PART 1 (OPEN TO THE PUBLIC	ITEM NO

REPORT OF THE LEAD MEMBER FOR COMMUNITY & SOCIAL SERVICES DIRECTORATE

TO THE CABINET ON 17 JULY 2001

TITLE: SECTION 31 REGISTRATION PARTNERSHIP ARRANGEMENTS FOR PEOPLE WITH LEARNING DIFFICULTIES LIVING IN SALFORD

RECOMMENDATIONS:

That the Cabinet agrees with the Section 31 application being forwarded to the Secretary of State for Health.

That Cabinet appoints one of its members as the Chair of the Integrated Learning Disability Board which will be established in Salford from October 2001.

EXECUTIVE SUMMARY:

Following high level meetings last year between the Leader of the Council and Chief Executive, Cabinet agreed that the Community & Social Services Directorate and the NHS in Salford should begin planning for an integrated service for people with learning disabilities in the City, with the City Council becoming the lead commissioner for these health and social care services.

Work has gone on during the succeeding months in preparing an application to the Secretary of State to put in place such arrangements and this application is now ready for submission and is attached.

BACKGROUND DOCUMENTS:
(Available for public inspection)

CONTACT OFFICER: Anne Williams 0161 793 2200

WARD(S) TO WHICH REPORT RELATE(S): All

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Section 31 Registration

Partnership Arrangements

For People With

Learning Difficulties Living

In Salford

Salford Community & Social Services
Salford & Trafford Health Authority
Salford Primary Care Trust

June 2001

CONTENTS

Partnership Arrangements to Support Integrated Commissioning For People With Learning Difficulties Living In Salford

Section 31 Registration

1. Introduction

This document is intended to accompany the Registration Form for Section 31 of the Health Act 1999, focusing on the commissioning of specialist services for people with learning difficulties. The partnership arrangements proposed have been developed through work undertaken over the last nine months between Salford & Trafford Health Authority, Salford Community & Social Services, Trafford Social Services and Salford and Trafford Primary Care Groups/ Trusts. The broad model of integrated commissioning proposed in July 2000 has been agreed at Leader, Chair and Chief Officer level. Further work has included facilitated 'time out' sessions with senior officers across the partner agencies and with relevant supporting officers across personnel, finance, contracting and information to take the proposed integrated commissioning arrangements forward.

At a local level, there are several important contextual issues to consider in putting forward plans for new partnership arrangements:

- There is an agreed joint strategy for the future development of services to support people with learning difficulties and their families and a Joint Investment Plan which details plans for developing services to meet the goals set out in the strategy
- There have been some very positive experiences of joint working in Salford and Trafford, such as the resettlement schemes, advocacy projects, supported living projects, as well as the Salford and Trafford Integrated Commissioning Project Board which adopts a joint partnership approach to holistic service development
- Despite the above examples of positive joint working, there is a recognition locally that there is a need to establish new commissioning infrastructures and processes, to ensure that the modernisation of specialist services and the linkage with generic services is achieved
- Work has been undertaken recently to map resources and services for people with learning difficulties, in terms of services people receive, service providers and costs of current service provision, which informed the development of the Joint Investment Plan. Several issues have emerged from this work, including the need to maximise monetary resources available to provide appropriate, flexible and responsive support, using opportunities presented through initiatives such as

Independent Living Fund, Direct Payments, Welfare to Work and Supporting People.

We believe that using the new flexibilities in the Health Act 1999, Section 31, will enable the development of better partnerships with people supported by services and their families, in developing more seamless services across specialist and generic agencies to promote social inclusion and independence for people with learning difficulties.

2. PRINCIPLES

The joint strategy and Joint Investment Plan incorporated into the document 'Bringing the Future Nearer' (April 2001) highlights key principles that inform how future services should be planned, commissioned and provided. These are:

- People who are supported by services should be treated as individuals, with their own hopes and their own support needs; any future commissioning arrangements should adopt and ensure a person-centred approach
- The support needs of people with learning difficulties and their families do not fall into particular categories, such as 'health' or 'social', but reflect diversity; to meet these support needs, commissioning needs to take a 'whole systems' approach, i.e. that commissioning spans a wide range of community, individual and personal support needs to enable people with learning difficulties to be part of their local community
- People with learning difficulties should be supported to be full members of their local communities – commissioning needs to make explicit the expectations around community involvement
- Specialist and generic services need to link together more fully, to make sure that people receive the support they need, when they need it
- 'People working together is like the strands in a rope that when put together make the rope strong and reliable for years' ('Looking Forward to the Future,' **April 2000**) – partnerships with those who are supported by services, partnership with local communities, partnerships between agencies, partnerships with people who provide services and partnerships between providers are all important, both in commissioning and provision of services
- Ethnic and religious diversity is recognised and valued in Salford, and service responses will be tailored to meet needs from all parts of the community
- It is imperative that staff participation is central to the commissioning and providing process, to ensure that people who are delivering services are informed and empowered to offer flexible responses to needs.

