware and software applications to enable staff in different agencies to work better together.

Background Information

- DOH list of partnership projects using Section 31 arrangements
www.doh.gov.uk/jointunit.
- Audit Scotland report on Commissioning Community Care Services which is available free from Audit Scotland, 110 George Street, Edinburgh EH2 4LH, telephone 0131 477 1234.
- “Modernising Community Care – The Housing Contribution”, Scottish Executive, July 1999.



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3. JOINT DEVELOPMENT PRIORITIES AND TARGETS

Implementing the Circular CCD7/2001

Local partners should agree an underpinning framework when considering the development of services, which will lead naturally to an agreement on joint priorities and targets. It may contain:

- A local vision of older people's services or community care services in the future;
- Aims and objectives for the local area derived from that vision;
- A joint strategy with a 3-5 year timescale that maps how they will achieve this vision;
- A joint detailed implementation plan with "staging posts" of what they wish to achieve, year by year. This will include relevant information such as the planning stages, consultation, recruitment and training of staff, and dates by which different funding decisions have to be made by different agencies, taking account of their different decision-making cycles;
- A business plan for each organisation or a joint business plan with a 12-month timescale setting out the priorities for the year;
- Short- and medium-term targets and performance measures (see Section 5, Joint Performance Management Framework);
- Efficient and effective monitoring and review processes that involve all the local partners and enable them to maintain the momentum of improvement.

Agreement on shared services, shared principles and shared values

Fundamental to the process of developing joint resourcing and joint management must be a shared vision of how older people's services or community care services should develop locally over the next 3–5 years. This agreement can be drawn from existing documents such as the Community Plan, Community Care Plan and Partnership in Practice Agreements (PIPs) and plans under development such as local housing strategies, (which include Supporting People Strategic Plans) due in April 2003.

Alternatively, organisations may take this opportunity to rethink their joint vision of what their services should look like in 3-5 years' time. As a consequence of this, they may decide to move to a more integrated model of management to meet the challenge they set for themselves.

These developments should be set out in the Local Partnership Agreement, which should not be a summary of individual projects; rather it should be a clear exposition of how joined up services would be set in place and how these will improve the quality of life for individuals and their carers.

The new partnership arrangements will also have to take account of recent policy developments, e.g. the Learning Disability Review, the requirement to produce Partnership in Practice Agreements (PiPs) and the associated Change Fund.

Agreeing Specific Joint Priorities and Targets

Cost effective use of resources will be one of the criteria against which local partnership arrangements can be assessed by their stakeholders, individuals using services, carers and the agencies themselves. Agencies will therefore want to show how they can improve services and how best fund them. They should focus on priorities which are both national priorities, e.g. winter pressures and delayed discharges, and also local priorities agreed between the partners. For example:

- A major shift in the balance of care – moving away from traditional forms of institutional care and placing the emphasis on services such as domiciliary services, housing support, care and repair schemes and better access to equipment and adaptations. All of these services are aimed at helping people to remain in their own homes in the community.
- New and better ways of working – including jointly commissioned services for people with complex needs, access to advocacy, direct payments, and brokerage services, client/patient held care plans, integrated information services and single shared assessment.
- A better quality of life – including people having more control over their lives, being more part of the community and enjoying better health.

Measurable improvements in services

Local partners will need to be clear from the outset about the tangible improvements to services and how these can be measured. These may be drawn from existing strategies or plans such as the Health Improvement Plan or new ones which may be agreed in drawing up the Local Partnership Agreement.

Examples are:

- reduce the rate of increase in emergency hospital admission of people aged 75 and over;

- increase the number of people receiving a single shared assessment;
- reduce the proportion of delayed hospital discharges of people aged 75 and over.

See also Section 5, Local Performance Management Framework

Background Information

“Modernising Community Care – An Action Plan”, The Scottish Office 1998
www.scotland.gov.uk/library/documents-w3/mcc-00.htm.



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4. JOINT GOVERNANCE AND ACCOUNTABILITY

Governance and accountability arrangements must ensure that public services and the individuals within them (whether appointed staff, NHS Board members or Councillors) can provide to:

- their patients, people who use services and carers;
- the members of the partnership;
- stakeholders outside the partnership;
- the public.

an account of:

- the quality and effectiveness of health, housing, social care and support services provided;
- the proper and efficient use of money;
- their aims, objectives and priorities;
- how they are meeting internal and external regulatory requirements;
- how they are making continuous and measurable improvements.

The different ways that “governance” and “accountability” are used

NHSScotland uses the word governance particularly in relation to:

- Corporate governance;
- Clinical governance;
- Staff governance.

Local authorities use the word accountability particularly in relation to:

- Political accountability;
- Legal/statutory accountability;
- Professional accountability.

Both use the word accountability in relation to:

- Financial matters (see Section 2, Joint Resourcing);
- Patients, people who use services and carers;
- The public.

Developing joint governance and accountability arrangements

In bringing together resources and services to be jointly managed, agencies will need to assure themselves that they have kept or developed proper governance or accountability arrangements. They may, for example, wish to undertake risk assessments to check that this is being done.

