APPENDIX 2

SECTION 31

PARTNERSHIP AGREEMENT

Between

HALTON BOROUGH COUNCIL,

ST HELENS COUNCIL

and

HALTON AND ST HELENS PRIMARY CARE TRUST

March 2008

SECTION 31 PARTNERSHIP ARRANGEMENT

1. NAMES OF STATUTORY PARTNERS

Sue Lightup
Director of Adult Social Care and Health
St Helens Council

Eugene Lavan
Acting Director of Strategic Commissioning
Halton and St Helens Primary Care Trust

Dwayne Johnson
Strategic Director, Health & Community
Halton Borough Council

2. DATE OF AGREEMENT

XX 2008

3. DATE WHEN PARTNERSHIP IS INTENDED TO START

XX 2008

4. TITLE OF OFFICER RESPONSIBLE FOR THE PARTNERSHIP

Director of Adult Social Care and Health
St Helens Council

Director of Strategic Commissioning
Halton and St Helens PCT

Strategic Director, Health & Community
Halton Borough Council

5. CONTACT NAME

Robert Vickers – St Helens Council
Dave Sweeney - Halton and St Helens PCT
Paul McWade – Halton Borough Council

6. CONTACT TELEPHONE NUMBER

01744 456311 (St Helens Council)
01928 593600 (Halton and St Helens PCT)
0151 471 7437 (Halton Borough Council)

7. WHICH FLEXIBILITIES ARE BEING USED

- Lead Commissioning (LC)

8. WHICH CARE GROUP OR CATEGORY DOES THE PARTNERSHIP SERVE

Out of hospital/Community Services for the following group of individuals:

- Adult Mental Health (Adults of Working Age)
- Substance Misuse (Drugs and Alcohol) – All ages
- Adult Learning Disabilities – 18 years plus
- Older People – 65+ but covering some 55+ years
- Carers – all ages
- Physical and Sensory Disability – 18 years plus, including HIV/AIDS

COMMISSIONING AGREEMENT

1. INTRODUCTION

1.1. This Agreement is set within the context of the philosophy underpinning the modernisation of public services (not by any means exclusively in health and social care) and the radical developmental agenda in Adult Community Services.

1.2. "Our health, Our Care, Our Say" has outlined a new governmental vision and direction for community services based on the longer term aim of securing a 'sustained realignment' of the entire health and social care system.

In essence, the Government's vision is that.

"Far more services will be delivered – safely and effectively – in settings closer to home; people will have real choices in both primary care and social care; and services will be integrated and built around the needs of individuals and not service providers."

1.3. The same whole systems approach is being applied using the 7 adult social care outcomes, objective setting and performance management. This approach supports a greater local focus on health and well-being. The seven outcomes on adult social care detailed by the Department of Health (DH) in "Independence, Well-being and Choice" are:

- Improved health and emotional well-being.
- Improved quality of life.
- Making a positive contribution.
- Choice and Control.
- Freedom from discrimination.
- Economic well-being.
- Personal Dignity.

These seven domains set the Our Health, Our Care, Our Say outcomes firmly within the context of social inclusion, sustainable communities and citizenship pursued by Local Government and the Department for Communities and Local Government (DCLG). In other words, they are broader than, but also embrace, the more traditional understanding of health and well-being commonly set out by the National Health Services (NHS) and Department of Health (DH).

The aim is to have improved outcomes by:

- Better prevention with earlier intervention
- More choice with a stronger voice
- Tackling inequalities and improving access to Community Services
- More support for people with long term needs.

1.4. This means a sustained realignment of health and social care involved a range of interlocking and interdependent agendas potentially involving the entire NHS and Local Government. It implies fundamental shifts in relationships, responsibilities and resources within, and between services, These can include:

- The NHS: from secondary to primary/community services and prevention with increasing engagement at primary care localities and practice based commissioning.

- Public Health: from NHS Leadership to community co-leadership, reducing the gap in health inequalities and improving well-being.

- Social Care: from residential to home care, reablement and prevention, promoting independence for all sectors of the vulnerable adult population

- Health and Social Care: from health care pathways to health and social care pathways, especially for long term conditions with increasing emphasis on self management, choice and personalisation.

- Local Government: from social care to universal services, social inclusion and community engagement.

- Local Governance: from patients and clients to partners and citizens; and from individual targets to partnerships for well-being.