In developing integrated commissioning, it is important that the following principles underpin and inform new structures, decision making processes and inter-agency partnership working:

- There needs to be open, clear and honest communication within agencies, between agencies and with people supported by services and their families, in all levels of decision making; this will ensure that people making decisions and people affected by decisions made will have a full, informed understanding. This will entail partner agencies communicating what they can do well and also stating clearly where further development work is needed
- People supported by services and their families need to be active participants in the commissioning process – to achieve this, agencies must be willing to provide appropriate support for people and training where necessary
- There needs to be development undertaken to ensure there is a wide variety of service providers whose values, practices and cultures are consistent with 'Bringing the Future Nearer'
- There needs to be a recognition of inequalities and action plans to redress these in the commissioning process
- There is a need for complete financial transparency across agencies, to ensure an accurate financial baseline informs pooled budget arrangements and to ensure that all partners and key stakeholders are well informed of any changes to financial resources available to develop services.
- There needs to be clarity about commissioning of generic health services by the emerging Primary Care Trusts, about commissioning of specialist services from the joint commissioners and about commissioning of secure services from Sefton Health Authority.

3. Aims, Objectives and Targets

COMMISSIONING

A wide definition of commissioning is used in this context, to ensure the span of activities undertaken within commissioning is encompassed.
Commissioning in its wider sense is an activity or process of mapping or assessing needs, resources and current services; developing vision and setting direction, developing implementation plans; facilitating implementation and ensuring quality improvement (Derek Thomas, 1999).

Lead commissioning is where one agency (Health Authority, Local Authority, Primary Care Trust) transfers funds and delegates functions to another to take responsibility for commissioning both health and social care.

Pooled budgets are the means whereby health and social services bring resources together into a joint budget accessible to both commission and

provide services. This will enable more flexible and integrated support and care to be offered to people with learning difficulties and their families.

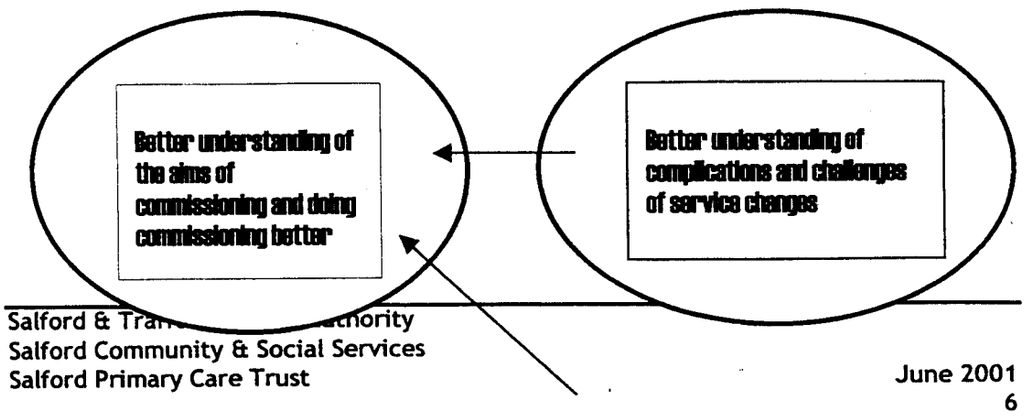
Under joint commissioning, it is also possible to have integrated provision. However, the model of commissioning emerging locally is one where there is an integration at commissioning level but a diversification at provider level, to ensure a broader range of generic services is available and to avoid further 'specialisation' of services provided.
It is clear in Salford that the proposed partnership arrangements will be positive and beneficial in:

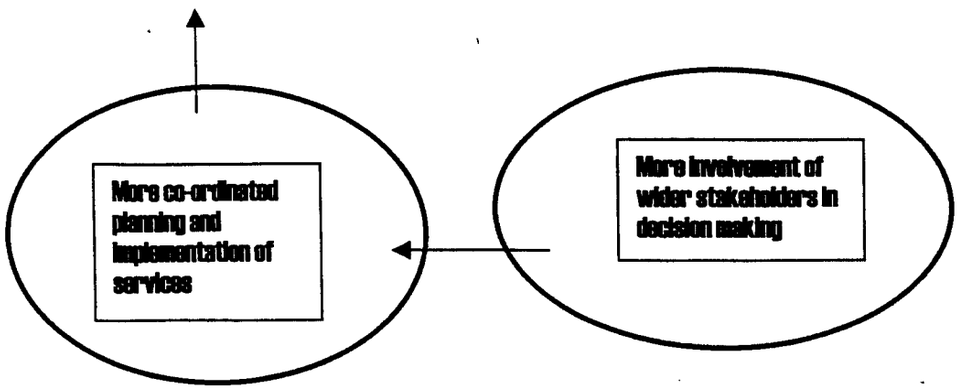
- Ensuring effective implementation of the agreed joint strategy, and the Joint Investment Plan, 'Bringing the Future Nearer', (April 2001)
- Leading major reconfiguration of NHS specialist services and Local Authority provider services
- Actively and positively developing and working in partnership with the independent sector, strengthening links between the statutory and independent sector
- Developing more co-ordinated and flexible services that can better respond to people's support needs, particularly in times of crisis or difficulty in their lives
- Ensuring 'Best Value' , in terms of efficiency and effective use of available resources.