Put simply, “agencies and individuals must do the right thing, do the right thing correctly, and be seen to have done the right thing correctly”.

Building on existing arrangements

Agencies must set in place proper joint governance and accountability arrangements, open to public scrutiny and straddling the partner agencies. These should build on the agencies’ corporate governance arrangements such as those which exist within local authorities and NHS Boards. The role of the NHS Board in governance is set out in “Rebuilding our National Health Service”, which states: “The overall purpose of the unified NHS Board is to ensure the efficient, effective and accountable governance of the local NHS system and to provide strategic leadership and direction for the system as a whole, focusing on agreed outcomes.” (“Rebuilding our National Health Service”, Scottish Executive, May 2001, page 9).

Meeting local requirements

Partners are not required to set in place any one model of joint governance or accountability arrangements. They need to decide what is most appropriate for local needs and circumstances. It is clear that partners are considering governance arrangements to be important, for example decision-making processes, monitoring, operational and management arrangements, delegation of responsibilities, and reporting lines to parent agencies. Partner agencies will want to think carefully how they can assure accountability as it is possible for it to become more diffuse in partnership arrangements.

Integrating key governance and accountability arrangements

There are a number of important issues that are integral to the partnership governance arrangements.

a. Best Value. Local authorities have a duty of Best Value. They have to subject all the activities and services for which they are responsible to a Best Value review over a maximum 5 year period. Best Value will continue to operate for all local authority functions wherever they are sited. NHS bodies do not have the same duty of Best Value but can work together with local authorities over this, and it may positively influence their future patterns of service delivery.

b. Quality assurance. The Scottish Executive is developing quality standards on a range of services, e.g. for single care homes which will replace residential care homes and nursing homes. The Care Commission will also play a major part in ensuring the quality of many services. Agencies will wish to have regard to these wider policy and care developments in agreeing and implementing their local partnership arrangements.

c. Clinical Governance. The development of local partnership arrangements should take into account the different understanding of NHS staff regarding clinical governance and social work staff's understanding of management, financial or administrative governance and accountability. They will need to work to ensure that all staff understand the issues and best ways of ensuring clinical governance. See also Section 7, Human Resources.

Where new partnership bodies are being set up, partners could consider developing a Service Governance Policy, extending to health, housing and social work staff. A Service Governance Policy could also incorporate the views of professional groups.

Promising Practice: The Service Governance Policy developed by the Manchester Mental Health Partnership covers the relevant issues for both NHS and social work staff in comprehensive detail. In the document, key elements of joint governance, such as practice guidelines, risk management, evidence based care, continuing professional development, human resource implications and the health and social care framework of accountability have been set out.

Manchester Mental Health Partnership Service Governance Policy
www.scotland.gov.uk/health/jointfutureunit/servicegovernance.pdf

Promising Practice: Ulster Community HSS Trust Service Governance Policy

d. Complaints Procedures

The partners generally agree that complaints will be handled under the joint management and governance arrangements. A joint protocol and process can then be agreed and set in place to do so. This will enable a complaint about a partnership issue to be dealt with more appropriately.

It is usually the case that the responsible manager would take the complaint through the informal processes. The relevant joint committee/partnership board or identified body would undertake a formal review.

However, this does not remove a person's rights under the present statutory arrangements. There may also be circumstances when a referral to one or more parent bodies is necessary. The important fact is that procedures need to be clear, that service users and patients are informed of their rights and that they are kept informed of how their complaint is being handled.

Background Information

“The Governance in Partnerships, A Checklist of Good Practice”, Department of Health, 2001 www.scotland.gov.uk/health/jointfutureunit/governancepartnerships.pdf



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5. JOINT PERFORMANCE MANAGEMENT FRAMEWORK

Implementing the Circular CCD7/2001

Local authorities and NHS health agencies already have separate comprehensive performance management frameworks. These can also be used as the basis for measuring the effectiveness of the partnership. Jointly agreed performance measures will enable staff and managers to consider how to improve their performance. They will also ensure that continuous improvement is part of the thinking integral to the local partnership arrangements.

It is advisable to have a range of performance measures which can capture a balanced view of progress, cover the interests of all stakeholders and reflect the business activities as a whole. The performance management framework must focus on outcomes. However it is not currently intended that the Scottish Executive will be prescriptive about which performance measures should be used at a local level.

The Scottish Executive is currently working on the development of national performance measures for joint resourcing and joint management. This is called the Joint Performance Information and Assessment Framework (JPIAF). Consideration about how the existing regulatory regimes will tackle audit and performance assessment of new partnership bodies is being undertaken.

It is preferable if partner agencies agree locally on a joint performance management framework, the associated performance measures for their partnership arrangement and which agency is responsible for collecting the information. It is likely, however, that the performance measures will be a combination of local and national performance measures for social work, housing, and health. Partners will want to agree the important issues for them, for example equity of service provision and uptake across geographical boundaries and communities of interest.

