Policy into Practice
Partnership Working between Health and Social Care: the Health Act 1999

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Partnership working has been the watchword across health and social care in recent years. The 1997 Labour government came to power with a commitment to break down the 'Berlin Wall' between health and social services. Partnerships between existing organisations, rather than the upheaval of structural reconfigurations, were the preferred means of achieving this (Hudson and Henwood, 2002; Glendinning et al., 2002). Since 1997 there has been a stream of legislation and policy guidance, often backed by substantial amounts of targeted funding, to support this objective.

The specific proposals on partnership working which resulted in the Health Act 1999, first appeared in a discussion document, *Partnership in Action* (Department of Health, 1998) which identified three levels at which joint working was needed:

- *Strategic planning:* at this level, agencies need to plan jointly for the medium term, and share information about how they intend to use their resources towards the achievement of common goals.
- *Service commissioning:* when securing services for their local populations, agencies are expected to have a common understanding of the needs they are jointly meeting, and the kind of provision likely to be most effective.
- *Service provision:* regardless of how services are purchased or funded, users need coherent, integrated packages of care.

Partnership in Action focused solely upon the health-social services interface, but the responses to the consultation prompted a widening of the range of possible statutory partners. The subsequent Health Bill therefore included provision for a wider range of local authority functions to be involved, provided these had a health-related element.

The legislative basis for the new ways of working in partnership comes from section 31 of the Health Act 1999. The 'section 31 flexibilities' relax some of the statutory duties and obligations of NHS and local authority organisations that had been perceived to create barriers to closer collaborative working. They allow NHS and local authority organisations to:

- *Pool budgets for specific services*: money contributed to the pooled budget loses its original NHS or local authority 'identity' and can be used to commission comprehensive packages of services for users, irrespective of the balance between 'health' and 'social' needs.
- *Delegate overlapping or closely contingent commissioning responsibilities to a single lead agency,* which commissions an integrated range of services on behalf of all the partners.
- *Integrate health and social services into a single organisation* or transfer some elements of one partner's services to another partner, in order to deliver a wider range of related services from a single organisation.

One, two or all three of the flexibilities can be used, simultaneously or in succession. At the time the legislation was enacted, use of the flexibilities was optional, and early predictions assumed a high take-up rate. The flexibilities became operational in April 2000. Prospective partnerships are required to register their intended use of the flexibilities with their NHSE Regional Office (Strategic Health Authority since 2002), and registrations are forwarded to the Joint Health and Social Care Unit at the Department of Health and published on its website (www.doh.gov.uk/jointunit/). It was originally anticipated that up to 100 sites would be using the flexibilities from the earliest possible opportunity, but notifications were very slow at first. However, currently about 130 schemes have been notified, and basic details about them are accessible on the above website.

The Nuffield Institute for Health (University of Leeds) and the National Primary Care Research and Development Centre (University of Manchester) were commissioned by the Department of Health to undertake the national evaluation of early use of the new opportunities. The evaluation aimed to identify the aims, objectives, early outcomes and wider consequences of using the flexibilities. It consisted of:

- a baseline postal survey of all the 32 sites

which had notified the Joint Unit by late 2000 that they intended to use the flexibilities;
- an assessment, using the Partnership Assessment Tool (Hardy et al., 2000), of the strength of these local partnerships;
- semi-structured interviews with key stakeholders in a sub-sample of ten sites, selected for maximum variability;
- further semi-structured interviews with key stakeholders in a sub-sample of three of these sites, selected to illustrate the widest potential impact of the flexibilities;
- a follow-up postal survey of the original 32 sites, to assess progress in implementation.

Three interim reports (Hudson et al., 2001, 2002a, 2002b) were prepared, containing detailed findings from the various stages of the evaluation, followed by a summary report which brings together the key findings from the evaluation as a whole (Glendinning et al, 2002a). All of these reports can be downloaded in full from the website of either the Nuffield Institute for Health (www.leeds.ac.uk/nuffield) or the National Primary Care R&D Centre (www.npcrdc.man.ac.uk).

Most of the partnerships based their decision to use the flexibilities on a history of collaboration between health and social services ranging from two to 15 years. For many, therefore, the flexibilities offered the opportunity to further progress their established local collaborative strategies. A minority of partnerships had deliberately used the notification process to help 'kick start' problematic local relationships, for example following critical independent reviews. One or two partnerships had been confused about the notification process and admitted to being far from prepared to go 'live' at the time of notification. These different histories impacted on the subsequent pace of change: partnerships with less extensive collaborative histories had to work particularly hard to build up trust, especially in relation to financial matters.

Factors that helped the decision to use the flexibilities included:

- Broadly equal levels of commitment to the partnership among the contributing organisations, and perceived equity in the financial situations of the partner organisations.
- Coterminous boundaries between health and social services partner organisations.
- Senior managers with clear vision and strong commitment to the partnership.
- 'Dense' and stable local networks in which key individuals had built up shared personal histories and continued to interact in many different contexts.
- Senior and/or middle managers with necessary time and skills to devote to developing the partnership.
- Local Health Action Zones, which provided experience of collaborative working, facilitation and sometimes financial backing as well.
- The transition by local Primary Care Groups to Trust status, which could provide the catalyst for organisational restructuring around a section 31 partnership.