- Commissioning processes: from separate services to outcomes focussed around individual and community well-being, linking strategic commissioning with micro commissioning.

- Power: from professionals and services to individuals and communities.

1.5. This Agreement recognises the Statutory Health and Social Care agencies responsible for ensuring a common thread throughout the modernisation process which acknowledges the importance of jointness across professional, managerial and organisational systems. This can significantly influence the style, effectiveness and responsiveness of the delivery of a 'whole system' service response to vulnerable individuals with complex needs.

2. AGREEMENT OBJECTIVES/AIMS

2.1. Commissioning is not a new activity for the NHS and Local Government. The Inter-Agency Group on Adult Social Care (IAG) have commissioned "Working together for well-being – from vision to reality", a paper as part of a longer term programme of work on adult social care and community well-being. Within this, whilst differences in language and approach can be illustrated, the descriptions of commissioning resonate for both social care and NHS.

2.2. The Commission for Social Care Inspections (CSCI) has recently described Strategic Commissioning as being:

"at the heart of effective and efficient service development. It happens when Council's use all the knowledge and local intelligence available to them to "

- Build up a comprehensive picture of need and of the cost and quality of available resources; and then to:
- Help to develop the local care market to ensure services are there to meet needs".

2.3. David Behan, the former Chief Inspector of CSCI and the new Director General of DH for Social Care added a description of the process linking the needs identification and market management in his definition of commissioning as:

"The process of translating aspirations and need into timely and quality services for people which meet their care needs; promote their independence; provide choice; are cost effective, and support the whole community."

The process is about transforming and changing lives, it is not about Commissioning commodities.

2.4. Recent NHS guidance on commissioning and a commitment to Work Class Commissioning has given much attention to working with a greater plurality of providers in contestable markets. This focus Is legitimate given that most of the previous experience of commissioning in the NHS, unlike local government, has been within an internal market' and through a process based on Service Level Agreements (SLA's) in which service specifications were limited and agreements were not legally enforceable (with the exception of foundation hospitals).

2.5. The NHS Guidance describes effective commissioning as being "about the care that adds maximum value for patients in a system that promotes fairness, inclusion and respect from all Sections of Society…… Good Commissioners seek to reinforce a virtuous circle of service redesign around the patient.

2.6. The guidance also distinguishes 10 elements within a "Commissioning Cycle for health services."

The elements of the cycle are:-

- Assessing needs - this will be further strengthened by the work underway on a Joint Strategic Needs Assessment and the Adult Plan.

- Reviewing provision - this has covered to date some extensive mapping of existing services.

- Deciding priorities - using the needs assessments, Strategic objective, the gaps analysis, the National Standards and feedback from consultations.

- Designing services - based on models of best practice, disinvesting in services no longer for the purpose and redesigning new services.

- Developing the PCT prospectus - establishing the market from which services are currently supplied and determining how they may need to be altered in the future.

- Shaping the structure of supply - working with providers to develop new Services.

- Managing demand and ensuring appropriate access to care – working to develop single points of access, user/carer expertise and better access for hard to reach groups.
- Clinical decision-making - based on effective whole system pathways led by effective clinical leadership.

- Managing performance - with joint data collection, including the local agreement performance indicators and benefiting from joint analysis

- Patient and public feedback - through the extensive network of patient and user forums, PPIF's and LINKS

2.7. The above illustrates that a whole systems commissioning framework is a pre-requisite for improved health and well-being outcomes. The breadth of the Our Health, Our Care, Our Say Agenda also supports such an approach. This Agreement seeks to harness and focus all the relevant commissioning activities and align systems of outcomes and performance management to deliver effective commissioning locally.

2.8. The national policy context framework remains sensitive to a range of local factors, including demography, the social economic profile, resource base, quality of partnerships, leadership, local structures and priorities. The synergy between the national and local positions and experience to-date is reflective of this Commissioning Agreement.

2.9. The key objectives/aims of this Agreement are:

- **National Standards** – as a baseline for continuous improvement. These are identified in professional, organisational or service specific terms and increasingly subject to inspection and audit. Governance, audit and protocols as well as external regulations therefore underpin practice.

- **Devolving responsibilities and accountability** – to the front-line of service within a national framework and with an increased emphasis on local involvement, engagement and mutuality. This is best evidenced in individual and community empowerment, allied to devolved decision making and increasingly will be through integrated professional teams commissioning individual service arrangements.