BENEFITS OF INTEGRATED COMMISSIONING

It is important to identify what the expected benefits of future integrated commissioning would be:

- Better understanding of what commissioning is aiming to achieve and more skills in doing the commissioning - this would enable more people to develop a wider skill base, so that they could participate in commissioning
- Better awareness and understanding of the complications and challenges of service changes – this would also include developing the ability to put strategic planning and vision into action
- More co-ordinated planning and development of services – this would involve increased inter-sectoral and inter-agency service development, enabling more coherent linkages across specialist and generic services
- More involvement of wider stakeholders in decision making- this would include empowering people to make changes themselves, i.e. using their own resources to make things happen





If the benefits above are realised, people with learning difficulties and their families, for whom integrated commissioning is undertaken, would be enabled to exercise choice and to be active participants in future service planning. It would therefore achieve the aspirations of people with learning difficulties being treated as equals, with individual rights, choices and aspirations, supported appropriately by services.

AIMS, OUTCOMES, TARGETS

Aims

- To improve access to services by people with learning difficulties and their families
- To prevent overlap and duplication of services
- To make more effective and flexible use of current resources
- To provide a consistent approach to service provision, based on identified need
- To ensure equity in resource allocation and service provision
- To work within an agreed strategic framework for service development
- To build upon existing local joint work and partnerships across specialist and generic services and with people supported by services and their families

Outcomes

- Improved access to appropriate services
- Improved identification and treatment of ill-health, reducing health inequalities
- People more supported in their local communities by integrated and seamless services
- Planning for adult life begins at the age of 14
- An integrated joint community team undertaking assessment and commissioning appropriate support packages
- Seamless services, with appropriately skilled staff, receiving ongoing education, competency development and training

Targets

- The Project Board is to develop appropriate and realistic targets, in line with the joint strategy and the JIP, as well as the Local Area Plan as required by 'Valuing People' (DOH, March 2001), to include:
  - To establish an Integrated Commissioning Board by October 2001
  - To appoint an Head of Service by July 2001
  - To develop the systems and infrastructure for integrated commissioning in place and fully operational by March 2002

To have fully involved partner agencies, people supported and carers in the planning and development of the new partnership arrangements by October 2001

4. Levels of Integrated Commissioning

The model of commissioning that is being developed is one that operates at three levels – at a strategic level, at a service level, and at an individual level.

It is important that at a strategic level, a jointly agreed strategy and vision of future services underpins planning and commissioning. This strategy and vision needs to have involved key stakeholders at a service and individual level, ensuring that information and experience at these levels are incorporated into the highest level of strategic working.

At a strategic level, it is important that commissioning decisions are based on need (what support needs are identified through assessment), resources (what will be needed to provide appropriate support in terms of people, finance, equipment and environment) and outcomes (the expected benefits from a particular set of support arrangements). It is important that there are links made between needs, resources and outcomes to inform the commissioning process.

