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TOWARDS INTEGRATED COMMISSIONING OF SPECIALIST HEALTH CARE AND SOCIAL SUPPORT FOR PEOPLE WITH LEARNING DIFFICULTIES LIVING IN SALFORD AND TRAFFORD

Salford Community & Social Services
Salford & Trafford Health Authority
Trafford Social Services

DRAFT DISCUSSION PAPER

Prepared by M.C.Dunne, D.Thomas on behalf of
Salford & Trafford Commissioner Group
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1. INTRODUCTION

This paper represents a first but very important step in a move towards more integrated commissioning of specialist services for people with learning difficulties. It draws on discussions that have been held over the last six months between senior managers in Salford & Trafford Health Authority, Salford Community & Social Services and Trafford Social Services. These discussions include a facilitated 'time out' session held on 21 June 2000.

It also draws on the learning emerging from experience nationally where joint commissioning is well established (for example, Oxford, Lewisham / Southwark, Tameside and Leeds) or where more recent discussions have been held about organisational options to enable joint commissioning to progress (for example, Rochdale, Manchester, Halton, Liverpool and Nottingham).

This paper has been prepared to inform discussions in Salford and Trafford that are now being undertaken with other departments within the Local Authorities and with senior managers within the Primary Care Groups and emerging Primary Care Trusts.

In the first instance, it will be used to inform discussions about future commissioning at the meeting on 4 August 2000 between the Chair of Salford & Trafford Health Authority, the Chief Executives of Salford City Council, Trafford MBC, Salford & Trafford Health Authority, Leader of Salford City Council, Leader of Trafford MBC, the Director of Salford Community & Social Services and the Executive Director for Social Services and Well-Being from Trafford MBC.

The paper seeks to:

- Outline some major contextual considerations to be taken into account
- Make explicit the important principles that the partners to any agreement between the NHS and Local Authorities believe are essential or non-negotiable

- Highlight what it is expected that new partnership structures will achieve
- Explore various options and indicate emerging preferences
- Identify the timetable for establishing new integrated commissioning arrangements.

This paper is primarily about new commissioning arrangements but it does also make reference to issues regarding future provider management.

2. CONTEXT

The key points to highlight about the current context are as follows:

- There are strong pressures and expectations at a national level that the NHS and Local Authorities should work in close partnership
- There are several requirements for joint planning, such as Health Improvement Programmes, Community Care Plans and Joint Investment Plans
- The NHS Act 1999 offers new flexibilities in terms of
  - Lead agency commissioning
  - Lead agency management
  - Pooled budgetary arrangements
- The modernisation agenda of the NHS and Local Authorities, as well as the emergence of new Primary Care Trusts as commissioners of health care at a local level, bring imperatives for change in the commissioning, planning and delivery of services
- A national strategy for people with learning difficulties is expected in Autumn 2000; this will provide a framework for future development of specialist and generic health care and social support services.

At a local level, there are several important contextual issues to take account of:

- There is an agreed joint strategy for the future development of services to support people with learning difficulties and their families
- 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 Commissioner Group 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. This work is to inform the development of the Joint Investment Plan. Several issues are

emerging 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.

3. AIMS / OBJECTIVES

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 and Trafford that new organisational arrangements are needed within commissioning in order to:

- Ensure effective implementation of the agreed joint strategy, and the Joint Investment Plan which is presently being developed
- Lead major reconfiguration of NHS specialist services and Local Authority provider services
- Actively and positively develop and work in partnership with the independent sector, strengthening links between the statutory and independent sector
- Develop 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

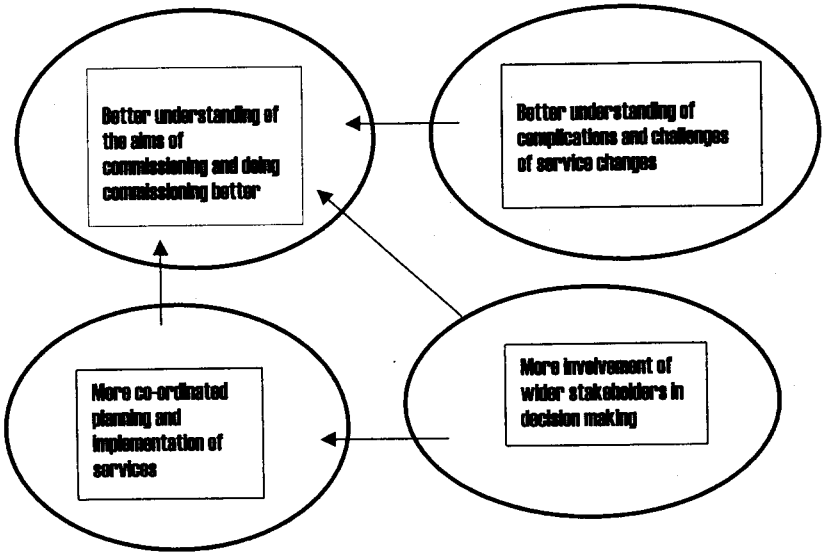
- Ensure 'Best Value' , in terms of efficiency and effective use of available resources.