- **Increased flexibility** – in the delivery of services with great emphasis on it being locally accessible, provided in a range of settings and able to respond 24/7. Role design through developing a balanced workforce, including generic workers able to operate across professional and organisational boundaries, emphasises this approach. There are no fixed organisational assumptions, with plurality and contestability shaping the future.

- **Choice** – through the commitment to develop the kinds of services that people actually want and redesigning services around the stated wishes of those who use them and their carers. Developing a range of provision that reflects individual, community and wider population sensitivity is the challenge incorporated through the delivery mechanisms for joint commissioning and allied practice based commissioning and individualised or personalised budgets.

- **A holistic approach** – that requires partnership working not only to address ill health, but also to address the underlying influences on people's well-being such as housing, employment, education and training. This is reflected increasingly in whole systems language, systematic solutions and integrated approaches.

3 NATIONAL POLICY OBJECTIVES

3.1. The above can be best achieved by working together to improve people's experience using the key seven outcomes set out in Our Health, Our Care and Our Say.

Improved health and emotional well-being

- Improved access to the building block of primary health care promoting responses that reflect enablement, independence and well-being. Developing preventative responses.

- Maximising the management of chronic illness and disease in community through increasing capacity, capability and integrated working thus preventing hospital admissions.

- The ability to deliver new models of community focused responses.

- Increased emphasis upon promotion and prevention.

- Clear pathways between primary and community and specialist/tertiary services.

Improved Quality of Life

- Improving quality through governance, risk assessment and management in a consistent manner, delivered through a competent well-trained workforce.

- Contestability to ensure standards of excellence in performance are assured and available on a comprehensive basis to all.

- Able to recruit and retain high quality staff

- Competency at a leadership and management level with strong understanding of mental health, learning disabilities and substance misuse.

- Strong governance in the quality of service.

Making a positive contribution

- Increased accountability to the local population through transparent approaches.

- Devolved responsibility to enable change and adaptation in service delivery in order to respond to local views.

- A sensitivity to the needs of differing communities through diversity in provision and a willingness to listen and adapt what and how services are provided.

- Able to reflect and deliver local requirements to meet service needs with clarity in local accountability.

- Improved relationships between primary, community and specialist services.

• Increase in the attention given by primary care to mental health, learning disabilities and substance misuse.

Choice and Control

- An increased engagement with service users and carers reflected in their greater influence.

- Ensuring a greater focus on localisation in delivery and accountability accompanied by empowerment of service users and professionals.

- Procurement of service provider to meet needs promoting personal control and choice in design.

- Greater development of personalisation where possible

- Strong opportunities for service users and carers to be involved in decision making and service evaluation.

• Promotion of service innovation and initiative

Freedom from Discrimination

- A need to address social exclusion and health inequalities within and between different communities and localities through positive action.

- Ensuring that disability, physical and mental ill health and well-being, together with the regeneration of individuals are addressed holistically at a primary and social care level.

• Access to high quality training and development for staff.

Economic Well-being

- Effective partnership working based on a knowledge of the whole system and the inter-dependencies of the different elements.

- Achieving value for money and cost effectiveness.

- Confidence that money invested in St Helens is spent in St Helens and in Halton is spent in Halton.

- Promoting and extending opportunities for the maximisation of benefits.

• Fair and proportionate allocation of resources to mental health, learning disabilities and substance misuse.

Personal Dignity

- Increased functionality through integrated teams of selected professionals offering a wide range of responses and speedier access to a whole system of skills.

- Emphasising active prevention through integrated approaches focusing upon high risk groups.

- Integration of health and social care at the point of use.

• Far more services delivered in settings closer to home or at home that are build round the needs of individuals not service providers.

Additionally the Agreement will strive to assure the following highly desirable benefits.

5 GOVERNANCE AND ACCOUNTABILITY

5.1 Each Partner retains Statutory responsibility for their functions carried out under the Commissioning Agreement. The vehicle for the delivery of such functions will be the LA ASC&H Commissioning Division for Older People, Learning Disabilities, Physical and Sensory Disabilities, Drugs and Alcohol and HIV aids. For the PCT the Partnership Commissioning Team within the Directorate of Strategic Commissioning will be responsible for Mental Health.