The Performance Assessment Framework for NHSScotland (PAF)

The NHS PAF has been developed by the Scottish Executive and came into effect on 30 September 2001. It places equal weight on the quality of clinical and service delivery, financial management, and public involvement. It provides clearer, more objective and broad based measures against which to assess the performance of all NHS agencies. (There is no equivalent Scottish social care PAF). Partners can draw on the PAF in setting their performance measures for the partnership.

Taking the Lead

It is important to ensure that there is a real commitment by all the partners to monitor jointly the improvements in services. Partners should agree which agency will take the lead, which is responsible for which area of work, which agency collects what data and how it used for monitoring. There should be clear reporting lines in relation to the performance management framework and what the timescales for this will be.

<p><i>Promising Practice:</i> Perth and Kinross objectives in increasing home care, Annexe to Heads of Agreement</p>
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Background Information

“A Measure of Success, setting and monitoring local performance targets”, Audit Commission, 1999.

“Aiming to Improve, the principles of performance measurement”, Audit Commission, 2000.

“On Target, the practice of performance indicators”, Audit Commission, 1999.



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6. LOCAL PARTNERSHIP AGREEMENTS

Implementing the Circular CCD7/2001

As part of the new partnership arrangements, local community care partners are now required to draw up Local Partnership Agreements. The full Partnership Agreements should be submitted to the Joint Future Unit, Scottish Executive, by 1 April 2003. These are not meant to be new policy statements, rather they are action plans. They should provide a clear joint vision of the future direction and funding of community care services in each local partnership in Scotland. They should therefore include:

1. The joint development priorities and targets for a three year period, covering either older people's services or the key community care client groups and their carers.
2. Developments in joint service management and joint resourcing proposed to support the stated development priorities and targets.
3. The performance management framework to be used to monitor progress, evaluate impact and guide corrective action, if necessary.
4. The governance and accountability framework for the partnership arrangements. This could include a joint committee or other joint management arrangements, with clear empowerment by and reporting lines to parent agencies.
5. The development plan to extend joint resourcing and joint management to all of community care services.

The Local Partnership Agreement

Local authorities (particularly social work and housing), health boards and NHS Trusts and Community Scotland (formerly Scottish Homes) should draw up written Local Partnership Agreements (LPAs). Agencies should produce one for older people's services by 1 April 2003, and subsequently for all community care services collectively or for each care group individually. They should be reviewed annually, but this can be done within the context of other documents such as the Community Plan or Community Care Plan.

The LPAs should be primarily documents that inform individuals, their carers and staff about the partnership arrangements. Detailed legal, financial and other essential but complex information can be included in appendices to the Local Partnership Agreement. These appendices should be signed by the representatives of each partner. The agreement itself should not be an overly legalistic document.

Template for the LPA

There will be many issues that partners will have to consider and reach agreement on in order to ensure clarity of understanding. Most of these issues are included in the Template for a full Local Partnership Agreement, at Appendix 1. The Local Partnership Agreement will be a summary of the detailed work that will need to be done locally. The Template can also be used as a checklist to assist partnerships.

The Local Partnership Agreement may differ in degree of specificity according to whether it reflects broad brush management arrangements, for example at an early stage, or detailed agreements about new partnership bodies to be set up.

Developing the Agreement

Completing the written Local Partnership Agreement can act as an impetus to setting in place joint resourcing and joint management arrangements. The agreement will usually draw on the existing policy and planning priorities set out in documents such as the Community Plan, the Health Improvement Plan (HIP), Community Care Plan and local housing strategies. The Local Partnership Agreement should not be held up unnecessarily in order to fit in with existing planning processes. The decisions set out in the Local Partnership Agreement will be included in future documents such as the next HIP or Community Plan.

Local Partnership Agreements should be drawn up by the partners locally. Each local authority area, or group of local authorities working together where it is more appropriate, should with their partner NHS Board or Boards develop a Local Partnership Agreement. Responsibility for its completion is shared by the local authorities and NHS agencies. The responsibility for the partnership arrangement and implementing it rests with the local partners.

People who use social care and health services

The Local Partnership Agreement should identify who will benefit from the new arrangements, e.g. the community care group such as older people and relevant information such as age ranges. It should also include details of the agencies such as the local authority, NHS board, acute trust, primary care trust and local health care co-operatives. If separate arrangements are being made for different care groups, it may be necessary to repeat the details as set out in the Template for each care group.

Review, variation and termination of agreements and resolution of disputes

Partnerships and Local Partnership Agreements should be reviewed at regular intervals, e.g. annually, both as part of the monitoring process and because there

may be changes required in services. This may be due to client and patient preferences, Best Value or inspection recommendations that need to be implemented, service developments or changes in strategies. Reports to the joint committee, partnership body, and/or individual partners should identify when a review based on these specific changes is necessary.

Partnerships may also be reviewed because of a dispute in the partnership itself. It is helpful to agree a protocol to deal with this which would include:

- How disputes about budgets, quality of services, human resources, etc will be handled, e.g. by referring the matter to the relevant chief executive officers, committee and NHS board, and subsequently to arbitration;
- Timescales for changing the arrangement or ending it, and an exit strategy;
- Withdrawal of one of the multiple partners;
- What will happen if the arrangement is terminated, e.g. continuity of service, position of staff, asset allocation, and responsibility for debts.