BENEFITS OF INTEGRATED COMMISSIONING

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

The main benefits 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.

4. PRINCIPLES

The joint strategy 'Looking Forward to the Future: Joint Plan for Supporting People with Learning Difficulties in Salford and Trafford 2000-2005' highlights key principles that inform how future services should be planned, commissioned and provided. These are detailed below:

- 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' [1] – 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
- 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 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

[1] 'Looking Forward to the Future...', Consultation Document, April 2000, p.14.

- 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 the joint strategy 'Looking Forward to the Future'
- 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.

5. INTEGRATED COMMISSIONING

MODEL

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.

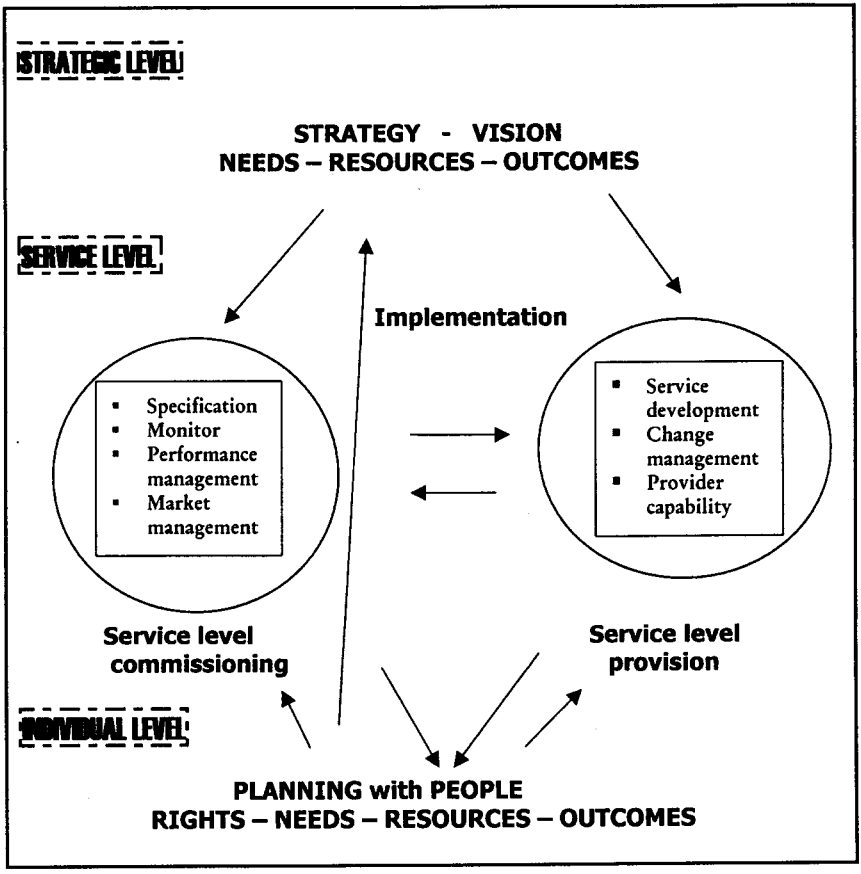
The decisions made at a strategic level will inform the configuration, organisation and delivery of services, but these decisions will fully involve service providers, commissioners at a service level, people supported by services and carers in partnership with commissioners. At a service level, vision 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.



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.

SCOPE

The remit and scope of integrated commissioning will initially be with young people and adults . The joint strategy identifies a goal of adulthood being seen to start earlier, at 16 years of age, thus lowering the age limit in some services for access by

young people with learning difficulties. 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 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).