The most common objectives which partnerships hoped to achieve from using the flexibilities were:

- Greater efficiency in the deployment of resources and/or staff, including reducing duplication and expensive out-of-area placements and making better use of scarce resources;
- Being able to provide more flexible, seamless patterns of services;
- Improving the distribution of services across the locality to achieve greater equity;
- Enhancing the experiences of service users, for example by being able to provide a wider range of support options or services targeted at ethnic minority groups.

Inevitably, the real process of policy implementation is messier than that portrayed by official injunction, and the national evaluation attempted to unpick some of the issues that need to be addressed. Five issues will be examined:

- Drawing up legal frameworks;
- Deciding on financial arrangements
- Reconciling local and central imperatives
- Human resource issues
- Information and management strategies

Drawing Up Legal Frameworks

Underpinning the establishment of section 31 partnerships was a very considerable amount of work in setting up appropriate legal frameworks which could safeguard probity and were also consistent with the partner organisations own other statutory responsibilities. Partnerships that were based on established, good, informal relationships initially saw legal agreements as unnecessarily heavy-handed and formal; local authority legal and financial staff were sometimes unpopular for their insistence on tight accountability, probity and risk management frameworks. It was important to involve local authority legal officers right from the start of discussions about the use of section 31, and for senior service managers to try and promote a 'can do' approach to these negotiations. However with hindsight, respondents appreciated the importance of clear legal and financial frameworks, particularly when setting up pooled budgets and integrated provider organisations, which were described as *'really scary'* and *'hugely complex'*.

Deciding on Financial Arrangements

A willingness to commit resources is the most tangible sign of a commitment to partnership, but it can also be the most difficult to achieve. Pooled budgets was the most widely used of the section 31 flexibilities, but presented considerable challenges. Some sites reported difficulties in determining the size of partners' respective contributions. It was not enough simply to contribute historically determined budgets if one partner had been overspending or was suspected of trying to transfer a budget deficit to the partnership. Even though pooling resources with a more affluent organisation might appear a rational response, it could undermine emerging trust between partners.

Initially, partnerships were preoccupied by the different Value Added Tax (VAT) regimes in local authorities and the NHS, as the choice of lead agency for VAT purposes had significant financial consequences. However, these problems had largely been resolved by the final round of interviews, as a result of guidance from the Department of Health, and Customs and Excise (accessible from the Joint Unit website). But as partnerships bedded down, new sets of financial problems arose:

- Agreement had to be reached on the value of the infrastructure-related resources (payroll management, training resources, research and development activities, for example) which partner organisations contributed to a pooled budget. There was pressure to disaggregate those aspects of partner organisations' infrastructure that related to the partnership; but at the same time they had to continue providing this infrastructure support to the remainder of their services.
- Methods had to be developed for managing risk in relation to uncommon but high cost cases. This was particularly problematic in mental health service partnerships, where legal obligations could *require* the provision of very expensive services at very short notice.
- It was not easy to decide what proportions of any national increases in NHS and local authority budgets should be contributed to a pooled budget. Different mainstream budget increases created further problems when they were converted into across-the-board inflation pay awards, with one partner feeling it was subsidising the other, which had not been able to contribute the full inflation increase. It could also be difficult to persuade NHS partners that new 'growth' money should be pooled and spent on unspecified health and social care services, rather than on health services alone.
- Partnerships had experienced few difficulties in agreeing which elements of their services should attract charges for users. However, user charges had implications for the management of pooled budgets because of differences between the gross and net savings made if, say, fewer residential places were used. The decision by central government that intermediate care was an NHS service for which no charge should be levied had a similar knock-on effect on pooled budgets, because of the loss of anticipated income from user charges. Furthermore, over time the volume of services that attracted charges could expand or contract, thereby also impacting on the total resources within the pool.
- Although it may have been easier, initially, to use 'badged' or 'soft' money within a pooled

budget – short-term funding aimed at a particular problem or initiative – rather than risk committing mainstream budgets, these proved difficult to manage in the longer term. These resources could generate inaccurate expectations about the permanent level of contributions, which were subsequently disappointed when a time-limited grant ended. In addition, such resources usually had to be specifically accounted for, which meant disaggregating them from the pool.
- Finally, pooled budgets effectively ring-fenced resources and reduced the overall financial flexibility in partners' mainstream budgets. Ring-fenced resources could also constrain local plans to extend the flexibilities into other service areas if this threatened the financial stability of the partner organisations.