Varying, omitting or adding clauses to Local Partnership Agreements should realistically have the agreement of all partners. Agreement on the mechanism for terminating the agreement and the period of notice, e.g. 12 months, should also be identified.

Where a new partnership body has been set up then more detailed arrangements will need to be incorporated into Local Partnership Agreements. These and other further details, e.g. on the right to assign or transfer, proper law and arbitration, survival of terms and costs of agreement may be best set out in separate documents.

<p><i>Promising Practice:</i> City of Edinburgh and Lothian Health Lincolnshire LD Services</p>

Background Information

“Partnership Agreement”, Manchester Health Authority, South Manchester Primary Care Trust and Manchester City Council, 2000.

www.scotland.gov.uk/health/jointfutureunit/manchesterha.pdf



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7. HUMAN RESOURCES

Implementing the Circular CCD7/2001

The Circular already issued by the Executive requires local partners to undertake three steps in relation to human resources. Firstly, either as part of the Local Partnership Agreement or as a stand alone document, the partner agencies should develop a Human Resources statement of intent for staff which signifies their wish to support staff as fully as possible and to ensure that, wherever possible, staff are not disadvantaged by the changes. Secondly, local partners should also produce a joint development and training plan. Finally, local partners should set up a local Joint Staff Forum.

Working together

The impact of the partnership arrangements on staff will depend on the nature of the partnership arrangements set in place. However, it is important to stress that, in Scotland, most of the partnership arrangements ensure that existing staff would be employed, in the first place, by their current employer and would only be seconded or attached after discussion. This secondment or attachment could either be as an individual or as a group arrangement. New staff employed would normally be employed by either the local authority or the health service.

The different cultures that staff are accustomed to and the methods of working, training, supervision, policies and procedures will all require thought to ensure that the staff involved feel that they can “fit” into the new partnership arrangements. The expertise of all the staff will need to be valued if the joint arrangements are to work effectively and for staff to gain trust in each other.

Consultation with staff

The importance of consultation with all the relevant stakeholders in developing a partnership arrangement must be highlighted. It is vital to consult and work with staff from the earliest possible time to consider and develop the arrangements.

Many staff will be able to contribute a valued input to the development of partnership arrangements, and may well come up with proposals themselves about better co-ordination of services. Front line staff are often in a good position to see what the barriers are and how they can be overcome. They, like all stakeholders, will be able to make suggestions about the better delivery of services.

Training and development

Shared learning across health services and local authorities will need to underpin the partnership arrangements. Given the wide range of functions that are likely to be involved, in time this may involve many staff, some of whom will not have a history of working so closely together.

The shared learning they take part in will be crucial to the success of schemes, both to developing an understanding of the different roles that people perform and to develop a common language on which to base these activities. In some areas, especially health and social care, joint training is well established. However, the joint development and training plan issued by the partner agencies will be crucial for all partnership arrangements.

Education and training at national and local levels will have a significant part to play in developing competencies, training and promoting lifelong learning activities which take account of the opportunities offered in the partnership arrangements. The Integrated Human Resources Working Group, chaired by Peter Bates, has taken this forward. It reported to the Minister in May 2002 and the Joint Future Implementation and Advisory Group, jointly chaired by Trevor Jones, Chief Executive, NHS Scotland and Rory Mair, Chief Executive, CoSLA, is taking forward the implementation of the IHRWG Report.

Background Information

- NHS Education for Scotland, (NES)
- Scottish Social Services Council, (SCCC)
- Integrated Human Resources Working Group Report

Click here for more information:

www.cetsw.org.uk

www.topss-scotland.org.uk

www.scotland.gov.uk/government/rcp

Integrated Human Resources Working Group (IHRWG)

Ian Aitken

Forth Valley Primary Care NHS Trust

David Archibald

Dumfries and Galloway Council

Peter Bates

Tayside Health Board

Dan Brown

CoSLA

George Buchannan

Renfrewshire and Inverclyde Primary Care

Martin Burnell

Fife Council

Jim Devine

Unison

Joe Di Paula

Unison

David Esplin

BMA Scotland

David Evans

Pay and Workforce Research

Stephen Gallagher

Scottish Executive, Joint Future Unit

Jacqui Jones

Stirling Council

Helen Kelly

Forth Valley Primary Care NHS Trust

Lynne Khindria

Lanarkshire Acute Hospitals NHS Trust

Patricia Leiser

Ayrshire and Arran Acute Hospital NHS Trust

Keith Makin

Dumfries and Galloway Council

Arthur McCourt

Highland Council

Alex McLuckie

GMB

Margery Naylor

Scottish Executive, Joint Future Unit

Ian Reid

Greater Glasgow Primary Care NHS Trust

Anne Ritchie

West Dumbartonshire Council

Anne Thomson

Royal College of Nursing

Carole Wilkinson

Scottish Social Services Council

Angus Skinner

Scottish Executive, Social Work Services
Inspectorate



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8. COMMUNICATION AND INVOLVEMENT

Implementing the Circular CCD7/2001

As part of the process of developing and putting in place new arrangements, it is essential that people who use services and patients, carers and staff are kept informed, consulted with, and involved. Other stakeholders such as service providers in the voluntary and independent sectors, together with the wider public, may be affected by the new arrangements. Thorough consultation, although it involves some initial effort, will be worthwhile in building understanding of the new joint way of delivering services.