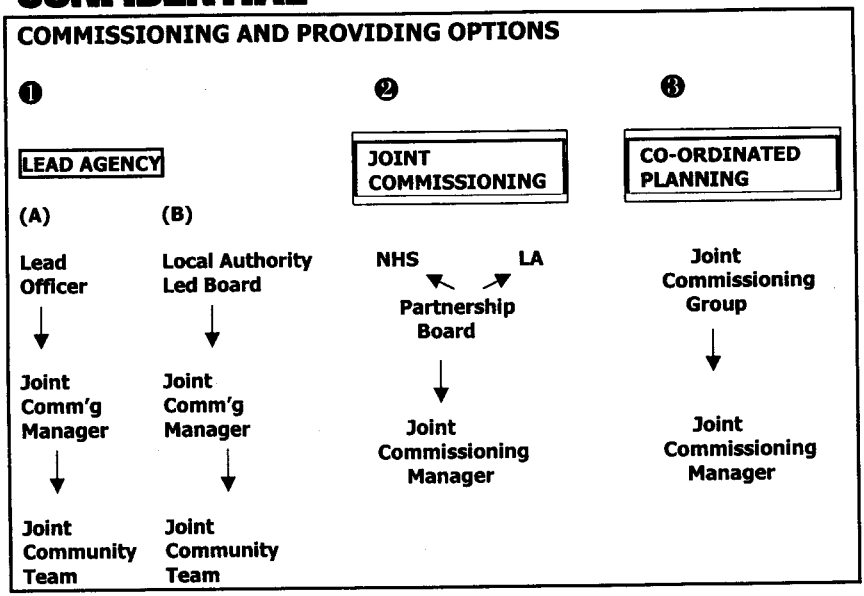
The model of integrated commissioning being developed will not commission secure services – this is undertaken by Sefton Health Authority on a regional basis. Generic health care will not be commissioned – this will be role of Primary Care Trusts. However, there will be strong links forged between commissioning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

6. ORGANISATIONAL OPTIONS

There are important issues to take into account when discussing organisational options. These are:

- There is enthusiasm and commitment to transfer leadership in commissioning for learning difficulties to both Salford and Trafford Local Authorities
- These proposed commissioning arrangements represent a new beginning with much improved commissioning capacity and status which will be delivered by
  - A high status Joint Commissioning Board
  - The appointment of a joint commissioning manager at a senior level to drive the new integrated commissioning agenda
  - A real commitment to creating teamwork, especially in service level commissioning and provision
  - Pooled budgets under Section 31 of the Health Act 1999.

The main commissioning and providing options are shown diagrammatically below.



The advantages and disadvantages of each option are set out below.

Option 1(a): Lead Officer within Lead Agency model

The advantages of this option are:
1. It would be clear who is directly responsible for commissioning
2. There would be clear lines of accountability for the commissioning process and arrangements.

The disadvantages of this option are:
1. This option places too much emphasis on a lead officer to resolve issues between many agencies
2. Joint ownership may be lessened
3. The lead officer may not be given sufficient power to effect change.

Option 1(b): Local Authority Led Board within Lead Agency model

The advantages of this option are:
1. It would be clear who is directly responsible for commissioning
2. There would be better opportunity for partnership working across statutory and non-statutory agencies
3. There would be increased confidence in commissioning decisions as a result of the involvement of key stakeholders

4. There would be increased confidence in the appropriate use of financial resources across agencies and financial transparency would be encouraged
5. This model would make the crucial link needed with the Local Authority modernisation agenda and democratic accountability.

The disadvantages of this option are:

1. There is a danger that health commissioners may not fully participate in the commissioning process if the Local Authority have the lead role
2. As this is a more innovative model, there is a danger that establishing the infrastructure would be a lengthy process which may delay developments.

Option 2: Partnership Board within Joint Commissioning model

The advantages of this option are:

1. There would be a strong partnership between the NHS and the Local Authority
2. There would be more opportunity for partnership working across statutory and non-statutory agencies
3. There would be increased confidence in commissioning decisions as a result of the involvement of key stakeholders.

The disadvantages of this option are:

1. There may be a perpetuation of the current divisions in commissioning and provision between the NHS and Social Services
2. There may be too much dominance given to the NHS and Social Services in decision making at the risk of excluding other commissioning partners
3. The separate lines of accountability may limit flexibility in decision making
4. There may not be a strong enough lead in commissioning, which may lead to the partners being deflected into other Local Authority or NHS commissioning priorities.

Option 3: Joint Commissioning Group within a Co-ordinated Planning Model

The advantages of this option are;

1. This would build on existing joint commissioning planning arrangements, structures and relationships.

The disadvantages of this option are:

1. This may lack a strong linkage to political processes in Local Authorities
2. These structures may have the tendency to become 'issue-based' rather than adopting a strategic approach

3. There may be a lack of accountability for the Joint Commissioning Manager, as well as potentially restricting the autonomy and influence of the manager to drive the commissioning agenda.