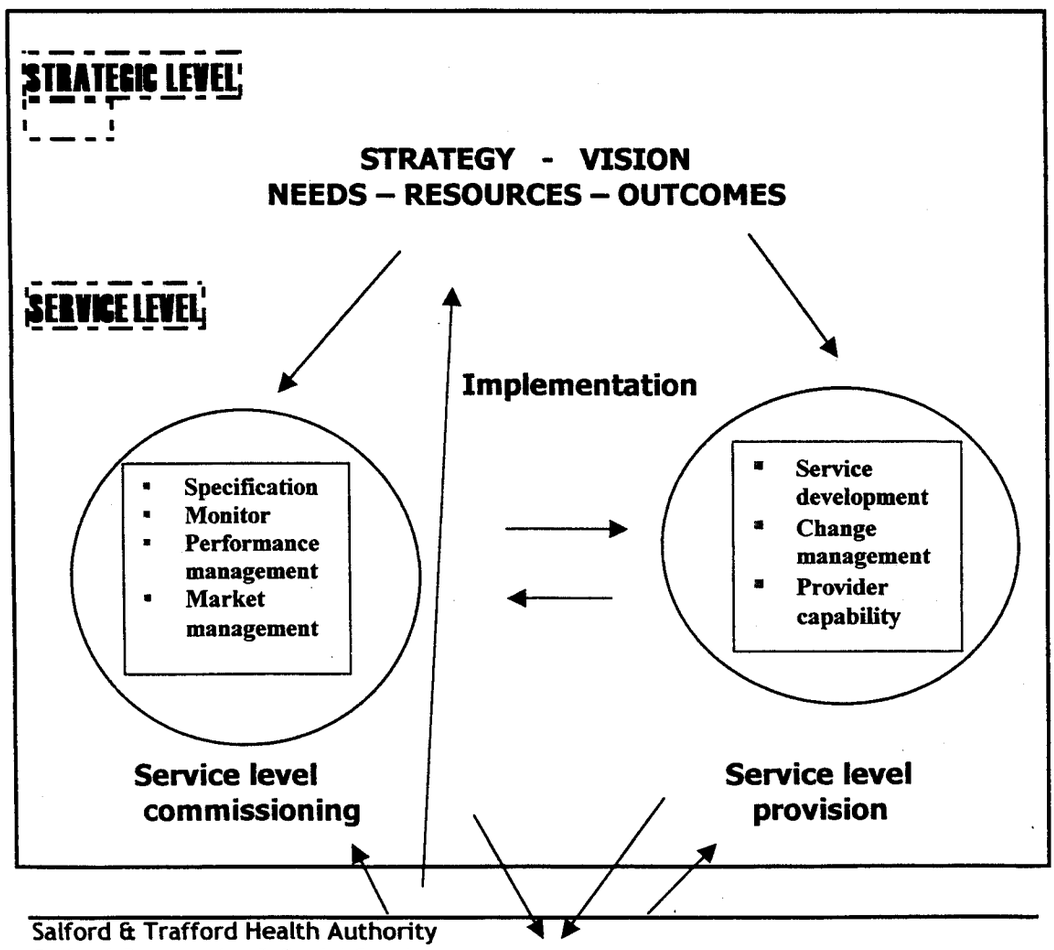
The decisions made at a strategic level will inform the configuration, organisation and delivery of services, but these decisions will fully involve service providers, commissioners at a service level, people supported by services and carers in partnership with commissioners. At a service level, vision and strategy are translated into action, both in terms of commissioning and providing. In terms of service level commissioning, it will be necessary to ensure that services are clearly specified with service providers and that they are regularly monitored. Providers of services will be performance managed by service level commissioners. In terms of provision, it is important that services are developed and continuously improved. Providers of services need to have the capacity and capability to deliver high quality services according to the commissioning specification, working in partnership with commissioners. Providers also need to have the capability to manage change

in accordance with the strategic direction set in partnership between commissioners and providers.

At an individual level, planning with individuals is undertaken, with links made between the rights of the individual, their needs, resources and outcomes. However, the model is not a top-down linear model. Activity is ongoing at all levels and there are interconnections between all levels. There is not a progression from strategy to service commissioning and providing to individual commissioning and providing. Information about support needs should inform service level activity and strategic activity, just as service level activity should inform strategic planning.

If this model is operating effectively, it would mean that more people, as key stakeholders, would be more involved in the commissioning process. Consequently, there would be a wider shared communication and understanding of priorities, ways of working, and outcomes expected. This would in turn lessen the need for people to lobby individually for services for support.

This is shown as a diagram below.



INDIVIDUAL LEVEL

PLANNING with PEOPLE
RIGHTS – NEEDS – RESOURCES – OUTCOMES

Whilst there is likely to be a lead commissioning role at each level, there is a need for mixed teams to work at all levels, including those who have provider or practitioner roles. Examples of this include community teams and voluntary sector organisations working with Independent Living Fund on supported living and transition projects working across agencies to plan more effective support for young people from an earlier age.

5. Improvements in Health

The contribution to health outcomes will be through:

- Ensuring health issues are addressed by all service providers through effective contracting and commissioning
- Ensuring close working relationships with Primary Care Trusts, enabling increased access to primary care and generic health services, as well as health promotion services
- Working within the Health Improvement Programme and the Health Action Zone
- Making links across regeneration and economic development programmes seeking to enhance people's opportunities for better health and reducing health inequalities
- Reducing pressure on specialist health service resources and promoting public health

6. Consultation

The process of developing the joint strategy 'Looking Forward to the Future' and the Joint Investment Plan has been underpinned by a firm and consistent commitment, not just to consultation with people with learning disabilities, their families and generic agencies, but to ongoing and meaningful involvement in the planning process. The initial ideas for integrated commissioning are contained in the joint strategy and the plans for integrated commissioning arrangements are contained in the Joint Investment Plan. The model and approach adopted for involvement of people supported and carers as key stakeholders and partners received a Health Action Zone award for innovative work.
Involvement has been as follows:

- Stakeholder days on both the strategy and the Joint Investment Plan, involving more than 200 people in Salford, across health and social care commissioners and providers, elected members, health bodies non-executives, people supported, carers, independent, voluntary and private sector providers, advocacy groups and the Community Health Council (at these, there was strong support across sectors for integrated commissioning arrangements to be developed to take services forward effectively)
- Public forums on the joint strategy, involving more than 50 people across services, people with learning difficulties, carers and members of local communities
- Representation across generic and specialist agencies, with people supported and carers, on the Strategy Project Team and the Joint Investment Plan, and on relevant subgroups of these bodies, overseeing the planning and production of final plans
- Presentation of the plans by people supported and carers to NHS bodies, the Cabinet, and the Community Health Council
- Planned public launch of the Joint Investment Plan, with invites sent to people supported, carers, service commissioners and providers
- Regular briefings of elected members, the Chief Executive, and the Leader of the Council, gaining support
- Meeting of Chair of the HA and the Leader to agree the broad model of integrated commissioning (August 2000)
- Regular information to all staff who may be affected by the new arrangements
- Consultation with and involvement of staff in developing the newly designed Joint Community Teams (ongoing)
- Involvement of key officers across finance, information, contracts, personnel, complaints and administration in developing the proposals and the systems which will support the partnership arrangements (ongoing)