Partners will already have mechanisms in place for involving stakeholders in community planning and community care planning. We envisage that the stakeholders for joint resourcing and joint management will include:

- People who use services, patients, carers, voluntary and support/advocacy groups, e.g. local health councils and community care forums;
- Staff and their professional bodies and trade unions;
- Providers, including NHS trusts, voluntary and private providers and registered social landlords;
- Other agencies such as community councils and community organisations;
- The general public.

Partner agencies should agree how they will consult (see Checklist 1, Consultation with Stakeholders). One agency may take the lead in arranging the consultation process on behalf of all the partners. Councillors, through their community leadership role, will play a significant part.

Similarly, locally based NHS and local authority staff should be encouraged to play their parts in developing local partnership arrangements. This ensures that they understand and support the way services are being developed, and that they will be suitable and appropriate to meet local needs. The involvement of staff will greatly assist in speeding up decision making, action and improvement to services (see Section 7, Human Resources).

The local partners should also consider agreeing a joint process for keeping their stakeholders informed about the new arrangements (see Checklist 2 Communications with Stakeholders).

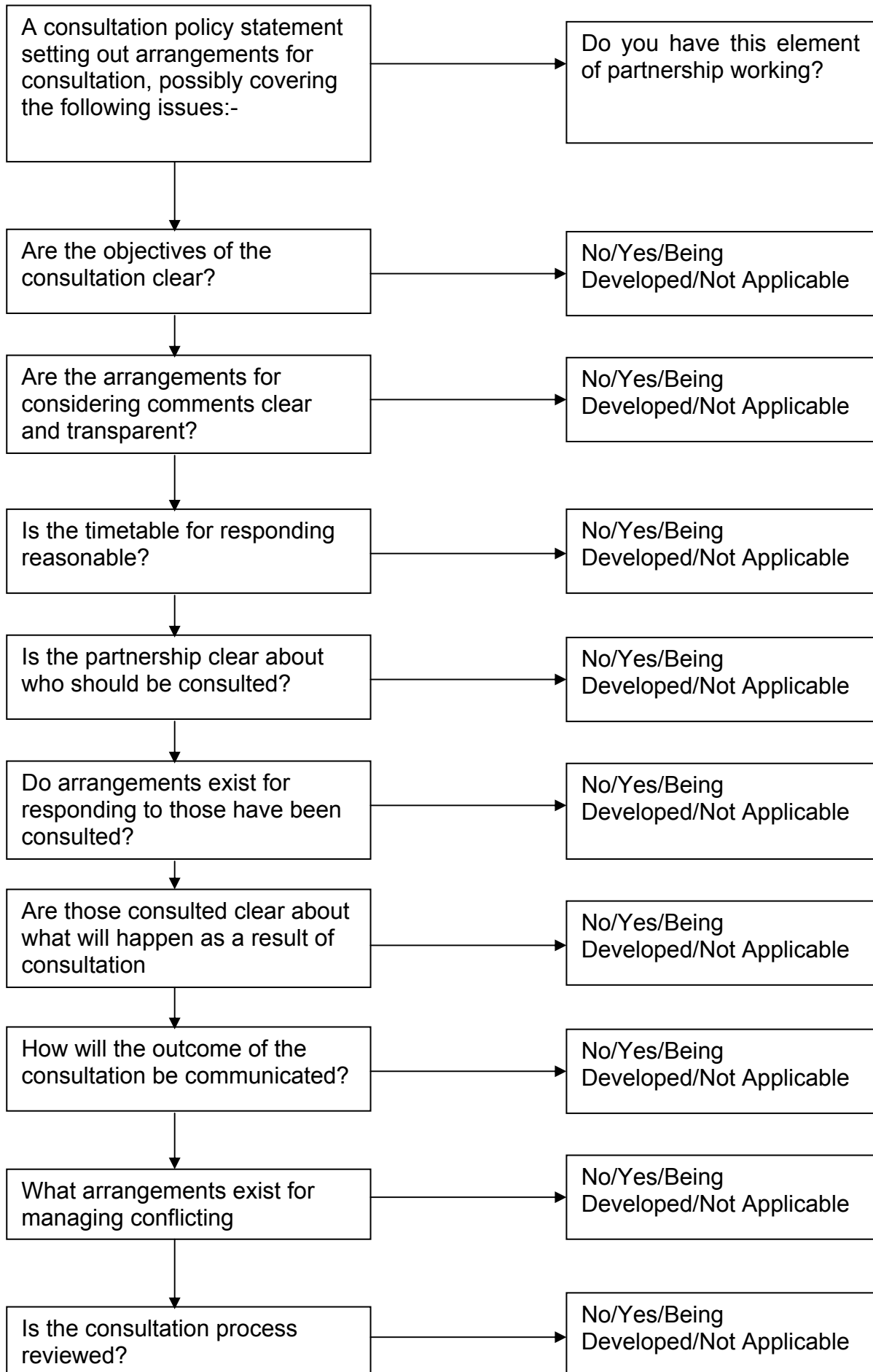
They will also want to reach a consensus about people who use services and patient involvement, in particular the involvement of under-represented or disadvantaged groups and ethnic minority groups.

