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POLICY BRIEFINGS

*West Sussex Voluntary Organisations' Liaison Group
Ground Floor, Parbrook House, Natts Lane,
Billingshurst, West Sussex RH14 9EY*

☎ 01403 787940 📠 01403 787941

Health Act 1999

Partnership Arrangements and Transferred Funding *Summary of Government Regulations and Guidance on new funding arrangements for health and community care*

INTRODUCTION

The 1999 Health Act gave powers to health and local authorities, primary care trusts (PCTs), and NHS Trusts to make partnership arrangements to:

pool funds,
have a lead organisation commission services, and/or
provide integrated services.

The Act also allows health authorities and PCTs to transfer money to local authorities (or the voluntary sector) for any health-related local authority function. Local authorities can transfer funds to health authorities and PCTs, to improve the health of people in their area. **These powers apply from April 2000.**

Government regulations and guidance on how these arrangements will operate were produced in March 2000.

The following pages provide further information on:

Partnership Arrangements (Section 31)

Transferred Funding (Sections 29 & 30)

PARTNERSHIP ARRANGEMENTS (HEALTH ACT 1999 Sec. 31)

The purpose of these arrangements are to give NHS bodies and local authorities the flexibility to provide more co-ordinated and innovative services, across a wide range of NHS and local authority functions. They can be used to join up existing services or develop new ones.

A partnership arrangement can cover:

- **All health-related local authority functions**, including social services for children and adults; housing allocation, home repairs, housing advice, financial assistance to voluntary organisations concerned with homelessness and housing people in priority housing need or threatened with homelessness; education; passenger transport, travel concessions and road safety; sport and leisure; youth services; libraries; waste collection and disposal. They can involve borough, county, unitary or district councils.
- **Most health services for children and adults**, including hospital and community health services, rehabilitation, prevention, and services aimed at avoiding hospital admission; mental health aftercare; contraception. Specifically excluded are surgery, radiotherapy, termination of pregnancies, endoscopy, laser and other invasive treatments and emergency ambulance services.

Initiatives under these arrangements must fulfil Health Improvement Programme (HImp) objectives, and be included in other plans as appropriate, such as Joint Investment Plans, Community Plans and Childrens Services Plans. They must be reported in local authority Best Value plans and in NHS performance assessments. They can be used with other initiatives such as Health Action Zones, Sure Start, Education Action Zones and neighbourhood renewal schemes.

Written agreements must be completed for each partnership arrangement. NHS regional offices must be notified of proposals, and should provide advice and support, working with SSI Social Care Regions and Government Offices for the Regions.

Consultation

Regulations state that there must be consultation with those who will be affected before partnership arrangements can be put in place. The guidance states that this should include:

- ✓ users, carers, and support/voluntary organisations representing their interests,
- ✓ Community Health Councils,
- ✓ providers (including those in the voluntary sector),
- ✓ town and parish councils,
- ✓ community organisations and the public.

The guidance points out that even with relatively small partnership arrangements, the benefit of involving users will outweigh the practical effort required, and thorough consultation is an important part of developing the proposal.

The statutory organisations involved in the proposed partnership should agree how the consultation should be done, using existing mechanisms or a separate consultation exercise as appropriate. Consultation should take place as early in the process as possible. The size and scope of the consultation should be proportionate to the size and significance of the proposal.

Pooled Funds

Health Authorities, PCTs, and local authorities can make an agreement to pool funds, which can be used to provide or purchase health and local authority services for a particular client group. An NHS Trust that provides a service covered by the pooled fund can also be a partner to the arrangement, and commit funds.

Statutory agencies should work with users and carers, PCGs, and other organisations such as schools and Housing Associations to develop proposals.

Partners should agree the aims, outcomes, and targets for the pooled fund, the money each contributes, and arrangements for managing and monitoring the work and the finances. One agency will host the fund, and there will be a pool manager responsible for managing the budget, and reporting on progress. The partnership grant can be used in a pooled budget.

Health and local authority staff identified in the agreement will be able to access the resources in the pool to provide services, after assessing individuals.

Delegated Functions: Lead Commissioning and Integrated Provision

Lead Commissioning is where one agency commissions a range of services for a client group, as a way of ensuring co-ordinated provision. Local authorities, health authorities or PCTs can be partners in this. They should set out in a written agreement what functions will be delegated to the lead commissioner, and what money will be transferred to finance the services commissioned. Lead commissioners will be able to contract with other providers, including the voluntary sector.

Integrated provision enables different professionals to work within one management structure, and for staff to work across service boundaries. The integrated provider may provide the services itself, or by contracting with other agencies, including the voluntary sector. Local authorities, PCTs and NHS Trusts can be integrated providers.

Lead commissioning and integrated provision can be combined, and can be used with pooled budgets.