7. Local Authority Leadership

Consideration has been given to Salford City Council undertaking the role of lead commissioning agency under the proposed partnership arrangements. The partners feel that lead Local Authority commissioning would be both beneficial and would contribute significantly to health and social care outcomes identified in section 3.
The key benefits would be:

- There is enthusiasm and commitment to transfer leadership in commissioning for learning difficulties to Salford City Council
- It would be clear who is directly responsible for commissioning
- There would be better opportunity for partnership working across statutory and non-statutory agencies

- There would be increased confidence in commissioning decisions as a result of the involvement of key stakeholders
- There would be increased confidence in the appropriate use of financial resources across agencies and financial transparency would be encouraged
- This model would make the crucial link needed with the Local Authority modernisation agenda and democratic accountability.
- This model will enable stronger links to be forged across education, leisure, housing, community regeneration and wider community and economic development.

8. Promotion of Existing Joint Working

There is a significant amount of positive and effective local joint working, at strategic level (across senior officers leading the process), at service level (e.g. development of joint care management initiatives to meet need more effectively) and at an individual level (e.g. through joint support packages). This has been built upon through the process of developing the joint strategy and the Joint Investment Plans, including the plans for integrated commissioning.

The proposed partnership arrangements will provide a formal infrastructure to consolidate and progress local joint working, some of which has developed in an informal way. The development of an Integrated Commissioning Board will provide robust joint management of commissioning and extend the involvement of partners in this management.

***need to put examples of good joint working and how integrated commissioning will better support this work

9. Who will be Supported by Services?

The remit and scope of integrated commissioning will initially be with young people and adults from the age of 18. The joint strategy identifies a goal of adulthood being seen to start earlier, at 16 years of age, thus lowering the age at which planning begins for young people with learning difficulties, which will require integrated commissioning work across children and adult services. Integrated commissioning will contribute to the achievement of this goal.

There are differential eligibility criteria across services at present and it is expected that integrated commissioning will align these. Recent work undertaken locally on an outline specification for specialist joint community teams for people with learning difficulties adopts a broad definition of

eligibility and this will be adopted in the integrated model of commissioning being developed. This definition is:

- Those with severe learning difficulties which happen during the development period (childhood) who have difficulty getting the skills needed for everyday living and who therefore need personal assistance in an ongoing way
- Those whose learning difficulties are less severe but who still have serious problems in their personal and interpersonal skills and who may need support from time to time in dealing with home life, employment, or relationships with others.

This broad definition is needed because of the complex and disadvantaged lives of some people with learning difficulties ('Better by Design', April 2000). Carers and families of those people identified above will be supported by services. The services will be provided for all those people above who are resident in Salford. Further work will be undertaken to identify issues with neighbouring authorities if necessary.

The model of integrated commissioning being developed will not commission secure services – this is undertaken by Sefton Health Authority on a regional basis. Generic health care will not be commissioned – this will be role of Primary Care Trusts. However, there will be strong links forged between commissioning of specialist, secure and generic services, to ensure a 'whole systems' approach to service development.

10. Resources to be Committed

The Health Authority and Local Authorities identified in mid-2000 the resources to be committed to the partnership in an agreed paper "Understanding the Financial Baseline." For the purposes of this registration, the resources identified in 2000 have been uplifted by 2.9% to reflect inflation. On that basis, the table below shows the estimated 2001-02 resources to be committed by the partners.