<p><i>Promising Practice:</i> Fife Council Moray Council</p>
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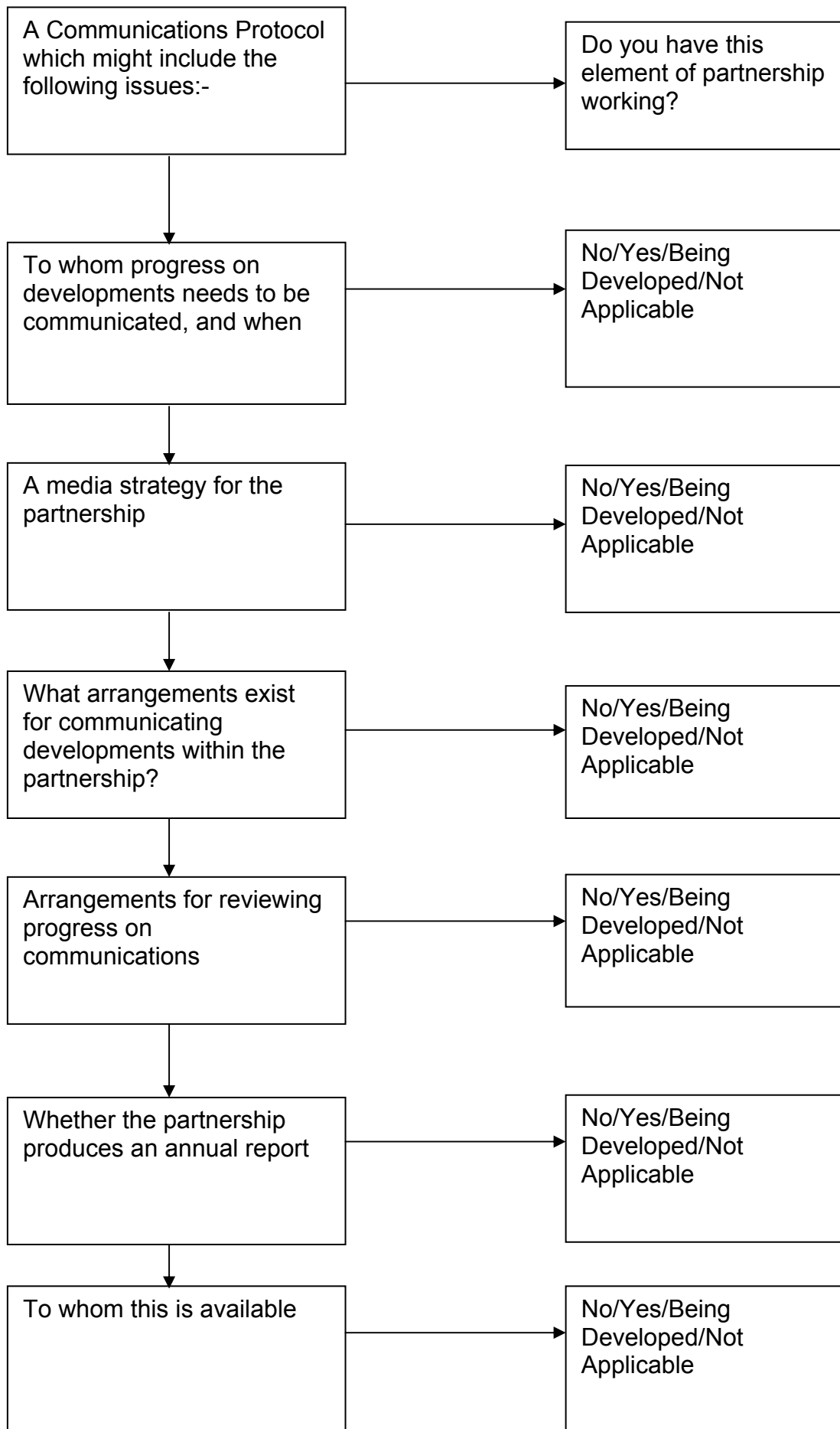
Background Information

1. "Patient Focus and Public Involvement in the new NHS". www.doh.gov.uk/involve.htm
2. "Listen Up – Effective Community Consultation", Audit Commission, 1999. www.audit-commission.gov.uk/publications/breffect.shtml
3. "Designed to Involve: public involvement in the new primary care structures", Scottish Consumer Council, 1999 www.scotconsumer.org.uk/rep99/rep99.pdf

CHECKLIST 1 – CONSULTATION WITH STAKEHOLDERS



CHECKLIST 2 – COMMUNICATIONS WITH STAKEHOLDERS





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9. PARTNERSHIP WORKING

Implementing the Circular CCD7/2001

There are a number of factors which make partnership working more or less easily achievable. Partnership working is a potentially powerful tool for tackling difficult policy and operational problems. It can also help to secure more efficient and effective use of scarce resources. It should be valued because it leads to a greater control of scarce resources rather than being seen as a loss of control over resources.