PREFERRED OPTION FOR LEARNING DIFFICULTIES

The preferred option future integrated commissioning of services for people with learning difficulties of commissioners as of June 2000 is that shown in option 1(b), a model within which there would be Local Authority lead agency commissioning with a Local Authority Led Board, comprising a wide range of partners. This option has been chosen for the following reasons:

- There would be a clear commissioning lead, in line with national policy and agreed local direction
- This model would ensure there is a high status for learning difficulties in Local Authorities, politically and managerially
- This model will enable stronger links to be forged across education, leisure, housing, community regeneration and wider community and economic development.

7. TOWARDS NEW COMMISSIONING

The preferred option for both Salford and Trafford, as set out above, is that of Lead Agency Commissioning.

Composition of Joint Commissioning Board

It is proposed that the Joint Commissioning Boards in both Salford and Trafford 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

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

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Remit of Joint Commissioning Board

It is proposed that the remit of the Joint 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
- Manage the work of the Joint Commissioning Manager and her/his team through 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' and clinical governance requirements
- Ensure continuous improvement and development in services.

Leadership and Accountability

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

The Joint Commissioning Boards in Salford and Trafford 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. It would also mean that the Joint Commissioning Manager would be accountable to the Chair of the Joint Commissioning Board.

Remit of Joint Commissioning Manager

The proposed remit of the Joint Commissioning Manager 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 manage 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

It is expected that the Joint Commissioning Manager would be supported politically and managerially by the Joint Commissioning Board.

Immediate Effects of Integrated Commissioning

It is important to note the immediate effects of any new integrated commissioning arrangements would be within and across agencies. These include:

- The changes brought about by the appointment of a Joint Commissioning Manager at senior level within Local Authorities
- The need for short-term infrastructure and work on organisational options for homes currently managed by Salford Community NHS Trust and the link with project work underway on future NHS specialist services
- The implications of the new commissioning arrangements for the contracting, commissioning and finance structures within Local Authorities
- There is an expectation that applications for pooled budget status in both Salford and Trafford under Section 31 of the Health Act 1999 would go forward in Autumn 2000 (awaiting confirmation of application timetables from NHSE North West Regional Office), to go live in April 2001.

8. NEXT NEW STEPS

DRAFT TIMETABLE

AREA OF WORK	LEAD	TIMESCALE	FUNDING
Further design work	Comm Group	Sep 2000	Balance to SASP
Wider stakeholder discussions on integrated commissioning proposals	Comm Group	Sep 2000	Balance to SASP
JIP development	MC Dunne	Oct 2000	Balance to SASP
Develop Joint Commissioning Boards	Comm Group (with consultancy support)	Dec 2000	?
Appoint Joint Commissioning Managers	Comm Group (with consultancy support)	Oct 2000	To be identified
Appoint admin support	Comm Group	Oct 2000	To be identified
Application for Section 31 pooled budget	Comm Group (with consultancy support)	To be confirmed – to go live in April 2001	To be identified
Training for Board members	Various	Mar 2001	To be identified
Establish information systems	Various	Mar 2001	?
Develop governance, monitoring, audit arrangements	Joint Commissioning Boards	Mar 2001	?
Development of joint community teams	Joint Commissioning Manager	April 2001	To be identified
Implement changes to Financial / contracting processes in LAs	LA	Mar 2001	?

ANNEX 1

AREAS TO BE CONSIDERED FOR REGISTRATION UNDER SECTION 31 PARTNERSHIP ARRANGEMENTS HEALTH ACT 1999 (NHSE)

- Which flexibilities are being used (consider scope of pooled budget being applied for, what services to be included, age criteria for services)?
- Intended aims, outcomes and targets set by the partnership
- Health gain expected from the partnership, as defined by the Health Improvement Programme (e.g. enhanced capabilities for individuals, improved quality of life, reducing health inequalities, equality of access to services)
- Who has been consulted and how this has been done
- How the Local Authority functions are going to contribute to a health outcome through this partnership
- How this partnership promotes existing partnership arrangements
- Who the service users will be (e.g. age range, client group, PCG,LA area)
- How much financial resource is to be committed to the partnership by each partner
- Details required on robust arrangements (to satisfaction of all signatories) on following:
  - Governance arrangements
  - Monitoring
  - Accounting and auditing
  - Operational and management arrangements
  - Human resources (staff, terms & conditions, policies)
  - Information sharing
  - Eligibility criteria and assessment processes
  - Complaints
  - Financial issues
  - How disputes would be resolved
  - What exit strategies are planned