General

- There should be arrangements to manage the partnership, such as a joint committee or partnership board. Community representatives, providers, voluntary organisations, users and carers can be involved, for example through participation in the partnership board, or in a forum which advises and makes recommendations to the board.
- There should be arrangements for dealing with complaints, which should be made clear to users and staff. Ideally, these should be dealt with by the partnership itself, with a manager responsible for the informal processes, and the joint committee/partnership board responsible at a formal level. The guidance suggests involving users, carers, CHCs and CABx in drawing up arrangements; setting up an independent mediation service; identifying access to independent advice; and having clear timescales.
- People receiving social care through a direct payment can be included in a partnership arrangement.
- Local authority functions undertaken within a partnership arrangement will still be subject to best value, even if the service is being provided by another organisation.

- Criteria for eligibility for the service should be harmonised, and in line with guidance due later this year on eligibility for social services and for continuing health care. Assessment procedures should also be streamlined, e.g. having common procedures; agreeing one staff member responsible for all assessments.
- As at present, NHS services should remain free of charge, while local authorities can charge for services. Partner agencies will need to agree what approach to take on charging. This is particularly important where the distinction between charged-for and non-charged for services is blurred, for example where a single assessment is made for health and social care services, or where there is an integrated provider. Charging arrangements must be made clear to users at the outset of the assessment process, and given in writing before a care plan is agreed with the user. However, as part of their best value review of services, local authorities should consider whether the cost of collecting the charges outweighs the income gained.
- Partnership agreements should include arrangements for reviewing, changing or terminating the partnership, and handling disputes.
- There should be arrangements for sharing information across agencies while maintaining client confidentiality. The guidance contains recommendations on what these should cover.

References:

Guidance on the Health Act Section 31 Partnership Arrangements on

www.doh.gov.uk/jointunit/index.htm

Implementation of Health Act 1999 Partnership Arrangements H5C2000/010 LAG(2000). 27.3.00.

Circular available from Dept of Health, P0 Box 777, London SE1 6XH Fax 01623 724524 or website above.

Statutory Instrument 2000/617 NHS Bodies and Local Authorities Partnership

Arrangements Regulations 2000 on www.legislation.hms.gov.uk

TRANSFERRED FUNDING (HEALTH ACT 1999 Sec. 29 and 30)

Health Authorities and PCTs can transfer funding to local authorities (or the voluntary sector) for any health-related local authority functions, for services that will improve the health of the local population more effectively than spending the money in the NHS. Local authorities can ask the voluntary sector to provide or commission these services on their behalf. This replaces the previous joint finance arrangements, in which health authorities could only transfer funding to local authorities for social services related activity.

Local authorities can transfer money to a PCT or health authority, to improve the health of people in their area, in relation to a similar range of NHS services as under the partnership arrangements.

Health and local authorities and PCTs, working with the voluntary sector, should ensure that transferred money addresses local health needs and supports the objectives set out in the HImP. A partnership board, health action zone or HImP steering group could be used to formally agree the transfers, which should also be discussed with primary care groups.

Transfers will be recorded by a written agreement in advance between the statutory sector parties, and an annual record of how the money has been spent.

References:

*Commencement of Sections 29 and 30 of the Health Act 1999 Circular HSC 2000/011 LAG
2000/10 3 1.3.00*

*Statutory Instrument 2000 No 618 The NHS (Payments by local authorities to NHS bodies)
(prescribed functions) Regulations 2000*

Directions covering conditions of transferred payment

All available from www.doh.gov.uk/jointunit/28a28bb.htm

ISSUES

There is considerable scope for partnership working between the voluntary sector, health and local authorities and primary care trusts to develop innovative and holistic initiatives that work across traditional service boundaries.

However, it is essential that:

- Voluntary organisations, users and carers have a strong voice in decisions on the use of the partnership arrangements and transferred funding, and have opportunities to enter into joint initiatives with the statutory sector. The voluntary sector should agree mechanisms with health and local authorities that will ensure this. It needs to be clear how decisions will be made and how the money has been spent. Voluntary organisations, including user & carer-led groups, should have the opportunity to contract for services under partnership arrangements. The arrangements for overseeing and reviewing individual partnership initiatives need to genuinely involve voluntary organisations and users. It is important that good practice in joint working is extended to mainstream services, and not just confined to partnership initiatives.
- Voluntary organisations, including user and carer-led and smaller groups, have access to transferred funding on the basis of what they can contribute to improving health and fulfilling local priorities. This requires explicit and well-publicised criteria that value the contribution of the voluntary sector, with clear mechanisms for applying. Ring-fenced funding for innovative projects should be negotiated, but must not be a substitute for access to transferred funding as a whole.
- Voluntary organisations and users are able to influence primary care group and primary care trust decision-making, work collaboratively with them, and access resources, including contracts for services. As responsibility for purchasing and providing services will increasingly be devolved to PCGs and PCTs, it is essential that there are clear and well-publicised mechanisms for participation in planning and developing PCG and PCT-led or joint initiatives, and for applying for funding or obtaining contracts.

The arrangements do not address the general lack of clarity about the boundary between free health care and charged-for social care, or eligibility for services. Organisations that advise or represent the interests of service users may want to monitor the impact of partnership arrangements on charging and on eligibility, including whether users are properly informed about charges.