Nevertheless, partnership working can be difficult to do well. The Community Care and Health (Scotland) Act gives local authorities and health agencies new powers. It permits:

- payments between NHSScotland and local authorities and vice versa;
- delegation of functions;
- pooled budgets.

It also gives Ministers the power to enforce joint working arrangements where services or systems are judged to be failing.

http://www.scottish.parliament.uk/parl_bus/legis.html#34.

The Nuffield Centre for Community Care Studies undertook a review of current joint working between March and September 2000 on behalf of the Joint Future Group. It focussed on the challenges and solutions, developed by partners actively driving this work forward, and on case studies of innovative practice.

www.gla.ac.uk/centres/nuffield/iwp/index.html.

Some of the obstacles to joint working can stem from broad-brush factors, e.g. change fatigue or a silo mentality. Positive leadership at all levels in managing these and the following issues in relation to joint resourcing and joint management is essential.

<p><i>Promising Practice:</i> West Dunbartonshire Multi-Agency Partnership Strategic Agreement</p>
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Local partners will have different experiences of joint working and these will affect the speed at which they can move towards joint resourcing and joint management.

Other factors which will affect joint working are the local geography, personalities, and history of service provision. All these factors make it impossible to prescribe a “one size fits all” for arrangements in Scotland.

The Accounts Commission (see below) has a number of useful publications on promoting joint working. The Nuffield Institute’s useful study on joint working includes case studies identifying the drivers and barriers to integrated working between health and social care.

Some specific factors have been identified as real obstacles to joint working:

- Mis-match of boundaries;
- Commitment of budgets over long periods of time.

Mis-match of boundaries

Lack of shared boundaries makes developing partnership arrangements more complex, particularly if there is a large number of partners. It is helpful to identify what specific difficulties there are and what arrangements can be agreed to overcome these. For example a local authority, health board or trust can take on responsibility for commissioning and/or providing services for other partners.

Some areas are working towards achieving greater co-terminosity for example by considering changes to Local Health Care Co-operative boundaries within Primary Care Trusts or internal social work and housing boundaries since these are not fixed by legislation. This is highly desirable as co-terminosity, for example, between Local Health Care Co-operatives and internal social work areas, provides a very positive start for joint resourcing and management, especially locality management and devolved funding of services.

<p><i>Promising Practice:</i> East Ayrshire SW areas and Local Health Care Co-operatives</p>
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Commitment of budgets over long periods of time

Some local authorities have expressed a reluctance or inability to commit budgets over a 3 year period. However, all agreements can be renegotiated, if there are reasons for needing to do so.

Some partners have expressed their belief that they cannot commit budgets over a number of years, for a number of reasons, because this would limit their flexibility or because their partners may not be able to maintain the same level of financial commitment over a number of years.

While this may clearly be an issue for some partners, it is possible, if the senior management and political will is there, to commit budgets on the basis that if agencies are experiencing financial difficulties, all parties can renegotiate their financial commitment. A statement covering this issue should be included with Local Partnership Agreement. We have come across one agreement, involving a pooled budget, in England where the partners have signed – off a 10 year agreement which it is reckoned will assist long term decision making about resources rather than hinder it.

<i>Promising Practice: Lincolnshire Learning Disability Services Pooled Budgets</i>

Background Information

“Integrated working, case studies identifying the drivers and barriers to integrated working between health and social care”, studies by the Joint Future Group, Scottish Executive, Nuffield Centre for Community Care, 2001
www.gla.ac.uk/centres/nuffield/iwp/index/html.

“A Fruitful Partnership, effective partnership working”, Audit Commission, 1998.

“Promising Beginnings, a compendium of initiatives to improve joint working”, Audit Commission, 1998.



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10. INFORMATION SHARING

Current National Position

The development of detailed guidance about sharing information between local social work and NHSScotland is currently being undertaken by two main initiatives, both supported by the Scottish Executive:

- Work on the ethical framework is currently co-ordinated by the Information-sharing sub-group of the Confidentiality and Security Advisory Group for Scotland (CSAGS);
- Work on the technical framework is currently being progressed within the 'eCare' Programme.

The Data Protection Act (1998) does not prevent the sharing of information between agencies. Rather it sets out the conditions under which information can be shared. That is that information sharing requires the explicit and informed consent of the service user or patient. We believe that this is good practice and a driver for person centred services. But we also accept that agencies may need some support to deliver on this requirement.

The CSAGS - sponsored work programme therefore includes:

- The development of a "generic" information sharing protocol which can be used alongside specific information sharing scenarios to develop local protocols and procedures to meet the requirements of the Data Protection Act.
- Consideration of the concept of "Information Governance" and how this or another suitable framework might apply to joint working.

The sub-group hopes to make recommendations to the CSAGS group early in 2002 but already some agencies are developing their own protocols in anticipation of national requirements.

