

Means to an end

Joint financing across health
and social care

National report summary

October 2009



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Summary

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

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

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

Joint financing arrangements are tailored to local circumstances

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

NHS and social care organisations increasingly need to work in partnership to improve value for money, services and user outcomes

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

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

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

Recommendations

Local NHS bodies and councils should:

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

The Department of Health (DH) should:

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

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

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

Recommendations

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

Source: Audit Commission

Table 2: Checklist to measure performance of joint funding arrangements

	Detail	Current targets/ sources (where relevant)
Overview measures	<ol style="list-style-type: none"> 1 The extent to which agreed outcomes are being fulfilled and targets met. 2 How far integrated care arrangements or the aims of joint financing are being achieved. 3 The extent to which the use of NHS Act 2006 section 75 flexibilities or integrated care arrangements have contributed to improved (or reduced) performance of the service. 	
Performance indicators	<p>Admissions</p> <ul style="list-style-type: none"> ■ Reduction in hospital admissions as a result of falls (that is, fractured neck of femur admissions for patients over 65 years; over 75 years; and over 85 years old). ■ Reduction in avoidable emergency admissions/bed days for patients over 65 years. ■ Reduction in delayed transfers of care, particularly for patients over 65 years. 	PAF D41, NI 131, DH DSO
	<p>Access and appropriateness of services</p> <ul style="list-style-type: none"> ■ Shared use of support services and facilities promoting one point of contact (where appropriate). ■ Reduction in duplication of client contacts. ■ Single processes agreed for joint teams – for example, assessment. ■ Reduction in people receiving services ‘out of area’. ■ Improved times from referral to agreement of care packages. ■ Improved times from agreement to delivery of care. 	

	Detail	Current targets/ sources (where relevant)
Performance indicators	Achieving independence	
	<ul style="list-style-type: none"> An increase in the number of vulnerable adults (mental health, physical disability, learning disability, those over 65 years) helped to live at home/supported to live independently/achieving or maintaining independent living. 	PAF C29-32, NI 136, NI 141, NI 142, PSA 17, 18, CLG DSO NI 125, PSA 18
	<ul style="list-style-type: none"> An increase in the number of patients over 65 years achieving independence through rehabilitation/intermediate care. 	PAF D54
	<ul style="list-style-type: none"> Increased percentage of items of equipment and adaptations delivered within seven days and an increase in the number of people benefiting from this provision. 	NI 150, NI 146, PSA 16
	<ul style="list-style-type: none"> An increase in the number of vulnerable adults (mental health and learning disability) in contact with services in employment. 	
	Skills	
	<ul style="list-style-type: none"> Staff skill mixes reviewed, to reduce duplication where it exists and secure better use of scarce professional skills and time. Improvements in staff recruitment, retention and morale. 	
	Satisfaction	
	<ul style="list-style-type: none"> Raised service user satisfaction in terms of access to services, compared with a baseline year. 	NHS Patient Survey Programme; CQC national surveys of local health services and community mental health services; SCIE annual social care user experience survey.

Source: Audit Commission

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We welcome your feedback. If you have any comments on this report, are intending to implement any of the recommendations, or are planning to follow up any of the case studies, please email: nationalstudies@audit-commission.gov.uk

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