Estimated partnership resources 2001-02

Agency	£million
Health Authority	6.69
Salford City Council	9.68
Total	16.37

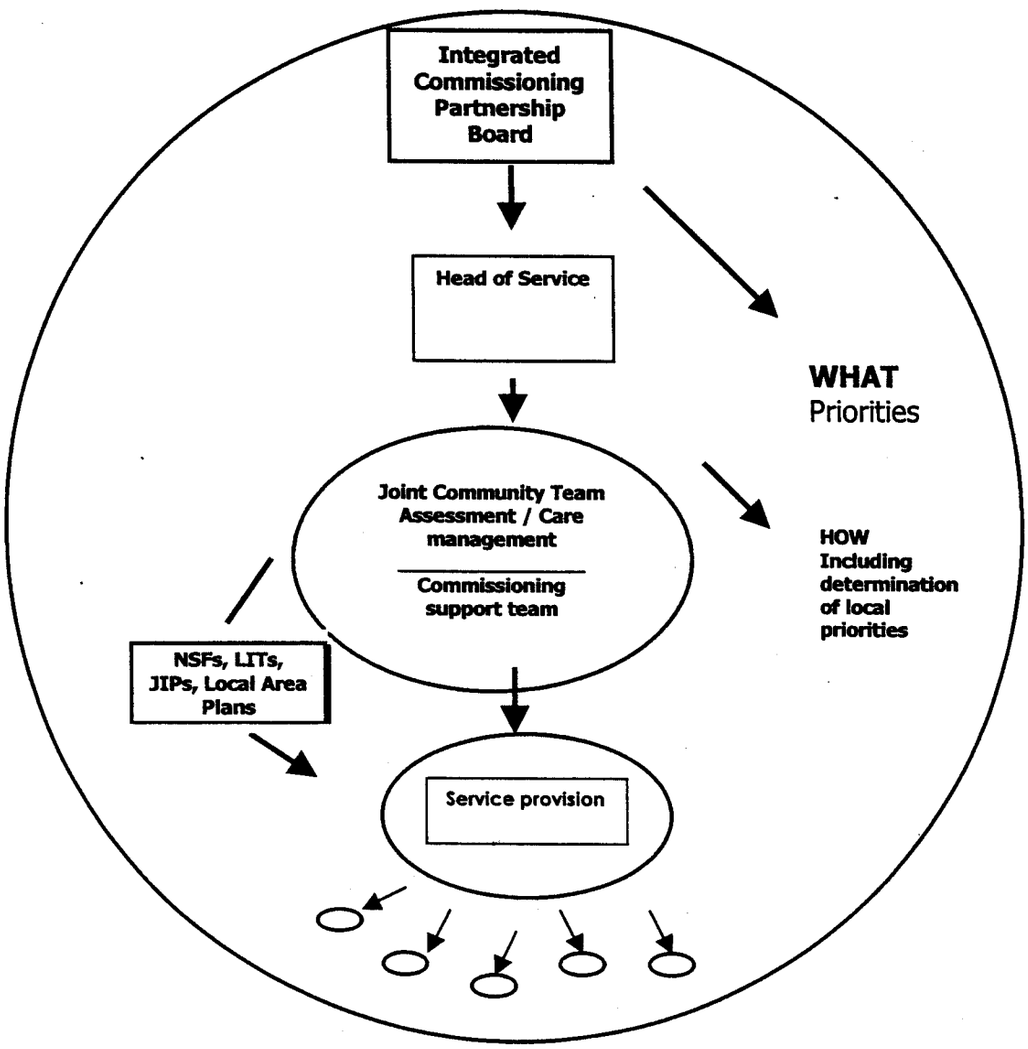
Further work is in hand to update the financial baseline:

- To reflect accurately partners' contributions and 2001-02 levels of budgeted investment;
- To disaggregate commissioning expenditure plans from investment in service provision.

11. Governance Arrangements

Proposed Integrated Commissioning Structures

The diagram below shows the planned structures for integrated commissioning.



Joint Community Team

The Joint Community Team will be constituted as identified in the outline specification 'Better By Design'. Early development of the team is currently being undertaken, with wide stakeholder involvement at a facilitated workshop to be held in June 2001 to further develop the role, function, remit and membership of the team. The Head of Service will take a lead on developing the team to become operational from April 2002.

Staff who may be affected by this development are being consulted on an ongoing basis, as outlined in Section 6.

Commissioning Support Team

Early work is being undertaken on shaping the Commissioning Support Team, whose role will be to support the work of the Head of Service and the Joint Community Team. The outline remit of the team would be to:

- Provide timely and accurate needs, activity data, financial and contracting information to inform the commissioning process and to support the monitoring and performance assessment process
- Provide support to any reconfiguration of services
- Provide technical support to the process of developing eligibility criteria / care assessment processes.

In Salford, there are already components of the commissioning support team in place. Work is being undertaken on establishing the team in a robust and structured partnership arrangement.

Composition of Integrated Commissioning Board

It is proposed that the Integrated Commissioning Board in Salford would be chaired by leading cabinet member, to ensure high level political commitment to learning difficulties.

Membership should reflect a range of agencies involved in the commissioning and provision of services for people with learning difficulties, to include

- Health (Primary Care Groups, Primary Care Trusts, NHS Trusts, HA)
- Social Services
- Education
- Housing
- People supported by services
- Carers
- Voluntary and independent sector

Representation from statutory agencies will comprise officers and non-executive / elected members.

Members of the Board would take a leadership role and shared responsibility for development of best services in the localities.

Work is currently in progress on the development of a formal constitution of the Integrated Commissioning Board, but an outline constitution can be found below.