5.2 The lead arrangements for each partnership commissioning area are as follows:

Commissioning Area	**Lead Organisation**
Mental Health	Halton and St Helens PCT
Older People (inc Intermediate Care)	Local Authority
Alcohol and Substance Misuse*	Local Authority
Adult Learning Disability	Local Authority
Physical Disability	Local Authority
*The PCT will develop a joint PCT/LA role to support the commissioning of health outcomes for alcohol services.	

5.3 The arrangements reflect the outcomes of the review led by the PCT "Understanding Adult Partnerships" and the recommendations flowing from this. It will reinforce the positives allied to Mental Health and Substance Misuse and Older People and seek to bring new impetus and energy in relation to Adults with Learning Disability Commissioning and Physical and Sensory Disability. It will deliver the outcomes sought in "Our Health, Our Care, Our Say and the DH Commissioning Framework for Health and Wellbeing.

5.4 Historically Halton and St. Helens Council have hosted the three Lead officer posts for the service areas constituted within the previous Joint Commissioning Unit. Both the PCT and the LA will continue to fund Commissioning Manager posts to reflect the commitment of the statutory partner organisations to the commissioning of all service areas.

5.5 Identifying clear organisational Leads within the Commissioning arrangements in the Local Authority and the PCT should afford openness and transparency, whilst

retaining a shared ownership and responsibility for the respective service commissioning agendas. In effect the Leads will ensure that both the Local Authority and NHS business and performance requirements are discharged leading to effective and efficient outcomes and delivery

5.6 The rationale for this position is that the Modernisation of Mental Health Services and the National Health Service Plan establishes clear leadership and performance within Health/Primary Care Trust, working in collaboration and partnership with Local Authorities and other stakeholders through the **Mental Health Partnership Board/LIT**. Whilst importantly the Local Authority remains a key leader in relation to well-being and Community Mental Health Services, the greatest investment remains with the PCT through primary and secondary mental health services. Efforts to include Mental Well-being approaches with other key partners continues.

5.7 The opposite is the case in relation to Learning Disability Services. The Valuing People policy perspective clearly establishes lead responsibility with Local Authorities. Local Authorities remain the accountable body and leader of the **Local Valuing People Partnership Boards** and the major commissioners, purchasers and providers of services to Learning Disabled people and their parents and carers. This is, as with mental health not to minimise the importance of collaboration and partnership.

5.8 The **Partnership Boards for Older People** has been in place since the National Service Framework for Older People was introduced. It has a strong local voice through the membership of St Helens Senior Voice and Halton Open. As well as the NSF for Older People, the Boards seek to improve the Commissioning Strategy for OP and OP with Mental Health Problems. A national dementia strategy is expected in 2008.

5.9 The National Drugs Strategy, together with the National Alcohol Harm Reduction Policy perspective reinforces a coherent approach across Children and Young People, Crime and Disorder, Safer Communities and Treatment Services. Within St Helens and Halton the co-ordination of this agenda is through the **Crime and Disorder Reduction Partnership**, supported by a number of thematic groups. Again the Local Authority is the focus for co-ordinating the substance misuse agenda and assuring performance. It is, therefore, appropriate for the Local Authority to Lead Commissioning in relation to drugs and alcohol, whilst recognising the significant part played by treatment in underpinning the other three inter-related thematic strands of the policy agenda.

5.10 Day-to-day accountabilities for staff located within the Commissioning Division will reflect the Lead Organisational positions. The form that such accountability will take, will reflect lead roles, placing Mental Health Commissioning Manager to the Operational Director (Mental Health, Learning Disabilities and Substance Misuse) Halton and St Helens PCT and Commissioning Managers, Learning Disabilities, Substance Misuse and Older People and PSD to the appropriate Assistant / Operational Directors in the 2 Councils.

5.11 Such accountabilities will be cognisant of the employment status of postholders and policies and procedures applicable to the employing organisation. However the accountable line manager will ensure business planning and performance management to enable efficient and effective use of resources. In essence the CM's will be responsible for demonstrating continuous improvements for the service areas contained within the Commissioning Division.

5.12 A clear expectation exists that Commissioning Unit Staff will receive regular supervision (One to One's and that monthly Team Meetings involving LA Assistant Director and PCT Operational Director will take place to drive and assure communication, co-ordination and service commissioning Agenda's.