Promising Practice: Leeds Inter-agency Draft protocol
Perth & Kinross General protocol

Meantime, practical experimentation and learning is being undertaken by a number of local 'eCare' projects, sponsored by the Modernising Government Fund.

The eCare Programme is sponsoring work on a common framework for network connections between partner agencies; and support for key inter-agency information flows such as referrals, the sharing of a needs assessments, and hospital discharge notifications.

The Programme also aims to produce a shared ICT (Information and Communications Technologies) Strategy for Community Care in Scotland. Again, practical experimentation and learning is being undertaken by the local eCare projects to inform the development of this strategy.

These developments are intended to provide a supportive framework for local partnerships. They will help develop a clear and shared understanding of how information will be protected and used and of how ICT can be best deployed in support of joint working. Work on these will run in parallel with the development of local partnership arrangements. It is anticipated that the scope of the local arrangements on these topics will develop over time.

Local developments

Local Partnership Agreements should include a statement of partners' intentions regarding the implementation of a local information-sharing framework, together with the development of relevant accountability and management arrangements. It is helpful if resources are flagged-up at an early stage.

Promising Practice: North and South Lanarkshire and Lanarkshire Primary Care Trust eCare project

Background Information

CSAGS www.show.scot.nhs.uk/csags

ECare Programme www.show.scot.nhs.uk/ecare

Information Sharing - Guidance on the Health Act Section 31, Partnership Arrangements, Appendix C, Department of Health, 2000.



APPENDIX 1

Template for a full Local Partnership Agreement

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This template sets out, in comprehensive detail, all the issues which partners will want to consider as part of their local arrangements. They should be included in the full Local Partnership Agreement and sent to the Joint Future Unit by 1 April 2003.

1. Names of the local partner agencies, and of the representatives of each partner agency, together with space for the individuals to sign.
2. Name of the partnership arrangement/body (if appropriate)
3. Date of Agreement
4. Dates when the partnership arrangement is intended to start and be reviewed
5. Statement on shared vision, shared principles, and shared values

Identify whether this partnership arrangement is for older people or all community care services.

6. Joint Management

Describe the joint management arrangements, such as the joint high level board or committee, senior management group, partnership body, joint and single managers. [The details for this section are fully set out in the Joint Performance Information and Assessment Framework (JPIAF), under the JPIAF Performance Indicators 1-3. See Circular CCD1/2003].

7. Joint Resourcing

Include information on the services and functions to be jointly resourced under the partnership arrangements. Provide a copy of the Joint Resourcing Financial Framework (JRFF) agreed between the partners covering significant matters outlined in the CIPFA guidance on aligned budgeting and the joint resourcing self-assessment framework. [The JRFF will be used as the basis for the JPIAF Performance Indicator 4. See Circular CCD1/2003].

8. Joint Development Priorities and Targets

- Identify what are the intended **outcomes** for the partnership over the next 3-5 year period, either for older people, or all community care services;
- Include or summarise the Implementation Plan and timescales;
- Identify how the partnership will lead to measurable improvements in services.

9. Joint Governance and Accountability

Include outline agreement on:

- Political accountability, e.g. the role of Scrutiny Committees;
- Corporate governance;
- Clinical/service governance;
- How complaints will be handled;
- Statutory/legal accountability;
- Professional accountability.

10. Joint Performance Management Framework

Include or summarise:

- Local performance measures which the partnership will use;
- People who use services/patient and carer feedback;
- Monitoring and evaluation of progress;
- How corrective action can be taken.

11. Local Partnership Working

Include:

- Any boundary issues;
- Other

12. Human Resources

Include intentions or agreements on:

- Statement of Intent;
- Joint Development and Training Plan;
- Joint Staff Forum;
- Arrangements, e.g. for attachments, joint posts, etc;
- Involvement of staff, e.g. consultation.

13. Communications and Involvement

Identify:

- Who has been consulted and how this has been done;
- What communication and with whom it has been, or will be undertaken;
- Whether a joint consultation and communication policy/protocol has been agreed.

14. Information Sharing

Include:

- Agreement on information about individuals that can be shared including how the requirement for explicit and informed consent will be met;
- Mechanisms for building confidence around information sharing i.e. protocol development, joint training etc, and with which agencies;
- Capital investment on ICT to develop new ways to do this.

15. Extension of joint resourcing and joint management

- Details of proposed extension of joint resourcing and joint management to all community care services and timescales

16. Single Shared Assessment

As a consequence of the JPIAF now having been agreed, local partnerships should return the JPIAF information about SSA as annexes to the fLPA. This information should cover the requirements of the JPIAF Performance Indicators 5, 7, 8, 9. (See Circular CCD1/2003 for fuller details).

17. Appendices

Further details may be included as specific arrangements are worked out, e.g.

1. Glossary;
2. Governance arrangements;
3. Management arrangements;
4. Financial arrangements;
5. Performance management arrangements;
6. Human resource arrangements;
7. Schedule of legal or statutory functions and services of partner agencies included in the partnership;
8. Legal details of the partnership agreement including review, variation and termination of the agreement, and resolution of disputes.