Reconciling Central and Local Imperatives

Implementing the section 31 flexibilities does not take place in isolation, and progress has been shaped by wider, national policies and pressures. In some localities, the strong national policy emphasis on partnership working proved to be a useful source of pressure, but in other respects national policy pressures could be experienced as unhelpful, particularly if they appeared to identify different objectives to those which local partners were aiming for, or if they seemed to underestimate the time and effort involved in implementation. One particular concern, given the work involved in setting up section 31 partnerships, was the expectation by central government that such arrangements should be used for relatively small amounts of 'badged' funding.

Some other issues also adversely impacted on implementation. The organisational turbulence in the NHS, as health authorities were abolished and PCGs merged and became Trusts, could be profoundly disruptive, particularly if key new appointments did not retain members of previously developed networks. Moreover, the immediate priorities of the new PCTs were unlikely to include the implementation of section 31 partnerships. Disruption could be minimised where key staff moved from the health authority to the local PCT, and where such changes also increased the coterminosity of agency boundaries. National performance management and audit systems also still operated as if health and social care services were discrete operations. Therefore section 31 partnerships were required to disagreggate their activities and return separate sets of data.

Human Resource Issues

Although all of the section 31 partnerships challenge previous ways of working, the integrated provider element presented the greatest challenges, particularly for front-line staff. In all of the partnerships, closer collaboration immediately highlighted areas of duplication in the activities of health and social care staff and led to planned changes in their roles. For a number of sites, the integration of front-line health and social care services was a key objective and one that also featured among their early successes. However these successes could be hard to win.

The human resource challenges can broadly be divided into 'soft' and 'hard' problems. Partnerships were generally tackling the 'soft' problems – cultural, training and attitudinal issues – first, before turning to the 'hard' questions of changes in employment terms and conditions. Strategies for changing attitudes and practice included:

- Consultation and workshop exercises to develop common aspirations, vision and sense of purpose;
- Developing common processes and protocols across partner organisations and localities;
- Integrating health and social care staff under a single management structure. However, this raised the question of ensuring appropriate professional accountability and supervision.

Some practical, 'hard' human resources problems were particularly protracted and difficult to resolve at local levels:

- Local government and the NHS have different pension schemes; during the first year after the flexibilities went 'live', central government negotiations were required to enable staff to transfer between employers without loss of pension entitlements.
- It was not clear whether local authority

insurance policies covered staff seconded to an integrated provider organisation.
- Local authorities are required by law to employ Approved Social Workers; amending legislation will be required to allow their employment legally to be transferred to an NHS integrated provider.

None of the in-depth study sites had completed all the processes involved in transferring the employment of staff to a new integrated provider organisation within the first two years of the flexibilities going 'live'.

Information Management and Technology Issues (IM&T)

Two types of information problems constrained the section 31 partnerships: technical barriers (hardware and software incompatibility) and confidentiality issues. Although most partnerships identified the management and sharing of information as a task that needed to be addressed, few had got beyond initial identification of the problems involved.

Technical problems included incompatibility between coding systems and standards; incompatibility *within* local government departments and NHS sectors (one partnership was trying to bring together different clinical information and patient administration systems from three acute NHS trusts); and incompatibility *between* NHS and local government IM&T systems. Although non-NHS organisations should, in principle, be able to access the NHS Net (subject to agreeing a Code of Connection to maintain the integrity of the network), this did not appear to be possible in some sites. In any case, it is not possible to access NHS Net while connected to another network, so a social care worker would need first to disconnect from the local authority network, a time-consuming process and potential deterrent.

Implementation of the national IM&T strategies for health and social care is the responsibility of local implementation teams. However, some partnerships felt that joining up these two strategies was not given sufficient priority locally, particularly in the context of high profile NHS IM&T objectives like electronic booking systems and health records. Continuing fragmentation was reinforced by the requirement to supply separate performance data for health and social services – a particular problem for social services staff that had been seconded to an NHS organisation.

In all sites, the integration of IM&T and clarification of responsibilities for IT management and operational support had lagged behind other aspects implementation and threatened to constitute major continuing barriers. Even where the technical problems were being addressed, there was little evidence of progress on matters of confidentiality and access to individual data, where traditional professional demarcations remained an enduring obstacle.

Conclusion

The section 31 flexibilities have undoubtedly made a significant difference to local partnerships; some of the changes are tangible, others less so. Significant tangible changes include the closer coordination of processes, protocols and structures associated with 'joined up' commissioning, pooled budgets and integrated provider organisations. This harmonization has led to some early improvements in efficiency and effectiveness. However, some of the intangible changes may be more significant – the removal of 'hiding places', and the transformation of thinking from a pre-occupation with narrow organizational silos to more of a 'whole systems' approach.

However, implementation has not been easy. Some of the barriers, such as the different financial planning systems and performance management systems for the NHS and local government, need to be addressed by central government. Others, such as those rooted in cautious local relationships, require greater effort from local policy and provider networks. Underpinning all successful implementation has been a high level of local commitment, trust and effective leadership. Organisational and professional cultures that confront fragmentation and promote a holistic approach are the foundations upon which policy tools such as section 31 can be built.

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