5.13 Reporting will be both internal to the partner organisations, across the partner organisations and to the established planning, forums for each service areas. Reporting is summarised as:

- LA ASCH and PCT Senior Management Team Meetings.
- Joint Exchange Meeting Halton and St Helens PCT and St Helens Council.
- St Helens and Halton Mental Health Partnership Boards.
- St Helens and Halton PSD Partnership Boards.
- St Helens and Halton Valuing People Partnership Boards.
- St Helens Drugs and Alcohol Strategy Commissioning Group.
- Halton's Drugs and Alcohol Strategy Commissioning Group.
- St Helens and Halton Older People Partnership Boards.

5.14 It is envisaged that the Commissioners will proactively review current investments to assure value for money and the efficient and effective deployment of resources and identify service gaps and priorities to enable future financial profiling and investment planning. This can be done jointly where both organisations commission or contract for the same or similar services.

5.15 It is not intended to develop pooled budgets, although transparency of expenditure and investments will be established. As such the financial regulations and Standing Orders will apply to each organisation. Commissioning Managers will be budget holders and institute appropriate budget monitoring procedures, applicable to the respective organisations to assure efficient and effective utilisation of resources. Such procedures will be compliant and sustainable to enable appropriate auditing.

5.16 Equally the Commissioning Service Leads will institute procedures to capture data and enable Local Authority and PCT Performance targets and measures to be assured and achieved within established timelines.

5.17 The Commissioning Agreement recognises the diversity and plurality of provision within all three areas and the importance of market management to maximise resource deployments and outcomes for service users and carers. As such the Commissioning Unit will work collaboratively with Procurement and Contractual colleagues to ensure that where appropriate joint approaches are established. This will include best practice, lessons from VFM reviews in Supporting People Programme, Regional Learning Disability High Cost Care Packages Initiative, Mental Health Out of Area Placement Scoping and cross fertilisation work to achieve sound procurement principles and standards.

5.18 Both organisations remain committed to continuous service improvement through robust performance management. The Commissioning leads will seek to lever in

opportunities for additional support through improvement agencies such as CSIP, IdeA, NWIN etc in order to drive improvement on.