Remit of Integrated Commissioning Board

It is proposed that the remit of the Integrated Commissioning Board would be to:

- Provide strategic leadership for the commissioning of health and social care for people with learning difficulties and their families
- Ensure the implementation and regular review of the joint strategy
- Ensure the development and implementation of the Joint Investment Plan
- Development and implementation of the Local Area Plan
- Work within the clinical governance agenda , to ensure professional leadership for disciplines working within the Joint Community Teams; ensure practice is evidence-based and that the service actively evaluates its practice
- Manage the work of the Head of Service and her/his team through the Director of Community & Social Services
- Help to manage the interface with those who commission other specialist services and interfaces with generic health, social care, housing, education, transport, employment, leisure and other services within the Local Authority and the independent sector
- Secure adequate resources to appropriately support people
- Work in line with 'Best Value' requirements
- Ensure continuous improvement and development in services, undertaking a quality assurance remit.

Leadership and Accountability

In the preferred option outlined, Salford City Council would take the lead commissioning role for Salford.

The Integrated Commissioning Board in Salford would have a leadership role and shared responsibility for service development in their respective areas. The leadership provided would ensure:

- A continuous commissioning focus
- Continuing and active involvement of both the Local Authority and the NHS
- Access to pooled budgets
- A focus on the support needs of people with learning difficulties rather than service priorities
- Accessibility of the Board to influence by wider stakeholder groups.

The model of leadership and accountability in this model is similar to the Manchester, Salford and Trafford Health Action Zone Partnership Board. The preferred option for the Chair of the Board is to have a Chair who is a leading Cabinet member. This would ensure learning difficulties is high on

the political agenda as well as the organisational and service agenda. This model would give clear lines of accountability to the Local Authority. The Head of Service would be accountable to the Chair of the Integrated Commissioning Board.
Proposed reporting arrangements would be as follows:

- The Board would report to the Local Authority Cabinet on a quarterly basis
- The Board would report to the Local Authority Policy and Resources Committee on an annual basis
- Performance reports would be provided by the Board to the Health Authority (frequency to be agreed) and to Salford Primary Care Trust – as the NHS is undergoing organisational change at present, the status, function and frequency of performance reports may be revisited in the near future.

Decision making

The Board will receive delegated powers from the Council and the Health Authority to make decisions on their joint behalf for the service area agreed at the setting up of the Partnership.
The numbers of representatives from each agency is being discussed, as is the level of representation required for the Board to be quorate.

Decisions shall be taken by a consensus. If there is no agreement, the decision shall be referred back to the Council and the Health Authority for a joint decision.

Appointments

The Council Cabinet shall appoint the Chair of the Board
Executive members of the Board shall be appointed by their respective agencies
Non-executive members shall be appointed by the agency they represent.
Work is being undertaken on appointment of people supported and carers to the Board.

Working Groups

The Board may establish working groups to support its integrated commissioning work. These groups will report regularly to the Board and may make recommendations to the Board.

Monitoring

The Board would receive regular reports on activity levels, finances, complaints, registration and inspection reports and internal or external

evaluations. The Board will be responsible for responding to this information as necessary.

Accounting and Auditing

The Board would receive the audited accounts of the services commissioned and would work within the requirements of local authority audit, ensuring the financial accounting was accurate and efficient and met the requirements of the respective contributing agencies.

Remit of Head of Service

The proposed remit of the Head of Service will be:

- Provide focus and leadership for the commissioning agenda, not just undertaking a planning function
- To provide high level commissioning expertise, reflected in a high status appointment
- To develop commissioning infrastructures
- To work across boundaries and political arenas
- To manage the pooled budget
- To develop and manage the joint community teams
- To oversee the implementation of the joint strategy and Joint Investment Plan
- To actively and effectively involve wider groups of stakeholders in the commissioning process

Managerially, line management would be within Community & Social Services. It is expected that the Head of Service would be supported politically and managerially by the Integrated Commissioning Board.

Meetings of the Board

The Board will meet at least every six weeks in its shadow phase, between October 2001 and March 2002, and at least once every two months from April 2002. Agendas for meetings will be split into items that are open to the public and items that are subject to a 'closed agenda'. Meetings will be widely publicised and mechanisms will be established to ensure effective representation from people supported and carers, including

- holding meetings in publicly accessible places
- giving notice of the date, time and venue of meetings at least six weeks in advance

Agenda

The agenda for the meeting and reports to the Board will be made available to Board members at least three working days prior to a meeting

Confidentiality

All Board members must accept the confidentiality of some items of business.

Code of Conduct

The Board will be bound by a code of conduct that will govern behaviour in meetings, confidentiality, partnership approaches to all aspects of the work of the Board and the declaration of any conflicts of interest.

Minutes of the Board

Minutes of the Board will be published within two weeks of a Board meeting to all members, the Chief Executive of the Council and the Chief Executive of the Health Authority.
Minutes will also be circulated to relevant local statutory, independent and voluntary sector bodies, including carer's groups, user groups and advocacy groups, as well as the library.

12. Review of the Partnership Arrangement

The partners have agreed that there will be a number of opportunities and reasons for review:

- annually, whether the partnership has performed as planned;
- annually, when the Joint Investment Programme covering the medium term is considered;
- strategic reviews, including the impact of the National Service Framework;
- responding to changes in best practice, including clinical governance issues;
- best value reviews or inspection recommendations
- difficult relations between the partners.

The partners propose that reviews will take place as both parties agree, or on the recommendation of the Board. The duration of the partnership will be for 3 years, with a planned formal review after year 2. The partnership could then be extended by agreement between the partners.

13. Human Resources

Human resource issues would be the responsibility of the lead agency (Community & Social Services) and would therefore operate under Local Authority terms and conditions. Where relevant, staff will be seconded from their existing employer. There are existing examples of mixed staff teams and in developing the partnership arrangements, consideration would be given to comparison of terms and conditions and human resource policies applicable across health and local authority employers and the learning from this will be used in developing staff teams for integrated commissioning.

Staff in provider services would remain on their existing terms and conditions.

14. Information Sharing

At present, there is a good working relationship between partner agencies and information is shared on a regular basis as needed, for example around joint contracting arrangements and around individuals, working within rules of confidentiality. There are also joint allocation panels operating effectively. Assessment and review documentation is also shared across agencies where relevant to inform the commissioning process.

The proposed partnership arrangements would enable the development of:

- shared protocols for information sharing, taking into account requirements around Caldicott and the Data Protection Act
- the development of a joint database of people supported by services or in need of support from services – the Adult Register would be operationalised and developed to support this process
- joint files held by the Joint Community Team when a joint base is established.

Work is being undertaken to develop joint information systems.

15. Identification of Functions Included

The functions to be included are:

- all non-specialist commissioning for adults with learning difficulties
- management of Joint Community Teams
- management of practitioners in Joint Community Teams
- management of Commissioning Support Team.

16. Eligibility and Assessment

An unconstituted document has been developed and is in operation informally across health and Social Services. This will be developed as part of the systems development to ensure a joint approach.
Recent work has been undertaken on the development of a joint assessment tool, focusing in inter-disciplinary assessment across agencies, to avoid duplication or gaps in assessment of need. This work will be developed in parallel (initially) and integrally (longer term) to the development of the Joint Community Team.

17. Complaints

Existing systems of complaints management within individual agencies will be developed by the cross locality team undertaking systems development, overseen by the Commissioning Project Team and consolidated into a single arrangements under the remit of the Integrated Commissioning Board. The proposed complaints system would take a 'best practice' approach in learning from existing operating systems.
Provider services would continue to operate their own systems, as required by contracting arrangements; reports would be provided to the Commissioning Team on a regular basis on receipt and resolution of complaints.

18. Finance

The partners are following the advice in the circular HSC2000/10 that charges for services remain outside the scope of the partnership. Contributions by the local authorities to the pool will be made in total, with receipts from charges accruing to the local authority centrally.

Advice on VAT issues has been sought by Trafford MBC on behalf of all partners. A response is awaited. Partnership arrangements will be designed to ensure that VAT matters are correctly treated.

We understand that the District Auditor is taking a close interest in the development of this partnership. The partners will ensure that these discussions continue and that auditors are satisfied that arrangements are both robust and offer value for money.

Work is being undertaken by the cross locality team on risk management arrangements.

19. Disputes / Exit Strategies

It is expected that most disputes between partners will be resolved within the Partnership Board, given that there will be wide representation across partner agencies. Where necessary, reference may be made to the Local Authority/Health Authority Chief Executives, or using arbitration through the NHS Executive (NW) and the Government's regional office (NW).

The period of notice to withdraw from the partnership shall be:

- a minimum of 7 months if notice given in the period April-August for withdrawal at 31 March the following year;
- a maximum of 18 months if notice is given after September, for withdrawal at the end of the following financial year

Final assessment of liabilities on winding-up of the partnership will be identified following the production of final accounts.

Partner agencies would only be able to seek dissolution of the Board and the partnership arrangements if there were clearly demonstrable benefits in doing so and an alternative arrangement that could be developed which would meet need more effectively.

20. Conclusion and Way Forward

The partners are satisfied that sufficient work has been undertaken to identify issues which may prohibit the development of the partnership and to resolve issues which may impede progress. Work is underway to develop the technical systems to support the proposed partnership arrangements (systems action plan can be found at Annex 1).

There is strong support and commitment across agencies, including elected members and non-executives, as well as from people supported and their carers, to develop integrated commissioning to enable more effective and flexible use of resources to meet identified need.

DRAFT TIMETABLE

AREA OF WORK	LEAD	TIMESCALE
Further system design work	Cross locality team, overseen by Commissioning Project Board	Sep 2001
Establish shadow Integrated Commissioning Boards	Commissioning Project Board	October 2001
Appoint Head of Service	Commissioning Project Board	September 2001
Appoint administrative support	Commissioning Project Board	July 2001
Registration under Section 31	Commissioner Project Board	July 2001
Training for Board members	Various	Mar 2002
Establish systems – to be shadow from October 2001, live from April 2002 (finance, contracting, governance, complaints, audit, monitoring)	Cross locality team, Commissioning Project Board	Mar 2002
Development of joint community teams	Head of Service	April 2002