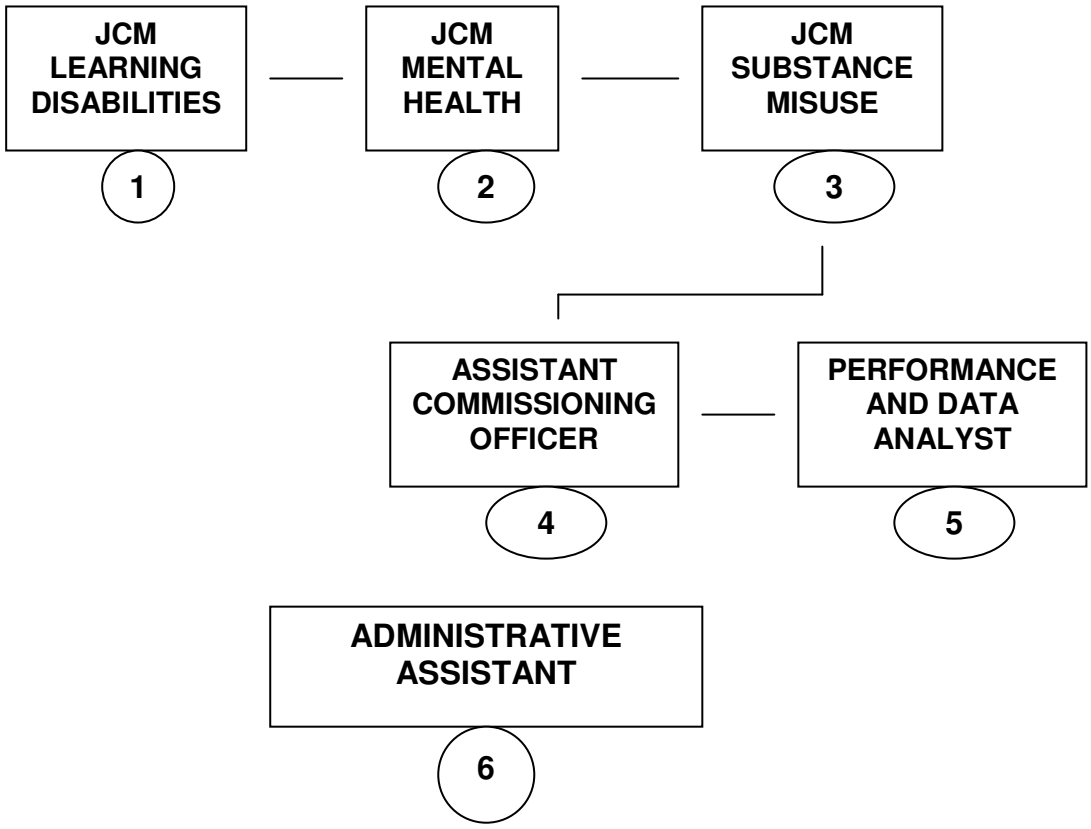
6. DURATION, REVIEW AND TERMINATION

6.1. This Agreement will continue for a 3 year period until terminated in accordance with this Agreement.

6.2. Any of the Partners may terminate this Agreement by giving at least six months prior written notice to the other expiring at the end of the relevant Financial Year or such other date as mutually agreed by the Partners.

7. STAFF AND ACCOMMODATION RELATING TO THE COMMISSIONING AGREEMENT.

7.1. The Lead Commissioning arrangements will contain the following posts.



- **Posts 1, 2, 3,** are currently established by St Helens Council.
- **Post 4, 6** are established by Halton and St Helens PCT.
- **Post 5** is established by Halton and St Helens PCT and funded from the Pooled Treatment Budget. This is the only post not funded by LA/PCT base budgets.

7.2. With the reconfiguration of PCT functions and locations, the current Manager locations may require review.

7.3. The arrangements for Lead Commissioning roles and responsibilities, their Job Descriptions/Person Specifications are referenced within Appendix 3 to this Agreement.

8. RESOURCES

8.1 The financial commitments of the constituent agencies are set out below for financial year 2008/09. **(they aren't included)**

9. COMPLAINTS

9.1 Complaints and compliments relating to services commissioned by Halton and St Helens Council and Halton and St Helens PCT will be dealt with in accordance with the Joint Protocol for the handling of complaints and compliments.

10. DISPUTES

10.1 The Partners will act together in good faith to resolve any disputes, which may arise under this Agreement. If after the usual escalation through the organisations the parties are unable to resolve a dispute an arbitrator shall be nominated who will either adjudicate on the point at issue or will direct the parties as to the method of dispute resolution.

11. RISK MANAGEMENT

11.1 Each of the Partners shall assume responsibility for their own liability for all claims within their own sphere of influence and arising from this Agreement, including clinical negligence, Professional indemnity and Employers and Public Liability however arising. This assumption of liability also applies to existing contracts operated by the Partners and any liability arising therefrom. The Partners hereby each individually indemnify each other from any liability arising from this Agreement. Neither Partner will accept claims from the other Partner which relates to the period prior to the commencement of this Agreement.

12. DATA PROTECTION

12.1 The Partners acknowledge their respective obligations under the Freedom of Information Act 2000 and the Environment Information Regulations 2000, Calidcott Guidance and the Data Protection Act.

12.2 The Partners agree that each will facilitate the performance by the other of their obligations under the Act, the Regulations and under any other legislation that requires disclosure of information.

12.3 The Partners will have an established and agreed information sharing protocol.

12.4 The Partners will abide by relevant joint protocols for the sharing of data that are agreed by their constitutional organisations according to the most recent agreement.

13. REFERENCES

Integrated Care Network – Advisory Note Designing agreements for Health Act Flexibilities (2003)
Audit Commissioners – Governing Partnerships (2005)
DH – The Commissioning Framework for Health and Wellbeing (2007)

DH – Making Partnerships Work: Examples of Good Practice (2007)

SIGNED BY:

Eugene Lavan
Acting Director of Strategic Commissioning
Halton and St Helens PCT

SIGNATURE: …….. DATE: ……..

Sue Lightup
Director of Adult Social Care and Health
St Helens Council

SIGNATURE: …….. DATE: ……..

Dwayne Johnson
Strategic Director, Health & Community
Halton Borough Council

SIGNATURE: …….. DATE: ……..

Halton Strategic PARTNERSHIP

The Virtual Organisation